Utah Health Improvement Plan 2017–2020

A Healthier Tomorrow, Together
For more information, contact:

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

This report is also available online at https://ibis.health.utah.gov/pdf/opha/publication/UHIP.pdf.
We invite anyone to provide feedback on this report. Please do so through email (chdata@utah.gov).

This report may be reproduced and distributed without permission.

Suggested citation:
Table of Contents

Table of Contents ................................................................. iii
List of Figures and Tables .................................................. v
Contributing Groups & Agencies ......................................... vii
Executive Summary .......................................................... ix

State Health Assessment and Improvement Plan Process ......................... 1
Purpose .............................................................................. 3
State Public Health System .................................................. 3
State Health Assessment and Improvement Planning Process .................. 6

Reducing Obesity and Obesity-related Chronic Conditions .................. 17
Background/Contextual Information for Health Priority ....................... 19
Current Efforts ..................................................................... 22
Goals, Objectives, and Strategies ............................................ 22
Alignment ............................................................................ 23
Resources ............................................................................ 23
Barriers/Challenges ................................................................ 23
Partners .............................................................................. 23

Reducing Prescription Drug Misuse, Abuse, and Overdose ................. 25
Background/Contextual Information for Health Priority ....................... 27
Opioid Overdose Deaths ....................................................... 27
Drug Misuse and Abuse ....................................................... 30
Current Efforts ..................................................................... 32
Goals, Objectives, and Strategies ............................................ 34
Alignment ............................................................................ 36
Resources ............................................................................ 37
Barriers/Challenges ................................................................ 37
Partners .............................................................................. 37

Improving Mental Health and Reducing Suicide .............................. 39
Background/Contextual Information for Health Priority ....................... 41
Mental Health Status .......................................................... 41
Depression .......................................................................... 42
Suicide .............................................................................. 44
Current Efforts ..................................................................... 47
Goals, Objectives, and Strategies ............................................ 47
Alignment ............................................................................ 48
Resources ............................................................................ 48
Barriers/Challenges ................................................................ 49
Partners .............................................................................. 49

Additional Participation ....................................................... 49
Ongoing Monitoring of UHIP ............................................. 51
Appendices .......................................................................... 55
List of Acronyms .................................................................. 57
Glossary .............................................................................. 59
Healthy People Objectives .................................................. 65
Available Services/Resources ............................................... 67

Local Health District Summary Tables ......................................... 71
Bear River .......................................................................... 73
Central Utah ....................................................................... 74
Davis County ...................................................................... 75
Salt Lake County ............................................................... 76
San Juan ............................................................................ 77
Southeast Utah ................................................................. 78
Southwest Utah ............................................................... 79
Summit County ................................................................... 80
Tooele County .................................................................... 81
TriCounty .......................................................................... 82
Utah County ....................................................................... 83
Wasatch County ............................................................... 84
Weber-Morgan ................................................................... 85
State of Utah ....................................................................... 86

Data Sources .......................................................................... 87
Individual Acknowledgments .................................................. 97

A Healthier Tomorrow, Together
List of Figures and Tables

**State Health Assessment and Improvement Plan Process**
Figure 1. State Public Health System ...........................................................................................................3
Map 1. Local Health Districts ..........................................................................................................................4
Map 2. Indian Tribal Lands in Utah ..................................................................................................................5
Figure 2. State Health Assessment and Improvement Plan Process .....................................................................6
Figure 3. Utah Health Improvement Plan Stakeholder Asset Map ........................................................................7
Figure 4. Utah Health Improvement Plan (UHIP) Organizational Structure .....................................................9
Figure 5. Public Health System and the 10 Essential Public Health Services ..................................................12
Figure 6. State Health System Integration with Various Plans and Assessments ..............................................14

**Reducing Obesity and Obesity-related Chronic Conditions**
Figure 7. Adult Obesity by Year, Utah, 2009–2016 ..........................................................................................19
Figure 8. Adult Obesity by Income, Utah, 2016 ...............................................................................................19
Table 1. Adult Obesity Prevalence State Comparison, by Age, Gender, Race, Ethnicity, Income, Education, and Local Health District .................................................................20
Map 3. Adult Obesity by Local Health District, 2016 .....................................................................................20
Figure 9. Adolescent Obesity by Year, Utah, 1999–2017 .................................................................................21
Table 2. Adolescent Obesity Prevalence State Comparison, by Grade, Gender, Race/Ethnicity, and Local Health District ..............................................................................................................21
Map 4. Adolescent Obesity by Local Health District, Utah, 2017 ....................................................................21

**Reducing Prescription Drug Misuse, Abuse, and Overdose**
Figure 10. Opioid Overdose Deaths per 100,000 by Year, Utah, 1999–2016 ....................................................27
Figure 11. Unintentional and Undetermined Opioid Deaths per 100,000 Population, Utah and U.S., 1999–2016 ........................................................................................................................................27
Figure 12. Unintentional and Undetermined Opioid Overdose Deaths by Drug Type, Utah Adults Aged 18+, 2000–2016 ........................................................................................................................................28
Figure 13. Unintentional and Undetermined Opioid Overdose Deaths per 100,000 by Year, Utah, 1999–2016 ........................................................................................................................................29
Table 4. Unintentional and Undetermined Opioid Overdose Deaths State Comparison, by Age, Gender, and Race ........................................................................................................................................29
Table 5. Unintentional and Undetermined Opioid Overdose Deaths by Local Health District .........................30
Map 5. Unintentional and Undetermined Opioid Overdose Deaths by Local Health District, 2014–2016 ..........30
Table 6. Pain Reliever Misuse State Comparison and by Age ...........................................................................31
Table 7. Illicit Drug Use in Past Month State Comparison and by Age ...............................................................31
Table 8. Illicit Drug Use Disorder in Past Year State Comparison and by Age ...................................................31
Figure 14. Marijuana Use in Past Month, Utah Students in Grades 8, 10, and 12, 2017 ........................................32
Figure 15. Utah Coalition for Opioid Overdose Prevention Structure ..............................................................33
Figure 16. Utah Coalition for Opioid Overdose Prevention Strategic Plan Logic Model ..................................34
Figure 17. Substance Misuse and Addictions Prevention Framework ...............................................................37

**Improving Mental Health and Reducing Suicide**
Figure 18. Poor Mental Health Status by Year, Utah Adults Aged 18+, 2009–2016 ..............................................41
Table 9. Poor Mental Health Status State Comparison, by Age, Gender, and Race, Adults Aged 18+ ..................41
Table 10. Poor Mental Health Status by Ethnicity, Income, Education, and Local Health District, Adults Aged 18+ ........................................................................................................................................42
Figure 19. Poor Mental Health Status by Education, Utah Adults Aged 25+, 2016 .............................................42
Map 6. Poor Mental Health Status by Local Health District, Utah Adults Aged 18+, 2016 .................................42
List of Figures and Tables

Figure 20. Depression by Year, Utah Adults Aged 18+, 2011–2016 ................................................................. 43
Table 11. Depression State Comparison, by Age, Gender, Race, Ethnicity, and Income, Adults Aged 18+ ......................................................... 43
Table 12. Depression by Education and Local Health District, Adults Aged 18+ ................................................. 44
Map 7. Depression by Local Health District, Utah Adults Aged 18+, 2014–2016 .................................................. 44
Figure 21. Suicides per 100,000 Population Aged 10+ by Year, Utah and U.S., 1999–2016 ................................. 45
Figure 22. Suicides per 100,000 Population by Year, Utah, 2000–2016 ............................................................... 45
Table 13. Suicide State Comparison, by Age, Gender, Race, and Ethnicity ......................................................... 46
Figure 23. Suicide by Age and Gender, Utah, 2014–2016 ................................................................................. 46
Figure 24. Suicides by Age Group and Method of Injury, Utah, 2014–2016 ....................................................... 46
Table 14. Suicide by Local Health District ....................................................................................................... 47
Map 8. Suicide by Local Health District, Utah, 2014–2016 ............................................................................ 47

Ongoing Monitoring of UHIP

Appendices

Local Health District Summary Tables
Table 15. Bear River Summary ....................................................................................................................... 73
Table 16. Central Utah Summary ..................................................................................................................... 74
Table 17. Davis County Summary .................................................................................................................. 75
Table 18. Salt Lake County Summary ........................................................................................................... 76
Table 19. San Juan Summary ......................................................................................................................... 77
Table 20. Southeast Utah Summary ................................................................................................................ 78
Table 21. Southwest Utah Summary ............................................................................................................... 79
Table 22. Summit County Summary .............................................................................................................. 80
Table 23. Tooele County Summary ............................................................................................................... 81
Table 24. TriCounty Summary ...................................................................................................................... 82
Table 25. Utah County Summary ................................................................................................................... 83
Table 26. Wasatch County Summary ............................................................................................................. 84
Table 27. Weber-Morgan Summary ............................................................................................................... 85
Table 28. State of Utah Summary .................................................................................................................. 86

Data Sources

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

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

Photos on front cover courtesy of Utah Travel Council.

Groups
(see page 8 for description of groups)
Community Advisory Panel
Minority Community Representatives
Students/Interns
State Health Assessment Workgroup
Utah Health Improvement Plan Coalition
Utah Health Improvement Plan Executive Committee
Utah Health Improvement Plan Operational Committee
Utah Health Improvement Plan Workgroup Co-Chairs

Agencies
American Cancer Society Cancer Action Network
American Heart Association of Utah
Bear River Health Department
Brigham Young University
Central Utah Health Department
Commission on Criminal and Juvenile Justice
Comunidades Unidas
Davis County Board of Health/School District
Davis County Health Department
Division of Occupational and Professional Licensing
Division of Substance Abuse and Mental Health, Utah Department of Human Services
Get Healthy Utah
HealthInsight
Huntsman Cancer Institute
Intermountain Healthcare
International Rescue Committee
National Association of Local Boards of Health
Regence BlueCross BlueShield of Utah
Sacred Circle Facility (Confederated Tribes of the Goshute Reservation)
Salt Lake Community College
Salt Lake County Health Department
San Juan Public Health Department
SelectHealth
Skull Valley Band of Goshute
Southeast Utah Health Department
Southwest Utah Public Health Department
Summit County Health Department
Tooele County Health Department
TriCounty Health Department
United Way
University of Utah
University of Utah College of Nursing
University of Utah Health
University of Utah Health Sciences & School of Medicine
Urban Indian Center of Salt Lake
Utah Association of Local Health Departments (UALHD)
UALHD Affiliate Group Chairs
Utah Commission on Aging
Utah County Health Department
Utah Department of Environmental Quality
Utah Department of Health (UDOH)
Utah Department of Transportation
Utah Health Advisory Council
Utah Health Policy Project
Utah Hospital Association
Utah House of Representatives
Utah Indian Health Advisory Board
Utah Navajo Health Systems
Utah Poison Control Center
Utah State Board of Education
Utah State University
Voices for Utah Children
Wasatch County Health Department
Wasatch Front Regional Council
Weber-Morgan Health Department
Weber State University
Executive Summary

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

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

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

The Utah State Health Assessment was completed and posted online in the Fall of 2016. 

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

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

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

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

Collaboration
Effective
Evidence-based
Respect
Transparency
Trustworthy
Service
Integrity
Innovation
Transparency
This section describes the process followed by the Utah Department of Health (UDOH) as it facilitated the Utah State Health Assessment (SHA) and the Utah Health Improvement Plan (UHIP).

**Purpose**

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

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

**State Public Health System**

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

*Figure 1. State Public Health System*

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

---

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

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

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

The local health districts in Utah include the following:

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

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

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

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

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

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

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

---

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.

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

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

---


State Health Assessment and Improvement Planning Process

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

Figure 2. State Health Assessment and Improvement Plan Process

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

Figure 3. Utah Health Improvement Plan Stakeholder Asset Map

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

Circle of Engagement:
The Circle of Engagement includes individuals committed to the plan who can be called on to help with specific tasks at particular times. They don’t see themselves as the primary drivers of the implementation effort but are willing to assume their fair share of responsibility for specific aspects of it, although it is up to the Core Circle to follow-up and ensure completion of assignments. This circle includes individuals who may or may not have been involved in the development of the plan. It also includes individuals who can become increasingly engaged in its implementation and leadership, and who may eventually move into the Core Circle.
**Circle of Champions:**
The Circle of Champions includes individuals who typically hold positions of leadership in their respective organizations and are, or need to be, committed to the plan. They may not be very involved in the daily activities of its implementation. They are the authorizers of the effort, advocates for it, the ones whose blessings can clear away some of the roadblocks. They are cheerleaders who can appear when it is strategically helpful, to affirm the work that has been done, and to provide top-level support. They need to be kept informed of what’s happening (big picture) and where to plug in strategically without having to be involved in the details.

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

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

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

- **The Community Advisory Panel.** The Community Advisory Panel is a group of leaders from Intermountain Healthcare, the UDOH, LHDs, Local Mental Health and Substance Abuse Authorities, the Utah Hospital Association, and AUCH. This group was formed to collaborate and share resources for the Intermountain Healthcare Community Health Needs Assessment, the LHDs needs assessments, and the SHA. This group agreed upon a process to gather community input across the state, the list of more than 100 health indicators to review, and a data sharing process to gain access to information by local health district area and hospital catchment area. This collaborative effort reduced duplication of effort and improved collaboration between these agencies. This group also discusses the best ways to collaborate during improvement planning and implementation in order to efficiently and effectively utilize available resources. The group meets regularly, usually once a quarter or more depending on need.

- **The State Health Assessment Workgroup.** This workgroup included UDOH and LHD employees and was responsible for analyzing data on the more than 100 health indicators, feedback from the 27 community input meetings held around the state, and needs assessments conducted throughout the state over the past five years. The group decided on initial prioritization criteria and a process to apply the criteria. Upon applying these criteria, the initial list of health indicators was reduced to 30 for consideration by other groups. The SHA Workgroup also provided feedback and helped develop the process for the Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the state health system.

- **Community Input Partners.** Twenty-seven community input meetings were held around the state to gather input on health needs and to discuss the health assessment process. These meetings were held as a collaborative process between Intermountain Healthcare, the UDOH, and the LHDs. A second round of meetings were held by Intermountain Healthcare to get feedback on their identified priorities and to gather information regarding local resources that may be available to address the identified health priorities.

- **Intern.** A volunteer intern reviewed numerous health needs assessments conducted around the state by various organizations and identified common needs identified in the assessments.

As mentioned in the Executive Summary, part of the update process included an update in the UHIP oversight structure. Below are the groups that are part of that structure.
• The **Utah Health Improvement Plan Executive Committee**. This group is the decision making body for the final SHA priorities as well as the UHIP.

• The **Utah Health Improvement Plan Operational Committee**. This committee ensures that the UHIP process is moving forward. It is comprised of members of the UDOH and LHDs. This group received updates and gave feedback on the SHA process and assisted in setting up the meetings of the UHIP Coalition.

• The **Utah Health Improvement Plan Coalition**. This group includes representatives from several partner agencies including LHDs, healthcare systems, environmental health, substance abuse and mental health, transportation, academia, health insurances/payers, community organizations, business, ethnic groups—African Americans, Hispanics, Asians, Pacific Islanders, American Indian Tribes of Utah—health advocacy organizations, education systems, and religious organizations. This group assisted in the second round of prioritization of health issues (taking the reduced list from the SHA Workgroup and voting to reduce to a few priorities). This group also gave feedback on the UHIP, and will hear and give feedback on implementation and progress of the plan.

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

**Vision and Mission**

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

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

Mission statement: “To unite the Utah public health system and improve the health of the people of Utah”
Community Input
Intermountain Healthcare, the UDOH, and the LHDs worked together to host 27 focus group meetings around the state to gather feedback regarding the health needs and disparities of each community. People from the community were invited to attend. The following groups were invited to be represented:

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

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

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

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

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

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

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

The data for these health indicators were reviewed online by the SHA Workgroup and the above criteria rated.
The top 30 scoring indicators then were mapped against:

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

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

They were asked to consider the following things:

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

And answer the following questions:

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

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

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

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

- Get feedback on system needs that should be considered as part of improvement planning
- Get feedback on factors that may impact success of targeted health issues that were prioritized
The UHIP Coalition was guided by a public health system definition of "all entities that contribute to the health and well-being of the residents in the state" while thinking about the 10 essential public health services in the following diagram.¹

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

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

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

While discussing the following questions:

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

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

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

While discussing the following questions:

- Opportunities:
  - What are the factors that might influence or contribute to successful outcomes?
  - Are there any new opportunities or upcoming changes that might positively impact the status quo?
- Threats:
  - What are the factors that might prevent successful outcomes?
  - Are there any new threats or upcoming changes that might negatively impact the status quo?
Multiple Assessments and Plans
During the SHA process many people began asking how the UHIP was different from the agencies' strategic plans. The graphic below was created to explain how different plans and assessments within the state health system might interconnect.

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

Priorities Chosen
As a result of these analyses, discussions, and prioritization, a list of potential health priorities was given to the UHIP Executive Committee for consideration. The UHIP Executive Committee based their decision on the analysis during the SHA process, feedback from the UHIP Coalition, alignment with partner agencies' focus areas, and because it was felt these broad and complex issues would benefit from the UHIP statewide collaborative process. The three priority areas chosen were:
1. Reducing obesity and obesity-related chronic conditions
2. Reducing prescription drug misuse, abuse, and overdose
3. Improving mental health and reducing suicide

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

Planning
Once the priorities were chosen, the UHIP Executive Committee determined co-chairs to lead the efforts. For all areas, there were already some existing efforts or coalitions. The UHIP Workgroups were formed and plans drafted. The workgroup plans were presented to the UHIP Coalition in May 2017 for feedback. The outcomes goals, strategies, and objec-
tives the UHIP Workgroups are focusing on do not represent all of the efforts for these priority areas. The workgroup plans address strategies that will expand or enhance current efforts, encourage broader collaboration, and that were possible to improve under existing resources. Discussions were also held regarding if the plans would reach high-risk populations for the areas and how they may need to be modified, if possible, to address disparate populations.
Reducing Obesity and Obesity-related Chronic Conditions
Background/Contextual Information for Health Priority

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

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

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

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

For adults, the measure is defined as the percentage of survey respondents aged 18 years and older who have a body mass index (BMI) greater than or equal to 30.0 kg/m² calculated from self-reported weight and height.

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

Data source: Utah Behavioral Risk Factor Surveillance System
Table 1. Adult Obesity Prevalence State Comparison, by Age, Gender, Race, Ethnicity, Income, Education, and Local Health District

<table>
<thead>
<tr>
<th>STATE COMPARISON (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>29.6%</td>
<td>29.3% - 29.8%</td>
<td>29.6%</td>
<td>29.4% - 29.9%</td>
</tr>
<tr>
<td>Colorado (best)</td>
<td>22.3%</td>
<td>21.4% - 23.2%</td>
<td>22.4%</td>
<td>21.4% - 23.3%</td>
</tr>
<tr>
<td>Utah (10th of 51)</td>
<td>25.4%</td>
<td>24.2% - 26.5%</td>
<td>26.2%</td>
<td>25.1% - 27.4%</td>
</tr>
<tr>
<td>Mississippi (worst)</td>
<td>37.3%</td>
<td>35.4% - 39.1%</td>
<td>38.0%</td>
<td>36.1% - 39.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE IN YEARS (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–34</td>
<td>16.8%</td>
<td>15.0% - 18.8%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
| 35–49                   | 30.3%| 27.9% - 32.7% | - | - !
| 50–64                   | 33.1%| 30.7% - 35.5% | - | - !
| 65+                     | 26.8%| 24.7% - 29.0% | - | - |

<table>
<thead>
<tr>
<th>GENDER (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25.6%</td>
<td>24.0% - 27.2%</td>
<td>26.6%</td>
<td>25.1% - 28.3%</td>
</tr>
<tr>
<td>Female</td>
<td>25.1%</td>
<td>23.5% - 26.7%</td>
<td>25.8%</td>
<td>24.2% - 27.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RACE (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
</table>
| American Indian/AK Native | 34.6%| 25.6% - 44.9% | 37.1%| 27.7% - 47.6% !
| Asian                   | 9.3% | 4.5% - 18.2% | 11.1%| 5.3% - 21.8% !
| Black                   | 30.9%| 18.7% - 46.5% | 33.2%| 20.8% - 48.6% |
| Pacific Islander        | 40.7%| 26.3% - 56.9% | 45.3%| 30.8% - 60.7% !
| White                   | 25.2%| 24.0% - 26.4% | 25.8%| 24.6% - 27.0% |

<table>
<thead>
<tr>
<th>ETHNICITY (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
</table>
| Hispanic                | 28.8%| 24.7% - 33.4% | 32.3%| 27.6% - 37.3% !
| Non-Hispanic            | 24.9%| 23.8% - 26.1% | 25.6%| 24.5% - 26.8% |

<table>
<thead>
<tr>
<th>INCOME (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
</table>
| 0-$24,999               | 25.8%| 23.0% - 28.9% | 29.8%| 26.5% - 33.3% !
| $25,000-$49,999         | 28.2%| 25.6% - 30.9% | 29.7%| 27.0% - 32.5% !
| $50,000-$74,999         | 26.6%| 24.0% - 29.5% | 26.8%| 24.3% - 29.5% |
| $75,000 or more         | 23.9%| 22.0% - 25.8% | 22.6%| 20.8% - 24.5% !

<table>
<thead>
<tr>
<th>EDUCATION—Adults 25+ (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below High School</td>
<td>33.3%</td>
<td>27.5% - 39.7%</td>
<td>33.5%</td>
<td>27.8% - 39.8%</td>
</tr>
</tbody>
</table>
| High School or GED           | 32.9%| 30.2% - 35.6% | 32.8%| 30.1% - 35.5% !
| Some Post High School        | 29.3%| 27.2% - 31.5% | 29.6%| 27.5% - 31.9% |
| College Graduate             | 23.6%| 21.9% - 25.4% | 23.8%| 22.1% - 25.5% !

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICT (2016)</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>27.7%</td>
<td>23.4% - 32.5%</td>
<td>29.8%</td>
<td>25.5% - 34.6%</td>
</tr>
<tr>
<td>Central Utah</td>
<td>27.0%</td>
<td>22.9% - 31.6%</td>
<td>27.4%</td>
<td>23.4% - 31.9%</td>
</tr>
<tr>
<td>Davis County</td>
<td>26.0%</td>
<td>22.8% - 29.4%</td>
<td>26.5%</td>
<td>23.5% - 29.9%</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>24.7%</td>
<td>22.6% - 26.8%</td>
<td>25.1%</td>
<td>23.1% - 27.2%</td>
</tr>
<tr>
<td>San Juan</td>
<td>32.1%</td>
<td>23.3% - 42.4%</td>
<td>31.3%</td>
<td>23.7% - 40.2%</td>
</tr>
<tr>
<td>Southeast Utah</td>
<td>28.8%</td>
<td>23.3% - 35.1%</td>
<td>28.2%</td>
<td>22.5% - 34.7%</td>
</tr>
<tr>
<td>Southwest Utah</td>
<td>21.4%</td>
<td>18.0% - 25.3%</td>
<td>23.0%</td>
<td>19.3% - 27.1%</td>
</tr>
</tbody>
</table>
| Summit County                 | 12.9%| 8.0% - 20.1% | 14.1%| 8.8% - 21.9% !
| Tooele County                 | 28.5%| 23.2% - 34.5% | 28.7%| 23.5% - 34.5% |
| TriCounty                     | 34.2%| 29.4% - 39.3% | 33.4%| 28.8% - 38.3% !
| Utah County                   | 22.6%| 20.0% - 25.3% | 25.8%| 23.2% - 28.6% |
| Wasatch County                | 21.5%| 15.3% - 29.3% | 22.5%| 16.1% - 30.4% |
| Weber-Morgan                  | 34.1%| 30.3% - 38.0% | 33.8%| 30.1% - 37.7% !

**Obesity - Adult:** This measure is defined as the percentage of survey respondents aged 18 years and older who have a BMI greater than or equal to 30.0 kg/m² calculated from self-reported weight and height.

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

**Data source:** Utah Behavioral Risk Factor Surveillance System
Obesity and Obesity-related Conditions

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Crude (burden)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATE COMPARISON (2015)</strong></td>
<td>Rate</td>
</tr>
<tr>
<td>U.S.</td>
<td>13.9%</td>
</tr>
<tr>
<td>Montana (best)</td>
<td>10.3%</td>
</tr>
<tr>
<td>Utah</td>
<td>**</td>
</tr>
<tr>
<td>Mississippi (worst)</td>
<td>18.9%</td>
</tr>
<tr>
<td><strong>GRADE IN SCHOOL (2017)</strong></td>
<td></td>
</tr>
<tr>
<td>Grade 9</td>
<td>9.4%</td>
</tr>
<tr>
<td>Grade 10</td>
<td>11.4%</td>
</tr>
<tr>
<td>Grade 11</td>
<td>7.5%</td>
</tr>
<tr>
<td>Grade 12</td>
<td>10.2%</td>
</tr>
<tr>
<td><strong>GENDER (2017)</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13.9%</td>
</tr>
<tr>
<td>Female</td>
<td>5.3%</td>
</tr>
<tr>
<td><strong>RACE/ETHNICITY (Grades 8, 10, and 12, 2017)</strong></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>15.9%</td>
</tr>
<tr>
<td>Asian</td>
<td>7.0%</td>
</tr>
<tr>
<td>Black</td>
<td>15.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>13.9%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>29.1%</td>
</tr>
<tr>
<td>White</td>
<td>8.1%</td>
</tr>
<tr>
<td><strong>LOCAL HEALTH DISTRICT (Grades 8, 10, and 12, 2017)</strong></td>
<td></td>
</tr>
<tr>
<td>Bear River</td>
<td>8.3%</td>
</tr>
<tr>
<td>Central Utah</td>
<td>9.9%</td>
</tr>
<tr>
<td>Davis County</td>
<td>8.0%</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>11.0%</td>
</tr>
<tr>
<td>San Juan</td>
<td>12.1%</td>
</tr>
<tr>
<td>Southeast Utah</td>
<td>9.4%</td>
</tr>
<tr>
<td>Southwest Utah</td>
<td>10.0%</td>
</tr>
<tr>
<td>Summit County</td>
<td>5.4%</td>
</tr>
<tr>
<td>Tooele County</td>
<td>10.8%</td>
</tr>
<tr>
<td>TriCounty</td>
<td>6.7%</td>
</tr>
<tr>
<td>Utah County</td>
<td>8.8%</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>6.8%</td>
</tr>
<tr>
<td>Weber-Morgan</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

* 2017 national data not yet available
** Utah data not available for 2015
^ Data by race/ethnicity and local health district are from the 2017 Prevention Needs Assessment.
It is likely that these data, based on self-reported height and weight, under represent the prevalence of overweight or obesity among high school students.

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

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

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

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

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

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

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

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

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

Goals, Objectives, and Strategies

<table>
<thead>
<tr>
<th>Goal 1: Reduce Utah obesity rates by facilitating a culture of wellness within worksites by June 30, 2020 in the state of Utah.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1:</strong> By June 30, 2018, data on 60 worksites will be collected to determine needs for moving from “good” to “better” to “best” ranking.</td>
</tr>
<tr>
<td>Objective 1 Measures: Number of worksites that complete the online worksite assessment</td>
</tr>
<tr>
<td>Objective 1 Baseline: 0 worksites as of June 2017</td>
</tr>
<tr>
<td>Objective 1 Target: 60 worksites by June 30, 2018</td>
</tr>
<tr>
<td>Strategy 1 for Objective 1: Using a standardized assessment tool, collect data on worksites that need assistance with moving from good to better to best and creating a culture of wellness within their organization.</td>
</tr>
<tr>
<td><strong>Objective 2:</strong> By October 1, 2018, wellness resources will be provided to 20 employers through personal contact.</td>
</tr>
<tr>
<td>Objective 2 Measures: Number of employers that received wellness resources</td>
</tr>
<tr>
<td>Objective 2 Baseline: 0 employers as of June 2017</td>
</tr>
<tr>
<td>Short-term Objective 2 Target: 20 employers by October 1, 2018</td>
</tr>
<tr>
<td>Strategy 1 for Objective 2: Provide wellness resources to employers.</td>
</tr>
<tr>
<td><strong>Objective 3:</strong> By June 30, 2018, at least five representatives from agencies/businesses that have a successful wellness program will be recruited to act as wellness champions.</td>
</tr>
<tr>
<td>Objective 3 Measures: Number of representatives identified as wellness champions</td>
</tr>
<tr>
<td>Objective 3 Baseline: 0 representatives as of June 2017</td>
</tr>
<tr>
<td>Objective 3 Target: 5 representatives by June 30, 2018</td>
</tr>
</tbody>
</table>
**Objective 3.1:** By December 31, 2018, a mentor model is available to help 15 businesses move from good to better or better to best on assessment.

Objective 3.1 Measures: Number of businesses benefiting from mentor model
Objective 3.1 Baseline: 0 businesses as of June 2017
Objective 3.1 Target: 15 businesses by December 31, 2018
Strategy 1 for Objective 3.1: Increase the capacity of worksites to improve wellness scores by providing mentors, champions, and educational opportunities.

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

Objective 4 Measures: Number of worksites completing three annual assessments
Objective 4 Baseline: 0 worksites as of June 2017
Objective 4 Target: 40 worksites by June 30, 2020
Strategy 1 for Objective 4: Reassess on an annual basis to document improvements in worksite wellness.

Other goal measures:
- Percentage of Utahns aged 18+ who were obese by year
- Percentage of adolescents who were obese in Utah by year

**Alignment**
This priority area aligns with the Healthy People 2020 goals

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

NWS-10: Reduce the proportion of children and adolescents who are considered obese
  - NWS-10.2: Children aged 6 to 11 years
    - U.S. Target: 15.7%
    - Utah Target: 10.0%
  - NWS-10.3: Adolescents aged 12 to 19 years
    - U.S. Target: 16.1%
    - Utah Target: 10.0%

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

**Resources**
Community guides for workforce wellness

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

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

Opioid Overdose Deaths

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

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

![Opioid Overdose Deaths per 100,000 by Year, Utah, 1999–2016](image1)

Trend graph depicts age-adjusted rates.

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

![Unintentional and Undetermined Opioid Deaths per 100,000 Population, Utah and U.S., 1999–2016](image2)

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

Through several concurrent efforts, an observed decrease in unintentional and undetermined prescription opioid deaths has been seen in Utah since 2014. However, the increase in deaths related to heroin and other illicit opioids is concerning (Figure 12).
In Utah there were 2.2 million opioid prescriptions dispensed in 2016. Table 3 gives information about the prescribing practices in Utah.


<table>
<thead>
<tr>
<th>Mortality Indicators per 100,000 Population</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Drug Overdose Deaths</td>
<td>22.0</td>
<td>22.7</td>
<td>20.1</td>
</tr>
<tr>
<td>Rate of Drug Overdose Deaths Involving Opioids</td>
<td>16.5</td>
<td>15.7</td>
<td>14.8</td>
</tr>
<tr>
<td>Rate of Drug Overdose Deaths Involving Prescription Opioids</td>
<td>14.5</td>
<td>13.5</td>
<td>11.1</td>
</tr>
<tr>
<td>Rate of Drug Overdose Deaths Involving Heroin</td>
<td>3.7</td>
<td>4.2</td>
<td>5.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescribing Indicators</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Patients Prescribed High-dose Prescription Opioids</td>
<td>12.1%</td>
<td>10.3%</td>
</tr>
<tr>
<td>% of Long-acting/Extended-release Opioids Prescribed to Opioid-naïve Patients</td>
<td>15.7%</td>
<td>20.8%</td>
</tr>
<tr>
<td>% of Patients with Overlapping Opioid Prescriptions</td>
<td>22.0%</td>
<td>21.4%</td>
</tr>
<tr>
<td>% of Patients with Overlapping Opioid and Benzodiazepine Prescriptions</td>
<td>13.8%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Rate of Multiple Provider Episodes (≥5 prescribers and ≥5 pharmacies in a 6-month period) per 100,000 Population</td>
<td>27.1</td>
<td>21.9</td>
</tr>
</tbody>
</table>

Data source: Utah Controlled Substance Database

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

The highest rates of unintentional and undetermined opioid overdose deaths occurred in Utahns aged 25–64 (Table 4). Southeast Utah and Weber-Morgan Local Health Districts had significantly higher death rates from unintentional and undetermined opioid overdose deaths (29.9 and 19.7 per 100,000, respectively) during 2014–2016 (Map 5 and Table 5).

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

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

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

#### Crude (burden)

<table>
<thead>
<tr>
<th>STATE COMPARISON (2016)</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>12.5</td>
<td>12.4-12.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebraska (best)</td>
<td>2.1</td>
<td>1.5-2.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah (32nd of 51)</td>
<td>13.9</td>
<td>12.6-15.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia (worst)</td>
<td>38.8</td>
<td>35.9-41.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Age in Years (2016)

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>•**</td>
<td>** **</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>15–24</td>
<td>7.9</td>
<td>5.6-10.9</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>25–34</td>
<td>25.4</td>
<td>20.7-30.1</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>35–44</td>
<td>28.7</td>
<td>23.5-33.9</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>45–54</td>
<td>24.8</td>
<td>19.6-31.0</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>55–64</td>
<td>22.3</td>
<td>17.2-28.5</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>65+</td>
<td>**</td>
<td>** **</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

#### Gender (2016)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17.3</td>
<td>15.2-19.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10.4</td>
<td>8.8-12.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Race (2012–2016)

<table>
<thead>
<tr>
<th>Race</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/AK Native</td>
<td>12.3</td>
<td>8.3-17.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander*</td>
<td>* 1.4-4.2</td>
<td>* 1.1-3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black*</td>
<td>* 2.5-8.4</td>
<td>* 2.8-10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>14.2</td>
<td>13.6-14.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Ethnicity (2016)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>6.9</td>
<td>4.6-9.9</td>
<td>7.5</td>
<td>4.9-10.9</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>15.0</td>
<td>13.5-16.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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](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](http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality).

Data source: CDC National Center for Health Statistics
Table 5. Unintentional and Undetermined Opioid Overdose Deaths by Local Health District

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

* 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](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](http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality).

Data source: CDC National Center for Health Statistics

**Drug Misuse and Abuse**

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

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

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

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

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

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

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

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

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

---

**Table 6. Pain Reliever Misuse State Comparison and by Age**

<table>
<thead>
<tr>
<th>STATE COMPARISON (2015–2016)</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>4.5%</td>
<td>4.3% - 4.6%</td>
</tr>
<tr>
<td>New Jersey (best)</td>
<td>3.8%</td>
<td>3.2% - 4.4%</td>
</tr>
<tr>
<td>Utah (43rd of 51)</td>
<td>4.9%</td>
<td>4.2% - 5.7%</td>
</tr>
<tr>
<td>Oregon (worst)</td>
<td>5.4%</td>
<td>4.6% - 6.4%</td>
</tr>
</tbody>
</table>

**AGE IN YEARS (2015–2016)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–17</td>
<td>3.7%</td>
<td>2.8% - 4.9%</td>
</tr>
<tr>
<td>18–25</td>
<td>8.3%</td>
<td>6.7% - 10.3%</td>
</tr>
<tr>
<td>26+</td>
<td>4.4%</td>
<td>3.6% - 5.4%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>STATE COMPARISON (2015–2016)</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>2.8%</td>
<td>2.7% - 2.9%</td>
</tr>
<tr>
<td>New Jersey (best)</td>
<td>2.2%</td>
<td>1.7% - 2.7%</td>
</tr>
<tr>
<td>Utah (4th of 51)</td>
<td>2.7%</td>
<td>2.1% - 3.4%</td>
</tr>
<tr>
<td>Vermont (worst)</td>
<td>4.3%</td>
<td>3.5% - 5.3%</td>
</tr>
</tbody>
</table>

**AGE IN YEARS (2015–2016)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–17</td>
<td>6.0%</td>
<td>4.6% - 7.6%</td>
</tr>
<tr>
<td>18–25</td>
<td>15.0%</td>
<td>12.3% - 18.3%</td>
</tr>
<tr>
<td>26+</td>
<td>5.9%</td>
<td>4.7% - 7.4%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>STATE COMPARISON (2015–2016)</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>2.8%</td>
<td>2.7% - 2.9%</td>
</tr>
<tr>
<td>New Jersey (best)</td>
<td>2.2%</td>
<td>1.7% - 2.7%</td>
</tr>
<tr>
<td>Utah (19th of 51)</td>
<td>2.7%</td>
<td>2.1% - 3.4%</td>
</tr>
<tr>
<td>Alaska (worst)</td>
<td>4.3%</td>
<td>3.5% - 5.3%</td>
</tr>
</tbody>
</table>

**AGE IN YEARS (2015–2016)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–17</td>
<td>2.6%</td>
<td>1.9% - 3.6%</td>
</tr>
<tr>
<td>18–25</td>
<td>6.9%</td>
<td>5.2% - 9.0%</td>
</tr>
<tr>
<td>26+</td>
<td>1.7%</td>
<td>1.3% - 2.4%</td>
</tr>
</tbody>
</table>

Data source: National Survey on Drug Use and Health SAMHSA

Note: Because of changes in measurement in 2015 for 7 of the 10 illicit drug categories—hallucinogens, inhalants, methamphetamine, and the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives—estimates of use of any illicit drug and these seven illicit drug categories in 2016 are not comparable with estimates prior to 2015.
Current Efforts

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

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

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

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

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

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

In 2015, the UDOH received one-time funding to address prescription drug abuse, misuse, and overdose deaths by continuing data collection efforts to help target interventions, develop provider materials, increase naloxone awareness, expand public awareness efforts, and develop provider tools and resources to address prescription drug abuse.
The Utah Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH) is charged with providing drug and alcohol abuse prevention activities in Utah. Information on the DSAMH may be found at https://dsamh.utah.gov/.

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

Figure 15. Utah Coalition for Opioid Overdose Prevention Structure

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

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

The logic model for these efforts is shown in Figure 16.
Goals, Objectives, and Strategies

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

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

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

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

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

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

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

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

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

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

Strategy 1 for Objective 2: Increase provider utilization of the controlled substance database in at least one health system by March 2018.
### Goal 2: Decrease opioid overdoses by 10% from 2015 to 2019.

#### Objective 1: Improve timeliness of data, surveillance, and evaluation efforts.
- **Objective 1 Measures:** Rate of undetermined/unintentional drug overdose deaths involving opioids per 100,000 population
- **Objective 1 Baseline:** 13.6 undetermined/unintentional drug overdose deaths involving opioids per 100,000 population in 2015
- **Objective 1 Target:** 12.3 undetermined/unintentional drug overdose deaths involving opioids per 100,000 population in 2019
- **Strategy 1 for Objective 1:** Identify gaps in current data collection efforts and explore opportunities to address gaps by October 2017.
- **Strategy 2 for Objective 1:** Increase frequency of surveillance reports in three high-burden areas by March 2018.

#### Objective 2: Promote public awareness of opioid risks, signs of an overdose, safe storage, safe disposal, and naloxone.
- **Objective 2 Measures:** Rate of drug overdose hospitalizations involving opioids per 10,000 population, acute care hospitals only including all opioids including heroin, unintentional, or undetermined
- **Objective 2 Baseline:** 1.9 hospitalizations per 10,000 population in 2015
- **Objective 2 Target:** 1.7 hospitalizations per 10,000 population in 2019
- **Strategy 1 for Objective 2:** Reduce community norms favorable to misuse and abuse in at least three high-burden areas through public awareness messages and efforts by March 2018.
- **Strategy 2 for Objective 2:** Target at least three high-burden areas to promote existing public awareness messages by March 2018.
- **Strategy 3 for Objective 2:** Develop an opioid abuse, misuse, and overdose prevention social media plan and publish three social media posts each week with targeted boosts in at least three high-burden areas by July 2017.

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

#### Objective 1: Increase pharmacy based naloxone access and education.
- **Objective 1 Measures:** Percentage of pharmacies participating in Utah’s Statewide Standing Order
- **Objective 1 Baseline:** 0% of pharmacies participating in Utah’s Statewide Standing Order in 2015
- **Objective 1 Target:** 50% of pharmacies participating in Utah’s Statewide Standing Order in 2019
- **Strategy 1 for Objective 1:** Increase pharmacy participation in the Talk to Your Pharmacist Month campaign.
- **Strategy 2 for Objective 1:** Increase pharmacy participation in Utah’s Statewide Standing Order.

#### Objective 2: Increase community-based naloxone access and education.
- **Objective 2 Measures:** Number of naloxone doses dispensed through Utah's Statewide Standing Order or by enrolled Opiate Overdose Outreach Providers
- **Objective 2 Baseline:** 0 naloxone doses dispensed through Utah's Statewide Standing Order or by enrolled Opiate Overdose Outreach Providers in 2015
- **Objective 2 Target:** 10,000 naloxone doses dispensed through Utah's Statewide Standing Order or by enrolled Opiate Overdose Outreach Providers in 2019
- **Strategy 1 for Objective 2:** Increase availability, access, training, and dissemination of naloxone in three high burden areas by July 2017.

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

#### Objective 1: Increase the number of individuals accessing public substance abuse disorder treatment.
- **Objective 1 Measures:** Number of individuals served in public substance abuse disorder treatment
- **Objective 1 Baseline:** 15,049 individuals served in public substance abuse treatment in 2015
- **Objective 1 Target:** 16,550 individuals served in public substance abuse treatment in 2019
- **Strategy 1 for Objective 1:** Identify treatment resources, gaps, and barriers in three high-burden areas and provide recommendations to increase access to treatment by October 2017.
- **Strategy 2 for Objective 1:** Increase the number of medication assisted treatment training opportunities and providers receiving the training in three high-burden communities by March 2018.
Other goal measures:

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

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

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

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

Alignment

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

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

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

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

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

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

The UHIP Workgroup plan also aligns with the following Health People 2020 objectives:

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

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

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

**U.S. Target:** 7.1 percent for adults 18 and older
Resources

There are currently collaborative partnerships that can be utilized to address the UHIP goals, including the UCOOP. There is currently federal and state funding allocated to assist with addressing this issue. There is a grant that was awarded to enhance access to and reporting of data from the Utah Division of Occupational and Professional Licensing Controlled Substance Database.

Websites

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

Barriers/Challenges

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

Partners

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

- Intermountain Healthcare
- The Partnership for a Drug-Free America
- Utah Department of Health
- Utah Department of Human Services
- Salt Lake City Police Department
- Utah Poison Control Center
- Veteran’s Administration - Salt Lake City Health Care System
- SMART - Utah County
- Bear River LHD
- Heber Valley Counseling Center
• Midvale United
• Neighborhoods United
• Salt Lake County LHD
• Summit Valley Mental Health
• Tooele Valley Mental Health
• Utah Council for Crime Prevention
• Utah Department of Commerce
• Utah Department of Environmental Quality
• Utah Division of Substance Abuse and Mental Health
• Weber Human Services
• Utah Substance Abuse Advisory Council
Improving Mental Health and Reducing Suicide
Background/Contextual Information for Health Priority

Mental Health Status

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

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

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

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

<table>
<thead>
<tr>
<th>STATE COMPARISON (2016)^</th>
<th>Crude (burden) Rate</th>
<th>95% CIs</th>
<th>Age-adjusted (comparison) Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>16.8%</td>
<td>16.6% - 17.1%</td>
<td>17.2%</td>
<td>16.9% - 17.4%</td>
</tr>
<tr>
<td>South Dakota (best)</td>
<td>12.2%</td>
<td>10.7% - 13.9%</td>
<td>12.8%</td>
<td>11.2% - 14.6%</td>
</tr>
<tr>
<td>Utah (21st of 51)</td>
<td>17.1%</td>
<td>16.0% - 18.1%</td>
<td>16.5%</td>
<td>15.6% - 17.5%</td>
</tr>
<tr>
<td>West Virginia (worst)</td>
<td>22.0%</td>
<td>20.9% - 23.2%</td>
<td>23.0%</td>
<td>21.7% - 24.3%</td>
</tr>
</tbody>
</table>

AGE IN YEARS (2016)

| 18–34        | 22.9% | 20.8% - 25.2% | -     | -     | -     |
| 35–49        | 16.2% | 14.4% - 18.1% | -     | -     | -     |
| 50–64        | 13.5% | 11.9% - 15.2% | -     | -     | ✓     |
| 65+          | 9.8%  | 8.4% - 11.4%  | -     | -     | ✓     |

GENDER (2016)

| Male         | 13.0% | 11.8% - 14.2% | 12.5%   | 11.3% - 13.7% ✓ |
| Female       | 21.1% | 19.5% - 22.8% | 20.6%   | 19.2% - 22.2% ! |

RACE (2014–2016)

| American Indian/AK Native | 21.4% | 16.6% - 27.0% | 21.2%   | 16.6% - 26.7% ! |
| Asian                   | 13.5% | 10.0% - 17.9% | 12.1%   | 8.8% - 16.4%   |
| Black                   | 19.1% | 14.1% - 25.4% | 20.2%   | 15.0% - 26.5%  |
| Pacific Islander        | 17.7% | 12.4% - 24.7% | 18.1%   | 12.4% - 25.7%  |
| White                   | 16.4% | 15.9% - 17.0% | 16.2%   | 15.6% - 16.7%  |

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

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

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

Data source: Utah Behavioral Risk Factor Surveillance System
Table 10. Poor Mental Health Status by Ethnicity, Income, Education, and Local Health District, Adults Aged 18+

<table>
<thead>
<tr>
<th>ETHNICITY (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>95% Cls</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15.4%</td>
<td>12.3% -19.1%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>17.2%</td>
<td>16.2% -18.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCOME (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–$24,999</td>
<td>27.8%</td>
<td>24.8% -31.1%</td>
</tr>
<tr>
<td>$25,000–$49,999</td>
<td>18.7%</td>
<td>16.4% -21.2%</td>
</tr>
<tr>
<td>$50,000–$74,999</td>
<td>15.6%</td>
<td>13.4% -18.1%</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>11.0%</td>
<td>9.5% -12.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATION—Adults 25+ (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below High School</td>
<td>21.4%</td>
<td>16.7% -27.0%</td>
</tr>
<tr>
<td>High School or GED</td>
<td>16.5%</td>
<td>14.5% -18.7%</td>
</tr>
<tr>
<td>Some Post High School</td>
<td>16.7%</td>
<td>15.0% -18.5%</td>
</tr>
<tr>
<td>College Graduate</td>
<td>10.9%</td>
<td>9.7% -12.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICT (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>17.2%</td>
<td>13.7% -21.3%</td>
</tr>
<tr>
<td>Central Utah</td>
<td>13.4%</td>
<td>10.1% -17.6%</td>
</tr>
<tr>
<td>Davis County</td>
<td>16.2%</td>
<td>13.5% -19.4%</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>16.6%</td>
<td>14.8% -18.5%</td>
</tr>
<tr>
<td>San Juan</td>
<td>17.8%</td>
<td>10.8% -27.9%</td>
</tr>
<tr>
<td>Southeast Utah</td>
<td>17.1%</td>
<td>12.9% -22.4%</td>
</tr>
<tr>
<td>Southwest Utah</td>
<td>15.0%</td>
<td>12.1% -18.5%</td>
</tr>
<tr>
<td>Summit County</td>
<td>13.1%</td>
<td>8.8% -18.9%</td>
</tr>
<tr>
<td>Tooele County</td>
<td>19.7%</td>
<td>15.1% -25.1%</td>
</tr>
<tr>
<td>TriCounty</td>
<td>16.8%</td>
<td>13.4% -20.9%</td>
</tr>
<tr>
<td>Utah County</td>
<td>17.8%</td>
<td>15.3% -20.7%</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>11.0%</td>
<td>7.1% -16.7%</td>
</tr>
<tr>
<td>Weber-Morgan</td>
<td>21.5%</td>
<td>18.4% -25.0%</td>
</tr>
</tbody>
</table>

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

Depression

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

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

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

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

Adults in Summit County (17.1%) and TriCounty (18.2%) Local Health Districts reported lower rates of doctor-diagnosed depression during 2014–2016 (Table 12).
Utah adults who reported chronic illnesses and/or poor health status in general, were also more likely to report having ever been told they had a depressive disorder. It is known that behavioral health problems often co-occur with chronic diseases and may exacerbate poor health outcomes.

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

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

Trend graph depicts age-adjusted rates.

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

<table>
<thead>
<tr>
<th>STATE COMPARISON (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>16.6% 16.4%-16.8%</td>
<td>16.7% 16.5%-17.0%</td>
</tr>
<tr>
<td>New York (best)</td>
<td>11.7% 11.1%-12.4%</td>
<td>11.8% 11.1%-12.5%</td>
</tr>
<tr>
<td>Utah (39th of 51)</td>
<td>21.5% 20.5%-22.6%</td>
<td>21.5% 20.5%-22.6%</td>
</tr>
<tr>
<td>Oregon (worst)</td>
<td>25.0% 23.6%-26.4%</td>
<td>25.9% 24.4%-27.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGE IN YEARS (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–34</td>
<td>22.6% 20.5%-24.8%</td>
<td>- - - -</td>
</tr>
<tr>
<td>35–49</td>
<td>21.7% 19.7%-23.8%</td>
<td>- - - -</td>
</tr>
<tr>
<td>50–64</td>
<td>22.9% 20.9%-25.0%</td>
<td>- - - -</td>
</tr>
<tr>
<td>65+</td>
<td>17.3% 15.6%-19.1%</td>
<td>- - - -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENDER (2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14.9% 13.6%-16.3%</td>
<td>14.8% 13.5%-16.1%</td>
</tr>
<tr>
<td>Female</td>
<td>28.1% 26.5%-29.8%</td>
<td>28.3% 26.7%-29.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RACE (2014–2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/AK Native</td>
<td>23.4% 19.1%-28.4%</td>
<td>23.9% 19.5%-28.9%</td>
</tr>
<tr>
<td>Asian</td>
<td>11.2% 7.6%-16.3%</td>
<td>10.1% 7.0%-14.2%</td>
</tr>
<tr>
<td>Black</td>
<td>18.8% 14.0%-24.6%</td>
<td>19.9% 15.0%-26.0%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>13.3% 8.5%-20.1%</td>
<td>11.1% 7.2%-16.9%</td>
</tr>
<tr>
<td>White</td>
<td>21.9% 21.3%-22.5%</td>
<td>21.9% 21.4%-22.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ETHNICITY (2014–2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>15.2% 13.6%-16.9%</td>
<td>16.9% 15.0%-18.9%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>21.8% 21.3%-22.4%</td>
<td>21.9% 21.3%-22.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCOME (2014–2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–$24,999</td>
<td>29.3% 27.8%-30.8%</td>
<td>31.3% 29.7%-32.9%</td>
</tr>
<tr>
<td>$25,000–$49,999</td>
<td>22.6% 21.3%-23.9%</td>
<td>23.0% 21.7%-24.3%</td>
</tr>
<tr>
<td>$50,000–$74,999</td>
<td>20.5% 19.2%-21.9%</td>
<td>20.4% 19.0%-21.8%</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>16.9% 16.1%-17.9%</td>
<td>16.7% 15.8%-17.7%</td>
</tr>
</tbody>
</table>

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

Data source: Utah Behavioral Risk Factor Surveillance System
Table 12. Depression by Education and Local Health District, Adults Aged 18+

<table>
<thead>
<tr>
<th>EDUCATION—Adults 25+ (2014–2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>95% CIs</td>
</tr>
<tr>
<td>Below High School</td>
<td>21.5%</td>
<td>19.1% - 24.1%</td>
</tr>
<tr>
<td>High School or GED</td>
<td>21.2%</td>
<td>20.2% - 22.4%</td>
</tr>
<tr>
<td>Some Post High School</td>
<td>23.9%</td>
<td>22.9% - 25.0%</td>
</tr>
<tr>
<td>College Graduate</td>
<td>18.0%</td>
<td>17.2% - 18.8%</td>
</tr>
</tbody>
</table>

LOCAL HEALTH DISTRICT (2014–2016)

<table>
<thead>
<tr>
<th></th>
<th>Rate</th>
<th>95% CIs</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>19.2%</td>
<td>17.3% - 21.3%</td>
<td>19.4%</td>
<td>17.5% - 21.4%</td>
</tr>
<tr>
<td>Central Utah</td>
<td>19.3%</td>
<td>17.0% - 21.9%</td>
<td>19.9%</td>
<td>17.6% - 22.5%</td>
</tr>
<tr>
<td>Davis County</td>
<td>22.1%</td>
<td>20.4% - 23.8%</td>
<td>21.7%</td>
<td>20.1% - 23.4%</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>22.0%</td>
<td>21.0% - 23.0%</td>
<td>21.9%</td>
<td>21.0% - 22.9%</td>
</tr>
<tr>
<td>San Juan</td>
<td>14.5%</td>
<td>9.9% - 20.7%</td>
<td>14.8%</td>
<td>10.2% - 21.0%</td>
</tr>
<tr>
<td>Southeast Utah</td>
<td>21.5%</td>
<td>18.4% - 24.9%</td>
<td>21.1%</td>
<td>17.9% - 24.8%</td>
</tr>
<tr>
<td>Southwest Utah</td>
<td>18.4%</td>
<td>16.7% - 20.3%</td>
<td>19.1%</td>
<td>17.2% - 21.1%</td>
</tr>
<tr>
<td>Summit County</td>
<td>16.7%</td>
<td>13.6% - 20.3%</td>
<td>17.1%</td>
<td>13.8% - 20.9%</td>
</tr>
<tr>
<td>Tooele County</td>
<td>24.0%</td>
<td>20.8% - 27.6%</td>
<td>23.8%</td>
<td>20.6% - 27.3%</td>
</tr>
<tr>
<td>TriCounty</td>
<td>18.5%</td>
<td>15.9% - 21.3%</td>
<td>18.2%</td>
<td>15.7% - 20.9%</td>
</tr>
<tr>
<td>Utah County</td>
<td>20.8%</td>
<td>19.4% - 22.3%</td>
<td>20.6%</td>
<td>19.3% - 21.9%</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>17.1%</td>
<td>13.5% - 21.5%</td>
<td>17.0%</td>
<td>13.5% - 21.2%</td>
</tr>
<tr>
<td>Weber-Morgan</td>
<td>22.7%</td>
<td>21.0% - 24.5%</td>
<td>22.6%</td>
<td>20.9% - 24.4%</td>
</tr>
</tbody>
</table>

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

Suicide

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

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

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

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

Significant risk factors for suicide ideation among Utah youth were being bullied at school or online and substance use in the previous month. Multiple logistic regression identified being female, in 10th grade, non-White, and low parental education as risk factors for suicide ideation and attempt. Youth in the TriCounty Local Health District also were at higher risk. Students who reported participating more frequently in religious activities and those from Bear River, Southwest, Summit, and Wasatch Local Health Districts had lesser risk of suicide ideation. Supportive social environments were found to be protective for suicide ideation and attempts. Supportive social environments are characterized by ones in which youth feel...
involved, valued, and able to ask for and receive help when they need it. Supportive family environments had the biggest impact on reducing suicide ideation, followed by community environments, school environments, and peer environments.\(^1\)

Other conditions and stressors that may be related to suicide include:\(^2\)

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

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

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

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

![Graph showing suicide rates per 100,000 population aged 10+ for Utah and the U.S. from 1999 to 2016.]

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

![Graph showing suicide rates per 100,000 population for Utah from 2000 to 2016.]

---

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

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

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

<table>
<thead>
<tr>
<th>STATE COMPARISON (2016)^</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>95% CIs</td>
</tr>
<tr>
<td>U.S.</td>
<td>13.9</td>
<td>13.8 - 14.0</td>
</tr>
<tr>
<td>District of Columbia (best)</td>
<td>5.9</td>
<td>4.2 - 8.0</td>
</tr>
<tr>
<td>Utah (47th of 51)</td>
<td>20.1</td>
<td>18.5 - 21.7</td>
</tr>
<tr>
<td>Montana (worst)</td>
<td>25.6</td>
<td>22.5 - 28.7</td>
</tr>
</tbody>
</table>

### AGE IN YEARS (2016)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10–14*</td>
<td>3.9</td>
<td>1.9 - 7.2</td>
</tr>
<tr>
<td>15–17</td>
<td>14.9</td>
<td>9.3 - 22.5</td>
</tr>
<tr>
<td>18–19</td>
<td>21.0</td>
<td>12.7 - 32.9</td>
</tr>
<tr>
<td>20–24</td>
<td>22.9</td>
<td>17.4 - 29.6</td>
</tr>
<tr>
<td>25–34</td>
<td>27.2</td>
<td>22.6 - 32.5</td>
</tr>
<tr>
<td>35–44</td>
<td>31.2</td>
<td>26.0 - 37.0</td>
</tr>
<tr>
<td>45–54</td>
<td>35.0</td>
<td>28.8 - 42.2</td>
</tr>
<tr>
<td>55–64</td>
<td>25.1</td>
<td>19.7 - 31.5</td>
</tr>
<tr>
<td>65–74</td>
<td>19.9</td>
<td>14.1 - 27.3</td>
</tr>
<tr>
<td>75+</td>
<td>24.6</td>
<td>16.8 - 34.8</td>
</tr>
</tbody>
</table>

### GENDER (2016)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>29.9</td>
<td>27.2 - 32.8</td>
</tr>
<tr>
<td>Female</td>
<td>10.1</td>
<td>8.6 - 11.8</td>
</tr>
</tbody>
</table>

### RACE (2014–2016)

<table>
<thead>
<tr>
<th>Race</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/AK Native</td>
<td>24.6</td>
<td>17.0 - 34.4</td>
</tr>
<tr>
<td>Asian</td>
<td>9.6</td>
<td>5.9 - 14.6</td>
</tr>
<tr>
<td>Black*</td>
<td>8.4</td>
<td>4.0 - 15.4</td>
</tr>
<tr>
<td>Pacific Islander*</td>
<td>8.8</td>
<td>3.8 - 17.4</td>
</tr>
<tr>
<td>White</td>
<td>20.4</td>
<td>19.4 - 21.4</td>
</tr>
</tbody>
</table>

### ETHNICITY (2014–2016)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Rate</th>
<th>95% CIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>9.7</td>
<td>8.1 - 11.6</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>21.3</td>
<td>20.3 - 22.3</td>
</tr>
</tbody>
</table>

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

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

---

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

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

**Data source:** Utah Death Certificate Database

**Percentage of Suicides**

- **Firearm:** 48.6%
- **Suffocation:** 45.0%
- **Poisoning:** 23.7%
- **Other:** 5.5%

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

Table 14. Suicide by Local Health District

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICT (2014–2016)</th>
<th>Crude (burden)</th>
<th>Age-adjusted (comparison)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>95% CIs</td>
</tr>
<tr>
<td>Bear River</td>
<td>17.5</td>
<td>14.1 - 21.5</td>
</tr>
<tr>
<td>Central Utah</td>
<td>29.3</td>
<td>22.8 - 37.2</td>
</tr>
<tr>
<td>Davis County</td>
<td>14.3</td>
<td>12.1 - 16.8</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>21.4</td>
<td>19.9 - 23.0</td>
</tr>
<tr>
<td>San Juan*</td>
<td>16.7</td>
<td>7.2 - 33.0</td>
</tr>
<tr>
<td>Southeast Utah</td>
<td>32.2</td>
<td>22.9 - 44.0</td>
</tr>
<tr>
<td>Southwest Utah</td>
<td>22.1</td>
<td>18.7 - 26.0</td>
</tr>
<tr>
<td>Summit County</td>
<td>16.8</td>
<td>10.3 - 26.0</td>
</tr>
<tr>
<td>Tooele County</td>
<td>22.7</td>
<td>16.4 - 30.6</td>
</tr>
<tr>
<td>TriCounty</td>
<td>31.3</td>
<td>23.6 - 40.7</td>
</tr>
<tr>
<td>Utah County</td>
<td>14.4</td>
<td>12.7 - 16.3</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>19.4</td>
<td>11.3 - 31.1</td>
</tr>
<tr>
<td>Weber-Morgan</td>
<td>23.9</td>
<td>20.6 - 27.7</td>
</tr>
</tbody>
</table>

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

Current Efforts

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

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

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

Goals, Objectives, and Strategies

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

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

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

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

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

Strategy 1 for Objective 1: At least 10 new organizations will formally adopt the Zero Suicide Framework systematic approach to quality improvement in health and behavioral healthcare settings.
**Goal 2: Increase social norms supportive of help seeking and recovery.**

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

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

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

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

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

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

Objective 1 Measures: Number of formal partnerships established

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

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

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

Other goal measures:

- Percentage of adults aged 18 years and older who reported seven or more days when their mental health was not good in the past 30 days.
- Percentage of adults aged 18 and older who have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression.
- Number of resident deaths resulting from the intentional use of force against oneself per 100,000 population.

**Alignment**

Aligns with the following Healthy People 2020 objectives:

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

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

**U.S. Target:** 72.3%

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

**U.S. Target:** 75.9%

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

**U.S. Target:** 5.8%

MHMD-1: Reduce the suicide rate

**U.S. Target:** 10.2 suicides per 100,000 population

**Utah Target:** 13.3 suicides per 100,000 population

**Resources**

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

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

Partners

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

Additional Participation

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

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

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

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

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

**Website**
Updates on the UHIP can be found online at [http://utphpartners.org/ship/ship.html](http://utphpartners.org/ship/ship.html).
Appendices
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>18 Initiative</td>
</tr>
<tr>
<td>AK Native</td>
<td>Alaska Native</td>
</tr>
<tr>
<td>ASIST</td>
<td>Applied Suicide Intervention Skills Training</td>
</tr>
<tr>
<td>AUCH</td>
<td>Association for Utah Community Health</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>Center TRT</td>
<td>Center for Training and Research Translation</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Plan</td>
</tr>
<tr>
<td>CMEs</td>
<td>continuing medical education credit hours</td>
</tr>
<tr>
<td>CMHC</td>
<td>Community Mental Health Centers</td>
</tr>
<tr>
<td>DEQ</td>
<td>Department of Environmental Quality</td>
</tr>
<tr>
<td>DSAMH</td>
<td>Division of Substance Abuse and Mental Health</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>4th edition of the Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>EMS</td>
<td>emergency medical services</td>
</tr>
<tr>
<td>EPICC</td>
<td>Healthy Living through Environment, Policy, and Improved Clinical Care program</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>GED</td>
<td>General Education Development</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Classification of Diseases, Tenth Revision</td>
</tr>
<tr>
<td>IT</td>
<td>information technology</td>
</tr>
<tr>
<td>LDL</td>
<td>low-density lipoprotein</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>lesbian, gay, bisexual, transgender, or queer</td>
</tr>
<tr>
<td>LHD</td>
<td>local health department</td>
</tr>
<tr>
<td>MDEs</td>
<td>major depressive episodes</td>
</tr>
<tr>
<td>MME</td>
<td>morphine milligram equivalent</td>
</tr>
<tr>
<td>MMWR</td>
<td>Morbidity and Mortality Weekly Report</td>
</tr>
<tr>
<td>N/A</td>
<td>not available</td>
</tr>
<tr>
<td>NAMI</td>
<td>National Alliance on Mental Illness</td>
</tr>
<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
</tr>
<tr>
<td>NHLBI</td>
<td>National Heart, Lung, and Blood Institute</td>
</tr>
<tr>
<td>OVRS</td>
<td>Office of Vital Records and Statistics</td>
</tr>
<tr>
<td>PNA</td>
<td>Prevention Needs Assessment</td>
</tr>
<tr>
<td>QPR</td>
<td>Question, Persuade, Refer</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SHA</td>
<td>Utah State Health Assessment</td>
</tr>
<tr>
<td>SHIP</td>
<td>State Health Improvement Plan (refers to state health improvement plan process and improvement plan from 2012–2016. The new plan is referred to as the Utah Health Improvement Plan.)</td>
</tr>
<tr>
<td>SMI</td>
<td>serious mental illness</td>
</tr>
<tr>
<td>SWOT</td>
<td>strengths, weaknesses, opportunities, threats</td>
</tr>
<tr>
<td>UALHD</td>
<td>Utah Association of Local Health Departments</td>
</tr>
<tr>
<td>UCOOP</td>
<td>Utah Coalition for Opioid Overdose Prevention</td>
</tr>
<tr>
<td>UDOH</td>
<td>Utah Department of Health</td>
</tr>
<tr>
<td>UHIP</td>
<td>Utah Health Improvement Plan</td>
</tr>
<tr>
<td>UDOT</td>
<td>Utah Department of Transportation</td>
</tr>
<tr>
<td>UIHAB</td>
<td>Utah Indian Health Advisory Board</td>
</tr>
<tr>
<td>UNIS</td>
<td>Utah Notification and Information System</td>
</tr>
<tr>
<td>UTVDRS</td>
<td>Utah Violent Death Reporting System</td>
</tr>
<tr>
<td>VIPP</td>
<td>Violence and Injury Prevention Program</td>
</tr>
<tr>
<td>WONDER</td>
<td>Wide-ranging Online Data for Epidemiologic Research</td>
</tr>
<tr>
<td>YRBS</td>
<td>Youth Risk Behavior Survey</td>
</tr>
<tr>
<td>YRBSS</td>
<td>Youth Risk Behavior Surveillance System</td>
</tr>
</tbody>
</table>
academic detailing – structured visits by trained personnel to healthcare practices for the purpose of delivering tailored training and technical assistance to healthcare providers to help them use best practices (see https://www.cdc.gov/tobacco/stateandcommunity/pdfs/academicdetailingfaq_120913_cleared_508.pdf)

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

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

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

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

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

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

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

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

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

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

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

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

catchment area – the geographical area served by an institution

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**HealthInsight** – a private, nonprofit, community-based organization dedicated to improving health and healthcare, composed of locally governed organizations in four western states: Nevada, New Mexico, Oregon and Utah (see [http://healthinsight.org/about-us](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](https://www.healthypeople.gov/2020/About-Healthy-People))

**hepatitis** – an inflammation of the liver

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

**House Bill 11** – Overdose Reporting Amendments: this bill provides that a person who reports a person's overdose from a controlled substance or other substance may claim an affirmative defense to specified charges of violating the Utah Controlled Substances Act if the person remains with the person who is subject to the overdose and cooperates with responding medical providers and law enforcement officers; and provides that remaining with a person subject to an overdose and cooperating with medical providers and law enforcement is a mitigating factor when determining the penalty for a related violation of the Utah Controlled Substances Act (see [http://le.utah.gov/~2014/bills/static/HB0011.html](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](http://le.utah.gov/~2010/bills/static/HB0028.html))

**House Bill 119** – Opiate Overdose Emergency Treatment: this bill defines terms; permits the dispensing and administration of an opiate antagonist to a person who is reasonably believed to be experiencing an opiate-related drug overdose event; establishes immunity for the good faith administration of an opiate antagonist; clarifies that the administration of an opiate antagonist is voluntary and that the act does not establish a duty to administer an opiate antagonist; clarifies that it is not unlawful or unprofessional conduct for certain health professionals to prescribe an opiate antagonist to: a person at increased risk of experiencing an opiate-related drug overdose event or a family member, friend, or other person in a position to assist a person who is at increased risk of experiencing an opiate-related drug overdose; and requires
a person who prescribes or dispenses an opiate antagonist to advise a person to seek a medical evaluation after experiencing a drug overdose and taking an opiate antagonist (see http://le.utah.gov/~2014/bills/static/HB0119.html)

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

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

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

**Latino** – see listing for Hispanic or Latino

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

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

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

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

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

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

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

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

**Naloxone Law** – see listing for House Bill 119

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

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

**Native American** – see listing for American Indian/Alaska Native

**Native Hawaiian/Pacific Islander** – see listing for Pacific Islander

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

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

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

**opioid** – Opioids are medications that relieve pain. They reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes
the effects of a painful stimulus. Medications that fall within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs.

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

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

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

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

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

**psychotherapeutics** – pain relievers, tranquilizers, stimulants, and sedatives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Utah Notification and Information System – a secure communication system that exchanges information within and between agencies and disciplines throughout the State of Utah. UNIS utilizes multiple formats to deliver notifica-
tions which include email, phone, fax, pager, and text messaging. (see https://unis.utah.gov)

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

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

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

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

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

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

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

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

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

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

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

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

Healthy People 2020 Objectives Referenced in Report

Mental Health and Mental Disorders
MHMD-1 – Reduce the suicide rate
MHMD-4.2 – Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs)
MHMD-9 – Increase the proportion of adults with mental health disorders who receive treatment
MHMD-9.1 – Increase the proportion of adults aged 18 years and older with serious mental illness (SMI) who receive treatment
MHMD-9.2 – Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment

Nutrition and Weight Status
NWS-9 – Reduce the proportion of adults who are obese
NWS-10 – Reduce the proportion of children and adolescents who are considered obese
NWS-10.2 – Reduce the proportion of children aged 6 to 11 years who are considered obese
NWS-10.3 – Reduce the proportion of adolescents aged 12 to 19 years who are considered obese
NWS-12 – Eliminate very low food security among children
NWS-13 – Reduce household food insecurity and in doing so reduce hunger

Substance Abuse
SA-13.3 – Reduce the proportion of adults reporting use of any illicit drug during the past 30 days
SA-14.3 – Reduce the proportion of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older
SA-15 – Reduce the proportion of adults who drank excessively in the previous 30 days
SA-19.1 – Reduce the past-year nonmedical use of pain relievers
Available Services/Resources

Reducing Obesity and Obesity-related Chronic Conditions

Obesity—Adults
The UDOH EPICC Program
http://www.choosehealth.utah.gov
Utah Worksite Wellness Council
http://utahworksitewellness.org
Making the Healthy Choice the Easy Choice, The Utah Nutrition and Physical Activity Plan 2010–2020
The National Center for Chronic Disease Prevention and Health Promotion
https://www.cdc.gov/obesity/index.html
National Heart, Lung, and Blood Institute (NHLBI) Obesity Education Initiative
https://www.nhlbi.nih.gov/about/org/oei

Obesity—Minor
Action for Healthy Kids Program
http://www.actionforhealthykids.org/
Utah Department of Health
http://www.choosehealth.utah.gov/

Reducing Prescription Drug Misuse, Abuse, and Overdose

Prescription Drug Deaths
Use Only As Directed media campaign
http://www.useonlyasdirected.org
Utah Poison Control Center
http://poisoncontrol.utah.edu
National Institutes of Health: National Institute on Drug Abuse
http://drugabuse.gov
Utah Division of Substance Abuse and Mental Health
Utah Department of Human Services
https://dsamh.utah.gov/

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

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

The State of Obesity: Better Policies for a Healthier America
http://healthymericans.org/report/115/
The Surgeon General’s Call to Action to Prevent and Decrease Overweight & Obesity
https://www.surgeongeneral.gov/library/calls/
Information on the BRFSS may be found at
http://www.cdc.gov/brfss/
Trust for America's Health
http://healthymericans.org/reports/stateofobesity2017

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

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

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

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

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

More information on the BRFSS may be found at http://www.cdc.gov/brfss/
Local mental health centers
http://dsamh.utah.gov/mental-health/#box1
Utah Psychological Association
https://utpsych.org/directory/

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

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

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

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

Mobile Crisis Outreach Team—Salt Lake County
801-587-3000
Man Therapy
http://mantherapy.org/
Available Services/Resources

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

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

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

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

Permission to Grieve: For Survivors of a Loved One's Suicide

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

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

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

Utah Violence and Injury Prevention Plan

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
Local Health District Summary Tables
### Table 15. Bear River Summary

<table>
<thead>
<tr>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page</td>
<td>Crude (burden) Rate</td>
</tr>
</tbody>
</table>

**REDUcing Obesity and Obesity-Related Chronic Conditions**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity—Adult, 2016</strong> <em>(Percentage of adults with a body mass index of 30 or more)</em></td>
<td>20 27.7% 29.8% ≈ 26.2% 29.6%</td>
</tr>
<tr>
<td><strong>Obesity—Minor, 2017§</strong> <em>(Percentage of students in grades 8, 10, and 12)</em></td>
<td>21 8.3% – ≈ 9.5% N/A</td>
</tr>
</tbody>
</table>

**Reducing Prescription Drug Misuse, Abuse, and Overdose**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016</strong> <em>(Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])</em>*</td>
<td>29 8.4 10.1 ✓ 14.7 10.4</td>
</tr>
<tr>
<td><strong>Pain Reliever Misuse, 2015–2016</strong> <em>(Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</em></td>
<td>31 N/A N/A N/A 4.9% 4.5%</td>
</tr>
<tr>
<td><strong>Illicit Drug Use, 2015–2016</strong> <em>(Percentage of persons aged 12+ reporting illicit drug use in the past month)</em></td>
<td>31 N/A N/A N/A 7.4% 10.4%</td>
</tr>
<tr>
<td><strong>Illicit Drug Use Disorder, 2015–2016</strong> <em>(Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</em></td>
<td>31 N/A N/A N/A 2.7% 2.8%</td>
</tr>
</tbody>
</table>

**Improving Mental Health and Reducing Suicide**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Status, 2016</strong> <em>(Percentage of adults with 7+ days poor mental health in past 30 days)</em></td>
<td>41 17.2% 16.3% ≈ 16.5% 17.2%</td>
</tr>
<tr>
<td><strong>Depression, 2014–2016</strong> <em>(Percentage of adults ever told by a doctor they had a depressive disorder)</em></td>
<td>43 19.2% 19.4% ≈ 21.0% N/A</td>
</tr>
<tr>
<td><strong>Suicide, 2013–2016#</strong> <em>(Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, <em>U03])</em></em></td>
<td>46 17.5 18.7 ≈ 21.2 13.3</td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.

# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
Table 16. Central Utah Summary

<table>
<thead>
<tr>
<th>Issue</th>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
<tr>
<td>REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)</td>
<td>20</td>
<td>27.0%</td>
<td>27.4%</td>
</tr>
<tr>
<td>Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)</td>
<td>21</td>
<td>9.9%</td>
<td>–</td>
</tr>
<tr>
<td>REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016</td>
<td>29</td>
<td>10.3</td>
<td>12.2</td>
</tr>
<tr>
<td>Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</td>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>I illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)</td>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</td>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>IMPROVING MENTAL HEALTH and REDUCING SUICIDE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)</td>
<td>41</td>
<td>13.4%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)</td>
<td>43</td>
<td>19.3%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])</td>
<td>46</td>
<td>29.3</td>
<td>31.3</td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
Table 17. Davis County Summary

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

### REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS

#### Obesity—Adult, 2016
(Percentage of adults with a body mass index of 30 or more)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
<tr>
<td>20</td>
<td>26.0%</td>
<td>26.5%</td>
</tr>
</tbody>
</table>

#### Obesity—Minor, 2017§
(Percentage of students in grades 8, 10, and 12)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>8.0%</td>
<td>–</td>
</tr>
</tbody>
</table>

### REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE

#### Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016
(Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>10.9</td>
<td>11.6</td>
</tr>
</tbody>
</table>

#### Pain Reliever Misuse, 2015–2016
(Percentage of persons aged 12+ reporting pain reliever misuse in the past month)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Illicit Drug Use, 2015–2016
(Percentage of persons aged 12+ reporting illicit drug use in the past month)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Illicit Drug Use Disorder, 2015–2016
(Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### IMPROVING MENTAL HEALTH and REDUCING SUICIDE

#### Mental Health Status, 2016
(Percentage of adults with 7+ days poor mental health in past 30 days)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>16.2%</td>
<td>15.6%</td>
</tr>
</tbody>
</table>

#### Depression, 2014–2016
(Percentage of adults ever told by a doctor they had a depressive disorder)

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>22.1%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

#### Suicide, 2014–2016#
(Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>14.3</td>
<td>15.3</td>
</tr>
</tbody>
</table>

---

§ All data in this row are from the 2017 Prevention Needs Assessment.

# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
Table 18. Salt Lake County Summary

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

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
Table 19. San Juan Summary

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

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

<table>
<thead>
<tr>
<th>REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
<tr>
<td>Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)</td>
<td>20</td>
<td>28.8%</td>
</tr>
<tr>
<td>Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)</td>
<td>21</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])</td>
</tr>
<tr>
<td>Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</td>
</tr>
<tr>
<td>Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)</td>
</tr>
<tr>
<td>Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPROVING MENTAL HEALTH and REDUCING SUICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)</td>
</tr>
<tr>
<td>Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)</td>
</tr>
<tr>
<td>Suicide, 2014–2016§ (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])</td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
Table 21. Southwest Utah Summary

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Page</th>
<th>Community Data</th>
<th>Utah</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
<td>Compare</td>
</tr>
</tbody>
</table>

- **REDDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS**
  - **Obesity—Adult, 2016**
    (Percentage of adults with a body mass index of 30 or more)
    - 20 21.4% 23.0% ≈ 26.2% 29.6%
  - **Obesity—Minor, 2017§**
    (Percentage of students in grades 8, 10, and 12)
    - 21 10.0% - ≈ 9.5% N/A

- **REDDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE**
  - **Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016**
    (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])
    - 29 13.0 15.1 ≈ 14.7 10.4
  - **Pain Reliever Misuse, 2015–2016**
    (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)
    - 31 N/A N/A N/A 4.9% 4.5%
  - **Illicit Drug Use, 2015–2016**
    (Percentage of persons aged 12+ reporting illicit drug use in the past year)
    - 31 N/A N/A N/A 7.4% 10.4%
  - **Illicit Drug Use Disorder, 2015–2016**
    (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)
    - 31 N/A N/A N/A 2.7% 2.8%

- **IMPROVING MENTAL HEALTH and REDUCING SUICIDE**
  - **Mental Health Status, 2016**
    (Percentage of adults with 7+ days poor mental health in past 30 days)
    - 41 15.0% 15.7% ≈ 16.5% 17.2%
  - **Depression, 2014–2016**
    (Percentage of adults ever told by a doctor they had a depressive disorder)
    - 43 18.4% 19.1% ≈ 21.0% N/A
  - **Suicide, 2014–2016#**
    (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])
    - 46 22.1 24.4 ≈ 21.2 13.3

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

### REducing Obesity and Obesity-Related Chronic Conditions

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
</tbody>
</table>

**Obesity—Adult, 2016**
(Percentage of adults with a body mass index of 30 or more)

| 20 | 12.9% | 14.1% | ✓ | 26.2% | 29.6% |

**Obesity—Minor, 2017**
(Percentage of students in grades 8, 10, and 12)

| 21 | 5.4% | – | ≈ | 9.5% | N/A |

### Reducing Prescription Drug Misuse, Abuse, and Overdose

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
</tbody>
</table>

**Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016**
(Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])

| 29 | * | * | ≈ | 14.7 | 10.4 |

**Pain Reliever Misuse, 2015–2016**
(Percentage of persons aged 12+ reporting pain reliever misuse in the past month)

| 31 | N/A | N/A | N/A | 4.9% | 4.5% |

**Illicit Drug Use, 2015–2016**
(Percentage of persons aged 12+ reporting illicit drug use in the past month)

| 31 | N/A | N/A | N/A | 7.4% | 10.4% |

**Illicit Drug Use Disorder, 2015–2016**
(Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)

| 31 | N/A | N/A | N/A | 2.7% | 2.8% |

### Improving Mental Health and Reducing Suicide

<table>
<thead>
<tr>
<th>Page</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
</tbody>
</table>

**Mental Health Status, 2016**
(Percentage of adults with 7+ days poor mental health in past 30 days)

| 41 | 13.1% | 13.1% | ≈ | 16.5% | 17.2% |

**Depression, 2014–2016**
(Percentage of adults ever told by a doctor they had a depressive disorder)

| 43 | 16.7% | 17.1% | ✓ | 21.0% | N/A |

**Suicide, 2014–2016**
(Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])

| 46 | 16.8 | 15.6 | ≈ | 21.2 | 13.3 |

---

All data in this row are from the 2017 Prevention Needs Assessment.

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

* Death rates are flagged as Unreliable when the rate is calculated with a numerator of 20 or less. More information: [http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable](http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable).
## Table 23. Tooele County Summary

<table>
<thead>
<tr>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
</tbody>
</table>

**REDDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS**

<table>
<thead>
<tr>
<th></th>
<th>Page</th>
<th>Community Summary</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity—Adult, 2016</strong></td>
<td>20</td>
<td>The community is performing BETTER than the state, and the difference is statistically significant.</td>
<td>26.2% 29.6%</td>
</tr>
<tr>
<td>(Percentage of adults with a body mass index of 30 or more)</td>
<td></td>
<td>≈ 28.5% 28.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Obesity—Minor, 2017§</strong></td>
<td>21</td>
<td>The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</td>
<td>9.5% N/A</td>
</tr>
<tr>
<td>(Percentage of students in grades 8, 10, and 12)</td>
<td></td>
<td>≈ 10.8% -</td>
<td></td>
</tr>
</tbody>
</table>

**REDDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE**

<table>
<thead>
<tr>
<th></th>
<th>Page</th>
<th>Community Summary</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016</strong></td>
<td>29</td>
<td>The community is performing BETTER than the state, and the difference is statistically significant.</td>
<td>14.7 10.4</td>
</tr>
<tr>
<td>(Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])</td>
<td></td>
<td>≈ 16.4 16.8</td>
<td></td>
</tr>
<tr>
<td><strong>Pain Reliever Misuse, 2015–2016</strong></td>
<td>31</td>
<td>The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</td>
<td>4.9% 4.5%</td>
</tr>
<tr>
<td>(Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</td>
<td></td>
<td>N/A N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Illicit Drug Use, 2015–2016</strong></td>
<td>31</td>
<td>The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</td>
<td>7.4% 10.4%</td>
</tr>
<tr>
<td>(Percentage of persons aged 12+ reporting illicit drug use in the past month)</td>
<td></td>
<td>N/A N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Illicit Drug Use Disorder, 2015–2016</strong></td>
<td>31</td>
<td>The community is performing BETTER than the state, and the difference is statistically significant.</td>
<td>2.7% 2.8%</td>
</tr>
<tr>
<td>(Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</td>
<td></td>
<td>N/A N/A</td>
<td></td>
</tr>
</tbody>
</table>

**IMPROVING MENTAL HEALTH and REDUCING SUICIDE**

<table>
<thead>
<tr>
<th></th>
<th>Page</th>
<th>Community Summary</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Status, 2016</strong></td>
<td>41</td>
<td>The community is performing BETTER than the state, and the difference is statistically significant.</td>
<td>16.5% 17.2%</td>
</tr>
<tr>
<td>(Percentage of adults with 7+ days poor mental health in past 30 days)</td>
<td></td>
<td>≈ 19.7% 19.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Depression, 2014–2016</strong></td>
<td>43</td>
<td>The community value is the same or ABOUT THE SAME as the state. Differences are not statistically significant.</td>
<td>21.0% N/A</td>
</tr>
<tr>
<td>(Percentage of adults ever told by a doctor they had a depressive disorder)</td>
<td></td>
<td>≈ 24.0% 23.8%</td>
<td></td>
</tr>
<tr>
<td><strong>Suicide, 2014–2016§</strong></td>
<td>46</td>
<td>The community is performing BETTER than the state, and the difference is statistically significant.</td>
<td>21.2 13.3</td>
</tr>
<tr>
<td>(Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])</td>
<td></td>
<td>≈ 22.7 25.2</td>
<td></td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
<table>
<thead>
<tr>
<th>Reducing Obesity and Obesity-Related Chronic Conditions</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity—Adult, 2016</strong>&lt;br&gt;(Percentage of adults with a body mass index of 30 or more)</td>
<td>20</td>
<td>34.2%</td>
<td>33.4%</td>
<td>!</td>
</tr>
<tr>
<td><strong>Obesity—Minor, 2017§</strong>&lt;br&gt;(Percentage of students in grades 8, 10, and 12)</td>
<td>21</td>
<td>6.7%</td>
<td>—</td>
<td>≈</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reducing Prescription Drug Misuse, Abuse, and Overdose</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016</strong>&lt;br&gt;(Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])</td>
<td>29</td>
<td>15.9</td>
<td>18.2</td>
<td>≈</td>
</tr>
<tr>
<td><strong>Pain Reliever Misuse, 2015–2016</strong>&lt;br&gt;(Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</td>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Illicit Drug Use, 2015–2016</strong>&lt;br&gt;(Percentage of persons aged 12+ reporting illicit drug use in the past month)</td>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Illicit Drug Use Disorder, 2015–2016</strong>&lt;br&gt;(Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</td>
<td>31</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving Mental Health and Reducing Suicide</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Status, 2016</strong>&lt;br&gt;(Percentage of adults with 7+ days poor mental health in past 30 days)</td>
<td>41</td>
<td>16.8%</td>
<td>16.2%</td>
<td>≈</td>
</tr>
<tr>
<td><strong>Depression, 2014–2016</strong>&lt;br&gt;(Percentage of adults ever told by a doctor they had a depressive disorder)</td>
<td>43</td>
<td>18.5%</td>
<td>18.2%</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Suicide, 2014–2016§</strong>&lt;br&gt;(Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])</td>
<td>46</td>
<td>31.3</td>
<td>34.8</td>
<td>!</td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
### Table 25. Utah County Summary

<table>
<thead>
<tr>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utah</td>
</tr>
<tr>
<td></td>
<td>Crude (burden) Rate</td>
</tr>
</tbody>
</table>

#### REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS

- **Obesity—Adult, 2016**
  - (Percentage of adults with a body mass index of 30 or more)
  - Page 20
  - Crude (burden) Rate: 22.6%
  - Age-adjusted (comparison) Rate: 25.8%
  - Compare: ≈
  - Comparison Values: 26.2% Utah, 29.6% U.S.

- **Obesity—Minor, 2017§**
  - (Percentage of students in grades 8, 10, and 12)
  - Page 21
  - Crude (burden) Rate: 8.8%
  - Age-adjusted (comparison) Rate: ~
  - Compare: ≈
  - Comparison Values: 9.5% Utah, N/A U.S.

#### REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE

- **Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016**
  - (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])
  - Page 29
  - Crude (burden) Rate: 12.1
  - Age-adjusted (comparison) Rate: 14.2
  - Compare: ≈
  - Comparison Values: 14.7 Utah, 10.4 U.S.

- **Pain Reliever Misuse, 2015–2016**
  - (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)
  - Page 31
  - Crude (burden) Rate: N/A
  - Age-adjusted (comparison) Rate: N/A
  - Compare: N/A
  - Comparison Values: 4.9% Utah, 4.5% U.S.

- **Illicit Drug Use, 2015–2016**
  - (Percentage of persons aged 12+ reporting illicit drug use in the past month)
  - Page 31
  - Crude (burden) Rate: N/A
  - Age-adjusted (comparison) Rate: N/A
  - Compare: N/A
  - Comparison Values: 7.4% Utah, 10.4% U.S.

- **Illicit Drug Use Disorder, 2015–2016**
  - (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)
  - Page 31
  - Crude (burden) Rate: N/A
  - Age-adjusted (comparison) Rate: N/A
  - Compare: N/A
  - Comparison Values: 2.7% Utah, 2.8% U.S.

#### IMPROVING MENTAL HEALTH and REDUCING SUICIDE

- **Mental Health Status, 2016**
  - (Percentage of adults with 7+ days poor mental health in past 30 days)
  - Page 41
  - Crude (burden) Rate: 17.8%
  - Age-adjusted (comparison) Rate: 15.7%
  - Compare: ≈
  - Comparison Values: 16.5% Utah, 17.2% U.S.

- **Depression, 2014–2016**
  - (Percentage of adults ever told by a doctor they had a depressive disorder)
  - Page 43
  - Crude (burden) Rate: 20.8%
  - Age-adjusted (comparison) Rate: 20.6%
  - Compare: ≈
  - Comparison Values: 21.0% Utah, N/A U.S.

- **Suicide, 2014–2016#**
  - (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])
  - Page 46
  - Crude (burden) Rate: 14.4
  - Age-adjusted (comparison) Rate: 16.4
  - Compare: ✓
  - Comparison Values: 21.2 Utah, 13.3 U.S.

---

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

The community is performing **BETTER** than the state, and the difference is statistically significant.

The community value is the same or **ABOUT THE SAME** as the state. Differences are not statistically significant.

The community is performing **WORSE** than the state, and the difference is statistically significant.

### Table 26. Wasatch County Summary

<table>
<thead>
<tr>
<th>REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)</td>
<td>20 21.5% 22.5% ≈ 26.2% 29.6%</td>
<td></td>
</tr>
<tr>
<td>Obesity—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)</td>
<td>21 6.8% – ✓ 9.5% N/A</td>
<td></td>
</tr>
</tbody>
</table>

### REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE

| Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6]) | 29 ** ** – 14.7 10.4 |  |
| Pain reliever misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month) | 31 N/A N/A N/A 4.9% 4.5% |  |
| Illicit drug use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month) | 31 N/A N/A N/A 7.4% 10.4% |  |
| Illicit drug use disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year) | 31 N/A N/A N/A 2.7% 2.8% |  |

### IMPROVING MENTAL HEALTH and REDUCING SUICIDE

| Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days) | 41 11.0% 11.2% ≈ 16.5% 17.2% |  |
| Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder) | 43 17.1% 17.0% ≈ 21.0% N/A |  |
| Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03]) | 46 19.4 19.9 ≈ 21.2 13.3 |  |

---

§ All data in this row are from the 2017 Prevention Needs Assessment.

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

** Data are suppressed when the data meet the criteria for confidentiality constraints. More information: [http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality](http://wonder.cdc.gov/wonder/help/mcd.html#Assurance of Confidentiality).
Table 27. Weber-Morgan Summary

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

<table>
<thead>
<tr>
<th>REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity—Adult, 2016</strong> (Percentage of adults with a body mass index of 30 or more)</td>
<td>34.1%</td>
<td>33.8%</td>
</tr>
<tr>
<td><strong>Obesity—Minor, 2017</strong>§ (Percentage of students in grades 8, 10, and 12)</td>
<td>8.8%</td>
<td>–</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016</strong> (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])</td>
<td>18.4</td>
<td>19.7</td>
</tr>
<tr>
<td><strong>Pain Reliever Misuse, 2015–2016</strong> (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Illicit Drug Use, 2015–2016</strong> (Percentage of persons aged 12+ reporting illicit drug use in the past month)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Illicit Drug Use Disorder, 2015–2016</strong> (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPROVING MENTAL HEALTH and REDUCING SUICIDE</th>
<th>Community Data</th>
<th>Comparison Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Status, 2016</strong> (Percentage of adults with 7+ days poor mental health in past 30 days)</td>
<td>21.5%</td>
<td>21.5%</td>
</tr>
<tr>
<td><strong>Depression, 2014–2016</strong> (Percentage of adults ever told by a doctor they had a depressive disorder)</td>
<td>22.7%</td>
<td>22.6%</td>
</tr>
<tr>
<td><strong>Suicide, 2014–2016</strong>§ (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])</td>
<td>23.9</td>
<td>24.9</td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
<table>
<thead>
<tr>
<th>REDUCING OBESITY and OBESITY-RELATED CHRONIC CONDITIONS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese—Adult, 2016 (Percentage of adults with a body mass index of 30 or more)</td>
<td>Page</td>
<td>Crude (burden) Rate</td>
<td>Age-adjusted (comparison) Rate</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>25.4%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Obese—Minor, 2017§ (Percentage of students in grades 8, 10, and 12)</td>
<td>21</td>
<td>9.5%</td>
<td>–</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REDUCING PRESCRIPTION DRUG MISUSE, ABUSE, and OVERDOSE</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional and Undetermined Opioid Overdose Deaths, 2014–2016 (Rate per 100,000 [ICD-10 codes X40–X44 and Y10–Y14 with T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6])</td>
<td>29</td>
<td>13.7</td>
<td>14.7</td>
</tr>
<tr>
<td>Pain Reliever Misuse, 2015–2016 (Percentage of persons aged 12+ reporting pain reliever misuse in the past month)</td>
<td>31</td>
<td>4.9%</td>
<td>–</td>
</tr>
<tr>
<td>Illicit Drug Use, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug use in the past month)</td>
<td>31</td>
<td>7.4%</td>
<td>–</td>
</tr>
<tr>
<td>Illicit Drug Use Disorder, 2015–2016 (Percentage of persons aged 12+ reporting illicit drug dependence or abuse in the past year)</td>
<td>31</td>
<td>2.7%</td>
<td>–</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPROVING MENTAL HEALTH and REDUCING SUICIDE</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Status, 2016 (Percentage of adults with 7+ days poor mental health in past 30 days)</td>
<td>41</td>
<td>17.1%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Depression, 2014–2016 (Percentage of adults ever told by a doctor they had a depressive disorder)</td>
<td>43</td>
<td>21.0%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Suicide, 2014–2016# (Rate per 100,000 [ICD-10 codes X60–X84, Y87.0, *U03])</td>
<td>46</td>
<td>19.8</td>
<td>21.2</td>
</tr>
</tbody>
</table>

§ All data in this row are from the 2017 Prevention Needs Assessment.
# All Utah data in this row are from the Utah Death Certificate Database; U.S. data from CDC WONDER Compressed Mortality File 1999–2016 Series 20 No. 2V, 2017.
Collaboration
Effective
Evidence-based
Respect
Transparency
Trustworthy
Service
Integrity
Innovation

Data Sources
Reducing Obesity and Obesity-related Chronic Conditions

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

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


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.

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


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

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

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

Reducing Prescription Drug Misuse, Abuse, and Overdose

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

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


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


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

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

**Annual Estimates**: Utah Office of the Medical Examiner

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

**Utah Estimates**: Utah Controlled Substance Database

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


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](http://wonder.cdc.gov/wonder/help/mcd.html#Unreliable).


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

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

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

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

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

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

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

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


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

**UCD - Injury Intent: Unintentional, Undetermined**

**UCD - Injury Mechanism & All Other Leading Causes: Poisoning**

---

**Pain Reliever Misuse (Tables 6 and 15-28)**


Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.
Prescription psychotherapeutic subtypes were revised in 2016; one effect was the comparability of codeine products between 2015 and 2016.

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

Illicit Drug Use (Tables 7 and 15–28)

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

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

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

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

Prescription psychotherapeutics do not include over-the-counter drugs.

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

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

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

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

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

Based on the PNA Survey, Form B.

**Improving Mental Health and Reducing Suicide**

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

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


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

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

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

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

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

The confidence bounds are asymmetric.

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

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

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


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

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

Denominator includes all survey respondents aged 18 years and older except those with ‘missing’, ‘don’t know’, and ‘refused’ answers. If the query was limited to a particular sub-population-group, only those respondents are included in the denominator.
Age-adjusted rates are based on five age groups: 18–24, 25–34, 35–44, 45–54, and 65+ except for estimates by race. Age-adjusted rates for race estimates are based on three age groups: 18–34, 35–49, and 50+.

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

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

(Utah Estimates)

Utah Estimates: Utah Death Certificate Database.

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

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

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

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

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

Crude rates.

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


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

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

National and Other State Estimates: CDC, NCHS.

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

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

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

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

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


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

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

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

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

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

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

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

Percentage of Suicides by Age Group and Method of Injury, Utah, 2014–2016 (Figure 24) death. Accidental and suspicious deaths are certified by the Medical Examiner. Death certificate data go through extensive edits for completeness and consistency. The OVRS does annual trainings for funeral directors and local registrars.

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


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

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

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

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

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

Note that several individuals served on more than one group.

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency</th>
<th>Group/Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allyn Nakashima</td>
<td>UDOH State Epidemiologist</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Amy Bate</td>
<td>UALHD - PIO Affiliate</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Amy Frandsen</td>
<td>Utah Department of Human Services DSAMH</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Ana Maria Lopez</td>
<td>University of Utah Health Sciences &amp; School of Medicine Huntsman Cancer Institute</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Angela Stander</td>
<td>UDOH Violence and Injury Prevention Program</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Anna Dillingham</td>
<td>Davis County Health Department</td>
<td>State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Anna Fondario</td>
<td>UDOH Violence and Injury Prevention Program</td>
<td>Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair</td>
</tr>
<tr>
<td>Barbara Crouch</td>
<td>Utah Poison Control Center</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Brenda Ralls</td>
<td>UDOH EPICC Program</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Brian Bennion</td>
<td>Weber-Morgan Health Department</td>
<td>Community Advisory Panel State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Brian Hatch</td>
<td>Davis County Health Department</td>
<td>Utah Health Improvement Plan Coalition Utah Health Improvement Plan Executive Committee</td>
</tr>
<tr>
<td>Brook Carlisle</td>
<td>American Cancer Society Cancer Action Network</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Bruce Costa</td>
<td>Central Utah Health Department</td>
<td>Community Advisory Panel Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Bryce Bird</td>
<td>Utah Department of Environmental Quality</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Carrie Bennett</td>
<td>Utah County Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Carl Hanson</td>
<td>Brigham Young University</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Cristie Chesler</td>
<td>UDOH Bureau of Epidemiology</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Cynthia Boshard</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel</td>
</tr>
<tr>
<td>Danny Bennion</td>
<td>Salt Lake County Health Department</td>
<td>State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>David Blodgett</td>
<td>Southwest Utah Public Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>David Cunningham</td>
<td>Southeast Utah Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>David Lewis</td>
<td>UDOH Development and Performance Improvement</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Dean Penovich</td>
<td>UDOH EMS and Preparedness</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Debbie Marvidikis</td>
<td>Southeast Local Health District</td>
<td>Utah Health Improvement Plan Coalition Utah Health Improvement Plan Workgroup Co-Chair</td>
</tr>
<tr>
<td>Dennis Cechinni</td>
<td>Advocate</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Name</td>
<td>Agency</td>
<td>Group/Contribution</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>Don Wood</td>
<td>UDOH Primary Care and Rural Health</td>
<td>State Health Assessment Workgroup</td>
</tr>
<tr>
<td>Donna Singer</td>
<td>Utah Indian Health Advisory Board Utah Navajo Health Systems</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Doug Thomas</td>
<td>Department of Human Services DSAMH</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Dulce Diez</td>
<td>UDOH Health Disparities Reduction</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Dustin Jones</td>
<td>UDOH EPICC Program</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Ed Napia</td>
<td>Urban Indian Center of Salt Lake</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Fahina Tavake-Pasi</td>
<td>Minority Community Representative</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Farrin Wiese</td>
<td>UALHD - ULACHES Affiliate</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Gary Edwards</td>
<td>Salt Lake County Health Department</td>
<td>Community Advisory Panel Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Executive Committee</td>
</tr>
<tr>
<td>Greg Bell</td>
<td>Utah Hospital Association</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Greg Williams</td>
<td>UDOH Environmental Public Health Tracking</td>
<td>State Health Assessment Workgroup</td>
</tr>
<tr>
<td>Heather Borski</td>
<td>UDOH Disease Control and Prevention</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Executive Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Heather Bush</td>
<td>UDOH Prevention, Treatment and Care Program</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Heidi Goedhart</td>
<td>Utah Department of Transportation</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Hope Jackson</td>
<td>Sacred Circle Facility (Confederatges Tribes of the Goshute Reservation)</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Isa Perry</td>
<td>Davis County Health Department</td>
<td>Community Advisory Panel State Health Assessment Workgroup</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Janae Duncan</td>
<td>UDOH Bureau of Health Promotion</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Jeffrey Coombs</td>
<td>Tooele County Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Jennifer Brown</td>
<td>UDOH Disease Control and Prevention</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Jennifer Bryant</td>
<td>UDOH Development and Performance Improvement</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Jenny Johnson</td>
<td>UDOH Public Information and Marketing</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Jeramie Tubbs</td>
<td>TriCounty Health Department</td>
<td>Utah Health Improvement Plan Workgroup Co-Chair</td>
</tr>
<tr>
<td>Jeremy Christensen</td>
<td>Utah Department of Human Services</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Jim Davis</td>
<td>Utah Health Advisory Council Utah State University</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Executive Committee</td>
</tr>
<tr>
<td>Jim VanDerslice</td>
<td>University of Utah</td>
<td>Community Advisory Panel</td>
</tr>
<tr>
<td>Jonelle Fitzgerald</td>
<td>Wasatch County Local Health District</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Workgroup Co-Chair</td>
</tr>
<tr>
<td>Jordan Mathis</td>
<td>TriCounty Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Executive Committee</td>
</tr>
</tbody>
</table>
# Individual Acknowledgments

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency</th>
<th>Group/Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joseph Miner</td>
<td>UDOH Executive Director</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Executive Committee</td>
</tr>
<tr>
<td>Josey Hill</td>
<td>UDOH Development and Performance Improvement</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Julianna Preston</td>
<td>HealthInsight</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Kael Forsythe-Barker</td>
<td>Student</td>
<td>Maps</td>
</tr>
<tr>
<td>Karen Kwan</td>
<td>Salt Lake Community College</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Ken Johnson</td>
<td>National Association of Local Boards of</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td>Health Weber State University</td>
<td></td>
</tr>
<tr>
<td>Kevin Condra</td>
<td>Salt Lake County Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Kim Myers</td>
<td>Utah Department of Human Services DSAMH</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Workgroup Co-Chair</td>
</tr>
<tr>
<td>Kim Neerings</td>
<td>UDOH Public Health Assessment</td>
<td>State Health Assessment Workgroup Report Formatting and Data Analyst</td>
</tr>
<tr>
<td>LeAnna VanKeuren</td>
<td>Urban Indian Center of Salt Lake</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Lewis Singer</td>
<td>Utah Commission on Aging</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Lincoln Nehring</td>
<td>Voices for Utah Children</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Lisa Kane</td>
<td>UDOH Public Health Assessment</td>
<td>Community Input Support</td>
</tr>
<tr>
<td>Lisa Nichols</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Liz Joy</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel</td>
</tr>
<tr>
<td>Lloyd Berentzen</td>
<td>Bear River Health Department</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Luis Garza</td>
<td>Comunidades Unidas</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Lynne Nilson</td>
<td>UDOH Maternal and Child Health</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Marc Babitz</td>
<td>UDOH Family Health and Preparedness</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Executive Committee</td>
</tr>
<tr>
<td>Marc Watterson</td>
<td>American Heart Association of Utah</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Maria Montes</td>
<td>Comunidades Unidas</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Marina Haddock Potter</td>
<td>Intern</td>
<td>Other Health Assessment Review and Summary</td>
</tr>
<tr>
<td>Mark Hiatt</td>
<td>Regence BlueCross BlueShield of Utah</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Mary Lou Emerson</td>
<td>Commission on Criminal and Juvenile Justice</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Matt LaFrance</td>
<td>Tooele County Health Department</td>
<td>State Health Assessment Workgroup</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Matt McCord</td>
<td>UDOH Environmental Public Health Tracking</td>
<td>Maps</td>
</tr>
<tr>
<td>Matt Slonaker</td>
<td>Utah Health Policy Project</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Melanie Wallentine</td>
<td>Utah Division of Occupational and Professional Licensing</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Melissa Zito</td>
<td>UDOH Indian Health Liaison</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Michael Friedrichs</td>
<td>UDOH Bureau of Health Promotion</td>
<td>State Health Assessment Workgroup</td>
</tr>
<tr>
<td>Mikelle Moore</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Name</td>
<td>Agency</td>
<td>Group/Contribution</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mimi Ujiie</td>
<td>UDOH Development and Performance Improvement</td>
<td>State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Nathan Checketts</td>
<td>UDOH Medicaid and Health Financing</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Navina Forsythe</td>
<td>UDOH Public Health Assessment</td>
<td>Community Advisory Panel State Health Assessment Workgroup Utah Health Improvement Plan Coalition Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Pam Goodrich</td>
<td>Central Utah Local Health District</td>
<td>Utah Health Improvement Plan Workgroup Co-Chair</td>
</tr>
<tr>
<td>Patrick Poulin</td>
<td>International Rescue Committee</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Paul Patrick</td>
<td>UDOH Family Health and Preparedness</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Ralph Clegg</td>
<td>Utah County Health Department</td>
<td>Community Advisory Panel Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Randy Probst</td>
<td>Wasatch County Health Department</td>
<td>Community Advisory Panel Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Rebecca Fronberg</td>
<td>UDOH EPICC Program</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Richard Bullough</td>
<td>Summit County Health Department</td>
<td>Community Advisory Panel Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Robert Rolfs</td>
<td>UDOH Deputy Director</td>
<td>Community Advisory Panel Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Robyn Atkinson</td>
<td>UDOH Utah Public Health Laboratory</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Sam LeFevre</td>
<td>UDOH Environmental Epidemiology</td>
<td>State Health Assessment Workgroup</td>
</tr>
<tr>
<td>Sarah Hodson</td>
<td>Get Healthy Utah</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Scott Hess</td>
<td>Wasatch Front Regional Council</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Scott McLeod</td>
<td>United Way</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Scott Zigich</td>
<td>Davis County Board of Health/School District</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Sean Meegan</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel</td>
</tr>
<tr>
<td>Shaheen Hossain</td>
<td>UDOH Data Resources Program</td>
<td>State Health Assessment Workgroup Utah Health Improvement Plan Operational Committee</td>
</tr>
<tr>
<td>Shari Watkins</td>
<td>UDOH Fiscal Operations</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Sheila Walsh-McDonald</td>
<td>UDOH Government Relations</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Stephanie Croasdell Stokes</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Steve Eliason</td>
<td>Utah House of Representatives University of Utah Health Care</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Steven Phillips</td>
<td>UDOH Fiscal Operations</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Sydnee Dickson</td>
<td>Utah State Office of Education</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Tamara Hampton</td>
<td>UDOH Executive Director's Office</td>
<td>Utah Health Improvement Plan Coalition</td>
</tr>
<tr>
<td>Tamara Sheffield</td>
<td>Intermountain Healthcare</td>
<td>Community Advisory Panel</td>
</tr>
</tbody>
</table>
## Individual Acknowledgments

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

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.