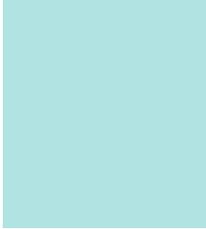




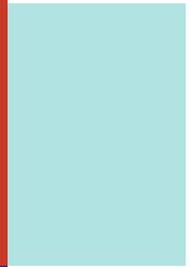
Respect



Utah State Health Assessment 2016

Effective

Service



Evidence-based



Trustworthy



Integrity



Innovation



Transparency

Collaboration

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This report is also available on the Internet at <https://ibis.health.utah.gov/pdf/oph/publication/SHAReport2016.pdf>

We invite anyone to provide feedback on this report. Please do so through email (chdata@utah.gov) or by filling out an online form: <https://goo.gl/forms/TfnU85nvbA5wtvJ3>

This State Health Assessment version 1 is being presented to the public for review and opportunity for comment. Once comments have been reviewed and incorporated version 2 will be posted.

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DEPARTMENTS

August 1, 2016

We are pleased to present this Utah State Health Assessment report. This report is the product of a multi-agency, collaborative process which gathered feedback from communities and assessed health data to identify areas of greatest need. These areas will be considered as priorities for the Utah Health Improvement Plan.

A thorough assessment is needed on a regular basis to determine where resources and collaborative efforts should be focused to improve the health of Utah residents. After a careful review of more than 100 data indicators, information from 27 community input meetings, 16 agency or program specific needs assessments, and a public health system needs and strengths analysis, seven health issues and three system issues were identified as areas of high need in the state. These high need areas are identified in the executive summary and the report.

We wish to thank everyone around the state who participated or gave input, and all of the agency representatives who contributed to this process. We recognize that complex public health issues take a focused and collective effort to effect change. We are fortunate to have strong and dedicated partners working together to improve the health of all Utahns.

We welcome feedback on the report, the State Health Assessment process that was used, and the results. Feedback may be submitted to chdata@utah.gov.


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Utah Department of Health
Utah Health Improvement Plan
Executive Committee Co-Chair

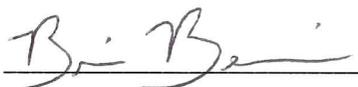

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(see page 7 for description of groups)

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Tom Hudachko	UDOH Public Information and Marketing	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.

Photos on front cover courtesy of Utah Travel Council.

This report provides information on the Utah State Health Assessment process and results. The Utah State Health Assessment is a comprehensive evaluation of population health and the collaborative public health system needs and strengths. The purpose of this report is to inform interested members of the public what process was used to gather feedback from community members, evaluate data on health issues, review other reports, and prioritize concerns. The results of the process are also presented.

It is important to regularly conduct a statewide needs assessment to inform the public health system what health issues need resources and collaborative intervention or prevention efforts. The Association of State and Territorial Health Officials State Health Assessment Guidance and Resources was utilized as the model for the process. Several collaborative groups were utilized or newly formed to facilitate these efforts. Data on more than 100 health indicators, broken out, where possible, by geography, age, sex, race, ethnicity, income, and education as well as trends over time were reviewed. Twenty-seven community input meetings were held around the state to gather views on the health issues of greatest need and disparity for a particular area. Other needs assessments conducted by community or health agencies were reviewed. A prioritization methodology was decided upon and applied to the data and information gathered. The top 30 priorities were then taken to a broader Utah Health Improvement Plan Coalition that consists of state and local health agencies, Tribes, partner agencies, and health systems for further review and prioritization. The Coalition also assisted in the public health system strengths, weaknesses, opportunities, and threats analysis. The result was a reduced list of seven primary health issues and three health system issues to consider for action as part of the Utah State Health Improvement Plan. Healthcare access was a main area of concern in both the health issues prioritization and the strengths, weaknesses, opportunities, and threats discussion.

The health issues prioritized for consideration for the Utah Health Improvement Plan include:

- Diabetes/pre-diabetes
- Obesity/physical activity
- Mental health/suicide
- Prescription drug misuse/overdose deaths
- Healthcare access
- Air quality
- Immunizations

The results of the strengths, weaknesses, opportunities, and threats discussion suggest the following areas of the health system may need attention:

- Funding
- Mental/physical health integration
- Improved access to care in rural areas

Further data on these areas of concern are included in this report. These issues have been provided to the Utah Health Improvement Plan Executive Committee for consideration as priorities in the updates to the Utah Health Improvement Plan. Work on the Utah Health Improvement Plan will be a collaborative effort across multiple agencies and communities. As has been noted in the literature, improvement in population health for these complex health issues takes a united effort.

Collaboration

Respect

Effective

State Health Assessment Process

Service

2016

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

State Health Assessment Process Overview

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

Purpose

The last comprehensive state assessment was completed in 2012. Although several assessments and reports have been conducted by the UDOH since then, they have not been as comprehensive with the purpose of assessing the highest priority needs of the state. The Utah State Health Assessment was conducted for multiple reasons. In late 2014, Intermountain Healthcare approached the UDOH and the local health departments 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 committee resulted in a decision that it was time to complete a new Utah State Health Assessment to reassess the highest priority needs and update accordingly. Thus the Utah State Health Assessment purpose is to update the old assessment, foster collaboration, and inform the State Health Improvement Plan update.

Note that up to now we have referred to the State Health Improvement Plan as the SHIP, however in this update process it was decided to rename it 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 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 state health assessment is assessing 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 state health assessment 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: State Public Health System



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/nphsp/essentialservices.html>.

The public health system in Utah is decentralized. It consists of the state Utah Department of Health and 13 local health departments. The UDOH along with the local health departments work to detect and prevent outbreaks of infectious disease, promote healthy lifestyles and safe behaviors, protect citizens from man-made and natural disasters, and provide access to healthcare services for Utah's most vulnerable populations.¹

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
- 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

Local health departments (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.

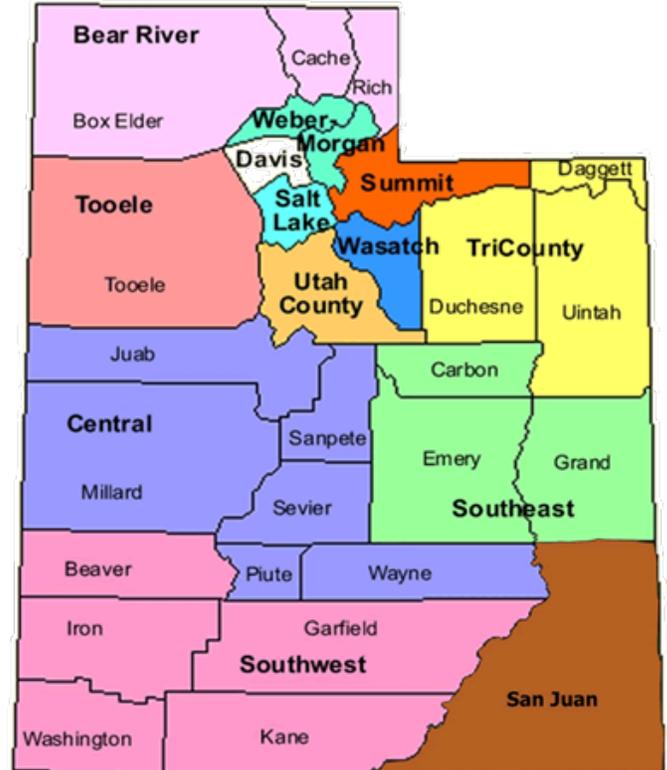
Local health departments are often the front line for reporting communicable diseases and other events, such as signs and symptoms of exposure to biologic agents of terrorism. The Utah Notification and Information System (UNIS), Utah's health alert network, consists of a network of local, state, and 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. 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

Map: Local Health Districts



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 the LHDs on issues related to air and water quality and contaminants. The Division of Substance Abuse and Mental Health 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.

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

State Health Assessment Process

The state health assessment process was a collaborative process with community and stakeholder involvement. The Association of State Territorial Health Officials State Health Assessment Guidance and Resources was used as a model for the State Health Assessment and State Health Improvement Plan update processes. We also utilized the graphic provided by County Health Rankings to demonstrate the State Health Assessment and State Health Improvement Plan process.²

Figure: State Health Assessment and Improvement Plan Process



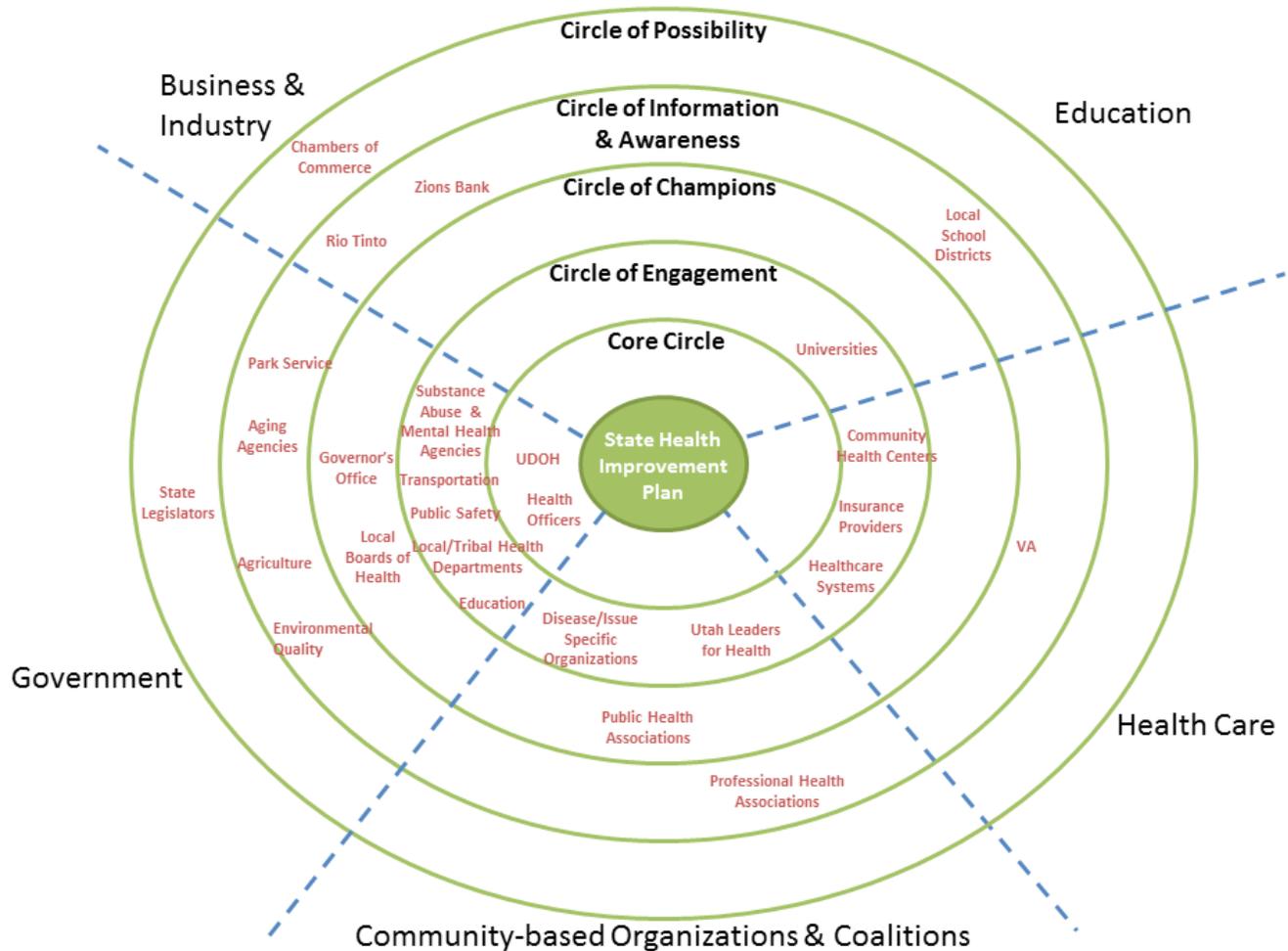
1 Association for Utah Community Health—Overview. Accessed online 5/18/16 at <http://www.auch.org/about-auch/overview>.

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

Collaboration

The previous State Health Improvement Plan 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: Utah Health Improvement Plan Stakeholder Asset Map



Core Circle:

The Core Circle of participants are those that plan and facilitate the implementation of the State Health Improvement Plan. They also coordinate the participation of people 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 people 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 people who may or may not have been involved in the development of the plan. It also includes people 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 are people 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 are people 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 are people you wouldn't immediately think of as being at all related to the plan or its implementation but who just might find areas of common interest. Even though they may not have been around when the plan was developed, they could turn out to 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 people/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 State Health Assessment 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, and the LHDs. This group was formed to collaborate and share resources for the Intermountain Healthcare Community Health Needs Assessment, the LHD needs assessments, and the Utah State Health Assessment. 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 has reduced duplication of effort and improved collaboration between these agencies. This group is also exploring 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 State Health Assessment 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 is being 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. This group will also be notified of the state health assessment publication.
- **Intern**. A volunteer intern reviewed numerous health needs assessments conducted around the state by various organizations and identified common needs identified in these assessments.
- The **Utah Health Improvement Plan Coalition**. This group contains 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 State Health Assessment Workgroup and voting to reduce to a few priorities). This group will also give feedback on the Utah State Health Improvement Plan, and hear and give feedback on implementation and progress of the State Health Improvement Plan.

- The **Utah Health Improvement Plan Operational Committee**. This committee ensures that the Utah Health Improvement Plan process is moving forward. It is comprised of members of the UDOH and LHDs. This group received updates and gave feedback on the Utah State Health Assessment process and assisted in setting up the meeting of the Utah Health Improvement Plan Coalition.
- The **Utah Health Improvement Plan Executive Committee**. This group is the decision making body for the final Utah State Health Assessment priorities as well as the State Health Improvement Plan.

The health system partners have realized the importance of collaboration to reduce duplication of efforts, share resources, and reduce potential gaps in execution. Additionally 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 State Health Improvement Plan Coalition (which included UDOH and LHD staff). The State Health Improvement Plan Coalition for the old plan has been replaced by the Utah Health Improvement Plan Coalition (which also includes several other members from throughout the state health systems in addition to UDOH and LHD staff) for the new plan that is being developed.

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, UDOH, and LHDs (members of the Community Advisory Panel) 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 department
- 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 State Health Assessment Workgroup later added some measures for the Utah State Health Assessment. 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. A list of the health assessments reviewed can be found in the Other Data Utilized section of this report.

Prioritization

The State Health Assessment 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 State Health Assessment Workgroup and the above criteria rated.

The top 30 scoring indicators then were mapped against:

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

The Utah Health Improvement Plan Coalition then took the reduced list of indicators and discussed and voted on priorities to recommend to the Utah Health Improvement Plan Executive Committee. They were instructed that the purposes of the State Health Assessment and the Utah Health Improvement Plan were to identify statewide health improvement priorities that a) are important to the community and b) will benefit from a collaborative process to share and focus limited resources to improve the health of all Utahns. The Coalition was broken into groups to discuss the priority list for the State Health Assessment and the Utah Health Improvement Plan.

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 groups then shared the results of their discussions and a round of voting was held where each participant had five votes to distribute.

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

The State Health Assessment Workgroup, after reviewing relevant literature, helped format and refine the process of conducting the SWOT analysis. This analysis was done with the Utah Health Improvement Plan Coalition and information from the analysis was provided to the Utah Health Improvement Plan Executive Committee to consider as potential priorities for the Utah Health Improvement Plan 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

They were 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: Public Health System and the 10 Essential Public Health Services



Regarding the internal workings of the state health system, the Coalition was asking 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

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>.

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?

Regarding external impacts on the health system, the 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

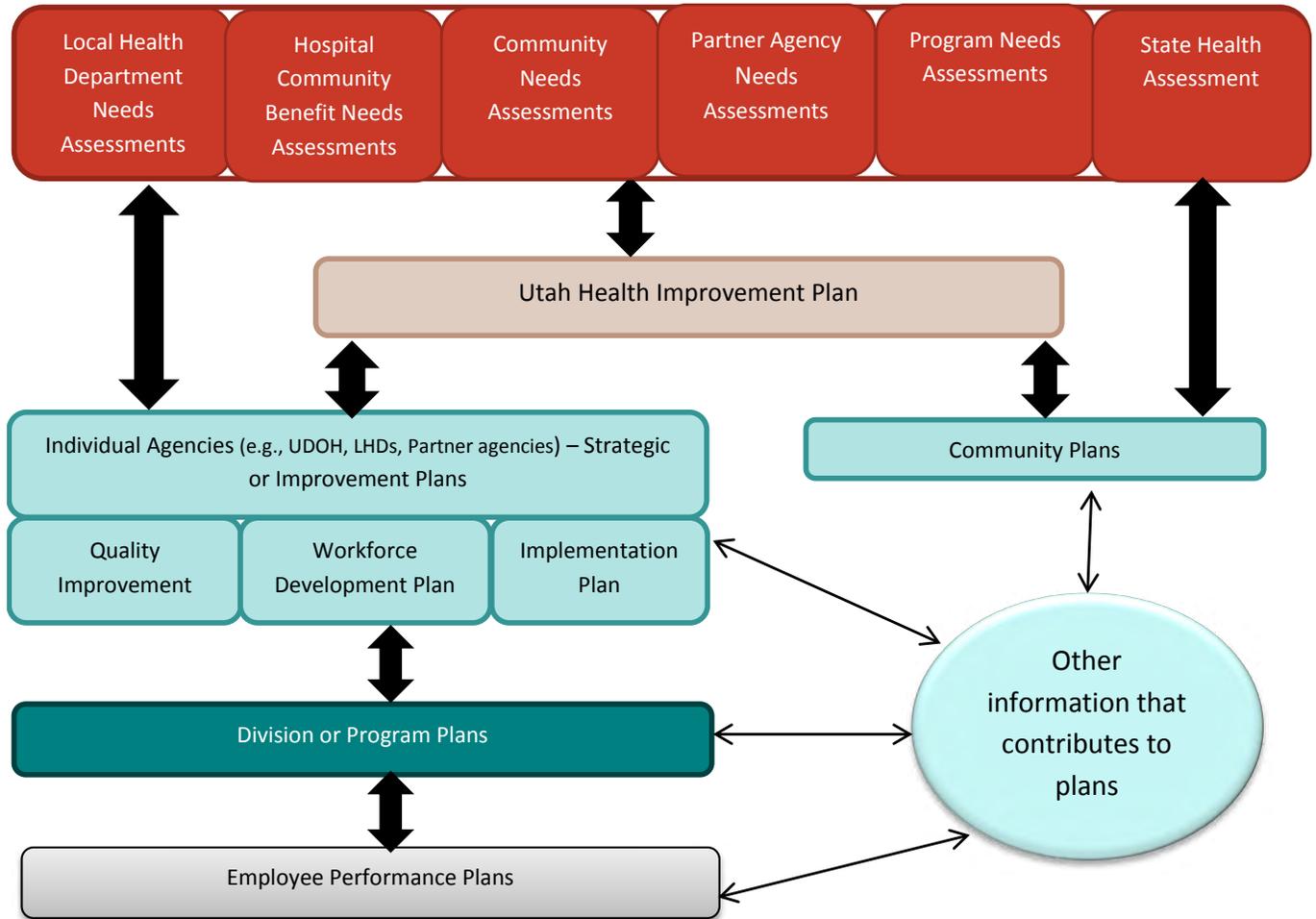
While discussing the following questions:

- 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 Utah State Health Assessment process many people began asking how the Utah Health Improvement Plan 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: State Health System Integration with Various Plans and Assessments



Final Results

As a result of these analyses, discussions, and prioritization, a list of potential health priorities was created and given to the Utah Health Improvement Plan Executive Committee for consideration for the update of the Utah Health Improvement Plan.

Description of State

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Counties

Urban/Rural/Frontier Mix

Most (80%) of the Utah population resides in five counties (Cache, Weber, Davis, Salt Lake, and Utah) called the “Wasatch Front.”¹ These are the only five counties in Utah classified as “urban” (more than 100 persons per square mile). The remainder of Utah’s 29 counties are split between “rural” (6.1 to 99.9 persons per square mile) and “frontier” (under 6.1 persons per square mile). These sparsely populated areas are susceptible to limited infrastructure.²

Geography

Utah, commonly referred to as the “Cross-roads of the West”, is centrally located in the Intermountain West.³

Utah covers 84,904 square miles. Spanning approximately 350 miles north to south and 270 miles east to west, Utah is the 13th largest state in the nation.⁴

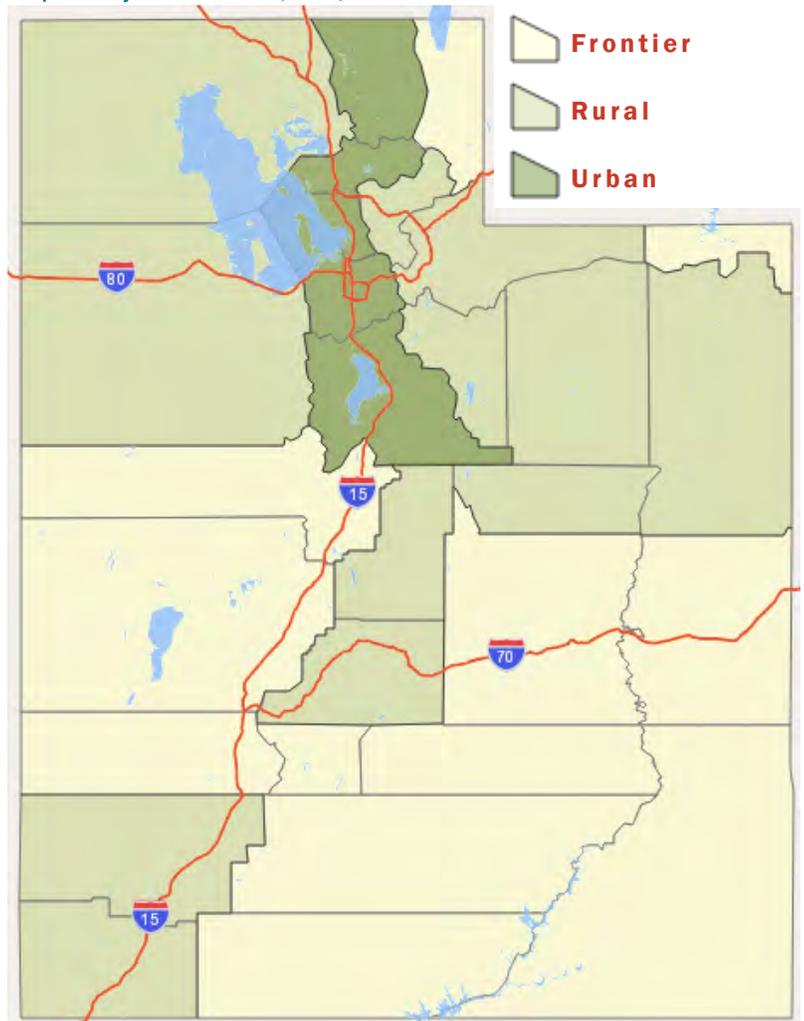
The geography of Utah is comprised of three major provinces: the Great Basin, Colorado Plateau, and Rocky Mountain provinces.⁵

The Great Basin is largely covered by the Great Salt Lake. The Great Basin is bordered by the Wasatch Mountains.⁶

The Colorado Plateau contains several national and state parks and recreation areas. Land areas in this province are typically layered, flat-lying, sedimentary rock. This region includes the Uinta Basin, Canyonlands, and High Plateaus subprovinces.⁷

The Rocky Mountains province refers to the Wasatch and Uinta mountain ranges.⁸

Map: County Classifications, Utah, 2014



Climate/Environmental Influencers of Health

The climate is relatively dry, but varied with warm summers and cold winters. Average temperatures in July are in the low 70s F but can have several days above 100 degrees F in many areas of the state. Winters average temperatures are slightly below freezing with the exception of the southwest area of the state.⁹

1 Table 6. Population density by land use (frontier, rural and urban) and county of residence: Utah, 2014. Utah's Vital Statistics: Births and Deaths, P S-11. Accessed 7/21/2016 at http://health.utah.gov/vitalrecords/pubs_vs2011/2014bx_Final_12072015.pdf.

2 Utah Primary Care Needs Assessment, March 2016. Office of Primary Care and Rural Health, Utah Department of Health.

3 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html.

4 Utah Geography from NETSTATE. Accessed 7/21/2016 at http://www.netstate.com/states/geography/ut_geography.htm.

5 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html.

6 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html.

7 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html.

8 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html.

9 “Utah.” *Compton's by Britannica*. Britannica Online for Kids. Encyclopedia Britannica, Inc., 2016. Web. 23 June 2016. Accessed 6/23/2016 at <http://kids.britannica.com/comptons/article-306658/Utah>.

Utah has a very diverse climate. Geographies of high mountains and plateaus are typically humid while the basins, valleys, and flatlands are usually arid.¹ Mountains and other high elevations tend to have the cooler climates, while lower elevations typically have higher temperatures.²

Precipitation is varied in Utah, with an average of less than five inches per year in areas west of the Great Salt Lake, to more than 40 inches in some of the Wasatch Mountains. Southern parts of the state generally receive less than 10 inches of moisture per year. Snowfall is mostly predominant in the northern mountains.³

Winds are usually below 20 miles per hour. However, sometimes strong winds occur, particularly near the canyon mouths along the west of the Wasatch Mountains. Dust storms also occur occasionally over western Utah.⁴

Earthquakes are a concern in Utah due to the large number of faults. Landslides, floods, and avalanches are other natural hazards to the area.⁵

The environment plays a key role in the public health of Utah. From air and water quality to radon and lead, there are many environmental factors that can influence the health of our residents.⁶

Transportation

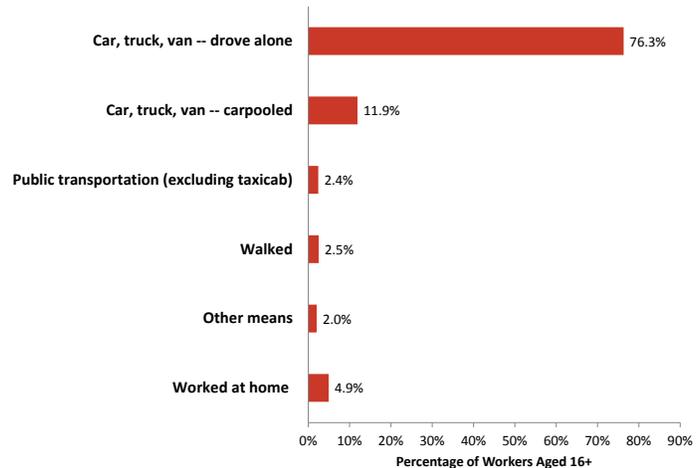
The most important road in Utah is Interstate 15 (I-15), which runs north-south through the center to the southwest of the state. There are also two east-west Interstates: I-80, which runs through the north of Tooele, Salt Lake, and Summit counties; and I-70, which begins in the southeast corner of Millard County and spans through Sevier, Emery, and Grand counties. The northern area of the state is also served by I-84, which enters from Idaho into the northeast portion of Box Elder County and joins with I-15, then splits again in south Weber, running along the border of Weber and Davis counties, and then across Morgan County and into Summit County, where it joins I-80. Central Salt Lake County is also served by the I-215 belt loop.

Several highways serve more rural areas of the state, including US-89, US-40, US-6, US-191, and US-50.

Utah currently has eight regional transit systems.⁷

- Cache Valley Transit District (CVTD): Provides fixed-route and paratransit service throughout Cache County and Lewiston, Idaho
- Utah Transit Authority (UTA): Provides myriad transit, paratransit, and ride-share services throughout Box Elder, Davis, Salt Lake, Tooele, Utah, and Weber counties
- Cedar Area Transportation System (CATS): Under Cedar City authority, provides fixed-route and paratransit service throughout the city
- SunTran: Under City of St. George authority, provides fixed-route and paratransit service throughout the city
- Park City Transit: Under Park City authority, provides fixed-route and paratransit service throughout Park City and surrounding areas within Summit County
- Basin Transit Association (BTA): Provides fixed-route service to Duchesne, Roosevelt, and Vernal
- Navajo Transit System: Provides fixed-route service throughout the Navajo Nation in Arizona, New Mexico, and Utah (including the Aneth, Blanding, Bluff, and Oljato communities in Utah)
- Ute Tribe Transit: Provides transit service throughout the Ute reservation

Figure: Percentage of Workers Aged 16 Years and Older Commuting by Mode in Utah, 2010–2014 ACS



1 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html

2 Climate of Utah. Western Regional Climate Center. Accessed 6/23/16 at <http://www.wrcc.dri.edu/narratives/UTAH.htm>.

3 Climate of Utah. Western Regional Climate Center. Accessed 6/23/16 at <http://www.wrcc.dri.edu/narratives/UTAH.htm>.

4 Climate of Utah. Western Regional Climate Center. Accessed 6/23/16 at <http://www.wrcc.dri.edu/narratives/UTAH.htm>.

5 Physical Geography of Utah. Utah History to Go. Accessed 5/17/16 at http://historytogo.utah.gov/utah_chapters/the_land/physicalgeographyofutah.html.

6 Environmental Topics. Accessed 5/17/16 at <https://ibis.health.utah.gov/epht-view/topic/Environment.html>.

7 2015 State Management Plan Policies and Procedures. UDOT Public Transit Team. Accessed 6/24/16 at <http://www.udot.utah.gov/main/uconowner.gf?n=20689302010058122>.

The Utah Department of Transportation (UDOT) also supports active transportation (human powered travel like walking or biking). One UDOT strategic goal includes developing facilities for the use of pedestrians and bicyclists. They also provide maps of walking and biking trails throughout the state (<http://www.udot.utah.gov/main/f?p=100:pg:0:::V.T.:275>).¹ An estimated 76% of Utah workers drove to work alone in 2010–2014, and 12% carpooled. Among those who commuted to work, it took them on average 22 minutes to get to work.²

Airports in Utah include Salt Lake International Airport as well as several small airports throughout the state.³

Occupation and Industry

Industry data describe the kind of business conducted by a person's employing organization. Occupation describes the kind of work the person does on the job.

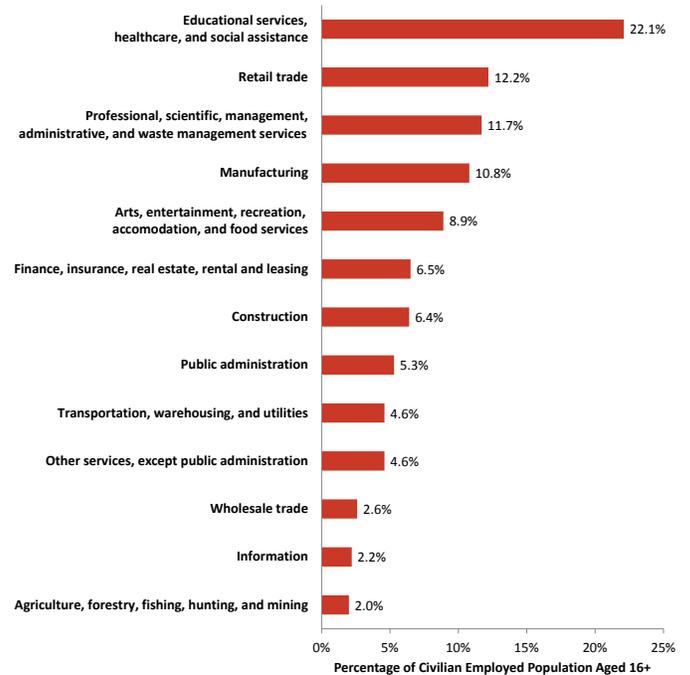
In 2010–2014, the majority of the civilian employed population 16 years and older in Utah worked in the following industries: educational services, healthcare, and social assistance (22.1%); retail trade (12.2%); professional, scientific, management, administrative, and waste management services (11.7%); and manufacturing (10.8%).⁴

Occupations for the civilian employed population 16 years and older in Utah in 2010–2014 included management, business, sciences, and arts occupations (36.6%); sales and office occupations (26.4%); service occupations (15.6%); production, transportation, and material moving occupations (12.3%); and natural resources, construction, and maintenance occupations (9.1%).⁵

Health Professional Shortage Areas⁶

The UDOH Office of Primary Care and Rural Health recently conducted a Primary Care Needs Assessment to report on health status and healthcare access throughout Utah. The report examines Health Professional Shortage Areas (HPSAs) in primary care, dental, and mental health services. The analysis of shortage areas includes looking at rational service areas, the population to provider ratio in those areas, and demographic issues that are known to be barriers to care access. The service areas are described by geographic area, population group, or facility. HPSAs are designations based on results of provider surveys that are updated every three years.

Figure: Percentage of Civilian Employed Population Aged 16 Years and Older by Industry in Utah, 2010–2014 ACS



1 Active Transportation. Utah Department of Transportation. Accessed 6/24/16 at <http://www.udot.utah.gov/main/f?p=100:pg:0:::1:T.V:11>.

2 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

3 Utah Airport Operators Association Airport Listing (as of April 8, 2014). Accessed 6/24/16 at <http://www.uaoa.org/pdf/UAOA%20Airport%20Directory%20April%202014.pdf>.

4 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

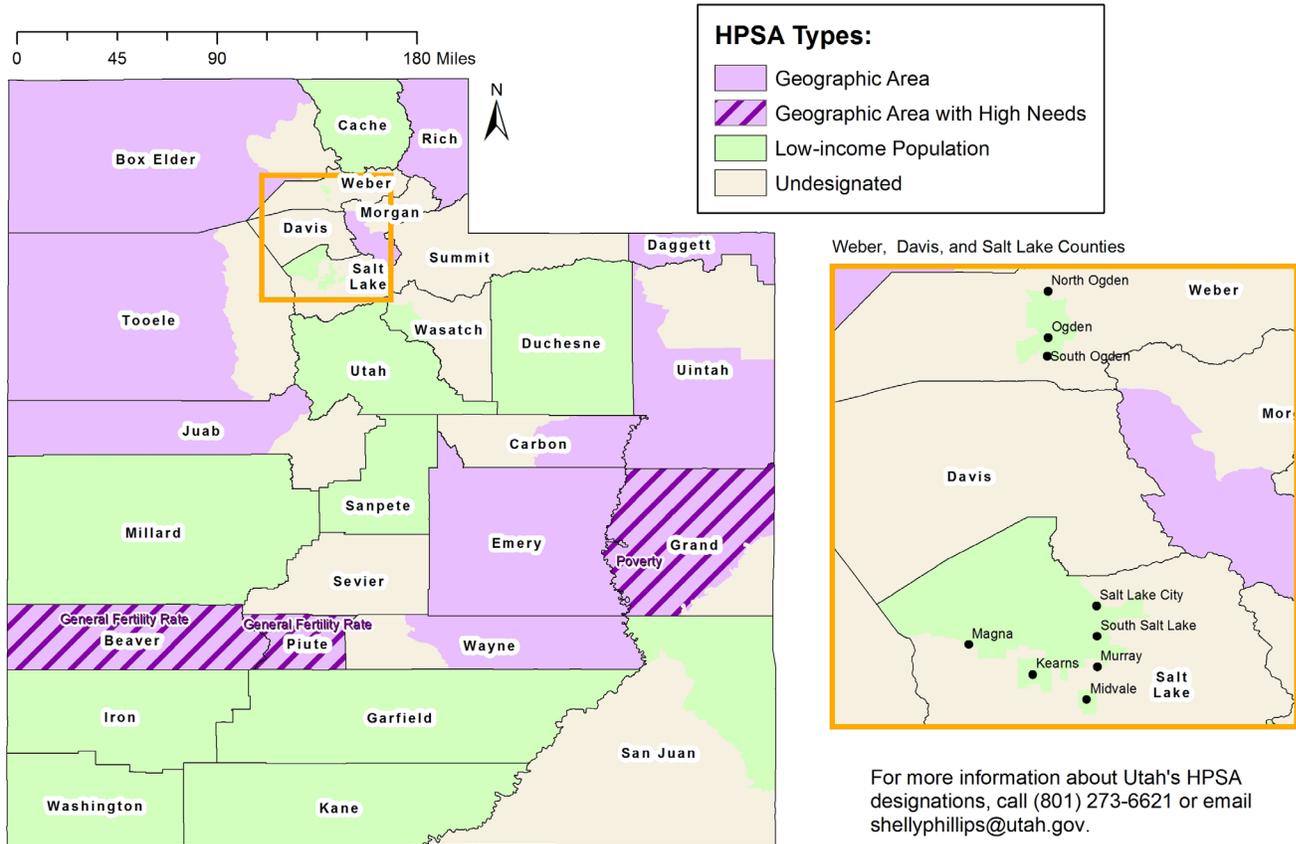
5 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

6 Utah Department of Health Office of Primary Care and Rural Health.

In primary medical care, Utah has 26 counties with shortage areas based on either geography, population group, or facility. It is estimated that only 67% of the need is met for the 535,396 persons living in those areas and that 59 more practitioners would be needed to no longer be designated as a shortage area.

Map: Utah's Primary Medical Care Health Professional Shortage Areas

UTAH'S PRIMARY MEDICAL CARE Health Professional Shortage Areas (HPSAs)



Office of Primary Care and Rural Health, Utah Department of Health

Revised March 2016

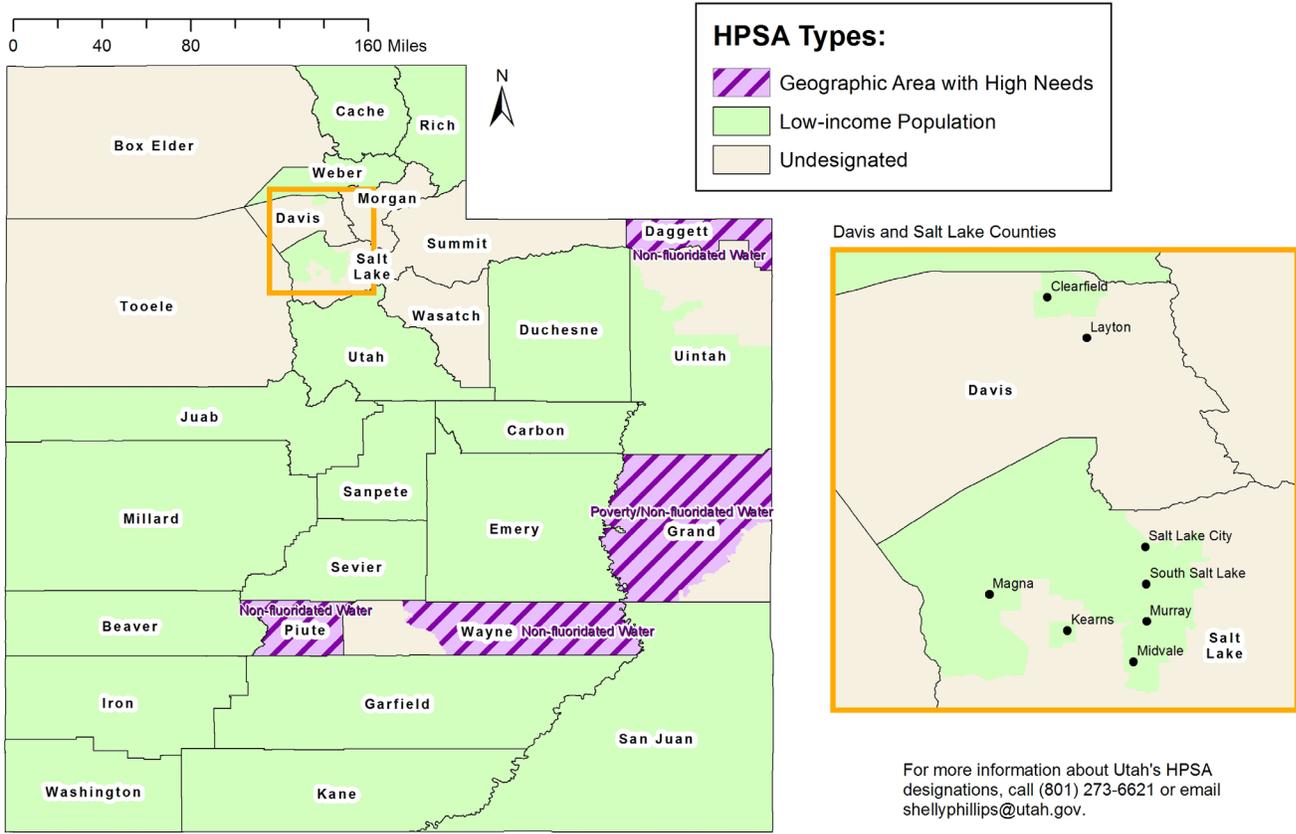
For more information about Utah's HPSA designations, call (801) 273-6621 or email shellyphillips@utah.gov.

Description of State

In dental care, Utah has 24 counties with shortage areas based on either geography, population group, or facility. It is estimated that only 60% of the need is met for the 593,221 persons living in those areas and that 59 more practitioners would be needed to no longer be designated as a shortage area.

Map: Utah's Dental Care Health Professional Shortage Areas

UTAH'S DENTAL CARE Health Professional Shortage Areas (HPSAs)



Office of Primary Care and Rural Health, Utah Department of Health

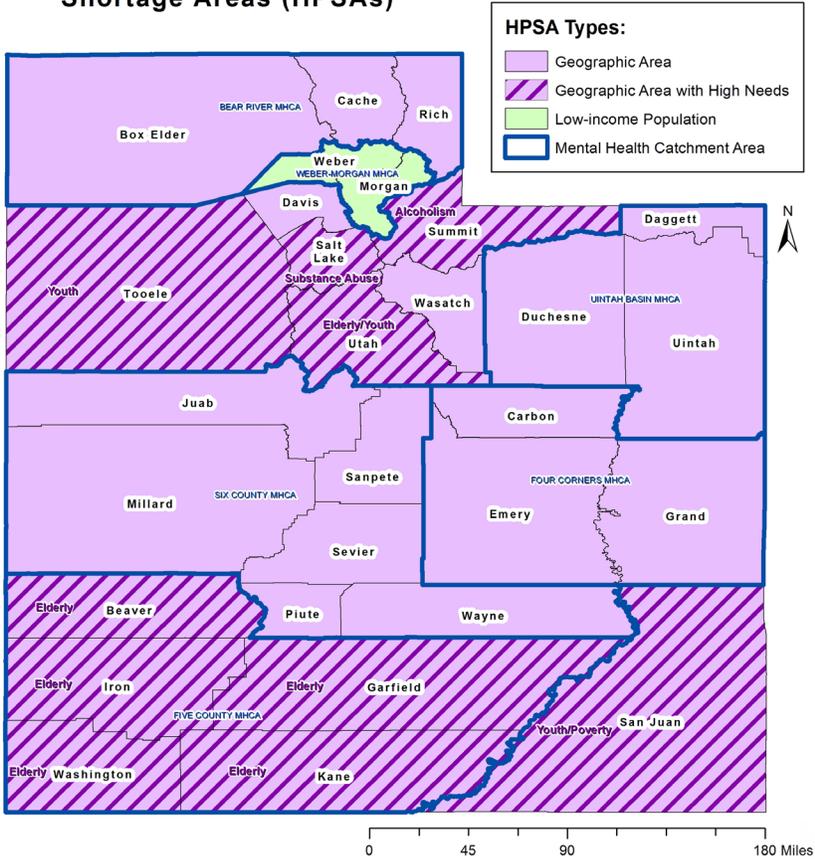
Revised March 2016

For more information about Utah's HPSA designations, call (801) 273-6621 or email shellyphillips@utah.gov.

In mental healthcare, all 29 Utah counties are designated as shortage areas based on either geography, population group, or facility. It is estimated that only 66% of the need is met for the state population and that 38 more practitioners would be needed to no longer be designated as a shortage area.

Map: Utah's Mental Healthcare Health Professional Shortage Areas

**UTAH'S MENTAL HEALTH
Health Professional
Shortage Areas (HPSAs)**



For more information about Utah's HPSA designations, call (801) 273-6621 or email shellyphillips@utah.gov.

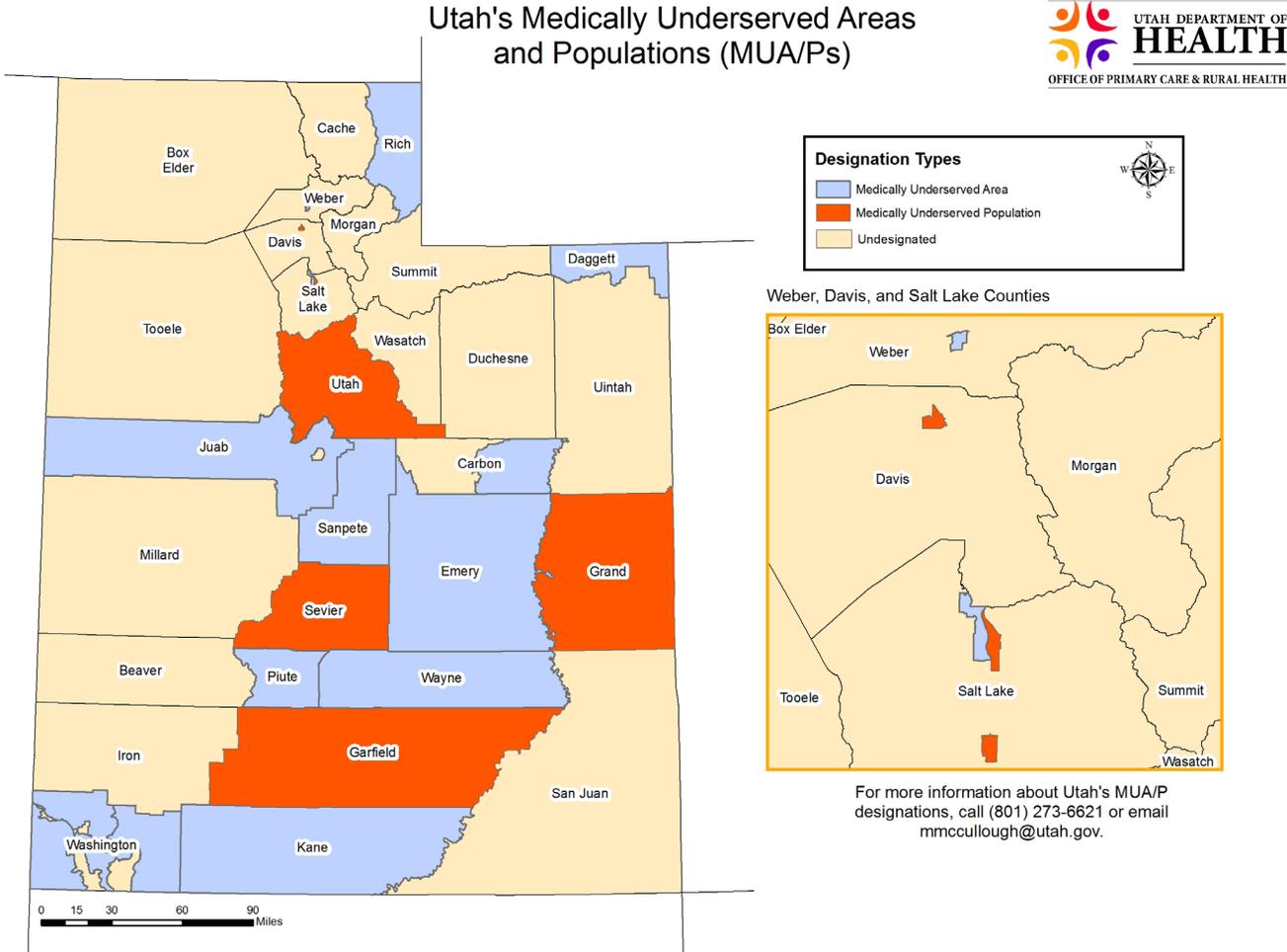
Office of Primary Care and Rural Health, Utah Department of Health

Revised March 2016

Description of State

The needs assessment report also includes Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP). These are areas or populations designated by the U.S. Department of Health and Human Services Health Resources and Services Administration as having too few primary care providers, high infant mortality, high poverty, and a high aged population. Twenty-two Utah counties have MUA or MUP whole or partial designations.

Map: Utah's Medically Underserved Areas and Medically Underserved Populations



Office of Primary Care and Rural Health, Utah Department of Health

Revised July 2016

The UDOH Office of Primary Care and Rural Health utilizes these designations to access federal programs that provide resources to help combat provider shortages.

Demographics

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Overall Population

Households and Types

The American Community Survey (ACS) defines a housing unit as “a house, an apartment, a mobile home or trailer, a group of rooms, or a single room occupied as separate living quarters, or if vacant, intended for occupancy as separate living quarters.” A household includes all the people who occupy a housing unit as their usual place of residence.

In 2010–2014, Utah had a total of 999,700 housing units, 10% of which were vacant. Of the total housing units, 75% were in single-unit structures, 21% were in multi-unit structures, and 4% were mobile homes. An estimated 43% of the housing units were built since 1990.¹

In 2010–2014, Utah had 896,200 occupied housing units—624,600 (70%) owner occupied and 271,600 (30%) renter occupied. An estimated 71% of householders of these units had moved in since 2000. An estimated 72% of the owner occupied units had a mortgage. An estimated 2% of the households did not have telephone service. An estimated 5% had no vehicles available and another 27% had three or more.²

Most homes in Utah were heated by gas (87.3%), which includes utility, bottled, tank, or LP gas. Electricity heated 10.8% of homes. The remaining 1.9% of homes were heated by fuel oil, kerosene, other fuels, or no fuels at all.³

According to the 2010–2014 ACS, there were a total of 896,200 households in Utah with an average size of 3.1 people. Most households were married-couple families. Almost 20% of households were people living alone, and 6% were female-headed households with children (no husband present).⁴

Individual Counts

In 2010–2014, an estimated 31% of the Utah population, or approximately 900,000 were children, and 69%, or 2.1 million were adults.⁵

Figure: Types of Housing Units in Utah (percentage distribution), 2010–2014 ACS

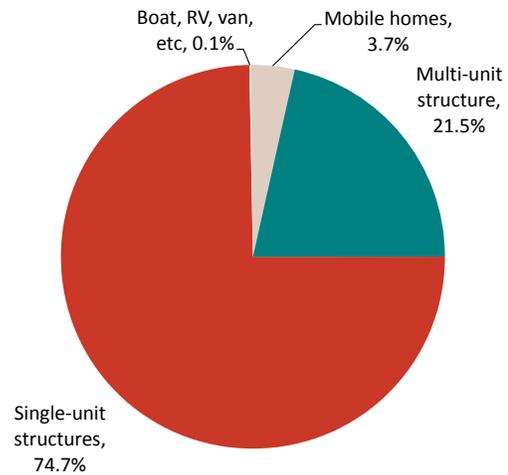


Figure: House Heating Fuel Used (percentage distribution) in Utah, 2010–2014 ACS

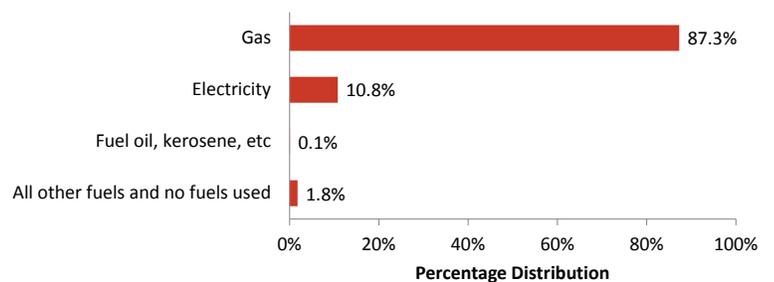
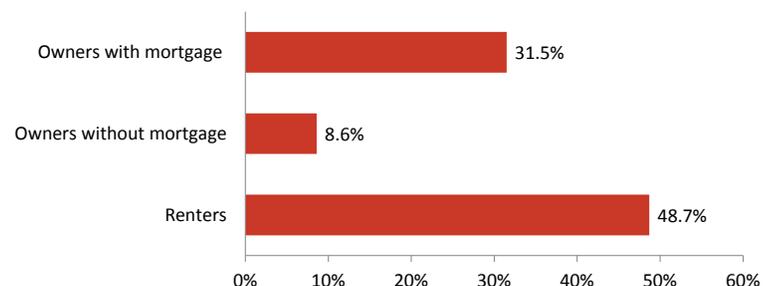


Figure: Percentage of Occupants With a Housing Cost Burden in Utah, 2010–2014 ACS



1 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

2 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

3 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

4 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/18/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

5 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

Population Dispersion

Seventy-five percent of the Utah population reside along the Wasatch Front (Salt Lake, Davis, Weber, and Utah counties). The remainder of the population lives in rural (21%) and frontier (4%) counties, according to 2006–2010 ACS data.¹

Birth Rates²

Birth rate is the number of live births in a given year per 1,000 persons in the total population. Tracking birth rate patterns among Utah and U.S. women as a whole is critical to understanding population growth and change in this country and in Utah. Birth rates directly relate to a population's need for timely and appropriate preconception, prenatal, neonatal, and postpartum care.

In 2014, there were 51,164 live births to Utah residents, a rate of 17.4 per 1,000 Utahns. This is a slight decrease from the 2013 birth rate of 17.5, and ultimately, the lowest birth rate in a decade.

Utah continued to report the highest birth rate in the U.S. with 17.4 live births per 1,000 total population in 2014. The U.S. rate has essentially stayed the same from the 2013 rate of 12.4.

Distribution by Age³

In Utah, 43% of all households have one or more people under the age of 18; 21% of all households have one or more people 65 years and over. The median age was 29.9 years.

The largest age group in the population during 2010–2014 was children (31.1% under age 18), followed by adults aged 25–44 (28.1%) and adults aged 45–64 (19.9%).

Gender

In 2010–2014, the Utah population was 1.4 million (50%) females and 1.4 million (50%) males.⁴

Race and Ethnicity⁵

For people reporting one race alone, 90% were White; 1% were Black or African American; 1% were American Indian and Alaska Native; 2% were Asian; 1% were Native Hawaiian and Other Pacific Islander, and 4% were some other race. An estimated 2% reported two or

Figure: Types of Households in Utah, 2010–2014 ACS

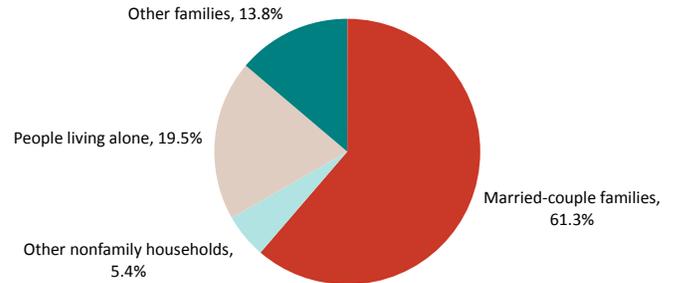


Figure: Birth Rates, Utah and U.S., 2004–2014 NVSS

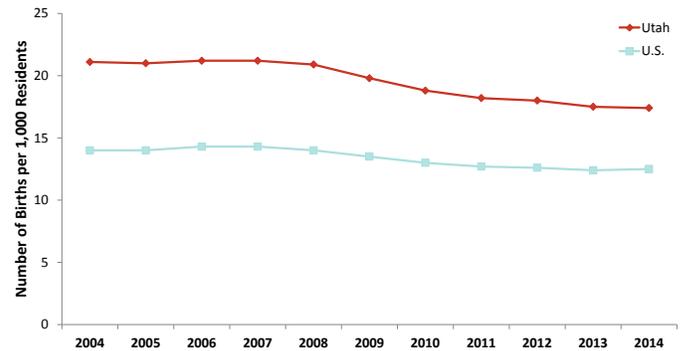


Figure: Age Distribution of People in Utah, 2010–2014 ACS

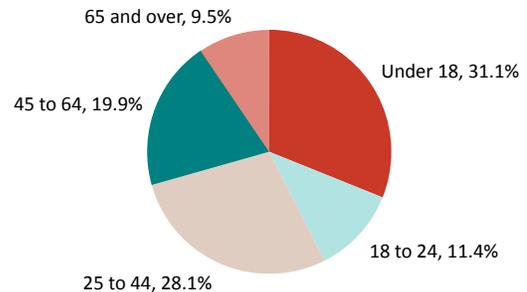
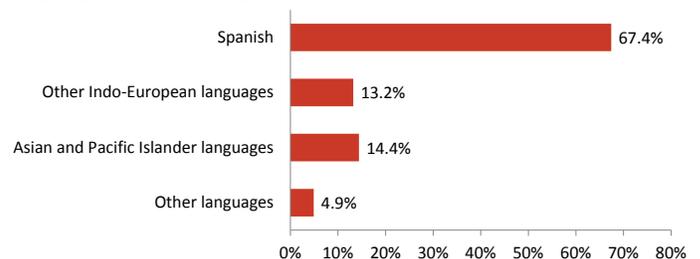


Figure: Percentage of the Population 5 Years and Older Who Speak a Language Other Than English, Utah, 2010–2014 ACS



1 Utah Rural Health Plan, February 2013. Accessed 6/6/16 at <https://www.ruralhealthinfo.org/pdf/utah-rural-health-plan-2013.pdf>.

2 Birth Rates. Retrieved on 6/6/16 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website: https://ibis.health.utah.gov/indicator/view/BrthRat.UT_US.html.

3 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/18/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

4 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

5 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/18/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

more races. An estimated 13% of the people in Utah were Hispanic. An estimated 80% of the people in Utah were White non-Hispanic. People of Hispanic origin may be of any race.

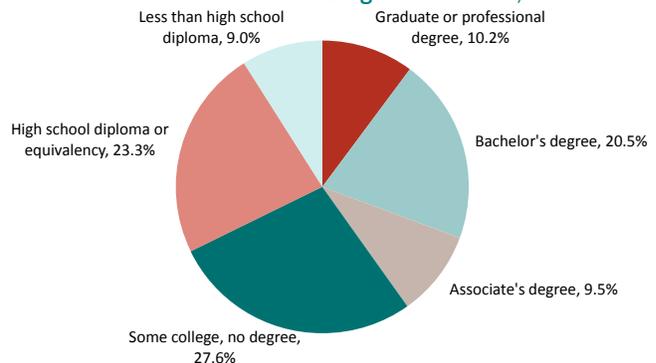
Among people at least five years old living in Utah in 2010–2014, 15% spoke a language other than English at home. Of those speaking a language other than English at home, 67% spoke Spanish and 33% spoke some other language; 36% reported that they did not speak English “very well.”

Education¹

In 2010–2014, 91% of people aged 25 years and older had at least graduated from high school and 31% had a bachelor’s degree or higher. An estimated 9% did not complete high school.

The total school enrollment in Utah was 932,300 in 2010–2014. Nursery school and kindergarten enrollment was 110,600 and elementary or high school enrollment was 571,000 children. College or graduate school enrollment was 250,800.

Figure: Educational Attainment of Adults Aged 25+ in Utah, 2010–2014 ACS

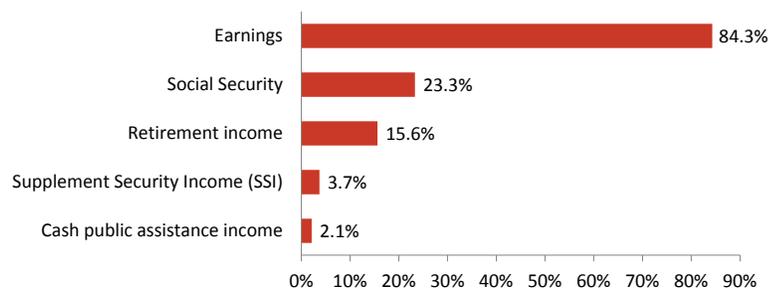


Income²

The median income of households in Utah was \$59,846. An estimated 9% of households had income below \$15,000 a year and 8% had income more than \$150,000.

An estimated 84% of the households received earnings and 16% received retirement income other than Social Security. An estimated 23% of the households received Social Security. The average income from Social Security was \$18,329. These income sources are not mutually exclusive; that is, some households received income from more than one source.

Figure: Proportion of Households by Income Sources in Utah, 2010–2014 ACS

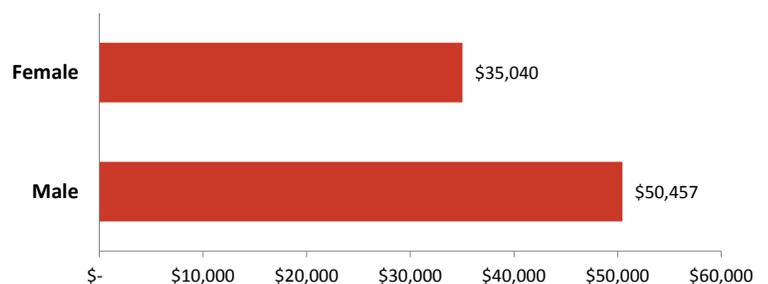


Employment³

In Utah, 63% of the population aged 16 and older were employed; 32% were not currently in the labor force.

An estimated 79% of the people employed were private wage and salary workers; 16% were federal, state, or local government workers; and 5% were self-employed in their own (not incorporated) business.

Figure: Median Earnings for Full-time Year-round Workers by Sex, Utah, 2010–2014 ACS



Religion

According to data from the Behavioral Risk Factor Surveillance System in 2014, the majority (59%) of Utah adults are LDS (Latter-day Saints/Mormon), with the next highest category being "No religion" (19%).⁴

According to 2015 Gallup data, 55% of Utah adults are very religious (religion is important in their lives and say they attend religious services weekly or nearly weekly), 15% are moderately religious (religion is not important in their lives but

1 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

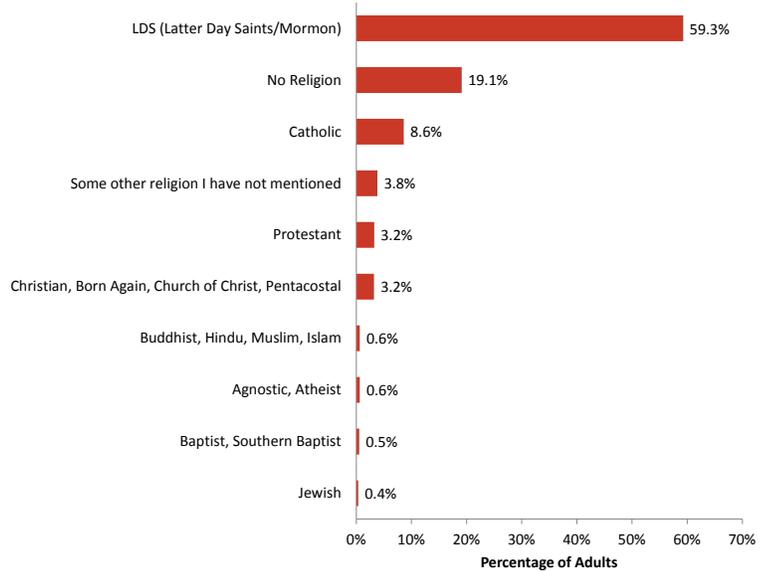
2 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

3 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/19/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

4 2014 Utah Behavioral Risk Factor Surveillance System

attend religious services weekly or nearly weekly, or religion is important in their lives but do not attend religious services weekly or nearly weekly), and 31% are nonreligious (religion is not important in their lives and they seldom or never attend religious services). Nationwide, 40% are very religious, 29% are moderately religious, and 31% are nonreligious.¹

Figure: Religious Affiliation of Utah Adults Aged 18+, 2014 BRFSS



Politics

Percent voting

Current data indicate that 86% of registered voters are active (see table).²

However, for the 2014 general election, only 46% of active registered voters cast ballots. Percentages varied by county ranging from 35% in Utah County to 76% in Wayne County.³

Structure of Legislature and Districts

The Utah Legislature is comprised of 29 Senators and 75 members of the House of Representatives. The majority of both entities (more than 80%) are Republican (only five Senators and 12 Representatives are affiliated with the Democratic Party).⁴

The Speaker of the House of Representatives is the presiding officer of the House and the President of the Senate presides over the Senate. These positions are formally elected by the members of their house at the beginning of the general session.⁵

All members of the Legislature are members of standing committees and joint appropriation subcommittees during the 45-day general session, as well as of interim committees between general sessions. Each committee has a chair and vice chair appointed by the President of the Senate and the Speaker of the House.⁶

Table: Voters by Party and Status, Utah (updated June 2016)²

	Active	Inactive*	Total
Unaffiliated	475,201	112,505	587,706
Republicans	634,572	62,422	696,994
Democrats	135,570	23,823	159,393
Independent American	11,609	1,340	12,949
Libertarian	7,827	1,758	9,585
Constitution	3,749	786	4,535
Total	1,268,528	202,634	1,471,162

* An "Inactive Voter" is a voter that has not voted in 2 regular general elections and has failed to respond to a notice sent to them by the county clerk.

Governor's Priority and Health Initiatives

The Governor's Priorities include education, jobs, energy, and self-determination.

Governor Gary Herbert's goal for education is to increase the percentage of Utah adults with a postsecondary certificate or degree to 66% by 2020. The Utah Education Roadmap identified four priority areas to target in order to achieve this goal: 1) ensure early learning, 2) strengthen and support teachers, 3) ensure access and equity, and 4) complete certificates and degrees.⁷

For jobs, Governor Herbert has issued the following call to action: accelerate private sector job creation of 100,000 jobs in 1,000 days. Four objectives have been identified to address this: 1) strengthen and grow existing Utah businesses, both

¹ State of the States. Gallup, Inc. Accessed 6/6/16 at http://www.gallup.com/poll/125066/State-States.aspx?g_source=WWWV7HP&g_medium=topic&g_campaign=tiles.

² Voters by Party and Status. Accessed 6/6/16 at <https://elections.utah.gov/party-and-status>.

³ 2014 General Canvass Report. Downloaded on 6/6/16 from <https://elections.utah.gov/election-resources/election-results>.

⁴ 2015-2016 Legislative Roster. Accessed 6/6/16 at <http://le.utah.gov/documents/2015roster.pdf>.

⁵ Organization of the Utah State Legislature. Accessed 6/6/16 at <http://le.utah.gov/documents/aboutthelegislature/organizationofthelegislature.htm>.

⁶ Organization of the Utah State Legislature. Accessed 6/6/16 at <http://le.utah.gov/documents/aboutthelegislature/organizationofthelegislature.htm>.

⁷ Utah Education Roadmap. Accessed 6/6/16 at http://www.utah.gov/governor/docs/priorities/education/PACE_Roadmap_3_bleeds.pdf.

urban and rural; 2) increase innovation, entrepreneurship, and investment; 3) increase national and international business; and 4) prioritize education to develop the workforce of the future.¹

The call to action identified for energy is to ensure access to affordable, reliable, and sustainable energy by producing 25% more electrical energy than we consume by 2020. The three objectives identified to respond to this call to action are: 1) advocate responsible energy resource development, 2) promote policies and practices for improved air quality, and 3) aggressively pursue technology innovations in energy efficiency and development.²

The self-determination call to action from the Governor is to cultivate solutions for healthcare reform, public lands, and immigration. The three objectives identified to assist with this effort are: 1) become the healthiest people in the nation through innovation, market principles, and healthcare reform; 2) promote rural economic progress while protecting our natural treasures by ensuring appropriate multiple-use of public lands; and 3) work with the Congressional Delegation and Legislature to identify and implement practical solutions to address illegal immigration.³

Special Populations

In Utah, 61,500 grandparents lived with their grandchildren under 18 years of age. Of those grandparents, 30% of them had financial responsibility for their grandchildren.⁴

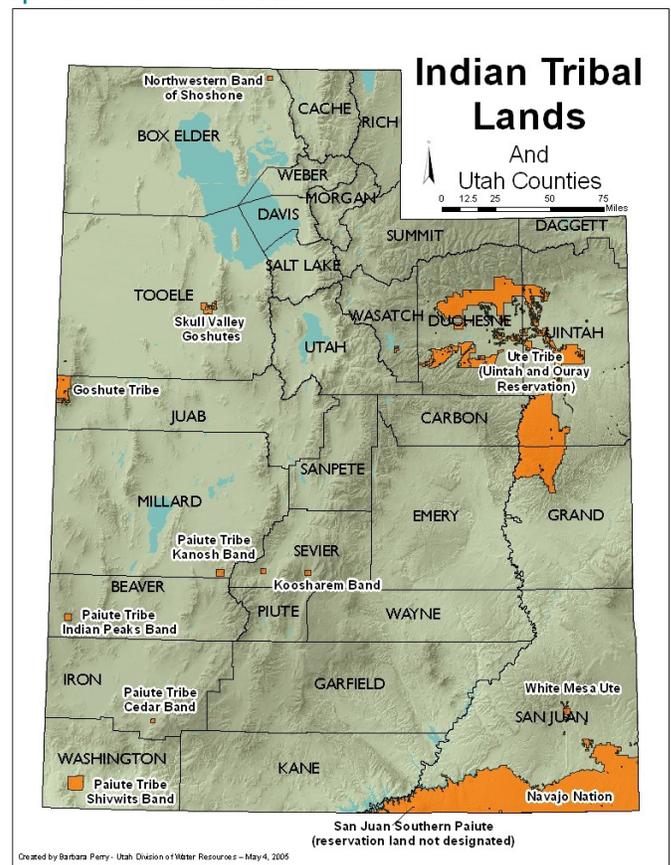
In Utah, among the civilian noninstitutionalized population in 2010–2014, 9% reported a disability. The likelihood of having a disability varied by age—from 3% of people under 18 years old, to 8% of people 18 to 64 years old, and to 35% of those 65 and older.⁵

Approximately 3.7% of Utah residents are veterans of a foreign war. Of those, 6.3% live below the poverty level, and 27.5% suffer from a disability.⁶

There are eight federally recognized Indian tribes in the state of Utah: Confederated Tribes of Goshute Indians, Navajo, Northern Ute Tribe, Northwestern Band of Shoshone, Paiute Indian Tribe of Utah, San Juan Southern Paiute, Skull Valley Band of Goshute, and White Mesa Band of the Ute Mountain Ute. These tribal lands are located throughout 13 of Utah's 29 counties (see map).⁷

In 2012, a Gallup Poll of Utah residents found that 2.7% of residents identify as gay, lesbian, bisexual or transgender (LGBT). Nationally, rates ranged from 1.7% in North Dakota to 10.0% in Washington D.C.⁸ A 2012–2014 Gallup Poll of metropolitan areas found that 4.7% of Salt Lake City's population identified as LGBT. The national metropolitan range was 2.6% to 6.2%.⁹ Between 2000 and 2010 the number of same-sex households in Utah increased by 72.5%.¹⁰

Map: Indian Tribal Lands in Utah



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

1 Priorities: Jobs—Governor Gary Herbert. Accessed 6/6/16 at <http://www.utah.gov/governor/priorities/jobs.html>.

2 Priorities: Energy—Governor Gary Herbert. Accessed 6/6/16 at <http://www.utah.gov/governor/priorities/energy.html>.

3 Priorities: Self-Determination—Governor Gary Herbert. Accessed 6/6/16 at <http://www.utah.gov/governor/priorities/self-determination.html>.

4 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/18/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

5 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/18/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

6 Table S2101. Veteran Status. U.S. Census Bureau, 2010–2014 American Community Survey 5-Year Estimates. Accessed 7/14/2016 from http://factfinder.census.gov/aces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S2101&prodType=table.

7 Utah Department of Health Federally Recognized Tribes of Utah Consultation Policy. Accessed 8/8/2016 from <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Utah-Department-of-Health-Federally-Recognized-Tribes-of-Utah-Consultation-Policy.pdf>.

8 LGBT Percentage Highest in D.C., Lowest in North Dakota. Gallup. Accessed 7/14/2016 from http://www.gallup.com/poll/160517/lgbt-percentage-highest-lowest-north-dakota.aspx?utm_source=LGBT%20state&utm_medium=search&utm_campaign=tiles.

9 San Francisco Metro Area Ranks Highest in LGBT Percentage. Gallup. Accessed 7/14/2016 from <http://www.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbt-percentage.aspx>.

10 Appendix Table 2a. Same-sex Couple Households, by State: Census 2000 and 2010 Summary File 1. Accessed 7/14/2016 from <http://www.census.gov/hhes/samesex/data/decennial.html>.

Health Data

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Overview

The Community Advisory Panel had decided on 100 health data indicators. The State Health Assessment Workgroup added 16. One hundred and sixteen measures across 17 categories were reviewed and prioritized by the State Health Assessment Workgroup. The list of data indicators is below.

Table: Health Indicators Reviewed and Prioritized

Category	Measure
Social Determinants of Health	Persons Living in Poverty
	Child Poverty
	Food Insecurity
	Housing Cost Burden
	Lack of Social and Emotional Support
Environmental Health	Air Quality
	Water Quality
	Food Deserts/Low Food Access
	Modified Food Retail Environment Index
	Housing—Overcrowded or Substandard Housing
	Recreation and Fitness Facility Access
	Safety—Crime Rates
	Walk and Bike Friendly
	Transportation Use
	Transportation Home Bound
Occupational Fatalities	
General Health	General Health Status
	Life Expectancy
	Mortality/Leading Causes of Death
	Disability/Activity Limitation
Respiratory Conditions	Uncontrolled Asthma
	Chronic Obstructive Pulmonary Disease (COPD)
Cancers	All Cancer Deaths
	Breast Cancer
	Colon Cancer
	Lung Cancer
	Skin Cancer
Cardiovascular Conditions	High Blood Pressure
	High Cholesterol
	Coronary Heart Disease
	Heart Failure
	Stroke
Diabetes Conditions	Pre-diabetes
	Diabetes Prevalence
Obesity/Physical Activity	Overweight
	Obesity
	Recommended Physical Activity
	Vegetable Consumption
	Fruit Consumption

Category	Measure
Other Chronic Conditions	Arthritis
	Alzheimer's Disease
Vaccine Preventable Diseases	Pertussis
	Influenza-Associated Hospitalization
	Hepatitis B, chronic
	Hepatitis B, acute
	Hepatitis A
	Tetanus
	Diphtheria
	Varicella (chickenpox)
Other Infectious Diseases	Chlamydia
	Gonorrhea
	HIV
	Syphilis, all stages
	Hepatitis C, chronic
	Hepatitis C, acute
	West Nile Virus, total
	Tuberculosis, active
	<i>Campylobacter</i>
	Shiga Toxin-producing <i>E. coli</i>
	<i>Salmonella</i>
	Giardiasis
	Cryptosporidiosis
	Healthcare-Associated Infections
Rabies, animal	
Mental Health	Mental Health Status
	Suicide
	Attempted Suicide
	Depression
Addictive Behaviors	Prescription Drug Misuse and Deaths
	Cigarette Smoking
	Vaping
	Binge Drinking
	Chronic Drinking
	Illicit Substance Use/Abuse
Care Access	No Health Insurance
	Cost as a Barrier to Care
	Primary Provider
	Non-emergent Emergency Department (ED) Use
	Regular Dental Care
	Providers per Population

Category	Measure
Preventive Services	Mammogram
	Cholesterol Checked
	Colon Cancer Screening
	Influenza Vaccination
	Pneumococcal Vaccinations
	Childhood Vaccination
	Sun Safety
	HIV Testing
Maternal and Child Health	Infant Mortality
	Fetal Deaths
	No Prenatal Care Until Third Trimester
	Multivitamin Use Before Pregnancy
	Preterm Births
	Low Birth Weight
	Gestational Diabetes
	Obese Body Mass Index (BMI) Prior to Pregnancy
	Excessive Gestational Weight Gain
	Alcohol Use During Pregnancy
	Smoking During Third Trimester of Pregnancy
	Breastfeeding
	Unintended Pregnancy
	Duration Between Pregnancies
	Births to Women Under 18
	Developmental Screening
Cytomegalovirus	
Autism	
Violence and Injury Prevention	Seatbelt Use
	Helmet Use
	Unintended Injury Deaths
	Falls
	Motor Vehicle Traffic Crashes
	Firearm
	Drowning
	Poisoning
	Fire Deaths
	Sexual Assault
	Violent Crimes

After the initial State Health Assessment (SHA) prioritization process and comparison to different priority reports, the indicators were narrowed to 30 for consideration by the Utah Health Improvement Plan Coalition to include in the updated Utah Health Improvement Plan. That list is below.

Table: Candidate Priority Indicators

Category	Indicator	SHA Workgroup Priority	UDOH Strategic Plan	CDC 6 18 Initiative	Current SHIP Goal	Intermountain Priority	Community Input Priority	State Innovation Model Priority	Other Needs Assessment Priority	America's Health Rankings
Social Determinants of Health	Persons/Children Living in Poverty	X								
	Food Insecurity	X					X			
Environmental Health	Air Quality						X		X	
	Housing—Overcrowded or Substandard Housing	X					X			
	Occupational Fatalities									X
Respiratory Conditions	Uncontrolled Asthma			X						
Cardiovascular Conditions	High Blood Pressure	X		X		X				
Diabetes Conditions	Pre-diabetes/Diabetes Prevalence	X				X		X		
Obesity/Physical Activity	Obesity	X	X		X		X		X	
	Recommended Physical Activity	X	X		X		X		X	
Mental Health	Mental Health Status	X					X		X	
	Suicide	X	X				X			
	Depression	X	X			X	X	X		
Addictive Behaviors	Prescription Drug Misuse/Deaths		S			X				S
	Cigarette Smoking/Tobacco Use	X	X	X						
	Binge and Chronic Drinking		X							
	Illicit Substance Use/Abuse	X	S				X		X	S
Care Access	No Health Insurance	X					X		S	X
	Cost as a Barrier to Care	X					X		S	
	Primary Provider						X			X
	Non-emergent ED Use	X					X			
	Regular Dental Care	X					X			
Preventive Services	Childhood Vaccination				X		X			X
Maternal and Child Health	Unintended Pregnancy			X						
	Developmental Screening									
	Autism						X			
Violence and Injury Prevention	Helmet Use (minor)	X					X			
	Unintended Injury Deaths		X						X	
Infectious Diseases	Healthcare-Associated Infections			X					X	
	Chlamydia/Salmonella/Pertussis									X

S = Similar measure

Data sheets were created for each indicator in order to enhance the Coalition members' ability to have informed discussion and voting. The data sheets are included here and contain the following sections where information is available.

- Description of the measure
- Data indicating how the state of Utah is doing, how it compares with national data, and comparison with a Healthy People 2020 initiative where there is a similar initiative
- Information regarding known disparities
- Risk factors for the health issue, or where the area of concern may contribute to poor health outcomes
- What is currently being done to improve performance on the indicator and related evidence-based practices. Note that this information includes only some efforts noted by programs, but is not an inclusive list of all efforts related to the health issue or all evidence-based practices.
- Data interpretation issues
- A chart that shows performance over time
- Comparison information
- Data broken down by
 - * Age
 - * Gender
 - * Race
 - * Ethnicity
 - * Education
 - * Income
 - * Local health district

Not all breakouts were available for all data. Additionally, where possible, both crude and age-adjusted rates were provided. Crude rates are provided to inform of the overall burden of the health issue in the state. Age-adjusted rates are provided to allow for comparison across the breakouts not due to differences in the age distribution of the population.

In order to obtain as many data breakouts as possible, estimates may have come from different sources or cover different year time periods. The year time periods are included in the data sheets and explanation of data sources are included in data sources section of the report.

As we compare across breakouts, we have flags indicating whether each breakout is statistically significantly different than the state rate. A green check (✓) indicates the community is performing BETTER than the state. A red exclamation point (!) indicates the community is performing WORSE than the state. These comparison flags, as well as national rankings, are based on age-adjusted rates.

Where data were available by local health district, maps have been provided showing statistical significance compared to the state rate (better or worse).

Note that data represented in these sheets may have been updated from earlier versions that were distributed at meetings.

Information and available resources for each of the measures being reported may be found in the Appendix of this report.

Social Determinants of Health

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Persons Living in Poverty

American Community Survey (ACS)

Description

Persons living in poverty is defined as the percentage of persons living in households whose income is at or below the federal poverty threshold as defined by the U.S. Census Bureau.

How Are We Doing?

According to the American Community Survey (ACS), approximately 11.7% of Utah residents, or 339,900 Utahns, were living in poverty in 2014. This includes 118,789 children aged 17 and under.

National Comparison

Utah has a lower percentage of persons living in poverty than compared to the nation (11.7% vs. 15.5% in 2014).

Healthy People Objective (see Appendix)

SDOH-3.1: Proportion of persons living in poverty

U.S. Target: Not applicable. This measure is being tracked for informational purposes.

Disparities

Persons under 18 years of age have a higher poverty rate than the state. Males are less likely to live in poverty. American Indian/Alaska (AK) Native, Asian, Black, Hispanic, and those with two or more races have higher poverty rates than the overall state rate. People with less than high school education are more likely to live in poverty.

Davis County, Summit County, Tooele County, TriCounty, and Wasatch County local health districts (LHDs) have poverty rates lower than the state rate. Bear River, Central Utah, San Juan, Southeast Utah, and Southwest Utah LHDs have rates that are higher than the state rate.

Risk Factors

Poverty increases risk for poor diet/nutrition, tobacco use, alcohol use, and hypertension.¹

People living in poverty are less likely to have health insurance coverage and often find it more difficult to pay for needed medical care.

Some literature suggests that they are more likely to be hospitalized for conditions that should have been controlled in the outpatient setting ("ambulatory care sensitive conditions" or ACSCs).

Being in poor mental or physical health can influence an individual's ability to be employed. People with little education are less likely to earn a living wage.

What Is Being Done?

Healthcare "safety net" programs, such as Medicaid, CHIP (Children's Health Insurance Plan), and the Primary Care Network (PCN) provide some relief to those who are eligible. Utah's community health centers also fill a critical niche in providing high-quality healthcare services to Utahns of any income level.

Programs such as Head Start and those that provide assistance linking people with jobs, aim to reduce poverty by increasing social functioning and self-sufficiency. Other programs, such as minimum wage requirements, food stamps, Temporary Assistance for Needy Families (TANF), and government subsidized health insurance and child care, provide assistance to families needing additional support.

Utah has an intergenerational poverty initiative that involves several state agencies collaborating to analyze data related to intergenerational poverty and work toward a goal to "reduce the number of Utah families in the cycle of poverty, improving their quality of life, and helping them become economically stable".² To reduce the cycle of poverty, the initiative is focusing on early childhood development, education, family economic stability, and health. For more information

- 11.7% of Utah residents lived in poverty in 2014
- Rate decreases with age
- Disparities include American Indian/Alaska Native, Asian, Black, Hispanic, and those with two or more races
- Higher rates among adults aged 25+ with less than a high school education
- Significantly higher for Bear River, Central Utah, San Juan, Southeast Utah, and Southwest Utah LHDs
- Significantly lower for Davis County, Summit County, Tooele County, TriCounty, and Wasatch County LHDs

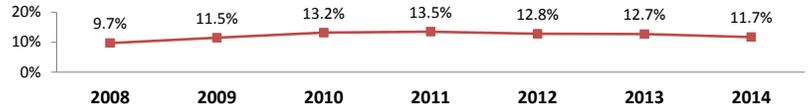
¹ Blakely et al (2005), Distribution of Risk Factors by Poverty. Accessed 8/7/2016 from <http://www.who.int/publications/cra/chapters/volume2/1941-2128.pdf>.

² Utah Department of Workforce Services. Utah's Intergenerational Poverty Initiative. Accessed 8/7/2016 from <http://www.jobs.utah.gov/edo/intergenerational/index.html>.

Persons Living in Poverty

see <http://www.jobs.utah.gov/edo/intergenerational/index.html>.

Figure: Percentage of Persons Living in Poverty by Year, Utah, 2008–2014

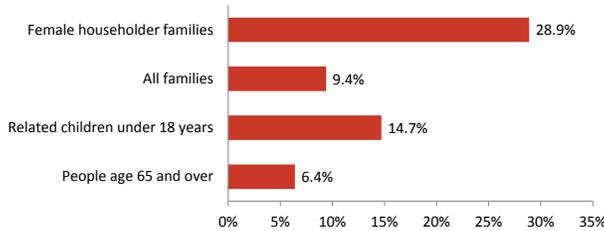


Data Interpretation Issues

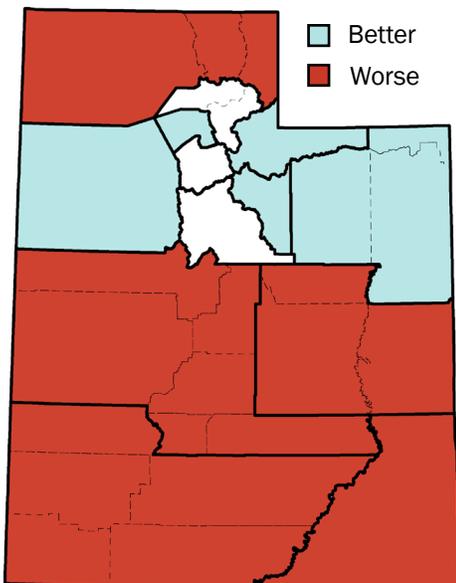
Poverty status is determined by comparing annual income to a set of dollar values called thresholds that vary by family size, number of children, and age of householder. If a family's before tax income is less than the dollar value of their threshold, then that family and every individual in it are considered to be in poverty. For people not living in families, poverty status is determined by comparing the individual's income to his or her threshold.

The poverty threshold for a family of four including two children was \$24,008 in 2014.¹ Poverty thresholds are updated annually to allow for changes in the cost of living using the Consumer Price Index for All Urban Consumers (CPI-U). They do not vary geographically.

Figure: Poverty Rates in Utah by Family Type, 2010–2014 ACS



Map: Poverty by Local Health District, Utah, 2014



1 DeNavas-Walt, Carmen and Bernadette D. Proctor, U.S. Census Bureau, Current Population Reports, P60-252, Income and Poverty in the United States: 2014, U.S. Government Printing Office, Washington, DC, 2015. Accessed 8/8/2016 from <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>.

Crude (burden)

STATE COMPARISON (2010–2014)

	Rate	90% CIs
U.S.	15.6%	15.5% - 15.7%
New Hampshire (best)	8.9%	8.6% - 9.2%
UTAH (15th of 51)	12.8%	12.5% - 13.1%
Mississippi (worst)	22.6%	22.3% - 22.9%

AGE IN YEARS (2014)

Age Group	Rate	90% CIs	Status
<18	13.3%	12.2% - 14.4%	!
18–64	11.8%	11.3% - 12.3%	✓
65+	6.7%	6.0% - 7.4%	✓

GENDER (2014)

Gender	Rate	90% CIs	Status
Male	10.8%	10.2% - 11.4%	✓
Female	12.6%	11.9% - 13.3%	

RACE (2014)

Race	Rate	90% CIs	Status
American Indian/AK Native	33.3%	27.7% - 38.9%	!
Asian	16.1%	12.1% - 20.1%	!
Black	22.7%	16.8% - 28.6%	!
Pacific Islander	17.7%	8.8% - 26.6%	
White	10.1%	9.6% - 10.6%	✓
Two or More Races	16.1%	14.3% - 18.8%	!

ETHNICITY (2014)

Ethnicity	Rate	90% CIs	Status
Hispanic	23.6%	21.2% - 26.0%	!
White, Non-Hispanic	9.0%	8.5% - 9.5%	✓

EDUCATION—Adults 25+ (2014)

Education Level	Rate	90% CIs	Status
Below High School	20.7%	18.7% - 22.7%	!
High School or GED	11.2%	10.3% - 12.1%	✓
Some College	8.1%	7.5% - 8.7%	✓
Bachelor's degree or higher	4.5%	4.0% - 5.0%	✓

LOCAL HEALTH DISTRICT (2014)[‡]

Local Health District	Rate	90% CIs	Status
Bear River	13.4%	12.0% - 14.8%	!
Central Utah	14.1%	12.5% - 15.7%	!
Davis County	7.2%	6.1% - 8.3%	✓
Salt Lake County	11.9%	11.1% - 12.7%	
San Juan	29.2%	24.6% - 33.8%	!
Southeast Utah [†]	14.8%	13.0% - 16.6%	!
Southwest Utah	14.8%	13.1% - 16.5%	!
Summit County	6.8%	5.6% - 8.0%	✓
Tooele County	8.1%	6.4% - 9.8%	✓
TriCounty	10.3%	8.9% - 11.7%	✓
Utah County	12.6%	11.6% - 13.6%	
Wasatch County	7.1%	5.5% - 8.7%	✓
Weber-Morgan	12.0%	10.5% - 13.5%	

[†] Includes Carbon, Emery, and Grand counties

[‡] Data for local health district based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

Child Poverty

American Community Survey (ACS)

Description

Child poverty is defined as the percentage of children (aged 17 and under) living in households whose income is at or below the federal poverty threshold as defined by the U.S. Census Bureau.

How Are We Doing?

According to the American Community Survey (ACS), approximately 13.3% of Utah children aged 17 and under (approximately 118,789 Utah children) were living in poverty in 2014.

Children born into poverty are less likely to have regular healthcare, proper nutrition, and opportunities for mental stimulation and enrichment.

National Comparison

Utah has a lower percentage of children in poverty than the U.S. as a whole (13.3% vs. 21.7% in 2014).

Healthy People Objective (see Appendix)

SDOH-3.2: Proportion of children aged 0–17 years living in poverty

U.S. Target: Not applicable. This measure is being tracked for informational purposes.

Disparities

Central Utah, Salt Lake County, San Juan, Southeast Utah, and Southwest Utah local health districts (LHDs) have child poverty rates that are higher than the state. Davis County, Summit County, Tooele County, Utah County, and Wasatch County LHDs have child poverty rates that are lower than the state.

Risk Factors

Being a younger or single parent increases the risk of living in poverty.

Families in poverty are less likely to have private health insurance coverage. Many children living at or near the poverty level are eligible for public health insurance programs, such as Medicaid and CHIP (Children's Health Insurance Program).

One of the best ways for adults to avoid poverty is to get a good education. Adolescents who give birth are more likely to live in poverty since they are more likely to limit their education.

The association between poverty and health status is probably bi-directional. That is, persons with chronic mental or physical illness are less able to achieve their educational goals and get good jobs. At the same time, persons who have lower incomes are less able to afford healthcare and may have less healthy lifestyles. For instance, persons with lower education and income levels are more likely to smoke cigarettes and less likely to get regular exercise.

Low socio-economic status is a risk factor for many diseases and health problems for persons of all ages. Children in poverty are at higher risk for health problems such as asthma and dental disease.

Children in poverty are also at increased risk of hunger and poor performance in school. An important goal of services to children in poverty is to break the "cycle of poverty" in which children in poverty are raised in conditions that promote poverty in adulthood.

What Is Being Done?

Utah has an intergenerational poverty initiative that involves several state agencies collaborating to analyze data related to intergenerational poverty and work toward a goal to "reduce the number of Utah families in the cycle of poverty, improving their quality of life, and helping them become economically stable".¹ To reduce the cycle of poverty the initiative is focusing on early childhood development, education, family economic stability, and health. For more information see <http://www.jobs.utah.gov/edo/intergenerational/index.html>.

There are programs such as Medicaid and CHIP (Children's Health Insurance Program) that pay for healthcare for eligible children.

- 13.3% of children lived in poverty in 2014
- Lower rates among children aged 16–17 years
- Significantly higher for Central Utah, Salt Lake County, San Juan, Southeast Utah, and Southwest Utah LHDs
- Significantly lower for Davis County, Summit County, Tooele County, Utah County, and Wasatch County LHDs

¹ Utah Department of Workforce Services. Utah's Intergenerational Poverty Initiative. Accessed 8/7/2016 from <http://www.jobs.utah.gov/edo/intergenerational/index.html>.

Child Poverty

Data Interpretation Issues

Poverty status is determined by comparing annual income to a set of dollar values called thresholds that vary by family size, number of children, and age of householder. If a family's before tax income is less than the dollar value of their threshold, then that family and every individual in it are considered to be in poverty. For people not living in families, poverty status is determined by comparing the individual's income to his or her threshold.

The poverty thresholds are updated annually to allow for changes in the cost of living using the Consumer Price Index for All Urban Consumers (CPI-U). They do not vary geographically. The poverty threshold for a family of four including two children was \$24,008 in 2014.¹

Figure: Percentage of Children in Poverty in Utah by Year, 2008-2014



Map: Child Poverty by Local Health District, Utah, 2014

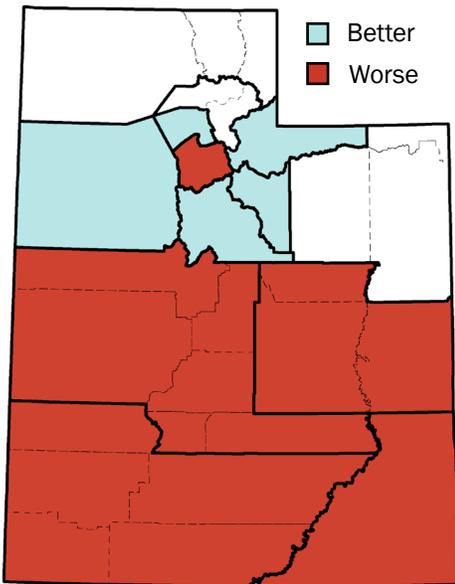
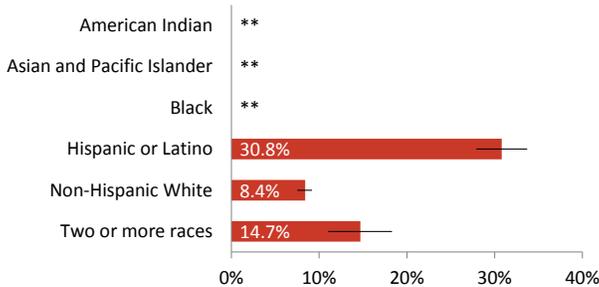


Figure: Child Poverty Rates in Utah by Race, 2014 ACS



Crude (burden)

STATE COMPARISON (2010-2014)	Rate	90% CIs
U.S.	21.6%	21.4% - 21.8%
New Hampshire (best)	11.2%	10.6% - 11.8%
UTAH (7th of 51)	14.7%	14.2% - 15.2%
Mississippi (worst)	31.9%	31.3% - 32.5%

AGE IN YEARS (2014)

Age Group	Rate	90% CIs
Under 5	14.3%	12.9% - 15.7%
5 years	16.1%	12.4% - 19.8%
6-11 years	13.5%	12.2% - 14.8%
12-14 years	12.3%	10.7% - 13.9%
15 years	12.1%	9.7% - 14.5%
16-17 years	10.1%	8.3% - 11.9% ✓

GENDER (2014)

Gender	Rate	90% CIs
Male	13.4%	12.3% - 14.5%
Female	13.2%	12.2% - 14.2%

RACE/ETHNICITY (2014)[^]

Race/Ethnicity	Rate	90% CIs
American Indian	**	** **
Asian and Pacific Islander	**	** **
Black	**	** **
Hispanic or Latino	30.8%	27.9% - 33.7% !
Non-Hispanic White	8.4%	7.5% - 9.2% ✓
Two or more races	14.7%	11.0% - 18.3%

LOCAL HEALTH DISTRICT (2014)[‡]

Local Health District	Rate	90% CIs
Bear River	13.5%	11.4% - 15.6%
Central Utah	18.4%	16.1% - 20.7% !
Davis County	8.3%	6.5% - 10.1% ✓
Salt Lake County	15.1%	13.5% - 16.7% !
San Juan	30.5%	24.2% - 36.8% !
Southeast Utah [†]	19.0%	16.1% - 21.9% !
Southwest Utah	19.6%	16.6% - 22.6% !
Summit County	7.9%	5.8% - 10.0% ✓
Tooele County	10.5%	7.9% - 13.1% ✓
TriCounty	11.6%	9.6% - 13.6%
Utah County	11.0%	9.3% - 12.7% ✓
Wasatch County	9.8%	7.3% - 12.3% ✓
Weber-Morgan	14.9%	12.3% - 17.5%

[^] Data for race/ethnicity from Kids Count Data Center.
^{**} Estimates suppressed when the confidence interval around the percentage is greater than or equal to 10 percentage points.
[†] Includes Carbon, Emery, and Grand counties
[‡] Data for local health district based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

¹ DeNavas-Walt, Carmen and Bernadette D. Proctor, U.S. Census Bureau, Current Population Reports, P60-252, Income and Poverty in the United States: 2014, U.S. Government Printing Office, Washington, DC, 2015. Accessed 8/8/2016 from <http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf>.

Food Insecurity

Map the Meal Gap Hunger Study

Description

This indicator reports the estimated percentage of the population that experienced food insecurity at some point during the report year. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food.

The United States Department of Agriculture (USDA) defines food security as "access by all people at all times to enough food for an active, healthy life." The USDA Economic Research Service Office sponsors an annual survey conducted by the U.S. Census Bureau as an addition to the Current Population Survey. The survey asks an adult in each household several questions related to food insecurity. Food insecure status depends on the number of food insecure conditions indicated by the questions for the adult or their children.¹

How Are We Doing?

An estimated 14.2% of the total population experienced food insecurity during 2014. An estimated 18.2% of children under 18 years of age experienced food insecurity.

National Comparison

The Utah 2014 reported rate of food insecurity was 14.2% of the total population. This was lower than the United States rate of 15.4%.

Healthy People Objective (see Appendix)

NWS-12: Eliminate very low food security among children

U.S. Target: 0.2 percent

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

U.S. Target: 6.0 percent

Disparities

San Juan County is the most food insecure area of the state at 19.0%.

Nationally, seniors, African Americans, Hispanics, and people living in rural areas are more likely to suffer from food insecurity.

Risk Factors

Nationally, food insecurity rates were higher than the national average for households with children (especially if there were children under age 6), single parent households, households headed by Black or Hispanic persons, and low-income households (below 185 percent of the poverty threshold).²

What Is Being Done?

Feeding America is the nation's network of more than 200 food banks and the largest hunger-relief charity in the United States. Each year, Feeding America secures and distributes three billion pounds of food and grocery products through 61,000 agencies nationwide. The agency network provides charitable food assistance to an estimated 37 million people in need annually. In addition to outreach, Feeding America works with other foundations to produce hunger studies like Map the Meal Gap to help combat hunger by learning about food insecurity at the local level.

Utah has several food banks and pantries throughout the state to assist families in being able to obtain food. There is a mobile pantry that assists in underserved communities or areas where clients may not be able to access other food pantries. The Department of Workforce Services provides food stamps to families who qualify through their Supplemental Nutrition Assistance Program.

- An estimated 14.2% of the population experienced food insecurity during 2014
- San Juan county is the most food insecure area of the state at 19.0%
- Nationally, seniors, African Americans, Hispanics, and people living in rural areas are more likely to suffer from food insecurity

1 Coleman-Jensen, A., Rabbit, M., Gregory, C., and Singh, A., (2015), Household food security in the United States in 2014. Economic Research Report Number 194. United States Department of Agriculture. Accessed 8/8/2016 from <http://ers.usda.gov/publications/err-economic-research-report/err194.aspx>.

2 Coleman-Jensen, A., Gregory, C., & Singh, A. (2014). Household Food Security in the United States in 2013. United States Department of Agriculture Economic Research Service (USDA ERS). Accessed 8/8/2016 from <http://www.ers.usda.gov/media/1565415/err173.pdf>.

Food Insecurity

Figure: Percentage of Persons That Experienced Food Insecurity in Utah by Year, 2012-2014

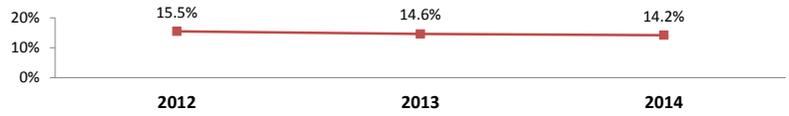
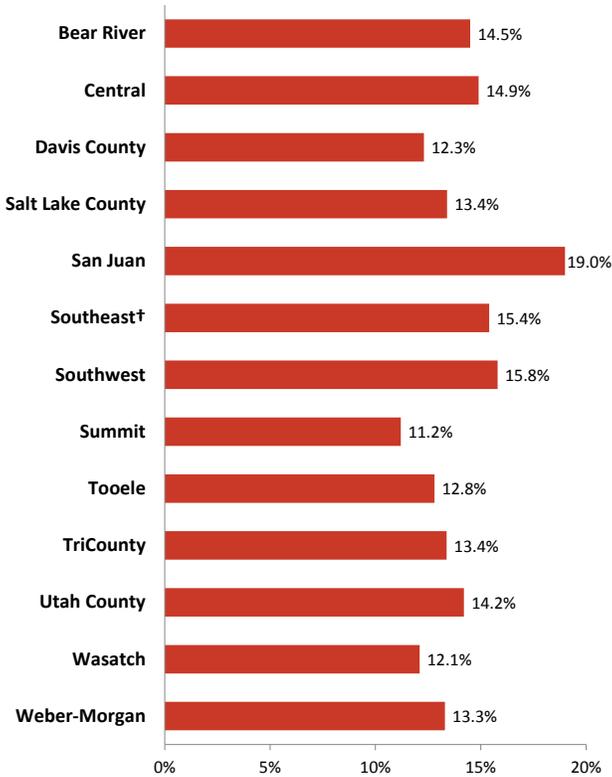


Figure: Food Insecurity by Local Health District, Utah, 2014



STATE COMPARISON (2014)

Entity	Crude Rate (burden)
U.S.	15.4%
North Dakota (best)	8.0%
UTAH (27th of 51)	14.2%
Mississippi (worst)	22.3%

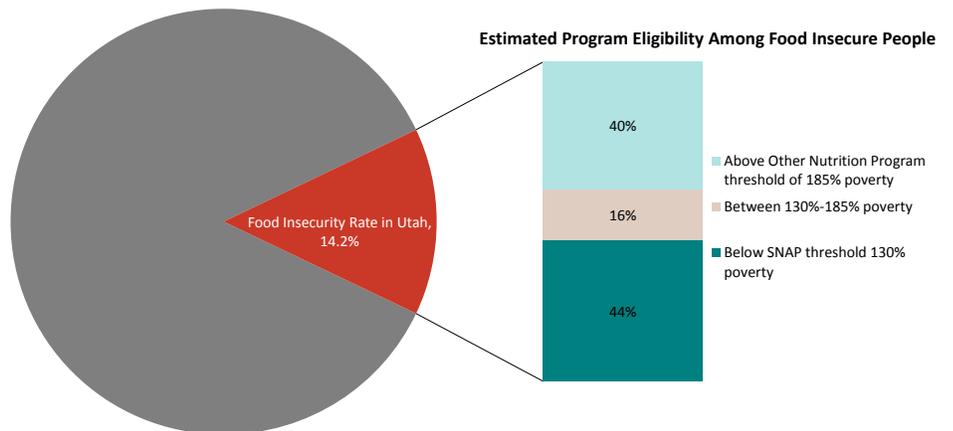
LOCAL HEALTH DISTRICT (2014)

Local Health District	Crude Rate (burden)
Bear River	14.5%
Central Utah	14.9%
Davis County	12.3%
Salt Lake County	13.4%
San Juan	19.0%
Southeast Utah†	15.4%
Southwest Utah	15.8%
Summit County	11.2%
Tooele County	12.8%
TriCounty	13.4%
Utah County	14.2%
Wasatch County	12.1%
Weber-Morgan	13.3%

† Includes Carbon, Emery, and Grand counties

Figure: Food Insecurity in Utah, 2014

416,670	Food Insecure People in Utah
\$2.78	Average Cost of a Meal
\$204,334,000	Additional Money Required to Meet Food Needs



Source: Feeding America Map the Meal Gap website, <http://map.feedingamerica.org/county/2014/overall/utah>.

Environmental Health

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Air Quality (PM_{2.5})

U.S. EPA Air Quality System

Description

Air quality is measured as the percentage of days with PM_{2.5} levels over the National Ambient Air Quality Standards (NAAQS).

Particulate matter that measures 2.5 micrometers in diameter or less is often called PM_{2.5}. Particulate matter 10 (PM₁₀) measures one-seventh the width of a strand of human hair, so one can imagine just how small PM_{2.5} really is. PM_{2.5} is composed of metals, allergens, nitrates, sulfates, organic chemicals, soil, and dust that are emitted from sources such as combustion products, soot from fireplaces, and blowing dust from construction sites and agricultural activities.

How Are We Doing?

Several of the most urban counties in Utah have days that do not comply with the PM_{2.5} standard. This may be due in part to the unique geography and seasonal conditions in Utah. PM_{2.5} levels increase seasonally in the winter, often due to inversions. The Utah Department of Environmental Quality (DEQ) is working to decrease the number of days over the PM_{2.5} standard.

Areas of Cache, Utah, Box Elder, Davis, Salt Lake, Tooele, and Weber counties have been designated as nonattainment areas for the PM_{2.5} 2006 NAAQS.¹

National Comparison

In 2014 Utah ranked 47th out of 50 for the percentage of days with PM_{2.5} levels over the NAAQS.

Healthy People Objective—Related measure (see Appendix)

EH-1: Reduce the number of days the Air Quality Index (AQI) exceeds 100, weighted by population and AQI

U.S. Target: 1,980,000,000 AQI-weighted people days

Disparities

Urban areas of the state have worse air quality than the rural areas.

Risk Factors

Exposure to particulate matter is associated with harmful heart and lung health effects. People with heart failure, coronary heart disease, asthma, and chronic obstructive pulmonary disease; older adults; and children may be sensitive to air pollution. People who are sensitive may experience shortness of breath, chest tightness or pain, coughing, or irregular heart-beat. Doctor or emergency room visits, hospital stays, and school and work absences may increase due to these effects.²

What Is Being Done?

The DEQ is working to decrease Utah's PM_{2.5} emissions to comply with national standards. Because of the contribution of automobile emissions to particulate matter, DEQ encourages the public to use mass transit and to stay indoors on days with high pollution levels, which you can check at <http://www.health.utah.gov/utahair>. In addition, DEQ has studied the effects of high particulate matter levels on children playing outside at recess so that schools may make informed decisions about when to keep children indoors.

The DEQ provides a 3-day air quality forecast that gives an air quality index to help people plan activities to minimize the effects of pollution on their health and an action forecast notifying the public of voluntary or mandatory actions they need to take.³

Ultimately, the air quality in Utah depends on each individual taking steps to reduce the amount of energy being used and pollution being emitted.

Data Interpretation Issues

Data on PM_{2.5} levels are only available where air monitors exist. In Utah, monitors exist in areas in Box Elder, Cache, Davis, Duchesne, Salt Lake, Tooele, Uintah, Utah, Washington, and Weber counties. The Environmental Protection Agency (EPA) and DEQ have scientifically determined where in Utah PM_{2.5} is likely to exceed the NAAQS standard.

• In 2014 Utah ranked 47th out of 50 for the mean percentage of days with PM_{2.5} levels over the National Ambient Air Quality Standards

• Urban areas of the state have worse air quality than the rural areas

• Percentages in Utah ranged from 0.0% in Tooele and Washington counties to 4.1% in Salt Lake County

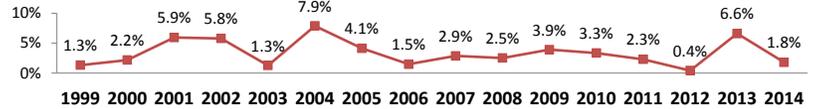
1 PM-2.5 (2006) Nonattainment Area Partial County Descriptions. Green Book. U.S. Environmental Protection Agency. Accessed 8/7/2016 from <https://www3.epa.gov/airquality/greenbook/rnp.html#4400>.

2 Utah Air: Particulate Matter. Utah Department of Health Bureau of Epidemiology. Accessed 8/7/2016 from <http://www.health.utah.gov/utahair/pollutants/PM/index.html#Health>.

3 Utah DEQ: DAQ: Forecast. Utah Department of Environmental Quality. Accessed 9/1/2016 from <http://air.utah.gov/forecast.php?id=slc>.

Air Quality (PM_{2.5})

Figure: Percentage of Days PM_{2.5} Over NAAQS Standard in Utah by Year, 1999–2014



Data for this report represent ambient air, or outside air quality. The relationship between ambient concentrations and personal exposure can vary significantly depending upon the pollutant, activity patterns, and micro-environments.

Data for this report came from the EPA and therefore, may differ slightly from data from other sources. One reason for a possible difference is that these data include exceptional events, which includes air pollution generated from fireworks, construction, fires, and other sources.

The Utah Department of Environmental Quality reports on three different source categories of air contaminants (area, point, and mobile). For definitions of these sources, see page 20 of the Utah Division of Air Quality 2015 Annual Report at http://www.deq.utah.gov/Divisions/daq/info/annualreports/docs/2015/02Feb/Final_Annual_Report_2015.pdf.

STATE COMPARISON (2014) Crude Rate (burden)

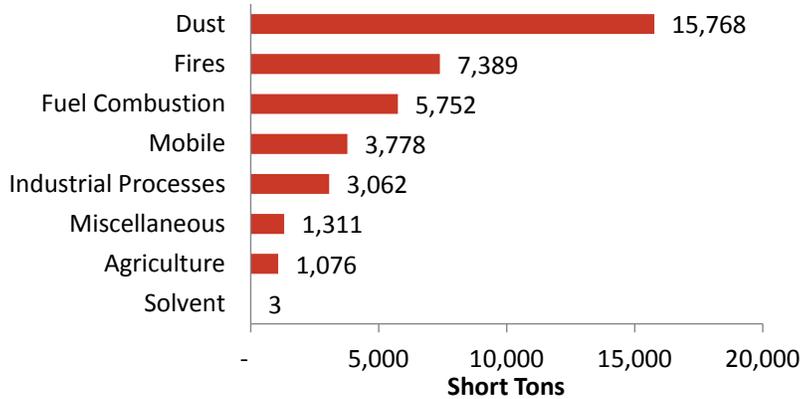
Multiple (best)	0.0%
UTAH mean (47th of 50)	1.8%
Alaska mean (worst)	9.7%

COUNTY (2014)

Box Elder	1.7%
Cache	3.3%
Davis	3.3%
Duchesne	**
Salt Lake	4.1%
Tooele	0.0%
Uintah	**
Utah	0.8%
Washington	0.0%
Weber	1.2%

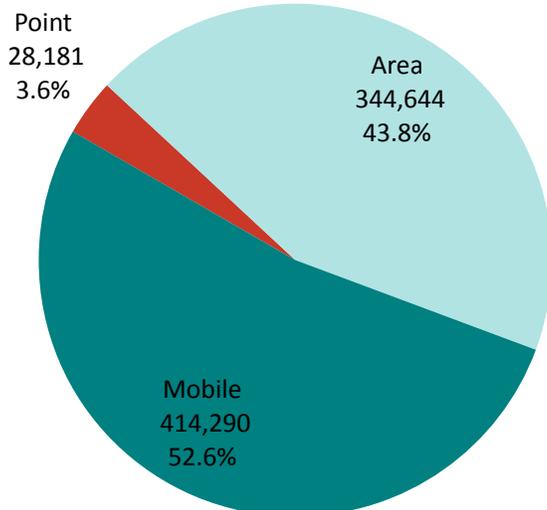
**The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

Figure: 2011 Primary PM_{2.5} Particle Emissions by Source Sector in Utah, EPA



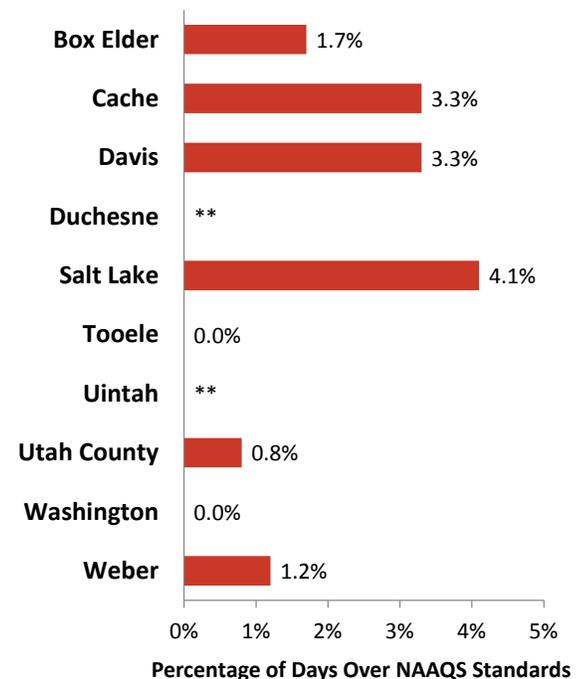
Source: Particulate Matter (PM). Utah Department of Health Bureau of Epidemiology. Accessed 8/9/2016 from <http://www.health.utah.gov/utahair/pollutants/PM/index.html#Sources>.

Figure: 2011 PM_{2.5} Emissions by Source Category, Utah Division of Air Quality



Source: Utah Division of Air Quality 2015 Annual Report. Accessed 9/15/2016 from http://www.deq.utah.gov/Divisions/daq/info/annualreports/docs/2015/02Feb/Final_Annual_Report_2015.pdf.

Figure: Percentage of Days PM_{2.5} Over NAAQS Standard by County, Utah, 2014



Substandard Housing

American Community Survey (ACS)

Description

This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%.

Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Lacking complete plumbing facilities means the housing is missing either (a) hot and cold running water, (b) a flush toilet, or (c) a bathtub or shower.

Lacking complete kitchen facilities means the housing is missing either (a) a sink with a faucet, (b) a stove or a range, or (c) a refrigerator.

How Are We Doing?

National Comparison

In 2014, the percentage of occupied housing units with one or more substandard conditions in Utah was 32.2% which was lower than the U.S. rate of 35.6%.

Healthy People Objective (see Appendix)

There are several Healthy People Objectives related to different aspects of substandard housing. EH-13 through EH-19 are measures related to specific aspects of housing concerns. SDOH-4 targets the proportion of households that experience housing cost burden. See Appendix for full list of Healthy People Objectives referenced in this report.

Disparities

Nationally, African-American and Hispanic persons are more likely to live in substandard housing than those who are White.

Risk Factors

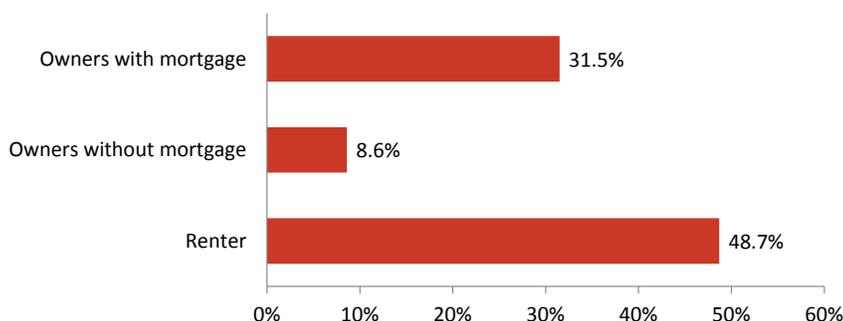
Substandard housing increases risks for environmental diseases and injuries.

What Is Being Done?

Assisting citizens with locating affordable housing is done by the state Housing and Community Development (HCD) Division and local housing authorities around the state. For a list of HCD programs see <https://jobs.utah.gov/housing/hcdprograms.html>.

- 32.2% of Utah occupied housing units had one or more substandard conditions
- Nationally, African-Americans and Hispanics are more likely to live in substandard housing than Whites
- Percentages of housing units in substandard conditions varied from 25.0% in Central Utah LHD to 36.3% in Wasatch County LHD

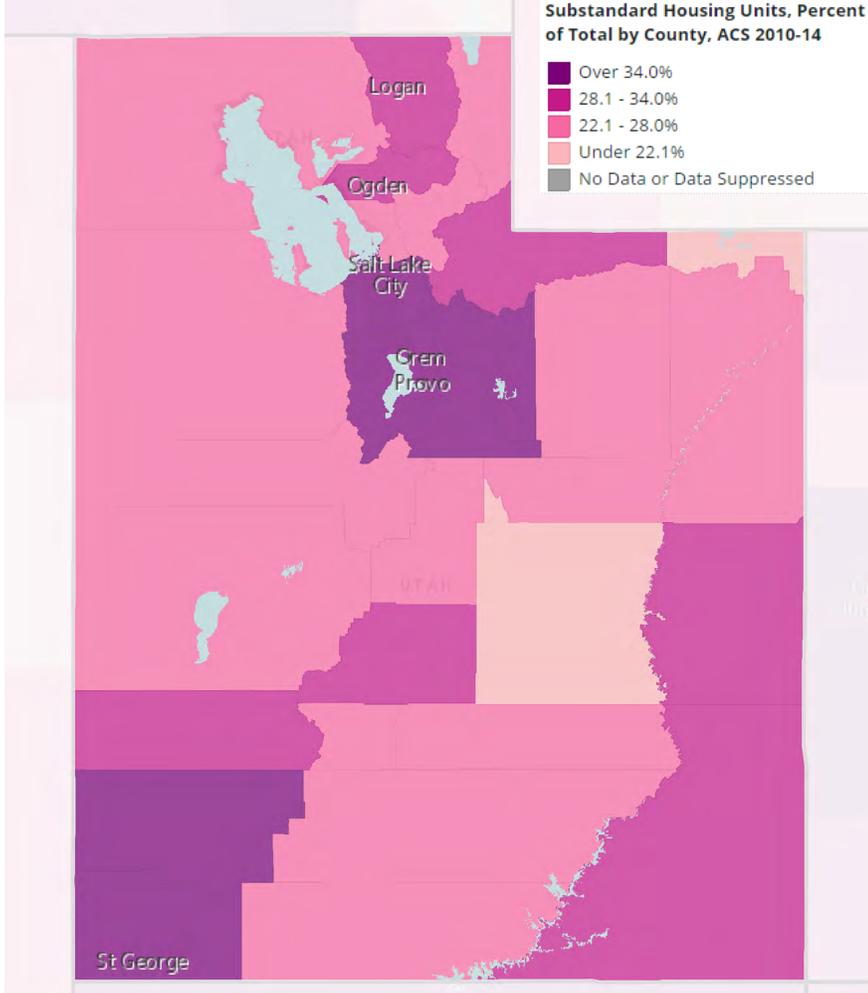
Figure: Occupants With a Housing Cost Burden (owner costs <30% of household income) in Utah, 2010–2014 ACS¹



1 Population and Housing Narrative Profile, 2010–2014 American Community Survey 5-Year Estimates, Utah. Accessed 5/18/16 at http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/profile/2014/5yr/np01.html?SUMLEV=40&state=49.

Substandard Housing

Map: Substandard Housing by County, Utah, 2010–2014



Map downloaded from Community Commons website, <http://www.communitycommons.org/>.

STATE COMPARISON (2010–2014) Crude Rate (burden)

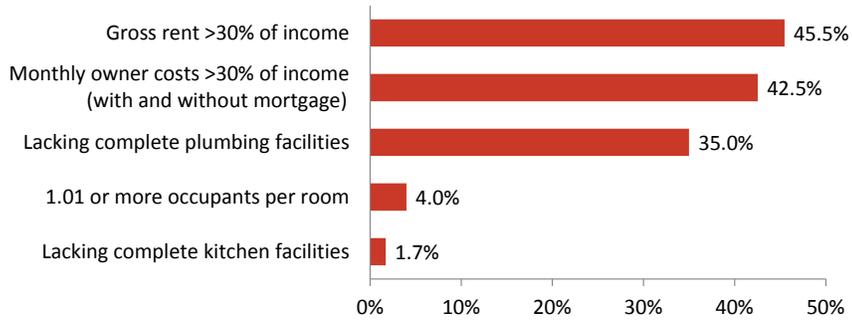
U.S.	35.6%
North Dakota (best)	22.0%
UTAH (25th of 51)	32.2%
California (worst)	47.5%

LOCAL HEALTH DISTRICT (2010–2014)

Bear River	29.6%
Central Utah	25.0%
Davis County	26.8%
Salt Lake County	34.4%
San Juan	30.5%
Southeast Utah†	25.4%
Southwest Utah	36.0%
Summit County	30.7%
Tooele County	25.5%
TriCounty	26.4%
Utah County	34.4%
Wasatch County	36.3%
Weber-Morgan	29.7%

† Includes Carbon, Emery, and Grand counties

Figure: Percentage of Housing Units in Utah Having Substandard Condition, 2010–2014



Source: Community Commons website, <http://www.communitycommons.org/>.

Occupational Fatalities

America's Health Rankings

Description

This measure is defined as the number of fatal occupational injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers.

How Are We Doing?

National Comparison

Utah is currently ranked 21 on this indicator in America's Health Rankings with a rate of 4.0 deaths per 100,000 workers in 2015.

Healthy People Objective (see Appendix)

OSH-1.1: Reduce deaths from work-related injuries in all industries

U.S. Target: 3.6 deaths per 100,000 full-time equivalent workers

Disparities

Nationally, occupational fatalities have been noted to be higher for Hispanic workers than for non-Hispanic workers.¹

Risk Factors

The top causes of fatal occupational injury in Utah during 2014 were transportation incidents (41%), contact with objects and equipment (23%), exposure to harmful substances or environments (17%), and violence and other injuries by persons or animals (13%).

What Is Being Done?

Nationally, work has been done to increase safety procedures and regulations to improve oversight. The National Institute for Occupational Safety and Health (NIOSH) publishes several suggestions for improving safety in the workplace.

The Utah Occupational Safety and Health Division within the State of Utah Labor Commission works to ensure a safe and healthy workplace for all workers in Utah. They offer information on laws, develop administrative rules, provide consultation, and list resources.

Data Interpretation Issues

"Occupational Fatalities is the combined rate of fatal injuries in the following industries: construction, manufacturing, trade, transportation, utilities, professional, and business services, as defined by the North American Industry Classification System (NAICS). Rather than using an occupational fatality rate for all workers, this industry-adjusted rate is used to account for the different mix of industries in each state to more accurately reflect the variation in unsafe working conditions between the states. Occupational fatalities are measured over a 3-year span because of their low incidence rate. In states where occupational fatality data is not available for a specific industry, the national rate for that industry was used to calculate the state's occupational fatality rate. The 2015 ranks are based on 2012 to preliminary 2014 occupational fatality data from the Census of Fatal Occupational Injuries (CFOI), collected by the Bureau of Labor Statistics, U.S. Department of Labor. CFOI includes fatalities resulting from non-intentional injuries such as falls, electrocutions, and acute poisonings as well as from motor vehicle crashes that occurred during travel for work. Also included are intentional injuries (i.e., homicides and suicides) that occurred at work. Fatalities that occur during a person's commute to or from work are not counted. The 2014 industry population data used to calculate rates is from the Bureau of Economic Analysis." (from the United Health Foundation America's Health Rankings website: <http://www.americashealthrankings.org/UT/WorkFatalities>)

- Utah is currently ranked 21 on this indicator in America's Health Rankings with a rate of 4.0 deaths per 100,000 workers in 2015
- Nationally, occupational fatalities have been noted to be higher for Hispanic workers than for non-Hispanic workers

¹ Occupational Fatalities. America's Health Rankings. Accessed 8/8/2016 from <http://www.americashealthrankings.org/UT/WorkFatalities>.

Occupational Fatalities

STATE COMPARISON (2015)	Crude (burden)	
	Rate	95% CIs
U.S.	3.7	3.6 - 3.8
New York (best)	2.0	1.7 - 2.3
UTAH (21st of 50)	4.0	3.1 - 4.9
Wyoming (worst)	12.0	8.6 - 15.4

Figure: Occupational Fatalities per 100,000 Workers in Utah by Year, 2000–2015

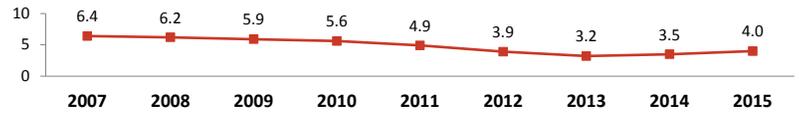
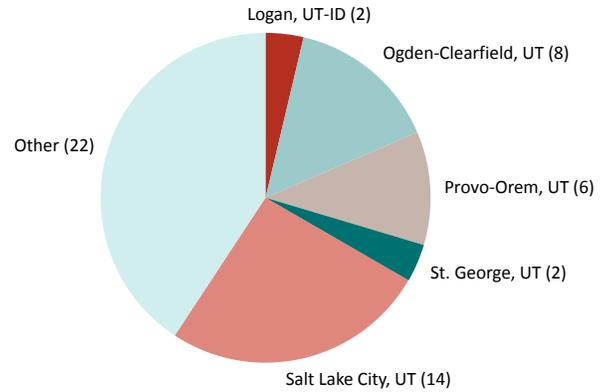
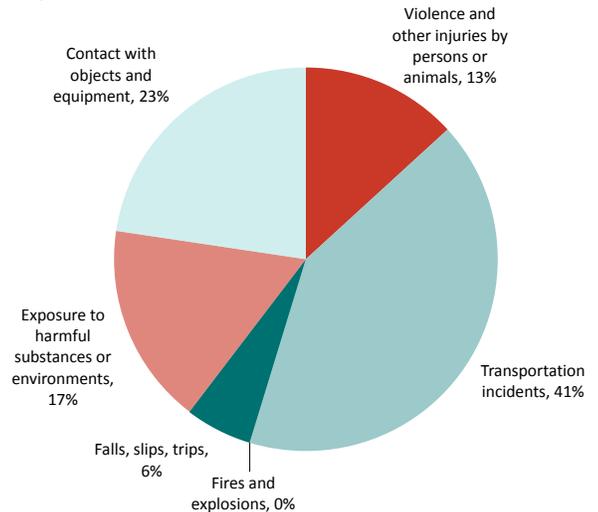


Figure: Number of Fatal Occupational Injuries by Metropolitan Statistical Area (MSA), Utah, 2014



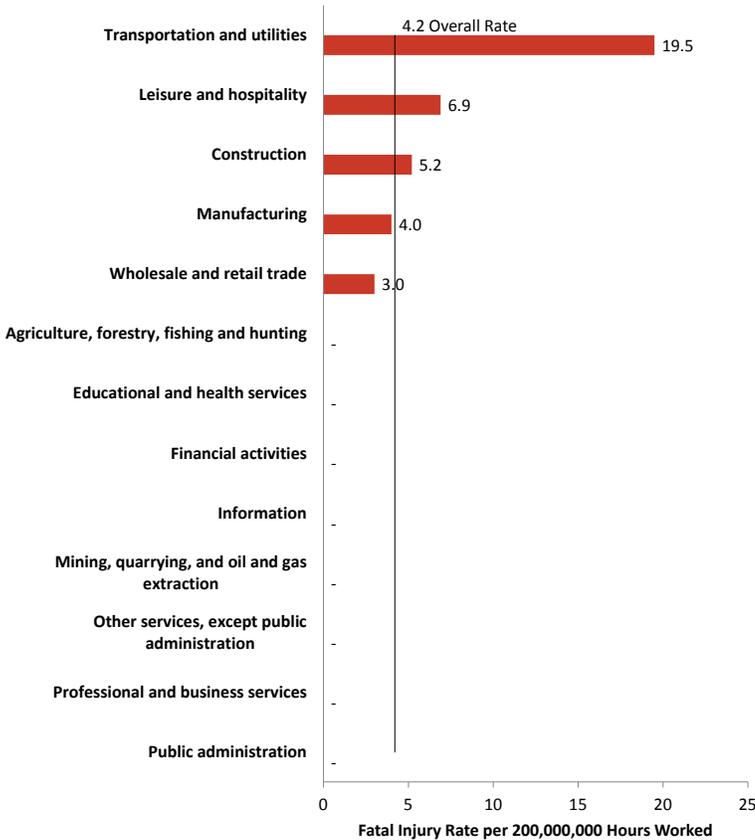
Note: Metropolitan areas used in this table are based on definitions from the Office of Management and Budget (OMB). These OMB MSA definitions are predicated upon combinations of state and county identifiers. Source: U.S. Department of Labor, Bureau of Labor Statistics, in cooperation with state, New York City, District of Columbia, and federal agencies, Census of Fatal Occupational Injuries. Accessed 8/1/2016 from http://www.bls.gov/iif/oshwc/cfoi/cfoi_msa_2014.pdf.

Figure: Number of Fatal Occupational Injuries by Major Event or Exposure, Utah, 2014



Note: Based on the BLS Occupational Injury and Illness Classification System (OIICS) 2.01 implemented for 2011 data forward. Source: U.S. Department of Labor, Bureau of Labor Statistics, in cooperation with state, New York City, District of Columbia, and federal agencies, Census of Fatal Occupational Injuries. Accessed 8/1/2016 from <http://www.bls.gov/iif/oshwc/cfoi/tgs/2014/iiffw49.htm#iiffw49demindocc.f.1>.

Figure: Fatal Occupational Injury Rates by Industry, Utah, 2014



Notes: CFOI has used several versions of the North American Industry Classification System (NAICS) since 2003 to define industry. For more information on the version of NAICS used in this year, see the definitions page at <http://www.bls.gov/iif/oshcdef.htm>. Workers under the age of 16 years, volunteer workers, and members of the resident military are not included in rate calculations to maintain consistency with the Current Population Survey (CPS) employment. The ownership category government is not presented separately and may be included in any industry category. In 2007, the Census of Fatal Occupational Injuries (CFOI) adopted hours-based state fatal injury rates. Employment-based rates were used previously. Because of substantial differences between rates calculated using the two methods, hours-based state fatal injury rates should not be compared to the employment-based rates from previous years.

Source: U.S. Bureau of Labor Statistics, Current Population Survey, Census of Fatal Occupational Injuries, 2016. Accessed 8/1/2016 from <http://www.bls.gov/iif/oshwc/cfoi/rate2014ut.htm>.

Respiratory Conditions

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Uncontrolled Asthma

Emergency Department Encounter Database

Description

Uncontrolled asthma is reported as the number of emergency department (ED) visits due to asthma per 10,000 Utah residents.

How Are We Doing?

Utah is well below the Healthy People 2020 (HP2020) targets for aged 0–4 and 5–64 (Utah had rates of 37.6 and 23.8, respectively), and in 2013 Utah met its state ED target for 0–4. The ED visit rate among the elderly aged 65+ in 2014 (21.0 per 10,000 population) currently exceeds the HP2020 target (13.7 per 10,000 population). In Utah in 2014, the overall ED visit rate due to asthma was 24.7 per 10,000 population (crude rate).

Healthy People Objective (see Appendix)

RD-3: Reduce emergency department (ED) visits for asthma

RD-3.1: Children under age 5 years

U.S. Target: 95.7 ED visits per 10,000

Utah Target: 46.7 ED visits per 10,000

RD-3.2: Children and adults aged 5 to 64 years

U.S. Target: 49.6 ED visits per 10,000

Utah Target: 21.2 ED visits per 10,000

RD-3.3: Adults aged 65 years and older

U.S. Target: 13.7 ED visits per 10,000

Utah Target: 16.3 ED visits per 10,000

Disparities

Utah children aged 0–4 had the highest asthma ED rate compared to other age groups.

Asthma ED visits are highest among young male children when compared to young female children. However, among adolescents and adults, females have higher rates.

Risk Factors

Environmental factors such as allergens, cigarette smoke, and air pollution may contribute to asthma. Individuals need to avoid risk factors and triggers to assist in controlling their asthma.

What Is Being Done?

The Utah Asthma Program (UAP), in conjunction with the Utah Asthma Task Force and other partners, strive to maximize the reach, impact, efficiency, and sustainability of comprehensive asthma control services through providing a seamless alignment of the full array of services across the public health and healthcare sectors, so that people with asthma receive all of the services they need.

The UAP focuses on three types of strategies to create and support a comprehensive asthma control program. These include: building infrastructure strategies to support leadership, strategic partnerships, strategic communications, surveillance, and evaluation; linking services strategies to expand school- and home-based services; and creating health systems strategies to improve coverage, delivery, quality, and use of clinical services.

These strategies are expected to increase asthma control and quality of life by increasing access to healthcare and by increasing coordination and coverage for comprehensive asthma control services both in the public health and healthcare sectors. Specifically, these strategies include identifying people with poorly controlled asthma, linking them to healthcare providers and National Asthma Education and Prevention Program Expert Panel Report 3 (NAEPP EPR-3) guidelines-based care, educating them on self-management, providing a supportive school environment, and referring to or providing home trigger reduction services for those who need them. The linkage function has the added benefit of bringing more people who might be high utilizers of emergency room and hospital services into primary care and also providing a resource for primary care providers to refer people for intensive self-management education and trigger reduction services when needed.

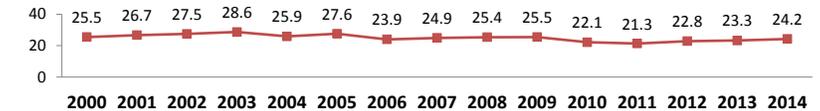
- 24.7 asthma ED visits per 10,000
- Highest rate for children aged 0–4
- Higher rates among females
- Significantly higher for Salt Lake County, Southeast Utah, Tooele County, TriCounty, and Weber-Morgan LHDs
- Significantly lower for Bear River, Davis County, Southwest Utah, Summit County, and Utah County LHDs

Uncontrolled Asthma

Data Interpretation Issues

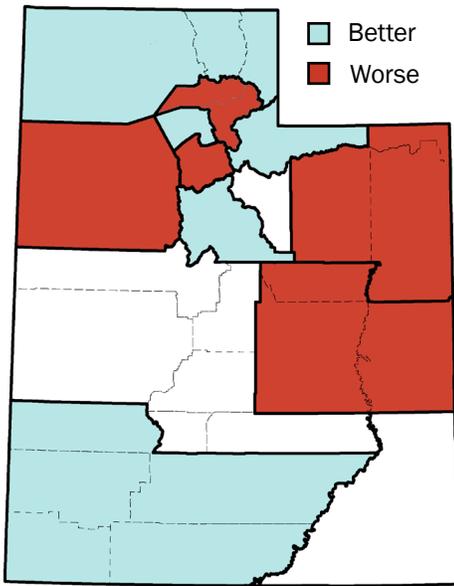
All ED encounters are included in the presented data, which includes those that were treat and release visits, as well as those that resulted in hospital admission.

Figure: Uncontrolled Asthma per 10,000 Persons in Utah by Year, 2000-2014



Trend graph depicts age-adjusted rates.

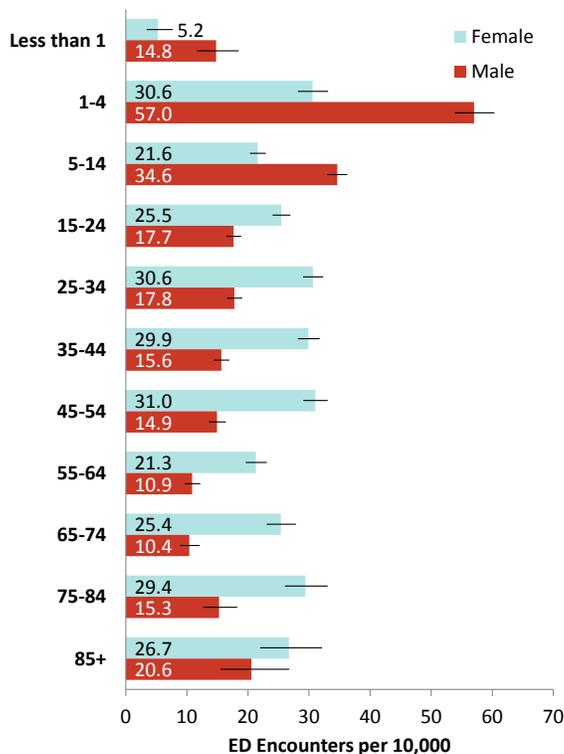
Map: Uncontrolled Asthma by Local Health District, 2014



	Crude (burden)		Age-adjusted (comparison)		
OVERALL (2014)	Rate	95% CIs	Rate	95% CIs	
UTAH	24.7	24.1 - 25.3	24.2	23.7 - 24.8	
AGE IN YEARS (2014)					
0-4	37.6	35.2 - 40.1	-	-	- !
5-64	23.8	23.2 - 24.4	-	-	- ✓
65+	21.0	19.4 - 22.7	-	-	- ✓
GENDER (2014)					
Male	22.7	21.9 - 23.5	21.3	20.5 - 22.0 ✓	
Female	26.7	25.9 - 27.6	27.1	26.2 - 28.0 !	
LOCAL HEALTH DISTRICT (2014)					
Bear River	16.6	14.7 - 18.7	16.2	14.3 - 18.2 ✓	
Central Utah	25.9	22.4 - 29.7	25.6	22.1 - 29.5	
Davis County	20.6	19.1 - 22.2	19.7	18.2 - 21.3 ✓	
Salt Lake County	31.3	30.3 - 32.4	30.9	29.9 - 32.0 !	
San Juan	23.0	16.0 - 31.9	23.8	16.4 - 33.4	
Southeast Utah†	32.7	27.4 - 38.7	34.3	31.9 - 38.8 !	
Southwest Utah	19.0	17.3 - 21.0	19.0	17.1 - 21.0 ✓	
Summit County	11.3	8.2 - 15.1	11.3	8.1 - 15.2 ✓	
Tooele County	40.1	35.3 - 45.4	38.7	33.9 - 44.0 !	
TriCounty	45.9	40.6 - 51.8	44.3	39.0 - 50.1 !	
Utah County	14.5	13.5 - 15.5	14.7	13.6 - 15.8 ✓	
Wasatch County	18.0	13.4 - 23.8	18.4	13.6 - 24.4	
Weber-Morgan	27.2	25.2 - 29.3	26.9	24.9 - 29.0 !	

† Includes Carbon, Emery, and Grand counties

Figure: Uncontrolled Asthma by Age and Sex, Utah, 2013-2014



Cardiovascular Conditions

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

High Blood Pressure

Behavioral Risk Factor Surveillance System

Description

This measure reports the proportion of adults who have ever been told by a doctor, nurse, or other health professional that they have high blood pressure. High blood pressure is defined as a systolic (upper) number of 140 or greater and a diastolic (lower) number of 90 or greater.

How Are We Doing?

The proportion of Utah adults who reported being told they had high blood pressure has remained relatively constant over the past decade. In 2014, approximately 1 in 4 (24.7%) Utah adults reported being told they had high blood pressure (age-adjusted rate).

National Comparison

The most recent year available for U.S. data was 2013. In that year, Utah had lower age-adjusted high blood pressure prevalence than the U.S.

Healthy People Objective (see Appendix)

HDS-5.1: Reduce the proportion of adults with hypertension

U.S. Target: 26.9 percent

Utah Target: 22.8 percent

Disparities

The percentage of adults who reported being told they had high blood pressure was much lower for women than men in every age group up to age 65.

Adults in households with annual incomes above \$75,000 had a lower rate of high blood pressure compared to the state rate. Those in households in the lowest income categories (<\$50,000) had a higher rate of high blood pressure compared to the state rate.

Doctor-diagnosed high blood pressure varied by educational level. College graduates (23.3%) had lower rates than those with less than a high school education (29.8%).

For combined years 2013 and 2014, Black Utahns had a higher rate of doctor-diagnosed high blood pressure (38.7%) compared to the general Utah population (24.8%).

Among local health districts (LHDs), Southeast Utah and Weber-Morgan had significantly higher rates of high blood pressure than the state overall. Summit County LHD had a rate that was statistically significantly lower than the state.

Risk Factors

High blood pressure is one of the most common primary diagnoses in the U.S.¹ Risk for developing hypertension increases with age. Oral contraceptives may increase risk of high blood pressure in women, especially if the women are older or obese.²

Some risk factors for high blood pressure can be reduced through lifestyle changes. These include exercise, reducing excess weight, tobacco cessation, and low-sodium diet. The Health and Medicine Division also recommends increasing dietary potassium, which can be achieved by eating more fruits and vegetables. Some risk factors are more difficult to control, such as family history and genetics. Certain medications can affect blood pressure as well. Individuals are encouraged to discuss their risk factors with a physician and monitor their blood pressure regularly.

What Is Being Done?

The Healthy Living through Environment, Policy, and Improved Clinical Care Program (EPICC) was formed in 2013, consolidating three UDOH programs (Diabetes Prevention and Control Program, Heart Disease and Stroke Prevention Program, and the Physical Activity, Nutrition and Obesity Program). The purpose of the consolidation was to ensure a productive, collaborative, and efficient program focused on health outcomes.

EPICC aims to reduce the incidence of diabetes, heart disease, and stroke by targeting risk factors including reducing obesity, increasing physical activity and nutritious food consumption, and improving diabetes and hypertension control.

EPICC is part of the Utah Million Hearts Coalition, which is part of a national effort to reduce the number of heart attacks and strokes in the U.S. by 1 million by 2017. The Utah Million Hearts Coalition has initiated efforts to educate primary care staff on the proper measurement of high blood pressure. Measuring high blood pressure properly helps to reduce the number of people who

- 24.7% of Utah adults have high blood pressure
- Rate increases with age
- Higher among males
- Disparity among Black population
- Higher rates among lower income levels
- Higher rate among adults aged 25+ with a high school or equivalent education; lower rate for college graduates
- Significantly higher for Southeast Utah and Weber-Morgan LHDs; significantly lower rate for Summit County LHD

1 IOM (Institute of Medicine). 2010. *A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension*. Washington, DC: The National Academies Press.

2 Heart Disease and Stroke Statistics—2009 Update. A Report From the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. *Circulation*. 2009;119:e1-e161.

High Blood Pressure

have high blood pressure but have not been diagnosed with the condition. It also helps to ensure that people who have been diagnosed with high blood pressure are treated effectively.

Evidence-based Practices

Healthcare organizations can improve high blood pressure control among their patient populations. Some strategies that have proven effective and sustainable include:

- Maximizing use of electronic medical records that allow providers to track patient care over time, and incorporate prompts and reminders to improve care.
- Integrating team-based care that makes full use of the skills of the team members to identify and treat patients with high blood pressure, provide patient support and follow-up care, and help patients manage their medicines and stick to a blood pressure control plan.
- Reinforcing the importance of behaviors that affect blood pressure, such as eating a healthy, low sodium diet; being physically active; maintaining a healthy weight; and not smoking.

Data Interpretation Issues

In order to be accurately diagnosed with hypertension, a patient must have had a blood pressure reading of more than 140/90 on two separate visits. The questionnaire does not capture whether a patient was told they had high blood pressure on a single visit or whether they were actually diagnosed with hypertension.

Map: High Blood Pressure by Local Health District, 2013–2014

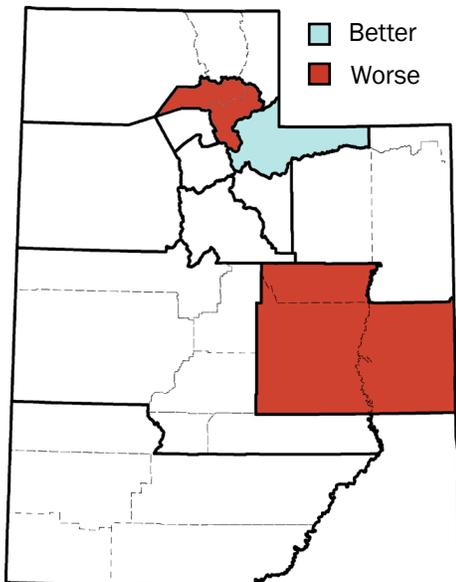
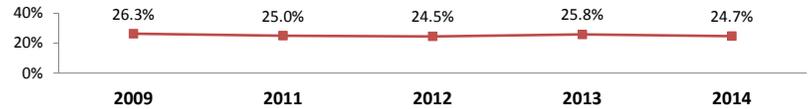


Figure: Percentage of Utahns Aged 18+ With High Blood Pressure by Year, 2009–2014



Trend graph depicts age-adjusted rates.

STATE COMPARISON (2013)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	32.4%	32.1% - 32.7%	30.4%	30.2% - 30.7%
Minnesota (best)	27.0%	25.7% - 28.4%	25.3%	24.1% - 26.5%
UTAH (3rd of 51)	24.2%	23.3% - 25.1%	25.8%	25.0% - 26.7%
Louisiana (worst)	39.9%	37.9% - 41.9%	38.5%	36.6% - 40.4%
AGE IN YEARS (2014)				
18–34	6.7%	5.3% - 8.5%	-	- - ✓
35–49	17.4%	15.1% - 20.0%	-	- - ✓
50–64	35.9%	33.0% - 39.0%	-	- - !
65+	57.2%	54.0% - 60.3%	-	- - !
GENDER (2014)				
Male	26.1%	24.1% - 28.2%	27.7%	25.7% - 29.7% !
Female	20.8%	19.2% - 22.6%	21.6%	20.1% - 23.2% ✓
RACE (2013–2014)				
American Indian/AK Native	20.4%	15.0% - 27.2%	23.2%	17.4% - 30.2%
Asian	16.2%	11.2% - 22.8%	22.1%	15.9% - 29.9%
Black	35.1%	25.5% - 46.0%	38.7%	30.3% - 47.7% !
Pacific Islander	21.5%	13.9% - 31.8%	32.0%	23.1% - 42.3%
White	24.0%	23.1% - 24.8%	24.5%	23.7% - 25.2%
ETHNICITY (2014)				
Hispanic	15.1%	11.6% - 19.5%	21.5%	17.0% - 26.8%
Non-Hispanic	24.4%	23.0% - 25.8%	24.9%	23.6% - 26.2%
INCOME (2014)				
0–\$24,999	25.6%	22.6% - 28.9%	31.5%	28.2% - 35.1% !
\$25,000–\$49,999	26.6%	23.8% - 29.7%	27.5%	24.8% - 30.4% !
\$50,000–\$74,999	25.0%	21.8% - 28.6%	25.1%	22.2% - 28.3%
\$75,000 or more	20.0%	17.8% - 22.4%	20.5%	18.2% - 22.9% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	27.4%	21.9% - 33.8%	29.8%	24.7% - 35.5%
High School or GED	32.7%	29.5% - 35.9%	32.5%	29.5% - 35.6% !
Some Post High School	28.2%	25.7% - 30.8%	28.9%	26.5% - 31.4%
College Graduate	22.7%	20.6% - 25.0%	23.3%	21.3% - 25.4% ✓
LOCAL HEALTH DISTRICT (2013–2014)				
Bear River	23.8%	20.6% - 27.4%	26.6%	23.3% - 30.0%
Central Utah	25.2%	21.7% - 29.2%	25.1%	21.9% - 28.5%
Davis County	22.6%	20.2% - 25.1%	25.5%	23.4% - 27.7%
Salt Lake County	24.4%	23.0% - 25.8%	25.3%	24.1% - 26.7%
San Juan	34.2%	22.6% - 48.2%	33.8%	23.5% - 45.8%
Southeast Utah†	35.1%	30.2% - 40.4%	30.3%	25.6% - 35.4% !
Southwest Utah	27.0%	24.0% - 30.2%	25.0%	22.3% - 27.9%
Summit County	21.3%	17.8% - 25.1%	20.1%	17.1% - 23.5% ✓
Tooele County	27.6%	23.5% - 32.1%	28.6%	24.7% - 32.8%
TriCounty	25.7%	22.1% - 29.7%	27.9%	24.6% - 31.4%
Utah County	19.9%	17.9% - 22.1%	23.3%	21.2% - 25.5%
Wasatch County	27.0%	23.0% - 31.3%	23.9%	20.2% - 28.1%
Weber-Morgan	27.8%	25.1% - 30.6%	28.0%	25.6% - 30.5% !

† Includes Carbon, Emery, and Grand counties

Note: Comparisons and national ranking based on age-adjusted rates.

Diabetes Conditions

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Diabetes Prevalence

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of Utah adults (18+) who reported being told by a healthcare professional that they have diabetes (excludes women who were told they had diabetes only during pregnancy or those who reported they had “borderline” or pre-diabetes).

How Are We Doing?

The prevalence of diabetes has risen and will likely continue to rise steadily, both nationally and in Utah. Several factors contribute to this increase. Increasing rates of obesity and sedentary lifestyles add to the number of people at risk for developing diabetes, while improvements in medical care mean people with diabetes are living longer.¹

A large number of individuals have pre-diabetes. Pre-diabetes is a condition in which blood sugar rates are elevated but not yet high enough to reach the clinical threshold of a diabetes diagnosis. An estimated 86 million Americans aged 20 and older have pre-diabetes. Unless those individuals take steps to reduce their risk of diabetes, such as increasing physical activity, eating a more nutritious diet, or losing weight, the majority will have diabetes within 10 years.

National Comparison

According to the 2014 Behavioral Risk Factor Surveillance System (BRFSS), Utah adults have an age-adjusted rate of 7.7% that are diagnosed with diabetes (crude rate of 7.1%), compared to the U.S. age-adjusted rate of 9.5%.

Healthy People Objective (see Appendix)

D-1: Reduce the annual number of new cases of diagnosed diabetes in the population

U.S. Target: 7.2 new cases per 1,000 population aged 18 to 84 years

Utah Target: 7.2 new cases per 1,000 population aged 18 to 84 years

Disparities

For both males and females, the highest rates of diabetes are observed for adults aged 65 and older. Overall, one of five adults aged 65 and older has been diagnosed with diabetes.

Prevalence of diabetes is especially high for members of the Pacific Islander, Black, and American Indian/Alaska (AK) Native populations.

The highest rates of diabetes among adults aged 25 and over are for adults who have less than a high school degree (13.9%).

Weber-Morgan Local Health District (LHD) had a significantly higher rate of diabetes prevalence than the state overall, with a rate of 8.9%. Summit County, Utah County, and Wasatch County LHDs had significantly lower rates than the state.

Risk Factors

Anyone can develop diabetes, but the risk is greater for those who are older, overweight or obese, physically inactive, or a member of a minority racial or ethnic group. As the Utah population ages, and as the proportion of high-risk minority ethnic and racial groups in the population increases, a greater percentage of Utahns will be at risk for developing diabetes.

Some risk factors cannot be modified, such as older age, race, or ethnicity. Nevertheless, risk can be substantially reduced through adhering to a nutritious diet and participating in regular physical activity.

What Is Being Done?

The Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program encourages people with diabetes to enroll in a diabetes self-management education class. These classes are usually taught by a dietitian, pharmacist, or certified diabetes educator, and have been shown to help individuals develop the skills they need to manage their diabetes.

- 7.1% of Utah adults have diabetes
- Rate increases with age
- Higher rates among low income and lower education levels
- Disparities include American Indian/Alaska Native, Black, and Pacific Islander populations as well as the Hispanic population
- Significantly higher for Weber-Morgan LHD
- Significantly lower for Summit County, Utah County, and Wasatch County LHDs

1 Projection of the year 2050 burden of diabetes in the US adult population: dynamic modeling of incidence, mortality, and prediabetes prevalence. *Population Health Metrics*. Advancing innovation in health measurement. 2010. 8:29. Accessed 8/5/2016 at <http://www.pophealthmetrics.com/content/8/1/29>.

Diabetes Prevalence

The Utah Arthritis Program supports Chronic Disease Self-Management Programs and Diabetes Self-Management Programs throughout the state. (This program is also called the Living Well with Chronic Conditions Program.) This six-week program is available throughout the state at no cost and taught by community members.

Evidence-based Practices

Diabetes self-management classes have been shown to improve blood sugar control among participants. In Utah, programs are available that are recognized by the American Diabetes Association or certified by the American Association of Diabetes Educators. For more information, visit <http://health.utah.gov/arthritis/classes/dsmp.html>.

Map: Adult Diabetes Prevalence by Local Health District, Utah, 2012-2014

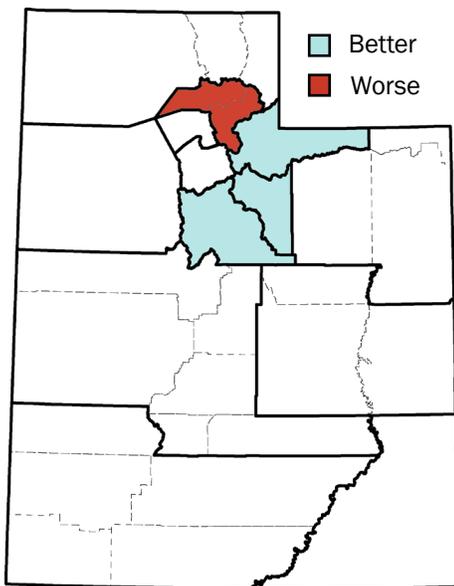


Figure: Adult Diabetes Prevalence by Age Group, Utah, 2014

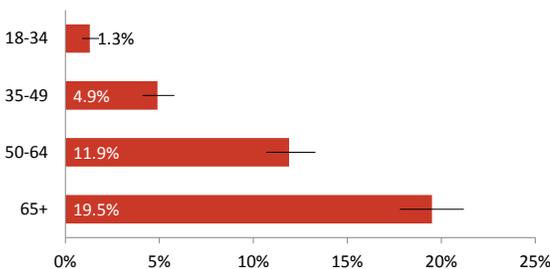
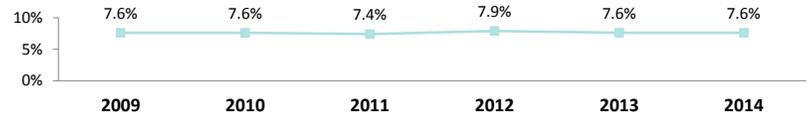


Figure: Percentage of Utahns Aged 18+ With Diabetes by Year, 2009-2014



Trend graph depicts age-adjusted rates.

STATE COMPARISON (2014)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	10.5%	10.3% - 10.7%	9.5%	9.4% - 9.7%
Colorado (best)	7.3%	6.8% - 7.8%	6.8%	6.4% - 7.3%
UTAH (8th of 51)^	7.1%	6.7% - 7.6%	7.7%	7.2% - 8.2%
Mississippi (worst)	13.0%	11.8% - 14.3%	12.0%	10.9% - 13.2%
AGE IN YEARS (2014)				
18-34	1.3%	0.9% - 1.8%	-	-
35-49	4.9%	4.1% - 5.8%	-	-
50-64	11.9%	10.7% - 13.3%	-	-
65+	19.5%	17.8% - 21.2%	-	-
GENDER (2014)				
Male	7.5%	6.9% - 8.2%	8.4%	7.7% - 9.1%
Female	6.7%	6.1% - 7.4%	7.0%	6.4% - 7.7%
RACE (2013-2014)				
American Indian/AK Native	12.0%	8.7% - 16.4%	13.4%	9.8% - 18.2%
Asian	3.7%	2.1% - 6.3%	5.5%	3.2% - 9.2%
Black	12.5%	7.9% - 19.1%	15.6%	10.5% - 22.5%
Pacific Islander	12.3%	7.0% - 20.7%	17.7%	10.7% - 28.0%
White	6.9%	6.6% - 7.3%	7.1%	6.7% - 7.5%
ETHNICITY (2014)				
Hispanic	8.8%	7.1% - 10.9%	13.7%	11.1% - 16.7%
Non-Hispanic	6.8%	6.4% - 7.3%	7.0%	6.6% - 7.5%
INCOME (2014)				
0-\$24,999	10.3%	9.0% - 11.7%	12.8%	11.3% - 14.5%
\$25,000-\$49,999	7.9%	6.9% - 9.1%	8.6%	7.5% - 9.8%
\$50,000-\$74,999	6.6%	5.6% - 7.8%	7.4%	6.2% - 8.7%
\$75,000 or more	4.6%	4.0% - 5.3%	5.3%	4.4% - 6.4%
EDUCATION—Adults 25+ (2014)				
Below High School	12.8%	10.3% - 15.9%	13.9%	11.2% - 17.0%
High School or GED	9.7%	8.7% - 10.9%	9.9%	8.8% - 11.0%
Some Post High School	8.3%	7.4% - 9.2%	8.4%	7.5% - 9.3%
College Graduate	6.0%	5.3% - 6.7%	6.4%	5.7% - 7.2%
LOCAL HEALTH DISTRICT (2012-2014)				
Bear River	6.6%	5.6% - 7.7%	7.5%	6.4% - 8.8%
Central Utah	8.1%	6.8% - 9.6%	7.7%	6.4% - 9.1%
Davis County	7.4%	6.5% - 8.4%	7.9%	7.0% - 8.9%
Salt Lake County	7.4%	6.9% - 7.9%	7.9%	7.4% - 8.4%
San Juan	12.4%	7.2% - 20.6%	12.4%	7.4% - 20.1%
Southeast Utah†	10.0%	8.0% - 12.3%	8.3%	6.3% - 10.8%
Southwest Utah	7.4%	6.3% - 8.8%	6.6%	5.5% - 8.0%
Summit County	3.5%	2.5% - 4.8%	3.6%	2.7% - 4.8%
Tooele County	7.7%	6.3% - 9.5%	8.1%	6.6% - 9.8%
TriCounty	8.4%	6.9% - 10.3%	8.4%	7.0% - 10.2%
Utah County	5.2%	4.6% - 6.0%	6.8%	6.1% - 7.6%
Wasatch County	5.7%	4.6% - 7.2%	5.6%	4.6% - 6.7%
Weber-Morgan	8.8%	7.7% - 10.0%	8.9%	7.8% - 10.1%

† Includes Carbon, Emery, and Grand counties

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

Obesity/Physical Activity

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Description

This 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/m² calculated from self-reported weight and height.

How Are We Doing?

In 2014, Utah had the 8th lowest obesity rate in the nation.

In just 15 years, the age-adjusted proportion of obese Utah adults increased from 15.8% in 1997 to 26.3% in 2014. In 2009 the survey methodology changed to include cell phone sample and to use "Iterative proportional fitting" (raking) as its weighting method, however the trend has remained consistent despite this change.

National Comparison

The age-adjusted prevalence of obesity in Utah adults is slightly lower than the U.S. In 2014, the obesity prevalence rate in Utah adults was 26.3%. The obesity prevalence for U.S. adults in 2014 was 28.8%.

Healthy People Objective (see Appendix)

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

U.S. Target: 30.5 percent

Utah Target: 24.0 percent

Disparities

Adults aged 35 and older had obesity rates higher than the state rate.

Age-adjusted rates are used to compare rates for race and local health districts to account for the differences in ages. In 2014, the Pacific Islander population had higher rates than the state, while the Asian population had lower rates than the state. An estimated 30% of Hispanic/Latino adults were obese.

Risk Factors

Genetic or familial factors may increase the risk for being overweight or obese for some people, but anyone whose calorie intake exceeds the number of calories they burn is at risk. Physical activity and a healthy diet are both important for obtaining and maintaining a healthy weight.

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.

What Is Being Done?

In 2013, through funding from the Centers for Disease Control and Prevention (CDC) the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program was established.

EPICC works in schools, worksites, communities, healthcare, and childcare to promote healthy lifestyles in Utah.

Evidence-based Practices

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.

- **25.7% of Utah adults are obese (crude rate)**
- **Lower rates among Utahns aged 18–34; higher rates among other age groups**
- **Disparities include Pacific Islander and Hispanic populations**
- **Lower rate among Asian population**
- **Higher rates among lower income and education levels**
- **Significantly lower for Southeast Utah, Summit County, and Wasatch County LHDs**

Data Interpretation Issues

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

Map: Adult (18+) Obesity by Local Health District, 2014

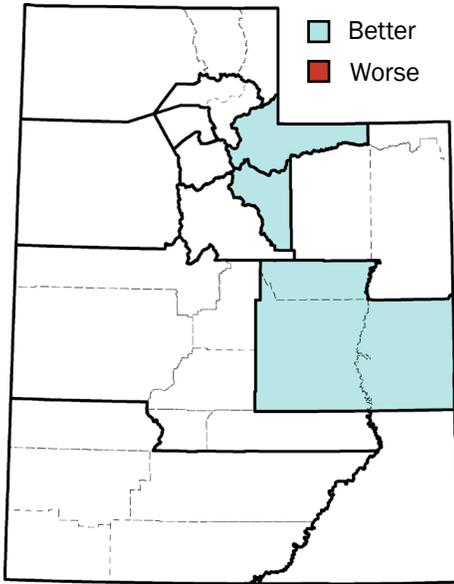


Figure: Obesity by Education, Utah Adults 25+, 2014

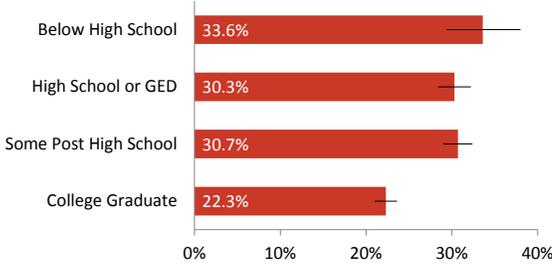


Figure: Percentage of Utahns Aged 18+ Who Were Obese by Year, 2009–2014



Trend graph depicts age-adjusted rates.

STATE COMPARISON (2014)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	28.9%	28.6% - 29.2%	28.8%	28.6% - 29.1%
Colorado (best)	21.3%	20.4% - 22.2%	21.1%	20.2% - 22.0%
UTAH (8th of 51)	25.7%	24.9% - 26.6%	26.3%	25.4% - 27.2%
Arkansas (worst)	35.9%	33.8% - 38.0%	36.1%	33.9% - 38.4%
AGE IN YEARS (2014)				
18–34	18.8%	17.4% - 20.3%	-	-
35–49	29.0%	27.2% - 30.8%	-	-
50–64	32.4%	30.6% - 34.2%	-	-
65+	28.4%	26.5% - 30.4%	-	-
GENDER (2014)				
Male	25.7%	24.5% - 26.9%	26.3%	25.1% - 27.6%
Female	25.8%	24.5% - 27.1%	26.2%	25.0% - 27.5%
RACE (2014)				
American Indian/AK Native	30.7%	23.5% - 39.0%	31.7%	24.5% - 39.8%
Asian	8.0%	4.4% - 14.2%	9.4%	5.1% - 16.6%
Black	31.4%	22.1% - 42.4%	33.7%	23.7% - 45.4%
Pacific Islander	37.0%	25.5% - 50.2%	39.8%	28.3% - 52.6%
White	25.8%	24.9% - 26.7%	26.4%	25.5% - 27.3%
ETHNICITY (2014)				
Hispanic	28.5%	25.3% - 31.8%	30.0%	26.6% - 33.6%
Non-Hispanic	25.4%	24.5% - 26.3%	25.8%	24.9% - 26.7%
INCOME (2014)				
0–\$24,999	28.2%	26.1% - 30.4%	32.1%	29.7% - 34.5%
\$25,000–\$49,999	29.3%	27.4% - 31.4%	31.1%	29.1% - 33.2%
\$50,000–\$74,999	28.1%	26.0% - 30.2%	27.6%	25.5% - 29.9%
\$75,000 or more	22.4%	20.9% - 23.8%	21.0%	19.4% - 22.6%
EDUCATION—Adults 25+ (2014)				
Below High School	33.0%	28.8% - 37.5%	33.6%	29.4% - 38.0%
High School or GED	30.0%	28.2% - 31.9%	30.3%	28.4% - 32.2%
Some Post High School	30.6%	29.0% - 32.3%	30.7%	29.0% - 32.4%
College Graduate	22.5%	21.2% - 23.8%	22.3%	21.0% - 23.6%
LOCAL HEALTH DISTRICT (2014)				
Bear River	24.5%	21.0% - 28.4%	25.3%	21.9% - 29.0%
Central Utah	28.4%	24.0% - 33.3%	29.1%	24.7% - 33.9%
Davis County	26.1%	23.5% - 28.9%	26.5%	23.9% - 29.2%
Salt Lake County	26.4%	24.9% - 27.9%	26.6%	25.1% - 28.1%
San Juan	33.2%	19.5% - 50.4%	29.7%	18.2% - 44.6%
Southeast Utah†	20.6%	16.0% - 26.2%	19.6%	14.9% - 25.3%
Southwest Utah	23.3%	20.3% - 26.5%	23.2%	20.1% - 26.5%
Summit County	16.3%	12.4% - 21.2%	16.4%	12.2% - 21.6%
Tooele County	31.0%	25.4% - 37.3%	30.4%	25.0% - 36.5%
TriCounty	31.0%	25.7% - 36.8%	30.1%	25.1% - 35.6%
Utah County	24.8%	22.6% - 27.1%	27.0%	24.8% - 29.3%
Wasatch County	20.2%	16.4% - 24.6%	20.0%	16.3% - 24.2%
Weber-Morgan	28.7%	25.8% - 31.8%	28.8%	25.9% - 31.9%

† Includes Carbon, Emery, and Grand counties

Description

For individuals aged 2 to 20, overweight and obesity is determined by calculating the individual's body mass index (BMI) and comparing it to age and sex standardized growth charts distributed by the Centers for Disease Control and Prevention (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.

How Are We Doing?

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 2010.¹

Obesity rates for adolescents come from two sources. The Youth Risk Behavior Survey (YRBS, 2013) which surveyed children in grades 9–12, and the Prevention Needs Assessment (PNA, 2015) which surveyed students in grades 8, 10, and 12. The sources differ depending on which comparisons we are attempting to make and what other data are contained in the survey. The obesity rate from the 2013 YRBS was 6.4%, the obesity rate from the 2015 PNA was 9.6%.

National Comparison

In the U.S. there has been more than a 300% increase during the past 38 years in the number of obese children aged 2 to 19 years (5.2% in 1971–74 and 16.9% in 2011–12).² An increase has also been observed in Utah between 1994 and 2010 with the number of overweight third grade boys and girls increasing by 97% and 40%, respectively.³

In 2013 a total of 13.7% of American public high school students were obese compared to 6.4% of Utah public high school students.

Healthy People Objective (see Appendix)

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 percent

Utah Target: 10.0 percent

NWS-10.3: Adolescents aged 12 to 19 years

U.S. Target: 16.1 percent

Utah Target: 10.0 percent

Disparities

Among adolescents in 2013, 6.4% of Utah public high school students were obese; boys were almost twice as likely as girls to be obese (8.3% compared to 4.5%).

The obesity rate in 2015 among adolescents in grades 8, 10 and 12 was lower in Summit County (5.1%), TriCounty (7.1%), Davis County (7.8%), and Wasatch County (9.0%) local health districts (LHDs) than the state rate (9.6%). The obesity rate among adolescents in grades 8, 10, and 12 was higher in Salt Lake County LHD (10.8%) than the state rate.

Adolescent obesity rates varied dramatically by race and ethnicity. According to the 2015 Prevention Needs Assessment data, Pacific Islander (24.1%), American Indian (19.2%), and Hispanic (16.8%) youth in grades 8, 10, and 12 all had higher rates of obesity than the state rate (9.6%). White adolescents (7.9%) had lower rates than the state rate.

Risk Factors

Genetic or familial factors may increase the risk for being overweight or obese for some people, but anyone whose calorie intake exceeds the number of calories they burn is at risk. Physical activity and a healthy diet are both important for obtaining and maintaining a healthy weight.

- 6.4% of Utah students in grades 9–12 (2013 YRBS); 9.6% of students in grades 8, 10, and 12 (2015 PNA) are obese
- Higher rates among males
- Disparities include Pacific Islander (24.1%), American Indian (19.2%), and Hispanic (16.8%)
- Significantly lower in Summit County, TriCounty, Davis County, and Wasatch County LHDs
- Significantly higher in Salt Lake County LHD

¹ Utah Department of Health, Bureau of Health Promotion, Physical Activity, Nutrition and Obesity Program Height/Weight Measurement

² National Center for Health Statistics, Centers for Disease Control and Prevention. *Prevalence of overweight among children and adolescents: United States, 1963–1965 Through 2011–2012*. Accessed 12/14/2015 from http://www.cdc.gov/nchs/data/hestat/obesity_child_11_12/obesity_child_11_12.pdf.

³ Utah Department of Health, Bureau of Health Promotion, Physical Activity, Nutrition and Obesity Program Height/Weight Measurement

What Is Being Done?

In 2013, through funding from the Centers for Disease Control and Prevention (CDC) the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program was established. EPICC works in schools, communities, healthcare, and childcare to promote healthy lifestyles in Utah.

Evidence-based Practices

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.

Data Interpretation Issues

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.

Map: Adolescent Obesity by Local Health District, Utah, 2015

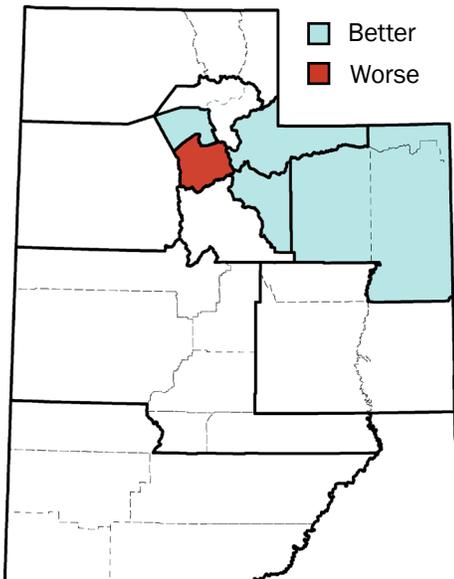
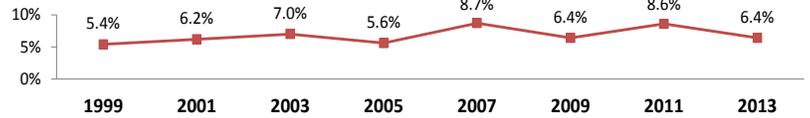


Figure: Percentage of Adolescents Who Were Obese in Utah by Year, 1999–2013



	Crude (burden)	
STATE COMPARISON (2013)	Rate	95% CIs
U.S.	13.7%	12.6% - 14.9%
Utah (best)	6.4%	4.9% - 8.4%
UTAH (1st of 42)	6.4%	4.9% - 8.4%
Kentucky (worst)	18.0%	15.7% - 20.6%
GRADE IN SCHOOL (2011 and 2013)		
Grade 9	7.2%	4.9% - 10.4%
Grade 10	7.5%	5.9% - 9.5%
Grade 11	8.4%	6.6% - 10.7%
Grade 12	6.8%	4.6% - 9.8%
GENDER (2013)		
Male	8.3%	6.5% - 10.6% !
Female	4.5%	2.9% - 6.8%
RACE/ETHNICITY (Grades 8, 10, and 12, 2015)		
American Indian	19.2%	14.4% - 25.2% !
Asian	9.3%	5.7% - 14.7%
Black	13.2%	8.9% - 19.1%
Hispanic	16.8%	14.7% - 19.3% !
Pacific Islander	24.1%	17.8% - 31.8% !
White	7.9%	7.2% - 8.6% ✓
LOCAL HEALTH DISTRICT (Grades 8, 10, and 12, 2015) [^]		
Bear River	8.6%	7.3% - 10.0%
Central Utah	9.2%	7.3% - 11.6%
Davis County	7.8%	6.4% - 9.5% ✓
Salt Lake County	10.8%	9.9% - 11.8% !
San Juan	11.3%	6.5% - 18.7%
Southeast Utah [†]	10.5%	6.3% - 17.0%
Southwest Utah	8.4%	6.5% - 10.9%
Summit County	5.1%	3.7% - 6.9% ✓
Tooele County	10.5%	8.1% - 13.4%
TriCounty	7.1%	5.8% - 8.6% ✓
Utah County	9.4%	7.1% - 12.3%
Wasatch County	9.0%	8.7% - 9.2% ✓
Weber-Morgan	10.9%	7.7% - 15.3%

[†] Includes Carbon, Emery, and Grand counties

[^] Data by race/ethnicity and local health district are from the 2015 Prevention Needs Assessment.

Physical Activity—Adult

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults aged 18 years and older who meet aerobic physical activity recommendations of getting at least 150 minutes per week of moderate-intensity activity, or 75 minutes of vigorous-intensity activity, or an equivalent combination of moderate-vigorous intensity activity.

How Are We Doing?

The Healthy People 2020 (HP2020) U.S. target for recommended aerobic physical activity is 47.9%. This target has been reached.

National Comparison

The U.S. rate for 2013 was 50.1% (49.8–50.5%). The Utah rate for 2013 was 55.7% (age-adjusted rates). Utah was ranked 9th in the nation.

Healthy People Objective (see Appendix)

PA-2.1: Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination

U.S. Target: 47.9 percent

Utah Target: 47.9 percent

Disparities

Persons aged 18–34 had lower reported rates of achieving the recommended physical activity levels. American Indian/Alaska (AK) Native, Hispanic, and Black adults were less likely to get the recommended physical activity levels. Lower income and education levels are also associated with less activity. Southwest Utah and Summit County local health districts (LHDs) had higher activity levels than rest of the state.

Risk Factors

Lack of physical activity can be a risk factor for high blood pressure, coronary heart disease, obesity, diabetes, certain cancers, anxiety, depression, and poor bone health along with other chronic diseases.¹²³

What Is Being Done?

In 2013, through funding from the Centers for Disease Control and Prevention (CDC) the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program was established.

EPICC works:

- In Worksites
 - The Utah Council for Worksite Health Promotion recognizes businesses that offer employee fitness and health promotion programs.
 - EPICC partners with LHDs to encourage worksites to complete the CDC Scorecard and participate in yearly health risk assessment for their employees. EPICC provides toolkits and other resources for employers interested in implementing wellness programs through the choosehealth.utah.gov website: <http://www.choosehealth.utah.gov/worksites/wellness-programs.php>.
- In Communities
 - LHDs work with cities within their jurisdictions to create a built environment or infrastructure that encourages physical activity.

Evidence-based Practices

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

- 55.3% of Utah adults exercised (crude rate)
- Less activity among Utahns aged 18–34; more activity among Utahns aged 65+
- Disparities include American Indian/Alaska Native, Black, and Hispanic populations
- Lower income and education levels are also associated with less physical activity
- Significantly higher physical activity levels for Southwest Utah and Summit County LHDs

1 Booth, F. W., Roberts, C. K. and Laye, M. J. 2012. Lack of Exercise Is a Major Cause of Chronic Diseases. *Comprehensive Physiology*. 2:1143–1211.

2 Risks of Physical Inactivity. Johns Hopkins Medicine Health Library. Accessed 8/7/2016 from http://www.hopkinsmedicine.org/healthlibrary/conditions/cardiovascular_diseases/risks_of_physical_inactivity_85.p00218/.

3 World Health Organization. Physical Activity. Accessed 8/7/2016 from <http://www.who.int/dietphysicalactivity/pa/en/>.

Physical Activity—Adult

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.

Map: Adult Physical Activity by Local Health District, 2013

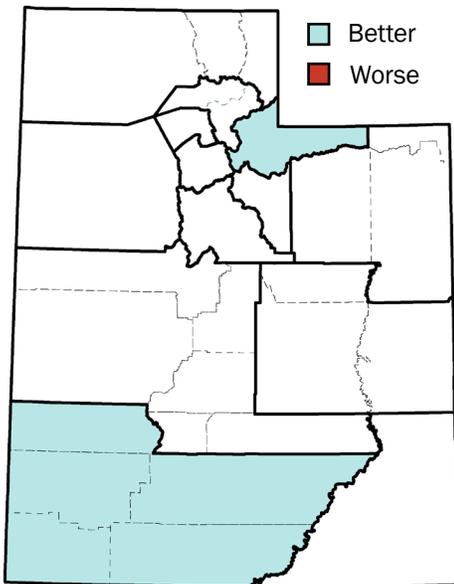
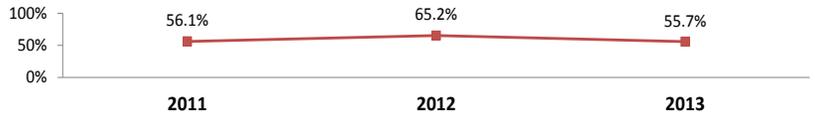


Figure: Percentage of Adults Reporting Physical Activity in Utah by Year, 2011–2013



Trend graph depicts age-adjusted rates.

	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2013)	Rate	95% CIs	Rate	95% CIs
U.S.	50.2%	49.9% - 50.5%	50.1%	49.8% - 50.5%
Oregon (best)	64.1%	62.2% - 65.9%	63.6%	61.6% - 65.6%
UTAH (9th of 51)	55.3%	54.1% - 56.4%	55.7%	54.5% - 56.8%
Mississippi (worst)	37.4%	35.7% - 39.1%	37.8%	36.0% - 39.6%
AGE IN YEARS (2013)				
18–34	51.8%	49.6% - 54.1%	-	- - - !
35–49	56.3%	54.0% - 58.5%	-	- - -
50–64	57.2%	55.1% - 59.4%	-	- - -
65+	60.2%	57.8% - 62.5%	-	- - - ✓
GENDER (2013)				
Male	55.2%	53.4% - 56.9%	56.0%	54.3% - 57.7%
Female	55.3%	53.7% - 56.9%	55.6%	54.0% - 57.1%
RACE (2013)				
American Indian/AK Native	44.9%	34.6% - 55.5%	42.0%	32.5% - 52.2% !
Asian	51.0%	39.6% - 62.3%	52.0%	40.9% - 62.9%
Black	38.6%	25.4% - 53.7%	38.5%	25.1% - 54.0% !
Pacific Islander	72.6%	59.6% - 82.6%	67.9%	52.0% - 80.6%
White	56.1%	54.9% - 57.3%	56.5%	55.3% - 57.7%
ETHNICITY (2013)				
Hispanic	44.9%	40.7% - 49.3%	45.9%	41.3% - 50.6% !
Non-Hispanic	56.7%	55.5% - 57.9%	57.1%	55.9% - 58.3% ✓
INCOME (2013)				
0–\$24,999	47.5%	44.7% - 50.3%	45.9%	43.0% - 48.8% !
\$25,000–\$49,999	52.8%	50.3% - 55.2%	53.1%	50.6% - 55.6% !
\$50,000–\$74,999	54.6%	51.8% - 57.2%	55.4%	52.6% - 58.3%
\$75,000 or more	64.6%	62.5% - 66.6%	64.2%	61.9% - 66.4% ✓
EDUCATION—Adults 25+ (2013)				
Below High School	37.9%	32.7% - 43.4%	38.2%	33.1% - 43.5% !
High School or GED	49.4%	47.0% - 51.9%	49.6%	47.2% - 52.0% !
Some Post High School	56.5%	54.5% - 58.5%	57.0%	55.0% - 59.0%
College Graduate	64.0%	62.2% - 65.8%	64.3%	62.6% - 66.0% ✓
LOCAL HEALTH DISTRICT (2013)				
Bear River	54.7%	49.9% - 59.4%	54.5%	50.1% - 58.9%
Central Utah	50.6%	44.5% - 56.8%	51.2%	45.4% - 57.0%
Davis County	55.7%	52.1% - 59.3%	56.8%	53.3% - 60.3%
Salt Lake County	53.8%	51.7% - 55.8%	54.2%	52.2% - 56.2%
San Juan	50.1%	33.4% - 66.8%	50.3%	34.6% - 65.9%
Southeast Utah†	53.8%	46.6% - 60.7%	53.4%	46.0% - 60.6%
Southwest Utah	60.0%	55.4% - 64.4%	60.5%	55.8% - 64.9% ✓
Summit County	63.3%	56.3% - 69.8%	62.8%	56.2% - 69.0% ✓
Tooele County	57.1%	50.5% - 63.6%	57.8%	51.4% - 64.0%
TriCounty	52.5%	46.6% - 58.4%	52.4%	46.9% - 57.7%
Utah County	56.6%	53.6% - 70.3%	57.2%	54.3% - 59.9%
Wasatch County	63.6%	56.3% - 70.3%	63.1%	55.5% - 70.1%
Weber-Morgan	56.0%	52.0% - 59.9%	55.9%	51.9% - 59.8%

† Includes Carbon, Emery, and Grand counties

Physical Activity—Minor

Youth Risk Behavior Surveillance System

Description

This measure reports the percentage of public high school students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on all of the past seven days.

How Are We Doing?

National Comparison

Utah high school students reported significantly lower rates of recommended physical activity in 2013 (19.7%) than the U.S. (27.1%). Utah has the worst state rate (42 of 42) of any state that reported this data in the Youth Risk Behavior Survey.

Healthy People Objective (see Appendix)

PA-3.1: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity

U.S. Target: 31.6 percent

Utah Target: 31.6 percent

Disparities

In 2013, 11.5% of girls and 27.6% of boys in Utah high schools reported getting at least 60 minutes of physical activity on all seven days of the week.

From the 2015 Prevention Needs Assessment (PNA) survey, adolescents in grades 8, 10, and 12 in Southeast Utah (31.4%), Southwest Utah (25.5%), Summit County (24.6%), and Central Utah (23.4%) local health districts (LHDs) had higher rates of getting at least 60 minutes of physical activity every day than the state rate (19.9%). Adolescents in TriCounty LHD (13.2%) had a lower rate of recommended physical activity than the state rate.

Risk Factors

Predictors of child involvement in physical activity include availability of facilities, neighborhood characteristics, parental involvement, and enjoyment of the activity.

Lack of physical activity can be a risk factor for future high blood pressure, coronary heart disease, obesity, diabetes, certain cancers, anxiety, depression, and poor bone health along with other chronic diseases.^{1,2,3}

What Is Being Done?

In 2013, through funding from the Centers for Disease Control and Prevention (CDC) the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program was established.

EPICC works:

- In Schools
 - Schools are encouraged to apply for the Healthy Schools Program through the Alliance for a Healthier Generation. Participation in this program assists schools to set up policy and environmental supports that make it easier for students and staff to be physically active and eat healthy food.
 - Action for Healthy Kids brings partners together to improve nutrition and physical activity environments in Utah schools by implementing the school-based state plan strategies and working with local school boards to improve or develop policies for nutritious foods in schools. This includes recommendations for healthy vending options.
- In Communities
 - LHDs work with cities within their jurisdictions to create a built environment or infrastructure that encourages physical activity.

- Worst state rate (42 of 42)
- Students in grade 9 more physically active than higher grades
- Females significantly less active
- Significantly higher physical activity levels for Central Utah, Southeast Utah, Southwest Utah, and Summit County LHDs
- Significantly lower physical activity levels for TriCounty LHD

1 Booth, F. W., Roberts, C. K. and Laye, M. J. 2012. Lack of Exercise Is a Major Cause of Chronic Diseases. *Comprehensive Physiology*. 2:1143–1211.

2 Risks of Physical Inactivity. Johns Hopkins Medicine Health Library. Accessed 8/7/2016 from http://www.hopkinsmedicine.org/healthlibrary/conditions/cardiovascular_diseases/risks_of_physical_inactivity_85.p00218/.

3 World Health Organization. Physical Activity. Accessed 8/7/2016 from <http://www.who.int/dietphysicalactivity/pa/en/>.

- In Childcare
 - LHDs statewide are implementing the Targeting Obesity in Preschools and Child Care Settings (TOP Star) program, which aims to improve the nutrition and physical activity environments and achieve best practice in child care centers and homes.
 - EPICC works with state and local partners through the Childcare Obesity Prevention Workgroup to implement policy and systems changes in early care and education across agencies statewide.

Figure: Percentage of Adolescents Reporting Physical Activity in Utah by Year, 2011-2013



STATE COMPARISON (2013)	Crude (burden)	
	Rate	95% CIs
U.S.	27.1%	25.5% - 28.8%
Oklahoma (best)	49.9%	45.4% - 54.4%
UTAH (42nd of 42)	19.7%	17.1% - 22.5%
Utah (worst)	19.7%	17.1% - 22.5%

GRADE IN SCHOOL (2013)		
Grade	Rate	95% CIs
Grade 9	24.8%	20.5% - 29.7% ✓
Grade 10	18.3%	14.5% - 22.8%
Grade 11	15.7%	11.7% - 20.6%
Grade 12	19.8%	14.8% - 25.9%

GENDER (2013)		
Gender	Rate	95% CIs
Male	27.6%	23.5% - 32.0% ✓
Female	11.5%	9.9% - 13.4% !

RACE/ETHNICITY (2013)		
Race/Ethnicity	Rate	95% CIs
White, Non-Hispanic	20.5%	17.6% - 23.8%
Hispanic (all races)	16.5%	12.6% - 21.3%
Non-White, Non-Hispanic	17.0%	12.5% - 22.8%

LOCAL HEALTH DISTRICT (2015) [^]		
Local Health District	Rate	95% CIs
Bear River	21.6%	18.5% - 25.0%
Central Utah	23.4%	20.9% - 26.2% ✓
Davis County	18.5%	15.4% - 22.1%
Salt Lake County	19.4%	17.1% - 22.0%
San Juan	21.7%	11.6% - 37.0%
Southeast Utah [†]	31.4%	23.8% - 40.0% ✓
Southwest Utah	25.5%	21.6% - 29.8% ✓
Summit County	24.6%	20.9% - 28.7% ✓
Tooele County	22.0%	19.5% - 24.7%
TriCounty	13.2%	10.1% - 17.0% !
Utah County	18.1%	15.9% - 20.4%
Wasatch County	18.8%	12.0% - 28.2%
Weber-Morgan	20.5%	17.3% - 24.0%

[†] Includes Carbon, Emery, and Grand counties

[^] Data by local health district are from the 2015 Prevention Needs Assessment

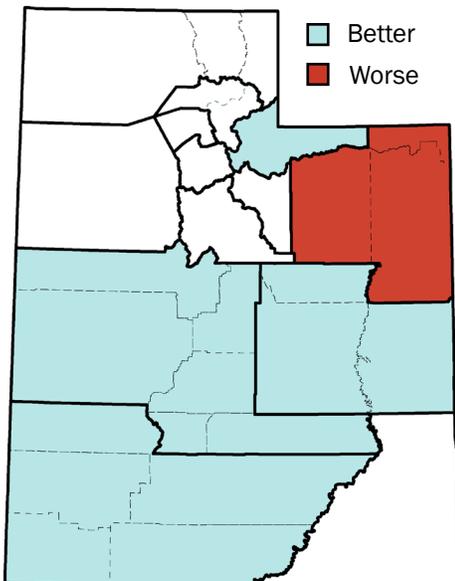
Evidence-based Practices

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.

Map: Adolescent Physical Activity by Local Health District, 2015



Mental Health

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Mental Health Status

Behavioral Risk Factor Surveillance System

Description

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.

How Are We Doing?

In 2014, approximately 15.9% (crude rate) of Utah adults reported seven or more days when their mental health was not good in the past 30 days.

National Comparison

Fewer Utah adults reported seven or more days when their mental health was not good in the past 30 days (15.5%) when compared to adults in the U.S. as a whole (16.5%) (age-adjusted rates).

Healthy People Objective—Related measure (see Appendix)

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 percent

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 percent

Disparities

In Utah, seven or more days when mental health was not good in the past 30 days was related to age, sex, income, and education. The percentage of people 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 (21.1%). Utah Asian adults reported the lowest percentage (12.5%).

Risk Factors

Risk factors 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.

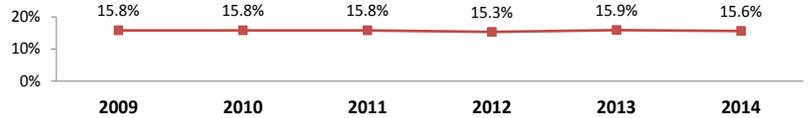
What Is Being Done?

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

- 15.9% 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 Salt Lake County and TriCounty LHDs
- Significantly lower rates of poor mental health for Utah County LHD

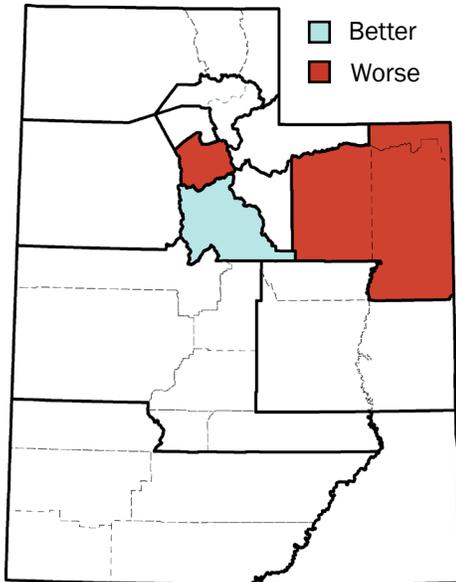
Mental Health Status

Figure: Percentage of Utahns Aged 18+ With Poor Mental Health by Year, 2009–2014



Trend graph depicts age-adjusted rates.

Map: Adult (18+) Mental Health Status by Local Health District, Utah, 2014



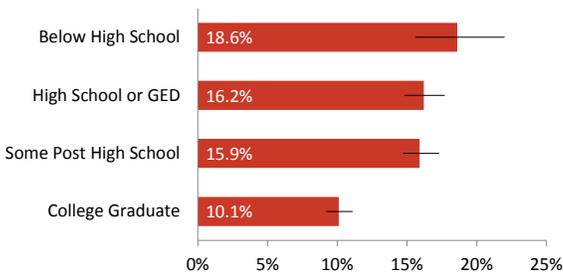
	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014) [^]	Rate	95% CIs	Rate	95% CIs
U.S.	16.3%	16.0% - 16.5%	16.5%	16.2% - 16.7%
South Dakota (best)	11.7%	10.4% - 13.2%	12.1%	10.7% - 13.7%
UTAH (19th of 51)	15.9%	15.2% - 16.7%	15.5%	14.8% - 16.2%
Tennessee (worst)	20.3%	18.6% - 22.1%	20.7%	18.9% - 22.7%
AGE IN YEARS (2014)				
18–34	20.3%	18.8% - 21.8%	-	- - - !
35–49	15.4%	14.0% - 16.8%	-	- - -
50–64	13.7%	12.4% - 15.0%	-	- - - ✓
65+	9.2%	8.1% - 10.4%	-	- - - ✓
GENDER (2014)				
Male	12.1%	11.1% - 13.0%	11.6%	10.8% - 12.6% ✓
Female	19.8%	18.6% - 20.9%	19.4%	18.3% - 20.5% !
RACE (2012–2014)				
American Indian/AK Native	21.3%	16.9% - 26.4%	21.1%	16.9% - 26.0% !
Asian	15.6%	11.9% - 20.2%	12.5%	9.5% - 16.2%
Black	15.1%	10.9% - 20.6%	16.5%	11.9% - 22.4%
Pacific Islander	17.3%	11.9% - 24.7%	15.0%	9.4% - 23.0%
White	16.0%	15.5% - 16.5%	15.7%	15.3% - 16.2%
ETHNICITY (2014)				
Hispanic	14.6%	12.4% - 17.0%	15.2%	12.8% - 18.0%
Non-Hispanic	16.1%	15.3% - 16.9%	15.7%	15.0% - 16.5%
INCOME (2014)				
0–\$24,999	26.1%	24.0% - 28.2%	26.0%	24.0% - 28.2% !
\$25,000–\$49,999	16.3%	14.8% - 18.0%	16.3%	14.7% - 17.9%
\$50,000–\$74,999	13.4%	11.8% - 15.1%	13.4%	11.7% - 15.2% ✓
\$75,000 or more	10.3%	9.2% - 11.5%	10.9%	9.6% - 12.4% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	19.1%	16.0% - 22.7%	18.6%	15.6% - 22.0% !
High School or GED	16.5%	15.0% - 18.1%	16.2%	14.8% - 17.7% !
Some Post High School	16.1%	14.9% - 17.5%	15.9%	14.7% - 17.3% !
College Graduate	10.3%	9.4% - 11.3%	10.1%	9.2% - 11.1% ✓
LOCAL HEALTH DISTRICT (2014)				
Bear River	15.3%	12.4% - 18.8%	14.6%	11.9% - 17.8%
Central Utah	15.4%	11.8% - 20.0%	15.1%	11.6% - 19.5%
Davis County	15.4%	13.2% - 17.8%	15.0%	13.0% - 17.4%
Salt Lake County	17.1%	15.9% - 18.5%	16.8%	15.6% - 18.2% !
San Juan*	12.4%	4.8% - 28.5%	10.5%	4.4% - 23.2%
Southeast Utah†	17.1%	12.7% - 22.8%	16.6%	12.1% - 22.3%
Southwest Utah	14.4%	11.8% - 17.5%	14.7%	12.0% - 17.8%
Summit County	11.8%	8.6% - 16.1%	13.2%	9.4% - 18.3%
Tooele County	17.7%	13.3% - 23.2%	17.2%	13.0% - 22.5%
TriCounty	20.1%	15.8% - 25.4%	20.1%	15.8% - 25.2% !
Utah County	14.6%	12.7% - 16.6%	13.4%	11.7% - 15.1% ✓
Wasatch County	13.3%	10.2% - 17.2%	12.5%	9.5% - 16.3%
Weber-Morgan	16.4%	14.1% - 19.0%	16.3%	14.0% - 18.9%

† Includes Carbon, Emery, and Grand counties

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

* Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

Figure: Mental Health Status by Education, Utah Adults 25+, 2014



Suicide

Utah Death Certificate Database

Description

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

How Are We Doing?

The 2014 Utah age-adjusted suicide rate was 20.5 per 100,000 population. From 2012 to 2014, the Utah age-adjusted suicide rate was 20.8 per 100,000 persons. This is an average of 557 suicides per year.

In 2014, suicide was the leading cause of death for Utahns aged 10–17 and 18–24. It is the second leading cause of death for those aged 25–44 and the fourth-leading cause of death for Utahns aged 45–64. Overall, suicide is the eighth-leading cause of death for Utahns aged 10+.

National Comparison

The suicide rate in Utah has been consistently higher than the national rate.

Healthy People Objective (see Appendix)

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

Disparities

In Utah from 2012 to 2014, males had significantly higher suicide rates than females in every age group. Males (31.2 per 100,000 population) had a significantly higher age-adjusted suicide rate compared to females (10.1 per 100,000 population).

Males aged 75 and older, followed closely by males aged 45–54 and 55–64, had the highest suicide rates among other male age groups. Females 45–54 years of age, followed closely by females aged 35–44 and 18–19, had the highest suicide rates among other female age groups.

From 2012 to 2014, Central Utah, Southeast Utah, and TriCounty local health districts (LHDs) had significantly higher age-adjusted suicide rates compared to the state rate.

Risk Factors

The 2013 Prevention Needs Assessment showed that students who had been bullied both at school and electronically were at especially high risk, being 5.8 times more likely to have considered suicide.

A lower risk of suicide ideation was found among students who regularly attended religious services or activities and regularly ate a meal with their family. Even among those who had experienced an episode of depressive symptoms in the previous year, students reporting religious involvement and family mealtimes were still less likely to have considered suicide in the past year.

Many conditions and stressors may be related to suicide including:¹

- 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.

What Is Being Done?

The UDOH Violence and Injury Prevention Program (VIPP) is funded by the U.S. Centers for Disease Control and Prevention (CDC) to implement the Utah Violent Death Reporting System (UTVDRS). UTVDRS is a data collection and monitoring system

- 20.5 suicides per 100,000 population
- Higher rates among Utahns aged 18–19, 35–64, and 74+; lower rate among those aged 10–14
- Higher for males than females
- Significantly lower rates among Asian, Pacific Islander, and Hispanic populations
- Significantly higher among non-Hispanic population
- Significantly higher for Central Utah, Southeast Utah, and TriCounty LHDs
- Significantly lower for Bear River, Davis County, and Utah County LHDs

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

Suicide

that will help Utahns better understand the public health problem of violence by informing 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 Office of the Medical Examiner, 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. UTVDRS is currently in its 11th year of data collection.

The VIPP has partnered with the Division of Substance Abuse and Mental Health (DSAMH) to facilitate the Suicide Prevention Coalition.

Map: Suicide by Local Health District, Utah, 2012-2014

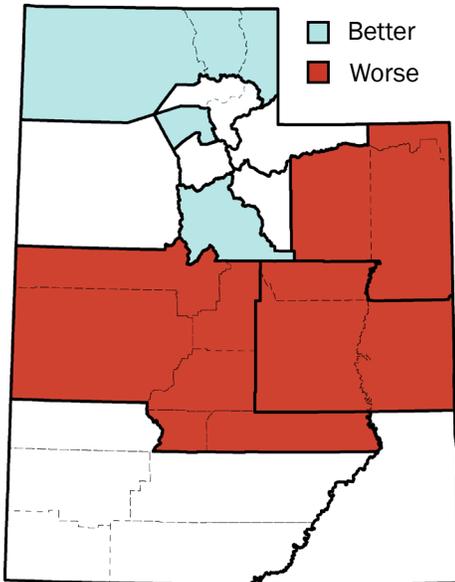


Figure: Suicide by Age and Gender, Utah, 2012-2014

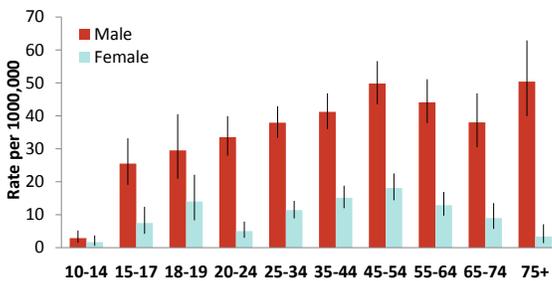
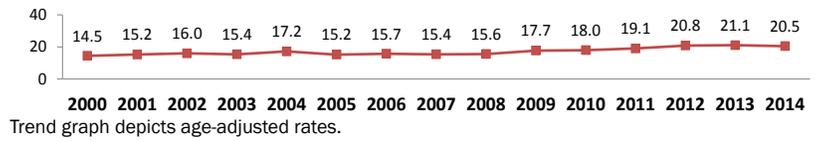


Figure: Suicides per 100,000 Population in Utah by Year, 2000-2014



STATE COMPARISON (2014) [^]	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	13.4	13.3 - 13.5	13.0	12.8 - 13.1
District of Columbia (best)	7.9	5.9 - 10.3	7.8	5.8 - 10.3
UTAH (47th of 51)	19.0	17.3 - 20.5	20.5	18.8 - 22.3
Montana (worst)	24.5	21.5 - 27.6	23.9	20.8 - 27.0

AGE IN YEARS (2014)					
10-14	2.4	0.9 - 5.2	-	-	✓
15-17	19.2	12.7 - 27.9	-	-	-
18-19	31.5	20.7 - 45.8	-	-	!
20-24	19.0	14.0 - 25.2	-	-	-
25-34	21.6	17.4 - 26.4	-	-	-
35-44	28.0	22.9 - 33.8	-	-	!
45-54	30.3	24.5 - 37.2	-	-	!
55-64	26.8	21.0 - 33.6	-	-	!
65-74	20.3	14.1 - 28.2	-	-	-
75+	35.0	25.3 - 47.1	-	-	!

GENDER (2014)					
Male	28.2	25.5 - 31.0	31.2	28.2 - 34.4	!
Female	9.4	7.9 - 11.1	10.1	8.5 - 12.0	✓

RACE (2012-2014)					
American Indian/AK Native	23.7	16.1 - 33.7	22.9	15.2 - 33.1	-
Asian	10.4	6.5 - 15.9	11.0	6.7 - 17.0	✓
Black	10.5	5.4 - 18.3	11.3	4.9 - 22.1	-
Pacific Islander*	8.3	3.3 - 17.0	7.5	2.9 - 15.7	✓
White	19.8	18.8 - 20.8	20.3	19.3 - 21.4	-

ETHNICITY (2012-2014)					
Hispanic	8.9	7.3 - 10.8	10.2	8.0 - 13.0	✓
Non-Hispanic	20.7	19.7 - 21.8	21.1	20.1 - 22.2	!

LOCAL HEALTH DISTRICT (2012-2014)					
Bear River	14.9	11.7 - 18.6	16.4	12.8 - 20.7	✓
Central Utah	30.6	23.9 - 38.7	33.6	26.0 - 42.7	!
Davis County	15.4	13.0 - 18.1	17.0	14.3 - 20.0	✓
Salt Lake County	20.1	18.6 - 21.8	21.3	19.6 - 23.0	-
San Juan*	22.2	10.6 - 40.7	25.4	12.1 - 47.1	-
Southeast Utah [†]	42.2	31.5 - 55.3	43.7	32.3 - 57.8	!
Southwest Utah	22.0	18.5 - 25.9	23.5	19.7 - 27.9	-
Summit County	15.6	9.2 - 24.6	16.8	9.6 - 27.3	-
Tooele County	23.1	16.6 - 31.2	25.7	18.4 - 35.0	-
TriCounty	29.4	21.8 - 38.8	32.6	24.1 - 43.2	!
Utah County	14.4	12.6 - 16.4	16.2	14.1 - 18.6	✓
Wasatch County	15.1	7.8 - 26.3	15.9	8.2 - 27.8	-
Weber-Morgan	21.5	18.3 - 25.0	22.1	18.8 - 25.9	-

[†] Includes Carbon, Emery, and Grand counties

[^] National data from CDC WONDER.

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

Depression

Behavioral Risk Factor Surveillance System

Description

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.

How Are We Doing?

National Comparison

Utah has consistently higher rates of self-reported lifetime depression than the U.S. rate (20.8% vs. 17.7% in 2014, age-adjusted rates).

Healthy People Objective (see Appendix)

MHMD-4.2: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes

U.S. Target: 5.8 percent

Disparities

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.

Adults aged 50–64 had significantly higher rates of depression than other age groups. Conversely, Utahns aged 65 and older had significantly lower rates of depression.

In Utah during 2014, adult women (26.9%) had significantly higher rates of doctor-diagnosed depression than men (14.8%).

Hispanic (18.4%), Asian (7.1%), and Hawaiian/Pacific Islander (12.2%) adults reported lower lifetime depression than the state rate during 2012–2014.

Adults with a household income less than \$25,000 (31.6%) and those with a household income \$25,000–\$49,999 (22.7%) had significantly higher rates of lifetime doctor-diagnosed depression, while adults with household incomes \$50,000–\$74,999 (18.9%) and those with an income greater than \$75,000 (15.7%) had lower rates of lifetime depression during 2012–2014.

Depression also varied by education during 2012–2014. Utah adults aged 25 and older with a college education (17.4%) had a lower rate of doctor-diagnosed depression than adults with less than a high school education (23.6%), those with a high school or GED (22.0%), and those with some college (23.3%).

Adults in Salt Lake County (22.4%) local health district (LHD) reported higher rates of doctor-diagnosed depression than the state rate, while adults in Summit County (17.4%), Utah County (19.6%) and Wasatch County (17.0%) LHDs reported lower rates of doctor-diagnosed depression during 2012–2014.

Risk Factors

Utah adults who reported chronic illnesses and/or poor health status in general, were also more likely to have reported 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 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.

What Is Being Done?

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

- 20.7% of Utah adults (2014 crude rate) have a depressive disorder
- Higher rates among Utahns aged 50–64; lower rates among those aged 65+
- Higher rates among females; lower rates among males
- Disparities include Black and White populations
- Significantly lower for Asian, Hawaiian/Pacific Islander, and Hispanic populations
- Higher rate among adults aged 25+ with some post high school education
- Lower rates among college graduates and higher income levels
- Significantly higher for Salt Lake County LHD
- Significantly lower for Summit County, Utah County, and Wasatch County LHDs

Depression

Data Interpretation Issues

The question asks about lifetime diagnosis and does not reflect current major depression.

Map: Adult Depression by Local Health District, 2012-2014

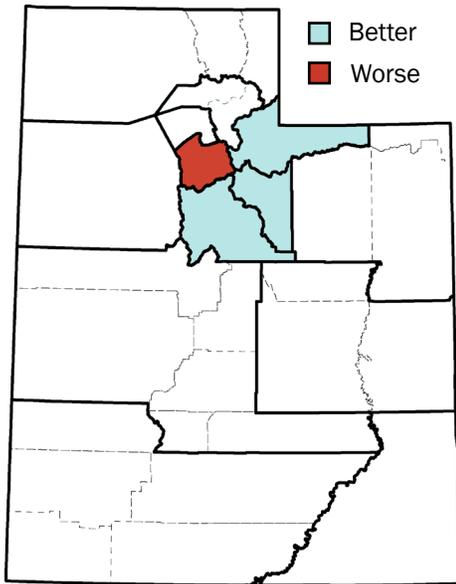
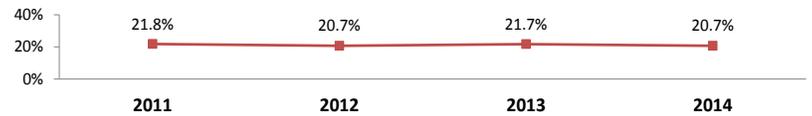


Figure: Percentage of Utahns Aged 18+ With Depression by Year, 2011-2014



Trend graph depicts age-adjusted rates.

	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014)	Rate	95% CIs	Rate	95% CIs
U.S.	17.8%	17.5% - 18.0%	17.7%	17.5% - 17.9%
Hawaii (best)	10.7%	9.8% - 11.7%	10.9%	9.9% - 12.0%
UTAH (34th of 51)	20.7%	20.0% - 21.5%	20.8%	20.0% - 21.6%
Maine (worst)	23.7%	22.5% - 24.9%	24.3%	22.9% - 25.8%
AGE IN YEARS (2014)				
18-34	20.8%	19.4% - 22.3%	-	-
35-49	21.6%	20.1% - 23.2%	-	-
50-64	22.9%	21.4% - 24.5%	-	-
65+	16.5%	15.0% - 18.0%	-	-
GENDER (2014)				
Male	14.8%	13.8% - 15.8%	14.8%	13.8% - 15.8%
Female	26.6%	25.5% - 27.9%	26.9%	25.7% - 28.1%
RACE (2012-2014)				
American Indian/AK Native	24.1%	19.6% - 29.3%	24.9%	20.2% - 30.1%
Asian	7.8%	5.4% - 11.2%	7.1%	5.0% - 10.0%
Black	25.1%	19.4% - 31.9%	28.2%	22.1% - 35.3%
Pacific Islander	13.6%	8.4% - 21.4%	12.2%	7.0% - 20.4%
White	21.9%	21.3% - 22.4%	21.9%	21.4% - 22.5%
ETHNICITY (2012-2014)				
Hispanic	17.8%	16.1% - 19.6%	18.4%	16.6% - 20.3%
Non-Hispanic	21.7%	21.1% - 22.2%	21.7%	21.2% - 22.3%
INCOME (2012-2014)				
0-\$24,999	29.8%	28.4% - 31.2%	31.6%	30.1% - 33.0%
\$25,000-\$49,999	22.2%	21.1% - 23.3%	22.7%	21.6% - 23.9%
\$50,000-\$74,999	19.5%	18.3% - 20.7%	18.9%	17.7% - 20.1%
\$75,000 or more	16.0%	15.2% - 16.9%	15.7%	14.8% - 16.7%
EDUCATION—Adults 25+ (2012-2014)				
Below High School	23.9%	21.6% - 26.5%	23.6%	21.3% - 26.0%
High School or GED	22.3%	21.2% - 23.4%	22.0%	20.9% - 23.1%
Some Post High School	23.7%	22.7% - 24.6%	23.3%	22.4% - 24.2%
College Graduate	17.8%	17.0% - 18.5%	17.4%	16.7% - 18.2%
LOCAL HEALTH DISTRICT (2012-2014)				
Bear River	19.7%	17.8% - 21.8%	20.1%	18.2% - 22.1%
Central Utah	20.9%	18.4% - 23.6%	21.4%	18.8% - 24.1%
Davis County	21.5%	20.0% - 23.1%	21.2%	19.7% - 22.8%
Salt Lake County	22.8%	21.9% - 23.7%	22.4%	21.5% - 23.3%
San Juan	19.1%	12.9% - 27.4%	18.2%	12.4% - 25.9%
Southeast Utah†	21.2%	18.1% - 24.7%	21.9%	18.5% - 25.9%
Southwest Utah	20.5%	18.4% - 22.6%	21.2%	19.0% - 23.5%
Summit County	17.7%	14.8% - 21.1%	17.4%	14.5% - 20.8%
Tooele County	22.5%	19.6% - 25.8%	21.9%	19.1% - 25.0%
TriCounty	19.4%	16.8% - 22.3%	19.5%	17.0% - 22.3%
Utah County	19.8%	18.5% - 21.1%	19.6%	18.4% - 20.9%
Wasatch County	17.6%	14.4% - 21.3%	17.0%	13.8% - 20.8%
Weber-Morgan	22.6%	20.9% - 24.5%	22.6%	20.9% - 24.4%

† Includes Carbon, Emery, and Grand counties

Figure: Adult Depression by Race, Utah, 2012-2014

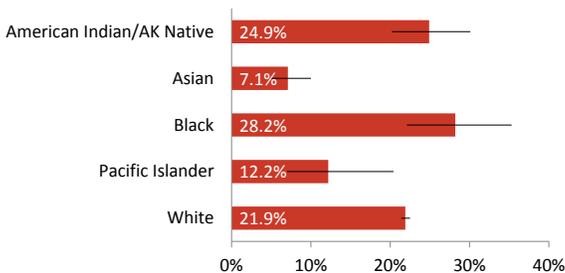
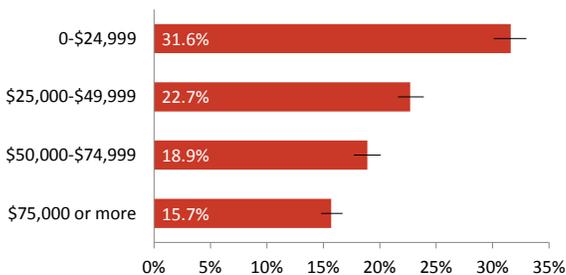


Figure: Adult Depression by Income, Utah, 2012-2014



Addictive Behaviors

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Prescription Drug Misuse/Deaths

National Survey on Drug Use and Health SAMHSA/CDC National Center for Health Statistics

Description

Prescription Drug Misuse: This measure reports the nonmedical use of pain relievers in the past year among persons aged 12 and over as a percentage.

Drug Overdose Deaths Involving Opioids: This measure reports the rate (per 100,000 population) of drug overdose deaths caused by acute poisonings that involve any opioid as a contributing cause of death, regardless of intent. Opioids include both prescription opioid pain relievers such as hydrocodone, oxycodone, and morphine, as well as heroin and opium. Deaths related to chronic use of drugs are excluded from this indicator.

How Are We Doing?

National Comparison

The Utah 2013–2014 prescription drug misuse rate of 3.9% was very similar to the U.S. rate of 4.1%.

Prescription pain medications underlie many Utah poisoning deaths. In 2014, Utah's age-adjusted death rate from drug overdose involving opioids (16.8) was well above the U.S. rate of 9.0 per 100,000.

Healthy People Objective (see Appendix)

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.

Disparities

The highest rate of prescription drug misuse is for persons aged 18 to 25. However, the highest rates of drug overdose deaths involving opioids occurred in persons aged 25 through 64.

Southeast Utah and Tooele County local health districts (LHDs) had significantly higher death rates from drug overdose involving opioids (39.2 and 27.4 per 100,000, respectively) during 2013–2014.

Risk Factors

Risk factors include the extent to which people believe the substances are harmful.

In Utah, the top five circumstances observed in prescription opioid deaths were substance abuse problem, physical health problem, diagnosed mental illness, history of alcohol abuse, and intimate partner problem.¹

What Is Being Done?

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. Since 2007, the UDOH launched a media campaign, Use Only As Directed, to educate the public about how to use prescription pain medication safely (visit useonlyasdirected.org for more information). UDOH also launched a statewide provider education intervention where physicians have the opportunity to receive continuing medical education credit hours (CMEs) for participation in small and large group presentations.

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 S.B. 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 (H.B. 11) and the Naloxone Law (H.B. 119). The Good Samaritan Law enables bystanders to report an overdose without fear of criminal prosecution for illegal possession of a controlled substance or

Misuse

- 3.9% of Utahns aged 12+ misused prescription drugs
- Utah ranks 20th in the nation
- Significantly higher rate among Utahns aged 18–25

Opioid Deaths

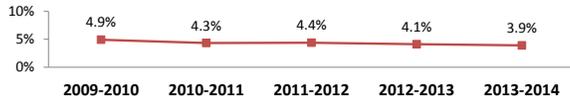
- 15.5 per 100,000 population (crude rate)
- Utah ranks 45th in the nation
- Significantly higher rate among Utahns aged 25–64
- Significantly higher for Southeast Utah and Tooele County LHDs

¹ Utah Department of Health Violence and Injury Prevention Program, Prescription Opioid Deaths in Utah, 2012 Fact Sheet <http://www.health.utah.gov/vipp/pdf/FactSheets/2012RxOpioidDeaths.pdf> (accessed 11/20/2015).

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.

Prescription Drug Misuse

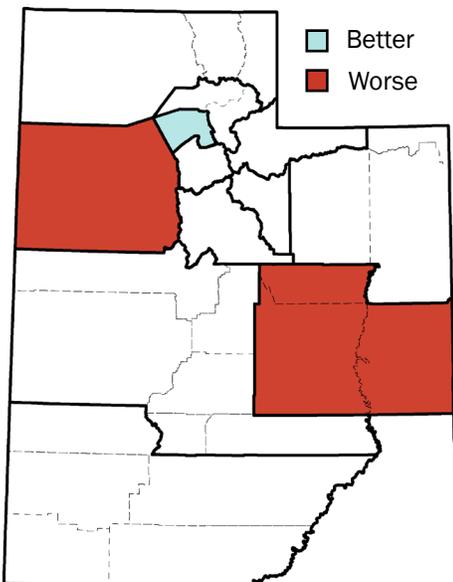
Figure: Percentage of Persons 12+ Reporting Prescription Drug Misuse in Utah by Year, 2009–2010 through 2013–2014



STATE COMPARISON (2013-2014)	Crude (burden)	
	Rate	95% CIs
U.S.	4.1%	3.9% - 4.2%
Maine (best)	3.2%	2.5% - 4.0%
UTAH (20th of 51)	3.9%	3.2% - 4.8%
Oklahoma (worst)	5.0%	4.0% - 6.2%

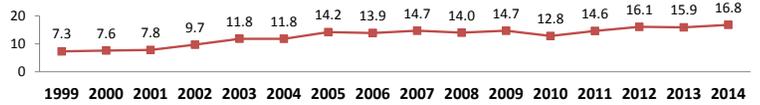
AGE IN YEARS (2013-2014)	Rate	95% CIs
12-17	4.2%	3.1% - 5.5%
18-25	7.0%	5.4% - 9.1% !
26+	3.1%	2.4% - 4.1%

Map: Opioid Overdose Deaths by LHD, 2013-2014



Overdose Deaths Involving Opioids

Figure: Overdose Deaths Involving Opioids per 100,000 by Year, Utah, 1999-2014



Trend graph depicts age-adjusted rates.

STATE COMPARISON (2014)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	9.0	8.9 - 9.1	9.0	8.9 - 9.1
Nebraska (best)	3.0	2.2 - 3.9	3.2	2.4 - 4.2
UTAH (45th of 51)	15.5	14.0 - 16.9	16.8	15.2 - 18.4
West Virginia (worst)	29.9	27.4 - 32.4	31.6	28.9 - 34.3

AGE IN YEARS (2014)

0-14	**	** **	-	-	-
15-24	6.8	4.6 - 9.5	-	-	- ✓
25-34	26.8	21.9 - 31.6	-	-	- !
35-44	30.3	24.8 - 35.8	-	-	- !
45-54	32.3	26.2 - 39.3	-	-	- !
55-64	24.6	19.1 - 31.2	-	-	- !
65+*	5.8	3.4 - 9.2	-	-	- ✓

GENDER (2014)

Male	18.1	15.9 - 20.3	18.9	16.6 - 21.2
Female	12.8	10.9 - 14.6	14.6	12.5 - 16.7 ✓

RACE (2010-2014)

American Indian/AK Native	12.0	8.1 - 17.3	13.4	8.9 - 19.3
Asian/Pacific Islander*	2.1	1.1 - 3.8	*	0.9 - 3.4 ✓
Black*	6.0	3.3 - 10.1	*	3.9 - 12.6 ✓
White	14.8	14.2 - 15.5	16.0	15.2 - 16.7

ETHNICITY (2014)

Hispanic	8.3	5.7 - 11.6	10.1	6.6 - 14.8 ✓
Non-Hispanic	16.6	15.0 - 18.2	17.9	16.2 - 19.6

LOCAL HEALTH DISTRICT (2013-2014)

Bear River	10.8	7.6 - 14.9	12.7	8.9 - 17.7
Central Utah	15.0	9.5 - 22.6	17.5	11.0 - 26.5
Davis County	10.9	8.5 - 13.7	11.9	9.3 - 15.1 ✓
Salt Lake County	17.7	15.9 - 19.5	17.7	15.9 - 19.4
San Juan*	**	** **	**	** **
Southeast Utah†	34.2	22.7 - 49.5	39.2	25.8 - 57.0 !
Southwest Utah	13.9	10.6 - 17.9	15.9	12.1 - 20.6
Summit County	12.9	6.2 - 23.7	*	6.0 - 23.1
Tooele County	25.3	17.2 - 36.0	27.4	18.6 - 38.9 !
TriCounty	13.0	7.3 - 21.4	*	8.8 - 25.8
Utah County	12.7	10.6 - 14.8	15.5	12.9 - 18.2
Wasatch County	**	** **	**	** **
Weber-Morgan	16.4	13.0 - 20.4	17.0	13.5 - 21.2

† Includes Carbon, Emery, and Grand counties

* 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>.

Cigarette Smoking—Adult

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults aged 18 years and older who smoke cigarettes every day or some days.

How Are We Doing?

The Utah adult smoking rate has decreased since the UDOH Tobacco Prevention and Control Program started receiving Master Settlement Agreement funds in 2000.

National Comparison

In 2014, the Utah adult smoking rate was 9.5% compared to the national rate of 17.8% (age-adjusted rates).

Healthy People Objective (see Appendix)

TU-1.1: Reduce cigarette smoking by adults

U.S. Target: 12.0 percent

Utah Target: 9.0 percent

Disparities

Adults with low household income and fewer years of formal education report higher rates of tobacco use than the general population.

Risk Factors

People who smoke have increased risk for developing heart disease, stroke, chronic obstructive pulmonary disease, and cancer. Smoking may also contribute to birth issues, poor bone health, oral health, macular degeneration, diabetes, and rheumatoid arthritis.¹

What Is Being Done?

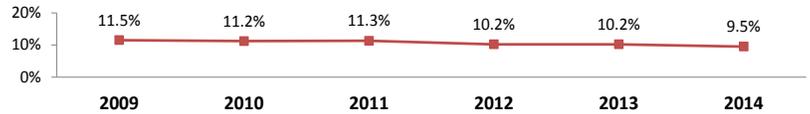
The UDOH Tobacco Prevention and Control Program (TPCP) and its partners use comprehensive programs to prevent young people from starting to use tobacco, help tobacco users quit, promote tobacco-free environments, and reduce tobacco-related disparities. These programs include an extensive anti-tobacco marketing campaign, free and confidential tobacco cessation services, school- and community-based prevention programs, and efforts to improve tobacco policies. Tobacco-free policies support tobacco-free norms and protect nonsmokers from secondhand smoke. The marketing campaign uses television, radio, billboard, print, and on-line media to reach youth, adults, pregnant women, racial and ethnic minorities, and rural populations with anti-tobacco messages. The campaign's goals are to counter tobacco industry promotions, inform Utahns about quitting services, and support local tobacco control efforts. Quitting services available to Utahns are accessible through Utah's tobacco cessation website, <http://www.waytoquit.org>, and include a toll-free Tobacco Quit Line (1-800-QUIT-NOW) and a web-based tobacco cessation program. TPCP also partners with community health clinics to offer counseling services for uninsured or underinsured tobacco users. Local health departments hold group-based quitting classes for adults and youth in local communities. Efforts to protect nonsmokers from secondhand smoke focus on strengthening tobacco-free policies in apartment complexes, workplaces, schools, and outdoor venues frequented by children.

- 9.7% of Utah adults smoke (crude rate)
- Higher rate for Utahns aged 18–34; lower rate for Utahns aged 65+
- Higher rate for males; lower for females
- Disparities include American Indian/Alaska Native and Black populations
- Higher rate for low income and lower education levels
- Lower rate for high income and higher education levels
- Significantly higher for Salt Lake County, Southeast Utah, Tooele County, TriCounty, and Weber-Morgan LHDs
- Significantly lower for Bear River, Davis County, Summit County, and Utah County LHDs

1 CDC Fact Sheet. Health Effects of Cigarette Smoking—Smoking & Tobacco Use. Accessed 8/8/2016 from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/#children.

Cigarette Smoking—Adult

Figure: Percentage of Utahns Aged 18+ Who Smoke Cigarettes by Year, 2009–2014



Trend graph depicts age-adjusted rates.

Map: Adult (18+) Smoking by Local Health District, 2013–2014

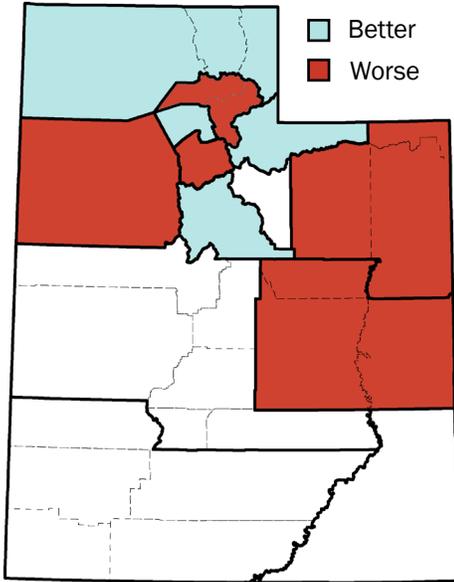


Figure: Adult (18+) Smoking by Race, Utah, 2013–2014

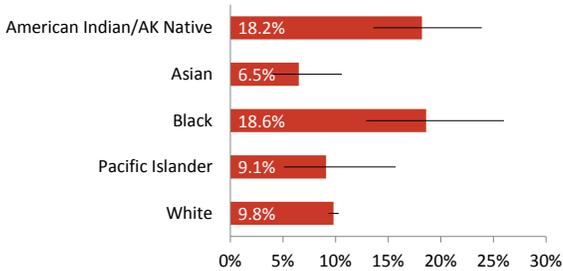
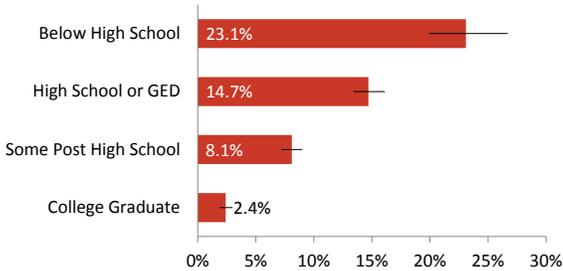


Figure: Adult Smoking by Education, Utah Adults 25+, 2014



	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014)	Rate	95% CIs	Rate	95% CIs
U.S.	17.4%	17.2% - 17.7%	17.8%	17.6% - 18.1%
Utah (best)	9.7%	9.1% - 10.3%	9.5%	8.9% - 10.1%
UTAH (1st of 51)	9.7%	9.1% - 10.3%	9.5%	8.9% - 10.1%
West Virginia (worst)	26.7%	25.3% - 28.1%	28.4%	26.9% - 30.0%
AGE IN YEARS (2014)				
18–34	11.2%	10.0% - 12.4%	-	- - - !
35–49	10.0%	8.8% - 11.3%	-	- - -
50–64	10.4%	9.2% - 11.7%	-	- - -
65+	4.5%	3.7% - 5.4%	-	- - - ✓
GENDER (2014)				
Male	11.2%	10.2% - 12.2%	10.9%	10.0% - 11.9% !
Female	8.2%	7.4% - 9.0%	8.1%	7.4% - 8.9% ✓
RACE (2013–2014)				
American Indian/AK Native	18.3%	13.6% - 24.2%	18.2%	13.6% - 23.9% !
Asian	6.6%	4.0% - 10.7%	6.5%	4.0% - 10.6%
Black	18.5%	12.8% - 26.1%	18.6%	12.9% - 26.0% !
Pacific Islander	8.8%	5.1% - 14.6%	9.1%	5.1% - 15.7%
White	9.8%	9.3% - 10.3%	9.8%	9.3% - 10.3%
ETHNICITY (2013–2014)				
Hispanic	10.3%	8.7% - 12.0%	10.1%	8.6% - 12.0%
Non-Hispanic	9.9%	9.5% - 10.4%	9.8%	9.4% - 10.3%
INCOME (2014)				
0–\$24,999	17.1%	15.4% - 19.0%	18.9%	17.0% - 20.9% !
\$25,000–\$49,999	10.5%	9.2% - 11.9%	10.9%	9.5% - 12.5%
\$50,000–\$74,999	9.0%	7.6% - 10.6%	8.2%	6.9% - 9.6%
\$75,000 or more	4.8%	4.1% - 5.7%	4.4%	3.7% - 5.3% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	25.8%	22.1% - 29.9%	23.1%	19.9% - 26.7% !
High School or GED	15.3%	13.9% - 16.9%	14.7%	13.4% - 16.1% !
Some Post High School	8.7%	7.7% - 9.7%	8.1%	7.2% - 9.0% ✓
College Graduate	2.5%	2.0% - 3.0%	2.4%	1.9% - 3.0% ✓
LOCAL HEALTH DISTRICT (2013–2014)				
Bear River	8.0%	6.3% - 10.1%	7.7%	6.1% - 9.6% ✓
Central Utah	11.2%	8.7% - 14.4%	11.5%	9.0% - 14.7%
Davis County	8.1%	6.8% - 9.5%	7.9%	6.7% - 9.3% ✓
Salt Lake County	11.1%	10.3% - 12.0%	10.8%	10.0% - 11.6% !
San Juan*	10.1%	3.7% - 24.5%	10.1%	4.1% - 23.0%
Southeast Utah†	17.9%	14.0% - 22.5%	20.1%	15.5% - 25.7% !
Southwest Utah	10.1%	8.4% - 12.2%	10.8%	8.9% - 13.1%
Summit County	5.4%	3.8% - 7.7%	5.4%	3.7% - 7.9% ✓
Tooele County	13.4%	10.4% - 17.3%	13.1%	10.1% - 16.8% !
TriCounty	15.3%	12.5% - 18.5%	15.3%	12.6% - 18.4% !
Utah County	6.2%	5.3% - 7.2%	5.9%	5.0% - 6.8% ✓
Wasatch County	7.0%	4.8% - 10.0%	7.0%	4.8% - 10.2%
Weber-Morgan	14.2%	12.5% - 16.2%	14.2%	12.5% - 16.2% !

† Includes Carbon, Emery, and Grand counties

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

Cigarette Smoking—Minor

Youth Risk Behavior Surveillance System

Description

This measure reports the percentage of students who smoked cigarettes on one or more of the past 30 days.

How Are We Doing?

The Utah teen smoking almost doubled from the mid-80s to the mid-90s.¹ Since the mid-90s, the high school smoking rate in Utah declined from 17.0% to 4.4%.²

National Comparison

The Utah youth smoking rate remains the lowest in the nation. In 2013, the smoking rate for Utah students in grades 9–12 was 4.4% compared to the U.S. rate of 15.7%.

Healthy People Objective (see Appendix)

TU-2.2: Reduce use of cigarettes by adolescents (past month)

U.S. Target: 16.0 percent

Utah Target: 5.0 percent

- 4.4% of Utah students in grades 9–12 smoke
- Significantly higher for Southeast Utah and TriCounty LHDs
- Significantly lower for Bear River and Davis County LHDs

Disparities

Youth in Southeast Utah and TriCounty local health districts (LHDs) report smoking at rates higher than the state rate.

Risk Factors

Stress, depression, and risk-taking behaviors are associated with cigarette smoking in youth.

People who smoke have increased risk for developing heart disease, stroke, chronic obstructive pulmonary disease, and cancer. Smoking may also contribute to birth issues, poor bone health, oral health, macular degeneration, diabetes, and rheumatoid arthritis.³

What Is Being Done?

The UDOH Tobacco Prevention and Control Program and its partners prevent youth tobacco use through a variety of programs and initiatives.

These programs include an anti-tobacco marketing campaign, school- and community-based prevention activities, tobacco cessation programs tailored to teens, and efforts to strengthen tobacco-free norms and protect children and nonsmokers from secondhand smoke through tobacco-free policies. These efforts are supported by local youth groups who share information about the dangers of tobacco use, expose tobacco industry marketing techniques, and educate about the benefits of tobacco-free policies.

The anti-tobacco marketing campaign uses television, radio, billboard, online, and print media to reach mainstream and high risk youth with anti-tobacco messages. The campaign's goals are to counter tobacco industry advertising, inform Utahns about quitting services, and reinforce and support local tobacco control initiatives. Quitting services available to Utah teens include a toll-free Tobacco Quit Line tailored to teens (1-800-QUIT-NOW) and group-based quitting classes. Efforts to strengthen tobacco-free policies focus on schools, multi-unit housing, and outdoor venues frequented by children and adolescents.

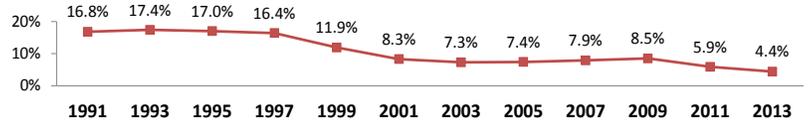
1 Bahr, S., et.al. (1998). Drug use among Utah students, 1984–1997. Provo, UT: Brigham Young University.

2 Youth Risk Behavior Survey, 1995–2013

3 CDC Fact Sheet. Health Effects of Cigarette Smoking—Smoking & Tobacco Use. Accessed 8/8/2016 from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/#children.

Cigarette Smoking—Minor

Figure: Percentage of Adolescents Who Smoke Cigarettes by Year, Utah, 1991–2013



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.

Map: Youth Smoking by Local Health District, 2015

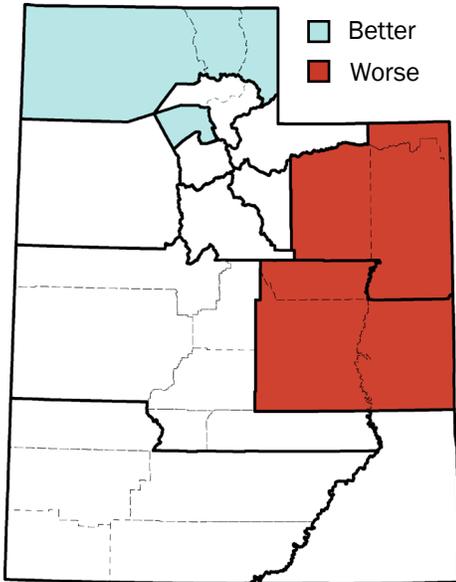


Figure: Youth Smoking by Grade in School, Utah, 2011 and 2013

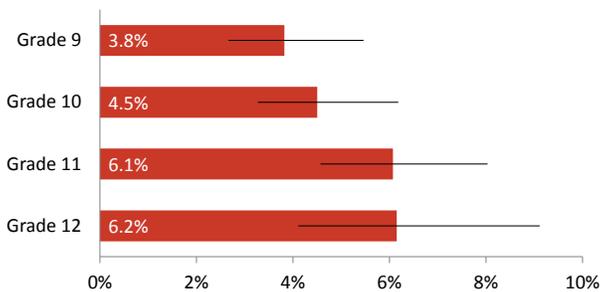
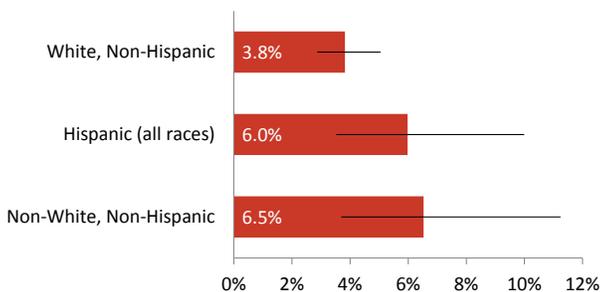


Figure: Youth Smoking by Race/Ethnicity, Utah, 2013



Crude (burden)

STATE COMPARISON (2013)	Rate	95% CIs
U.S.	15.7%	13.5% - 18.1%
Utah (best)	4.4%	3.3% - 5.8%
UTAH (1st of 42)	4.4%	3.3% - 5.8%
West Virginia (worst)	19.6%	16.8% - 22.7%

GRADE IN SCHOOL (2011 and 2013)

Grade	Rate	95% CIs
Grade 9	3.8%	2.7% - 5.5%
Grade 10	4.5%	3.3% - 6.2%
Grade 11	6.1%	4.6% - 8.0%
Grade 12	6.2%	4.1% - 9.1%

GENDER (2013)

Gender	Rate	95% CIs
Male	5.3%	3.5% - 7.8%
Female	3.5%	2.5% - 4.8%

RACE/ETHNICITY (2013)

Race/Ethnicity	Rate	95% CIs
White, Non-Hispanic	3.8%	2.9% - 5.1%
Hispanic (all races)	6.0%	3.5% - 10.0%
Non-White, Non-Hispanic	6.5%	3.7% - 11.2%

LOCAL HEALTH DISTRICT (2015)[^]

Local Health District	Rate	95% CIs	Status
Bear River	2.3%	1.8% - 2.9%	✓
Central Utah	4.2%	3.1% - 5.6%	
Davis County	2.5%	1.9% - 3.3%	✓
Salt Lake County	3.7%	3.2% - 4.3%	
San Juan	2.5%	1.6% - 4.1%	
Southeast Utah [†]	6.6%	4.6% - 9.4%	!
Southwest Utah	3.7%	2.9% - 4.8%	
Summit County	2.9%	1.3% - 6.3%	
Tooele County	4.4%	3.0% - 6.4%	
TriCounty	5.2%	4.9% - 5.4%	!
Utah County	2.7%	1.9% - 3.7%	
Wasatch County	2.8%	2.1% - 3.8%	
Weber-Morgan	4.3%	3.3% - 5.6%	

[†] Includes Carbon, Emery, and Grand counties

[^] Data by local health district are from the 2015 Prevention Needs Assessment.

Binge Drinking

Behavioral Risk Factor Surveillance System

Description

This measure is reported as the percentage of adults aged 18 years and older who reported binge drinking during the 30 days prior to the survey.

Binge drinking is defined as consuming five or more drinks on an occasion for men, or four or more drinks on an occasion for women. A drink of alcohol is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor.

How Are We Doing?

In 2014, it was estimated that 11.4% (crude rate) of Utah adults binge drank at least once in the 30 days prior to the survey. Utah is well below the Healthy People 2020 objective of 24.4% for this measure.

National Comparison

Estimates for 2014 show that 16.0% of U.S. adults reported binge drinking in the past 30 days whereas 11.4% of Utah adults reported binge drinking (crude rates).

The percentage of adults who reported binge drinking in the past 30 days was substantially lower in Utah than in the U.S. for all years reported between 1989–2014.

Healthy People Objective (see Appendix)

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

U.S. Target: 24.4 percent

Disparities

Binge drinking is more common among males and young adults in Utah. Binge drinking is more likely for persons aged 18–49, males, and the American Indian/Alaska (AK) Native and Hispanic populations. It is also related to lower income and lower education. Salt Lake County and Summit County local health districts (LHDs) had higher binge drinking rates than the state rate.

Risk Factors

Risk factors may include family history of alcoholism, mental health issues, high stress, low self-esteem, and peer pressure.

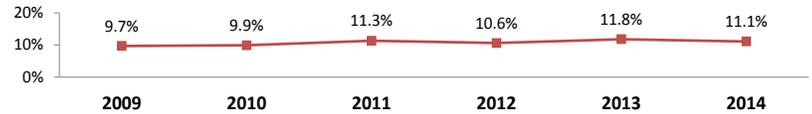
What Is Being Done?

The Utah Division of Substance Abuse and Mental Health is the agency responsible for ensuring that substance abuse and mental health prevention and treatment services are available statewide. The Division also acts as a resource by providing general information, research, and statistics to the public regarding substances of abuse and mental health services. For more information, visit <http://www.dsamh.utah.gov>.

- 11.4% of Utah adults binge drink
- Higher rates among Utahns aged <50; lower rates among Utahns aged 50+
- Higher rates among males
- Significantly higher rate for American Indian/Alaska Native population and the Hispanic population
- Higher rates among lower income and education levels
- Significantly higher for Salt Lake County and Summit County LHDs
- Significantly lower for Bear River, Central Utah, Davis County, and Utah County LHDs

Binge Drinking

Figure: Percentage of Utahns Aged 18+ Reporting Binge Drinking by Year, 2009–2014



Trend graph depicts age-adjusted rates.

Map: Adult (18+) Binge Drinking by Local Health District, 2014

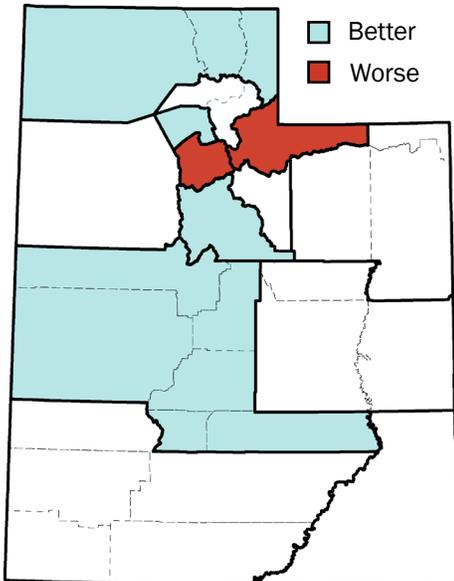


Figure: Binge Drinking by Age Group, Utah Adults 18+, 2014

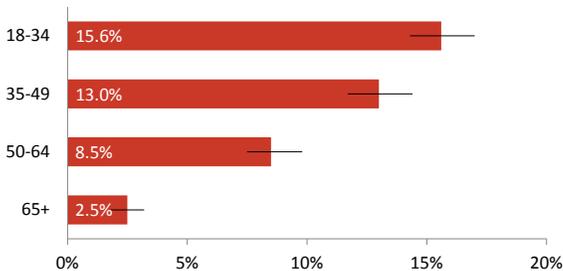
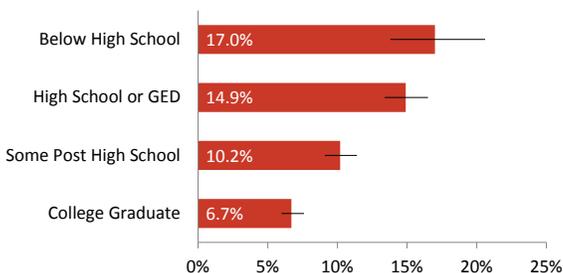


Figure: Binge Drinking by Education, Utah Adults 25+, 2014



	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014)	Rate	95% CIs	Rate	95% CIs
U.S.	16.0%	15.8% - 16.2%	16.8%	16.6% - 17.1%
West Virginia (best)	9.6%	8.6% - 10.6%	10.7%	9.6% - 11.9%
UTAH (2nd of 51)	11.4%	10.7% - 12.1%	11.1%	10.5% - 11.8%
North Dakota (worst)	24.0%	22.3% - 25.8%	25.1%	23.4% - 27.0%
AGE IN YEARS (2014)				
18-34	15.6%	14.3% - 17.0%	-	- - - !
35-49	13.0%	11.7% - 14.4%	-	- - - !
50-64	8.5%	7.5% - 9.8%	-	- - - ✓
65+	2.5%	1.8% - 3.2%	-	- - - ✓
GENDER (2014)				
Male	15.3%	14.3% - 16.4%	14.9%	13.9% - 16.0% !
Female	7.5%	6.8% - 8.4%	7.3%	6.6% - 8.1% ✓
RACE (2012-2014)				
American Indian/AK Native	18.4%	14.0% - 23.8%	18.4%	13.9% - 23.9% !
Asian	8.5%	5.9% - 12.1%	8.4%	5.8% - 12.0%
Black	13.4%	9.0% - 19.4%	12.4%	8.1% - 18.3%
Pacific Islander	12.4%	8.0% - 18.9%	9.6%	5.9% - 15.2%
White	11.2%	10.8% - 11.7%	11.1%	10.7% - 11.5%
ETHNICITY (2014)				
Hispanic	16.3%	13.8% - 19.1%	15.2%	12.8% - 18.0% !
Non-Hispanic	10.8%	10.1% - 11.5%	10.7%	10.0% - 11.4%
INCOME (2014)				
0-\$24,999	14.2%	12.5% - 16.0%	13.2%	11.6% - 15.1% !
\$25,000-\$49,999	12.6%	11.1% - 14.2%	12.7%	11.2% - 14.4% !
\$50,000-\$74,999	11.6%	10.1% - 13.4%	11.0%	9.5% - 12.8%
\$75,000 or more	10.4%	9.3% - 11.6%	9.9%	8.8% - 11.2%
EDUCATION—Adults 25+ (2014)				
Below High School	17.0%	13.7% - 20.8%	16.5%	13.3% - 20.1% !
High School or GED	14.9%	13.4% - 16.5%	14.7%	13.2% - 16.3% !
Some Post High School	10.2%	9.1% - 11.4%	10.0%	8.9% - 11.2%
College Graduate	6.7%	6.0% - 7.6%	6.5%	5.8% - 7.4% ✓
LOCAL HEALTH DISTRICT (2014)				
Bear River	7.8%	5.7% - 10.7%	7.2%	5.2% - 9.9% ✓
Central Utah	6.1%	3.9% - 9.4%	6.2%	4.0% - 9.7% ✓
Davis County	8.6%	7.0% - 10.6%	8.4%	6.8% - 10.2% ✓
Salt Lake County	14.5%	13.2% - 15.8%	14.1%	12.9% - 15.3% !
San Juan	**	** **	**	** **
Southeast Utah†	12.2%	8.2% - 17.8%	13.7%	9.0% - 20.3%
Southwest Utah	8.8%	6.7% - 11.4%	9.5%	7.2% - 12.4%
Summit County	21.3%	16.0% - 27.7%	21.3%	15.8% - 28.1% !
Tooele County	13.0%	8.6% - 19.2%	12.9%	8.6% - 18.9%
TriCounty	13.1%	9.3% - 18.1%	13.0%	9.3% - 17.7%
Utah County	7.5%	6.2% - 9.1%	7.1%	5.9% - 8.6% ✓
Wasatch County	11.7%	7.3% - 18.1%	11.1%	7.3% - 16.4%
Weber-Morgan	13.3%	11.0% - 15.9%	12.9%	10.8% - 15.5%

† Includes Carbon, Emery, and Grand counties

**The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

Chronic Drinking

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults aged 18 years and older who reported chronic drinking during the 30 days prior to the survey.

Chronic drinking is defined as an average daily alcohol consumption of >1 drink for women and >2 drinks for men in the past 30 days. This amount of alcohol consumption is considered to be exceeding the guidelines for low-risk drinking. A drink of alcohol is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor.

How Are We Doing?

In 2014, it was estimated that 3.3% (crude rate) of Utah adults exceeded the guidelines for low-risk drinking in the 30 days before for the survey.

National Comparison

Rates of chronic drinking in Utah are consistently below the national average. Utah currently has the lowest rate of chronic drinking in the nation.

Healthy People Objective (see Appendix)

SA-15: Reduce the proportion of adults who drank excessively in the previous 30 days
U.S. Target: 25.4 percent

Disparities

Salt Lake County and Summit County local health districts (LHDs) had higher rates of chronic drinking than the state rate. Persons aged 65 and older and adults with at least a college degree are less likely to drink chronically.

Risk Factors

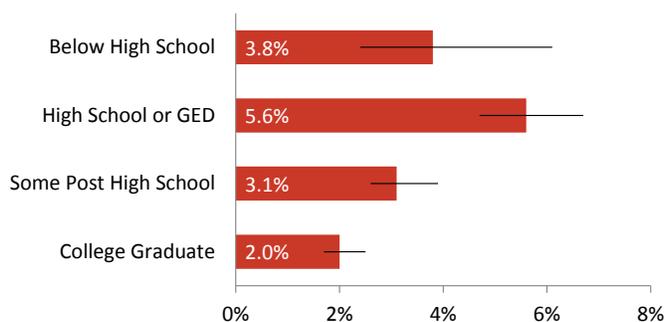
Risk factors may include family history of alcoholism, mental health issues, high stress, low self-esteem, and peer pressure.

What Is Being Done?

The Utah Division of Substance Abuse and Mental Health is the agency responsible for ensuring that substance abuse and mental health prevention and treatment services are available statewide. The Division also acts as a resource by providing general information, research, and statistics to the public regarding substances of abuse and mental health services. For more information, visit <http://www.dsamh.utah.gov>.

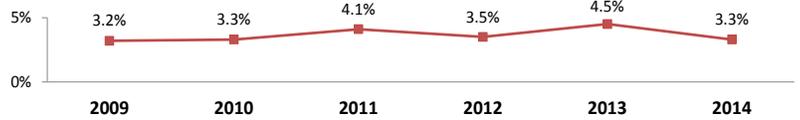
- 3.3% of Utah adults chronically drink alcohol
- Lower rates among Utahns aged 65+
- Higher rates among Utahns aged 25+ with high school or equivalent education level
- Lower rates among college graduates
- Significantly higher for Salt Lake County and Summit County LHDs
- Significantly lower for Davis County and Utah County LHDs

Figure: Chronic Drinking by Education, Utah Adults 25+, 2014



Chronic Drinking

Figure: Percentage of Utahns Aged 18+ Reporting Chronic Drinking by Year, 2009-2014



Trend graph depicts age-adjusted rates.

Map: Adult (18+) Chronic Drinking by Local Health District, 2013-2014

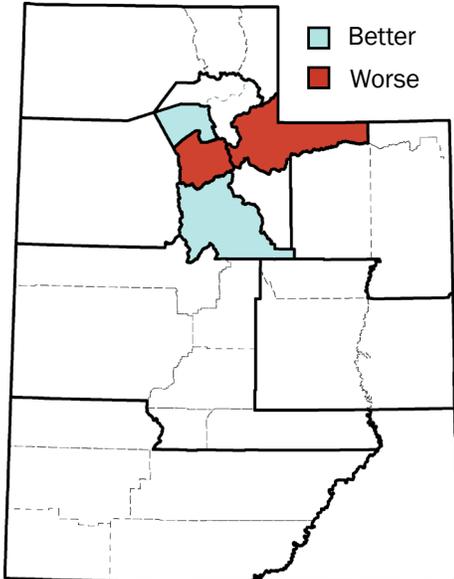
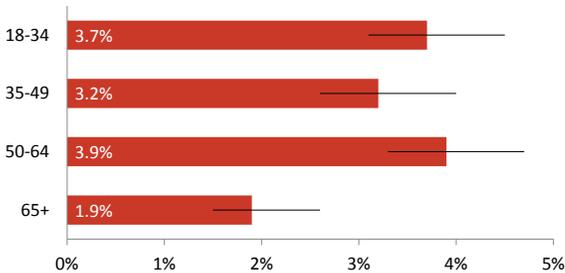


Figure: Adult Chronic Drinking by Age Group, Utah, 2014



	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014)	Rate	95% CIs	Rate	95% CIs
U.S.	5.8%	5.7% - 6.0%	5.9%	5.7% - 6.0%
Utah (best)	3.3%	3.0% - 3.7%	3.3%	3.0% - 3.7%
UTAH (1st of 51)	3.3%	3.0% - 3.7%	3.3%	3.0% - 3.7%
Vermont (worst)	9.1%	8.2% - 10.1%	9.5%	8.5% - 10.6%
AGE IN YEARS (2014)				
18-34	3.7%	3.1% - 4.5%	-	-
35-49	3.2%	2.6% - 4.0%	-	-
50-64	3.9%	3.3% - 4.7%	-	-
65+	1.9%	1.5% - 2.6%	-	-
GENDER (2014)				
Male	3.9%	3.3% - 4.5%	3.8%	3.3% - 4.4%
Female	2.8%	2.4% - 3.3%	2.8%	2.4% - 3.3%
RACE (2012-2014)				
American Indian/AK Native*	5.1%	2.8% - 9.1%	4.8%	2.6% - 8.7%
Asian*	3.2%	1.6% - 6.1%	2.7%	1.5% - 4.9%
Black*	5.1%	2.7% - 9.7%	4.0%	2.0% - 7.9%
Pacific Islander*	3.9%	1.6% - 9.1%	3.3%	1.3% - 8.4%
White	3.8%	3.6% - 4.1%	3.9%	3.6% - 4.1%
ETHNICITY (2014)				
Hispanic	3.3%	2.3% - 4.7%	2.9%	2.0% - 4.3%
Non-Hispanic	3.4%	3.0% - 3.8%	3.3%	3.0% - 3.7%
INCOME (2014)				
0-\$24,999	3.9%	3.1% - 4.9%	3.8%	3.0% - 4.8%
\$25,000-\$49,999	2.9%	2.3% - 3.7%	3.1%	2.4% - 3.9%
\$50,000-\$74,999	3.7%	2.8% - 4.8%	3.7%	2.8% - 4.9%
\$75,000 or more	3.6%	3.0% - 4.4%	3.4%	2.8% - 4.2%
EDUCATION—Adults 25+ (2014)				
Below High School	4.0%	2.5% - 6.4%	3.8%	2.4% - 6.1%
High School or GED	5.7%	4.8% - 6.8%	5.6%	4.7% - 6.7%
Some Post High School	3.2%	2.6% - 3.9%	3.1%	2.6% - 3.9%
College Graduate	2.1%	1.7% - 2.6%	2.0%	1.7% - 2.5%
LOCAL HEALTH DISTRICT (2013-2014)				
Bear River	4.1%	3.0% - 5.6%	4.1%	3.0% - 5.6%
Central Utah	3.2%	2.0% - 5.2%	3.2%	2.0% - 5.3%
Davis County	2.8%	2.1% - 3.7%	2.8%	2.1% - 3.8%
Salt Lake County	5.2%	4.6% - 5.9%	5.0%	4.5% - 5.7%
San Juan*	4.3%	1.8% - 10.1%	4.3%	2.0% - 9.2%
Southeast Utah†	5.9%	3.6% - 9.4%	5.7%	3.4% - 9.6%
Southwest Utah	3.3%	2.4% - 4.5%	3.4%	2.4% - 4.7%
Summit County	8.2%	6.2% - 10.8%	8.0%	5.9% - 10.8%
Tooele County	4.7%	2.9% - 7.4%	4.6%	2.9% - 7.2%
TriCounty	4.5%	3.1% - 6.5%	4.5%	3.1% - 6.4%
Utah County	1.4%	1.0% - 2.0%	1.4%	1.0% - 1.9%
Wasatch County	4.5%	2.6% - 7.7%	4.3%	2.5% - 7.5%
Weber-Morgan	4.6%	3.6% - 5.8%	4.6%	3.6% - 5.8%

† Includes Carbon, Emery, and Grand counties

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

Illicit Substance Use/Abuse

National Survey on Drug Use and Health SAMHSA

Description

Illicit Drug Use: This measure reports the percentage of persons aged 12 and over who reported illicit drug use in past month. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Illicit Drug Dependence or Abuse: This measure reports the percentage of persons aged 12 and over who reported illicit drug dependence or abuse in the past year. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

How Are We Doing?

National Comparison

Utah is ranked 7th with a rate of 7.3% of the population utilizing illicit substances. This is slightly lower than the U.S. rate of 9.8%. The reported use among Utah high school students for marijuana was the lowest in the nation in 2013, according to the Youth Risk Behavior Survey (YRBS).

Utah is ranked 27th with a rate of 2.7% of the population reporting illicit drug dependence or abuse. This is similar to the U.S. rate of 2.6%.

Healthy People Objective (see Appendix)

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

Disparities

Persons aged 18–25 years had a significantly higher rate of both use (14.4%) and dependence or abuse (6.1%). National data for the Healthy People objective indicate that persons with two or more races have the highest rate of illicit substance use.¹

Among youth in 2015, Weber-Morgan (9.7%) and Salt Lake County (9.4%) local health districts (LHDs) had significantly higher rates of current marijuana use than the state (6.9%) while Bear River (4.0%), Utah County (4.0%), Central Utah (4.5%), and Davis County (4.9%) LHDs had lower rates, according to the Prevention Needs Assessment Survey.

Risk Factors

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.²

Other risk factors include family history of 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.

What Is Being Done?

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 on their website: <http://www.dsamh.utah.gov/>.

Use

- 7.3% of Utahns use illicit substances
- Lower than the U.S., ranked 7th in the nation
- Higher among Utahns aged 18–25 years

Dependence or Abuse

- 2.7% of Utahns reported illicit drug dependence or abuse
- Similar to the U.S., ranked 27th in the nation
- Higher among Utahns aged 18–25 years
- Lower among Utahns aged 26+

1 Disparities Data Overview SA-13.3 by Race and Ethnicity. Healthy People 2020. Accessed 8/9/2016 from <https://www.healthypeople.gov/2020/data/disparities/summary/Chart/5201/3>.

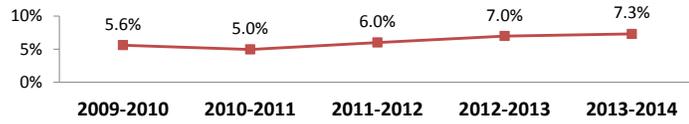
2 What are risk factors and protective factors?. National Institute on Drug Abuse. Accessed 8/9/2016 from

<https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors>.

Illicit Substance Use/Abuse

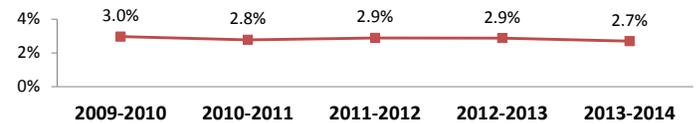
Illicit Drug Use in Past Month

Figure: Percentage of Persons Aged 12+ Reporting Illicit Drug Use in Past Month by Year, Utah, 2009-2010 through 2013-2014



Illicit Drug Dependence or Abuse in Past Year

Figure: Percentage of Persons Aged 12+ Reporting Illicit Drug Dependence or Abuse in Utah by Year, 2009-2010 through 2013-2014



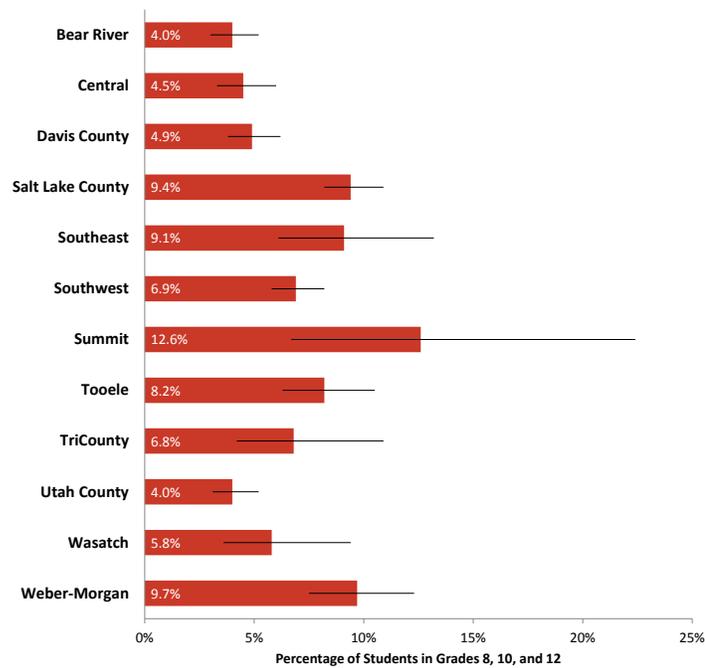
STATE COMPARISON (2013-2014)	Crude (burden)	
	Rate	95% CIs
U.S.	9.8%	9.5% - 10.0%
South Dakota (best)	5.8%	4.8% - 7.1%
UTAH (7th of 51)	7.3%	6.1% - 8.8%
Colorado (worst)	16.8%	14.7% - 19.2%

AGE IN YEARS (2013-2014)		
12-17	7.1%	5.6% - 9.0%
18-25	14.4%	11.8% - 17.5% !
26+	5.7%	4.4% - 7.3%

STATE COMPARISON (2013-2014)	Crude (burden)	
	Rate	95% CIs
U.S.	2.6%	2.5% - 2.8%
Montana (best)	2.1%	1.7% - 2.7%
UTAH (27th of 51)	2.7%	2.2% - 3.3%
District of Columbia (worst)	3.5%	2.8% - 4.5%

AGE IN YEARS (2013-2014)		
12-17	3.6%	2.7% - 4.7%
18-25	6.1%	4.7% - 7.9% !
26+	1.7%	1.2% - 2.5% ✓

Figure: Marijuana Use in Past Month, Utah Students in Grades 8, 10, and 12, 2015



Source: Utah Prevention Needs Assessment Survey

Care Access

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

No Health Insurance

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults without health insurance coverage. Health insurance is defined as including private coverage, Medicaid, Medicare, and other government programs.

How Are We Doing?

In 2014, an estimated 13.9% of adults were without health insurance coverage.

National Comparison

Comparing age-adjusted rates, Utah has a significantly lower rate of uninsured adults than the U.S.

Healthy People Objective (see Appendix)

AHS-1.1: Increase the proportion of persons with medical insurance
U.S. Target: 100 percent

Disparities

In Utah, persons aged 18–49 had higher uninsured rates. American Indian/Alaska (AK) Native, Black, Pacific Islander, and Hispanic populations were also less likely to have insurance. Lower income and lower education levels were also associated with higher rates of no health insurance.

Risk Factors

There is an association between poverty and lack of insurance. In 2013, approximately 28.7% of people living below the federal poverty level were uninsured compared to only 3.7% uninsured among people living at 300% or more of the federal poverty level.¹

What Is Being Done?

The UDOH administers programs to improve access to care, such as Medicaid, Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), and Utah's Premium Partnership for Health Insurance (UPP). The Department also works to improve the "safety net" for persons who lack health insurance. This is done through primary care grants to rural areas and clinics for children with disabilities. Local health departments provide preventive services such as immunizations and screenings at low or no cost to eligible persons who cannot afford them.

Data Interpretation Issues

Utah estimates of the uninsured in Utah are typically calculated using a set of state-added questions included on the Utah Behavioral Risk Factor Surveillance System (BRFSS). Data shown here are based on a single question of the core BRFSS in order to show comparisons to other states and to the nation overall. Therefore, rates shown here may reflect different rates of coverage than other reports that include multiple insurance questions.

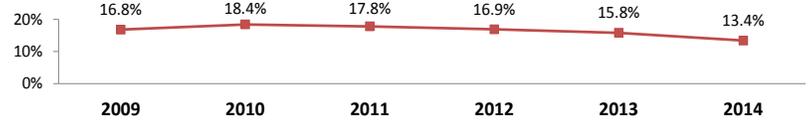
Compared with state surveys in Utah, the U.S. Current Population Survey (CPS) has historically yielded higher estimates of the Utah population with no health insurance coverage. Reasons may include differences in question wording, data weighting, and data imputation for missing values. For a thorough discussion of why state health insurance estimates differ from those produced by the U.S. Census Bureau, please refer to the State Health Access Data Assistance Center (SHADAC) publication 'Comparing Federal Government Surveys that Count the Uninsured: 2014' at <http://www.shadac.org/publications/comparing-federal-government-surveys-count-uninsured-2014>.

- 13.9% of Utah adults have no health insurance
- Higher rates among Utahns aged 18–49
- Disparities include American Indian/Alaska Native, Black, and Pacific Islander populations as well as the Hispanic population
- Higher rates among lower income and education levels
- Significantly lower rates for Bear River and Davis County LHDs

¹ Health Insurance Coverage. Retrieved on 8/5/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website: <http://ibis.health.utah.gov/>.

No Health Insurance

Figure: Percentage of Utahns Aged 18+ With No Health Insurance by Year, 2009–2014



Trend graph depicts age-adjusted rates.

Map: No Health Insurance by Local Health District, Utahns Aged 18+, 2014

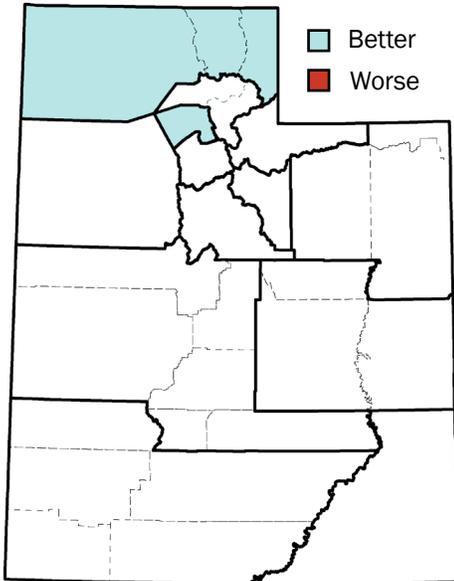


Figure: No Health Insurance by Ethnicity, Utah Adults Aged 18+, 2014

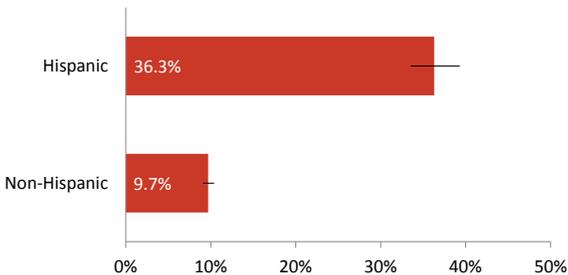
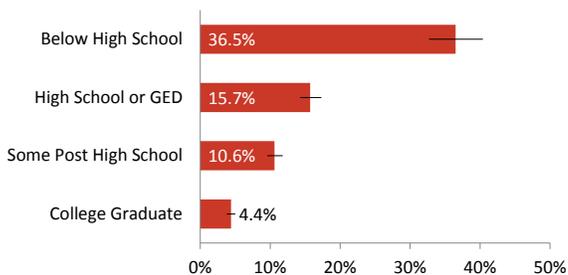


Figure: No Health Insurance by Education, Utah Adults 25+, 2014



	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014)	Rate	95% CIs	Rate	95% CIs
U.S.	14.1%	13.8% - 14.3%	14.9%	14.6% - 15.1%
Massachusetts (best)	4.6%	4.0% - 5.2%	4.8%	4.2% - 5.5%
UTAH (28th of 51)	13.9%	13.2% - 14.7%	13.4%	12.7% - 14.1%
Texas (worst)	24.9%	23.7% - 26.2%	25.1%	23.9% - 26.4%
AGE IN YEARS (2014)				
18–34	19.7%	18.2% - 21.3%	-	- - !
35–49	16.2%	14.8% - 17.8%	-	- - !
50–64	9.8%	8.7% - 11.1%	-	- - ✓
65+	0.9%	0.6% - 1.4%	-	- - ✓
GENDER (2014)				
Male	15.3%	14.2% - 16.5%	14.4%	13.4% - 15.5%
Female	12.5%	11.5% - 13.5%	12.3%	11.4% - 13.4%
RACE (2014)				
American Indian/AK Native	22.3%	15.1% - 31.6%	21.0%	14.6% - 29.3% !
Asian	11.3%	7.3% - 17.1%	9.5%	6.0% - 14.6%
Black	31.0%	21.9% - 41.9%	28.1%	20.0% - 38.1% !
Pacific Islander	30.6%	20.0% - 43.8%	27.5%	17.8% - 39.8% !
White	11.5%	10.8% - 12.2%	11.3%	10.6% - 12.0% ✓
ETHNICITY (2014)				
Hispanic	42.0%	38.8% - 45.4%	36.3%	33.5% - 39.3% !
Non-Hispanic	10.1%	9.4% - 10.8%	9.7%	9.1% - 10.4% ✓
INCOME (2014)				
0–\$24,999	32.3%	30.0% - 34.6%	33.8%	31.6% - 36.1% !
\$25,000–\$49,999	15.5%	13.9% - 17.3%	15.7%	14.1% - 17.5% !
\$50,000–\$74,999	6.2%	5.1% - 7.5%	6.0%	4.9% - 7.3% ✓
\$75,000 or more	2.9%	2.3% - 3.6%	2.9%	2.3% - 3.7% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	39.2%	35.0% - 43.6%	36.5%	32.7% - 40.4% !
High School or GED	16.0%	14.5% - 17.6%	15.7%	14.3% - 17.3% !
Some Post High School	10.9%	9.8% - 12.0%	10.6%	9.6% - 11.8% ✓
College Graduate	4.5%	3.9% - 5.2%	4.4%	3.8% - 5.0% ✓
LOCAL HEALTH DISTRICT (2014)				
Bear River	10.2%	7.7% - 13.4%	9.6%	7.3% - 12.5% ✓
Central Utah	13.7%	10.1% - 18.3%	15.0%	11.2% - 19.8%
Davis County	10.6%	8.7% - 12.7%	10.3%	8.6% - 12.3% ✓
Salt Lake County	13.3%	12.0% - 14.6%	12.9%	11.7% - 14.2%
San Juan*	14.6%	7.1% - 27.9%	11.8%	5.6% - 23.3%
Southeast Utah†	10.5%	6.7% - 16.1%	12.1%	7.9% - 18.1%
Southwest Utah	14.9%	12.2% - 18.0%	16.2%	13.3% - 19.5%
Summit County	7.6%	4.7% - 12.2%	8.3%	5.0% - 13.5%
Tooele County	8.9%	5.6% - 13.8%	8.8%	5.6% - 13.6%
TriCounty	15.7%	11.8% - 20.5%	15.6%	11.8% - 20.4%
Utah County	13.8%	12.0% - 15.8%	12.4%	10.9% - 14.1%
Wasatch County	12.4%	8.0% - 18.8%	12.3%	8.1% - 18.1%
Weber-Morgan	13.8%	11.5% - 16.6%	13.9%	11.5% - 16.6%

† Includes Carbon, Emery, and Grand counties

* Use caution in interpreting. The estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

Cost as a Barrier to Care

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults aged 18 years and older who reported they were unable to receive needed healthcare in the past year due to cost.

How Are We Doing?

The crude percentage of Utah adults who reported being unable to see a doctor in the past 12 months due to cost was 14.3% in 2014.

National Comparison

When comparing Utah to the U.S. as a whole, the age-adjusted percentage of adults who reported they were unable to get needed healthcare in the past year due to cost has been similar over the years. In 2014, this percentage was 14.9% in the U.S. compared to 14.2% in Utah.

Healthy People Objective (see Appendix)

AHS-6.2: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care

U.S. Target: 4.2 percent

Disparities

The percentage of adults unable to get care due to cost was higher than the state rate for adults aged 25–54 and lower for Utah adults aged 55 and older. Utah adults with lower income had a higher rate of reporting cost as a barrier to healthcare than those with higher income. Those without health insurance also had a higher reported rate than the insured. In Utah in 2014, 10.3% of adults with health insurance compared to 37.5% without insurance reported that cost was a barrier to care in the past 12 months (age-adjusted percentages).

Risk Factors

Poverty and lack of health insurance are risk factors of not being able to afford medical care.

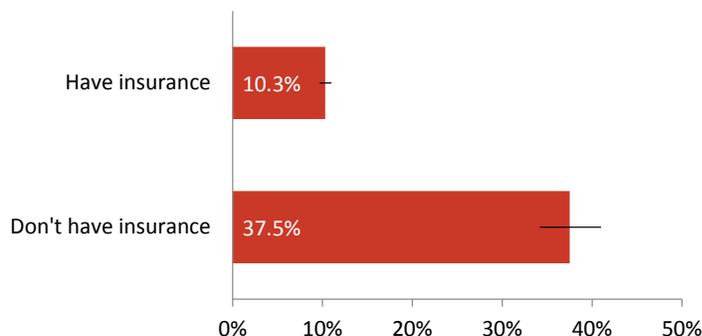
What Is Being Done?

The UDOH administers programs to improve access to care, such as Medicaid, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), UPP (Utah's Premium Partnership for Health Insurance), primary care grants, and clinics for children with disabilities. Local health departments provide preventive services such as immunizations and screenings at low or no cost to eligible persons who cannot afford them.

Members of the Association for Utah Community Health (AUCH), including Federally Qualified Health Centers and other providers, strive to meet the needs of the medically underserved in Utah. AUCH and its member organizations are part of a statewide and national movement to reduce barriers to healthcare by enhancing primary care service delivery through prevention, health promotion, and community participation.

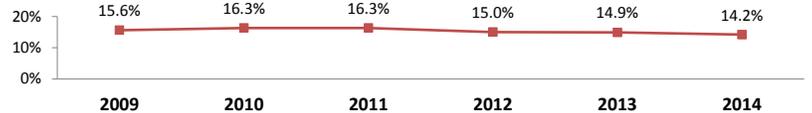
- 14.3% of Utah adults unable to receive needed healthcare because of cost
- Higher for Utahns aged 25–54 and lower for Utahns aged 55 and older
- Higher rates among females
- Disparities include American Indian/Alaska Native, Black, and Pacific Islander populations as well as the Hispanic population
- Lower rates among higher income levels
- Higher rates among adults aged 25+ with a high school education or less
- Lower rates among college graduates
- Significantly lower for Bear River and Davis County LHDs

Figure: Cost as a Barrier to Care by Health Insurance Coverage, Utahns Aged 18+, 2014



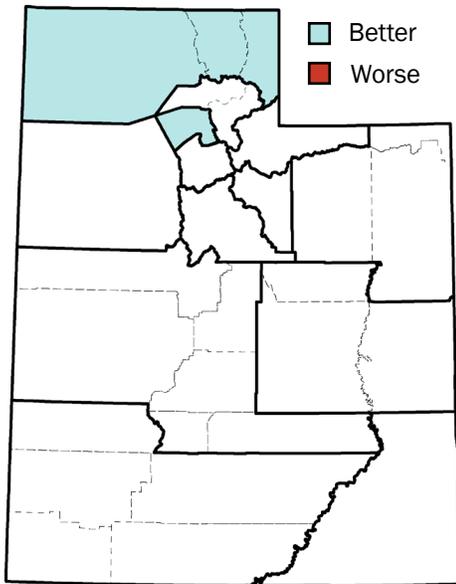
Cost as a Barrier to Care

Figure: Percentage of Utahns 18+ With Cost as a Barrier to Care by Year, 2009–2014



Trend graph depicts age-adjusted rates.

Map: Cost as a Barrier to Care by Local Health District, 2014



STATE COMPARISON (2014)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	14.3%	14.1% - 14.5%	14.9%	14.6% - 15.1%
North Dakota (best)	7.0%	6.0% - 8.1%	7.3%	6.3% - 8.5%
UTAH (28th of 51)	14.3%	13.6% - 15.1%	14.2%	13.5% - 14.9%
Mississippi (worst)	19.4%	17.7% - 21.3%	20.5%	18.7% - 22.4%
AGE IN YEARS (2014)				
18–24	13.6%	11.7% - 15.9%	-	- - -
25–34	18.8%	17.1% - 20.7%	-	- - - !
35–44	16.9%	15.3% - 18.7%	-	- - - !
45–54	17.0%	15.2% - 18.9%	-	- - - !
55–64	11.7%	10.2% - 13.3%	-	- - - ✓
65+	4.9%	4.1% - 5.9%	-	- - - ✓
GENDER (2014)				
Male	12.0%	11.0% - 13.0%	11.8%	10.9% - 12.8% ✓
Female	16.6%	15.6% - 17.7%	16.5%	15.5% - 17.6% !
RACE (2012–2014)				
American Indian/AK Native	25.4%	20.6% - 30.9%	25.6%	20.9% - 31.0% !
Asian	14.1%	10.7% - 18.3%	11.9%	9.0% - 15.6%
Black	23.6%	17.6% - 30.7%	24.4%	18.5% - 31.6% !
Pacific Islander	23.5%	17.1% - 31.5%	20.7%	15.0% - 28.0% !
White	13.7%	13.3% - 14.2%	13.7%	13.2% - 14.1% ✓
ETHNICITY (2014)				
Hispanic	25.0%	22.3% - 28.0%	24.0%	21.2% - 26.9% !
Non-Hispanic	12.8%	12.1% - 13.5%	12.7%	12.0% - 13.4% ✓
INCOME (2014)				
0–\$24,999	30.1%	28.0% - 32.3%	32.9%	30.7% - 35.2% !
\$25,000–\$49,999	16.6%	15.1% - 18.3%	17.6%	16.0% - 19.4% !
\$50,000–\$74,999	9.2%	7.9% - 10.7%	8.9%	7.6% - 10.4% ✓
\$75,000 or more	5.2%	4.5% - 6.1%	4.8%	4.1% - 5.6% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	28.0%	24.2% - 32.1%	27.1%	23.5% - 31.0% !
High School or GED	16.6%	15.1% - 18.2%	16.5%	15.0% - 18.1% !
Some Post High School	14.4%	13.2% - 15.7%	14.2%	13.0% - 15.5%
College Graduate	8.3%	7.5% - 9.2%	8.2%	7.4% - 9.1% ✓
LOCAL HEALTH DISTRICT (2014)				
Bear River	10.7%	8.4% - 13.6%	10.8%	8.5% - 13.6% ✓
Central Utah	12.3%	9.3% - 16.1%	13.3%	10.0% - 17.3%
Davis County	11.3%	9.5% - 13.5%	11.2%	9.5% - 13.3% ✓
Salt Lake County	15.2%	14.0% - 16.5%	14.9%	13.7% - 16.2%
San Juan	**	** **	**	** **
Southeast Utah [†]	16.9%	12.1% - 23.2%	18.1%	12.8% - 25.0%
Southwest Utah	15.7%	13.1% - 18.8%	16.8%	14.0% - 20.1%
Summit County	9.7%	6.5% - 14.3%	10.4%	6.9% - 15.6%
Tooele County	14.7%	10.5% - 20.2%	14.5%	10.4% - 19.8%
TriCounty	13.4%	10.2% - 17.6%	13.7%	10.4% - 17.9%
Utah County	13.5%	11.8% - 15.4%	13.0%	11.4% - 14.8%
Wasatch County	15.0%	10.7% - 20.7%	14.7%	10.5% - 20.2%
Weber-Morgan	15.0%	12.7% - 17.5%	15.4%	13.1% - 18.0%

[†] Includes Carbon, Emery, and Grand counties

**The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

Figure: Cost as a Barrier to Care by Age, Utah Adults, 2014

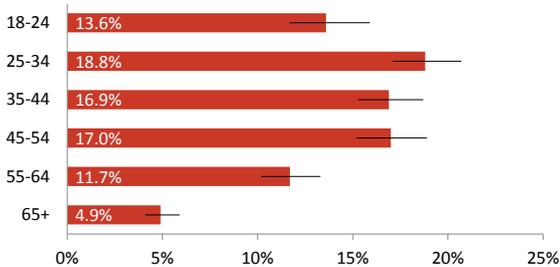
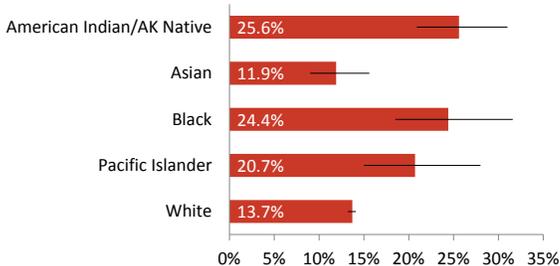


Figure: Cost as a Barrier to Care by Race, Utahns Aged 18+, 2012–2014



Primary Care Provider

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults who reported having one or more persons they think of as their personal doctor or healthcare provider.

How Are We Doing?

In 2014, 71.1% (crude rate) of Utah adults reported having at least one person they think of as their personal doctor or healthcare provider. However, 28.9% of Utahns did not have a personal doctor or healthcare provider.

National Comparison

In 2014, Utah (72.2%) had a similar age-adjusted rate of persons reporting a primary care provider when compared with the U.S. (75.9%), though the Utah rate was statistically significantly lower than that for the U.S.

Healthy People Objective (see Appendix)

AHS-3: Increase the proportion of persons with a usual primary care provider
U.S. Target: 83.9 percent

Disparities

Lack of a primary care provider was more common among young adults in Utah, especially men aged 18 to 34 (only 48.6% reported having a personal doctor in 2014).

In 2014, males were significantly less likely than females to have a personal doctor or healthcare provider (65.8% and 78.8%, respectively).

The American Indian/Alaska (AK) Native population was less likely to report having a primary provider.

Risk Factors

Poverty, transportation issues, appointment availability, and lack of insurance are risk factors for not having a primary care provider.

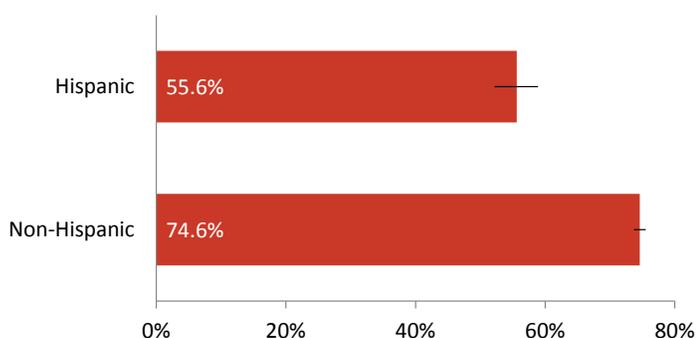
What Is Being Done?

The UDOH has programs such as Medicaid, Children's Health Insurance Program (CHIP), Utah's Premium Partnership for Health Insurance (UPP), and the Primary Care Network (PCN) to pay healthcare costs for low-income children and adults and those with disabilities.

The UDOH Office of Primary Care and Rural Health monitors and assesses health professional shortage areas and works with communities that need assistance recruiting health care professionals to their areas. They coordinate resources to improve primary care access and health care professional workforce availability.

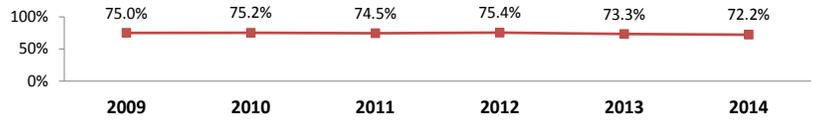
- 28.9% of Utah adults did not have a personal doctor or healthcare provider
- Males were less likely to have a personal doctor or healthcare provider
- Utahns aged 18-49 were less likely to have a primary care provider than persons aged 50+
- American Indian/Alaska Native and Hispanic populations were less likely to have a primary provider
- Low income and lower education levels were associated with not having a primary provider
- Adults in TriCounty and Weber-Morgan LHDs were significantly less likely to report a primary provider
- Bear River, Central Utah, and Davis County LHDs had higher percentages of adults with primary providers

Figure: Primary Care Provider by Ethnicity, Utahns Aged 18+, 2014



Primary Care Provider

Figure: Percentage of Adults With a Primary Care Provider by Year, Utah, 2009-2014



Trend graph depicts age-adjusted rates.

Map: Primary Care Provider by Local Health District, 2014

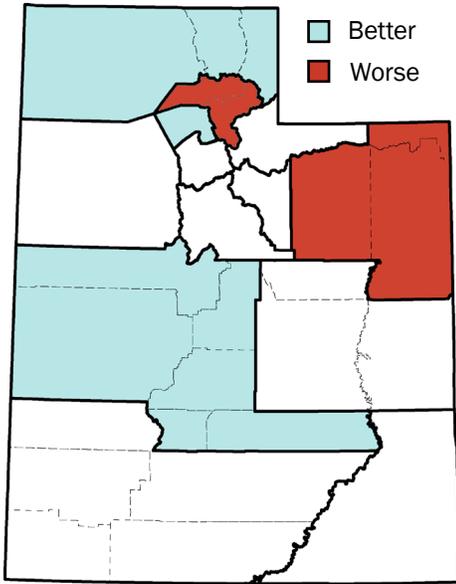


Figure: Primary Care Provider by Age and Gender, Utahns Aged 18+, 2014

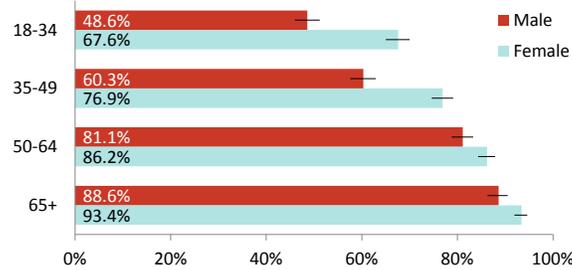
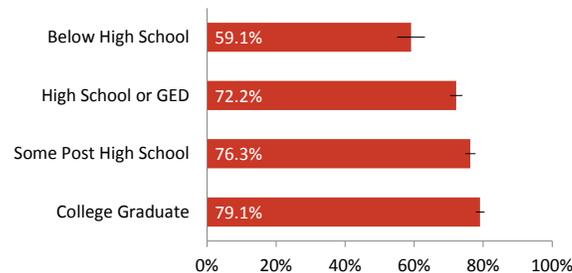


Figure: Primary Care Provider by Education, Utah Adults Aged 25+, 2014



	Crude (burden)		Age-adjusted (comparison)	
STATE COMPARISON (2014)	Rate	95% CIs	Rate	95% CIs
U.S.	77.2%	76.9% - 77.4%	75.9%	75.6% - 76.2%
Massachusetts (best)	89.3%	88.4% - 90.1%	88.6%	87.6% - 89.5%
UTAH (41st of 51)	71.1%	70.2% - 72.0%	72.2%	71.4% - 73.1%
Nevada (worst)	64.8%	62.2% - 67.3%	63.1%	60.5% - 65.6%
AGE IN YEARS (2014)				
18-34	57.9%	56.1% - 59.8%	-	- - - !
35-49	68.5%	66.7% - 70.2%	-	- - - !
50-64	83.7%	82.2% - 85.1%	-	- - - ✓
65+	91.2%	89.9% - 92.4%	-	- - - ✓
GENDER (2014)				
Male	64.1%	62.6% - 65.5%	65.8%	64.5% - 67.1% !
Female	78.1%	76.9% - 79.3%	78.8%	77.6% - 79.9% ✓
RACE (2012-2014)				
American Indian/AK Native	63.5%	57.8% - 68.9%	64.9%	59.2% - 70.2% !
Asian	63.0%	57.5% - 68.1%	69.7%	64.8% - 74.1%
Black	63.7%	56.2% - 70.5%	67.2%	60.2% - 73.5%
Pacific Islander	59.2%	50.8% - 67.1%	66.3%	58.4% - 73.4%
White	74.5%	73.8% - 75.1%	75.3%	74.7% - 75.9% ✓
ETHNICITY (2014)				
Hispanic	49.6%	46.3% - 52.9%	55.6%	52.2% - 58.9% !
Non-Hispanic	74.0%	73.0% - 74.9%	74.6%	73.7% - 75.5% ✓
INCOME (2014)				
0-\$24,999	59.6%	57.2% - 61.9%	61.5%	59.1% - 63.8% !
\$25,000-\$49,999	69.4%	67.3% - 71.4%	70.4%	68.3% - 72.3%
\$50,000-\$74,999	74.4%	72.2% - 76.5%	75.5%	73.3% - 77.6% ✓
\$75,000 or more	79.6%	78.1% - 81.0%	79.5%	77.9% - 81.1% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	56.1%	51.7% - 60.5%	59.1%	55.1% - 63.1% !
High School or GED	71.7%	69.8% - 73.5%	72.2%	70.4% - 74.0% !
Some Post High School	76.0%	74.4% - 77.5%	76.3%	74.8% - 77.8% ✓
College Graduate	78.2%	76.9% - 79.5%	79.1%	77.9% - 80.4% ✓
LOCAL HEALTH DISTRICT (2014)				
Bear River	75.4%	71.3% - 79.0%	77.8%	74.2% - 81.0% ✓
Central Utah	79.6%	74.7% - 83.8%	78.4%	73.5% - 82.7% ✓
Davis County	76.7%	73.9% - 79.3%	77.3%	74.7% - 79.7% ✓
Salt Lake County	71.3%	69.6% - 72.8%	72.1%	70.5% - 73.6%
San Juan	59.1%	41.0% - 75.0%	63.0%	50.0% - 74.3%
Southeast Utah†	78.9%	72.7% - 84.0%	76.6%	69.9% - 82.1%
Southwest Utah	72.9%	69.2% - 76.4%	71.1%	67.2% - 74.7%
Summit County	77.3%	71.3% - 82.3%	75.9%	69.5% - 81.4%
Tooele County	75.1%	68.6% - 80.5%	75.4%	69.5% - 80.5%
TriCounty	66.3%	60.8% - 71.4%	66.5%	61.1% - 71.5% !
Utah County	70.1%	67.5% - 72.5%	73.6%	71.5% - 75.6%
Wasatch County	76.3%	69.5% - 82.0%	76.6%	70.6% - 81.7%
Weber-Morgan	68.4%	65.2% - 71.5%	68.3%	65.2% - 71.3% !

† Includes Carbon, Emery, and Grand counties

Non-emergent ED Use

Utah Emergency Department Encounter Database

Description

This measure reports the number of non-emergent emergency department (ED) treat and release encounters per 100 ED encounters.

How Are We Doing?

The Utah 2014 rate of non-emergent treat and release encounters was 4.4 per 100 emergency department encounters.

Healthy People Objective (see Appendix)

No associated objective

Disparities

Females are more likely to use the emergency department for non-emergent issues.

Central Utah, Salt Lake County, Southeast Utah, TriCounty, and Weber-Morgan local health districts (LHDs) have higher rates of non-emergent emergency department use.

Risk Factors

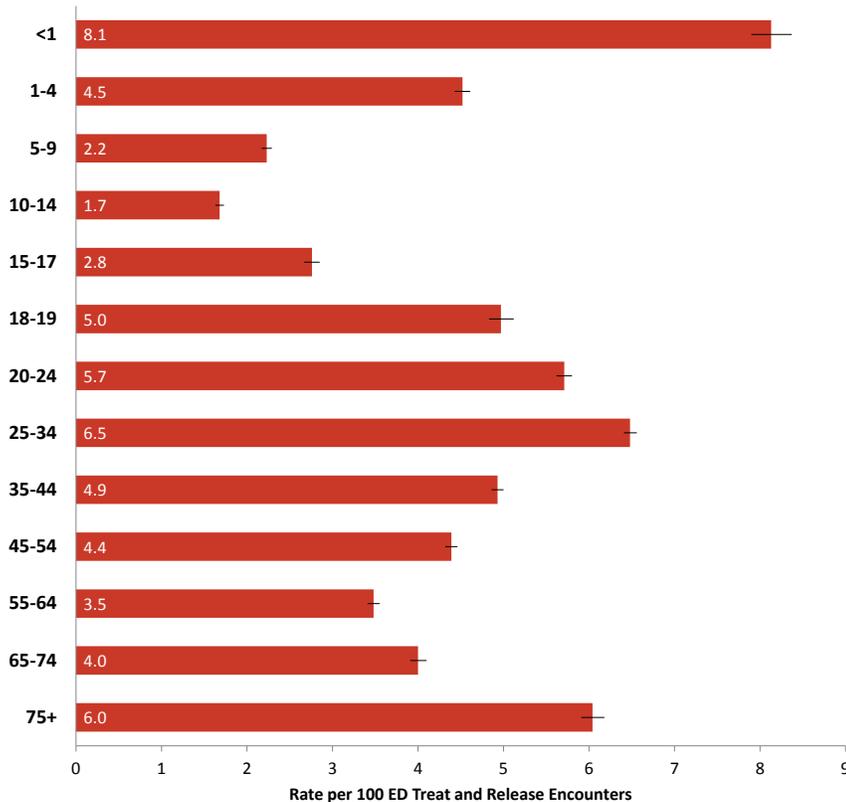
Community input indicated that persons without insurance may be more likely to use emergency rooms. Feedback indicates people may view it as more convenient due to hours of availability, not needing appointments, and having testing equipment on site.

What Is Being Done?

The Utah Medicaid Member Guide has included information regarding when to use an emergency room and when it is more appropriate to use a primary care doctor or urgent care.

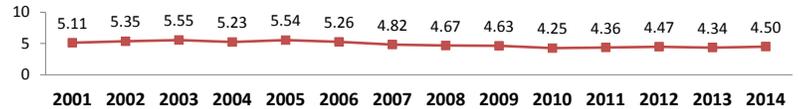
- 4.4 per 100 emergency department encounters are non-emergent
- Females are more likely to use the emergency department for non-emergent issues
- Central Utah, Salt Lake County, Southeast Utah, TriCounty, and Weber-Morgan LHDs have higher rates of non-emergent emergency department use

Figure: Non-Emergent ED Use by Age, Utah, 2014



Non-emergent ED Use

Figure: Non-emergent ED Use per 100 Encounters in Utah by Year, 2001–2014



Trend graph depicts age-adjusted rates.

Map: Non-emergent ED Use by Local Health District, 2014

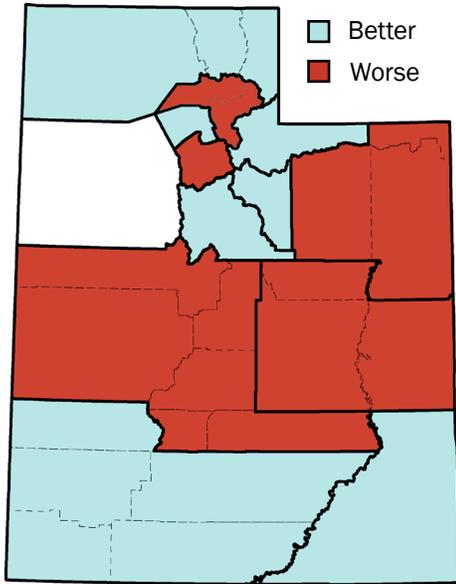
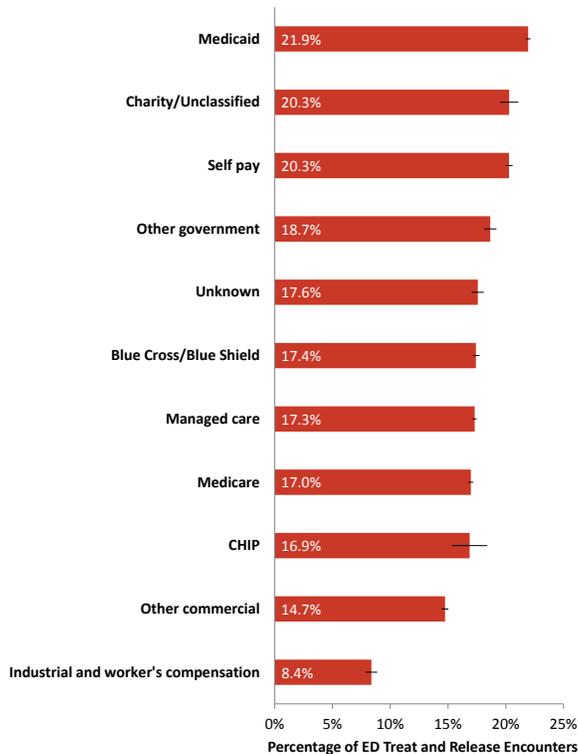


Figure: Percentage of ED Treat and Release Encounters That Were Non-Emergent by Payer Type, Utah, 2014



OVERALL (2014)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
UTAH	4.4	4.4 - 4.5	4.5	4.5 - 4.5

AGE IN YEARS (2014)

Age Group	Crude Rate	Crude 95% CIs	Age-adjusted Rate	Age-adjusted 95% CIs	Comparison
<1	8.1	7.9 - 8.4	-	-	- !
1-4	4.5	4.4 - 4.6	-	-	-
5-9	2.2	2.2 - 2.3	-	-	- ✓
10-14	1.7	1.6 - 1.7	-	-	- ✓
15-17	2.8	2.7 - 2.9	-	-	- ✓
18-19	5.0	4.8 - 5.1	-	-	- !
20-24	5.7	5.6 - 5.8	-	-	- !
25-34	6.5	6.4 - 6.6	-	-	- !
35-44	4.9	4.9 - 5.0	-	-	- !
45-54	4.4	4.3 - 4.5	-	-	-
55-64	3.5	3.4 - 3.6	-	-	- ✓
65-74	4.0	3.9 - 4.1	-	-	- ✓
75+	6.0	5.9 - 6.2	-	-	- !

GENDER (2014)

Gender	Crude Rate	Crude 95% CIs	Age-adjusted Rate	Age-adjusted 95% CIs	Comparison
Male	3.2	3.2 - 3.2	3.3	3.2 - 3.3	✓
Female	5.7	5.6 - 5.7	5.8	5.7 - 5.8	!

LOCAL HEALTH DISTRICT (2014)

Local Health District	Crude Rate	Crude 95% CIs	Age-adjusted Rate	Age-adjusted 95% CIs	Comparison
Bear River	3.9	3.8 - 4.0	4.0	3.9 - 4.1	✓
Central Utah	4.7	4.6 - 4.9	4.9	4.7 - 5.0	!
Davis County	3.3	3.2 - 3.3	3.4	3.3 - 3.4	✓
Salt Lake County	4.8	4.7 - 4.8	4.8	4.7 - 4.8	!
San Juan	2.9	2.7 - 3.2	3.0	2.7 - 3.3	✓
Southeast Utah†	7.3	7.1 - 7.6	7.6	7.3 - 7.9	!
Southwest Utah	4.1	4.0 - 4.1	4.2	4.1 - 4.3	✓
Summit County	2.5	2.4 - 2.7	2.6	2.5 - 2.8	✓
Tooele County	4.3	4.2 - 4.5	4.5	4.3 - 4.7	
TriCounty	6.1	5.9 - 6.3	6.1	5.9 - 6.4	!
Utah County	3.2	3.2 - 3.2	3.5	3.4 - 3.5	✓
Wasatch County	3.7	3.5 - 4.0	4.0	3.8 - 4.3	✓
Weber-Morgan	5.2	5.1 - 5.3	5.2	5.2 - 5.3	!

† Includes Carbon, Emery, and Grand counties

Regular Dental Care

Behavioral Risk Factor Surveillance System

Description

This measure reports the percentage of adults aged 18 years and older who reported a dental visit in the past year.

How Are We Doing?

In 2014, 69.0% of Utah adults reported visiting a dentist or dental clinic in the past year (age-adjusted rate). This percentage has varied little since 1995 when the question was first asked.

National Comparison

Since 1999, the percentage of Utah adults who reported visiting a dentist or dental clinic in the past year has been slightly higher than reported by adults in the U.S. as a whole (69.0% vs. 64.1% in 2014).

Healthy People Objective (see Appendix)

OH-7: Increase the proportion of children, adolescents, and adults who used the oral healthcare system in the past year

U.S. Target: 49.0 percent

Disparities

Utahns aged 18–34 were less likely to report having seen a dentist. Males were also less likely to report having seen a dentist in the past year.

American Indian/Alaska (AK) Native, Black, and Hispanic adults are less likely to have regular dental care.

Utah adults with higher incomes and more education are more likely to report a dental visit in the past year than those with lower incomes and less education.

Risk Factors

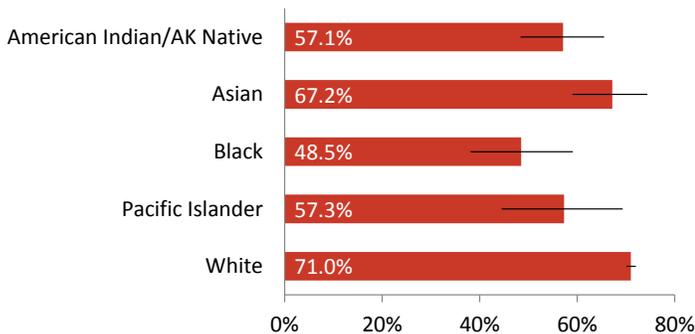
Regular dental care is needed to monitor for oral diseases. Risk factors for oral diseases include poor diet, smoking or tobacco use, alcohol use, and poor oral hygiene. Dental care helps screen for oral cancers, infections, gum disease, cavities, and tooth decay.¹

What Is Being Done?

The UDOH Oral Health Program's current priorities include promoting fluoride and dental sealants, preventing tooth decay in young children, and encouraging annual dental visits for both children and adults.

- 68.9% of Utah adults had a dental visit
- Utahns aged 18–34 were less likely to report a dental visit
- Males were less likely to have a dental visit
- Disparities include American Indian/Alaska Native, Black, and Hispanic populations
- Higher incomes and more education were positively associated with a dental visit
- Significantly lower rates of dental visits in Central Utah, San Juan, Southeast Utah, and TriCounty LHDs

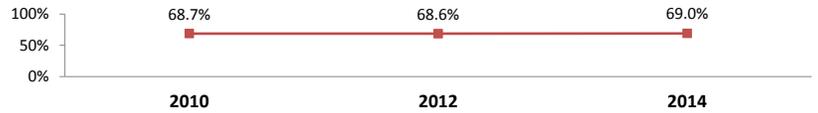
Figure: Regular Dental Care by Race, Utahns Aged 18+, 2014



1 World Health Organization. Oral Health. Accessed 8/8/2016 from <http://www.who.int/mediacentre/factsheets/fs318/en/>.

Regular Dental Care

Figure: Percentage of Utahns Aged 18+ With Regular Dental Care by Year, 2010–2014



Trend graph depicts age-adjusted rates.

Map: Regular Dental Care by Local Health District, 2014

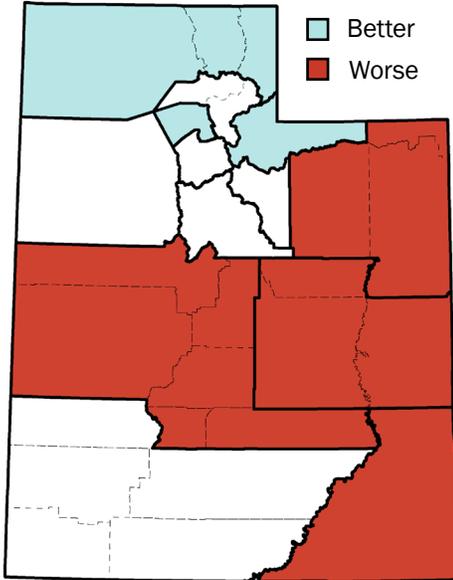


Figure: Regular Dental Care by Income, Utahns Aged 18+, 2014

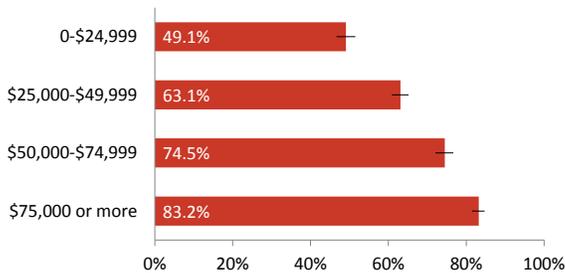
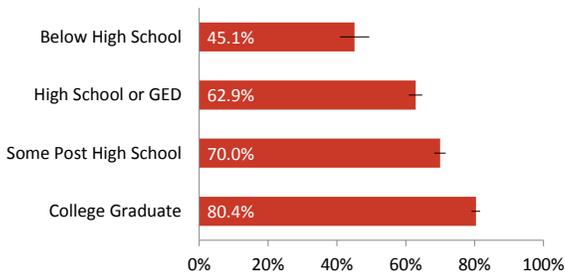


Figure: Regular Dental Care by Education, Utahns Aged 25+, 2014



STATE COMPARISON (2014)	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	64.4%	64.1% - 64.7%	64.1%	63.8% - 64.4%
Connecticut (best)	74.9%	73.5% - 76.3%	74.5%	73.0% - 76.0%
UTAH (13th of 51)	68.9%	68.0% - 69.8%	69.0%	68.1% - 69.9%
West Virginia (worst)	54.2%	52.6% - 55.7%	54.7%	53.0% - 56.4%
AGE IN YEARS (2014)				
18–34	65.9%	64.1% - 67.6%	-	- - - !
35–49	69.7%	68.0% - 71.5%	-	- - -
50–64	71.5%	69.8% - 73.3%	-	- - - ✓
65+	71.0%	69.0% - 72.9%	-	- - - ✓
GENDER (2014)				
Male	65.8%	64.5% - 67.2%	66.1%	64.8% - 67.5% !
Female	71.9%	70.7% - 73.2%	71.9%	70.6% - 73.1% ✓
RACE (2014)				
American Indian/AK Native	57.7%	48.8% - 66.2%	57.1%	48.4% - 65.5% !
Asian	65.1%	57.0% - 72.3%	67.2%	59.0% - 74.4%
Black	50.0%	39.7% - 60.3%	48.5%	38.1% - 59.1% !
Pacific Islander	59.9%	46.6% - 71.8%	57.3%	44.5% - 69.3%
White	70.9%	69.9% - 71.8%	71.0%	70.1% - 72.0% ✓
ETHNICITY (2014)				
Hispanic	54.5%	51.1% - 57.8%	54.7%	51.0% - 58.3% !
Non-Hispanic	70.9%	69.9% - 71.9%	71.1%	70.1% - 72.0% ✓
INCOME (2014)				
0–\$24,999	51.7%	49.3% - 54.0%	49.1%	46.7% - 51.5% !
\$25,000–\$49,999	63.6%	61.5% - 65.6%	63.1%	60.9% - 65.2% !
\$50,000–\$74,999	74.2%	72.1% - 76.3%	74.5%	72.1% - 76.7% ✓
\$75,000 or more	83.1%	81.7% - 84.4%	83.2%	81.5% - 84.7% ✓
EDUCATION—Adults 25+ (2014)				
Below High School	44.6%	40.3% - 49.0%	45.1%	40.9% - 49.4% !
High School or GED	62.6%	60.7% - 64.6%	62.9%	60.9% - 64.8% !
Some Post High School	69.6%	68.0% - 71.2%	70.0%	68.3% - 71.6%
College Graduate	80.2%	78.9% - 81.5%	80.4%	79.1% - 81.6% ✓
LOCAL HEALTH DISTRICT (2014)				
Bear River	73.1%	69.3% - 76.6%	73.5%	69.8% - 76.9% ✓
Central Utah	63.6%	58.3% - 68.7%	62.5%	57.1% - 67.6% !
Davis County	75.6%	72.9% - 78.1%	75.4%	72.7% - 77.8% ✓
Salt Lake County	67.8%	66.2% - 69.4%	68.0%	66.4% - 69.6%
San Juan	62.0%	45.2% - 76.3%	56.7%	45.3% - 67.4% !
Southeast Utah†	60.3%	53.7% - 66.6%	59.7%	52.6% - 66.5% !
Southwest Utah	69.5%	65.9% - 72.9%	68.9%	65.1% - 72.4%
Summit County	76.8%	71.0% - 81.8%	76.2%	70.0% - 81.5% ✓
Tooele County	67.0%	60.3% - 73.0%	66.8%	60.4% - 72.6%
TriCounty	58.0%	52.2% - 63.6%	58.2%	52.5% - 63.7% !
Utah County	70.0%	67.5% - 72.4%	70.5%	68.2% - 72.7%
Wasatch County	74.3%	68.3% - 79.5%	74.4%	68.6% - 79.4%
Weber-Morgan	71.4%	68.3% - 74.4%	71.5%	68.4% - 74.5%

† Includes Carbon, Emery, and Grand counties

Preventive Services

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Childhood Vaccination

National Immunization Survey

Description

This measure reports the percentage of children aged 19–35 months who received the recommended vaccines (4:3:1:3:3:1, or 4 DTaP, 3 Polio, 1 MMR, 3 HepB, Hib full series, 1 Varicella).

How Are We Doing?

The childhood vaccination coverage levels have steadily increased in Utah over the past years, from 71.1% of 2-year-old children fully immunized in 2011 to 80.5% in 2013. In 2014, the coverage rate in Utah was 74.6%. The change to brand-specific full series analysis for *Haemophilus influenzae* type B (Hib) vaccination likely lowered coverage rates in 2014 when compared to historical vaccination coverage rates. Past surveys classified the minimum number of Hib doses necessary as complete even though certain brands required more doses; the 2014 survey took into account the Hib vaccine brand, if known, and classified a child as complete only if the appropriate number of doses had been administered. The 2014 results are more accurate and better match methods now used by the Centers for Disease Control and Prevention (CDC).

National Comparison

In 2014, the Utah coverage rate for immunization of 74.6% was the same as the national average. Utah's immunization ranking (among the 50 states) was 24th in 2014, 16th in 2013, 15th in 2012, and 42nd in 2011. These data typically fluctuate from year to year and it is useful to look at 5–10 year trends to gain a clear understanding of how well we are immunizing our children.

Healthy People Objective (see Appendix)

IID-7: Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children

IID-7.1: Maintain an effective vaccination coverage level of 4 doses of the diphtheria-tetanus-acellular pertussis (DTaP) vaccine among children by age 19 to 35 months

U.S. Target: 90.0 percent

IID-7.2: Achieve and maintain an effective vaccination coverage level of 3 or 4 doses of *Haemophilus influenzae* type b (Hib) vaccine among children by age 19 to 35 months

U.S. Target: 90.0 percent

IID-7.3: Maintain an effective vaccination coverage level of 3 doses of hepatitis B (hep B) vaccine among children by age 19 to 35 months

U.S. Target: 90.0 percent

IID-7.4: Maintain an effective coverage level of 1 dose of measles-mumps-rubella (MMR) vaccine among children by age 19 to 35 months

U.S. Target: 90.0 percent

IID-7.5: Maintain an effective coverage level of 3 doses of polio vaccine among children by age 19 to 35 months

U.S. Target: 90.0 percent

IID-7.6: Maintain an effective coverage level of 1 dose of varicella vaccine among children by age 19 to 35 months

U.S. Target: 90.0 percent

Disparities

Children living in poverty were somewhat less likely to be fully immunized than children at or above poverty, although the difference was not statistically significant.

Although data by race and ethnicity were not available at the state level, Black, non-Hispanic children had significantly lower immunization rates nationally.

Risk Factors

Risk factors for children not receiving immunizations or immunization delays include single parent household, lack of primary care provider, lack of insurance, parental education on immunizations, and large family size.

- 74.6% of Utah children aged 19–35 months have recommended vaccinations
- Risk factors include single parent household, lack of primary care provider, lack of insurance, parental education on immunizations, and large family size

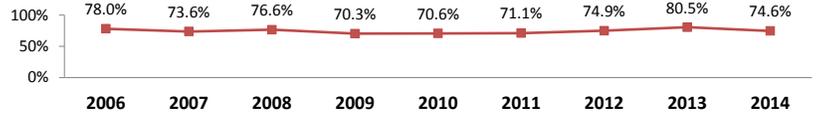
What Is Being Done?

The UDOH Immunization Program conducts annual assessments of private and public healthcare providers' immunization records to obtain state immunization levels. During these site visits, Utah Immunization Program provider representatives also train clinic staff on appropriate vaccine storage, handling, and administration according to the Advisory Committee on Immunization Practices (ACIP) recommended practices. Utah also has immunization coalitions that are working to maintain or improve current levels of immunization and to increase public awareness of immunizations.

The Utah Statewide Immunization Information System (USIIS) provides a mechanism for healthcare providers to track patient immunizations and send reminder cards to Utah parents whose children are due for immunizations. USIIS also includes adult immunizations, such as pneumonia, tetanus, and influenza.

Due to the increased costs of vaccine, public health clinics are now able to provide publicly purchased vaccine only to those who meet eligibility criteria and don't have insurance coverage.

Figure: Percentage of Children Fully Vaccinated in Utah by Year, 2006–2014



STATE COMPARISON (2014)	Crude (burden)	
	Rate	95% CIs
U.S.	74.6%	73.2% - 76.0%
Maine (best)	84.7%	79.7% - 89.7%
UTAH (24th of 51)	74.6%	67.2% - 82.0%
Wyoming (worst)	64.0%	54.8% - 73.2%

POVERTY (2014) [^]		
Below Poverty	72.7%	55.8% - 89.6%
At or Above Poverty	77.3%	69.6% - 85.0%

Note: Children in the 2014 NIS were born January 2011 through May 2013.

[^] Poverty status was based on 2013 U.S. Census poverty thresholds (available at <http://www.census.gov/hhes/www/poverty.html>).

Figure: Childhood Vaccination by Poverty, Utah, 2014

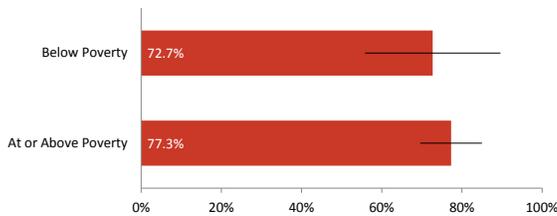


Figure: Childhood Vaccination by WIC Participation, Utah, 2014

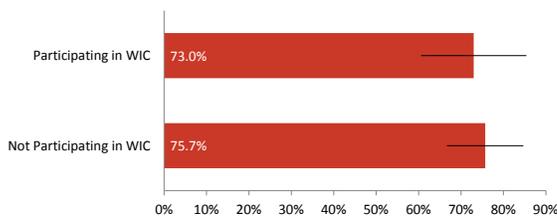
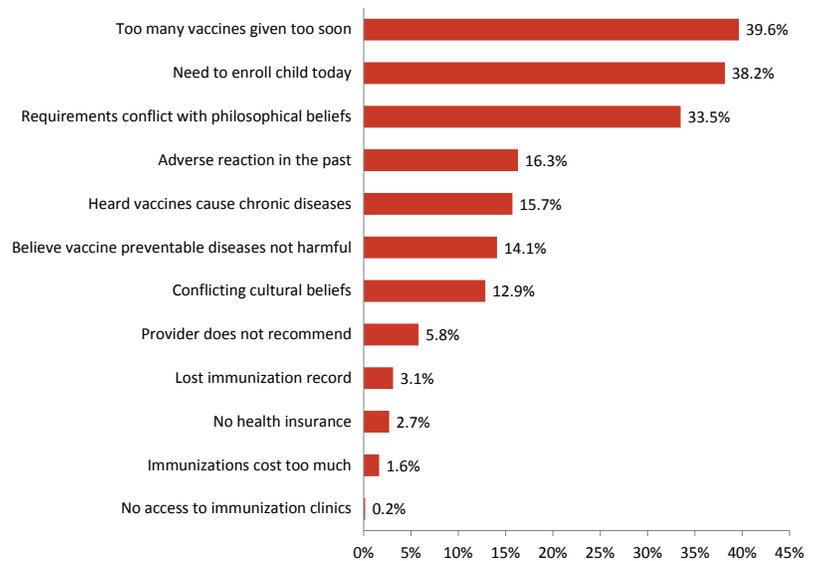


Figure: Reasons for Claiming Immunization Exemption*, Utah, 2015–2016 School Year



* Surveys allowed more than one reason marked by participants.
Source: Utah Department of Health Immunization Program

Maternal and Child Health

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Unintended Pregnancy

Pregnancy Risk Assessment Monitoring System

Description

This measure reports the percentage of Utah women with live births who reported their most recent pregnancy was unintended. Women who wanted to be pregnant later or didn't want to be pregnant were categorized as having an unintended pregnancy.

How Are We Doing?

In 2013, 22.8% of women reported that their birth resulted from an unintended pregnancy. Of the women who reported their pregnancies as unintended, 61.9% said they were using some method to avoid pregnancy at the time of conception. Contraceptive failure rates vary between methods used but are very low when used correctly. This high rate of contraceptive failure signals the need to increase education, services, and coverage of methods of long-acting reversible contraception that may be less prone to human error.

National Comparison

In 2011, the most recent year of comparable data, 31.8% of Utah women had a live birth that was the result of an unwanted or mistimed pregnancy. This was the second lowest rate of unintended pregnancy among states that participated in the Pregnancy Risk Assessment Monitoring System (PRAMS) survey.

Healthy People Objective (see Appendix)

Similar to HP2020 Objective FP-1: Increase the proportion of PREGNANCIES that ARE intended.

- 22.8% of women reported that their birth resulted from an unintended pregnancy in 2013
- More likely for mothers under age 25
- Rates are higher for Hispanic and non-White mothers, those living below the poverty level and those with high school or lower education

Disparities

Unintended pregnancies are more likely for mothers under age 25. Rates are higher for Hispanic and non-White mothers, those living below the poverty level and those with high school or lower education.

Risk Factors

Having an unintended pregnancy can contribute to short inter-pregnancy spacing (span between the birth of one child and the conception of another), which increases the risk of infant morbidity and mortality. In addition, unintended pregnancy can contribute to an increase in the rate of abortions as well as late entry into prenatal care. Women with inadequate care due to late entry are more likely to deliver a low birth weight baby.

What Is Being Done?

In order to reduce unplanned pregnancies, public health efforts may include:

Health Education—increase knowledge of human reproduction, conception, and proper use of available contraceptive methods; and promote optimal spacing of pregnancies for healthy outcomes.

Reproductive Health Services—increase dialogue between healthcare providers and women regarding reproductive health and family planning options.

Access to Healthcare—improve insurance coverage for family planning services.

As of August 1, 2012, non-grandfathered health plans and insurance issuers are required to provide coverage for preventive women's healthcare including contraception and counseling without cost sharing.

Evidence-based Practices

Various studies have indicated that the use of long-acting reversible contraceptive (LARC) devices such as implants and intrauterine devices (IUDs) effectively lower the incidence of unplanned pregnancy in population and clinic settings.

Additionally, a 2012 study conducted by Piepert et al. looked at the impact of providing free LARC and found that increased access to contraception effectively reduced unintended pregnancy.¹

1 Preventing Unintended Pregnancies By Providing No-Cost Contraception (Piepert, 2012): http://journals.lww.com/greenjournal/Fulltext/2012/12000/Preventing_Unintended_Pregnancies_by_Providing.7.aspx.

Unintended Pregnancy

Data Interpretation Issues

A stratified random sampling approach is used in selecting women 2–4 months postpartum to participate in PRAMS. The data are weighted by the CDC to represent the birth population for that year, adjusted for sampling probabilities, nonresponse, and noncoverage. Each strata must achieve a weighted response rate of 60% or it is not considered representative of that population.

See the PRAMS website at <http://www.cdc.gov/prams/methodology.htm> for more detailed information on PRAMS and its methodology.

Map: Unintended Pregnancy by Local Health District, 2013

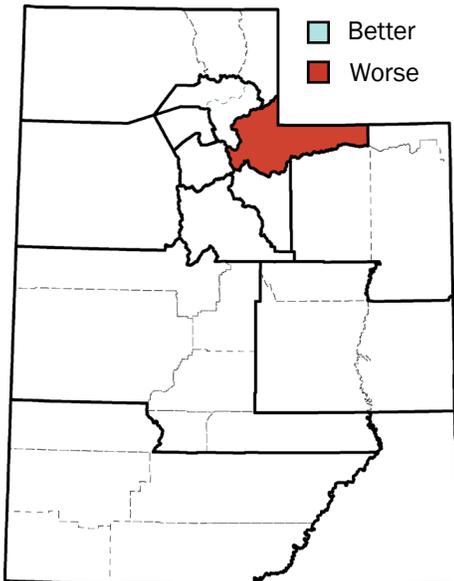


Figure: Unintended Pregnancy by Age Group, Utah, 2013

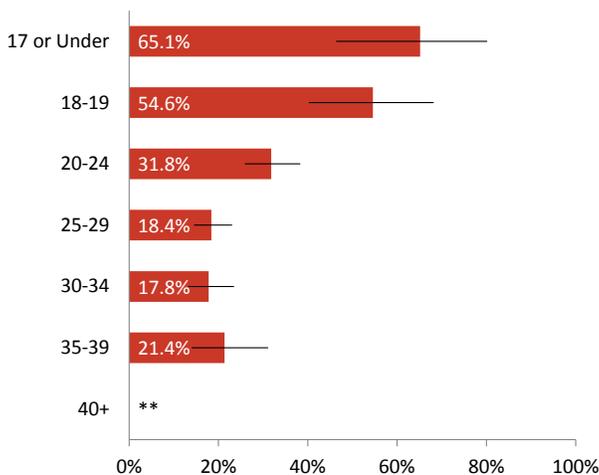


Figure: Percentage of Women With Unintended Pregnancy by Year, Utah, 2012–2013



Beginning in 2012, the PRAMS survey added the response “I wasn’t sure what I wanted”. The addition of this response likely diluted the percentage of responses in the other categories so 2012 data are not comparable to previous years.

Crude (burden)

STATE COMPARISON (2011) [^]	Rate	95% CIs
U.S.	40.0%	39.2% - 40.8%
Minnesota (best)	31.5%	28.8% - 34.4%
UTAH (2nd of 25)	31.8%	29.1% - 34.5%
Georgia (worst)	54.8%	50.4% - 59.1%

AGE IN YEARS (2013)

Age Group	Rate	95% CIs	
17 or Under	65.1%	46.4% - 80.2%	!
18–19	54.6%	40.3% - 68.2%	!
20–24	31.8%	25.9% - 38.3%	!
25–29	18.4%	14.5% - 23.1%	
30–34	17.8%	13.3% - 23.5%	
35–39	21.4%	14.0% - 31.2%	
40+	**	** **	

RACE (2013)

Race	Rate	95% CIs	
White	20.0%	17.3% - 23.0%	
Other than White	36.6%	29.7% - 44.0%	!

ETHNICITY (2013)

Ethnicity	Rate	95% CIs	
Hispanic	37.2%	30.7% - 44.1%	!
Non-Hispanic	20.1%	17.3% - 23.2%	

POVERTY LEVEL (2013)

Poverty Level	Rate	95% CIs	
<=100% FPL	37.7%	31.7% - 44.2%	!
101–133% FPL	30.2%	21.1% - 41.0%	
134–185% FPL	19.3%	13.2% - 27.3%	
>185% FPL	17.9%	14.6% - 21.7%	✓

EDUCATION (2013)

Education Level	Rate	95% CIs	
Less than High School	40.9%	35.2% - 46.7%	!
High School	28.2%	23.7% - 33.1%	!
Some College	20.3%	15.5% - 26.1%	
College Graduate	17.2%	12.9% - 22.6%	✓

LOCAL HEALTH DISTRICT (2013)

Local Health District	Rate	95% CIs	
Bear River	24.6%	14.5% - 34.8%	
Central Utah*	19.3%	4.2% - 34.4%	
Davis County	17.9%	10.6% - 25.2%	
Salt Lake County	24.9%	20.3% - 29.3%	
San Juan	**	** **	
Southeast Utah**	**	** **	
Southwest Utah	24.0%	12.8% - 35.3%	
Summit County	65.1%	31.2% - 99.0%	!
Tooele County*	22.8%	4.9% - 40.7%	
TriCounty*	22.6%	7.9% - 37.3%	
Utah County	20.7%	14.9% - 26.5%	
Wasatch County	**	** **	
Weber-Morgan	25.4%	15.5% - 35.2%	

[†] Includes Carbon, Emery, and Grand counties

*Use caution in interpreting; the estimates have a relative standard error greater than 30% and do not meet UDOH standards for reliability.

**The estimate has been suppressed because 1) the relative standard error is greater than 50% or cannot be determined, 2) the observed number of events is very small and not appropriate for publication.

[^] Beginning in 2012, the PRAMS survey added the response “I wasn’t sure what I wanted”. The addition of this response likely diluted the percentage of responses in the other categories so 2012 data are not comparable to previous years.

Developmental Screening

National Survey of Children's Health

Description

This measure reports the percentage of children aged 10 months to five years receiving developmental screening during a healthcare visit.

The data are gathered from the National Survey of Children's Health which is a parent-reported, standardized screening tool using age-appropriate questions to verify whether young children received standardized developmental, behavioral, and social screening. Parent respondents for all children between 10 months and five years old were asked whether they completed a questionnaire about their child's development, communication, or social behaviors during the previous 12 months.

The American Academy of Pediatrics (AAP) recommends that all children should be screened for developmental delays during their regular well-check visits at 9, 18 and 24 or 30 months.

How Are We Doing?

Although 70.2% of pediatricians reported using screening tools, parents report only 26.8% of children received a screening. This difference may be due to children not being seen by a pediatrician, parents not being aware they were completing developmental screens, or pediatricians utilizing them inconsistently.

National Comparison

Utah ranks 34th on this measure with a rate of 26.8% of children aged 10 months to 5 years receiving a developmental screening.

Healthy People Objective (see Appendix)

No associated objective

Disparities

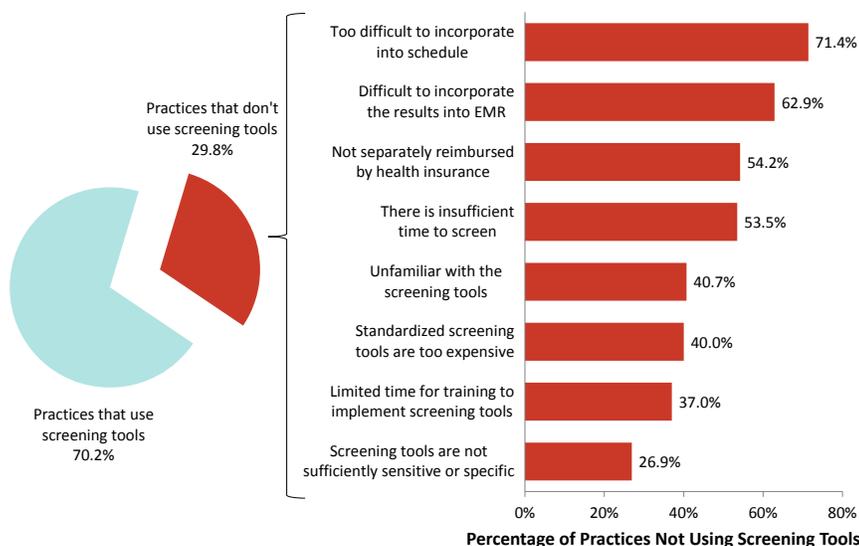
No disparities were noted in the data by race, education, or poverty. However parents in rural areas reported completing screenings significantly less frequently than those in urban areas.

Risk Factors

Pediatricians respond that reasons for not completing developmental screening include barriers of time, lack of insurance reimbursement, incompatibility with electronic medical record systems, cost, and lack of familiarity with the screening tools.

- Utah ranks 34th with a rate of 26.8% children receiving a developmental screening
- Reasons cited for not completing developmental screening include barriers of time, lack of insurance reimbursement, incompatibility with electronic medical record systems, cost, and lack of familiarity with the screening tools

Figure: Percentage of Practices Reporting Each Reason for Not Using the Standardized Developmental Screening Tools, Utah Practices Who Are Not Using Screening Tools, 2013



Developmental Screening

Figure: Percentage of Children With Developmental Screening in Utah by Year, 2007 through 2011-2014



What Is Being Done?

In 2013, a UDOH Developmental Screening Tool Survey was developed through a collaborative effort between the Bureau of Children With Special Health Care Needs (CSHCN) and the Data Resources Program within the Bureau of Maternal and Child Health (MCH). The survey was sent out statewide to pediatricians who were Utah AAP (American Academy of Pediatrics) members to better understand the use of standardized screening tools and the barriers for those not using them.

Early Childhood Utah, a program of the UDOH, is striving to build community-wide, coordinated early detection programs that ensure universal and periodic developmental and behavioral screening for all children. Through community involvement and training focusing on child care, home visiting, targeted case manager providers, and the availability of web-based screening, we have seen an increase in screening efforts using the Ages and Stages Questionnaire. Having the screening completed and scored before the healthcare visit facilitates parent-clinician communication.

Figure: Developmental Screening by Race/Ethnicity, Utah 2011-2012

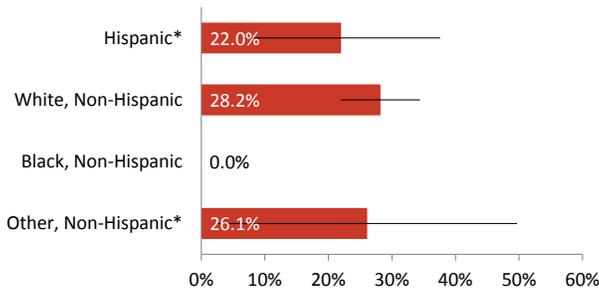
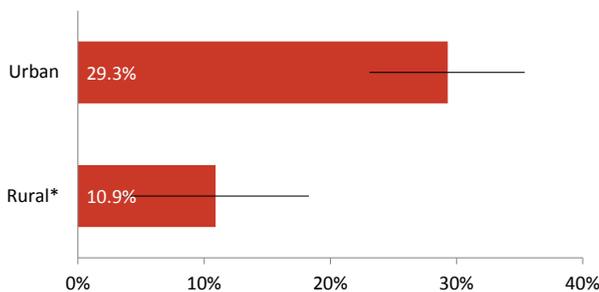


Figure: Developmental Screening by Residence, Utah, 2011-2012



STATE COMPARISON (2011-2012)	Crude (burden)	
	Rate	95% CIs
U.S.	30.8%	29.5% - 32.1%
North Carolina (best)	58.0%	51.2% - 64.8%
UTAH (34th of 51)	26.8%	21.3% - 32.3%
Mississippi (worst)	17.5%	12.0% - 23.1%
GENDER (2011-2012)		
Male	26.9%	19.3% - 34.5%
Female	26.7%	18.7% - 34.6%
RACE/ETHNICITY (2011-2012)		
Hispanic*	22.0%	6.5% - 37.6%
White, Non-Hispanic	28.2%	22.0% - 34.4%
Black, Non-Hispanic	0.0%	- -
Other, Non-Hispanic*	26.1%	2.6% - 49.7%
POVERTY (2011-2012)		
0-99% FPL	27.8%	14.2% - 41.4%
100-199% FPL	26.5%	15.1% - 37.9%
200-399% FPL	22.1%	14.4% - 29.7%
400% FPL or Higher	36.0%	22.1% - 49.8%
HIGHEST EDUCATION OF ADULT IN HOUSEHOLD (2011-2012)		
Less than High School*	31.1%	2.9% - 59.3%
High School Graduate*	26.3%	9.4% - 43.2%
More than High School	26.7%	20.8% - 32.6%
URBAN/RURAL RESIDENCE (2011-2012)		
Urban	29.3%	23.1% - 35.4%
Rural*	10.9%	3.5% - 18.3% !

* Estimates based on sample sizes too small to meet standards for reliability or precision. The relative standard error is greater than 30%.

Note: Hispanic includes all children reporting Hispanic/Latino origin; Non-Hispanic children reporting a single race category of either White or Black are grouped respectively; Non-Hispanic children reporting more than one race category are grouped under "Other, non-Hispanic". Non-Hispanic children reporting Asian, Native American, Native Alaskan or Native Hawaiian are categorized as "Other, non-Hispanic" due to small sample sizes in most states.

Household poverty level for the 9.3% of households in the sample with unknown values for income, household size, or both, was calculated using single imputation methods. The poverty level estimates and confidence intervals based on single imputed poverty will differ from those calculated using multiple imputations.

The Rural Urban Commuting Area (RUCA) taxonomy is derived from the relationships between cities and towns as measured by work commuting flows.

Autism

Autism and Developmental Disabilities
Monitoring Network

Description

This measure reports the estimated rate (per 1,000) of children aged eight diagnosed with autistic disorder, pervasive developmental disorder, or asperger disorder (collectively referred to as Autism Spectrum Disorder [ASD]).

How Are We Doing?

The national 2010 estimated prevalence rate in the Autism and Developmental Disabilities Monitoring Network (ADDM) was 14.7 per 1,000 children aged eight years. There are currently 11 ADDM sites in the United States. The Utah 2010 estimated rate was 18.6 per 1,000 children. Estimated rate is based on data from three counties, Salt Lake, Davis, and Tooele.

According to data from the 2014–2015 Behavioral Risk Factor Surveillance System, 58.2% of children diagnosed with autism were mild in severity; 13.6% had severe autism. Children were most likely diagnosed in a healthcare setting, although 21.9% reported the diagnosis occurred in a school setting. Utah children are typically diagnosed early in age. One quarter were diagnosed by age two, more than half were diagnosed by age four, and more than 75% were diagnosed by age six.

Healthy People Objective (see Appendix)

There are several objectives related to services for Autism Spectrum Disorder diagnoses, however none specifically about prevalence. The related objectives are under MICH-29.

- 18.6 per 1,000 children in Utah diagnosed with ASD
- Non-Hispanic White children were more likely than Black or Hispanic children to be diagnosed with ASD in the national ADDM network
- Rates higher for males than for females

Disparities

In the national ADDM network, non-Hispanic White children were more likely than Black or Hispanic children to be diagnosed with ASD. Rates are also higher for males than for females both nationally and in Utah.

Risk Factors

Some research indicates increased risk with adolescent mothers, stress during prenatal development, preterm birth, and family history of autism.

What Is Being Done?

In 2002, the Utah Autism and Developmental Disabilities Monitoring Project was established as an ADDM site. It was a collaborative project between the UDOH and the University of Utah. The project partners with agencies that serve children with developmental or cognitive disabilities to track children with ASD. The Utah Registry of Autism and Developmental Disorders does community outreach to raise awareness of ASD.

Figure: Autism by Gender, Utah, 2010

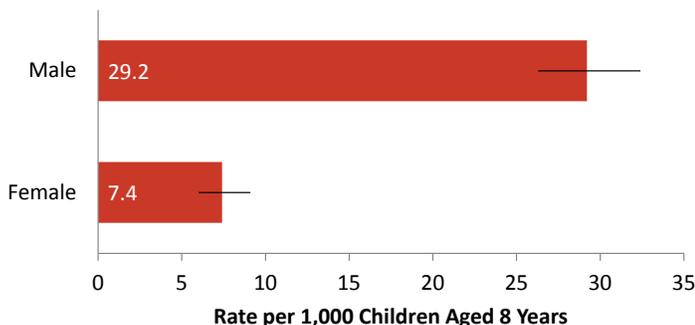


Figure: Autism by Race/Ethnicity, Utah, 2010

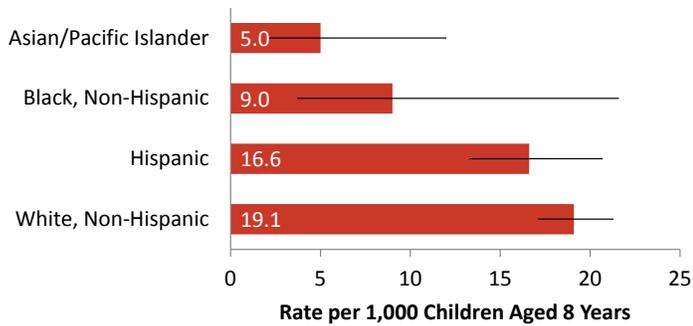
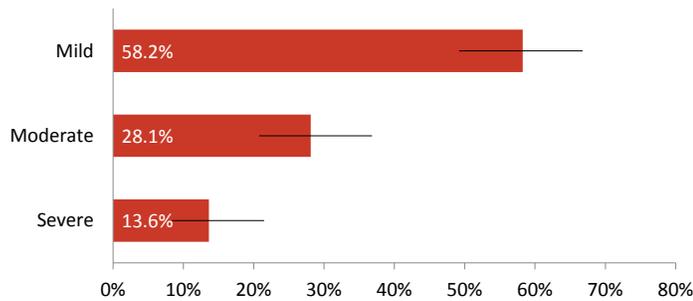
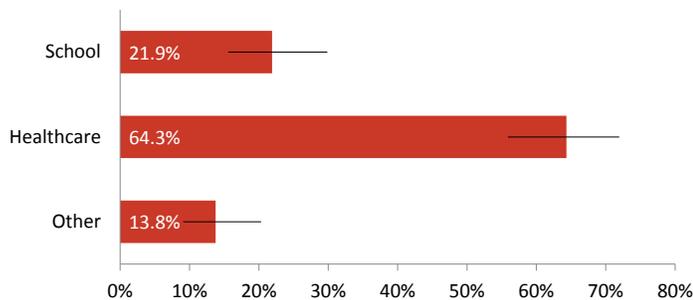


Figure: Autism Severity, Utah Children With Autism (All Ages), 2014–2015



Source: Utah Behavioral Risk Factor Surveillance System

Figure: Autism Diagnosis Setting, Utah Children With Autism (All Ages), 2014–2015



Source: Utah Behavioral Risk Factor Surveillance System

Crude (burden)

STATE COMPARISON (2010)^

	Rate	95% CIs
U.S.	14.7	14.3 - 15.1
Alabama (best)	5.7	4.8 - 6.8
UTAH (10th of 11)	18.6	16.9 - 20.4
New Jersey (worst)	21.9	20.4 - 23.6

GENDER (2010)

	Rate	95% CIs
Male	29.2	26.3 - 32.4 !
Female	7.4	6.0 - 9.1 ✓

RACE/ETHNICITY (2010)

	Rate	95% CIs
Asian/Pacific Islander	5.0	2.1 - 12.0 ✓
Black, Non-Hispanic	9.0	3.7 - 21.6
Hispanic	16.6	13.3 - 20.7
White, Non-Hispanic	19.1	17.1 - 21.3

SELECT COUNTIES (2010)

	Rate	95% CIs
Davis	17.4	14.1 - 20.8
Salt Lake	19.3	17.2 - 21.4
Tooele	13.3	6.8 - 19.7

^ National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin.

Note: Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

Violence and Injury Prevention

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Helmet Use—Minor

Youth Risk Behavior Survey

Description

This measure is reported as the percentage of students who never or rarely wore a bicycle helmet among students who rode a bicycle during the past 12 months.

How Are We Doing?

In 2013, 74.6% of Utah students reported never or rarely wearing a helmet while riding a bicycle in the past 12 months. Each year in Utah, an average of 372 bicyclists are injured in crashes with motor vehicles and five are killed.

Healthy People Objective (see Appendix)

Related indicator IVP-21: Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders.

Disparities

Hispanic children are less likely than non-Hispanic to wear bicycle helmets.

Risk Factors

Reasons for not wearing helmets as reported in surveys are not liking how they look and lack of comfort or poor fit.

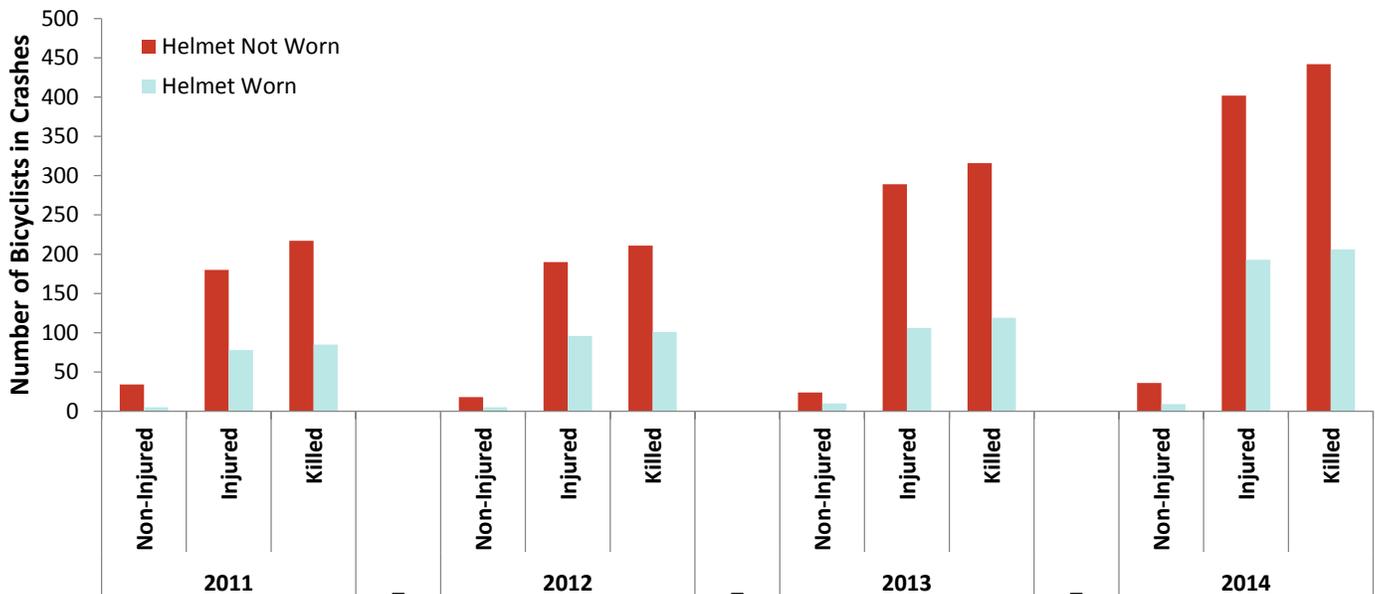
What Is Being Done?

Utah Department of Transportation (UDOT), Zero Fatalities, and the Highway Safety Office have launched an education program about car and bike safety called Road Respect: Car & Bike Rules to Live By. For more information, visit roadrespect.utah.gov or find the program on Facebook.

Additional information regarding bicycle helmet fit, a 'Share the Road Driver Education video' is available, and other resources are provided by the UDOH Violence and Injury Prevention Program on their website (<http://www.health.utah.gov/vipp/kids/bicycle-safety/prevention.html>).

- 74.6% of students reported never or rarely wearing a helmet
- In Utah, an average of 372 bicyclists are injured in crashes with motor vehicles and five bicyclists are killed each year
- Hispanic children are less likely than non-Hispanic to wear bicycle helmets

Figure: Helmet Use of Bicyclists in Crashes, Utah, 2011–2014



Source: 2014 Utah Crash Summary, Utah Department of Public Safety. Accessed online 8/4/2016 from <http://highwaysafety.utah.gov/wp-content/uploads/sites/22/2015/02/Section12Bicyclists2014-1.pdf>.

Helmet Use—Minor

Figure: Percentage of Students Reporting Helmet Use in Utah by Year, 1999–2013

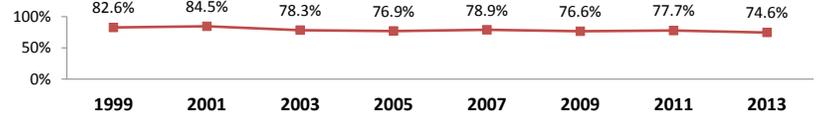
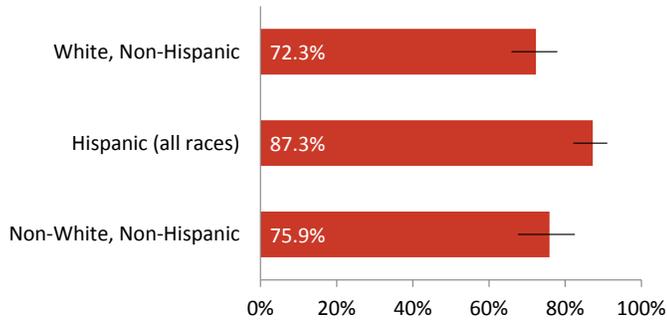


Figure: Helmet Use by Race/Ethnicity, Utah Students in Grades 9–12, 2013



Crude (burden)

STATE COMPARISON (2013)

	Rate	95% CIs
U.S.	87.9%	85.0% - 90.2%
New Hampshire (best)	60.0%	55.9% - 64.0%
UTAH (4th of 31)	74.6%	68.5% - 79.8%
Mississippi (worst)	93.2%	91.1% - 94.8%

GRADE IN SCHOOL (2013)

Grade	Rate	95% CIs
Grade 9	78.2%	64.3% - 87.7%
Grade 10	73.2%	68.9% - 77.2%
Grade 11	75.7%	65.5% - 83.6%
Grade 12	70.2%	59.0% - 79.4%

GENDER (2013)

Gender	Rate	95% CIs
Male	71.3%	64.2% - 77.5%
Female	78.5%	73.0% - 83.1%

RACE/ETHNICITY (2013)

Race/Ethnicity	Rate	95% CIs
White, Non-Hispanic	72.3%	65.9% - 77.9%
Hispanic (all races)	87.3%	82.2% - 91.1% !
Non-White, Non-Hispanic	75.9%	67.6% - 82.6%

Unintended Injury Deaths

Utah Death Certificate Database

Description

This measure is reported as the rate of unintended injury deaths due to all causes per 100,000 population.

How Are We Doing?

The annual age-adjusted rate of unintended injury deaths in Utah has been increasing for much of the last decade, from 33.4 per 100,000 population in 2005 to 44.9 in 2014. While several leading causes, such as motor vehicle crash deaths, have generally been decreasing, the rate of poisoning deaths has been increasing, and has been significantly higher than the other causes since 2011.

National Comparison

Since 2000, the U.S. unintended injury death rate has remained fairly steady. However, the rate in Utah has been increasing in recent years; though it was significantly lower than the national rate from 2003 to 2008, the Utah rate surpassed the national rate in 2010, and has been significantly higher than the U.S. rate since 2011.

Healthy People Objective (see Appendix)

IVP-11: Reduce unintentional injury deaths
U.S. Target: 36.4 deaths per 100,000 population
Utah Target: 29.4 deaths per 100,000 population

Disparities

In Utah, deaths from unintended injury deaths during 2014 were highest among those aged 75 and older. Rates were also significantly higher for those aged 45–54. Children and young adults under age 24 had significantly lower rates of unintended injury death.

Among Utah's local health districts (LHDs), unintended injury death rates for 2012–2014 were highest in the Southeast Utah, TriCounty, and Tooele County LHDs. Utah County and Weber-Morgan LHDs, at 36.9 and 40.9 per 100,000 population, respectively, had the lowest rates.

Based on 2012–2014 data, the Native American/Alaska (AK) Native population has a significantly higher rate (87.1 per 100,000 population) of unintended injury deaths than the White population (42.7), while the Hispanic population (59.6 per 100,000 population) had a significantly higher rate compared to the non-Hispanic population (42.8).

Risk Factors

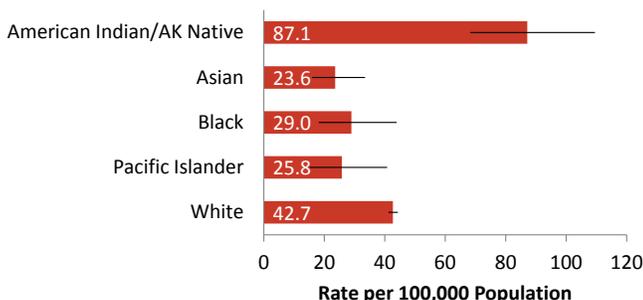
Risk factors may include not wearing seat belts, car seats, or helmets; not observing safety laws or regulations; not using safety equipment; and not choosing safe behaviors.

What Is Being Done?

The UDOH Violence and Injury Prevention Program (VIPPP) is working with several agencies, such as the Utah Department of Public Safety, Primary Children's Hospital, and Utah's 13 local health departments to promote the use of safety belts,

- Unintended injury death rate in Utah is 44.9 per 100,000 persons
- Rates are higher for persons aged 75 and older
- Males had a higher rate than females
- Disparities include American Indian/Alaska Native and Hispanic populations
- Significantly higher rates for Central Utah, Southeast Utah, Tooele County, and TriCounty LHDs
- Significantly lower rate for Utah County LHD

Figure: Unintended Injury Death by Race, Utah, 2012–2014



Unintended Injury Deaths

child safety seats, booster seats, and helmets in an effort to further reduce unintended injury deaths. Most injuries can be prevented by choosing safe behaviors, using safety equipment, and obeying safety laws. High-priority prevention areas include motor vehicle crash injury, fall-related injury, and accidental overdoses.

Map: Unintended Injury Deaths by Local Health District, 2012-2014

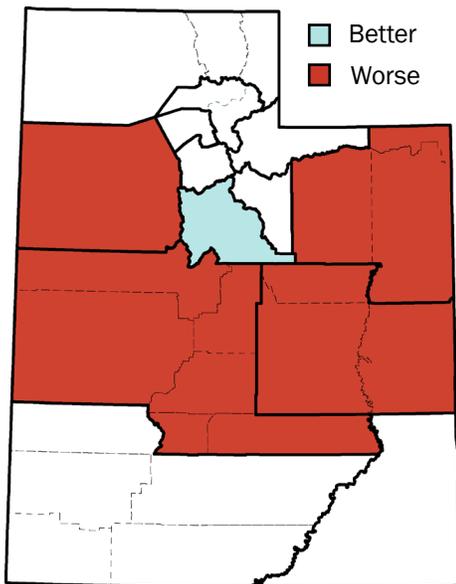


Figure: Unintended Injury Death by Age Group, Utah, 2014

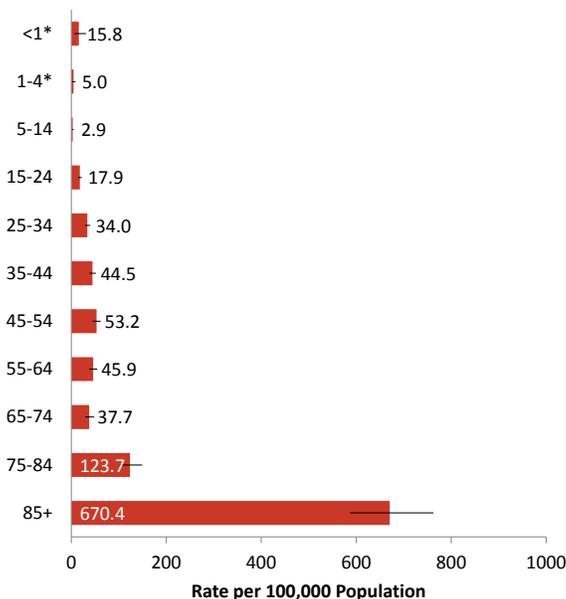
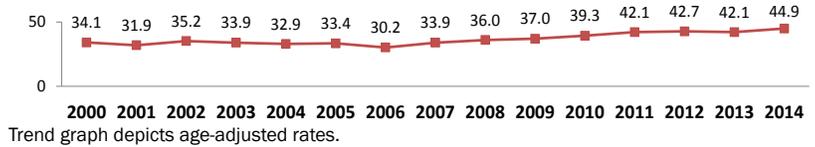


Figure: Unintended Injury Deaths per 100,000 in Utah by Year, 2000-2014



Trend graph depicts age-adjusted rates.

STATE COMPARISON (2014)^	Crude (burden)		Age-adjusted (comparison)	
	Rate	95% CIs	Rate	95% CIs
U.S.	42.7	42.4 - 42.9	40.5	40.3 - 40.7
Maryland (best)	28.0	26.7 - 29.4	26.6	25.3 - 27.9
UTAH (27th of 51)	39.7	37.4 - 41.9	44.9	42.3 - 47.6
New Mexico (worst)	73.6	69.9 - 77.2	72.1	68.4 - 75.8

AGE IN YEARS (2014)

<1*	15.8	6.8 - 31.1	-	-	-	✓
1-4*	5.0	2.4 - 9.1	-	-	-	✓
5-14	2.9	1.6 - 4.8	-	-	-	✓
15-24	17.9	14.3 - 22.2	-	-	-	✓
25-34	34.0	28.8 - 40.0	-	-	-	
35-44	44.5	38.1 - 51.7	-	-	-	
45-54	53.2	45.3 - 62.0	-	-	-	!
55-64	45.9	38.3 - 54.6	-	-	-	
65-74	37.7	29.1 - 48.1	-	-	-	
75-84	123.7	101.6 - 149.2	-	-	-	!
85+	670.4	587.0 - 762.2	-	-	-	!

GENDER (2014)

Male	47.6	44.2 - 51.3	58.0	53.7 - 62.6	!
Female	29.5	26.8 - 32.5	33.0	29.9 - 36.3	✓

RACE (2012-2014)

American Indian/AK Native	87.1	68.3 - 109.5	87.1	68.3 - 109.5	!
Asian	23.6	16.0 - 33.5	23.6	16.0 - 33.5	✓
Black	29.1	18.2 - 43.9	29.0	18.2 - 43.9	
Pacific Islander	25.8	15.2 - 40.8	25.8	15.2 - 40.8	✓
White	42.7	41.2 - 44.3	42.7	41.2 - 44.3	

ETHNICITY (2012-2014)

Hispanic	59.6	51.9 - 68.1	59.6	51.9 - 68.1	!
Non-Hispanic	42.9	41.3 - 44.5	42.8	41.3 - 44.5	

LOCAL HEALTH DISTRICT (2012-2014)

Bear River	34.2	29.4 - 39.7	42.1	36.0 - 49.0	
Central Utah	54.7	45.5 - 65.1	57.9	48.0 - 69.2	!
Davis County	33.4	29.8 - 37.2	41.0	36.6 - 45.8	
Salt Lake County	38.4	36.3 - 40.6	43.2	40.8 - 45.7	
San Juan	53.2	34.1 - 79.1	61.7	39.2 - 92.4	
Southeast Utah†	67.4	53.7 - 83.5	69.0	54.6 - 85.9	!
Southwest Utah	46.2	41.1 - 51.7	45.3	40.1 - 51.0	
Summit County	39.0	28.4 - 52.2	53.9	37.9 - 74.5	
Tooele County	52.2	42.2 - 63.8	66.1	53.0 - 81.5	!
TriCounty	58.8	47.8 - 71.5	66.6	54.0 - 81.4	!
Utah County	26.2	23.8 - 28.8	36.8	33.3 - 40.7	✓
Wasatch County	35.2	23.4 - 50.8	46.2	29.6 - 68.7	
Weber-Morgan	38.3	34.0 - 43.1	40.9	36.3 - 46.0	

† Includes Carbon, Emery, and Grand counties

*Use caution in interpreting. The estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

Infectious Diseases

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Healthcare-Associated Infections

National and State Healthcare-Associated Infections
Progress Report 2016

Description

This measure is reported as the standardized infection ratio (SIR) of healthcare-associated infections (HAIs) from acute care hospitals. The following five types of infections are included:

- Central line-associated bloodstream infections (CLABSI) from acute care hospitals
- Catheter-associated urinary tract infections (CAUTI)
- Surgical site infections (SSI) following colon surgery
- Hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia
- Hospital-onset *Clostridium difficile* infection (CDI)

- The Utah SIR rate is similar to or better than the U.S. rate for CLABSIs, MRSA, and CDIs
- The Utah SIR rate is worse than the U.S. rate for CAUTI and SSIs

How Are We Doing?

National Comparison

The Utah rate is similar to or better than the U.S. rate for three of these types of infections. The Utah SIR rate for CLABSIs is 0.452 (rank 19th), which is similar to the U.S. rate of 0.495. The Utah SIR rate for MRSA is 0.625 (15th of 51) which is similar to the U.S. rate of 0.868. The Utah SIR rate of CDIs is 0.828 (14th of 51) which is significantly better than the U.S. rate of 0.924.

The Utah SIR rate is worse than the U.S. rate in two types of infections. The Utah CAUTI SIR rate is the 51st (of 52) at 1.554, significantly higher than the U.S. rate of 1.000. For SSIs, Utah is 44th (of 51) with a SIR rate of 1.349, again significantly higher than the U.S. rate of 0.976.

Healthy People Objective (see Appendix)

HAI-1: Reduce central line-associated bloodstream infections (CLABSIs)

U.S. Target: 0.25 or 75 percent reduction

HAI-2: Reduce invasive healthcare-associated methicillin-resistant *Staphylococcus aureus* (MRSA) infections

U.S. Target: 6.56 infections per 100,000 persons or 75 percent reduction

Disparities

Disparity information is not available.

Risk Factors

The Centers for Disease Control and Prevention lists risk factors of use of indwelling medical devices, surgical procedures, injections, healthcare environment contamination, transmission of communicable diseases, and overuse of antibiotics.

What Is Being Done?

Nationally the CDC have been tracking healthcare-associated infections (HAIs) and have outlined prevention goals in the Office of Disease Prevention and Health Promotion's "National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination."¹

There is a Utah Healthcare Infections Prevention Governance Committee and a 2015 Utah Healthcare-Associated Infections Prevention Plan. The Utah prevention plan targets the following areas:

- Enhance HAI program infrastructure
- Surveillance, detection, reporting, and response
- Prevention
- Evaluation, oversight, and communication
- Infection control assessment and response
- Targeted healthcare infection prevention program

More information can be found here: <http://health.utah.gov/epi/diseases/HAI/>.

1 Office of Disease Prevention and Health Promotion. Overview, Health Care-Associated Infections. Accessed 8/8/2016 from <http://health.gov/hcq/prevent-hai.asp>.

Figure: Healthcare-Associated Infections in Utah by Type and Year, 2011–2014



Standardized Infection Ratio (SIR)

STATE COMPARISON (2014)

Central line-associated bloodstream infections (CLABSI) from acute care hospitals, all locations[^]

	SIR	95% CIs
U.S.	0.495	0.488 - 0.502
Hawaii (best)	0.229	0.148 - 0.337
UTAH (19th of 52)	0.452	0.355 - 0.569
Maine (worst)	0.867	0.693 - 1.073

Catheter-associated urinary tract infections (CAUTI), all locations[^]

	SIR	95% CIs
U.S.	1.000	0.990 - 1.010
Wyoming (best)	0.496	0.288 - 0.800
UTAH (51st of 52)	1.554	1.345 - 1.786
Connecticut (worst)	1.568	1.432 - 1.713

Surgical site infections (SSI) following colon surgery⁺

	SIR	95% CIs
U.S.	0.976	0.956 - 0.996
Mississippi (best)	0.620	0.471 - 0.801
UTAH (44th of 51)	1.349	1.083 - 1.662
Vermont (worst)	1.889	1.260 - 2.728

[^] Data from all ICUs, wards (and other non-critical care locations), and NICUs. This excludes LTAC locations (or facilities) and IRF locations (or facilities).

⁺ Note that almost all acute care hospitals are required to report SSIs following inpatient colon procedures to NHSN for participation in the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Quality Reporting Program. SSIs included in this table are those classified as deep incisional or organ/space infections following NHSN-defined inpatient colon procedures that occurred in 2014 with a primary skin closure technique, detected during the same admission as the surgical procedure or upon readmission to the same facility. The colon surgery SSI data published in this report use different risk adjustment methodology and a different subset of data than that which are used for public reporting by CMS.

^{*} Note that almost all acute care hospitals are required to report facility-wide MRSA bacteremia data to NHSN for participation in the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Quality Reporting Program. Hospital-onset is defined as event detected on the 4th day (or later) after admission to an inpatient location within the facility.

^{**} Note that almost all acute care hospitals are required to report facility-wide CDI data to NHSN for participation in the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Quality Reporting Program. Hospital-onset is defined as event detected on the 4th day (or later) after admission to an inpatient location within the facility.

Standardized Infection Ratio (SIR)

STATE COMPARISON (2014)

Hospital-onset methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia, facility-wide^{*}

	SIR	95% CIs
U.S.	0.868	0.850 - 0.886
Vermont (best)	0.205	0.052 - 0.559
UTAH (15th of 51)	0.625	0.445 - 0.856
Kentucky (worst)	1.249	1.086 - 1.430

Hospital-onset *Clostridium difficile* infection (CDI), facility-wide^{}**

	SIR	95% CIs
U.S.	0.924	0.918 - 0.929
Vermont (best)	0.552	0.438 - 0.687
UTAH (14th of 51)	0.828	0.758 - 0.903
Maryland (worst)	1.201	1.156 - 1.248

Table: Healthcare-Associated Infections in Acute Care Hospitals by Type, Utah and U.S., 2014

HAI TYPE	# of Hospitals Reporting* Total Hospitals in Utah: 51	2014 STATE SIR vs. 2013 State SIR	2014 STATE SIR vs. 2014 Nat'l SIR	2014 STATE SIR vs. Nat'l Baseline [^]	2014 STATE SIR	2014 NAT'L SIR
CLABSI National Baseline: 2008	27	▼ 32%	▼ 9%	▼ 55%	0.45	0.50
CAUTI National Baseline: 2009	28	▼ 5%	▲ 56%	▲ 55%	1.55	1.00
SSI, Abdominal Hysterectomy National Baseline: 2008	32	▼ 46%	▼ 29%	▼ 42%	0.58	0.83
SSI, Colon Surgery National Baseline: 2008	32	▲ 16%	▲ 39%	▲ 35%	1.35	0.98
MRSA Bacteremia National Baseline: 2011	37	▲ 4%	▼ 28%	▼ 37%	0.63	0.87
C. difficile Infections National Baseline: 2011	37	▲ 10%	▼ 10%	▼ 17%	0.83	0.92

Legend

- ▼ 2014 state SIR is significantly lower (better) than comparison group in column header
- ▲ or ▼ Change in 2014 state SIR compared to group in column header is not statistically significant
- ▲ 2014 state SIR is significantly higher (worse) than comparison group in column header

* The number of hospitals that reported to NHSN and are included in the SIR calculation. This number may vary across HAI types; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

[^] Nat'l baseline time period varies by HAI type. See first column of this table for specifics.

Source: Utah Healthcare Associated Infections Progress Report, accessed 8/3/2016 from <http://www.cdc.gov/hai/pdfs/stateplans/factsheets/ut.pdf>.

Description

This measure reports the rate of newly reported cases of chlamydia by date of diagnosis per 100,000 population.

How Are We Doing?

Chlamydia rates in Utah have increased from 2000 to 2014, except for a slight decrease in rate (2.6%) in 2013. The overall rate increase can be attributed to increased screening efforts, use of increasingly sensitive diagnostic testing, efforts to increase reporting by providers and laboratories, and improved information systems for reporting. Such increased rates can be interpreted as an advancement in disease control as more infections are identified and treated, providing opportunity to intervene in the spread of infection.

National Comparison

Chlamydial infections are the most frequently reported notifiable disease in the U.S., with 1,441,789 cases reported in 2014. Of these reported chlamydia infections, 66% were among those aged 15 to 24. The overall rate for chlamydia in the U.S. in 2014 was 456.1 cases per 100,000 persons. The chlamydia rate in Utah is significantly lower than the U.S. rate. In 2014, Utah's chlamydia rate ranked 4th lowest in the nation.¹

Healthy People Objective (see Appendix)

STD-1: Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections

STD-1.1 Females aged 15 to 24 years attending family planning clinics

STD-1.2 Females aged 24 years and under enrolled in a National Job Training Program

STD-1.3 Males aged 24 years and under enrolled in a National Job Training Program

Disparities

Chlamydial infections in both men and women are commonly asymptomatic, yet screenings occur more often among females, resulting in higher rates of reported infections among females. However, with the increased availability of urine testing, men are being tested for chlamydial infection more frequently. Over the past 10 years in Utah, the chlamydia rate in men increased by 106.2% as compared with a 66.4% increase in women over this period.

In Utah in 2014, persons aged 20 to 24 years reported the highest rates of chlamydia in both males and females. The rate for females in this age group in Utah during this timeframe was 1,712.8 cases per 100,000 persons compared with 3,651.1 cases per 100,000 persons in the U.S. in 2014. The rate for males aged 20 to 24 years in Utah in 2014 was 742.4 per 100,000 population compared with 1,368.3 cases per 100,000 persons in the U.S. in 2014.²

Risk Factors

Risk factors for sexually transmitted diseases include:

- Sexual activity among young adults aged 25 and younger
- Multiple sex partners
- Prior history of sexually transmitted diseases (STDs)
- Unprotected sex
- Illicit drug use

Those who fall within one or more of these categories should be tested for STDs in regular intervals. Sites of infection may include pharynx, rectum, vagina, cervix, and urethra. Due to anatomical and biochemical differences, women are also at increased risk for acquiring chlamydia than men.

- In 2014, the Utah chlamydia rate ranked 4th in the nation with a rate of 279.4 per 100,000 in the population
- Higher rates among Utahns aged 15-34
- Rates among females were significantly higher than males
- Significantly higher rate for Salt Lake County and San Juan LHDs

1 CDC. [Sexually Transmitted Disease Surveillance](#), 2014.

2 CDC. [Sexually Transmitted Disease Surveillance](#), 2014.

Chlamydia

What Is Being Done?

Persons who test positive for chlamydia are confidentially interviewed by a disease intervention specialist from their local health department (LHD) to educate the patient, ensure proper treatment, and to obtain sexual partner information for follow up. This process helps prevent diagnosed individuals from spreading the infection and the patient from becoming reinfected.

The UDOH Prevention, Treatment and Care Program, along with LHDs, currently provide STD presentations upon request to a variety of organizations, agencies, and facilities.

Data Interpretation Issues

Reported chlamydia rates are calculated by dividing the number of cases within the population of interest by the total number of persons within that population, then multiplying by 100,000. It should be noted that rates within small populations are volatile; a small change in the number of cases can noticeably change the rate. This change may look significant, but, statistically, it may not be. Caution is strongly recommended when interpreting small case numbers and rates.

Map: Chlamydia by Local Health District, 2014

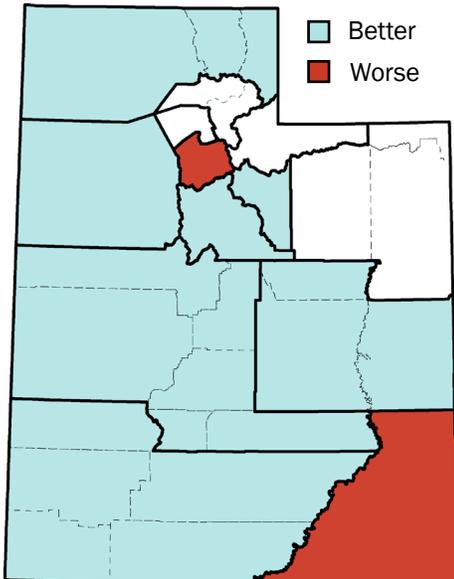


Figure: Chlamydia Cases per 100,000 in Utah by Year, 2009–2014



STATE COMPARISON (2014)	Crude (burden)	
	Rate	95% CIs
U.S.	456.1	- -
West Virginia (best)	254.5	- -
UTAH (4th of 50)	279.4	- -
Alaska (worst)	787.5	- -

AGE IN YEARS (2014)			
	Rate	95% CIs	
<1	0.0	- -	
1-9	0.0	- -	
10-14	20.5	15.2 - 26.9	✓
15-19	939.1	899.6 - 979.9	!
20-24	1,207.6	1164.7 - 1251.7	!
25-29	670.2	636.0 - 705.8	!
30-34	348.0	324.1 - 373.1	!
35-39	178.0	160.5 - 197.0	✓
40-44	115.8	100.4 - 132.8	✓
45-49	60.9	49.1 - 74.7	✓
50-54	37.2	28.3 - 48.1	✓
55-59	12.7	7.7 - 19.9	✓
60-64*	3.9	1.3 - 9.2	✓
65+	**	** **	

GENDER (2014)			
	Rate	95% CIs	
Male	188.1	181.2 - 195.2	✓
Female	366.2	356.4 - 376.1	!

RACE/ETHNICITY (2014)			
	Rate	95% CIs	
American Indian/AK Native	570.3	- -	
Asian	200.5	- -	
Black	1,133.6	- -	
Pacific Islander	702.3	- -	
Hispanic^	482.0	- -	
White	217.1	- -	
Two or More Races	53.7	- -	

LOCAL HEALTH DISTRICT (2014)‡			
	Rate	95% CIs	
Bear River	155.1	137.1 - 174.9	✓
Central Utah	142.4	116.9 - 171.8	✓
Davis County	289.1	271.0 - 308.0	
Salt Lake County	392.0	380.4 - 404.0	!
San Juan	373.7	283.1 - 484.2	!
Southeast Utah†	171.9	134.0 - 217.2	✓
Southwest Utah	199.1	180.8 - 218.8	✓
Summit County	232.7	187.4 - 285.7	
Tooele County	232.2	195.7 - 273.5	✓
TriCounty	239.9	201.8 - 283.1	
Utah County	167.6	157.0 - 178.6	✓
Wasatch County	126.3	88.0 - 175.6	✓
Weber-Morgan	281.2	260.8 - 302.7	

† Includes Carbon, Emery, and Grand counties

^ Includes persons of Hispanic ethnicity regardless of race.

‡ Data by LHD from Utah Department of Health Prevention, Treatment and Care Program

*Use caution in interpreting. The estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

** The estimate has been suppressed because 1) the relative standard error is greater than 50% or cannot be determined, 2) the observed number of events is very small and not appropriate for publication.

Description

This measure reports the number of reported culture-confirmed and probable cases of *Salmonella* infections per 100,000 population per year.

How Are We Doing?

The number of reported *Salmonella* infections in Utah decreased from 27.8 cases per 100,000 person-years in 1999 to 12.6 per 100,000 person-years in 2014. The Healthy People 2020 target is 11.4 cases per 100,000 person-years; there is still work to be done for Utah to achieve this target. The 5-year average for *Salmonella* infections in Utah is at 11.5, just over the Healthy People 2020 goal.

A portion of the decrease in the number of salmonellosis cases reported in Utah since 1999 may be attributed to efforts of the Utah Department of Agriculture and Food through their Egg and Poultry Grading Program. The mission of this service is to assure Utah consumes safe, wholesome, quality eggs, egg products, and poultry.

Recent national investigations have identified outbreaks of *Salmonella* linked to contaminated tomatoes eaten raw (2004 and 2008), dry dog food (2006 and 2007), ground beef (2004), pet rodents (2004), raw almonds (2003–2004), cantaloupe (2000–2002), peanut butter (2008), African Dwarf Frogs (2009), alfalfa sprouts (2010), queso fresco (2011) and poultry (2010–2012).

National Comparison

The average rate of reported salmonellosis cases in Utah during the 1995–2000 time period was higher than the U.S. average. However, during the 2002–2014 time period, the average rate (11.5 cases per 100,000 person-years) in Utah has been lower than the U.S. average rate (15.9 cases per 100,000 person-years) for the same time period.

Healthy People Objective (see Appendix)

FS-1.4: Reduce infections caused by *Salmonella* species transmitted commonly through food

U.S. Target: 11.4 cases per 100,000

Utah Target: 11.4 cases per 100,000

Disparities

Children aged four and younger had higher rates of *Salmonella* in 2014.

TriCounty local health district (LHD) also had a higher rate than the state rate.

Risk Factors

All age groups can be infected with *Salmonella*, but young children, the elderly, and those with compromised immune systems are the most severely affected.

What Is Being Done?

From 1994 to 2000, *Salmonella* Enteritidis (SE) was found in approximately 55% of all *Salmonella* infections. This was primarily due to several outbreaks associated with eating raw or undercooked eggs. However, since 2000, there has only been one outbreak of salmonellosis associated with eggs in Utah. This has resulted in a decrease in the number of *Salmonella* infections overall and a decrease in the proportion of *Salmonella* infections that are due to SE. In 2012, 22% of all *Salmonella* infections were the serotype SE. The improvement in decreasing *Salmonella* rates may be directly linked to the Utah Egg and Poultry Grading Program described in the “How Are We Doing?” section.

Additionally, improvements in laboratory and epidemiologic techniques, as well as improved communication between state and local jurisdictions, has resulted in improved outbreak detection, especially for outbreaks due to uncommon sources of *Salmonella*.

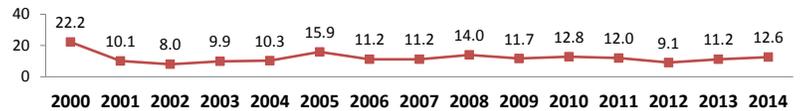
Per the Utah Communicable Disease Rule R386-702-3, healthcare providers and laboratories are required to report salmonellosis cases to the Bureau of Epidemiology or a LHD. The Bureau of Epidemiology assists LHDs with the investigation of cases and outbreaks and implementation of control measures to prevent further cases.

LHDs make an attempt to interview every case of salmonellosis reported to public health. Information gathered during these interviews includes food history, water exposure, animal exposure, travel history, and contact with ill individuals.

- *Salmonella* rate in Utah was 12.6 per 100,000 population
- Higher rates in children aged four and younger
- Significantly higher rate for TriCounty LHD

Salmonella

Figure: Salmonella Cases per 100,000 in Utah by Year, 2000–2014



Data from these interviews are analyzed and used to identify outbreaks and common sources of infection.

Some general guidelines to prevent the spread of *Salmonella* include the following:

- Always refrigerate meat, cook meats completely, and never eat raw meat.
- Always refrigerate eggs and cook eggs and food containing raw eggs completely. Never eat dough, batter, sauces, ice cream, or other foods that contain raw eggs.
- Use only pasteurized milk and juices.
- Carefully wash hands before and after preparing food, after using the toilet, changing diapers, or touching animals.

Visit <http://www.cdc.gov/handwashing/> for good hand washing techniques.

Map: Salmonella by Local Health District, 2013–2014



Crude (burden)

STATE COMPARISON (2014) [^]	Rate	95% CIs
U.S.	16.1	- -
Nevada (best)	6.1	- -
UTAH (16th of 51)	12.6	- -
Mississippi (worst)	33.1	- -

AGE IN YEARS (2014)

<1	47.4	30.4 - 70.6	!
1–4	20.3	14.6 - 27.6	!
5–14	8.2	5.9 - 11.1	✓
15–24	11.4	8.6 - 14.9	
25–34	14.7	11.4 - 18.8	
35–44	9.3	6.5 - 12.9	
45–54	10.1	6.9 - 14.3	
55–64	11.2	7.6 - 15.9	
65+	11.5	8.0 - 16.1	

GENDER (2014)

Male	11.6	9.9 - 13.5
Female	13.1	11.3 - 15.1

LOCAL HEALTH DISTRICT (2013–2014)

Bear River	13.4	9.8 - 17.9	
Central Utah	16.2	10.5 - 23.9	
Davis County	12.6	10.0 - 15.6	
Salt Lake County	12.2	10.8 - 13.8	
San Juan	**	** **	
Southeast Utah ^{*†}	6.1	2.0 - 14.2	
Southwest Utah	11.6	8.6 - 15.3	
Summit County [*]	9.0	3.6 - 18.6	
Tooele County [*]	9.8	5.1 - 17.1	
TriCounty	19.9	12.6 - 29.8	!
Utah County	10.6	8.8 - 12.7	
Wasatch County [*]	9.2	3.0 - 21.4	
Weber-Morgan	10.2	7.6 - 13.4	

[†] Includes Carbon, Emery, and Grand counties

[^] National data from MMWR Summary of Notifiable Infectious Diseases and Conditions—United States, 2014 and may vary from other data reported because of differences in 1) the date used to aggregate data, 2) the timing of reports, 3) the source of the data, 4) surveillance case definitions, and 5) policies regarding case jurisdiction.

^{*}Use caution in interpreting. The estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

^{**}The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

Pertussis

UDOH Bureau of Epidemiology

Description

This measure reports the rate of pertussis cases per 100,000 population. For surveillance purposes, pertussis is a cough illness lasting at least two weeks with one of the following: fits of coughing, “whoop” inhalation sound, or cough-induced vomiting, with or without laboratory evidence of infection.

How Are We Doing?

Pertussis rates in Utah increased from 2009–2012, with a notable increase in cases beginning in 2011. The 2012 data indicated that pertussis activity reached pre-vaccine era rates with 55.8 cases per 100,000 person-years. Consistent with the cyclical trend of pertussis, pertussis activity in Utah decreased in 2013 to 45.5 cases per 100,000 person-years and then decreased again in 2014 to 31.9 cases per 100,000 person-years.

There are several factors that may be contributing to the increase of pertussis rates in recent years, including: actual increases in disease occurrence, better laboratory tests, increased recognition by clinicians, the cyclical nature of pertussis peaking every 3–5 years, waning immunity of the adult booster (Tdap) around two years after the vaccine is given, and the higher risk of infection with pertussis in individuals who are not vaccinated (who have an eightfold greater risk if exposed). Incidence rates for Utah in 2014 showed a 29.9% decrease compared to the incidence rate in 2013.

National Comparison

Throughout the 1990s and up through 2004 (with the exception of 1998, when a statewide outbreak of pertussis occurred in Utah), the rate of pertussis in Utah mirrored national trends. Utah pertussis rates began to climb in 2005, and in 2006 Utah had a rate of pertussis nearly six times the national average. However, in Utah a substantial decrease in the rate of pertussis occurred in 2007 and continued to decline to near the U.S. average in 2008. Pertussis began to increase again in 2009 with rates remaining above the national average. 2012 data showed national rates to be double what they were in 2011, which was the same trend seen in Utah. However, Utah rates have been substantially higher than national rates since 2011. Rates now appear to be approaching national levels, as seen in the 2014 provisional national data.

Healthy People Objective (see Appendix)

Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases

IID-1.6: Reduce cases of pertussis among children under 1 year of age

U.S. Target: 2,500 cases

Utah Target: 31 cases per year

IID-1.7: Reduce cases of pertussis among adolescents aged 11 to 18 years

U.S. Target: 2,000 cases

Utah Target: 58 cases per year

Disparities

Age distribution data for 2014 indicates that 52.1% of cases are aged 14 years and younger. The incidence rates are highest in infants less than one year of age at 134.3 cases per 100,000 person-years, (n=68). Pertussis incidence in adolescents between the ages of 5–14 years was 58.0 per 100,000 person-years (n=297).

While the incidence rate in Utah has decreased, case count comparisons with the Healthy People 2020 goal show that the Utah pertussis rates in the less than one year age group are more than two times the Utah target and the 11–18 year age group are more than four times the Utah target.

Risk Factors

Young infants are at the highest risk for clinical disease and complications (pneumonia and encephalitis).

What Is Being Done?

Surveillance data are used to identify persons or areas in which additional efforts are required to reduce disease incidence. Surveillance data help to promptly identify outbreaks in which prophylaxis (treatment to prevent or mitigate disease) of contacts can help limit the spread of disease. Surveillance data are also used in evaluating vaccination policies at the state level.

- **31.9 pertussis cases per 100,000 Utahns**
- **Higher rates for children aged 14 and younger**
- **Significantly higher rates for Salt Lake County and Southwest Utah LHDs**

Pertussis

Childhood immunization is the most effective weapon against pertussis infection. The UDOH Immunization Program works with parents, physicians, and local health departments (LHDs) to provide immunization histories for all children under age two years and remind parents when vaccinations are due.

The adult pertussis vaccine (Tdap) is recommended for adolescents aged 7–18 years. Also, routine use of a single dose of Tdap for adults aged 19 years and older is recommended to replace the next booster dose of tetanus and diphtheria toxoids vaccine (Td). Tdap is also recommended for adults who have close contact with infants less than one year of age.

The UDOH Bureau of Epidemiology conducts ongoing statewide surveillance of pertussis cases. Per the Utah Communicable Disease Rule R386-702-3, health-care providers and laboratories are required to report suspected cases of pertussis to the UDOH or the LHD within three business days of identification. The Bureau of Epidemiology assists LHDs with the investigation of cases and implementation of control measures to prevent further cases.

Map: Pertussis by Local Health District, 2013–2014

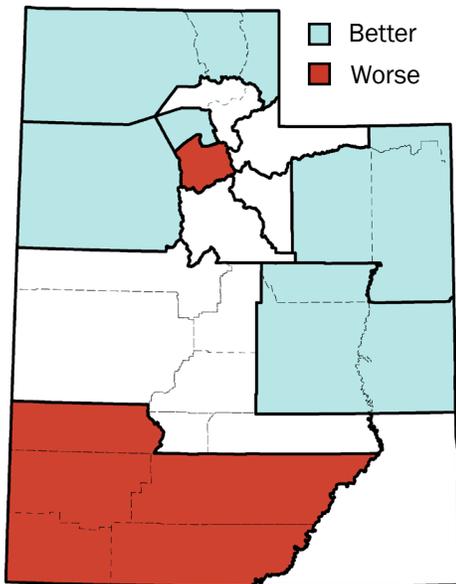
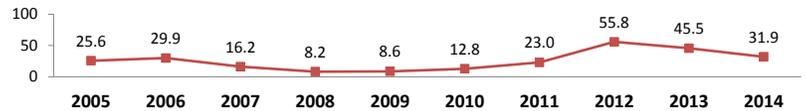


Figure: Pertussis Cases per 100,000 in Utah by Year, 2005–2014



Crude (burden)

STATE COMPARISON (2014) [^]	Rate	95% CIs
--------------------------------------	------	---------

U.S.	10.3	
West Virginia (best)	1.0	
UTAH (49th of 51)	31.9	
Montana (worst)	48.2	

AGE IN YEARS (2014)

<1	134.3	104.3 - 170.3	!
1–4	51.6	42.2 - 62.5	!
5–14	58.0	51.6 - 65.0	!
15–24	34.8	29.7 - 40.5	
25–34	11.1	8.2 - 14.7	✓
35–44	22.5	18.0 - 27.7	✓
45–54	19.6	14.9 - 25.2	✓
55–64	11.6	7.9 - 16.3	✓
65+	7.8	4.9 - 11.7	✓

GENDER (2014)

Male	28.3	25.6 - 31.1
Female	32.7	29.9 - 35.8

LOCAL HEALTH DISTRICT (2013–2014)

Bear River	23.6	18.7 - 29.3	✓
Central Utah	33.7	25.2 - 44.2	
Davis County	32.2	28.0 - 36.8	✓
Salt Lake County	41.1	38.4 - 43.8	!
San Juan	**	** **	
Southeast Utah* [†]	6.1	2.0 - 14.2	✓
Southwest Utah	49.1	42.7 - 56.2	!
Summit County	38.6	26.0 - 55.1	
Tooele County	19.6	12.6 - 29.2	✓
TriCounty*	6.9	3.0 13.6	✓
Utah County	41.0	37.3 - 44.9	
Wasatch County	45.9	29.7 - 67.8	
Weber-Morgan	42.6	37.1 - 48.7	

[†] Includes Carbon, Emery, and Grand counties

[^] National data from MMWR Summary of Notifiable Infectious Diseases and Conditions—United States, 2014 and may vary from other data reported because of differences in 1) the date used to aggregate data, 2) the timing of reports, 3) the source of the data, 4) surveillance case definitions, and 5) policies regarding case jurisdiction.

* Use caution in interpreting. The estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

** The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

Other Data Utilized

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Community Input

As mentioned in the State Health Assessment Process Overview, the Utah Department of Health, local health departments, and Intermountain Healthcare collaborated to facilitate community input meetings to give the communities a voice in sharing their healthcare needs and priorities.

Meetings Held

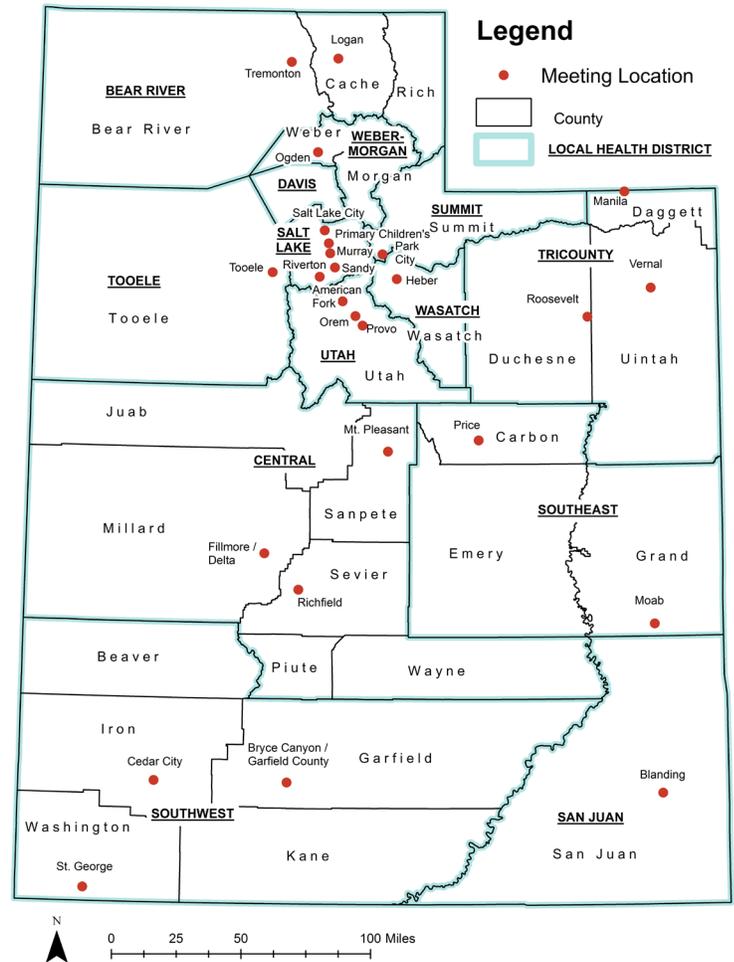
There were 27 community input meetings held around the state.

Table: Location and Dates of Community Input Meetings

Meeting Place	Meeting Date
American Fork	4/23/2015
Provo/Utah Valley	5/4/2015
Primary Children's Hospital	5/5/2015
Orem	5/6/2015
Logan	5/7/2015
Ogden	5/8/2015
Tremonton	5/11/2015
Murray/TOSH*	5/13/2015
Salt Lake City	5/14/2015
Heber	5/14/2015
Murray/IMC	5/18/2015
Riverton	5/22/2015
Park City	5/26/2015
Sandy	5/26/2015
Richfield	6/3/2015
Mt. Pleasant	6/10/2015
St. George	6/18/2015
Cedar City	6/18/2015
Bryce/Garfield County	6/19/2015
Delta/Fillmore	6/24/2015
Tooele	9/22/2015
Blanding	9/23/2015
Manila	10/20/2015
Vernal	10/21/2015
Roosevelt	10/22/2015
Moab	11/13/2015
Price	11/18/2015

* The Orthopedic Specialty Hospital

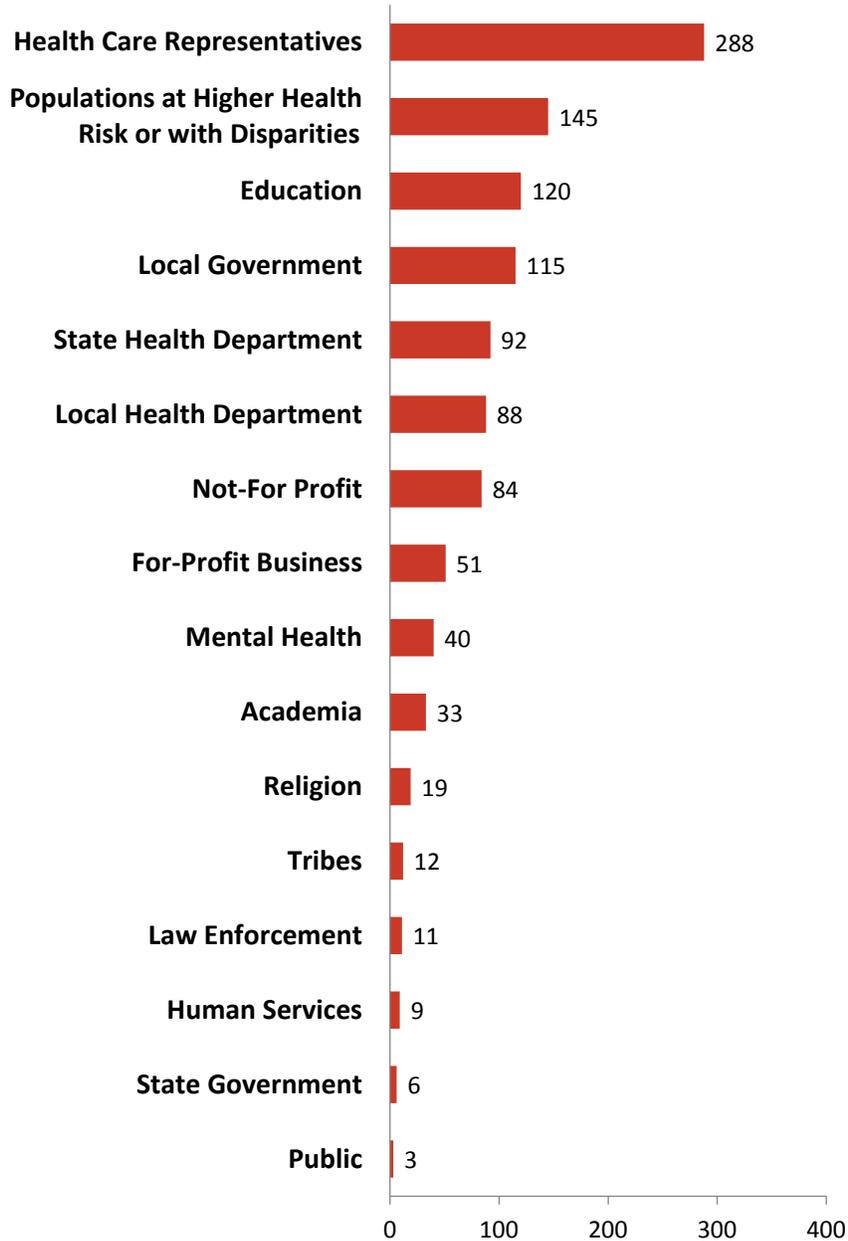
Map: Community Input Meeting Locations



Participants

The largest group of participants were representatives of healthcare, however there was broad representation across multiple areas.

Figure: Community Input Meeting Participants



Summary of Input

The main areas of need expressed by the community input participants are listed below.

Weight and Unhealthy Behaviors

- Healthy foods are more expensive
- Need education on what is healthy
- Need convenience
- Need motivation

Access to Healthcare

- Cost barriers
- Transportation needs
- Lack of health insurance
- Inappropriate use of emergency department
- Insurance/health system too complex
- Need care outside of working hours
- Lack of specialty providers or providers that work with their insurance

Behavioral Health Access

- Not enough providers (especially prescribers)
- Negative perception/stigma
- Lack of screening/prevention
- Lack of knowledge—need for education
- Suicide
- Lack of awareness of resources
- Need to integrate with physical health

Children's Health

- Kids prefer sedentary activities (e.g., video games)
- Lack of immunization
- Dental options for kids
- Parents unaware of issues, unsure what to do
- Recreational injuries
- Social media/bullying

Environment

- Lack of affordable quality housing for lower income
- Air quality
- Neighborhoods not safe for walking/biking
- Water quality

Other Health Assessments Reviewed

Several assessments were collected and reviewed. The list of assessments and main areas of needs identified are included below.

Table: List of Assessments Reviewed

Report Name/Citation	Agency/Program
2013 Community Health Status Assessment: Davis County, Utah	Davis County Health Department
Bear River Health District Community Health Assessment Report	Bear River Health Department
Blue Mountain Hospital Community Health Needs Assessment and Economic Impact Findings	National Rural Health Resource Center
Bureau of Health Promotion Small Area Report 2014	Bureau of Health Promotion, Utah Department of Health
Central Utah Community Health Assessment	Central Utah Public Health Department
Community Assessment: Southeastern Utah District Health Department	Southeastern Utah District Health Department
Community Health Assessment For Southwest Utah Public Health Department	Southwest Utah Public Health Department
A Health Needs Assessment of Summit County, Utah (Prepared for the Summit County Health Department)	The Center for Public Policy and Administration, University of Utah
Maternal and Child Health Services Title V Block Grant, Utah	Maternal and Child Health Bureau, Utah Department of Health
NAMI Utah Prevention by Design: 2015 Needs Assessment Update	National Alliance on Mental Illness Utah in partnership with the Utah Division of Substance Abuse and Mental Health, the Utah Department of Health and Utah's State Epidemiological Outcomes Workgroup
Salt Lake County Community Resources and Development's 2013 Community Needs Assessment: Low to Moderate Income Households in Salt Lake County, Utah	Salt Lake County Community Resources and Development
Tooele County Community Health Improvement Plan 2012-2017	Tooele County Health Department
Utah Department of Health Healthcare-associated Infections (HAI) Prevention Program 2013 Needs Assessment	Healthcare-Associated Infections (HAI) Prevention Program, Utah Department of Health
Utah Department of Health Healthcare-associated Infections (HAI) Prevention Program 2015 Needs Assessment: Utah Freestanding Dialysis Centers	Healthcare-Associated Infections (HAI) Prevention Program, Utah Department of Health
Utah Violence and Injury Prevention Plan Across the Lifespan 2011-2015 (DRAFT)	Violence and Injury Prevention Program, Utah Department of Health
Utah Violence and Injury Small Area Report	Violence and Injury Prevention Program, Utah Department of Health

Summary of Findings

The 16 needs assessments each cover various areas of the state's current health status and needs. Of these 16 reports, nine focus on specific parts of the state, covering the Blue Mountain Hospital community (Blanding), and Bear River, Central Utah, Davis County, Salt Lake County, Southeast Utah, Southwest Utah, Summit County, and Tooele County local health districts. The remaining seven assessments cover the entire state, but may focus on specific health issues. Various reports offer closer looks at mental illness, infection prevention, violence and injury prevention, households with low to moderate income, and maternal and child health.

These reports identify a wide variety of needs. One emphasized need is for infection prevention, including additional staff and training dedicated to this purpose. Another theme is violence and injury prevention, including suicide prevention, injury treatment, and the reduction of motor vehicle crashes as well as sexual assault and domestic violence. Several reports mention access to affordable health services, as well as community education and engagement. Obesity and diabetes are also major problems, for which the needs assessments suggest the promotion of healthy diets and exercise. Mental

health and substance abuse are also common issues. Finally, better air and water quality are often recommended. Less frequently mentioned issues include immunizations, communicable diseases, nursing indicators, emergency preparedness, senior services, dental and vision services, and child and maternal health promotion.

No major disparities were noted between the reports, though they did emphasize different aspects of health, and identify different needs which were most pressing in different parts of Utah. In addition, the assessments recommended a wide variety of interventions to address the health problems they highlighted.

Needs identified most included:

- Infection prevention
- Violence and injury prevention
- Affordable health services
- Obesity and diabetes—nutrition and exercise
- Mental health and substance abuse issues
- Poor air and water quality

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

The Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis was completed with the Utah Health Improvement Plan Coalition following the process outlined in the State Health Assessment Process Overview. Based on the notes taken by each discussion group and the report back to the group, the following areas were identified as needing attention:

- Funding
- Mental/physical health integration
- Improved access to care in rural areas

The following are areas to consider as potential barriers in the context of the health priorities that are chosen:

- Data sharing across partners
- Focus on community/population health rather than individual
- Outdated technology
- Reducing silos

State Health Assessment Prioritization Results

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

After the final voting, the following areas were submitted by the Utah Health Improvement Plan Coalition to the Utah Health Improvement Plan Executive Committee for consideration for the Utah Health Improvement Plan priorities.

- Diabetes/pre-diabetes
- Obesity/physical activity
- Mental health/suicide
- Prescription drug misuse/deaths
- Care access
- Air quality
- Immunizations

It was expressed that all of these issues are cross cutting and need multiple agency involvement, could benefit from a community navigator/coordinator, and are more difficult for the community to address on their own. It was also felt that health/physical health should be recategorized to include physical, mental, social, and environment.

The results of the Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis were also submitted to the Utah Health Improvement Plan Executive Committee.

Appendices

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

List of Acronyms

4:3:1:3:3:1 – refers to 4 doses of diphtheria-tetanus-pertussis (DTP), 3 doses of polio, 1 dose of measles-mumps-rubella (MMR), 3 doses of Hepatitis B (HepB), 3 or 4 doses of Haemophilus influenzae type B (Hib) (depending on product type received), and 1 dose of Varicella (Var) vaccine

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.

A1C – the Hemoglobin A1c (A1C) test measures the level of blood glucose for persons with diabetes

AAA – American Automobile Association

AAP – American Academy of Pediatrics

ABCS – appropriate aspirin prescription, blood pressure control, cholesterol control, and smoking cessation

ACIP – Advisory Committee on Immunization Practices

ACOG – American Congress of Obstetricians and Gynecologists

ACS – American Community Survey

ACSCs – Ambulatory Care Sensitive Conditions

ADA – American Diabetes Association

ADDM – Autism and Developmental Disabilities Monitoring Network

AHRQ – Agency for Healthcare Research and Quality

AK Native – Alaska Native

AQI – Air Quality Index

ASD – autism spectrum disorder

AUCH – Association for Utah Community Health

BMI – body mass index

BRFSS – Behavioral Risk Factor Surveillance System

BTA – Basin Transit Association

CAHMI – Child and Adolescent Health Measurement Initiative

CATS – Cedar Area Transportation System

CAUTI – catheter-associated urinary tract infections

CDC – Centers for Disease Control and Prevention

CDI – *Clostridium difficile* infection

Center TRT – Center for Training and Research Translation

CFOI – Census of Fatal Occupational Injuries

CHIP – Children’s Health Insurance Plan

CLABSI – central line-associated bloodstream infections

CMEs – continuing medical education credit hours

CMHC – Community Mental Health Centers

CMS – Centers for Medicare and Medicaid Services

COPD – chronic obstructive pulmonary disease

CPI-U – Consumer Price Index for All Urban Consumers

CPS – Current Population Survey

CSHCN – Children with Special Health Care Needs

CSTE – Council of State and Territorial Epidemiologists

CVTD – Cache Valley Transit District

DEQ – Department of Environmental Quality

DRC – Data Resource Center

DSAMH – Division of Substance Abuse and Mental Health

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

DTaP – diphtheria, tetanus toxoids, and acellular pertussis vaccine (includes children who might have been vaccinated with diphtheria and tetanus toxoids vaccine, or diphtheria, tetanus toxoids, and pertussis vaccine)

E. coli – *Escherichia coli*

ED – emergency department

EMS – emergency medical services

EPA – Environmental Protection Agency

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

FAQs – frequently asked questions

FPL – federal poverty level

FQHC – Federally Qualified Health Centers

GED – General Education Development

HAI – Healthcare-associated infections

H.B. – house bill

HCD – Housing and Community Development

HepB – hepatitis B vaccine

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

Hib – Haemophilus Influenzae type B vaccine

HIV – Human Immunodeficiency Virus

HMOs – health maintenance organizations

HP2020 – Healthy People 2020

HPSAs – Health Professional Shortage Areas

ICD-9 – International Classification of Diseases, Ninth Revision

ICD-10 – International Classification of Diseases, Tenth Revision

List of Acronyms

ICUs – intensive care units	PM – particulate matter
IMC – Intermountain Medical Center	PM_{2.5} – refers to particulate matter that is 2.5 micrometers long
IRF – inpatient rehabilitation facility	PNA – Prevention Needs Assessment
IT – information technology	Polio – poliovirus vaccine
IUD – intrauterine device	PRAMS – Pregnancy Risk Assessment Monitoring System
LARC – long-acting reversible contraceptive	QPR – Question, Persuade, Refer
LDL – low-density lipoprotein	RUCA – Rural Urban Commuting Area
LDS – Latter-day Saints/Mormon	RV – recreational vehicle
LGBT – lesbian, gay, bisexual, or transgender	SAIPE – Small Area Income and Poverty Estimates
LHD – local health district/department	SAMHSA – Substance Abuse and Mental Health Services Administration
LP gas – liquefied petroleum gas or liquid petroleum gas	SE – <i>Salmonella</i> Enteritidis
LTAC – long-term acute care	SHA – State Health Assessment
MCH – Maternal and Child Health	SHADAC – State Health Access Data Assistance Center
MDEs – major depressive episodes	SHIP – State Health Improvement Plan (refers to state health improvement plan process and Utah's improvement plan from 2012–2016. Utah's new plan will be referred to as the Utah Health Improvement Plan.)
MHCA – mental health catchment area	SIR – Standardized Infection Ratio
MMR – measles-mumps-rubella	SMI – serious mental illness
MMWR – Morbidity and Mortality Weekly Report	SSI – supplemental security income (as referenced in Demographics section)
MRSA – methicillin-resistant <i>Staphylococcus aureus</i>	SSI – surgical site infections (in reference to Healthcare-Associated Infections)
MUA – Medically Underserved Areas	STD – sexually transmitted disease
MUA/P – Medically Underserved Areas and Medically Underserved Populations	SWOT – strengths, weaknesses, opportunities, threats
MUP – Medically Underserved Populations	TANF – Temporary Assistance for Needy Families
n= – actual number of cases/events	Td – tetanus and diphtheria toxoids vaccine
N/A – not available	Tdap – tetanus, diphtheria, pertussis vaccine
NAAQS – National Ambient Air Quality Standard	TOP Star – Targeting Obesity in Preschools and Child Care Settings
NAEPP EPR-3 – National Asthma Education and Prevention Program Expert Panel Report 3	TOSH – The Orthopedic Specialty Hospital
NAICS – North American Industry Classification System	TPCP – Tobacco Prevention and Control Program
NAMI – National Alliance on Mental Illness	UAP – Utah Asthma Program
NCHS – National Center for Health Statistics	UDOH – Utah Department of Health
NHLBI – National Heart, Lung, and Blood Institute	UDOT – Utah Department of Transportation
NHSN – National Healthcare Safety Network	UNIS – Utah Notification and Information System
NICUs – newborn intensive care units	UPP – Utah's Premium Partnership for Health Insurance
NIOSH – National Institute for Occupational Safety and Health	USDA ERS – United States Department of Agriculture Economic Research Service
NIS – National Immunization Survey	USIIS – Utah Statewide Immunization Information System
NSCH – National Survey of Children's Health	
NVSS – National Vital Statistics System	
OVRS – Office of Vital Records and Statistics	
PCN – Primary Care Network	
PCS conditions – primary care sensitive conditions	

UT-ADDM – Utah Autism and Developmental Disabilities Monitoring Project

UTA – Utah Transit Authority

UTVDRS – Utah Violent Death Reporting System

VA – Veterans Affairs

Var – varicella vaccine

VFC – Vaccines for Children

VIPP – Violence and Injury Prevention Program

WCF – Workers Compensation Fund

WONDER – Wide-ranging Online Data for Epidemiologic Research

YRBS – Youth Risk Behavior Survey

YRBSS – Youth Risk Behavior Surveillance System

Accommodation and Food Services industry sector [2012 NAICS Code 72] – The Accommodation and Food Services sector comprises establishments providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment. (see <https://www.naics.com/naics-code-description/?code=72>)

Administrative and Support and Waste Management and Remediation Services industry sector [2012 NAICS Code 56] – The Administrative and Support and Waste Management and Remediation Services sector comprises establishments performing routine support activities for the day-to-day operations of other organizations. These essential activities are often undertaken in-house by establishments in many sectors of the economy. (see <https://www.naics.com/naics-code-description/?code=56>)

Advisory Committee on Immunization Practices – The Advisory Committee on Immunization Practices (ACIP) comprises medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 217a). (from <https://www.cdc.gov/vaccines/acip/about.html>)

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](#))

Agency for Healthcare Research and Quality – The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used. (see <http://www.ahrq.gov/cpi/about/index.html>)

Ages and Stages Questionnaire – developmental and social-emotional screening instruments for children between birth and age 6

Agriculture, Forestry, Fishing, and Hunting industry sector [2012 NAICS Code 11] – The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. (see <https://www.naics.com/naics-code-description/?code=11>)

Agriculture, Forestry, Fishing, Hunting, and Mining industry – 2012 NAICS Codes 11–21; combines [Agriculture, Forestry, Fishing, and Hunting](#) (2012 NAICS Code 11 - see separate listing) with [Mining, Quarrying, and Oil and Gas Extraction](#) (2012 NAICS Code 21 - see separate listing)

Air Quality Index – The Environmental Protection Agency calculates the Air Quality Index for five major air pollutants regulated by the Clean Air Act: ground-level ozone, particle

pollution (also known as particulate matter), carbon monoxide, sulfur dioxide, and nitrogen dioxide.

Alliance for a Healthier Generation – The Alliance for a Healthier Generation, founded by the American Heart Association and the Clinton Foundation, works to reduce the prevalence of childhood obesity and to empower kids to develop lifelong, healthy habits. The Alliance works with schools, companies, community organizations, healthcare professionals and families to transform the conditions and systems that lead to healthier children. (see <https://www.clintonfoundation.org/our-work/alliance-healthier-generation>)

ambient air – refers to the quality of outdoor air in the surrounding environment

American Academy of Pediatrics – an American professional association of pediatricians (see <https://www.aap.org>)

American Association of Diabetes Educators – a multi-disciplinary professional membership organization dedicated to improving diabetes care through innovative education, management and support (see <https://www.diabeteseducator.org/about-aade>)

American Community Survey – an ongoing statistical survey by the U.S. Census Bureau (see <https://www.census.gov/programs-surveys/acs/>)

American Congress of Obstetricians and Gynecologists – Founded in 1951, the American College of Obstetricians and Gynecologists (The College) is the specialty's premier professional membership organization dedicated to the improvement of women's health. (see <http://www.acog.org/About-ACOG/About-Us>)

American Diabetes Association – The moving force behind the work of the Association is a network of more than one million volunteers, a membership of more than 500,000 people with diabetes, their families and caregivers, a professional society of nearly 14,000 health care professionals, as well as more than 800 staff members. Their mission is to prevent and cure diabetes and to improve the lives of all people affected by this disease. (see <http://www.diabetes.org/>)

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://www.whitehouse.gov/omb/fedreg_1997standards)

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

Architecture and Engineering Occupations SOC Major Group [2010 SOC Code 17-0000] – includes Architects, Surveyors, and Cartographers (17-1000); Engineers (17-2000); and Drafters, Engineering Technicians, and Mapping Technicians (17-3000) (see <http://www.bls.gov/soc/2010/soc170000.htm>)

Arts, Design, Entertainment, Sports, and Media Occupations SOC Major Group [2010 SOC Code 27-0000]

– includes Art and Design Workers (27-1000); Entertainers and Performers, Sports and Related Workers (27-2000); Media and Communication Workers (27-3000); and Media and Communication Equipment Workers (27-4000) (see <http://www.bls.gov/soc/2010/soc270000.htm>)

Arts, Entertainment, and Recreation industry sector [2012 NAICS Code 71]

– The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. (see <https://www.naics.com/naics-code-description/?code=71>)

Arts, Entertainment, Recreation, Accommodation, and Food Services industry – 2012 NAICS Codes 71–72; combines [Arts, Entertainment, and Recreation](#) (2012 NAICS Code 71 - see separate listing) with [Accommodation and Food Services](#) (2012 NAICS Code 72 - see separate listing)

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://www.whitehouse.gov/omb/fedreg_1997standards)

Asperger disorder – Asperger syndrome is a pervasive developmental disorder that is characterized by an inability to understand how to interact socially. Typical features of the syndrome also may include clumsy and uncoordinated motor movements, social impairment with extreme egocentricity, limited interests and unusual preoccupations, repetitive routines or rituals, speech and language peculiarities, and non-verbal communication problems.

Association for Utah Community Health – The Association for Utah Community Health (AUCH) is 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 – This guide is 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/>)

Autism and Developmental Disabilities Monitoring Network – The Autism and Developmental Disabilities Monitoring (ADDM) Network is a group of programs funded by CDC to estimate the number of children with autism spectrum disorder (ASD) and other developmental disabilities living in different areas of the United States. (see <http://www.cdc.gov/ncbddd/autism/addm.html>)

bacteremia – the presence of live bacteria in the bloodstream

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 – The Behavioral Risk Factor Surveillance System (BRFSS) is 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>)

biochemical – characterized by, produced by, or involving chemical reactions in living organisms

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://www.whitehouse.gov/omb/fedreg_1997standards)

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

booster – an additional dose of a vaccine needed periodically to 'boost' the immune system

built environment – includes all of the physical parts of where people live and work (e.g., homes, buildings, streets, open spaces, and infrastructure)

Bureau of Economic Analysis – a federal agency that produces economic accounts statistics that enable government and business decision-makers, researchers, and the American public to follow and understand the performance of the Nation's economy (see <http://www.bea.gov/about/mission.htm>)

[UDOH] Bureau of Epidemiology – Within the Utah Department of Health, the mission of the Bureau of Epidemiology is to prevent sickness and death from infectious diseases and environmental hazards, and monitor diseases to reduce spread. The Bureau is also responsible for monitoring and responding to potential bioterrorism threats/events, communicable disease outbreaks, epidemics, and other unusual occurrences of illness. (see <http://www.health.utah.gov/epi/>)

Bureau of Labor Statistics – The Bureau of Labor Statistics of the U.S. Department of Labor is the principal Federal agency responsible for measuring labor market activity, working conditions, and price changes in the economy. Its mission is to collect, analyze, and disseminate essential economic information to support public and private decision-making. (see <http://www.bls.gov/bls/infhome.htm>)

Business and Financial Operations Occupations SOC Major Group [2010 SOC Code 13-0000] – includes Business Operations Specialists

(13-1000) and Financial Specialists (13-2000) (see <http://www.bls.gov/soc/2010/soc130000.htm>)

catchment area – the geographical area served by an institution

catheter-associated urinary tract infections – A catheter-associated urinary tract infection (CAUTI) occurs when germs (usually bacteria) enter the urinary tract through the urinary catheter and cause infection. (see https://www.cdc.gov/HAI/ca_uti/cauti_faqs.html#a3)

CDC 6|18 initiative – CDC is partnering with health care 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>)

CDC Scorecard – The CDC Worksite Health ScoreCard (HSC) is a tool designed to help employers assess the extent to which they have implemented evidence-based health promotion interventions in their worksites. (see http://www.cdc.gov/dhdsp/pubs/worksite_scorecard.htm)

Census Bureau – The Census Bureau is part of the U.S. Department of Commerce. The Census Bureau's mission is to serve as the leading source of quality data about the nation's people and economy. (see <https://www.census.gov/about/what.html>)

Census of Fatal Occupational Injuries – The Bureau of Labor Statistics (BLS) Census of Fatal Occupational Injuries (CFOI) produces comprehensive, accurate, and timely counts of fatal work injuries. CFOI is a Federal-State cooperative program that has been implemented in all 50 States and the District of Columbia since 1992. (see <http://www.bls.gov/iif/oshfat1.htm>)

Centers for Disease Control and Prevention (CDC) – CDC is 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>)

central line-associated bloodstream infections – A central line-associated bloodstream infection (CLABSI) is a serious infection that occurs when germs (usually bacteria or viruses) enter the bloodstream through the central line. A central line (also known as a central venous catheter) is a catheter (tube) that doctors often place in a large vein in the neck, chest, or groin to give medication or fluids or to collect blood for medical tests. (see <http://www.cdc.gov/HAI/bsi/CLABSI-resources.html>)

Childcare Obesity Prevention Workgroup – The Childcare Obesity Prevention Workgroup consists of state and local partners with a common goal of obesity prevention in early childhood. The workgroup supports and expands the TOP Star Program (Targeting Obesity in Preschool and Childcare Settings - see separate listing) and coordinates and advances obesity prevention efforts across early childhood systems in Utah.

[Utah] Children With Special Health Care Needs (CSHCN) – Part of the Utah Department of Health Division of Family Health and Preparedness, CSHCN provides and promotes family-centered, coordinated care and facilitates the development of community-based systems for these children and their families. (see <http://www.health.utah.gov/cshcn/about/>)

Children's Health Insurance Program – The Children's Health Insurance Program, or CHIP, is 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>)

chlamydia – Chlamydia is a common sexually transmitted disease. It is caused by bacteria called *Chlamydia trachomatis*.

chronic obstructive pulmonary disease (COPD) – a chronic and progressive lung disease

Clostridium difficile infection – *Clostridium difficile* [klo-strid-ee-um dif-uh-seel] (*C. difficile*) is a bacterium that causes inflammation of the colon, known as colitis. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to patients or contaminate surfaces through hand contact. (see <http://www.cdc.gov/hai/organisms/cdiff/cdiff-patient.html>)

combustion products – emissions from cars, manufacturing plants, or other types of factories

Community and Social Service Occupations SOC Major Group [2010 SOC Code 21-0000] – includes Counselors, Social Workers, and Other Community and Social Service Specialists (21-1000) and Religious Workers (21-2000) (see <http://www.bls.gov/soc/2010/soc210000.htm>)

Computer and Mathematical Occupations SOC Major Group [2010 SOC Code 15-0000] – includes Computer Occupations (15-1100) and Mathematical Science Occupations (15-2000) (see <http://www.bls.gov/soc/2010/soc150000.htm>)

Comunidades Unidas – Comunidades Unidas is a non profit organization it is offering low cost immigration services and referrals assistance to the Latino Community in Utah. (see <http://www.cuutah.org/>)

Construction and Extraction Occupations SOC Major Group [2010 SOC Code 47-0000] – includes Supervisors of Construction and Extraction Workers (47-1000); Construction Trades Workers (47-2000); Helpers, Construction Trades (47-3000); Other Construction and Related Workers (47-4000); and Extraction Workers (47-5000) (see <http://www.bls.gov/soc/2010/soc470000.htm>)

Construction industry sector [2012 NAICS Code 23] – The Construction sector comprises establishments primarily engaged in the construction of buildings or engineering projects (e.g., highways and utility systems). Establishments primarily engaged in the preparation of sites for new construction and establishments primarily engaged in subdividing land for sale as building sites also are included in this sector. (see <https://www.naics.com/naics-code-description/?code=23>)

Consumer Price Index for All Urban Consumers – The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The all urban consumer group is based on the expenditures of almost all residents of urban or metropolitan areas, including professionals, the self-employed, the poor, the unemployed, and retired people, as well as urban wage earners and clerical workers. Not included in the CPI are the spending patterns of people living in rural nonmetropolitan areas, farm families, people in the Armed Forces, and those in institutions, such as prisons and mental hospitals. (see <http://www.bls.gov/cpi/cpifaq.htm>)

County Health Rankings – The County Health Rankings rank the health of nearly every county in the nation and show that much of what affects health occurs outside of the doctor's office. (see <http://www.countyhealthrankings.org/about-project/rankings-background>)

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](#))

Current Population Survey – The Current Population Survey (CPS), sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS), is the primary source of labor force statistics for the population of the United States. (see <http://www.census.gov/programs-surveys/cps.html>)

Data Resources Program – The Data Resources Program in the Utah Department of Health provides health data and information support to the Maternal and Child Health Bureau (MCH) and Children with Special Health Care Needs (CSHCN), located in the Division of Family Health and Preparedness (DFHP). (see <http://health.utah.gov/drp/>)

dental sealants – Sealants are thin, plastic coatings painted on the chewing surfaces of the back teeth to form a shield over the tooth.

Department of Environmental Quality – see listing for [Utah Department of Environmental Quality](#)

Department of Human Services – see listing for [Utah Department of Human Services](#)

Department of Workforce Services – see listing for [Utah Department of Workforce Services](#)

developmental delays – Developmental delay is when a child does not reach developmental milestones at the expected times. Delay can occur in one or many areas—for example, gross or fine motor, language, social, or thinking skills.

diabetes – Diabetes is 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

diphtheria – Diphtheria is an infection caused by the bacterium *Corynebacterium diphtheriae*. Diphtheria causes a thick covering in the back of the throat. It can lead to difficulty breathing, heart failure, paralysis, and even death. Vaccines are recommended for infants, children, teens and adults to prevent diphtheria. (see <https://www.cdc.gov/diphtheria/>)

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

Economic Research Service Office – The Economic Research Service (ERS), an agency of the United States Department of Agriculture (USDA), provides economic research and information to inform public and private decision making on economic and policy issues related to agriculture, food, natural resources, and rural America. (see http://www.usda.gov/wps/portal/usda/usdahome?contentidonly=true&contentid=ERS_Agency_Splash.xml)

Education, Training, and Library Occupations SOC Major Group [2010 SOC Code 25-0000] – includes Post-secondary Teachers (25-1000); Preschool, Primary, Secondary, and Special Education School Teachers (25-2000); Other Teachers and Instructors (25-3000); Librarians, Curators, and Archivists (25-4000); and Other Education, Training, and Library Occupations (25-9000) (see <http://www.bls.gov/soc/2010/soc250000.htm>)

Educational and Health Services industry – 2012 NAICS Codes 61–62; NAICS aggregation that is unique to the Bureau of Labor Statistics combining [Educational Services](#) (2012

NAICS Code 61 - see separate listing) with [Health Care and Social Assistance](#) (2012 NAICS Code 62 - see separate listing)

Educational Services industry sector [2012 NAICS Code 61] – The Educational Services sector comprises establishments that provide instruction and training in a wide variety of subjects. (see <https://www.naics.com/naics-code-description/?code=61>)

Educational Services, Healthcare, and Social Assistance industry – 2012 NAICS Codes 61–62; combines [Educational Services](#) (2012 NAICS Code 61 - see separate listing) with [Health Care and Social Assistance](#) (2012 NAICS Code 62 - see separate listing)

electronic medical record(s) – an electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one healthcare organization

[Utah] Emergency Department Encounter Database – Utah licensed hospitals report information on emergency department patient encounters

encephalitis – inflammation of the brain, which may be caused by a bacterium, a virus, or an allergic reaction

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

Environmental Protection Agency – A federal agency, EPA's mission is to protect human health and the environment. (see <https://www.epa.gov/aboutepa/our-mission-and-what-we-do>)

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.

Farming, Fishing, and Forestry Occupations SOC Major Group [2010 SOC Code 45-0000] – includes Supervisors of Farming, Fishing, and Forestry Workers (45-1000); Agricultural Workers (45-2000); Fishing and Hunting Workers (45-3000); and Forest, Conservation, and Logging Workers (45-4000) (see <http://www.bls.gov/soc/2010/soc450000.htm>)

Federal physical activity guidelines – Based on the latest science, the Physical Activity Guidelines for Americans (PAG or the Guidelines) provide guidance on how children and

adults can improve their health through physical activity. (see <https://health.gov/paguidelines/>)

federal poverty level – The poverty guidelines, sometimes loosely referred to as the “federal poverty level” (FPL), are the other version of the federal poverty measure (in addition to the [poverty threshold](#) - see separate listing). They are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes—for instance, determining financial eligibility for certain federal programs. (see <https://aspe.hhs.gov/poverty-guidelines>)

federal poverty threshold – The poverty thresholds are the original version of the federal poverty measure. They are updated each year by the Census Bureau. The thresholds are used mainly for statistical purposes. (see <https://aspe.hhs.gov/poverty-guidelines>) (also see listing for [federal poverty level](#))

Federally Qualified Health Centers – Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. (see <http://www.hrsa.gov/healthit/toolbox/RuralHealthIToolbox/Introduction/qualified.html>)

Finance and Insurance industry sector [2012 NAICS Code 52] – The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. (see <https://www.naics.com/naics-code-description/?code=52>)

Finance, Insurance, Real Estate, Rental, and Leasing industry – 2012 NAICS Codes 52–53; combines [Finance and Insurance](#) (2012 NAICS Code 52 - see separate listing) with [Real Estate Rental and Leasing](#) (2012 NAICS Code 53 - see separate listing)

Financial Activities industry – 2012 NAICS Codes 52–53; NAICS aggregation that is unique to the Bureau of Labor Statistics combining [Finance and Insurance](#) (2012 NAICS Code 52 - see separate listing) with [Real Estate Rental and Leasing](#) (2012 NAICS Code 53 - see separate listing)

Food Preparation and Serving Related Occupations SOC Major Group [2010 SOC Code 35-0000] – includes Supervisors of Food Preparation and Serving Workers (35-1000); Cooks and Food Preparation Workers (35-2000); Food and Beverage Serving Workers (35-3000); and Other Food Preparation and Serving Related Workers (35-9000) (see <http://www.bls.gov/soc/2010/soc350000.htm>)

Haemophilus influenzae type B – Hib bacteria (*Haemophilus influenzae* type b) can cause severe infections such as meningitis and is spread through contact with mucus or droplets from the nose and throat of an

infected person, often by coughing or sneezing. Most of the time, Hib is spread by people who have the bacteria in their noses and throats but who are not ill (asymptomatic). (see <http://www.vaccines.gov/diseases/hib/#>)

Head Start – Housed under the U.S. Department of Health and Human Services, the Office of Head Start (an Office of the Administration for Children & Families) manages grant funding and oversees local agencies providing Head Start services. Head Start promotes school readiness of children under 5 from low-income families through education, health, social and other services. (see <http://www.acf.hhs.gov/ohs>)

Health and Medicine Division – The Health and Medicine Division (HMD) is a division of the National Academies of Sciences, Engineering, and Medicine (the Academies). The Academies are private, nonprofit institutions that provide independent, objective analysis and advice to the nation and conduct other activities to solve complex problems and inform public policy decisions related to science, technology, and medicine. HMD previously was the Institute of Medicine (IOM) program unit of the Academies. (see <https://www.nationalacademies.org/hmd/About-HMD.aspx>)

Health Care and Social Assistance industry sector [2012 NAICS Code 62] – The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities. (see <https://www.naics.com/naics-code-description/?code=62>)

Health Resources and Services Administration – The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce and innovative programs. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable. (see <http://www.hrsa.gov/about/index.html>)

Healthcare Practitioners and Technical Occupations SOC Major Group [2010 SOC Code 29-0000] – includes Health Diagnosing and Treating Practitioners (29-1000); Health Technologists and Technicians (29-2000); and Other Healthcare Practitioners and Technical Occupations (29-9000) (see <http://www.bls.gov/soc/2010/soc290000.htm>)

Healthcare Support Occupations SOC Major Group [2010 SOC Code 31-0000] – includes Nursing, Psychiatric, and Home Health Aides (31-1000); Occupational Therapy and Physical Therapist Assistants and Aides (31-2000); and Other Healthcare Support Occupations (31-9000) (see <http://www.bls.gov/soc/2010/soc310000.htm>)

HealthInsight – HealthInsight is 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 – Hepatitis is an inflammation of the liver.

[Utah] Highway Safety Office – An office of the Utah Department of Public Safety, the mission of the Utah Highway Safety Office is to develop, promote and coordinate traffic safety initiatives designed to reduce traffic crashes, injuries and fatalities on Utah's roadways. (see <http://highwaysafety.utah.gov/about/>)

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://www.whitehouse.gov/omb/fedreg_1997standards)

[H.B. 11] 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>)

[H.B. 119] 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>)

Housing and Community Development Division – The Housing and Community Development Division, a division of the Utah Department of Workforce Services, actively partners with other state agencies, local government, nonprofits and the private sector to build local capacity, fund services and infrastructure and to leverage federal and state resources for critical programs. (see <https://jobs.utah.gov/housing/>)

housing cost burden – Many government agencies define excessive as costs that exceed 30 percent of household income. The data for monthly housing costs as a percentage of household income are developed from a distribution of “Selected Monthly Owner Costs as a Percentage of Household Income” for owner-occupied and “Gross Rent as a Percentage of Household Income” for renter-occupied units.

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

industry – Industry data describe the kind of business conducted by a person's employing organization.

indwelling – left within a bodily organ or passage especially to promote drainage—used of an implanted tube (as a catheter)

Information industry sector [2012 NAICS Code 51] – The Information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, and (c) processing data. (see <https://www.naics.com/naics-code-description/?code=51>)

Installation, Maintenance, and Repair Occupations SOC Major Group [2010 SOC Code 49-0000] – includes Supervisors of Installation, Maintenance, and Repair Workers (49-1000); Electrical and Electronic Equipment Mechanics, Installers, and Repairers (49-2000); Vehicle and Mobile Equipment Mechanics, Installers, and Repairers (49-3000); and Other Installation, Maintenance, and Repair Occupations (49-9000) (see <http://www.bls.gov/soc/2010/soc490000.htm>)

Intermountain Healthcare – Intermountain Healthcare is 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 physi-

cians at more than 185 clinics in the Intermountain Medical Group, and health insurance plans from SelectHealth. (see <https://intermountainhealthcare.org/about/>)

iterative proportional fitting – Iterative proportional fitting (or raking) is a procedure for adjusting a table of data cells such that they add up to selected totals for both the columns and rows (in the two-dimensional case) of the table.

Latino – see listing for [Hispanic or Latino](#)

Legal Occupations SOC Major Group (2010 SOC Code 23-0000) – includes Lawyers, Judges, and Related Workers (23-1000) and Legal Support Workers (23-2000) (see <http://www.bls.gov/soc/2010/soc230000.htm>)

Leisure and Hospitality industry – NAICS aggregation that is unique to the Bureau of Labor Statistics combining [Arts, Entertainment, and Recreation](#) (2012 NAICS Code 71 - see separate listing) and [Accommodation and Food Services](#) (2012 NAICS Code 72 - see separate listing)

Life, Physical, and Social Science Occupations SOC Major Group (2010 SOC Code 19-0000) – includes Life Scientists (19-1000); Physical Scientists (19-2000); Social Scientists and Related Workers (19-3000); and Life, Physical, and Social Science Technicians (19-4000) (see <http://www.bls.gov/soc/2010/soc190000.htm>)

macular degeneration – deterioration of the macula, which is the small central area of the retina of the eye that controls visual acuity

major depressive episodes – a period characterized by the symptoms of major depressive disorder: primarily depressed mood for 2 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

Management, Business, Science, and Arts occupations – 2010 SOC Codes 11-0000–29-0000; combines [Management Occupations](#) (2010 SOC Code 11-0000 - see separate listing) with [Business and Financial Operations Occupations](#) (2010 SOC Code 13-0000 - see separate listing); [Computer and Mathematical Occupations](#) (2010 SOC Code 15-0000 - see separate listing); [Architecture and Engineering Occupations](#) (2010 SOC Code 17-0000 - see separate listing); [Life, Physical, and Social Science Occupations](#) (2010 SOC Code 19-0000 - see separate listing); [Community and Social Service Occupations](#) (2010 SOC Code 21-0000 - see separate listing); [Legal Occupations](#) (2010 SOC Code 23-0000 - see separate listing); [Education, Training, and Library Occupations](#) (2010 SOC Code 25-0000 - see separate listing); [Arts, Design, Entertainment, Sports, and Media Occupations](#) (2010 SOC Code 27-0000 - see separate listing); and [Healthcare](#)

Practitioners and Technical Occupations (2010 SOC Code 29-0000 - see separate listing)

Management Occupations SOC Major Group [2010 SOC Code 11-0000] – includes Top Executives (11-1000); Advertising, Marketing, Promotions, Public Relations, and Sales Managers (11-2000); Operations Specialties Managers (11-3000); and Other Management Occupations (11-9000) (see <http://www.bls.gov/soc/2010/soc110000.htm>)

Management of Companies and Enterprises industry sector [2012 NAICS Code 55] – The Management of Companies and Enterprises sector comprises (1) establishments that hold the securities of (or other equity interests in) companies and enterprises for the purpose of owning a controlling interest or influencing management decisions or (2) establishments (except government establishments) that administer, oversee, and manage establishments of the company or enterprise and that normally undertake the strategic or organizational planning and decision making role of the company or enterprise. Establishments that administer, oversee, and manage may hold the securities of the company or enterprise. (see <https://www.naics.com/naics-code-description/?code=55>)

Manufacturing industry sector [2012 NAICS Codes 31–33] – The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. (see <https://www.naics.com/naics-code-description/?code=31>)

Map the Meal Gap – Feeding America undertook the Map the Meal Gap project to learn more about hunger at the local community level. By understanding the population in need, communities can better identify strategies for reaching the people who most need food assistance. (see <http://map.feedingamerica.org/county/2014/overall>)

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 econometric models.

Master Settlement Agreement – The Master Settlement Agreement (MSA) is an accord reached in November 1998 between the state Attorneys General of forty-six states, five U.S. territories, the District of Columbia and the five largest tobacco companies in America concerning the advertising, marketing and promotion of tobacco products. In addition to requiring the tobacco industry to pay the settling states approximately \$10 billion annually for the indefinite future, the MSA also set standards for, and imposed restrictions on, the sale and marketing of cigarettes by participating cigarette manufacturers. (see <http://publichealthlawcenter.org/topics/tobacco-control/tobacco-control-litigation/master-settlement-agreement>)

Maternal and Child Health Bureau – A Bureau within the Utah Department of Health that provides public health leadership and consultation for improving the health of

mothers, infants, children and adolescents in the state. (see <http://health.utah.gov/mch/>)

methicillin-resistant *Staphylococcus aureus* (MRSA) – infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections

Mining, Quarrying, and Oil and Gas Extraction industry sector [2012 NAICS Code 21] – The Mining, Quarrying, and Oil and Gas Extraction sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations, beneficiating (e.g., crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity. (see <https://www.naics.com/naics-code-description/?code=21>)

moderate-intensity – requires a moderate amount of effort and noticeably accelerates the heart rate (also see listing for [vigorous-intensity](#))

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

naloxone – Naloxone is 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 [H.B. 119](#)

National Ambient Air Quality Standards – The Clean Air Act, which was last amended in 1990, requires EPA to set National Ambient Air Quality Standards (NAAQS) for pollutants that are common in outdoor air, considered harmful to public health and the environment, and that come from numerous and diverse sources. (see <https://www3.epa.gov/ttn/naaqs/>)

National and State Healthcare-associated Infections (HAI) Progress Report – The *National and State Healthcare-Associated Infections Progress Report* expands upon and provides an update to previous reports detailing progress toward the ultimate goal of eliminating HAIs. The HAI Progress Report consists of national and state-by-state summaries of healthcare-associated infections. (see <http://www.cdc.gov/hai/surveillance/progress-report/>)

National Immunization Survey (NIS) – The NIS is a large, on-going survey of immunization coverage among U.S. pre-school children (19 through 35 months old). (see <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html>)

National Institute for Occupational Safety and Health – The Occupational Safety and Health Act of 1970 established NIOSH. NIOSH is part of the U.S. Centers for Disease Control and Prevention, in the U.S. Department of Health

and Human Services. It has the mandate to assure “every man and woman in the Nation safe and healthful working conditions and to preserve our human resources.” (see <https://www.cdc.gov/niosh/about/default.html>)

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 Job Training Program – The National Job Training Program (NJTP) is an educational program for socioeconomically disadvantaged youth aged 16–24 years and is administered at more than 100 sites throughout the country.

National Survey of Children's Health – The National Survey of Children's Health (NSCH) was conducted three times between 2003 and 2012. It provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to quality health care, and the child's family, neighborhood, school, and social context. (see <http://childhealthdata.org/learn/NSCH>)

National Survey on Drug Use and Health – 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>)

Natural Resources, Construction, and Maintenance Occupations – 2010 SOC Codes 45-0000–49-0000; combines Farming, Fishing, and Forestry Occupations (2010 SOC Code 45-0000 - see separate listing) with Construction and Extraction Occupations (2010 SOC Code 47-0000 - see separate listing)

neonatal – of, relating to, or affecting the newborn and especially the human infant during the first month after birth

nitrate(s) – a chemical compound that contains oxygen and nitrogen and that is used in fertilizer

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

nonattainment areas – Areas of the country where air pollution levels persistently exceed the National Ambient Air Quality Standards (NAAQS) may be designated "nonattainment."

North American Industry Classification System – The North American Industry Classification System (NAICS, pronounced Nakes) was developed as the standard for use by Federal statistical agencies in classifying business establishments for the collection, analysis, and publication of statistical data related to the business economy of the U.S. (see <https://www.naics.com/frequently-asked-questions/>)

notifiable disease – A notifiable disease is any disease that is required by law to be reported to government authorities.

occupation – Occupation describes the kind of work the person does on the job. Occupation statistics are compiled from data that are coded based on the Standard Occupational Classification (SOC - see separate listing) Manual: 2010. (see <http://www.bls.gov/soc>)

Office and Administrative Support Occupations SOC Major Group [2010 SOC Code 43-0000] – includes Supervisors of Office and Administrative Support Workers (43-1000); Communications Equipment Operators (43-2000); Financial Clerks (43-3000); Information and Record Clerks (43-4000); Material Recording, Scheduling, Dispatching, and Distributing Workers (43-5000); Secretaries and Administrative Assistants (43-6000); and Other Office and Administrative Support Workers (43-9000) (see <http://www.bls.gov/soc/2010/soc430000.htm>)

Office of Disease Prevention and Health Promotion – An office of the U.S. Department of Health and Human Services, the Office of Disease Prevention and Health Promotion (ODPHP) sets national health goals and objectives and supports programs, services, and education activities that improve the health of all Americans. (see <https://health.gov/about-us/>)

[UDOH] Office of Primary Care and Rural Health – An office of the Utah Department of Health, the Office of Primary Care and Rural Health is a health resource for rural, multicultural, and underserved communities in Utah. (see <http://health.utah.gov/primarycare/>)

Office of the Medical Examiner – The Office of the Medical Examiner, State of Utah, 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>)

[Utah] Office of Vital Records and Statistics – The 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, health care providers, businesses, researchers, educational institutions and the Utah public for data and statistical information. (see <https://health.utah.gov/vitalrecords/About.html>)

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.

[Utah] Oral Health Program – The Utah Oral Health Program promotes oral health education and prevention, increases community awareness of the oral health needs in the state, and improves access to oral health care services. (see <http://health.utah.gov/oralhealth/aboutus.php>)

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/>)

Other Services, Except Public Administration industry sector [2012 NAICS Code 81] – The Other Services (except Public Administration) sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. (see <https://www.naics.com/naics-code-description/?code=81>)

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://www.whitehouse.gov/omb/fedreg_1997standards)

person-years – the product of the number of years times the number of members of a population who have been affected by a certain condition

Personal Care and Service Occupations SOC Major Group [2010 SOC Code 39-0000] – includes Supervisors of Personal Care and Service Workers (39-1000); Animal Care and Service Workers (39-2000); Entertainment Attendants and Related Workers (39-3000); Funeral Service Workers (39-4000); Personal Appearance Workers (39-5000); Baggage Porters, Bellhops, and Concierges (39-6000); Tour and Travel Guides (39-7000); and Other Personal Care and Service Workers (39-9000) (see <http://www.bls.gov/soc/2010/soc390000.htm>)

pervasive developmental disorder – The diagnostic category of pervasive developmental disorders (PDD) refers to a group of disorders characterized by delays in the development of socialization and communication skills.

Pregnancy Risk Assessment Monitoring System – PRAMS, the Pregnancy Risk Assessment Monitoring System, is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. Developed in 1987, PRAMS collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. (see <https://www.cdc.gov/prams/>)

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>)

Prevention, Treatment and Care Program (PTCP) – The Prevention, Treatment and Care Program (PTCP) supports CDC's Program Collaboration and Service Integration (PCSI) initiative and is an integrative program that incorporates HIV prevention, HIV surveillance, Ryan White Part B, refugee health, TB control, STD prevention, and viral hepatitis. The PTCP collaborates with Utah's local health departments (LHDs) and many community-based organizations and agencies to provide STD, HIV, TB, and refugee health services.

Primary Care Network – The Primary Care Network (PCN) is a health plan offered by the Utah Department of Health. It covers services administered by a primary care provider. (see <http://www.health.utah.gov/pcn/whatis.html>)

Production Occupations SOC Major Group [2010 SOC Code 51-0000] – includes Supervisors of Production Workers (51-1000); Assemblers and Fabricators (51-2000); Food Processing Workers (51-3000); Metal Workers and Plastic Workers (51-4000); Printing Workers (51-5100); Textile, Apparel, and Furnishings Workers (51-6000); Woodworkers (51-7000); Plant and System Operators (51-8000); and Other Production Occupations (51-9000) (see <http://www.bls.gov/soc/2010/soc510000.htm>)

Production, Transportation, and Material Moving Occupations – 2010 SOC Codes 51-0000–53-0000; combines Production Occupations (2010 SOC Code 51-0000 - see separate listing) with Transportation and Material Moving Occupations (2010 SOC Code 53-0000 - see separate listing)

Professional and Business Services industry – 2012 NAICS Codes 54–56; NAICS aggregation that is unique to the Bureau of Labor Statistics combining Professional, Scientific, and Technical Services (2012 NAICS Code 54 - see separate listing) with Management of Companies and Enterprises (2012 NAICS Code 55 - see separate listing) and Administrative and Support and Waste Management and Remediation Services (2012 NAICS Code 56 - see separate listing)

Professional, Scientific, and Technical Services industry sector [2012 NAICS Code 54] – The Professional, Scientific, and Technical Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. Activities performed include: legal advice and representation; accounting, bookkeeping, and payroll services; architectural, engineering, and specialized design services; computer services; consulting services; research services; advertising services; photographic services; translation and interpretation services; veterinary services; and other professional, scientific, and technical services. (see <https://www.naics.com/naics-code-description/?code=54>)

Professional, Scientific, Management, Administrative, and Waste Management Services industry – 2012 NAICS Codes 54–56; combines Professional, Scientific, and Technical Services (2012 NAICS Code 54 - see separate listing) with Management of Companies and Enterprises (2012 NAICS Code 55 - see separate listing) and Administrative and

Support and Waste Management and Remediation Services (2012 NAICS Code 56 - see separate listing)

Protective Service Occupations SOC Major Group [2010 SOC Code 33-0000] – includes Supervisors of Protective Service Workers (33-1000); Fire Fighting and Prevention Workers (33-2000); Law Enforcement Workers (33-3000); and Other Protective Service Workers (33-9000) (see <http://www.bls.gov/soc/2010/soc330000.htm>)

Public Administration industry sector [2012 NAICS Code 92] – The Public Administration sector consists of establishments of federal, state, and local government agencies that administer, oversee, and manage public programs and have executive, legislative, or judicial authority over other institutions within a given area. (see <https://www.naics.com/naics-code-description/?code=92>)

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)

raking – see listing for iterative proportional fitting

rational service areas – a description and rationale for the boundaries of the proposed designation

Real Estate and Rental and Leasing industry sector [2012 NAICS Code 53] – The Real Estate and Rental and Leasing sector comprises establishments primarily engaged in renting, leasing, or otherwise allowing the use of tangible or intangible assets, and establishments providing related services. (see <https://www.naics.com/naics-code-description/?code=53>)

Retail Trade industry sector [2012 NAICS Codes 44–45] – The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. (see <https://www.naics.com/naics-code-description/?code=44>)

rheumatoid arthritis – Rheumatoid arthritis is a chronic (long-term) disease that causes pain, stiffness, swelling and limited motion and function of many joints.

[S.B. 214] 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 deter-

mining 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>)

Sales and Office Occupations – 2010 SOC Codes 41-0000–43-0000; combines Sales and Related Occupations (2010 SOC Code 41-0000 - see separate listing) with Office and Administrative Support Occupations (2010 SOC Code 43-0000 - see separate listing)

Sales and Related Occupations SOC Major Group [2010 SOC Code 41-0000] – includes Supervisors of Sales Workers (41-1000); Retail Sales Workers (41-2000); Sales Representatives, Services (41-3000); Sales Representatives, Wholesale and Manufacturing (41-4000); and Other Sales and Related Workers (41-9000) (see <http://www.bls.gov/soc/2010/soc410000.htm>)

Salmonella – *Salmonella* is a bacteria that makes people sick. Most people infected with *Salmonella* develop diarrhea, fever, and abdominal cramps between 12 and 72 hours after infection. The illness usually lasts 4 to 7 days, and most individuals recover without treatment. (see <https://www.cdc.gov/salmonella/general/index.html>)

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>)

serotype – Serotypes are groups within a single species of microorganisms, such as bacteria or viruses, which share distinctive surface structures. (see <http://www.cdc.gov/salmonella/reportspubs/salmonella-atlas/serotyping-importance.html>)

Service Occupations – 2010 SOC Codes 31-0000–39-0000; combines Healthcare Support Occupations (2010 SOC Code 31-0000 - see separate listing) with Protective Service Occupations (2010 SOC Code 33-0000 - see separate listing); Food Preparation and Serving Related Occupations (2010 SOC Code 35-0000 - see separate listing); and Personal Care and Service Occupations (2010 SOC Code 39-0000 - see separate listing)

sleep apnea – Sleep apnea is 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 – The social determinants of health (SDH) are 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/)

socio-economic status – Socio-economic status is commonly conceptualized as the social standing or class of an individual or group. It is often measured as a combination of education, income and occupation.

Standard Occupational Classification [SOC] – The 2010 Standard Occupational Classification (SOC) system is used by Federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. (see <http://www.bls.gov/soc/>)

standardized infection ratio – The Standardized Infection Ratio (SIR) is a statistic used to track healthcare associated infections (HAIs) over time, at a national, state, or facility level. The SIR compares the actual number of HAIs at each hospital, to the predicted number of infections. The predicted number is an estimate based on national baseline data, and it is risk adjusted. Risk adjustment takes into account that some hospitals treat sicker patients than others.

Staphylococcus aureus bacteremia – Bacteremia caused by *Staphylococcus aureus* is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes.

State Health Access Data Assistance Center (SHADAC) – Affiliated with the University of Minnesota School of Public Health, SHADAC is a multidisciplinary health policy research center with a focus on state policy. (see <http://www.shadac.org/about-us>)

Substance Abuse and Mental Health Services Administration – The Substance Abuse and Mental Health Services Administration (SAMHSA) is 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>)

Suicide Prevention Coalition – The Utah Suicide Prevention Coalition is 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/>)

sulfate(s) – a salt that is formed when sulfuric acid reacts with another chemical element

Supplemental Nutrition Assistance Program (SNAP) – SNAP offers nutrition assistance to millions of eligible,

low-income individuals and families and provides economic benefits to communities. (see <http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap>)

surgical site infections – A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place.

targeted case manager – Targeted Case Management (TCM) refers to case management for specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas.

Temporary Assistance for Needy Families – The Temporary Assistance for Needy Families (TANF) program is designed to help needy families achieve self-sufficiency. States receive block grants to design and operate programs that accomplish one of the purposes of the TANF program. (see <http://www.acf.hhs.gov/ofa/programs/tanf>)

Title V – The Title V Maternal and Child Health Block Grant Program aims to improve the health and well-being of women (particularly mothers) and children. (see <http://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program>)

[Utah] Tobacco Prevention and Control Program – The Tobacco Prevention and Control Program (TPCP) at the Utah Department of Health and its partners, use comprehensive strategies to reduce tobacco use and tobacco-related disease and death. (see <http://www.tobaccofreeutah.org/>)

[Utah] Tobacco Quit Line – a program that refers to quit-smoking services at a person's health plan or to a quit coach at the Quit Line (see <http://www.tobaccofreeutah.org/quitline.html>)

TOP Star Program – TOP Star (Targeting Obesity in Preschools and Child Care Settings) is a program developed by the Utah Department of Health, local health departments, and other partners to help prevent obesity among children in childcare. The goal of TOP Star is to help childcare providers improve their nutrition and physical activity environments. (see <http://choosehealth.utah.gov/prek-12/childcare/top-star-program.php>)

Transportation and Material Moving Occupations SOC Major Group [2010 SOC Code 53-0000] – includes Supervisors of Transportation and Material Moving Workers (53-1000); Air Transportation Workers (53-2000); Motor Vehicle Operators (53-3000); Rail Transportation Workers (53-4000); Water Transportation Workers (53-5000); Other Transportation Workers (53-6000); and Material Moving Workers (53-7000) (see <http://www.bls.gov/soc/2010/soc530000.htm>)

Transportation and Utilities industry – 2012 NAICS Codes 48–49 and 22; NAICS aggregation that is unique to the Bureau of Labor Statistics combining [Transportation and Warehousing](#) (2012 NAICS Code 48–49 - see separate listing) with [Utilities](#) (2012 NAICS Code 22 - see separate listing)

Transportation and Warehousing industry sector [2012 NAICS Code 48–49] – The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. (see <https://www.naics.com/naics-code-description/?code=48>)

Transportation, Warehousing, and Utilities industry – 2012 NAICS Codes 48–49 and 22; combines [Transportation and Warehousing](#) (2012 NAICS Code 48–49 - see separate listing) with [Utilities](#) (2012 NAICS Code 22 - see separate listing)

treat and release – a patient that visits the ED, but is not admitted to the hospital as an inpatient; the patient does not stay overnight and is not admitted to another department of the hospital

Tribal Epidemiology Centers – Tribal Epidemiology Centers are 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/index.cfm?module=epi_tec_main)

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](#)

U.S. Current Population Survey – see listing for [Current Population Survey](#)

U.S. Department of Health and Human Services Health Resources and Services Administration – The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce and innovative programs. (see <http://www.hrsa.gov/about/index.html>)

U.S. Department of Labor – The Department of Labor administers a variety of federal labor laws to guarantee workers' rights to fair, safe, and healthy working conditions, including minimum hourly wage and overtime pay, protection against employment discrimination, and unemployment insurance. (see <https://www.dol.gov/>)

U.S. EPA Air Quality System – The Air Quality System (AQS) contains ambient air pollution data collected by EPA, state, local, and tribal air pollution control agencies from over thousands of monitors. AQS also contains meteorological data, descriptive information about each monitoring station (including its geographic location and its operator), and data quality assurance/quality control information. (see <https://www.epa.gov/aqs>)

United Health Foundation – a partnership dedicated to investing in a workforce to meet the health needs of the future and supporting initiatives that improve health quality and outcomes (see <http://www.unitedhealthfoundation.org/>)

United States Department of Agriculture (USDA) – a cabinet-level agency that oversees the American farming industry. USDA duties range from helping farmers with price support subsidies, to inspecting food to ensure the safety of the American public. (see <http://www.usda.gov>)

Utah Arthritis Program – The Utah Arthritis Program, in the Utah Department of Health, was created in 1999 to improve the quality of life for people affected by arthritis. The program receives money from the Centers for Disease Control and Prevention (CDC) and the Administration on Aging (AoA) to track how many Utahns have arthritis, provide arthritis education and increase participation in programs proven to help people with arthritis. (see <http://health.utah.gov/arthritis/aboutus.html>)

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 Asthma Program – The Utah Asthma Program (UAP) is located at the Utah Department of Health in the Bureau of Health Promotion. UAP is funded through the Centers for Disease Control and Prevention (CDC). The UAP's work plan focuses on three types of strategies to achieve this goal: infrastructure strategies to support leadership, strategic partnerships, strategic communications, surveillance, and evaluation; services strategies to expand school- and home-based services; and health systems strategies to improve coverage, delivery, quality, and use of clinical services. (see <http://health.utah.gov/asthma/aboutus.html>)

Utah Asthma Task Force – The Utah Asthma Task Force was formed in 2001. It is comprised of health professionals, educators, and community members that collaborate to improve asthma care and management in Utah. (see <http://health.utah.gov/asthma/Partners/ATF.html>)

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 ad-

dress the growing problem of prescription drug abuse in Utah. UCOOP includes private-public multidisciplinary partnerships involving more than 60 experts in the fields of substance abuse prevention and treatment, law enforcement, environmental quality, health care, human services and public health. 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 Communicable Disease Rule R386-702-3 – Reportable Diseases, Emergency Illnesses, and Health Conditions. (see <http://www.rules.utah.gov/publicat/code/r386/r386-702.htm#T3>)

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 Council for Worksite Health Promotion – The Healthy Worksite Awards Program recognizes the outstanding achievements of businesses in implementing worksite health promotion programs, including on-site policies and work environments that support healthy lifestyles. The Utah Council for Worksite Health Promotion (UCWHP), formerly the Governor's Council on Health and Fitness, administers the awards. (see http://www.health.utah.gov/ahy/Worksite/Worksite_home.htm)

Utah Death Certificate Database – Death Certificates are filled out for all deaths occurring in Utah.

Utah Department of Agriculture and Food – The Department of Agriculture and Food is responsible for the administration of Utah's agricultural laws, which mandate a wide variety of activities including inspection, regulation, information, rulemaking, loan issuance, marketing and development, pest and disease control, improving the economic position of agriculture, and consumer protection. (see <http://ag.utah.gov/about-udaf/our-responsibilities.html>)

Utah Department of Environmental Quality – DEQ's mission is to safeguard public health and Utahns' quality of life by protecting and enhancing the environment. (see http://www.deq.utah.gov/Admin/About_DEQ/index.htm)

Utah Department of Health Strategic Plan: Healthiest People goals – The first goal of the Utah Department of Health Strategic Plan is "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 3 of the Utah Department of Health Strategic Plan 2013–2016, http://health.utah.gov/about/documents/StrategicPlan_2014.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 Public Safety – Utah Department of Public Safety is a law enforcement agency in the State of Utah. The Department of Public Safety's mission is to provide a safe and secure environment for all people in Utah. (see <http://publicsafety.utah.gov/>)

Utah Department of Transportation (UDOT) – UDOT is the 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/main/f?p=100:pg:0:::1:T,V:33.>)

Utah Department of Workforce Services – The Utah Department of Workforce Services supports Governor Herbert's vision to strengthen Utah's economy by supporting the economic stability and quality of the workforce. The Department provides quality and streamlined services that connect a world-class workforce with employment. (see <http://jobs.utah.gov/department/about-dws.html>)

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

Utah Healthcare Infections Prevention Governance Committee – a multi-disciplinary panel of state leaders in patient safety, infectious diseases, and infection control. Membership is comprised from a broad base of care delivery groups across the State, and it is organized and staffed by the Utah Department of Health. (see http://health.utah.gov/epi/diseases/HAI/gov_committee/)

Utah Immunization Program – The mission of the Utah Department of Health Immunization Program is to improve the health of Utah's citizens through vaccinations to reduce illness, disability, and death from vaccine-preventable infections. (see http://www.immunize-utah.org/about_us.html)

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/pdfs/Bylaws%20FINAL%202013%20sigs.pdf>)

Utah Medicaid Member Guide – The Medicaid Member Guide is for people who are on Utah Medicaid. This book helps to explain Medicaid benefits, co-pays and co-insurance, rights and responsibilities, health and dental health plans, how to choose a plan, well child examinations and follow-up care, and immunizations. (see https://health.utah.gov/umb/forms/pdf/Medicaid_Member_Guide.pdf)

Utah Million Hearts Coalition – The Utah Million Hearts Coalition, in conjunction with the national Million Hearts initiative, aims to prevent heart attacks and strokes by improving clinical blood pressure measurement in Utah through accurate blood pressure measurement and control. (see <http://choosehealth.utah.gov/healthcare/million-hearts.php>)

Utah Native Legislative Liaison Committee – The Committee serves as a liaison between Utah Native American tribes and the Legislature and recommends legislation for each annual general session if modifications are in order. The Committee is responsible for balancing the best interests of the state of Utah and of the Utah Native American tribes when creating legislation. The Committee is also responsible for reviewing the operations of the Division of Indian Affairs and other state agencies working with Utah Native American tribes. (see <https://heritage.utah.gov/utah-indian-affairs/native-american-legislative-liaison-committee>)

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

Utah Occupational Safety and Health Division – The Utah Occupational Safety and Health Division, also known as UOSH is committed to accomplish its mission to achieve compliance and provide assistance with safety and health in Utah workplaces. UOSH has the legislative intent to implement, establish, and enforce occupational safety and health standards to ensure the safety and health of workers in the state of Utah. (see <http://www.laborcommission.utah.gov/divisions/UOSH/aboutUOSH.html>)

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 (CHIP).

Utah Violent Death Reporting System – The Utah Violent Death Reporting System (UTVDRS) is 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 Premium Partnership for Health Insurance – UPP (Utah's Premium Partnership for Health Insurance) helps make health insurance more affordable for families and individuals. UPP (pronounced 'up') helps persons pay their monthly health insurance premiums through their employer's health insurance plan or COBRA coverage. (see <http://health.utah.gov/upp/>)

Utah State Office of Education – The Utah State Office of Education, or USOE, is 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 Statewide Immunization Information System (USIIS) – USIIS is a secure, confidential immunization information system that helps healthcare providers, schools, child care centers and Utah residents maintain consolidated immunization histories. (see <http://www.usiis.org/index.shtml>)

Utilities industry sector [2012 NAICS Code 22] – The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal. (see <https://www.naics.com/naics-code-description/?code=22>)

varicella – a highly infectious viral disease, known familiarly as Chickenpox

vigorous-intensity – requires a large amount of effort and causes rapid breathing and a substantial increase in heart rate (also see listing for [moderate-intensity](#))

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://www.whitehouse.gov/omb/fedreg_1997standards)

Wholesale and Retail Trade industry – 2012 NAICS Codes 42 and 44–45; NAICS aggregation that is unique to the Bureau of Labor Statistics combining [Wholesale Trade](#) (2012 NAICS Code 42 - see separate listing) with [Retail Trade](#) (2012 NAICS Code 44–45 - see separate listing)

Wholesale Trade industry sector [2012 NAICS Code 42] – The Wholesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The merchandise described in this sector includes the outputs of agriculture, mining, manufacturing,

and certain information industries, such as publishing. (see <https://www.naics.com/naics-code-description/?code=42>)

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. 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 Fatalities – Zero Fatalities is a mutual effort from various states addressing the top behaviors that are killing people on America's roads. The focus varies by state, but include behaviors such as drowsy driving, distracted driving, aggressive driving, impaired driving, and not buckling up. (see <http://ut.zerofatalities.com/>)

Healthy People 2020 Objectives Referenced in Report

Access to Health Services

AHS-1.1 – Increase the proportion of persons with medical insurance

AHS-3 – Increase the proportion of persons with a usual primary care provider

AHS-6.2 – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care

Diabetes

D-1 – Reduce the annual number of new cases of diagnosed diabetes in the population

Environmental Health

EH-1 – Reduce the number of days the Air Quality Index (AQI) exceeds 100, weighted by population and AQI

EH-13 through E-19 – Healthy Homes and Healthy Communities

EH-13 – Reduce indoor allergen levels

EH-14 – Increase the proportion of homes with an operating radon mitigation system for persons living in homes at risk for radon exposure

EH-15 – Increase the proportion of new single-family homes (SFH) constructed with radon-reducing features, especially in high-radon-potential areas

EH-16 – Increase the proportion of the Nation's elementary, middle, and high schools that have official school policies and engage in practices that promote a healthy and safe physical school environment

EH-17 – (Developmental) Increase the proportion of persons living in pre-1978 housing that has been tested for the presence of lead-based paint or related hazards

EH-18 – Reduce the number of U.S. homes that are found to have lead-based paint or related hazards

EH-19 – Reduce the proportion of occupied housing units that have moderate or severe physical problems

Family Planning

FP-1 – Increase the proportion of pregnancies that are intended

Food Safety

FS-1.4 – Reduce infections caused by *Salmonella* species transmitted commonly through food

Healthcare-Associated Infections

HAI-1 – Reduce central line-associated bloodstream infections (CLABSIs)

HAI-2 – Reduce invasive healthcare-associated methicillin-resistant *Staphylococcus aureus* (MRSA) infections

Heart Disease and Stroke

HDS-5.1 – Reduce the proportion of adults with hypertension

Immunization and Infectious Diseases

IID-1.6 – Reduce cases of pertussis among children under 1 year of age

IID-1.7 – Reduce cases of pertussis among adolescents aged 11 to 18 years

IID-7 – Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children

IID-7.1 – Maintain an effective vaccination coverage level of 4 doses of the diphtheria-tetanus-acellular pertussis (DTaP) vaccine among children by age 19 to 35 months

IID-7.2 – Achieve and maintain an effective vaccination coverage level of 3 or 4 doses of *Haemophilus influenzae* type b (Hib) vaccine among children by age 19 to 35 months

IID-7.3 – Maintain an effective vaccination coverage level of 3 doses of hepatitis B (hep B) vaccine among children by age 19 to 35 months

IID-7.4 – Maintain an effective coverage level of 1 dose of measles-mumps-rubella (MMR) vaccine among children by age 19 to 35 months

IID-7.5 – Maintain an effective coverage level of 3 doses of polio vaccine among children by age 19 to 35 months

IID-7.6 – Maintain an effective coverage level of 1 dose of varicella vaccine among children by age 19 to 35 months

Injury and Violence Prevention

IVP-11 – Reduce unintended injury deaths

IVP-21 – Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders

Maternal, Infant, and Child Health

MICH-29 – Increase the proportion of young children with autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in special services in a timely manner

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

Occupational Safety and Health

OSH-1.1 – Reduce deaths from work-related injuries in all industries

Oral Health

OH-7 – Increase the proportion of children, adolescents, and adults who used the oral healthcare system in the past year

Physical Activity

PA-2.1 – Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination

PA-3.1 – Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity

Respiratory Diseases

RD-3 – Reduce emergency department (ED) visits for asthma

RD-3.1 – Reduce emergency department (ED) visits for asthma among children under age 5 years

RD-3.2 – Reduce emergency department (ED) visits for asthma among children and adults aged 5 to 64 years

RD-3.3 – Reduce emergency department (ED) visits for asthma among adults aged 65 years and older

Sexually Transmitted Diseases

STD-1 – Reduce the proportion of adolescents and young adults with *Chlamydia trachomatis* infections

STD-1.1 – Reduce the proportion of females aged 15 to 24 years with *Chlamydia trachomatis* infections attending family planning clinics

STD-1.2 – Reduce the proportion of females aged 24 years and under with *Chlamydia trachomatis* infections enrolled in a National Job Training Program

STD-1.3 – Reduce the proportion of males aged 24 years and under enrolled in a National Job Training Program with *Chlamydia trachomatis* infections

Social Determinants of Health

SDOH-3.1 – Proportion of persons living in poverty

SDOH-3.2 – Proportion of children aged 0–17 years living in poverty

SDOH-4 – Proportion of households that experience housing cost burden

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

Tobacco Use

TU-1.1 – Reduce cigarette smoking by adults

TU-2.2 – Reduce use of cigarettes by adolescents (past month)

Social Determinants of Health

Persons Living in Poverty

Utah Department of Workforce Services
P.O. Box 45249
Salt Lake City, UT 84145-0249
Phone: (801) 526-WORK (9675)
Fax: (801) 526-9211
Email: dwscontactus@utah.gov
<http://jobs.utah.gov/>

Community Action Partnership of Utah
<http://caputah.org/index.php>

Child Poverty

For information on the Medicaid program:
In the Salt Lake City area, call 801-538-6155.
In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free 1-800-662-9651.
In other states, call 1-801-538-6155.
Medicaid Customer Service staff are available to take inquiries.
Or visit the Utah Medicaid website:
<http://www.health.utah.gov/medicaid/>

For information on CHIP and the PCN:
Call the Health Resource Line: 1-888-222-2542
Or visit their websites:
CHIP: Children's Health Insurance Program (for children 0–18)—<http://www.health.state.ut.us/chip>
PCN: Utah Primary Care Network (for low-income adults)—<http://www.health.utah.gov/pcn/>

Voices for Utah Children is a private, not-for-profit organization that advocates for children. Information about their activities may be found on their website—<http://www.utahchildren.org>.

Food Insecurity

Utah Food Bank
<https://www.utahfoodbank.org/>

Utahns Against Hunger
<http://www.uah.org/>

Environmental Health

Air Quality

The Air Quality and Public Health in Utah web page (<http://www.health.utah.gov/utahair/>) provides a wide range of air quality-related topics. These topics include:

- [Air Quality Index](#)
- [Information about specific air pollutants](#)
- Health effects from air pollution
 - Adverse birth outcomes
 - Asthma
 - Chronic obstructive pulmonary disease
 - Heart disease and heart attacks

Air Quality and Public Health in Utah

This website provides information on particulate matter, its sources, ways to reduce exposure, and trend data.
<http://www.health.utah.gov/utahair/pollutants/PM/>

AirNow

This U.S. Government website provides information on air quality from a collaboration of different agencies.
<http://www.airnow.gov>

Substandard Housing

U.S. Department of Housing and Urban Development
<http://portal.hud.gov/hudportal/HUD?src=/states/utah>

Choose Clean Air Utah

This Utah Department of Environmental Quality website provides information about air pollution in Utah and information on how to make healthy choices.
<http://www.cleanair.utah.gov>

Environmental Protection Agency (EPA)

This EPA web page provides information about particulate matter (PM), adverse health effects, research, and regulations.
<http://www.epa.gov/pm>

Centers for Disease Control and Prevention (CDC)

These CDC websites provide information about specific air pollutants and the way it can harm human health.

- Air Pollution and Respiratory Health (<http://www.cdc.gov/nceh/airpollution/>)
- Air Pollutants (<http://www.cdc.gov/air/pollutants.htm>)
- Air Quality (<http://www.cdc.gov/air/>)

Utah Housing Coalition
<http://www.utahhousing.org/>

Occupational Fatalities

Utah Labor Commission
<http://laborcommission.utah.gov/divisions/UOSH/bls.html>

WCF Insurance
<https://www.wcf.com/>

Respiratory Conditions

Uncontrolled Asthma

Individual programs in the Bureau of Health Promotion at the Utah Department of Health provide information and education to citizens, physicians, and healthcare providers on chronic conditions. For instance, users can find helpful information on disease management and prevention at the Utah Asthma Program website: <http://www.health.utah.gov/asthma/>.

Community Resources

Asthma and Allergy Foundation of America
<http://www.aafa.org>

American Lung Association in Utah
<http://www.lungusa.org/utah>

Asthma and outdoor air pollution
<http://www.epa.gov/airnow/asthma-flyer.pdf>

Cardiovascular Conditions

High Blood Pressure

The Utah Department of Health's Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program works with healthcare organizations and other partners to improve the accuracy of blood pressure measurement and to improve medication adherence for people with high blood pressure.

In 2012, the Utah Department of Health published a statistical report titled The Impact of Heart Disease and Stroke in Utah. This report describes overall patterns in cardiovascular disease and risk factors at the state and national levels and among Utah sub-populations (age group, sex, race, ethnicity, and Utah Small Area).

To download the full report, visit http://www.choosehealth.utah.gov/documents/pdfs/reports/HD_Stroke_Burden_Report2012.pdf.

Heart disease and stroke are the first and fourth leading causes of death in the United States. Heart disease is responsible for 1 of every 3 deaths in the country. Million Hearts is a national initiative that has set an ambitious

goal to prevention 1 million heart attacks and strokes by 2017. The impact will be even greater over time.

Million Hearts aims to prevent heart disease and stroke by:

- Improving access to effective care.
- Improving the quality of care for the ABCS (appropriate aspirin prescription, blood pressure control, cholesterol control, and smoking cessation).
- Focusing clinical attention on the prevention of heart attack and stroke.
- Activating the public to lead a heart-healthy lifestyle.
- Improving the prescription and adherence to appropriate medications for the ABCS.

For information about the Million Hearts initiative, visit <http://www.millionhearts.hhs.gov>.

CDC's Blood Pressure website:
<http://www.cdc.gov/bloodpressure/>

American Heart Association
<http://www.heart.org/HEARTORG/>

Diabetes Conditions

Diabetes Prevalence

The American Diabetes Association (ADA) is a resource for all types of information on diabetes. Call 1-800-DIABETES or visit the website at <http://www.diabetes.org>. The ADA site also has a list of diabetes screening locations locally.

The National Diabetes Education Program (<http://www.yourdiabetesinfo.org>) has resources for diabetes management for professionals, businesses,

and patients. Most materials are available upon request at no charge.

The Utah Health Resource Line can provide information about enrolling in diabetes self-management classes. Call 1-888-222-2542 for more information.

Packets of information about diabetes, including a brochure describing A1C exams, are available at no charge from the Utah Department of Health by calling the Resource Line, 1-888-222-2542.

American Diabetes Association

<http://www.diabetes.org>

Diabetes Prevention Program

National Diabetes Information Clearinghouse

<http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram>

Division of Diabetes Translation, Centers for Disease Control and Prevention

<http://www.cdc.gov/diabetes>

American Association of Diabetes Educators

<http://www.diabeteseducator.org>

Obesity/Physical Activity

Obesity—Adults

The Utah Department of Health has established a program, Healthy Living through Environment, Policy and Improved Clinical Care (EPICC). The EPICC website has information on obesity prevention at <http://www.choosehealth.utah.gov>.

Utah Worksite Wellness Council is a non-profit organization made up of volunteers from organizations across Utah. Information is available at <http://utahworksitewellness.org>.

Making the Healthy Choice the Easy Choice, The Utah Nutrition and Physical Activity Plan 2010–2020 <http://www.health.utah.gov/obesity>

The National Center for Chronic Disease Prevention and Health Promotion provides consumer information at <http://www.cdc.gov/nccdphp/dnpa/obesity/>

National Heart, Lung, and Blood Institute (NHLBI) Obesity Education Initiative <http://www.nhlbi.nih.gov/about/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 <http://www.surgeongeneral.gov/topics/obesity>

Let's Move, America's Move to Raise a Healthier Generation of Kids <http://www.letsmove.gov>

More information on the Behavioral Risk Factor Surveillance System may be found on the website of the Centers for Disease Control and Prevention—<http://www.cdc.gov/brfss/>.

Obesity—Minor

Gold Medal School Initiative—for more information, call (801) 538-9454.

Action for Healthy Kids Program—for more information, visit <http://www.actionforhealthykids.org/>

Walk to School Day; Safe Routes to School—for more information, call (801) 538-9362.

Utah Department of Health EPICC website <http://choosehealth.utah.gov>

Information for school wellness policies is available at Action for Healthy Kids, <http://www.actionforhealthykids.org>.

Physical Activity—Adult

Visit <http://www.choosehealth.utah.gov> for more information about physical activity.

A Healthy Worksite Award Program—for more information, visit <http://www.health.utah.gov/worksitewellness>.

The Utah Cancer Control Program at the Utah Department of Health is also promoting physical activity by assisting communities to develop and implement bicycle and pedestrian master plans.

National Physical Activity Recommendations: <http://www.health.gov/paguidelines/> <http://www.cdc.gov/physicalactivity/everyone/guidelines/index.html>

CDC's Division of Nutrition, Physical Activity, and Obesity: <http://www.cdc.gov/nccdphp/dnpao>

The National Heart, Lung, and Blood Institute has extensive resources on physical activity for patients, healthcare providers, and general consumers: <http://www.nhlbi.nih.gov>

The CDC's Prevention Research Centers provide resources and information about physical activity to researchers, public health practitioners, and others who are interested in promoting physical activity in their communities: <http://www.cdc.gov/prc/>

More information on the Behavioral Risk Factor Surveillance System may be found on the website of the Centers for Disease Control and Prevention—<http://www.cdc.gov/brfss/>

Physical Activity—Minor

Comprehensive School Physical Activity Programs: A Guide for Schools http://www.cdc.gov/healthyouth/physicalactivity/pdf/13_242620-A_CSPAP_SchoolPhysActivityPrograms_Final_508_12192013.pdf

School Health Guidelines to Promote Healthy Eating and Physical Activity <http://www.cdc.gov/healthyschools/npao/strategies.htm>

Action for Healthy Kids Program—for more information, visit <http://www.actionforhealthykids.org>.

Let's Move initiatives for our youth launched by first lady Michelle Obama:

<http://www.letsmove.gov/>
<http://letsmoveschools.org/>
<http://www.fns.usda.gov/hussc/healthierus-school-challenge>

The Utah Department of Health's obesity website <http://www.choosehealth.utah.gov>

More information on the Youth Risk Behavior Surveillance System may be found on the website of the CDC—
<http://www.cdc.gov/nccdphp/dash/yrbs/index.htm>

Mental Health

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 Division 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 Division 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
<http://www.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 Behavioral Risk Factor Surveillance System may be found on the website of the CDC—<http://www.cdc.gov/brfss/>

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

Utah Psychological Association website has place for provider referrals <http://www.utpsych.org/directory>

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://www.mantherapy.org>

Suicide prevention 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>

Davis County/Layton

Davis Behavioral Health
 24 Hour Crisis Response
 801-773-7060

Ogden

Weber Mental Health
 Serving Morgan & Weber Counties
 Crisis/Suicide Prevention Hotline
 801-625-3700

Orem

Crisis Line of Utah County
 801-226-4433

Provo

Wasatch Mental Health
Crisis Line
801-373-7393

Salt Lake City

Valley Mental Health
Serving Salt Lake, Summit & Tooele Counties
801-261-1442

UDOH Violence and Injury Prevention Program
<http://health.utah.gov/vipp>

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. For more information visit <http://www.health.utah.gov/vipp/topics/nvdrs/>.

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>

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 Division 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 Division 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
<http://www.dsamh.utah.gov>

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

Utah Psychological Association website has place for provider referrals <http://www.utpsych.org/directory>

Addictive Behaviors

Prescription Drug Misuse/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
<http://www.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 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/>

Cigarette Smoking—Adults

The Utah Tobacco Quit Line and Utah's online quitting program offer assistance in quitting tobacco use to Utah adults and teens. For services and information call the Utah Tobacco Quit Line at 1-800-QUIT-NOW or visit Utah's tobacco cessation website at <http://www.waytoquit.org>.

Utah Department of Health, Tobacco Prevention and Control Program website
<http://www.tobaccofreeutah.org>

Tobacco Free Resource Line: 1-877-220-3466

More information on the Behavioral Risk Factor Surveillance System is available at the website of the CDC—<http://www.cdc.gov/brfss/>

More information on changes to the BRFSS methodology can be found at http://health.utah.gov/opha/OPHA_BRFSS.htm.

Cigarette Smoking—Minor

The Utah Tobacco Quit Line offers customized assistance for quitting tobacco use to Utah adults, teens, and Spanish speakers. For services and information call the Utah Tobacco Quit Line at 1-800-QUIT-NOW or visit Utah’s tobacco cessation website at <http://www.waytoquit.org>.

Utah Department of Health, Tobacco Prevention and Control program website: <http://www.tobaccofreeutah.org>

Tobacco Free Resource Line: 1-877-220-3466

More information on the Youth Risk Behavior Surveillance System can be found on the CDC YRBSS website—<http://www.cdc.gov/nccdphp/dash/yrbs/index.htm>.

Binge Drinking

NATIONAL:

The U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) has a toll-free referral helpline at 1-800-662-HELP (4357).

The U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Treatment Facility Locator <http://findtreatment.samhsa.gov/>

National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism <http://www.niaaa.nih.gov>

CDC National Center for Chronic Disease Prevention and Health Promotion, Alcohol and Public Health <http://www.cdc.gov/alcohol/>

UTAH:

Dial 2-1-1 for state and community service information. Code 2-1-1 can now be accessed from anywhere in the state of Utah. 211 Info Bank, a program of Community Services Council, is a free information and referral line for health, human, and community services. 211 provides information and referral on many topics.

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
<http://www.dsamh.utah.gov>

More information on the Behavioral Risk Factor Surveillance System may be found on the website of the CDC—<http://www.cdc.gov/brfss/>

Chronic Drinking

NATIONAL:

The U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) has a toll-free referral helpline at 1-800-662-HELP (4357).

The U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Treatment Facility Locator <http://findtreatment.samhsa.gov/>

National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism <http://www.niaaa.nih.gov>

CDC National Center for Chronic Disease Prevention and Health Promotion, Alcohol and Public Health <http://www.cdc.gov/alcohol/>

UTAH:

Dial 2-1-1 for state and community service information. Code 2-1-1 can now be accessed from anywhere in the state of Utah. 211 Info Bank, a program of Community Services Council, is a free information and referral line for health, human and community services. 211 provides information and referral on many topics.

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
<http://www.dsamh.utah.gov>

More information on the Behavioral Risk Factor Surveillance System may be found on the website of the CDC—<http://www.cdc.gov/brfss/>

Illicit Substance Use/Abuse

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 at 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. DSAMH is only one partner in the Utah Public Mental Health System and oversees the local community mental health centers and the Utah State Hospital.

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
<http://www.dsamh.utah.gov>

Care Access

No Health Insurance

MEDICAID: In the Salt Lake City area, call (801) 538-6155.

In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free 1-800-662-9651.

In other states, call 1-801-538-6155.

Medicaid Customer Service staff are available to take inquiries.

Call the Utah Health Resource Line: 1-888-222-2542 for information on CHIP and the PCN.

CHIP: Children's Health Insurance Program (for children 0-18)

<http://health.utah.gov/chip/>

PCN: Utah Primary Care Network (for low-income adults)

<http://health.utah.gov/pcn/>

UPP: Utah's Premium Partnership for Health Insurance

Phone: 1-888-222-2542

<http://www.health.utah.gov/upp>

Cost as a Barrier to Care

Utah Medicaid Program

1-800-662-9651

<http://www.health.utah.gov/medicaid/>

Utah Department of Health's Primary Care Network

(PCN):

1-888-222-2542

<http://www.health.utah.gov/pcn/>

Utah Children's Health Insurance Program (CHIP):

1-877-KIDS-NOW (1-877-543-7669)

<http://www.health.utah.gov/chip>

UPP (Utah's Premium Partnership for Health Insurance):

1-888-222-2542 (M - F, 8 a.m. - 5 p.m.)

<http://www.health.utah.gov/upp>

The Association for Utah Community Health (AUCH) is the primary care association for the state of Utah. AUCH members include Federally Qualified Health Centers (FQHC) and other providers who strive to meet the needs of the medically underserved. AUCH and its member organizations are part of a statewide and national movement to reduce barriers to healthcare by enhancing

primary care service delivery through prevention, health promotion, and community participation.

Association for Utah Community Health

860 East 4500 South

Salt Lake City, UT 84107

(801) 974-5522

<http://www.auch.org>

More information on the Behavioral Risk Factor Surveillance System may be found on the website of the CDC—<http://www.cdc.gov/brfss/>

Primary Provider

For information on the Medicaid program:
 In the Salt Lake City area, call 538-6155.
 In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free 1-800-662-9651.
 In other states, call 1-801-538-6155.
 Medicaid Customer Service staff are available to take inquiries.

Call the Utah Health Resource Line: 1-888-222-2542 for information on CHIP and the PCN.

CHIP: Children's Health Insurance Program (for children 0–18)

<http://www.utahchip.org/>

PCN: Utah Primary Care Network (for low-income adults)

<http://health.utah.gov/pcn/>

Non-emergent Emergency Department (ED) Use

Association for Utah Community Health (AUCH)

<http://www.auch.org/>

There are several after-hours clinics around the state that may be used in place of emergency departments for

non-emergent health issues. To find if one is available in your area, check with your insurance or do a web search for after-hours clinics.

Regular Dental Care

As of September 2015, Medicaid includes basic dental care for children and pregnant women. There is only emergency coverage for all other adults. For information call 801-538-6155 or 1-800-662-9651, or visit <https://medicaid.utah.gov/>.

CHIP includes preventive and restorative services for children. For more information call 1-877-KIDS-NOW or visit <http://health.utah.gov/chip/>.

There are a few dental clinics that provide services on a sliding fee scale or at a reduced rate. For more information on these clinics, contact your local health department or the UDOH Oral Health Program at (801) 273-2995 or visit the Oral Health Program—Find a Dentist website at <http://health.utah.gov/oralhealth/dentist.php>.

Dental Hygiene Schools throughout the state of Utah offer preventive services including sealants and fluoride treatments. Dental schools also offer treatment services in addition. Contact the Oral Health Program at (801) 273-2995 or visit <http://health.utah.gov/oralhealth>.

Healthy People 2020 for Oral Health

<http://www.healthypeople.gov/2020/topics-objectives/topic/oral-health>

CDC Oral Health Resources

<http://www.cdc.gov/OralHealth>

More information on the Behavioral Risk Factor Surveillance System may be found on the website of the CDC—<http://www.cdc.gov/brfss>

Preventive Services

Childhood Vaccination

Vaccines for Children (VFC) Program: This program gives free vaccines to physicians/clinics that allow patients to remain in their medical home. Patients must qualify for this program.

General information about immunizations for school-age children, adolescents, college students/missionaries, adults, and travel is available on the website:

<http://www.immunize-utah.org>. For information on vaccine providers in your area, contact the Immunization Hotline at 1-800-275-0659.

Maternal and Child Health

Unintended Pregnancy

See the following web page for information about family planning services in Utah: <http://health.utah.gov/mihp/familyplanning/familyplan.htm>

Utah Department of Health: Power Your Life
<http://www.poweryourlife.org>

Centers for Disease Control and Prevention: Unintended Pregnancy Prevention

<http://www.cdc.gov/reproductivehealth/unintendedpregnancy>

Affordable Care Act Expands Prevention Coverage for Women's Health and Well-Being

<http://www.hrsa.gov/womensguidelines>

Preventing Unintended Pregnancies By Providing No-Cost Contraception (Piepert, 2012) http://journals.lww.com/greenjournal/Fulltext/2012/12000/Preventing_Unintended_Pregnancies_by_Providing.7.aspx

Increasing Use of Contraceptive Implants and Intrauterine Devices To Reduce Unintended Pregnancy (ACOG, 2009) <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co642.pdf?dmc=1&ts=20160906T1559002404>.

Developmental Screening

Baby Watch Early Intervention
<http://www.utahbabywatch.org/>

Autism

Medicaid Autism Related Services
<http://health.utah.gov/ltc/asd/>

Autism Council of Utah—provider list
<http://autismcouncilofutah.org/service-providers/>

Violence and Injury Prevention

Helmet Use—Minor

Guide to fitting your helmet properly
http://www.health.utah.gov/vipp/pdf/BicycleSafety/WellnessCouncilTBIFlyer_helmet.pdf

Watch the Bike Helmet Fit Test video from Safe Kids Worldwide <http://www.safekids.org/video/safety-seconds-bike-helmets>

The Utah Department of Transportation, Zero Fatalities, and the Highway Safety Office have launched an education program about car and bike safety called Road Respect: Car & Bike Rules to Live By. For more information, visit <http://roadrespect.utah.gov/> or find the program on Facebook.

Bicycle Safety Resources
<http://www.health.utah.gov/vipp/kids/bicycle-safety/resources.html>

Unintended Injury Deaths

Utah Department of Health
Violence and Injury Prevention Program
801-538-6141
<http://health.utah.gov/vipp/>

Utah Poison Control Center
801-581-7504 (for general information)
1-800-222-1222 (emergency hotline)

Use Only As Directed
<http://useonlyasdirected.org/>

Utah Fire Marshal
801-284-6350
<http://firemarshal.utah.gov/>

Utah SAFE KIDS Coalition
801-538-6852
<http://www.safekidsutah.org/>

Primary Children's Hospital
801-588-2000

Utah Office of Highway Safety
801-293-2480
<http://publicsafety.utah.gov/highwaysafety/>

Utah Safety Council
801-262-5400
<http://www.utahsafetycouncil.org>

Intermountain Injury Control Research Center
801-581-6410
<http://iicrc.med.utah.edu/>

Utah AAA (American Automobile Association)
801-364-5615

NATIONAL WEBSITES

CDC National Center for Injury Prevention and Control
<http://www.cdc.gov/injury/>

National Highway Transportation Safety Administration
<http://www.nhtsa.dot.gov/>

Safe Kids Worldwide
<http://www.safekids.org/>

Children's Safety Network
<http://www.childrenssafetynetwork.org/>

U.S. Consumer Product Safety Commission
<http://www.cpsc.gov/>

Infectious Diseases

Healthcare-Associated Infections

Utah Department of Health
Bureau of Epidemiology

<http://health.utah.gov/epi/diseases/HAI/>

This CDC website has information on healthcare-associated infections <https://www.cdc.gov/hai/>

This AHRQ website has tools and resources for consumers and providers

<http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/hais/index.html>

Chlamydia

STD (sexually transmitted disease) clinics are located at local health departments where individuals can be tested and treated for STDs at minimal or no cost. Planned Parenthood has locations throughout Utah that also provide STD services at minimal cost. Condoms and educational materials are available at these locations.

STD presentations are available through the Utah Department of Health upon request.

The Utah Minor's Consent Law allows adolescents between the ages of 14 and 17 years to be tested and treated for an STD without the consent of a parent.

Fact sheets for communicable diseases may be found on the UDOH Bureau of Epidemiology website at <http://health.utah.gov/epi/diseases/chlamydia/factsheet.pdf>.

Testing and treatment locations and other resources are available at the UDOH Communicable Disease Prevention Program website at <http://health.utah.gov/epi/testing/>.

Screening Guidelines

<http://www.cdc.gov/std/sam/STD-HIV-Screening.htm>

CDC Division of Sexually Transmitted Disease Prevention

<http://www.cdc.gov/std>

CDC. *Sexually Transmitted Disease Surveillance, 2013*. Atlanta: U.S. Department of Health and Human Services; 2014. <http://www.cdc.gov/std/stats13/exordium.htm>

CDC. 2015 Sexually Transmitted Disease Treatment Guidelines

<http://www.cdc.gov/std/treatment>

Salmonella

Foodborne disease outbreaks and other outbreaks are investigated primarily by local health departments in collaboration with Utah Department of Health as needed.

For more information regarding local health departments in Utah, visit <http://www.ualhd.org/>.

To report a foodborne illness, visit <http://igotsick.health.utah.gov>.

More information about the Egg and Poultry Grading Program can be found by visiting

<http://ag.utah.gov/divisions/regulatory/egg.html>.

UDOH Bureau of Epidemiology Information for the General Public

<http://health.utah.gov/epi/public/>

Pertussis

Public health clinics and private provider offices offer vaccine to adults, adolescents, and children in their communities.

For general information about immunizations please call the UDOH Immunization Program at 1-800-275-0659 or visit <http://www.immunize-utah.org>.

UDOH Bureau of Epidemiology

<http://health.utah.gov/epi/index.html>

Pertussis FAQs, Centers for Disease Control and Prevention

<http://www.cdc.gov/pertussis/about/faqs.html>

Pertussis, Public Health Professionals, Centers for Disease Control and Prevention

<http://www.cdc.gov/pertussis/php.html>

Health, United States, 2014; National Center For Health Statistics

<http://www.cdc.gov/nchs/data/hus/hus14.pdf>

Reported pertussis incidence by age group:

1990–2014, Centers for Disease Control and Prevention

<http://www.cdc.gov/pertussis/images/incidence-graph-age.jpg>

Weekly Pertussis Report; Utah Department of Health

http://health.utah.gov/epi/diseases/pertussis/surveillance/pertussis_wkly_rpt_122714.pdf

Council of State and Territorial Epidemiologists (CSTE) Position Statement, Pertussis (2014)

<http://wwwn.cdc.gov/nndss/script/casedef.aspx?CondYrID=950&DatePub=1/1/2014%2012:00:00%20AM>

Local Health District Summary Tables

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Table: Bear River Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	13.4%	-	!	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	13.5%	-	≈	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	14.5%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	29.6%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	16.6	16.2	✓	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of adults with doctor-diagnosed hypertension)	61	23.8%	26.6%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	6.6%	7.5%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	24.5%	25.3%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	8.6%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	54.7%	54.5%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	21.6%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	15.3%	14.6%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	14.9	16.4	✓	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	19.7%	20.1%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	10.8	12.7	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	8.0%	7.7%	✓	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	2.3%	-	✓	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	7.8%	7.2%	✓	11.1%	16.8%

- ✓ The community is performing BETTER than the state, and the difference is statistically significant.
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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	4.1%	4.1%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	10.2%	9.6%	✓	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	10.7%	10.8%	✓	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	75.4%	77.8%	✓	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	3.9	4.0	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	73.1%	73.5%	✓	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	24.6%	-	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	34.2	42.1	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	155.1	-	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	13.4	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	23.6	-	✓	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

‡ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

Table: Central Utah Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
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SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	14.1%	-	!	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	18.4%	-	!	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	14.9%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	25.0%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	25.9	25.6	≈	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	25.2%	25.1%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	8.1%	7.7%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	28.4%	29.1%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	9.2%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	50.6%	51.2%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	23.4%	-	✓	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	15.4%	15.1%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	30.6	33.6	!	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	20.9%	21.4%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	15.0	17.5	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	11.2%	11.5%	≈	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	4.2%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	6.1%	6.2%	✓	11.1%	16.8%

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	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	3.2%	3.2%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	13.7%	15.0%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	12.3%	13.3%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	79.6%	78.4%	✓	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	4.7	4.9	!	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	63.6%	73.5%	!	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	19.3%	-	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	54.7	57.9	!	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	142.4	-	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	16.2	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	33.7	-	≈	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

Table: Davis County Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	7.2%	-	✓	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	8.3%	-	✓	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	12.3%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	3.3%	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	26.8%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	20.6	19.7	✓	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	22.6%	25.5%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	7.4%	7.9%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	26.1%	26.5%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	7.8%	-	✓	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	55.7%	56.8%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	18.5%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	15.4%	15.0%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	15.4	17.0	✓	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	21.5%	21.2%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	10.9	11.9	✓	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	8.1%	7.9%	✓	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	2.5%	-	✓	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	8.6%	8.4%	✓	11.1%	16.8%

- ✓ The community is performing BETTER than the state, and the difference is statistically significant.
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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	2.8%	2.8%	✓	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	10.6%	10.3%	✓	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	11.3%	11.2%	✓	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	76.7%	77.3%	✓	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	3.3	3.4	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	75.6%	75.4%	✓	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	17.9%	-	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	17.4	N/A	≈	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	33.4	41.0	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	289.1	-	≈	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	12.6	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	32.2	-	✓	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

Table: Salt Lake County Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	11.9%	-	≈	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	15.1%	-	!	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	13.4%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	4.1%	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	34.4%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	31.3	30.9	!	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	24.4%	25.3%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	7.4%	7.9%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	26.4%	26.6%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	10.8%	-	!	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	53.8%	54.2%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	19.4%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	17.1%	16.8%	!	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	20.1	21.3	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	22.8%	22.4%	!	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	17.7	17.7	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	11.1%	10.8%	!	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	3.7%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	14.5%	14.1%	!	11.1%	16.8%

- ✓ The community is performing BETTER than the state, and the difference is statistically significant.
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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	5.2%	5.0%	!	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	13.3%	12.9%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	15.2%	14.9%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	71.3%	72.1%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	4.8	4.8	!	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	67.8%	68.0%	≈	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	24.9%	–	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	19.3	N/A	≈	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	38.4	43.2	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	392.0	–	!	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	12.2	–	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	41.1	–	!	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

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Table: San Juan Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
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SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	29.2%	-	!	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	30.5%	-	!	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	19.0%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	30.5%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	23.0	23.8	≈	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	34.2%	33.8%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	12.4%	12.4%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	33.2%	29.7%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	11.3%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	50.1%	50.3%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	21.7%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	12.4%*	10.5%*	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	22.2	25.4	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	19.1%	18.2%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	^^	^^	-	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	10.1%*	10.1%*	≈	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	2.5%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	**	**	-	11.1%	16.8%

- ✓ 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	4.3%*	4.3%*	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	14.6%*	11.8%*	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	**	**	–	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	59.1%	63.0%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	2.9	3.0	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	62.0%	56.7%	!	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	**	–	–	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	53.2	61.7	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	373.7	–	!	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	**	–	–	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	**	–	–	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

**The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

^^ 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: Southeast Utah Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	14.8%	-	!	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	19.0%	-	!	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	15.4%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	25.4%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	32.7	34.3	!	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	35.1%	30.3%	!	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	10.0%	8.3%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	20.6%	19.6%	✓	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	10.5%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	53.8%	53.4%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	31.4%	-	✓	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	17.1%	16.6%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	42.2	43.7	!	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	21.2%	21.9%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	34.2	39.2	!	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	17.9%	20.1%	!	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	6.6%	-	!	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	12.2%	13.7%	≈	11.1%	16.8%

- ✓ The community is performing BETTER than the state, and the difference is statistically significant.
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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	5.9%	5.7%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	10.5%	12.1%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	16.9%	18.1%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	78.9%	76.6%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	7.3	7.6	!	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	60.3%	59.7%	!	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	**	–	–	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	67.4	69.0	!	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	171.9	–	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	6.1*	–	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	6.1*	–	✓	37.8	N/A

‡ All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

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Table: Southwest Utah Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
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SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	14.8%	-	!	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	19.6%	-	!	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	15.8%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	36.0%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	19.0	19.0	✓	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	27.0%	25.0%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	7.4%	6.6%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	23.3%	23.2%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	8.4%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	60.0%	60.5%	✓	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	25.5%	-	✓	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	14.4%	14.7%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	22.0	23.5	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	20.5%	21.2%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	13.9	15.9	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	10.1%	10.8%	≈	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	3.7%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	8.8%	9.5%	≈	11.1%	16.8%

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	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	3.3%	3.4%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	14.9%	16.2%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	15.7%	16.8%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	72.9%	71.1%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	4.1	4.2	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	69.5%	68.9%	≈	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	24.0%	-	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	46.2	45.3	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	199.1	-	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	11.6	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	49.1	-	!	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

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‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

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Table: Summit County Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	6.8%	-	✓	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	7.9%	-	✓	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	11.2%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	30.7%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	11.3	11.3	✓	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	21.3%	20.1%	✓	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	3.5%	3.6%	✓	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	16.3%	16.4%	✓	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	5.1%	-	✓	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	63.3%	62.8%	✓	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	24.6%	-	✓	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	11.8%	13.2%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	15.6	16.8	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	17.7%	17.4%	✓	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	12.9^	^	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	5.4%	5.4%	✓	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	2.9%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	21.3%	21.3%	!	11.1%	16.8%

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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	8.2%	8.0%	!	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	7.6%	8.3%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	9.7%	10.4%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	77.3%	75.9%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	2.5	2.6	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	76.8%	76.2%	✓	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	65.1%*	-	!	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	39.0	53.9	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	232.7	-	≈	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	9.0*	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	38.6	-	≈	37.8	N/A

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§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

^ 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>.

Tooele County

Table: Tooele County Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	8.1%	-	✓	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	10.5%	-	✓	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	12.8%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	0.0%	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	25.5%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	40.1	38.7	!	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	27.6%	28.6%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	7.7%	8.1%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	31.0%	30.4%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	10.5%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	57.1%	57.8%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	22.0%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	17.7%	17.2%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	23.1	25.7	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	22.5%	21.9%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	25.3	27.4	!	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	13.4%	13.1%	!	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	4.4%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	13.0%	12.9%	≈	11.1%	16.8%

- ✓ 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	4.7%	4.6%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	8.9%	8.8%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	14.7%	14.5%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	75.1%	75.4%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	4.3	4.5	≈	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	67.0%	66.8%	≈	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	22.8%*	-	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	13.3	N/A	≈	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	52.2	66.1	!	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	232.2	-	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	9.8*	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	19.6	-	✓	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

Table: TriCounty Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	10.3%	-	✓	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	11.6%	-	≈	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	13.4%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	26.4%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	45.9	44.3	!	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	25.7%	27.9%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	8.4%	8.4%	≈	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	31.0%	30.1%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	7.1%	-	✓	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	52.5%	52.4%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	13.2%	-	!	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	20.1%	20.1%	!	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	29.4	32.6	!	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	19.4%	19.5%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	13.0 [^]	[^]	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	15.3%	15.3%	!	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	5.2%	-	!	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	13.1%	13.0%	≈	11.1%	16.8%

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	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	4.5%	4.5%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	15.7%	15.6%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	13.4%	13.7%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	66.3%	66.5%	!	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	6.1	6.1	!	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	58.0%	58.2%	!	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	22.6%*	–	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	58.8	66.6	!	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	239.9	–	≈	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	19.9	–	!	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	6.9*	–	✓	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 Prevention Needs Assessment.

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†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

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Table: Utah County Summary

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		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
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SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	12.6%	-	≈	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	11.0%	-	✓	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	14.2%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	0.8%	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	34.4%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	14.5	14.7	✓	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	19.9%	23.3%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	5.2%	6.8%	✓	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	24.8%	27.0%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	9.4%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	56.6%	57.2%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	18.1%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	14.6%	13.4%	✓	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	14.4	16.2	✓	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	19.8%	19.6%	✓	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	12.7	15.5	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	6.2%	5.9%	✓	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	2.7%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	7.5%	7.1%	✓	11.1%	16.8%

- ✓ The community is performing BETTER than the state, and the difference is statistically significant.
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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	1.4%	1.4%	✓	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	13.8%	12.4%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	13.5%	13.0%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	70.1%	73.6%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	3.2	3.5	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	70.0%	70.5%	≈	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	20.7%	-	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	26.2	36.8	✓	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	167.6	-	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	10.6	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	41.0	-	≈	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

Table: Wasatch County Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	7.1%	-	✓	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	9.8%	-	✓	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	12.1%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	36.3%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	18.0	18.4	≈	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	27.0%	23.9%	≈	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	5.7%	5.6%	✓	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	20.2%	20.0%	✓	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	9.0%	-	✓	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	63.6%	63.1%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	18.8%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	13.3%	12.5%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	15.1	15.9	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	17.6%	17.0%	✓	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	^^	^^	-	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	7.0%	7.0%	≈	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	2.8%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	11.7%	11.1%	≈	11.1%	16.8%

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	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	4.5%	4.3%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	12.4%	12.3%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	15.0%	14.7%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	76.3%	76.6%	≈	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	3.7	4.0	✓	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	74.3%	74.4%	≈	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	**	-	-	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	35.2	46.2	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	126.3	-	✓	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	9.2*	-	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	45.9	-	≈	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

*Use caution in interpreting; the estimate has a coefficient of variation >30% and is therefore deemed unreliable by Utah Department of Health standards.

**The estimate has been suppressed because 1) the relative standard error is greater than 50% or 2) the observed number of events is very small and not appropriate for publication.

^^ 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: Weber-Morgan Summary

	Page	Community Data			Comparison Values	
		Crude (burden) Rate	Age-adjusted (comparison) Rate	Compare	Utah	U.S.
<div style="border: 1px solid red; padding: 5px;"> <p>✓ The community is performing BETTER than the state, and the difference is statistically significant.</p> <p>≈ The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</p> <p>! The community is performing WORSE than the state, and the difference is statistically significant.</p> </div>						
SOCIAL DETERMINANTS OF HEALTH						
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	12.0%	-	≈	11.8%	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	14.9%	-	≈	13.4%	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	13.3%	-	N/A	14.2%	15.4%
ENVIRONMENTAL HEALTH						
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	N/A	-	N/A	1.8%	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	29.7%	-	N/A	32.2%	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	N/A	-	N/A	4.0	3.7
RESPIRATORY CONDITIONS						
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	27.2	26.9	!	24.2	N/A
CARDIOVASCULAR CONDITIONS						
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	27.8%	28.0%	!	25.3%	N/A
DIABETES CONDITIONS						
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	8.8%	8.9%	!	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY						
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	28.7%	28.8%	≈	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	10.9%	-	≈	9.6%	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	56.0%	55.9%	≈	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	20.5%	-	≈	19.9%	N/A
MENTAL HEALTH						
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	16.4%	16.3%	≈	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	21.5	22.1	≈	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	22.6%	22.6%	≈	21.2%	N/A
ADDICTIVE BEHAVIORS						
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	16.4	17.0	≈	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	14.2%	14.2%	!	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	4.3%	-	≈	3.4%	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	13.3%	12.9%	≈	11.1%	16.8%

- ✓ The community is performing BETTER than the state, and the difference is statistically significant.
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- ! 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.
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	4.6%	4.6%	≈	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	N/A	N/A	N/A	7.3%	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	N/A	N/A	N/A	2.7%	2.6%
CARE ACCESS						
No Health Insurance, 2014 (Percentage of adults)	101	13.8%	13.9%	≈	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	15.0%	15.4%	≈	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	68.4%	68.3%	!	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	5.2	5.2	!	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	71.4%	71.5%	≈	69.0%	64.1%
PREVENTIVE SERVICES						
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	N/A	N/A	N/A	74.6%	74.6%
MATERNAL AND CHILD HEALTH						
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	25.4%	–	≈	22.8%	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	N/A	N/A	N/A	26.8%	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	N/A	N/A	N/A	18.6	14.7
VIOLENCE AND INJURY PREVENTION						
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	N/A	N/A	N/A	74.6%	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	38.3	40.9	≈	43.3	39.6
INFECTIOUS DISEASES						
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131	N/A	N/A	N/A		
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	281.2	–	≈	279.5	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	10.2	–	≈	11.8	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	42.6	–	≈	37.8	N/A

† All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

Table: State of Utah Summary

	Page	State Data		U.S.
		Crude (burden) Rate	Age-adjusted (comparison) Rate	
SOCIAL DETERMINANTS OF HEALTH				
Persons Living in Poverty, 2014[‡] (Percentage of persons)	41	11.8%	--	15.5%
Child Poverty, 2014[‡] (Percentage of children)	43	13.4%	--	21.7%
Food Insecurity, 2014 (Percentage of the population)	45	14.2%	--	15.4%
ENVIRONMENTAL HEALTH				
Air Quality (PM_{2.5}), 2014 (Percentage of days with PM _{2.5} levels over the NAAQS)	49	1.8%	--	N/A
Substandard Housing, 2010–2014 (Percentage of occupied housing units with 1+ substandard conditions)	51	32.2%	--	35.6%
Occupational Fatalities, 2015 (Number of fatal injuries in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers)	53	4.0	--	3.7
RESPIRATORY CONDITIONS				
Uncontrolled Asthma, 2014 (Number of ED Visits due to Asthma [ICD-9 code 493] per 10,000)	57	24.7	24.2	N/A
CARDIOVASCULAR CONDITIONS				
High Blood Pressure, 2013–2014 (Percentage of Adults with doctor-diagnosed hypertension)	61	23.8%	25.3%	N/A
DIABETES CONDITIONS				
Diabetes Prevalence, 2012–2014 (Percentage of adults)	65	7.1%	7.7%	N/A
OBESITY/PHYSICAL ACTIVITY				
Obesity—Adult, 2014 (Percentage of adults with a body mass index of 30 or more)	69	25.7%	26.3%	28.8%
Obesity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12)	71	9.6%	--	N/A
Physical Activity—Adult, 2013 (Percentage of adults that meet recommendation for aerobic physical activity)	73	55.3%	55.7%	50.1%
Physical Activity—Minor, 2015§ (Percentage of students in grades 8, 10, and 12 physically active for a total of at least 60 minutes per day on 7 of the past seven days)	75	19.9%	--	N/A
MENTAL HEALTH				
Mental Health Status, 2014 (Percentage of adults with 7+ days poor mental health in past 30 days)	79	15.9%	15.5%	16.5%
Suicide, 2012–2014# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])	81	19.2	20.8	12.7
Depression, 2012–2014 (Percentage of adults ever told by a doctor they had a depressive disorder)	83	21.2%	21.2%	N/A
ADDICTIVE BEHAVIORS				
Drug Overdose Involving Opioids, 2013–2014 (Rate per 100,000 [ICD-10 codes X40–X44, X60–X64, X85, and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])	87	15.3	16.4	8.5
Cigarette Smoking—Adult, 2013–2014 (Percentage of adults reporting current cigarette smoking)	89	10.0%	9.8%	N/A
Cigarette Smoking—Minor, 2015§ (Percentage of students in grades 8, 10, & 12 reporting current cigarette use)	91	3.4%	--	N/A
Binge Drinking, 2014 (Percentage of adults reporting 5+ drinks for men, 4+ drinks for women, on occasion 1 or more times in the past month)	93	11.4%	11.1%	16.8%

	Page	State Data		U.S.
		Crude (burden) Rate	Age-adjusted (comparison) Rate	
Chronic Drinking, 2013–2014 (Percentage of adults reporting >30 for women and >60 for men drinks per month)	95	3.9%	3.9%	N/A
Illicit Substance Use, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug use in the past month)	97	7.3%	N/A	9.8%
Illicit Substance Dependence or Abuse, 2013–2014 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)	97	2.7%	N/A	2.6%
CARE ACCESS				
No Health Insurance, 2014 (Percentage of adults)	101	13.9%	13.4%	14.9%
Cost as a Barrier to Care, 2014 (Percentage of adults unable to get needed care due to cost)	103	14.3%	14.2%	14.9%
Primary Provider, 2014 (Percentage of adults with one or more personal doctor or healthcare provider)	105	71.1%	72.2%	75.9%
Non-emergent Emergency Department (ED) Use, 2014 (Non-emergent ED encounter rate per 100 ED treat and release encounters)	107	4.4	4.5	N/A
Regular Dental Care, 2014 (Percentage of adults who reported a dental visit in the past year)	109	68.9%	69.0%	64.1%
PREVENTIVE SERVICES				
Childhood Vaccination, 2014 (Percentage of children aged 19–35 months with 4:3:1:3:3:1 vaccinations)	113	74.6%	--	74.6%
MATERNAL AND CHILD HEALTH				
Unintended Pregnancy, 2013 (Percentage of live births from unintended pregnancies)	117	22.8%	--	N/A
Developmental Screening, 2011–2012 (Percentage of children aged 10 months–5 years receiving developmental screening during a healthcare visit)	119	26.8%	--	30.8%
Autism, 2010†† (Rate per 1,000 children aged 8 years)	121	18.6	--	14.7
VIOLENCE AND INJURY PREVENTION				
Helmet Use—Minor, 2013 (Percentage of students in grades 9–12 who had ridden a bicycle during the past 12 months reporting that they never or rarely wore a bicycle helmet)	125	74.6%	--	87.9%
Unintended Injury Deaths, 2012–2014# (Rate per 100,000—ICD-10 codes V01–X59, Y85–Y86)	127	37.4	43.3	39.6
INFECTIOUS DISEASES				
Healthcare-Associated Infections, 2014 (Standardized Infection Ratio)	131			
Chlamydia, 2014‡‡ (Cases per 100,000 population)	133	279.5	--	456.1
Salmonella, 2013–2014§§ (Infections per 100,000)	135	11.8	--	N/A
Pertussis, 2013–2014§§ (Cases per 100,000)	137	37.8	--	N/A

‡ All data in this row based on the 2014 Model-based Small Area Income & Poverty Estimates (SAIPE) for School Districts, Counties, and States.

§ All data in this row are from the 2015 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 1999–2014 Series 20 No. 2T, 2015.

†† National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin. Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

‡‡ All Utah data in this row are from the Utah Department of Health Prevention, Treatment and Care Program; U.S. data from Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

§§ All data in this row are from the Utah Secured Communicable Disease data retrieved on 3/31/2016 from <http://ibis.health.utah.gov/>.

Data Sources

Collaboration

Respect

Effective

Service

Evidence-based

Trustworthy

Integrity

Innovation

Transparency

Social Determinants of Health

Persons Living in Poverty

National and State Estimates: U.S. Census Bureau, 2010–2014 American Community Survey 5-Year Estimates Table GCT1701: PERCENT OF PEOPLE BELOW POVERTY LEVEL IN THE PAST 12 MONTHS (FOR WHOM POVERTY STATUS IS DETERMINED).

Estimates for Age and Gender: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates Table B17001: POVERTY STATUS IN THE PAST 12 MONTHS BY SEX BY AGE.

Estimates for Race, Ethnicity, and Education: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates Table S1701: POVERTY STATUS IN THE PAST 12 MONTHS.

Trend Data: U.S. Census Bureau, American Community Survey 1-Year Estimates Table S1701: POVERTY STATUS IN THE PAST 12 MONTHS for years 2008–2014.

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey (ACS) website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the ACS website in the Methodology section.

Although the ACS produces population, demographic and housing unit estimates, it is the Census Bureau's

Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Local Health District Estimates: based on U.S. Census Bureau, 2014 Small Area Income and Poverty Estimates (SAIPE) accessed 7/7/16 at http://www.census.gov/did/www/saiepe/data/interactive/saiepe.html?s_appName=saiepe&map_yearSelector=2014&map_geoSelector=aa_c&s_state=49&menu=grid_proxy&s_measures=aa_snc.

Child Poverty

National and State Estimates: U.S. Census Bureau, 2010–2014 American Community Survey 5-Year Estimates Table GCT1702: PERCENT OF RELATED CHILDREN UNDER 18 YEARS BELOW POVERTY LEVEL IN THE PAST 12 MONTHS.

Estimates for Age and Gender: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates Table B17001: POVERTY STATUS IN THE PAST 12 MONTHS BY SEX BY AGE.

Estimates for Race/Ethnicity: National KIDS COUNT. Children in Poverty by Race and Ethnicity. Downloaded 8/8/2016 from <http://datacenter.kidscount.org/~media/606/CI%20Children%20in%20Poverty%20by%20Race%20with%20Multi.xlsx>.

Definitions: The share of children under age 18 who live in families with incomes below the federal poverty level, as defined by the U.S. Office of Management and Budget, by race and ethnicity

The federal poverty definition consists of a series of thresholds based on family size and composition. In calendar year 2014, a family of two adults and two chil-

dren fell in the “poverty” category if their annual income fell below \$24,008. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 15 (such as foster children). The data are based on income received in the 12 months prior to the survey.

Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2014 American Community Survey.

These were derived from American Fact Finder table C17001 (B,C,D,E,H,I) (factfinder2.census.gov/).

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2014 ACS. The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small sub-populations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau

expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.) Race/ethnic groups represented in this table are not mutually exclusive. The category of white includes only non-Hispanic white. The categories Black or African American, American Indian, Asian and Pacific Islander, and Two or More Races include both Hispanic and non-Hispanic. Those in the Hispanic or Latino category include those identified as being in one of the non-White race groups.

Footnotes: Updated September 2015

Trend Data: U.S. Census Bureau, American Community Survey 1-Year Estimates Table S1701: POVERTY STATUS IN THE PAST 12 MONTHS for years 2008–2014.

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the ACS website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the ACS website in the Methodology section.

Food Insecurity

National, State, and Local Health District Estimates:

Map the Meal Gap 2016: Overall Food Insecurity in Utah by County in 2014. Accessed 7/7/2016 at http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2014/UT_AllCounties_CDs_MMG_2014.pdf.

Map the Meal Gap's food insecurity rates are determined using data from the 2001–2014 Current Popula-

tion Survey on individuals in food insecure households; data from the 2014 ACS on median household incomes, poverty rates, homeownership, and race and ethnic demographics; and 2014 data from the Bureau of Labor Statistics on unemployment rates.

tion Survey on individuals in food insecure households; data from the 2014 ACS on median household incomes, poverty rates, homeownership, and race and ethnic demographics; and 2014 data from the Bureau of Labor Statistics on unemployment rates.

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Local Health District Estimates: based on U.S. Census Bureau, 2014 Small Area Income and Poverty Estimates (SAIPE) accessed 7/7/16 at http://www.census.gov/did/www/saipe/data/interactive/saipe.html?s_appName=saipe&map_yearSelector=2014&map_geoSelector=aa_c&s_state=49&menu=grid_proxy&s_measures=aa_snc.

tion Survey on individuals in food insecure households; data from the 2014 ACS on median household incomes, poverty rates, homeownership, and race and ethnic demographics; and 2014 data from the Bureau of Labor Statistics on unemployment rates.

Trend Estimates: Map the Meal Gap: Food Insecurity in the United States. Accessed 7/7/2016 at <http://map.feedingamerica.org>.

Environmental Health

Air Quality

State, County, and Trend Estimates: Environmental Protection Agency. Air Quality System Monitoring Data. PM2.5—Days Above Regulatory Standard (Monitor only). Accessed From Environmental Public Health Tracking Network: <http://ephtracking.cdc.gov>. Accessed on 3/29/2016.

Data provided by U.S. Environmental Protection Agency (EPA). Most data are submitted to EPA by state air programs, as required under the Clean Air Act.

Data completeness for each monitor was based on the availability of samples for a certain number of days

during each calendar quarter. Data are only provided for counties with monitors that pass the completeness criterion.

The daily PM2.5 National Ambient Air Quality Standard (NAAQS) is 35.0 micrograms per cubic meter.

Substandard Housing

National, State, and Local Health District

Estimates: U.S. Census Bureau, American Community Survey. 2010–14 via Community Commons. <http://www.communitycommons.org/>.

The ACS is a nationwide, continuous survey designed to provide communities with reliable and timely demographic, housing, social, and economic data. The ACS samples nearly 3 million addresses each year, resulting in nearly 2 million final interviews. The ACS replaces the long-form decennial census; however, the number of household surveys reported annually for the ACS is significantly less than the number reported in the long-form decennial census. As a result, the ACS combines detailed population and housing data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Negotiating between timeliness and accuracy, the ACS annually releases current, one-year estimates for geographic areas with large populations; three-year and five-year estimates are

also released each year for additional areas based on minimum population thresholds.

Citation: U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data (2008).

For more information about this source, including data collection methodology and definitions, refer to the ACS website. http://www.census.gov/acs/www/guidance_for_data_users/guidance_main/.

Counts of housing units by age and condition are acquired from the U.S. Census Bureau's ACS. Data represent estimates for the 5-year period 2008–2012. Mapped data are summarized to 2010 census tract boundaries. Area estimates are developed at the U.S. Census Bureau, and given as a value for each geographic area. Raw counts are not provided, inhibiting the ability to produce median ages for report areas.

For more information on the data reported in the ACS, please see the complete ACS 2012 Subject Definitions.

Occupational Fatalities

National, State, and Trend Estimates: America's Health Rankings, United Health Foundation. Accessed 3/25/16 at <http://www.americashealthrankings.org/UT/WorkFatalities>.

Occupational fatalities is the combined rate of fatal injuries in the following industries: construction, manufacturing, trade, transportation, utilities, professional, and business services, as defined by the North American Industry Classification System (NAICS). Rather than using an occupational fatality rate for all workers, this industry-adjusted rate is used to account for the different mix of industries in each state to more accurately reflect the variation in unsafe working conditions between the states. Occupational fatalities are measured over a 3-year span because of their low incidence rate. In

states where occupational fatality data is not available for a specific industry, the national rate for that industry was used to calculate the state's occupational fatality rate. The 2015 ranks are based on 2012 to preliminary 2014 occupational fatality data from the Census of Fatal Occupational Injuries (CFOI), collected by the Bureau of Labor Statistics, U.S. Department of Labor. CFOI includes fatalities resulting from non-intentional injuries such as falls, electrocutions, and acute poisonings as well as from motor vehicle crashes that occurred during travel for work. Also included are intentional injuries (i.e., homicides and suicides) that occurred at work. Fatalities that occur during a person's commute to or from work are not counted. The 2014 industry population data used to calculate rates is from the Bureau of Economic Analysis.

Respiratory Conditions

Uncontrolled Asthma

Estimates for State, Age, Gender, Local Health District and Trend: Utah Emergency Department Encounter Database. Retrieved on 4/4/2016 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 ICD-9 code used to define asthma is 493. All emergency department (ED) encounters are included in the presented data, which includes those that were treat and release visits, as well as those that resulted in hospital admission.

ICD Stands for International Classification of Diseases. It is a coding system maintained by the World Health Organization and the U.S. National Center for Health Statistics (NCHS) used to classify causes of death on death certificates and diagnoses, injury causes, and medical procedures for hospital and ED visits. 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. The 9th revision (ICD-9) is still used for hospital and ED visits.

The Emergency Department Encounter Database contains the consolidated information on complete billing, medical codes, personal characteristics describing a patient, services received, and charges billed for each patient ED encounter. The Bureau of Emergency Medical Services/Office of Health Care Statistics receives quarterly ED data from hospitals in various formats and media. The data are converted into a standardized format. The data are validated through a process of automated editing and report verification. Each record is subjected to a series of edits that check for accuracy, consistency, completeness, and conformity with the definitions specified in the Utah Hospital Emergency Patient Encounter Data Submittal Manual. Records failing the

edit check are returned to the data supplier for corrections of comment.

Coverage and Validity of Diagnosis Codes: Since the data come from the billing forms, all visits or encounters have a diagnosis code making coverage great. There is some difference of opinion regarding whether some providers may emphasize diagnosis codes that yield higher reimbursements. The hospital and ED data are considered "Administrative Data" because they were created for use in billing and remittance of payment. As such, they were not constructed for public health surveillance purposes primarily, and are weak in some areas, such as external cause of injury and race or ethnicity. But, in general, they are extremely valuable and reasonably complete and valid.

Cardiovascular Conditions

High Blood Pressure

National and State Estimates: 2013 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2013 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 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 <http://health.utah.gov/oph/publications/brfss/Raking/Raking%20impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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.

Doctor-diagnosed hypertension is based on the answer to the question: "Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?" Response options are "Yes", "No", and "Yes but female told only during pregnancy", and "Told borderline high or pre-hypertensive." Women who report having hypertension only during pregnancy and individuals who are told they are borderline high are considered as having answered "No."

In order to be accurately diagnosed with hypertension, a patient must have had a blood pressure reading of more than 140/90 on two separate visits. The questionnaire does not capture whether a patient was told they had high blood pressure on a single visit or whether they were actually diagnosed with hypertension.

Diabetes Conditions

Diabetes Prevalence

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20Impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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.

Diabetes prevalence is based on the answer to the question: “Have you ever been told by a doctor that you have diabetes?” Those with diabetes only during pregnancy are excluded from the numerator.

Obesity/Physical Activity

Obesity—Adults

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20Impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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

National and State Estimates: Laura Kann, PhD, Steve Kinchen, Shari L. Shanklin, MPH, et al. Youth Risk Behavior Surveillance — United States, 2013. MMWR 2014;63(No. SS-4):155–156.

Estimates for Grade, Gender, Race/Ethnicity, and Trend: Utah Youth Risk Behavior Survey. Retrieved on 3/30/2016 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 Youth Risk Behavior Surveillance (YRBS) survey is performed 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.

Local Health District Estimates: 2015 Prevention Needs Assessment Survey.

Based on the Prevention Needs Assessment Survey, Form B.

The Prevention Needs Assessment (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).

Physical Activity—Adult

National and State Estimates: 2013 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2013 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 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 <http://health.utah.gov/oph/publications/brfss/Raking/Raking%20impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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.

Percentage of adults with recommended aerobic physical activity as defined as “150+ min/week of at least moderate intensity, or 75+ min/week of vigorous intensity, or an equivalent combination of aerobic physical activity.”

Physical Activity—Minor

National and State Estimates: Laura Kann, PhD, Steve Kinchen, Shari L. Shanklin, MPH, et al. Youth Risk Behavior Surveillance — United States, 2013. MMWR 2014;63(No. SS-4):147–148.

Estimates for Grade, Gender, Race/Ethnicity, and Trend: Utah Youth Risk Behavior Survey. Retrieved on 3/30/2016 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 in odd-numbered years. 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.

Local Health District Estimates: 2015 Prevention Needs Assessment Survey

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.

Youth physical activity is defined as students who were physically active for a total of at least 60 minutes per day on seven of the past seven days.

Mental Health

Mental Health Status

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/oph/publications/brfss/Raking/Raking%20Impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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?”

Suicide

National and State Estimates: Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1999–2014 on CDC WONDER Online Database, released December 2015. Data are from the Compressed Mortality File 1999–2014 Series 20 No. 2T, 2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/cmfi-icd10.html> on Mar 31, 2016 4:37:46 PM.

The populations used to calculate standard age-adjusted rates are documented at <http://wonder.cdc.gov/wonder/help/cmfi.html#2000StandardPopulation>.

The method used to calculate age-adjusted rates is documented at <http://wonder.cdc.gov/wonder/help/cmfi.html#Age-AdjustedRates>.

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/cmfi.html#ConfidenceIntervals>.

Estimates for Age, Gender, Race, Ethnicity, Local Health District, and Trend: Utah Death Certificate Database. Retrieved on 3/31/2016 from

Utah Department of Health, 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.

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, such as suicide, 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. The 9th revision (ICD-9) is still used for hospital and emergency department visits.

Death certificates in Utah are required to be filed by funeral directors. Funeral directors obtain demographic

information from an informant, 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.

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).

Depression

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/oph/publications/brfss/Raking/Raking%20impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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?”

Addictive Behaviors

Prescription Drug Misuse

National, State, Age, and Trend Estimates: Nonmedical Use of Pain Relievers in the Past Year, by Age Group and State. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. Accessed 3/25/2016 from <http://www.samhsa.gov/data/population-data-nsduh/reports>.

Drug Overdose Deaths Involving Opioids

National, State, Age, Gender, Race, Ethnicity, Local Health District, and Trend Estimates: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2014 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999–2014, 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 Jul 19, 2016.

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

Cigarette Smoking—Adults

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

State estimates 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 are given.

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

Drug overdose deaths involving opioids in this report follow the definition in the Prevention for States Indicator Support Toolkit—Guidance for Required Indicators, which is deaths with any of the following ICD-10 codes as the underlying cause of death:

- X40–X44: accidental poisonings by drugs
- X60–X64: Intentional self-poisoning by drugs
- X85: Assault by drug poisoning
- Y10–Y14: Drug poisoning of undetermined intent

with any of the following ICD-10 multiple cause-of-death codes:

- T40.0: Opium
- T40.1: Heroin
- T40.2: Natural and semisynthetic opioids
- T40.3: Methadone
- T40.4: Synthetic opioids, other than methadone
- T40.6: Other and unspecified narcotics

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20impact%202011.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.

Cigarette Smoking—Minor

National and State Estimates: Laura Kann, PhD, Steve Kinchen, Shari L. Shanklin, MPH, et al. Youth Risk Behavior Surveillance — United States, 2013. *MMWR* 2014;63(No. SS-4):80–81.

Estimates for Grade, Gender, Race/Ethnicity, and Trend: Utah Youth Risk Behavior Survey. Retrieved on 3/30/2016 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 is conducted with a representative sample of Utah public high school students in grades 9 to 12. Surveys were only conducted in odd numbered years.

Data are self-reported and subject to recall bias. Data are from a sample survey and subject to selection

Binge Drinking

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

Age-adjusted rates are based on eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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.

Current cigarette smoking is defined as adults who have smoked at least 100 cigarettes in their life time and who now report smoking cigarettes every day or some days. Question Text: “Do you now smoke cigarettes every day, some days, or not at all?”

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.

Local Health District Estimates: 2015 Prevention Needs Assessment Survey.

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.

Youth cigarette smoking is defined as students who smoked cigarettes on one or more of the past 30 days.

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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20impact%202011.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 par-

ticular sub-population-group, only those respondents are included in the denominator.

Age-adjusted rates are based on eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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.

Chronic Drinking

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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

Question Text: “Considering all types of alcoholic beverages, how many times during the past 30 days did you have X [X=5 for men, X=4 for women] or more drinks on an occasion?”

Follow-up Question: “During the past 30 days, what is the largest number of drinks you had on any occasion?”

A drink of alcohol is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor.

Binge drinking is defined as consuming five or more drinks on an occasion for men, or four or more drinks on an occasion for women one or more times during the past 30 days.

about this methodology visit <http://health.utah.gov/oph/publications/brfss/Raking/Raking%20Impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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: “During the past month, how many days per week or per month did you drink any alcoholic beverages, on the average? On the days when you drank, about how many drinks did you drink on the average?”

A drink of alcohol is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.

Chronic drinking is defined as an average daily alcohol consumption of >1 drink for women and >2 drinks for men in the past 30 days. This amount of alcohol consumption is considered to be exceeding the guidelines for low-risk drinking.

Accessed 3/23/2016 from <http://www.samhsa.gov/data/population-data-nsduh/reports>.

Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, includ-

Illicit Substance Use

National, State, Age, and Trend Estimates: Illicit Drug Dependence or Abuse in the Past Year, by Age Group and State. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health.

ing data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.

Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

State estimates 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 are given.

Care Access

No Health Insurance

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20impact%202011.pdf>.

Cost as a Barrier to Care

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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.

Utah estimates of the uninsured in Utah are typically calculated using a set of state-added questions included on the Utah BRFSS. Data shown here are based on a single question of the core BRFSS in order to show comparisons to other states and to the nation overall. Therefore, rates shown here may reflect different rates of coverage than other reports that include multiple insurance questions.

Question Text: “Do you have any kind of healthcare coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?”

Health insurance is defined as including private coverage, Medicaid, Medicare, and other government programs.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20impact%202011.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 par-

ticular sub-population-group, only those respondents are included in the denominator.

Age-adjusted rates are based on eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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: “Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?”

Primary Provider

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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: “Do you have one person you think of as your personal doctor or healthcare provider?” Respondents can answer “Yes, only one”, “Yes, more than one” or “No.” For this indicator, the two “Yes” responses have been combined.

Non-emergent Emergency Department (ED) Use

Estimates for State, Age, Gender, Local Health District and Trend: Utah Emergency Department Encounter Database. Retrieved on 4/4/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

ED PCS (Primary Care Sensitive) Conditions (9 Categories) Filter: Non-Emergent. Only Treat and Release ED encounters are included in the presented data.

Treat and Release: A patient that visits the ED, but is not admitted to the hospital as an inpatient. The patient does not stay overnight and is not admitted to another department of the hospital.

The Emergency Department Encounter Database contains the consolidated information on complete billing, medical codes, personal characteristics describing a patient, services received, and charges billed for each patient ED encounter. The Bureau of Emergency Medical Services/Office of Health Care Statistics receives quarterly ED data from hospitals in various formats and media. The data are converted into a standardized format. The data are validated through a process of automated editing and report verification. Each record is subjected to a series of edits that check for accuracy, consistency, completeness, and conformity with the definitions specified in the Utah Hospital Emergency Patient Encounter Data Submittal Manual. Records failing the

edit check are returned to the data supplier for corrections of comment.

Coverage and Validity of Diagnosis Codes: Since the data come from the billing forms, all visits or encounters have a diagnosis code making coverage great. There is some difference of opinion regarding whether some providers may emphasize diagnosis codes that yield higher reimbursements. The hospital and ED data are considered "Administrative Data" because they were created for use in billing and remittance of payment. As such, they were not constructed for public health surveillance purposes primarily, and are weak in some areas, such as external cause of injury and race or ethnicity. But, in general, they are extremely valuable and reasonably complete and valid.

Regular Dental Care

National and State Estimates: 2014 Behavioral Risk Factor Surveillance System (BRFSS); U.S. 2014 Raked Weights

At the time of this update, the BRFSS U.S. dataset did not include an age variable but did include five age categories up to age 80+ (vs. the typical weighting scheme that includes 85+). Estimates with both weighting schemes were compared using Utah data, and the difference was about 1/100 of a percentage point.

Estimates for Age, Gender, Race, Ethnicity, Income, Education, Local Health District, and Trend: Utah Behavioral Risk Factor Surveillance System. Retrieved on 4/5/2016 from Utah Department of Health, 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 <http://health.utah.gov/opa/publications/brfss/Raking/Raking%20impact%202011.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 eight age groups: 18–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, and 85+ 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: "How long has it been since you last visited a dentist or a dental clinic for any reason?" **Interviewer Instruction:** Include visits to dental specialists, such as orthodontists.

Preventive Services

Childhood Vaccination

National, State, and Trend Estimates: Estimated Vaccination Coverage with Combined 6-vaccine series (4:3:1:3*:3:1) Among Children Aged 19–35 Months by State and Selected Area – National Immunization Survey (NIS), United States, 2014. Accessed 3/28/2016 from <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2014.html>.

The combined six-vaccine series (4:3:1:3*:3:1) includes ≥4 doses of DTaP, ≥3 doses of Polio, ≥1 dose of measles-containing vaccine, Hib full series, ≥3 HepB, and ≥1 Var. (In 2013 data, referred to as 4:3:1:4:3:1-FS).

Abbreviations: DTaP = diphtheria, tetanus toxoids, and acellular pertussis vaccine (includes children who

might have been vaccinated with diphtheria and tetanus toxoids vaccine, or diphtheria, tetanus toxoids, and pertussis vaccine); Polio = poliovirus vaccine; Hib = Haemophilus influenzae type b vaccine; HepB = hepatitis B vaccine; Var = varicella vaccine.

Children in the 2014 NIS were born January 2011 through May 2013.

Children in the 2014 NIS were born January 2011 through May 2013.

Maternal and Child Health

Unintended Pregnancy

National and State Estimates: Indicator of Intended Pregnancy, PRAMS (Pregnancy Risk Assessment Monitoring System) Data by Topic. Pregnancy Risk Assessment Monitoring System, Centers for Disease Control and Prevention. Accessed 3/28/2016 from http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&isIClassId=CLA4&isITopicId=TOP17&go=GO.

U.S. rate includes all PRAMS states with data available for a specific question for a specific year.

Estimates for Age, Race, Ethnicity, Poverty, and Education, and Trend: Utah Pregnancy Risk Assessment Monitoring System (PRAMS). Retrieved on 3/28/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

Local Health District Estimates: Data were provided by the Utah Pregnancy Risk Assessment and Monitoring System (PRAMS), a project of the Utah Department of Health (UDOH), the Office of Vital Records and Health Statistics of the UDOH, and the Centers for Disease Control and Prevention (CDC) of the U.S. Health and Human Services Department.

Question: "Thinking back to just before you got pregnant, how did you feel about becoming pregnant?" (check one answer).

Answer Options: I wanted to be pregnant sooner, I wanted to be pregnant later, I wanted to be pregnant then, I didn't want to be pregnant then or at any time in the future, or I wasn't sure what I wanted.

Women who wanted to be pregnant later or didn't want to be pregnant were categorized as having an unintended pregnancy.

Beginning in 2012, the PRAMS survey added the response "I wasn't sure what I wanted". The addition of this response likely diluted the percentage of responses in the other categories so 2012 data not comparable to previous years.

A stratified random sampling approach is used in selecting women 2–4 months postpartum to participate in PRAMS. The data are weighted by the CDC to represent the birth population for that year, adjusted for sampling probabilities, nonresponse, and noncoverage. Each strata must achieve a weighted response rate of 60% or it is not considered representative of that population.

See the PRAMS website at <http://www.cdc.gov/prams/methodology.htm> for more detailed information on PRAMS and its methodology.

Developmental Screening

Estimates for National, State, Gender, Race/Ethnicity, Poverty, Education, and Urban/Rural Residence: National Survey of Children's Health (NSCH). NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 3/30/2016 from <http://www.childhealthdata.org/>.

Indicator 4.16: Developmental screening

Indicator 4.16 uses age-appropriate questions to verify whether young children received standardized developmental, behavioral and social screening using a parent-reported, standardized screening tool or instrument.

Parent respondents for all children between 10 months and 5 years old were asked whether they completed a questionnaire about their child's development, communication or social behaviors during the previous

12 months (K6Q12). If the response to K6Q12 was "Yes", parents were asked if the questionnaire covered language or social development (K6Q13 and K6Q13A, respectively, for ages 10–23 months, and K6Q14A and K6Q14B for ages 2–5 years).

This 3-item measure to assess whether screening occurs was developed by the Child and Adolescent Health Measurement Initiative (CAHMI), with funding from the Commonwealth Fund and in conjunction with the Maternal and Child Health Bureau. Further information may be viewed on the CAHMI website (<http://www.cahmi.org/>) or by contacting CAHMI at cahmi@ohsu.edu.

Unknown values (responses coded as 'refused', 'don't know', or system missing) are not included in the denominator when calculating prevalence estimates and weighted population counts displayed in the data

query results table. In nearly every case, the proportion of unknown values is less than 1% and the exclusion of these values does not change the prevalence estimates (%) and only marginally affects the weighted population counts (Weighted Est.).

The UDOH Maternal and Child Health Bureau leads the development of the NSCH survey and indicators, in collaboration with the NCHS and a national technical expert panel. The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers. Previously validated questions and scales are used when available. Respondents' cognitive understanding of the survey questions is assessed during the pretest phase and revisions made as required. All final data components are verified by NCHS and Data Resource Center (DRC)/CAHMI staff prior to public release. The samples in 2003 and 2007 were drawn by random digit dial telephone sampling. The 2011/12 survey included the addition of cell phones to the sample. This has implications for the comparability of items between 2007 and 2011/12.

Hispanic includes all children reporting Hispanic/Latino origin; non-Hispanic children reporting a single race category of either White or Black are grouped respectively; non-Hispanic children reporting more than one race category are grouped under "Other, non-Hispanic". Non-Hispanic children reporting Asian, Native American, Native Alaskan or Native Hawaiian are categorized as "Other, non-Hispanic" due to small sample sizes in most states.

Household poverty level for the 9.3% of households in the sample with unknown values for income, household size, or both, was calculated using single imputation methods. The poverty level estimates and confidence intervals based on single imputed poverty will differ from those calculated using multiple imputations.

The Rural Urban Commuting Area (RUCA) taxonomy is derived from the relationships between cities and towns as measured by work commuting flows. Please note that there are no "rural" designations for two states: DC and RI. Several other states have very low rural populations. Data source: NCHS restricted data files.

Autism

Estimates for National, State, Gender, and Race/Ethnicity: Autism and Developmental Disabilities Monitoring Network Surveillance Year 2010 Principal Investigators. Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years – Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010. MMWR (Morbidity and Mortality Weekly Report) 2014;63(No. SS-2):15–16.

National data based on children living in Alabama, Arizona, Arkansas, Colorado, Georgia, Maryland, Missouri, New Jersey, North Carolina, Utah, and Wisconsin.

Utah estimates based on information collected from records of children living in Salt Lake, Davis, and Tooele counties.

County Estimates: Utah Autism and Developmental Disabilities Monitoring Project (UT-ADDM) study year 2010.

Violence and Injury Prevention

Helmet Use—Minor

National and State Estimates: Laura Kann, PhD, Steve Kinchen, Shari L. Shanklin, MPH, et al. Youth Risk Behavior Surveillance – United States, 2013. MMWR 2014;63(No. SS-4):53.

Estimates for Grade, Gender, Race/Ethnicity, and Trend: Utah Youth Risk Behavior Survey. Retrieved on 3/30/2016 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 is conducted with a representative sample of Utah public high school students in grades 9 to 12. Surveys were only conducted in odd numbered years.

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.

Unintended Injury Deaths

National and State Estimates: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Compressed Mortality File 1999–2014 on CDC WONDER Online Database, released December

2015. Data are from the Compressed Mortality File 1999–2014 Series 20 No. 2T, 2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Ac-

cessed at <http://wonder.cdc.gov/cmfc-icd10.html> on Mar 31, 2016 6:14:38 PM.

The populations used to calculate standard age-adjusted rates are documented at [http://wonder.cdc.gov/wonder/help/cmfc.html#2000 Standard Population](http://wonder.cdc.gov/wonder/help/cmfc.html#2000StandardPopulation).

The method used to calculate age-adjusted rates is documented at [http://wonder.cdc.gov/wonder/help/cmfc.html#Age-Adjusted Rates](http://wonder.cdc.gov/wonder/help/cmfc.html#Age-AdjustedRates).

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/cmfc.html#Confidence-Intervals](http://wonder.cdc.gov/wonder/help/cmfc.html#ConfidenceIntervals).

Estimates for Age, Gender, Race, Ethnicity, Local Health District, and Trend: Utah Death Certificate Database. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

Unintended injury deaths are determined using ICD-10 codes V01–X59, Y85–Y86 (does not include legal intervention), 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, such as suicide, 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. The 9th revision (ICD-9) is still used for hospital and emergency department visits.

Death certificates in Utah are required to be filed by funeral directors. Funeral directors obtain demographic information from an informant, 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 Utah 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.

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).

Infectious Diseases

Healthcare-Associated Infections

National and State Estimates: Centers for Disease Control and Prevention. 2014 National and State Healthcare-Associated Infections Progress Report. Published March, 2016. Available at <http://www.cdc.gov/hai/surveillance/progress-report/index.html>.

Trend Estimates: Centers for Disease Control and Prevention. 2012–2014 National and State Healthcare-Associated Infections Progress Reports and Standardized Infection Ratio (SIR) Report, 2011. Published September 2012–March 2016. Available at <http://www.cdc.gov/hai/surveillance/progress-report/previous-reports.html>.

For CLABSI (central line-associated bloodstream infections) and CAUTI (catheter-associated urinary tract infections), data from all intensive care units (ICUs), wards (and other non-critical care locations), and newborn intensive care units (NICUs). This excludes long-term

acute care (LTAC) locations (or facilities) and inpatient rehabilitation facility (IRF) locations (or facilities).

Note that almost all acute care hospitals are required to report surgical site infections (SSIs) following inpatient colon procedures to the National Healthcare Safety Network (NHSN) for participation in the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Quality Reporting Program. SSIs included in this table are those classified as deep incisional or organ/space infections following NHSN-defined inpatient colon procedures that occurred in 2014 with a primary skin closure technique, detected during the same admission as the surgical procedure or upon readmission to the same facility. The colon surgery SSI data published in this report use different risk adjustment methodology and a different subset of data than that which are used for public reporting by CMS.

Note that almost all acute care hospitals are required to report facility-wide methicillin-resistant *Staphylococcus*

aureus (MRSA) bacteremia data to NHSN for participation in the CMS Hospital Inpatient Quality Reporting Program. Hospital-onset is defined as event detected on the fourth day (or later) after admission to an inpatient location within the facility.

Note that almost all acute care hospitals are required to report facility-wide *Clostridium difficile* infection (CDI) data to NHSN for participation in the CMS Hospital Inpatient Quality Reporting Program. Hospital-onset is defined as event detected on the fourth day (or later) after admission to an inpatient location within the facility.

Chlamydia

National and Other State Estimates: Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Atlanta: U.S. Department of Health and Human Services; 2015. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>.

States were ranked by rate, then by case count, then in alphabetical order, with rates shown rounded to the nearest tenth.

Utah State Comparison Estimate: Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2014. Atlanta: U.S. Department of Health and Human Services; 2015. Accessed 3/28/2016 from <http://www.cdc.gov/std/stats14/surv-2014-print.pdf>. Also, Sexually Transmitted Disease Surveillance, Utah 2005–2014. Utah Department of Health; November 2015. Accessed 3/28/2016 from <http://health.utah.gov/epi/data/stdsurveillance/2005.2014.STDReport.pdf>. Rate cited is from the Utah Department of Health (UDOH) report. However, ranking order for all states was considered using this rate in place of the rate from the CDC report, and Utah's rank remained the same. Therefore, the UDOH rate was reported along with the ranking given by the CDC.

Estimates for Age and Gender: Utah Secured Communicable Disease data. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

Disease counts and calculated incidence rates represent totals reported to the UDOH and are determined using the CDC print criteria outlined in the CDC Event Code List of Nationally Notifiable Diseases and Other Conditions of Public Health Importance. For specific disease information, please visit each disease's page available at http://health.utah.gov/epi/diseases/a_z.html.

Cases were classified by Morbidity and Mortality Weekly Report (MMWR) year.

A disease incidence rate is the number of persons who became ill in a given time period, divided by the number of persons at risk during the same time period. Incidence rates in this module use a year as the time frame of reference and “person-years” in the denominator of the calculation. For events counted over an entire year, person-years is the total population for that geography. All population estimates apply to July 1 of the selected year.

Disease incidence data derive from reports of notifiable diseases, which are updated regularly.

Estimates for Race/Ethnicity and Trend: Sexually Transmitted Disease Surveillance, Utah 2005–2014. Utah Department of Health; November 2015. Accessed 3/28/2016 from <http://health.utah.gov/epi/data/stdsurveillance/2005.2014.STDReport.pdf>.

Cases were classified by MMWR year.

Local Health District Estimates: Utah Department of Health Prevention, Treatment and Care Program.

Cases were classified by MMWR year.

Salmonella

National and Other State Estimates: Centers for Disease Control and Prevention. Notice to Readers: Final 2014 Reports of Nationally Notifiable Infectious Diseases. Accessed 7/12/2016 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6436a8.htm>.

Rates were calculated for each state by dividing the number of reported cases into the total resident population. States were then sorted by rate and given a rank.

Utah State Comparison Estimate: Centers for Disease Control and Prevention. Notice to Readers: Final 2014

Reports of Nationally Notifiable Infectious Diseases. Accessed 7/12/2016 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6436a8.htm>. Also, Foodborne Illness—*Salmonella* Infections. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website: <http://ibis.health.utah.gov/>. Rate cited is from the Utah Department of Health (UDOH) report. However, ranking order for all states was considered using this rate in place of the rate from the CDC report, and Utah's rank remained the same.

Therefore, the UDOH rate was reported along with the ranking given by the CDC.

Estimates for Age, Gender, and Local Health District:

Utah Secured Communicable Disease data. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

Disease counts and calculated incidence rates represent totals reported to the UDOH and are determined using the CDC print criteria outlined in the CDC Event Code List of Nationally Notifiable Diseases and Other Conditions of Public Health Importance. For specific disease information, please visit each disease's page available at http://health.utah.gov/epi/diseases/a_z.html.

Cases were classified by MMWR year.

A disease incidence rate is the number of persons who became ill in a given time period, divided by the number

of persons at risk during the same time period. Incidence rates in this module use a year as the time frame of reference and “person-years” in the denominator of the calculation. For events counted over an entire year, person-years is the total population for that geography. All population estimates apply to July 1 of the selected year.

Disease incidence data derive from reports of notifiable diseases, which are updated regularly.

Estimates for Trend: Foodborne Illness—*Salmonella* Infections. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website: <http://ibis.health.utah.gov/>

Rates are derived from Utah annual surveillance reports. Data are preliminary and may change. The CSTE (Council of State and Territorial Epidemiologists) case definition includes all confirmed and probable cases of *Salmonella*.

Pertussis

National and Other State Estimates: Centers for Disease Control and Prevention. Notice to Readers: Final 2014 Reports of Nationally Notifiable Infectious Diseases. Accessed 7/12/2016 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6436a8.htm>.

Rates were calculated for each state by dividing the number of reported cases into the total resident population. States were then sorted by rate and given a rank.

Utah State Comparison Estimate: Centers for Disease Control and Prevention. Notice to Readers: Final 2014 Reports of Nationally Notifiable Infectious Diseases. Accessed 7/12/2016 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6436a8.htm>. Also, Pertussis Cases. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website: <http://ibis.health.utah.gov/>. Rate cited is from the UDOH report. However, ranking order for all states was considered using this rate in place of the rate from the CDC report, and Utah's rank remained the same. Therefore, the UDOH rate was reported along with the ranking given by the CDC.

Estimates for Age, Gender, and Local Health District:

Utah Secured Communicable Disease data. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>.

Disease counts and calculated incidence rates represent totals reported to the UDOH and are determined using the CDC print criteria outlined in the CDC Event Code List of Nationally Notifiable Diseases and Other Conditions of Public Health Importance. For specific disease information, please visit each disease's page available at http://health.utah.gov/epi/diseases/a_z.html.

Cases were classified by MMWR year.

A disease incidence rate is the number of persons who became ill in a given time period, divided by the number of persons at risk during the same time period. Incidence rates in this module use a year as the time frame of reference and “person-years” in the denominator of the calculation. For events counted over an entire year, person-years is the total population for that geography. All population estimates apply to July 1 of the selected year.

Disease incidence data derive from reports of notifiable diseases, which are updated regularly.

Estimates for Trend: Pertussis Cases. Retrieved on 3/31/2016 from Utah Department of Health, Center for Health Data and Informatics, Indicator-Based Information System for Public Health website <http://ibis.health.utah.gov/>

Rates are derived from Utah annual surveillance reports. Data are preliminary and may change.