# Completed Tours for Health's 2021 Accountable Base Budget Review

## Disease Control and Prevention

1. Alzheimer's Disease and Related Dementias Coordinating Council on Wednesday, April 21, 2021
2. Asthma Local Health Department Coordination Meeting on Wednesday, April 21, 2021
3. Utah Newborn Screening Committee Meeting on Thursday, April 22, 2021
4. Utah Coalition for Protecting Childhood Steering Committee Meeting on April 27, 2021
5. Breast and Cervical Cancer Meeting on April 27, 2021
6. Violence Injury Prevention Program Meeting on April 27, 2021
7. Youth Electronic Cigarette, Marijuana, Other Drug Prevention Committee on April 28, 2021
8. Asthma Staff Meeting on May 3, 2021
9. Be Wise Meeting on May 4, 2021
10. Health Resource Center Meeting on May 5, 2021
11. SCI/BI Rehabilitation Fund and Pediatric Neuro-Rehabilitation Fund Advisory Committee Meeting on May 6, 2021
12. Living Well Coalition on May 10, 2021
13. Tobacco Prevention & Control Program Meeting on May 10, 2021
14. Healthy Aging on May 12, 2021
15. Immunization Programs – Monthly Staff Meeting on May 19, 2021
16. UDOH Swimming Pool Advisory Committee on May 19, 2021
17. Environmental Epidemiology Program Staff Meeting on May 21, 2021
18. EPICC (Healthy Living through Environment, Policy, and Improved Clinical Care) Collaboration Group Meeting on May 25, 2021
19. HIV and STD Program Meeting Staff Meeting on May 26, 2021
20. Healthcare-Associated Infections and Antibiotic Resistance Program Meeting on May 26, 2021
21. Disability & Health Program Meeting on May 27, 2021
22. Utah Public Health Laboratory Tour on May 28, 2021
23. PKU Formula Meeting on June 8, 2021

## Medical Cannabis

1. Center for Medical Cannabis Team Meeting on May 5, 2021
2. Medical Cannabis Question and Answer on May 5, 2021

# Tobacco

1. What does your office do?

- Tobacco use is still the leading cause of preventable death in Utah. The Tobacco Prevention and Control program (TPCP) uses a comprehensive approach to reduce disease, disability and death related to tobacco use by preventing initiation, promoting quitting, eliminating exposure to secondhand smoke and addressing tobacco related disparities. The program applies a multi-component approach including (1) state and community interventions, (2) mass-reach media campaign, (3) cessation services, and (4) surveillance and evaluation. TPCP works with local health departments and other community agencies to develop and coordinate tobacco prevention, cessation and enforcement interventions in every Utah community. TPCP incorporates electronic cigarettes and vaping prevention and cessation into all of our services and initiatives. Vaping rates, especially among youth, have continued to rise quickly over the last few years, so it is a major area of concern for TPCP. TPCP includes the Youth Electronic Cigarette, Marijuana and Other Drugs Prevention program (YEMOP) established in SB37(2020).

2. How are you organized?

- TPCP has been in existence for over 20 years and is housed in the Bureau of Health Promotion. The program consists of one program manager, an assistant program manager/grant coordinator and 14 other staff members for a total of 16 staff. TPCP is currently fully-staffed. An organizational chart for TPCP can be found here: https://drive.google.com/file/d/1ZmJAzlFduQmO9Z9oQPJUITmgvsF0xYwg/view?usp=sharing

3. Which personnel do which tasks?

| Name | Title | Main Responsibilities |
|---|---|---|
| **Braden Ainsworth** | Program Manager | 1. Administer and oversee all aspects of the TPCP, including budget, contracts and staff<br>2. Represent Tobacco Prevention and Control Program within the UDOH and to outside agencies. (including communicating with key stakeholders and the legislature)<br>3. Develop budgets, plans, and coordinate the Tobacco Control Advisory Committee<br>4. Member of Collaboration Workgroup<br>5. Co-Chair of the Youth Electronic Cigarette, Marijuana and Other Drugs Prevention program. |
| **Christal Dent** | Assistant Program Manager | 1. TPCP lead under the Program Manager<br>2. Collaboration Workgroup Co-Chair<br>3. Federal Funding Coordinator<br>4. Coordinate CDC Grant Activities<br>5. Assist with federal funding activities and special projects<br><br>Grants: CDC and DSAMH |

| | | |
|---|---|---|
| **Troy Barnett** | Health Program Coordinator | 1. Lead LHD Liaison<br>2. Catalyst<br>3. Retailer Ed Workgroup<br>4. Tobacco-Free Environments Workgroup Chair<br>5. Compliance Checks<br>6. Assist with CDC grant<br><br>Contracts:<br>Central Health Department<br>Southeast Utah Public Health Department<br>Salt Lake County Health Department<br>Wasatch Health Department<br>Summit County Health Department |
| **Mercedes Rodriguez** | Youth Electronic Cigarettes Marijana and Other Drugs Prevention Program Coordinator | 1. Oversees budgets for the Youth Electronic Cigarette, Marijuana and other drugs Prevention Program.<br>2. Acts a liaison between the Youth Electronic Cigarette, Marijuana and other drugs Prevention Committee and the Tobacco Prevention and Control Program.<br>3. Works closely with the Utah Substance Abuse Advisory Council (USAAV), and other groups.<br>4. Oversees contracts for the Youth Electronic Cigarette, Marijuana and other drugs Prevention Program. |
| **Adriana Moreno** | Office Specialist | 1. Provide clerical support for the TPCP manager and staff.<br>2. Organize meeting facilities, equipment, refreshments, meals, etc. for various meetings.<br>3. Provide assistance with resource material requests.<br>4. Review, compile, and edit compliance check data submitted by LHDs. |
| **Camille Jessop** | Health Program Specialist | 1. Provide technical support to LHDs for retail tobacco permitting<br>3. Coordinate and provide technical support for tobacco retail environmental scans and e-liquid inspections<br>4. Coordinate and provide technical support for contractors/partners<br>5. Ensure compliance with applicable federal and/or state laws, regulations, and/or agency rules, standards and guidelines, etc<br>6. Retail Workgroup Co-Chair |
| **Christy Cushing** | Policy Analyst | 1. Tobacco Control Policy Specialist<br>2. Retail Workgroup Co-Chair<br>3. Tobacco Free Environments<br>4. Assist program manager with policy related issues and analysis<br>5. Oversee Policy Agenda<br>6. Utah Tobacco Free Alliance (UTFA) Staff Liaison |
| **Claudia Bohner (part-time)** | Epidemiologist | 1. Coordinate comprehensive TPCP evaluation plan<br>2. Conduct evaluation training and provide technical assistance<br>3. Oversee tobacco surveillance plan development and implementation<br>4. Support bureau-wide evaluation and surveillance projects and work-groups<br><br>Contracts: RTI and BRFSS |
| **Frances Favela** | Outreach Coordinator | 1. Oversees Disparities Outreach and Special Projects<br>2. Monitors Disparity Network Contracts<br>3. Hispanic Media Coordinator<br>4. Spanish QuitLine Assistant<br>5. Recovery Plus Coordinator<br>6. Outreach to Underserved Populations |

| | | |
|---|---|---|
| | | Grants: Disparity Networks |
| **Jordan Green** | Epidemiologist | 1. Conduct program evaluation and surveillance projects<br>2. Conduct evaluation training and provide technical assistance<br>3. Support bureau-wide evaluation and surveillance projects and work-groups |
| **Julie Christie** | Health Program Specialist | 1. LHD Liaison<br>2. Training Coordinator (Statewide Partner Meetings)<br>3. Prevention Workgroup<br>4. Youth Group Coordinator<br>5. Advocacy<br><br>Contracts:<br>Bear River Public Health Department<br>Tooele County Public Health Department<br>Utah County Public Health Department<br>Weber-Morgan Public Health Department |
| **Marci Nelson (part-time)** | Health Program Specialist | 1. Health Care Provider Outreach Coordinator<br>2. Medicaid Contract Liaison<br>3. Association for Utah Community Health Contract Liaison<br>4. Health Plan/Health Systems Team Member<br>5. TPCP Patient-Centered Outcomes Research Institute (PCORI) Project Liaison<br><br>Contracts: Medicaid and AUCH |
| **Ryan Bartlett** | Marketing Manager<br>Media Liaison | 1. Media Coordinator<br>2. Public Information Specialist<br>3. Coordinate development of local media plans<br><br>Contracts: R&R Partners |
| **Sandy Schulthies** | Health Program Specialist | 1. Cessation Programs Coordinator<br>2. Health Plan/Health Systems Team Member<br>3. Oversee Utah contract for Quit services<br>4. Cessation Workgroup Co-Chair<br><br>Contracts: Quit Line (Optum, formerly Alere Wellbeing) |
| **Sarah Mangone (part-time)** | Health Program Specialist | 1. LHD Liaison<br>2. Schools<br>3. Contracts Risk-Assessment Coordinator<br><br>Contracts:<br>Davis County Health Department<br>San Juan County Public Health Department<br>Southwest Utah Public Health Department<br>Tri-County Public Health Department |
| **Tyrone Whitehorse** | Health Program Specialist | 1. Assess cessation gaps/barriers for disparate populations<br>2. CDC E-cig Prevention/Cessation activities<br>3. Health plan Specialist<br>4. Coordinates work with Health Systems to implement electronic referrals |

4. How do you measure success?

- Reduction in tobacco and vaping product use rates are the primary measures of success for our program. The Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), Prevention Needs Assessment (PNA) and Student Health and Risk Prevention (SHARP) surveys are the main tools that we use to collect our data. Other measures that we look at are media engagement, cessation services utilization, perception of tobacco/vaping harm, public support for policy, policies passed, legislation passed and compliance check violation rates.

5. What have been the results of your success measuring the last few years?

- In 2019 Utah reached the all-time low for adult smoking of 8.0%, which is the lowest rate in the US. Youth smoking rates have also continued to steadily decrease to 1.5%.
- In 2020, there were several legislative successes. A E-cigarette tax, raising the smoking/vaping age to 21, increased retailer penalties, authority for UDOH to set nicotine limits, flavor restrictions and other retail requirements.
- In 2019, only 3% of Utahns reported someone smoked cigarettes in their home in the past week.
- 70% of Utah smokers wish to quit smoking within a year.

6. How are you funded? Why are you funded that way?

- TPCP receives funding from the Utah tobacco Master Settlement Agreement, through the Utah cigarette tax and e-cigarette tax restricted accounts in legislation, and from the CDC through a grant application process.
- TPCP also receives Medicaid matching dollars based on the number of media labor hours billed.

7. When was the last time that you had a major problem? How did you identify it? What was the solution that you implemented?

- The largest problem that we have faced over the last year has been the Covid-19 pandemic. As a program who works with people who are very negatively impacted by Covid-19, our hope was that the pandemic would increase quit attempts. However, our calls to the tobacco quitline and online cessation service utilization was significantly lower than anticipated. TPCP staff and LHD staff (who carry out many of our activities) were redirected to work on the Covid-19 response. With staff redirected and service utilization lower, it has been difficult to spend our budgets, which in a typical year, would have been spent. Fortunately we were allowed to redirect our funds to be used on Covid response. TPCP staff began billing Covid time to tobacco units and we notified our local partners that they could too. This has helped with our spending, but unfortunately the tobacco program initiatives took a hit.

8. When was the last major change in your office? What was it? How did it change your workflow?

- With the passage of SB37(2020) TPCP began to receive e-cigarette tax funds. Because of this new funding, we were able to create a new position and consolidate tasks that were spread out over several staff members into one position. This position is our Tobacco Retail and Compliance Specialist. The tobacco retail environment is one of the

most crucial areas for a successful tobacco program, but until recently there was no point person for this area, and several members of the TPCP team were trying to fill the gaps that existed simultaneously. This change has been fairly recent, but already has lead to some great outcomes. A retail subcommittee has been formed as part of the YEMOP committee and our new staff member along with Rep. Jen Daily-Provost is leading this group. This position is in the process of developing an online retail compliance process which is much needed as youth attempt to buy tobacco/vape products online. Through the consolidation of work, other TPCP staff have been able to better focus on their assigned tasks and refer retail tasks to the new staff member.

9. Do you seek for and receive private contributions to involve the community in the solution? If not, why?

- TPCP does not receive private contributions.
- TPCP does receive in-kind revenue for added campaign value through media vendor donations.
- TPCP has never considered receiving private contributions.

10. How much do you spend on services versus program administration?

- When comparing program administration costs versus services or contracts, the TPCP spends approximately 34% on administration and 66% on contracts and services.
- The above percentages are approximations because the e-cigarette tax revenue has not been coming in as anticipated, so our budgets have been adjusted almost monthly to account for this. However, our program trend is roughly ⅔ spending on services and contractors.

11. How do you emphasize preventative measures rather than reactive measures?

- While a portion of our efforts are on cessation, we strive to prevent tobacco/vaping use among youth. Evidence has shown that a comprehensive media campaign serves as an effective cessation AND prevention measure. All of our media is evaluated by Research Institute Triangle (RTI) for effectiveness as prevention messaging. We contract with local health departments to conduct product surveys and compliance checks in tobacco retail establishments as a prevention tool so that bad retailers aren't allowed to sell to youth. TPCP coordinates a Prevention Workgroup with our partners who meet monthly and work on prevention specific activities. TPCP requires LHD contractors to lead a local youth coalition in advocating for tobacco use prevention policies and programs. Policy efforts of TPCP are another powerful tool for prevention. TPCP and local partners focus on outdoor, workplace, and healthcare policies that prevent second-hand smoke and tobacco use and access. The TPCP works very closely with the YEMOP committee which is focused on prevention specific activities and coordinates with several other groups such as the Utah Prevention Action Committee (UPCA), Utah Substance Abuse and Mental Health Advisory (USAAV+) Council and schools. The TPCP also actively engages health care providers and health systems in the prevention process.

12. What would you do with more funding?

- Fortunately, with the passage of the e-cigarette tax, TPCP has been well funded. However, revenue has not been keeping up with projections. With full or more funding,

TPCP would focus specifically on those populations who are most adversely affected by tobacco. Those who are heavy drinkers, are on medicaid, American Native Americans, and those who are out of work are a handful of the groups who have much higher tobacco use rates than the state average. While we have initiatives that try to reach these groups, some are not as well funded as they could be and some are only superficially addressed through other initiatives.

13. What would you do with less funding?

- With less funding, we would need to reduce contract amounts with our various contracts. This would impact the services we are able to provide for free to the citizens of Utah, and the staff at our LHDs and community partners whom our funding supports.

Are there any areas where you would like to know what other States are doing to address certain issues (I can ask my national support organization)?

# VIPP

1. What does your office do?

VIPP's mission is to provide trusted data, comprehensive resources, valued community engagement, and strategic partnerships that prioritize comprehensive strategies and policies to prevent violence and injury in Utah communities. VIPP focuses its efforts on the primary prevention of injury and violence. Primary prevention aims to prevent injury and violence before it ever occurs. This is done by minimizing the known risks of injury and violence and by altering unhealthy or unsafe behaviors that lead to injury and violence. VIPP focuses on shared risk and protective factors or factors that influence more than one type of injury or violence. For example, one of VIPP's goals is to "Improve the socioeconomic conditions for Utahns". Poverty is a risk factor for mental illness, child maltreatment, suicide, youth violence, intimate partner violence, and obesity, just to name a few. By focusing on improving economic conditions for Utahns we can affect numerous health outcomes.

Program Goals:

- Build program capacity to include a learning culture for staff to advance health equity and a trauma-informed approach across Utah's population
- Provide awareness, support, education, training, and technical assistance on injury and violence prevention, shared risk and protective factors of injury and violence, and on populations disproportionately affected by injury and violence, to partners and grantees
- Intervene to lessen risks and the harmful outcomes of injury and violence and to reduce their occurrence among Utahns
- Improve the socioeconomic conditions for Utahns, disproportionately affected by poverty
- Promote individual, family, and community connectedness to decrease isolation and loneliness among Utahns
- Encourage social norms shown to promote safety and health among Utahns
- Encourage enhancement of Utahns physical environment to improve safe and healthy living
- Improve access to and utilization of healthcare, including behavioral healthcare

## Russell Frandsen

**From:** Nichole Shepard <nshepard@utah.gov>
**Sent:** Wednesday, April 21, 2021 4:33 PM
**To:** Russell Frandsen
**Cc:** Kristy Russell; Celsa Bowman
**Subject:** Follow Up to the Coordinating Council Meeting
**Attachments:** orgChart_HealthyAging_All-Programs.pdf

Hi Russell,

I'm following up with your question from the Coordinating Council this morning via this email,

*Health programs besides Alzheimer's, Asthma , Living Well Coalition are now in the Age Well Program? What previous initiatives are now included? An email later would also be fine, thanks.*

The official name of the program is UDOH, **Healthy Aging Program**. This program currently includes Arthritis, as well as Alzheimer's Disease and Related Dementia (ADRD) efforts. We are focused on maintaining all previous initiatives. I have a quick highlight of initiatives listed below and again we can review any of these items in more detail in our staff meetings if that's helpful.

- ADRD: State funded, State Plan, R432-270, Age Well Campaign, contracts, Dementia Dialogues, Caregiver Education and Support, Coordinating Council & 4 associated workgroups
- Arthritis: Federally funded, physician referrals, SDOH activities, contracts, Living Well Coalition, Serve as the Network Hub for Utah's delivery and expansion of evidence-based programs related to arthritis and other chronic conditions

The UDOH **Asthma Program** is a separate program from Healthy Aging. The staff and initiatives are different but I manage both programs. We have federal funding, a little Medicaid funding and we are looking for additional funds to expand services and reach more people with asthma. We have 3 overarching initiatives that are listed below.

- Infrastructure strategies to support leadership, strategic partnerships, strategic communications, surveillance, and evaluation.
- Services strategies to expand school- and home-based services.
- Health systems strategies to improve coverage, delivery, quality, and use of clinical services.

Hope this helps until the next meeting. Thanks for joining us!

Nichole Shepard, MPH | She/Her | Program Manager
Asthma Program & Healthy Aging Program
UDOH | PO Box 142107 | Salt Lake City, UT 84114
Office: 801-538-6259
Utah Arthritis Program | Living Well Utah | Utah Asthma Program | Age Well

| NBS Program | NBS Funding Source | Fee Collection Method |
|---|---|---|
| Alabama | General Funds; NBS Fee | Billed to medicaid and billed to hospitals/submitter |
| Alaska | NBS Fee | Billed to hospitals/submitters |
| Arizona | General Funds; NBS Fee; Title V | Billed to medicaid and billed to hospitals/submitter |
| Arkansas | NBS Fee | Billed to hospitals/submitters |
| California | NBS Fee | Billed to hospitals/submitters |
| Colorado | NBS Fee | Billed to hospitals/submitters |
| Connecticut | General Funds | Billed to hospitals/submitters |
| Delaware | NBS Fee | Billed to hospitals/submitters |
| District of Columbia | Title V | |
| Florida | NBS Fee; Insurance | Billed to hospitals/submitters |
| Georgia | General Funds | Billed to hospitals/submitters |
| Guam | | Billed to hospitals/submitters |
| Hawaii | NBS Fee | Collection kit purchase |
| Idaho | NBS Fee; Title V | Electronic payment, Visa, and Checks |
| Illinois | NBS Fee | Billed to hospitals/submitters |
| Indiana | NBS Fee | Billed to hospitals/submitters |
| Iowa | NBS Fee | Billed to hospitals/submitters |
| Kansas | Kansas Statute (K.S.A. 65-180) established the newborn screening fund, which is funded through the medical assistance fee fund. | |
| Kentucky | NBS Fee; Agency funds as needed | Billed to hospitals/submitters |

| NBS Program | NBS Funding Source | Fee Collection Method |
|---|---|---|
| Louisiana | General Funds; Insurance | Billing to Medicaid/insurance |
| Maine | NBS Fee | Billed to hospitals/submitters |
| Maryland | NBS Fee | Billed to hospitals/submitters |
| Massachusetts | NBS Fee | Billed to hospitals/submitters |
| Michigan | NBS Fee | Collection kit purchase |
| Minnesota | NBS Fee | Collection kit purchase |
| Mississippi | NBS Fee | Billed to hospitals/submitters |
| Missouri | NBS Fee; Federal Funds | Collection kit purchase |
| Montana | NBS Fee | Billed to medicaid and billed to hospitals/submitter |
| Nebraska | Title V | Billed to hospitals/submitters |
| Nevada | NBS Fee | Billed to hospitals/submitters |
| New Hampshire | NBS Fee | Collection kit purchase |
| New Jersey | General Funds; NBS Fee | Collection kit purchase |
| New Mexico | NBS Fee | Billed to hospitals/submitters |
| New York | SPECIAL REVENUE ACCOUNT | |
| North Carolina | NBS Fee | Billed to hospitals/submitters |
| North Dakota | General Funds; Title V; NBS Fee | Billed to hospitals/submitters |
| Ohio | NBS Fee | Collection kit purchase |
| Oklahoma | NBS Fee | Billed to hospitals/submitters; Medicaid is billed if the child has Medicaid. if not, the submitting hospital is billed. |
| Oregon | NBS Fee | Collection kit purchase |
| Pennsylvania | Title V | |
| Puerto Rico | NBS Fee | Billed to hospitals/submitters |
| Rhode Island | NBS Fee | Billed to hospitals/submitters |

| NBS Program | NBS Funding Source | Fee Collection Method |
|---|---|---|
| South Carolina | General Funds; Title V; NBS Fee | Billed to hospitals/submitters |
| South Dakota | NBS Fee | Billed to hospitals/submitters |
| Tennessee | NBS Fee | Billed to hospitals/submitters |
| Texas | General Funds; NBS Fee | Billing to Medicaid/CHIP; Collection Card purchase for non-Medicaid/CHIP covered patients |
| Utah | NBS Fee | Collection kit purchase |
| Vermont | NBS Fee | Billed to hospitals/submitters |
| Virginia | NBS Fee | Collection kit purchase |
| Washington | NBS Fee | Billed to hospitals/submitters |
| West Virginia | NBS Fee; Title V | Billed to hospitals/submitters |
| Wisconsin | NBS Fee | Billed to hospitals/submitters |
| Wyoming | General Funds; NBS Fee | Billed to hospitals/submitters |

NBS = Newborn Screening

Source: APHL, NewSTEPs Data Repository, as of April 22, 2021
Contact: NewSTEPs, newsteps@aphl.org

| NBS Program | Fee Holding Location | Initial Screen Fee |
|---|---|---|
| Alabama | Placed into general funds | $150 |
| Alaska | Program receipt | $159.5 |
| Arizona | In a NBS-specific fund | $36 |
| Arkansas | In a NBS-specific fund | $131 |
| California | In a NBS-specific fund | $141.25 |
| Colorado | In a NBS-specific fund | $111 |
| Connecticut | Placed into general funds | $110 |
| Delaware | In a NBS-specific fund | $135 |
| District of Columbia | | $ |
| Florida | In a NBS-specific fund | $ |
| Georgia | Placed into general funds | $80.4 |
| Guam | | $ |
| Hawaii | In a NBS-specific fund | $99 |
| Idaho | In a NBS-specific fund | $100 |
| Illinois | In a NBS-specific fund | $128 |
| Indiana | In a NBS-specific fund | $115 |
| Iowa | In a NBS-specific fund | $122 |
| Kansas | | $ |
| Kentucky | In a NBS-specific fund | $123 |

| NBS Program | Fee Holding Location | Initial Screen Fee |
|---|---|---|
| Louisiana | In a NBS-specific fund | $30 |
| Maine | In a NBS-specific fund | $110 |
| Maryland | In a NBS-specific fund | $106 |
| Massachusetts | In a NBS-specific fund | $133.9 |
| Michigan | In a NBS-specific fund | $135.29 |
| Minnesota | In a NBS-specific fund | $150 |
| Mississippi | Placed into general funds | $110 |
| Missouri | Missouri Public Health Servic | $95 |
| Montana | State laboratory funds | $134 |
| Nebraska | $20 of the $86.00 /infant scre | $86 |
| Nevada | In a NBS-specific fund | $81 |
| New Hampshire | In a NBS-specific fund | $71 |
| New Jersey | Laboratory revolving fund | $150 |
| New Mexico | In a NBS-specific fund | $138 |
| New York | | $ |
| North Carolina | | $128 |
| North Dakota | Not touched by North Dakota | $96 |
| Ohio | In a NBS-specific fund | $74.61 |
| Oklahoma | In a NBS-specific fund | $137.28 |
| Oregon | Funds support Public Health L | $80 |
| Pennsylvania | | $0 |
| Puerto Rico | In a NBS-specific fund | $118 |
| Rhode Island | In a NBS-specific fund | $162.98 |

| NBS Program | Fee Holding Location | Initial Screen Fee |
|---|---|---|
| South Carolina | In a NBS-specific fund | $127 |
| South Dakota | No holding; fee goes to contr | $75 |
| Tennessee | | $165 |
| Texas | Placed into general funds | $55.24 |
| Utah | In a NBS-specific fund | $118 |
| Vermont | In a NBS-specific fund | $203 |
| Virginia | In a NBS-specific fund | $138 |
| Washington | In a NBS-specific fund | $84.2 |
| West Virginia | In a NBS-specific fund | $125 |
| Wisconsin | State Laboratory of Hygiene | $109 |
| Wyoming | In a NBS-specific fund | $84 |

NBS = Newborn Screening

Source: APHL, NewSTEPs I
Contact: NewSTEPs, news

| NBS Program | Repeat Screen Fee | Second Screen Fee |
|---|---|---|
| Alabama | | |
| Alaska | Included in the initial fee | |
| Arizona | Included in the initial fee | $65 |
| Arkansas | $131 | |
| California | Included in the initial fee | |
| Colorado | Included in the initial fee | |
| Connecticut | Included in the initial fee | |
| Delaware | Included in the initial fee | |
| District of Columbia | Included in the initial fee | |
| Florida | | |
| Georgia | | |
| Guam | | |
| Hawaii | | |
| Idaho | Included in the initial fee | |
| Illinois | $128 | |
| Indiana | Included in the initial fee | |
| Iowa | Included in the initial fee | |
| Kansas | Included in the initial fee | |
| Kentucky | Included in the initial fee | |

| NBS Program | Repeat Screen Fee | Second Screen Fee |
|---|---|---|
| Louisiana | | |
| Maine | Included in the initial fee | |
| Maryland | Included in the initial fee | |
| Massachusetts | Included in the initial fee | |
| Michigan | $122.6 | |
| Minnesota | $150 | |
| Mississippi | $110 | |
| Missouri | $95 | |
| Montana | $134 | |
| Nebraska | Included in the initial fee | |
| Nevada | Included in the initial fee | |
| New Hampshire | $71 | |
| New Jersey | Included in the initial fee | |
| New Mexico | Included in the initial fee | |
| New York | | |
| North Carolina | Included in the initial fee | |
| North Dakota | Included in the initial fee | |
| Ohio | $74.61 | |
| Oklahoma | Included in the initial fee | |
| Oregon | Included in the initial fee | $0 |
| Pennsylvania | Included in the initial fee | |
| Puerto Rico | Included in the initial fee | |
| Rhode Island | | |

| NBS Program | Repeat Screen Fee | Second Screen Fee |
|---|---|---|
| South Carolina | Included in the initial fee | |
| South Dakota | Included in the initial fee | |
| Tennessee | Included in the initial fee | |
| Texas | $55.24 | $55.24 |
| Utah | Included in the initial fee | $0 |
| Vermont | Included in the initial fee | |
| Virginia | Included in the initial fee | |
| Washington | Included in the initial fee | $0 |
| West Virginia | Included in the initial fee | |
| Wisconsin | | |
| Wyoming | Included in the initial fee | |

NBS = Newborn Screening

Source: APHL, NewSTEPs

Contact: NewSTEPs, news

| NBS Program | Fee Notes |
|---|---|
| Alabama | NBS fees go into the General Fund Budget which funds all of the above - percer for each are not available |
| Alaska | $100 fee for non-requested repeats. |
| Arizona | |
| Arkansas | Fee is charged for each satisfactory specimen submitted for testing (initial and repeat). |
| California | All of the areas in the Fee Use Details marked "unknown" are covered by the N but the percentages are not disclosed. |
| Colorado | |
| Connecticut | not applicable since money collected goes into general funds |
| Delaware | |
| District of Columbia | |
| Florida | In addition to the hospital fees Florida bills Medicaid and private insurance for screening tests. Hospitals are billed $15 per live birth--not for screening specim |
| Georgia | GA NBS program does not charge for two repeats when babies are admitted to NICU. There is no charge for second screens when there is an out-of-range resu the initial screen. There is also no charge to the PCP for second screens when t initial screen from the hospital is Unsatisfactory. Fees go to the state general fu and are not allocated for newborn screening activities. |
| Guam | Public Health is not involved with setting fees or collecting them. The hospitals with billing and paying for screening. |
| Hawaii | |
| Idaho | |
| Illinois | |
| Indiana | IDH contracts with the IU NBS Lab. A portion of each $115 NBS fee stays with t In addition to lab tests, part of the initial short-term follow-up as well as the co service and other costs the lab incurs (ie IT support, administration, etc) are pa their portion of the fee. A smaller portion of the NBS fee goes to IDH for follow services, IT support, and state program management. |
| Iowa | Have requested a fee increase to sustain programming - no approval to move r forward for legislative approval from IDPH admin |
| Kansas | No fee collected in Kansas |
| Kentucky | |

| NBS Program | Fee Notes |
|---|---|
| Louisiana | |
| Maine | |
| Maryland | Fee is per baby regardless of the number of specimens received |
| Massachusetts | |
| Michigan | EHDI Fee from purchase of NBS card + CDC/HRSA |
| Minnesota | $10 goes to MN Hands & Voices and $5 goes to the Deaf Mentor/Adult Role M program – The NBS program does not receive these dollar amounts for each specimen. This $15 was added to the NBS fee by the Deaf and Hard of Hearing Commission. A small percentage of the fee does support internal LTFU staff, bu is no contracted support with external specialty centers. |
| Mississippi | Birthing facilities are billed $110 per screen. If there is poor specimen collectio yielding an unacceptable specimen to use, birthing facilities are billed $220. |
| Missouri | |
| Montana | Only one screen required for most infants. The Wisconsin laboratory bills the Montana lab approximately $35 per screen for their portion of the panel. Cost courier services are included in the "lab test" category since the Montana lab r the entire fee but does not provide a cost breakdown. |
| Nebraska | $66.00 of fee covers all initial testing and requested repeats, filter paper, shipp data management and results reporting. $20 of fee is returned to the State Prc to subsidize the metabolic foods and formula program and administrative cost |
| Nevada | |
| New Hampshire | |
| New Jersey | |
| New Mexico | Initial fee includes the second screen as well as a third NICU screen in applicab |
| New York | Because NYS does not charge a fee, the "fee use details" are not applicable. |
| North Carolina | |
| North Dakota | |
| Ohio | |
| Oklahoma | |
| Oregon | Unable to provide percentages since our breakdown doesn't match this schem |
| Pennsylvania | |
| Puerto Rico | |
| Rhode Island | The initial fee includes dried blood spot, hearing and developmental assessmer screening. |

| NBS Program | Fee Notes |
|---|---|
| South Carolina | NBS Screening fee includes lab and courier services only |
| South Dakota | |
| Tennessee | Fees charged for screening support the lab and follow-up activities. Fee is split (lab) and 1/3 (follow-up). Fees support IT, LIMS, Courier, EHDI, and Administrat well. Data on amount spent on these activities are unknown however are cove under the fee. |
| Texas | |
| Utah | |
| Vermont | Current fee $203.00 implemented 5/1/2019 |
| Virginia | |
| Washington | Clinic subsidy fee = $8.40 used to support the specialty clinics that provide mec care to babies identified with a newborn screening condition. |
| West Virginia | Initial fee includes a repeat screen fee when applicable. |
| Wisconsin | |
| Wyoming | |

NBS = Newborn Screening

Source: APHL, NewSTEPs I
Contact: NewSTEPs, news

| NBS Program | Fee Use |
|---|---|
| Alabama | Administration |
| Alabama | CCHD Services |
| Alabama | Courier Services |
| Alabama | Development - Support Fund |
| Alabama | EHDI Services |
| Alabama | IT Support |
| Alabama | Lab Tests |
| Alabama | Long Term Follow-Up Support |
| Alabama | General Fund Budget |
| Alabama | Short Term Follow-Up Services |
| Alaska | Administration |
| Alaska | CCHD Services |
| Alaska | Courier Services |
| Alaska | Development - Support Fund |
| Alaska | EHDI Services |
| Alaska | IT Support |
| Alaska | Lab Tests |
| Alaska | Long Term Follow-Up Support |
| Alaska | Other |
| Alaska | Short Term Follow-Up Services |
| Arizona | Administration |
| Arizona | CCHD Services |
| Arizona | Courier Services |
| Arizona | Development - Support Fund |
| Arizona | EHDI Services |
| Arizona | IT Support |
| Arizona | Lab Tests |
| Arizona | Long Term Follow-Up Support |
| Arizona | PKU monitoring services |
| Arizona | Short Term Follow-Up Services |
| Arkansas | Administration |
| Arkansas | CCHD Services |
| Arkansas | Courier Services |
| Arkansas | Development - Support Fund |
| Arkansas | EHDI Services |
| Arkansas | IT Support |
| Arkansas | Lab Tests |
| Arkansas | Long Term Follow-Up Support |
| Arkansas | Other |
| Arkansas | Short Term Follow-Up Services |
| California | Administration |
| California | CCHD Services |

| NBS Program | Fee Use |
|---|---|
| California | Courier Services |
| California | Development - Support Fund |
| California | EHDI Services |
| California | IT Support |
| California | Lab Tests |
| California | Long Term Follow-Up Support |
| California | California Biobank Program |
| California | Short Term Follow-Up Services |
| Colorado | Administration |
| Colorado | CCHD Services |
| Colorado | Courier Services |
| Colorado | Development - Support Fund |
| Colorado | EHDI Services |
| Colorado | IT Support |
| Colorado | Lab Tests |
| Colorado | Long Term Follow-Up Support |
| Colorado | Indirect |
| Colorado | Short Term Follow-Up Services |
| Connecticut | Administration |
| Connecticut | CCHD Services |
| Connecticut | Courier Services |
| Connecticut | Development - Support Fund |
| Connecticut | EHDI Services |
| Connecticut | IT Support |
| Connecticut | Lab Tests |
| Connecticut | Long Term Follow-Up Support |
| Connecticut | Other |
| Connecticut | Short Term Follow-Up Services |
| Delaware | Administration |
| Delaware | CCHD Services |
| Delaware | Courier Services |
| Delaware | Development - Support Fund |
| Delaware | EHDI Services |
| Delaware | IT Support |
| Delaware | Lab Tests |
| Delaware | Long Term Follow-Up Support |
| Delaware | Other |
| Delaware | Short Term Follow-Up Services |
| District of Columbi | Administration |
| District of Columbi | CCHD Services |
| District of Columbi | Courier Services |
| District of Columbi | Development - Support Fund |

| NBS Program | Fee Use |
|---|---|
| District of Columbi | EHDI Services |
| District of Columbi | IT Support |
| District of Columbi | Lab Tests |
| District of Columbi | Long Term Follow-Up Support |
| District of Columbi | Other |
| District of Columbi | Short Term Follow-Up Services |
| Florida | Administration |
| Florida | CCHD Services |
| Florida | Courier Services |
| Florida | Development - Support Fund |
| Florida | EHDI Services |
| Florida | IT Support |
| Florida | Lab Tests |
| Florida | Long Term Follow-Up Support |
| Florida | Other |
| Florida | Short Term Follow-Up Services |
| Georgia | Administration |
| Georgia | CCHD Services |
| Georgia | Courier Services |
| Georgia | Development - Support Fund |
| Georgia | EHDI Services |
| Georgia | IT Support |
| Georgia | Lab Tests |
| Georgia | Long Term Follow-Up Support |
| Georgia | Other |
| Georgia | Short Term Follow-Up Services |
| Guam | Administration |
| Guam | CCHD Services |
| Guam | Courier Services |
| Guam | Development - Support Fund |
| Guam | EHDI Services |
| Guam | IT Support |
| Guam | Lab Tests |
| Guam | Long Term Follow-Up Support |
| Guam | Other |
| Guam | Short Term Follow-Up Services |
| Hawaii | Administration |
| Hawaii | CCHD Services |
| Hawaii | Courier Services |
| Hawaii | Development - Support Fund |
| Hawaii | EHDI Services |
| Hawaii | IT Support |

| NBS Program | Fee Use |
|---|---|
| Hawaii | Lab Tests |
| Hawaii | Long Term Follow-Up Support |
| Hawaii | Other |
| Hawaii | Short Term Follow-Up Services |
| Idaho | Administration |
| Idaho | CCHD Services |
| Idaho | Courier Services |
| Idaho | Development - Support Fund |
| Idaho | EHDI Services |
| Idaho | IT Support |
| Idaho | Lab Tests |
| Idaho | Long Term Follow-Up Support |
| Idaho | Other |
| Idaho | Short Term Follow-Up Services |
| Illinois | Administration |
| Illinois | CCHD Services |
| Illinois | Courier Services |
| Illinois | Development - Support Fund |
| Illinois | EHDI Services |
| Illinois | IT Support |
| Illinois | Lab Tests |
| Illinois | Long Term Follow-Up Support |
| Illinois | Metabolic formulas |
| Illinois | Short Term Follow-Up Services |
| Indiana | Administration |
| Indiana | CCHD Services |
| Indiana | Courier Services |
| Indiana | Development - Support Fund |
| Indiana | EHDI Services |
| Indiana | IT Support |
| Indiana | Lab Tests |
| Indiana | Long Term Follow-Up Support |
| Indiana | State program |
| Indiana | Short Term Follow-Up Services |
| Iowa | Administration |
| Iowa | CCHD Services |
| Iowa | Courier Services |
| Iowa | Development - Support Fund |
| Iowa | EHDI Services |
| Iowa | IT Support |
| Iowa | Lab Tests |
| Iowa | Long Term Follow-Up Support |

| NBS Program | Fee Use |
|---|---|
| Iowa | Medical food/formula |
| Iowa | Short Term Follow-Up Services |
| Kansas | Administration |
| Kansas | CCHD Services |
| Kansas | Courier Services |
| Kansas | Development - Support Fund |
| Kansas | EHDI Services |
| Kansas | IT Support |
| Kansas | Lab Tests |
| Kansas | Long Term Follow-Up Support |
| Kansas | Other |
| Kansas | Short Term Follow-Up Services |
| Kentucky | Administration |
| Kentucky | CCHD Services |
| Kentucky | Courier Services |
| Kentucky | Development - Support Fund |
| Kentucky | EHDI Services |
| Kentucky | IT Support |
| Kentucky | Lab Tests |
| Kentucky | Long Term Follow-Up Support |
| Kentucky | Other |
| Kentucky | Short Term Follow-Up Services |
| Louisiana | Administration |
| Louisiana | CCHD Services |
| Louisiana | Courier Services |
| Louisiana | Development - Support Fund |
| Louisiana | EHDI Services |
| Louisiana | IT Support |
| Louisiana | Lab Tests |
| Louisiana | Long Term Follow-Up Support |
| Louisiana | Other |
| Louisiana | Short Term Follow-Up Services |
| Maine | Administration |
| Maine | CCHD Services |
| Maine | Courier Services |
| Maine | Development - Support Fund |
| Maine | EHDI Services |
| Maine | IT Support |
| Maine | Lab Tests |
| Maine | Long Term Follow-Up Support |
| Maine | Other |
| Maine | Short Term Follow-Up Services |

| NBS Program | Fee Use |
|---|---|
| Maryland | Administration |
| Maryland | CCHD Services |
| Maryland | Courier Services |
| Maryland | Development - Support Fund |
| Maryland | EHDI Services |
| Maryland | IT Support |
| Maryland | Lab Tests |
| Maryland | Long Term Follow-Up Support |
| Maryland | PKU monitoring services |
| Maryland | Short Term Follow-Up Services |
| Massachusetts | Administration |
| Massachusetts | CCHD Services |
| Massachusetts | Courier Services |
| Massachusetts | Development - Support Fund |
| Massachusetts | EHDI Services |
| Massachusetts | IT Support |
| Massachusetts | Lab Tests |
| Massachusetts | Long Term Follow-Up Support |
| Massachusetts | Other |
| Massachusetts | Short Term Follow-Up Services |
| Michigan | Administration |
| Michigan | CCHD Services |
| Michigan | Courier Services |
| Michigan | Development - Support Fund |
| Michigan | EHDI Services |
| Michigan | IT Support |
| Michigan | Lab Tests |
| Michigan | Long Term Follow-Up Support |
| Michigan | Other |
| Michigan | Short Term Follow-Up Services |
| Minnesota | Administration |
| Minnesota | CCHD Services |
| Minnesota | Courier Services |
| Minnesota | Development - Support Fund |
| Minnesota | EHDI Services |
| Minnesota | IT Support |
| Minnesota | Lab Tests |
| Minnesota | Long Term Follow-Up Support |
| Minnesota | Other |
| Minnesota | Short Term Follow-Up Services |
| Mississippi | Administration |
| Mississippi | CCHD Services |

| NBS Program | Fee Use |
|---|---|
| Mississippi | Courier Services |
| Mississippi | Development - Support Fund |
| Mississippi | EHDI Services |
| Mississippi | IT Support |
| Mississippi | Lab Tests |
| Mississippi | Long Term Follow-Up Support |
| Mississippi | Other |
| Mississippi | Short Term Follow-Up Services |
| Missouri | Administration |
| Missouri | CCHD Services |
| Missouri | Courier Services |
| Missouri | Development - Support Fund |
| Missouri | EHDI Services |
| Missouri | IT Support |
| Missouri | Lab Tests |
| Missouri | Long Term Follow-Up Support |
| Missouri | Other |
| Missouri | Short Term Follow-Up Services |
| Montana | Administration |
| Montana | CCHD Services |
| Montana | Courier Services |
| Montana | Development - Support Fund |
| Montana | EHDI Services |
| Montana | IT Support |
| Montana | Lab Tests |
| Montana | Long Term Follow-Up Support |
| Montana | Other |
| Montana | Short Term Follow-Up Services |
| Nebraska | Administration |
| Nebraska | CCHD Services |
| Nebraska | Courier Services |
| Nebraska | Development - Support Fund |
| Nebraska | EHDI Services |
| Nebraska | IT Support |
| Nebraska | Lab Tests |
| Nebraska | Long Term Follow-Up Support |
| Nebraska | Support for AID to pay for metabolic foods and formula |
| Nebraska | Short Term Follow-Up Services |
| Nevada | Administration |
| Nevada | CCHD Services |
| Nevada | Courier Services |
| Nevada | Development - Support Fund |

| NBS Program | Fee Use |
|---|---|
| Nevada | EHDI Services |
| Nevada | IT Support |
| Nevada | Lab Tests |
| Nevada | Long Term Follow-Up Support |
| Nevada | Other |
| Nevada | Short Term Follow-Up Services |
| New Hampshire | Administration |
| New Hampshire | CCHD Services |
| New Hampshire | Courier Services |
| New Hampshire | Development - Support Fund |
| New Hampshire | EHDI Services |
| New Hampshire | IT Support |
| New Hampshire | Lab Tests |
| New Hampshire | Long Term Follow-Up Support |
| New Hampshire | Other |
| New Hampshire | Short Term Follow-Up Services |
| New Jersey | Administration |
| New Jersey | CCHD Services |
| New Jersey | Courier Services |
| New Jersey | Development - Support Fund |
| New Jersey | EHDI Services |
| New Jersey | IT Support |
| New Jersey | Lab Tests |
| New Jersey | Long Term Follow-Up Support |
| New Jersey | Office Supplies / Printing |
| New Jersey | Short Term Follow-Up Services |
| New Mexico | Administration |
| New Mexico | CCHD Services |
| New Mexico | Courier Services |
| New Mexico | Development - Support Fund |
| New Mexico | EHDI Services |
| New Mexico | IT Support |
| New Mexico | Lab Tests |
| New Mexico | Long Term Follow-Up Support |
| New Mexico | Other |
| New Mexico | Short Term Follow-Up Services |
| New York | Administration |
| New York | CCHD Services |
| New York | Courier Services |
| New York | Development - Support Fund |
| New York | EHDI Services |
| New York | IT Support |

| NBS Program | Fee Use |
|---|---|
| New York | Lab Tests |
| New York | Long Term Follow-Up Support |
| New York | Other |
| New York | Short Term Follow-Up Services |
| North Carolina | Administration |
| North Carolina | CCHD Services |
| North Carolina | Courier Services |
| North Carolina | Development - Support Fund |
| North Carolina | EHDI Services |
| North Carolina | IT Support |
| North Carolina | Lab Tests |
| North Carolina | Long Term Follow-Up Support |
| North Carolina | Other |
| North Carolina | Short Term Follow-Up Services |
| North Dakota | Administration |
| North Dakota | CCHD Services |
| North Dakota | Courier Services |
| North Dakota | Development - Support Fund |
| North Dakota | EHDI Services |
| North Dakota | IT Support |
| North Dakota | Lab Tests |
| North Dakota | Long Term Follow-Up Support |
| North Dakota | Other |
| North Dakota | Short Term Follow-Up Services |
| Ohio | Administration |
| Ohio | CCHD Services |
| Ohio | Courier Services |
| Ohio | Development - Support Fund |
| Ohio | EHDI Services |
| Ohio | IT Support |
| Ohio | Lab Tests |
| Ohio | Long Term Follow-Up Support |
| Ohio | metabolic formula |
| Ohio | Short Term Follow-Up Services |
| Oklahoma | Administration |
| Oklahoma | CCHD Services |
| Oklahoma | Courier Services |
| Oklahoma | Development - Support Fund |
| Oklahoma | EHDI Services |
| Oklahoma | IT Support |
| Oklahoma | Lab Tests |
| Oklahoma | Long Term Follow-Up Support |

| NBS Program | Fee Use |
|---|---|
| Oklahoma | The NBS fee covers 100% of CCHD costs for education and reports but no follc |
| Oklahoma | Short Term Follow-Up Services |
| Oregon | Administration |
| Oregon | CCHD Services |
| Oregon | Courier Services |
| Oregon | Development - Support Fund |
| Oregon | EHDI Services |
| Oregon | IT Support |
| Oregon | Lab Tests |
| Oregon | Long Term Follow-Up Support |
| Oregon | Other |
| Oregon | Short Term Follow-Up Services |
| Pennsylvania | Administration |
| Pennsylvania | CCHD Services |
| Pennsylvania | Courier Services |
| Pennsylvania | Development - Support Fund |
| Pennsylvania | EHDI Services |
| Pennsylvania | IT Support |
| Pennsylvania | Lab Tests |
| Pennsylvania | Long Term Follow-Up Support |
| Pennsylvania | Other |
| Pennsylvania | Short Term Follow-Up Services |
| Puerto Rico | Administration |
| Puerto Rico | CCHD Services |
| Puerto Rico | Courier Services |
| Puerto Rico | Development - Support Fund |
| Puerto Rico | EHDI Services |
| Puerto Rico | IT Support |
| Puerto Rico | Lab Tests |
| Puerto Rico | Long Term Follow-Up Support |
| Puerto Rico | Other |
| Puerto Rico | Short Term Follow-Up Services |
| Rhode Island | Administration |
| Rhode Island | CCHD Services |
| Rhode Island | Courier Services |
| Rhode Island | Development - Support Fund |
| Rhode Island | EHDI Services |
| Rhode Island | IT Support |
| Rhode Island | Lab Tests |
| Rhode Island | Long Term Follow-Up Support |
| Rhode Island | Other |
| Rhode Island | Short Term Follow-Up Services |

| NBS Program | Fee Use |
|---|---|
| South Carolina | Administration |
| South Carolina | CCHD Services |
| South Carolina | Courier Services |
| South Carolina | Development - Support Fund |
| South Carolina | EHDI Services |
| South Carolina | IT Support |
| South Carolina | Lab Tests |
| South Carolina | Long Term Follow-Up Support |
| South Carolina | Other |
| South Carolina | Short Term Follow-Up Services |
| South Dakota | Administration |
| South Dakota | CCHD Services |
| South Dakota | Courier Services |
| South Dakota | Development - Support Fund |
| South Dakota | EHDI Services |
| South Dakota | IT Support |
| South Dakota | Lab Tests |
| South Dakota | Long Term Follow-Up Support |
| South Dakota | Other |
| South Dakota | Short Term Follow-Up Services |
| Tennessee | Administration |
| Tennessee | CCHD Services |
| Tennessee | Courier Services |
| Tennessee | Development - Support Fund |
| Tennessee | EHDI Services |
| Tennessee | IT Support |
| Tennessee | Lab Tests |
| Tennessee | Long Term Follow-Up Support |
| Tennessee | Other |
| Tennessee | Short Term Follow-Up Services |
| Texas | Administration |
| Texas | CCHD Services |
| Texas | Courier Services |
| Texas | Development - Support Fund |
| Texas | EHDI Services |
| Texas | IT Support |
| Texas | Lab Tests |
| Texas | Long Term Follow-Up Support |
| Texas | Other |
| Texas | Short Term Follow-Up Services |
| Utah | Administration |
| Utah | CCHD Services |

| NBS Program | Fee Use |
|---|---|
| Utah | Courier Services |
| Utah | Development - Support Fund |
| Utah | EHDI Services |
| Utah | IT Support |
| Utah | Lab Tests |
| Utah | Long Term Follow-Up Support |
| Utah | Other |
| Utah | Short Term Follow-Up Services |
| Vermont | Administration |
| Vermont | CCHD Services |
| Vermont | Courier Services |
| Vermont | Development - Support Fund |
| Vermont | EHDI Services |
| Vermont | IT Support |
| Vermont | Lab Tests |
| Vermont | Long Term Follow-Up Support |
| Vermont | Other |
| Vermont | Short Term Follow-Up Services |
| Virginia | Administration |
| Virginia | CCHD Services |
| Virginia | Courier Services |
| Virginia | Development - Support Fund |
| Virginia | EHDI Services |
| Virginia | IT Support |
| Virginia | Lab Tests |
| Virginia | Long Term Follow-Up Support |
| Virginia | Other |
| Virginia | Short Term Follow-Up Services |
| Washington | Administration |
| Washington | CCHD Services |
| Washington | Courier Services |
| Washington | Development - Support Fund |
| Washington | EHDI Services |
| Washington | IT Support |
| Washington | Lab Tests |
| Washington | Long Term Follow-Up Support |
| Washington | Other |
| Washington | Short Term Follow-Up Services |
| West Virginia | Administration |
| West Virginia | CCHD Services |
| West Virginia | Courier Services |
| West Virginia | Development - Support Fund |

| NBS Program | Fee Use |
|---|---|
| West Virginia | EHDI Services |
| West Virginia | IT Support |
| West Virginia | Lab Tests |
| West Virginia | Long Term Follow-Up Support |
| West Virginia | Other |
| West Virginia | Short Term Follow-Up Services |
| Wisconsin | Administration |
| Wisconsin | CCHD Services |
| Wisconsin | Courier Services |
| Wisconsin | Development - Support Fund |
| Wisconsin | EHDI Services |
| Wisconsin | IT Support |
| Wisconsin | Lab Tests |
| Wisconsin | Long Term Follow-Up Support |
| Wisconsin | Metabolic formula |
| Wisconsin | Short Term Follow-Up Services |
| Wyoming | Administration |
| Wyoming | CCHD Services |
| Wyoming | Courier Services |
| Wyoming | Development - Support Fund |
| Wyoming | EHDI Services |
| Wyoming | IT Support |
| Wyoming | Lab Tests |
| Wyoming | Long Term Follow-Up Support |
| Wyoming | Other |
| Wyoming | Short Term Follow-Up Services |

NBS= Newborn Screening

Source: APHL, NewSTEPs Data Repository, as of April 22, 2021
Contact: NewSTEPs, newsteps@aphl.org

ow-up.  The fee also covers contracts for genetic counseling and some confirmatory testing.

## Russell Frandsen

**From:** Nichole Shepard <nshepard@utah.gov>
**Sent:** Friday, May 14, 2021 6:17 PM
**To:** Russell Frandsen
**Cc:** Holly Uphold; kabaxter@utah.gov; ssmith1@utah.gov; Jake Hennessy
**Subject:** Re: Asthma Staff Meeting

Hi Russell,

Thank you for meeting with the Asthma Program staff. And thank you for your patience in getting this response back to you. Please see responses below in blue and let us know if you need any additional information to help with the audit process.

1. Home visiting Medicaid asthma program due October 2021, would October 1, 2022 work as a new date for the report with enough actual data to show initial results?
    a. Here is the official original request: Direct the Department of Health to provide (1) what specific savings were generated, (2) who received the savings, and (3) what the funding sources were for these savings for the asthma home based case management funding in Medicaid as part of its reports submitted to the Social Services Appropriations Subcommittee in October 2021 (motion passed at October 2020 meeting).
        1. Yes, we are expecting we will have enough data to showcase program success and generate recommendations for quality improvement. We can report on what is available come October 2021.
2. Is there anything needed from the Legislature (law changes, etc.) for you to be able to pursue private insurance reimbursement for asthma home visits?
    1. We have built a business case for asthma home visiting services and have individually approached private insurers seeking reimbursement for these services. While we haven't encountered any legal barriers, it is easier to persuade private insurers if Medicaid covers the service. If Medicaid reimburses for a service, often private insurers follow - so we have been told.
3. Are there any law changes that would help address asthma issues? We talked about this some yesterday, but do you have any specific suggestions?

- **The Inhaler Law**: while this isn't a change partners report: "as long as I've been here, we have had reports of school principals and even school nurses who don't know kids can self-carry and administer their inhaler (if they have an updated form every year.) The law was passed in 2004, but many educators and parents don't realize it exists. Plus, I think it's been changed over the years to add Epi pens and Stock Albuterol." Maybe there is an opportunity here to strengthen the communication of this law.
- **Mandatory Asthma 101 training** - Since asthma is the #1 cause of missed school days,is there a way we could mandate an Asthma 101 training at the beginning of EACH school year? Similar to what we have done with the new Stock Albuterol Law? We can record the training and upload it for electronic use at the schools. It would be helpful to merit some mandatory training.
- **Asthma Action Plans:** we have struggled with why local doctors will NOT fill out an AAP. I have had doctors tell us they won't fill out an Asthma Action Plan unless their patient is caught twice with their inhaler. Not sure how to fit that into a policy? The school nurses tell us it would make their life SO much easier if kids have an AAP. It would be so much easier if students had an AAP. Of course, that takes 3 people to coordinate – the school nurse, the parent, and the doctor.
- Utilize **Collaborative Practice Agreements** to make it easier for pharmacists to assist with monitoring and adjusting medications for patients with asthma.
- Increase **reimbursement** for and access to virtual healthcare services (telehealth) for those on Medicaid.

- Consider **indoor clean air policies** and funds to support infrastructure in building maintenance of schools to reduce potential allergy triggers. This may include avoid building schools close to busy highways as it increases exposure to asthma triggers.
- Increase access to **Home weatherization** assistance programs that provide loans or grants to low-income residents to repair or improve their homes, which can reduce asthma triggers such as mold and pests
- Comprehensive **smoke free policies** that prohibit smoking in all indoor spaces of workplaces, restaurants, and bars
- Modifying older **diesel engines** of school buses to run more cleanly to reduce air pollution
- Eliminating, when possible, or reducing exposure to **asthma triggers in the workplace**

Nichole Shepard, MPH | She/Her | Program Manager
Asthma Program & Healthy Aging Program
UDOH | PO Box 142107 | Salt Lake City, UT 84114
Office: 801-538-6259
Utah Arthritis Program | Living Well Utah | Utah Asthma Program | Age Well

COVID-19 is being closely monitored, stay up to date with state action.

On Tue, May 4, 2021 at 7:30 AM Russell Frandsen <rfrandsen@le.utah.gov> wrote:

Hi Asthma Team,

Thanks for your time yesterday. Below are a few follow ups. Could you please provide answers by Friday, May 14th?

1. Home visiting Medicaid asthma program due October 2021, would October 1, 2022 work as a new date for the report with enough actual data to show initial results?
    a. Here is the official original request: Direct the Department of Health to provide (1) what specific savings were generated, (2) who received the savings, and (3) what the funding sources were for these savings for the asthma home based case management funding in Medicaid as part of its reports submitted to the Social Services Appropriations Subcommittee in October 2021 (motion passed at October 2020 meeting).
2. Is there anything needed from the Legislature (law changes, etc.) for you to able to pursue private insurance reimbursement for asthma home visits?
3. Are there any law changes that would help address asthma issues? We talked about this some yesterday, but do you have any specific suggestions?

Russell Frandsen

Finance Officer

Office of the Legislative Fiscal Analyst

State of Utah

Phone 801-538-1034

Fax 801-538-1692

rfrandsen@le.utah.gov

http://budget.utah.gov/

-----Original Appointment-----
**From:** nshepard@utah.gov <nshepard@utah.gov>
**Sent:** Thursday, April 15, 2021 1:30 PM
**To:** nshepard@utah.gov; Holly Uphold; kabaxter@utah.gov; ssmith1@utah.gov; tours&training@utah.gov; Russell Frandsen
**Subject:** Asthma Staff Meeting
**When:** Monday, May 3, 2021 9:00 AM-11:00 AM America/Denver.
**Where:**

**You have been invited to the following event.**

## Asthma Staff Meeting

| | |
|---|---|
| When | Mon May 3, 2021 9am – 11am Mountain Time - Denver |
| Joining info | Join with Google Meet<br>meet.google.com/hhg-iiqg-iys<br><br>Join by phone<br>(US) +1 402-409-0063 (PIN: 743391747)<br><br>More phone numbers |
| Calendar | rfrandsen@le.utah.gov |
| Who | • nshepard@utah.gov - organizer<br>• Holly Uphold<br>• kabaxter@utah.gov<br>• ssmith1@utah.gov<br>• tours&training@utah.gov<br>• rfrandsen@le.utah.gov |

**more details »**

Going (rfrandsen@le.utah.gov)? **Yes** - **Maybe** - **No** more options »

Invitation from Google Calendar

You are receiving this courtesy email at the account rfrandsen@le.utah.gov because you are an attendee of this event.

********** IMPORTANT MESSAGE **********

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If you are not the intended recipient, any distributions or copying of this message, or the taking of any action based on its content is strictly prohibited.

**OFFICE OF THE**
**STATE AUDITOR**

December 7, 2020

Rich Saunders, Interim Executive Director
Utah Department of Health
288 N 1460 W
Salt Lake City, Utah 84116

RE: Issues Related to the Performance of the Utah Department of Health Pandemic Response

Dear Director Saunders,

The Office of the State Auditor evaluated data, processes, and methodologies related to the global COVID-19 pandemic from the Utah Department of Health (DOH). We interviewed various personnel, performed limited testing of data quality, and reviewed the production and use of associated modelling.

## 1. Current Health Data Systems Appear to Produce Adequate Quality Data

DOH maintains several data systems (e.g., Epitrax, UHARMS, ESSENCE) to collect information about the public health of Utah's population. This involves combining millions of pieces of information from diverse sources: individual lab reports, surveys of hospitals, etc. We sampled this data to test for completeness, but did not test for correspondence with individual lab reports stored by private companies or government-run hospitals and clinics. The structure and content of these data correspond with expectations relative to diverse data (e.g., periodicity, coding, demographics, corrections). Our interviews with the IT professionals and analysts responsible for making sense of this disparate information and subsequent review of the computer code showed how these data flowed within and across the systems, teams, and agencies to inform epidemiologists and other government officials about key measures to understand the pandemic situation.

While early data exhibited some inconsistencies, incremental improvements to DOH processes show systems largely produce timely and representative data. All complicated data systems balance data quality with other strategic goals, DOH should recognize and evaluate such tradeoffs. Data fidelity to the world, efficiencies across information verification, and clear communication with the public should be persistent goals of DOH throughout the pandemic and beyond. To increase public trust in this information resource, the website could provide a better explanation of the interconnectivity of high quality health databases and daily numbers, tables and graphs. DOH developed flexible methods for quickly communicating public health information across multiple dimensions of concern (e.g., case discovery, trends, risk factors) to the public via a daily updated dashboard that has increased in scope over time.

DOH also helped build and populate another dashboard system with coextensive data and additional non-public layers of information to inform the pandemic response among several hundred public and private (e.g., health system administrators) users. We have some concern, consistent with the concerns expressed internally in some interviews, that the time, effort, and complexities in coordinating these different platforms could lead to miscommunication and/or delay in producing real-time data relative to the evolving pandemic. However, these data point to no widespread manipulation or obvious fabrication of pandemic-related health information.

**2. Evaluate Controls to Systems like Epitrax for Data Integrity**

In evaluating the above systems, we detected some anomalies. While the inconsistencies appear reasonable, the fact they exist can cast doubt on expectations surrounding the public's consumption of this health information. For example, a recent improvement to the public dashboard allows for data aggregations to be downloaded each day. As time passes, sometimes months later, the number of positive case counts for the detection of SARS-COV-2 from lab reports change. This can be caused by new discovery (missing labs) or clarifications from case investigation (inaccuracy in initial data). These changes in data have always been apparent, but with data downloads, clear transparency, and adequate explanation the actual reasons for evolving data quality could engender more public confidence in this data.

The ability to alter databases should be tightly controlled. Hundreds of people, some of them newly trained employees conducting contact tracing activities, currently have the ability to modify data within sensitive systems. Least restrictive access, data logs, and careful review for changing data is warranted. We recommend implementing processes to either restrict or evaluate unexpected changes to these data with review before systems incorporate purportedly better information without losing much sensitivity in the flow of new data. For example, learning that someone died on a particular day, but is represented as having died on a different day in the database, creates confusion after that information is communicated in aggregate to the public. Backfilling data with the most accuracy possible is important, but can also create confusion if not properly monitored when apparently stable data is still being modified months after the fact.

**3. Retain the Data, Models, and Recommendations Underlying Public Health Advice and Orders to Adequately Justify Government Interventions**

As a primary agency, DOH has a variety of roles in responding to a Public Health Emergency. During a rapidly changing and complex event like a pandemic, public health advice—with the underlying data, models, and expertise—is constantly updated as a situation unfolds. Our request to produce the epidemiological models and other analyses encapsulating data-driven recommendations produced interviews, emails, and some access to system level data, but not specific data or model output upon which public health recommendations might be based. In order to improve the public response to pandemics, during the current situation and into the future, transparency and traceability in the facts and forecasts—as understood and communicated to stakeholders in the moment—is critical.

Epidemiological models, computer code, all relevant data, and the resultant output underlying public health recommendations should be retained. This information should persist beyond coordination meetings, voiced conversations, and emails. For example, when high stakes society wide restrictions are either imposed or relaxed, the underlying justification should be preserved in and across time to, if nothing else, preserve idiosyncratic improvement in the underlying models. While a constantly updated dashboard may contain the best current understanding of a situation, a vintage series of both the underlying data and its implications should be retained to discover the state of what was recommended, whether the advice was adopted, and what other intervening reasons prevailed in the course of decision making. Short of these facts, post hoc evaluation of potential courses of action become more speculative.

**4. Public Health Data Lightly Informed the Evolving Pandemic Response**

While the DOH, or the State for that matter, cannot control the prevailing message, it does have an important role in informing the public discourse regarding public emergencies. Declarations, proclamations, plans, press conferences, all combine to set expectations. On April 17, 2020, the Utah Leads Together – Version 2, plan introduced a color-coded Health Guidance System to "provide specific direction to Utah residents and businesses" (page 8). Within two weeks, the system largely moved from "red" to "orange" and then two weeks later to "yellow." Risk status changes seemed inconsistently connected to the data as statewide case growth accelerated in June and again in August. The semaphores were scrapped for a rules-based Transmission Index on October 13, 2020. DOH communicated internal frustration with the color-coded systems' lack of responsiveness given prevailing data in intervening months, indicating that such might undermine broader confidence in the government response.

Accurate delivery of facts, and a greater understanding of the full context surrounding good information can engender population level trust and resilience in the face of uncertainty beyond even the ability to shape people's behavior. While being "data-driven" or "data-informed" might be terms of art, it is clear that perception and fidelity to consistent, accurate, and timely data is a key to confidence in clear public messaging.

A global pandemic is an extraordinary event that stresses all aspects of a government's response, from operational systems to effective communication. Focus on exceptions, weaknesses, and other problems should not detract from other successes and improvements exhibited by the many devoted professionals within the State of Utah. We thank the Department of Health for their professionalism throughout this audit.

Sincerely,

David Stringfellow
Chief Economist & Deputy State Auditor

cc: Melanie Henderson, Internal Audit Director

# BeWise

1. What does your office do?

- Utah's WISEWOMAN Program, known locally as the BeWise Program, provides cardiovascular screening and health behavior support services to eligible Utah women ages 40-64. Grant funding enables qualifying women to receive free screenings and counseling about their risk for heart disease and stroke. Women are then supported as they participate in evidence-based lifestyle programs, individual health coaching, or referred to other community resources. Services delivered by the BeWise Program are designed to promote lifelong heart-healthy lifestyle changes.

- The BeWise program provides these services to mid-to-low income, uninsured or underinsured Utah women ages 40-64. In the current cooperative agreement that began in 2018 the program has screened 2,705 women, 80% (N = 2168) of program participants are Hispanic, 76% (N = 2046) speak Spanish as a primary language, 14% (N = 383) have uncontrolled hypertension, 56% (N = 1512) are pre-hypertensive, 15% (N=406) are diabetic, 35% (N=960) are pre-diabetic.

- To deliver services the program partners with local health departments, community health centers, community agencies, health care providers, pharmacies, and other agencies. Staff coordinate the delivery of program services, provide technical assistance, evaluate program effectiveness, manage grant funds, coordinate statewide efforts meeting the grant requirements, contracts management and all day to day operations of the grant.

2. How are you organized?

- The BeWise Program was first funded by the Centers for Disease Control in July 2008 and is currently fully staffed. To view a copy of the org chart visit https://drive.google.com/drive/folders/1yAEgz9mkmCCuZqaIRHlFjzfvo7toTc_K
- As a program, there are 3 positions that complete tasks and charge a portion of their time to the BeWise grant and are not represented on the org chart. These staff outside the BeWise Program who provide support are as follows (name of staff, %FTE in the grant, in which program they reside, and to whom they report):
    1. Theron Jeppson (10% FTE), Informatics Program, Reports to Joe Jackson
    2. Teresa Chaikowsky (5% FTE), DCP Finance, Reports to Brandy Frandsen
    3. Lily Doyle (20% FTE), B&C Program, Reports to Shellee Smith

3. Which personnel do which tasks?

**Kalynn Filion,** Program Manager II This position is the Principle Investigator for Utah's WISEWOMAN Program. This position is responsible for the administration of the cooperative agreement with general oversight of all components of the program. Responsible for program management and budget oversight (fiscal and resource management), comply with all conditions of grant award for WISEWOMAN. Team Lead for all Grant/Work plan requirements. Responsible for oversight of all day-to day operations related to the grant and staff supervision and ensures that all grant activities are completed during the grant period.

**Wyatt Jensen,** Lead Epidemiologist/ Evaluator/Data Manager: Lead Epidemiologist and Data Manager for BeWise. This position completes the evaluation activities, submits required Minimum Data Elements to CDC, and interfaces directly with CDC Evaluation Coordinators. This position also provides data to program and contracted staff by routinely generating reports and other summaries of program data as needed. Additionally, this position works closely with database contractors to improve and update the database collection system required by the CDC WISEWOMAN Grant. .
**MaryEllen Martinez**, Office Support: Provides staff support to program staff in accomplishing day to day activities in finalizing grant activities, and paying vendors. This is a shared position with the B&C Cancer Program.
**Stephanie Wilkinson**, Lifestyle Program Specialist. Coordinate with contractors to ensure that participants enrolled in Utah's LSPs and Health Coaching complete the recommended. This position monitors contractors progress and assists where needed to ensure that participants receive the full benefits of the WISEWOMAN Program. As a content expert, this position has a role in completing evaluation activities.
**Anna Testa,** Nurse Coordinator. Anna provides comprehensive patient navigation services to previously screened program participants with cardiovascular disease and risk factors including hypertension. This position coordinates all programmatic activities around continuous quality improvement and coordination of feedback sent to contractors on performance and areas that need improvement.
**Therron Jeppson**, Informatics. This position provides public health informatics support and project management for informatics related projects and serves as the Informatics liaison assigned to the program from the Division of Disease Control Prevention Informatics Program. This position is the project manager for BBHW which is the data collection system that the BeWise Program shares with the B&C Cancer Program.
**Teresa Chaikowsky**, DCP Financial Technician, This position assists in developing and preparing the program budget; reviewing, tracking, and monitoring expenditures and all other financial transactions; preparing monthly reports and meeting with BeWise program management monthly.
**Lily Doyle,** Accounting Technician/Billing. This position processes all billing requests for screening and follow-up service provided to women with alert and abnormal values.

4. How do you measure success?

- The BeWise program has 6 performance measures reported annually to CDC and are as follows:
    1. Number and percent of WISEWOMAN participants whose WISEWOMAN provider has a protocol for identifying patients with undiagnosed hypertension
    2. Number and percent of WISEWOMAN participants whose WISEWOMAN provider has policies or systems to implement a multi-disciplinary team approach to blood pressure control
    3. Number and percent of at risk women in WISEWOMAN referred to an appropriate healthy behavior support service.
    4. Number and percent of WISEWOMAN providers with an implemented community referral system (tracking bi-directional referrals) for healthy behavior support services for people with high risk for cardiovascular disease.

5. Number and percent of women in WISEWOMAN referred to a healthy behavior support service who attend at least one session.
6. Number and percent of women in WISEWOMAN with known high blood pressure who have achieved or are currently maintaining blood pressure control.

- In addition to CDC reported measures, the program completes evaluation activities to measure changes in self-reported health behaviors and improvements participants report making because of their participation in the program.

5. What have been the results of your success measuring the last few years?

In the current cooperative cycle, in program year 1, the BeWise program screened 1,055 women, year 2 screened 1,582, and so far in program year 3, 575 women, totaling in 3,212 screenings in this cooperative agreement. For women enrolled in year 1, 703 finished their health coaching sessions and a total number of 2,320 sessions were given in year 1, for year 2, 888 finished their sessions and a total number of 3,062 sessions were given in year 2, and year 3 so far, 94 have finished their health coaching and a total of 624 sessions were given so far this year.
For specific performance measure data for the entire cooperative cycle, visit: .
https://drive.google.com/drive/folders/1yAEgz9mkmCCuZqaIRHlFjzfvo7toTc_K
CDC WISEWOMAN Quick Scan for Utah.
https://drive.google.com/drive/folders/1yAEgz9mkmCCuZqaIRHlFjzfvo7toTc_K
In 2018, the BeWise program conducted an outcome evaluation to examine the changes in participants over time in the last cooperative agreement cycle (2013-2018).

- **Behavior Changes:** Eight percent of all participants with uncontrolled hypertension reported efforts to reduce the sodium in their diets. During health coaching sessions, 84% of participants received applicable tools, incentives, and community referrals to help them achieve their lifestyle goals. Overall, 16% of participants reported a decrease in the number of days their poor physical or mental health kept them from their usual activities. Additionally, 11% reported a decrease in the number of days their mental health was not good and 5% reported a decrease in the number of days their physical health was not good. Nine percent of participants reported an increase in their minutes of vigorous physical activity, while 46% reported an increase in their moderate physical activity.
- **Clinical measures:** When comparing values between baseline and re-screening (N=385), 55% of our participants decreased their systolic blood pressure values, 53% decreased their diastolic blood pressure values, 42% decreased their total cholesterol values, 43% decreased their blood glucose values, and 47% decreased their weight.
- **Client Survey:** When surveyed client's report that they are satisfied with the services they receive from the BeWise program. Nearly all are satisfied with the services received from their health coach (98% overall 67% Extremely Satisfied, 31% Satisfied) and 95% feel they were given adequate support to reach or work toward their goals. Additionally, an independent evaluation concluded that the BeWise program is very effective, with 84% of patients making changes in their

lives based on the education they received. Most of these changes were in diet and nutrition (67%), and exercise (45%) or walking more (12%).

- **Client Survey**: When asked how the program could improve most participants reported that the BeWise program doesn't need to change and is a positive program in their life (57%). When asked what can be improved, 22% of patients have suggested program expansion, based on positive experiences. Suggestions include advertising to reach more women and offering more frequent access to health coaches, classes, and appointments. The BeWise program should explore ways to expand services in order to benefit the health of more women

6. How are you funded? Why are you funded that way?

The Centers for Disease Control and Prevention's WISEWOMAN (Well-Integrated Screening and Evaluation for WOMen Across the Nation) program provides funding to states and tribal organizations that participate in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which helps ensure women participating in the NBCCEDP receive a full range of health services.

7. When was the last time that you had a major problem? How did you identify it? What was the solution that you implemented?

The BeWise Program conducts a monthly review of how complete screening data is in each contracting clinic and number of clients who have been referred to appropriate Health Behavior Support Services (HBSS). Once these reviews are completed, a detailed compliance report that describes progress and adherence to program requirements is created and shared with each contractor. Using the compliance reports the program hosts monthly calls with each contractor to discuss their progress, adherence to program policy and troubleshoot concerns.

Beginning in February 2019, while conducting routine quality assurance tasks, the Program noticed a decline in HBSS and Health Coaching services delivered to clients screened in one clinic in Salt Lake County. The program monitored this decline until April 2019, when it was determined that a problem was occurring that inhibited the delivery of health coaching services to women who accessed the program at this clinic. At this time, the program met with the Salt Lake County health coaching contractors to identify the obstacles to delivering services. The program and contractor collaboratively identified the challenges they were experiencing and determined that a joint meeting with the screening and health coaching contractors would be necessary to address the problem.

BeWise staff moderated the meeting with the screening and health coaching contractors. Acting in the role of moderator allowed us to keep the program's goals, priorities and expectations in the forefront of the conversation while helping each contractor to identify systems and process changes that would improve delivery of health coaching services. The contractors determined that screening services would be offered on specific agreed on dates to allow the health coaching contractors an opportunity to offer services after the screening was completed while the participant was at the clinic. By implementing this process change, the health coaching contractors were able to improve their ability to meet

performance measures that women are offered and attend at least one health coaching session.

8. When was the last major change in your office? What was it? How did it change your workflow?

In September 2018, the program began a new 5 year grant cycle When awarded new funding the program experienced a significant decrease in the amount of grant funding awarded. The decrease in funding was because of a decision on the federal decision to redistribute available funding to expand services into other parts of the nation. This impacted the number of women in Utah who have access to program services, reduced the number of clinics offering services, and reduced the number of staff available at the state to complete program activities. To navigate this change the Program Manager consulted with Bureau Leadership, Governance, contractors and BeWise staff.

9. Do you seek for and receive private contributions to involve the community in the solution? If not, why?

The program does not solicit private monetary contributions to the program however we do require in-kind match from contractors and community partners. As part of the contract Local health departments seek community partnerships that enable them to better provide resources and support tools to women accessing program services. The local health department reports as their in-kind match funds, donated goods, or volunteer hours that support the delivery of the program in the community and provide women and their families with the tools they need to be successful in making healthy choices.

10. How much do you spend on services versus program administration?

Program currently receives $1.1M per year
54% ($595,200) of funding is used to administer and evaluate the program at the state
46% ($504,800) of funding is used to pay for program services

11. How do you emphasize preventative measures rather than reactive measures, such as:

- Encouraging good nutrition and exercise? Yes
- Treating the underlying issue (e.g., mental health, substance abuse)? Not treating but we refer for these type of issues
- Educating in a way that helps individuals desire and realize change? Yes

The vision of the BeWise program is to ensure that eligible women can access preventive health services and gain the wisdom, skills, and resources necessary to improve their health. The program works to increase the skills, knowledge, and confidence of women and support their personal desire to adopt healthy eating habits, increase physical activity, and live tobacco-free. By providing these services the program prevents, delays or controls cardiovascular disease and other chronic conditions. Contractors providing services address individual health needs that may arise during health coaching sessions and are trained in Motivational Interviewing. Examples of challenges individuals may need assistance with may include: domestic violence, mental health issues, food security,

tobacco cessation, problem solving skills, sleep, mindfulness, social support, nutrition, physical activity etc.

For more information about additional education tools the program provides visit https://www.bewiseutah.org/

Screening and preventive services provided by the program are as follows:

1. Heart disease and stroke risk factor screening, which includes assessment of blood pressure, cholesterol, glucose, BMI, and personal medical history
2. Health risk assessments
3. Risk reduction counseling
4. Referrals for women with abnormal screening values to health care providers for medical evaluation and management of condition(s)
5. Follow-up for uncontrolled hypertension
6. Link participants to free or low cost medication resources
7. Referrals to health coaching, lifestyle programs, and other healthy behavior support options.

12. What would you do with more funding?

- With additional funding the program would expand availability of program services to more women ages 40-64, women younger than 40 and men.
- Improve and increase the support services given to each participant.

13. What would you do with less funding?

- The number of women we could serve would be decreased.

Are there any areas where you would like to know what other States are doing to address certain issues (I can ask my national support organization)?

- What other funding opportunities are available to other states to provide cardiovascular screening and health behavior support services?

**Source:**

**From:** Kalynn Filion <kfilion@utah.gov>
**Sent:** Tuesday, May 4, 2021 4:22 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** BeWise Program

## Cancer Breast & Cervical

1. What does your office do? The Utah Breast and Cervical Cancer Program, through the national Breast and Cervical Cancer Early Detection program (NBCCEDP), provides breast and cervical cancer screening to Utahns. Through our office, we collaborate with chronic disease and health promotion programs on prevention and risk reduction activities; Utah Cancer Registry for report and use of cancer burden data; partners such as Huntsman Cancer Institute, Intermountain Healthcare and American Cancer Society breast health equity. Establish and enhance program infrastructure to increase breast and cervical cancer screening rates. Establish contracts and MOUs with program partners on clinical service delivery and implementation of health system intervention strategies. Track, process and monitor expenditures. Prepare and submit required reports to CDC. Develop and implement an evaluation plan. Work with employers to implement wellness policies. Partner with CHWs and health educators for outreach and referrals to medical homes.
2. How are you organized? Program Manager II that is responsible for the program and oversees program activities, monitors expenditures, and manages 4 staff. Program Manager I that oversees contracts, manages 3 staff and works directly with CHWs.
3. Which personnel do which tasks?
**Marie Nagata** Program Manager II (0.5 FTE) Project Director for the DP17-1701 Grant. Responsible for program management and budget oversight of the Breast and Cervical Cancer Program. Lead for all program planning and project implementation. Ensure program complies with all conditions and requirements of the grant award. Responsible for oversight of all day-to day operations related to the grant and staff supervision. Coordination with internal and external programs and partners.
**Shellee Smith** Program Manager I (1.0 FTE) Identifies and establishes relationships with worksites and insurance companies to develop wellness policies that promote screenings. Works with contracted health systems and clinics to increase screenings. Manage all contracts with clinics, facilities and health systems. Responsible for contract monitoring and risk assessment.
**Brenda Nelson** Health Program Specialist III (1.0 FTE) Work with Health Systems to increase breast and cervical cancer screening rates. Provide worksite wellness training to worksites. Conduct assessments for each clinic. Lead clinics in identifying gaps and implementing enhanced EBIs. Provide assessment and final reports to CDC.
**Vacant** Evaluator (.6 FTE) Responsible for evaluation planning, implementation, and reporting of all program components. Conducts reviews of programmatic activities to ensure they are in alignment with evaluation plan structure and assists in directing new programmatic efforts based on available evaluation data. Regularly monitors and reports on both process and outcome level evaluation questions relevant to program activities.
**Joannah Sparks** Jr Business Analyst (1.0 FTE) Assists with the collection of complete and accurate patient data by testing for problems or errors and running data reports on an ongoing basis. Creates and updates clinic forms and documents for database users and partners. Develops and interprets financial reports. Prepares contracts and agreements for all UCCP service and outreach partners.
**Lily Doyle** Accounting Technician (.8 FTE) Reviews and verifies all billing documentation for completeness, accuracy and timely payment for partner reimbursement. Facilitates resolution with facilities, providers and patients who encounter billing issues.
**Jennifer Thiros** (1.0 FTE) Coordinates all clinical partnerships for cervical cancer screening. Provides program education and collaboration of diagnostic work up of UCCP women. Performs

quality reviews of clinics tracking clients who provide follow-up with abnormal cytology, HPV results and needing short term follow up.
**Katrina Parks** (1.0 FTE) Coordinates all clinical partnerships for breast cancer screening. Provides program education and collaboration of diagnostic work up of UCCP women. Performs quality reviews of clinics tracking clients to complete their diagnostic workup.
**Stephanie Pesantes** Medical Assistant (0.6 FTE) Triage calls, sends letters for client follow up, returns client phone calls, and processes enrollments. Assist clients with billing issues.
4. How do you measure success? Increased screening rates, increased enrollment numbers. Improvement of enrollment process to remove barriers from those seeking services.
5. What have been the results of your success measuring the last few years? We have been focusing on increasing our enrollment numbers by working with current screening partners and identifying and partnering with new health systems. We were on track to exceed the number of women ever enrolled on the program (8,500 women) when COVID began.
6. How are you funded? Why are you funded that way? We receive most of our funding through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through the Breast and Cervical Cancer Mortality Prevention Act of 1990, directed by CDC. Maintenance of Effort is required for this program. The average amount of non-Federal contributions toward breast and cervical cancer programs for the 2 year period preceding the first Federal fiscal year of funding.
7. When was the last time that you had a major problem? How did you identify it? What was the solution that you implemented? Our enrollment numbers are not increasing. We have begun to meet with each screening partner quarterly to provide updates, training and answer questions. After each meeting, we have seen an increase in screening.
8. When was the last major change in your office? What was it? How did it change your workflow? December 2020. Our CDC Project Officer has been working with us to Decentralize (move the work from the state office to health systems). We have traditionally been a very large program doing the majority of the work at the state. Our system is very labor intensive. We have had to significantly decrease staff based on funding and had to RIF 2 staff. We have shifted responsibilities and are currently identifying what is not required, but we have always done because it has always been done that way. We no longer scan every mammogram report as they may be found through the facility. We now have access to health system databases where we can view reports and not wait for the paperwork to be sent.
9. Do you seek for and receive private contributions to involve the community in the solution? If not, why? We do not seek private contributions. We do have a requirement for 3:1 match from partners, which we identify through in-kind efforts.
10. How much do you spend on services versus program administration? 78% of funding is spent on services
11. How do you emphasize preventative measures rather than reactive measures, such as: Our entire program focuses on preventive screening. We partner with community clinics to provide preventive visits and pay for their clinical breast exam and pap test. We also work with worksites to implement worksite wellness policies for preventive health.
12. What would you do with more funding? we would be able to screen more women.
13. What would you do with less funding? the number of women we serve would be decreased
Are there any areas where you would like to know what other States are doing to address certain issues (I can ask my national support organization)?

# Years of Potential Life Lost (YPLL) Before Age 75

2019 Utah
All Races, Both Sexes
All Deaths

| Cause of Death | YPLL | Percent |
|---|---|---|
| All Causes | 167,444 | 100.0% |
| **Unintentional Injury** | **28,795** | **17.2%** |
| Malignant Neoplasms | 24,877 | 14.9% |
| **Suicide** | **22,741** | **13.6%** |
| Heart Disease | 16,817 | 10.0% |
| Perinatal Period | 9,949 | 5.9% |
| Congenital Anomalies | 7,482 | 4.5% |
| Diabetes Mellitus | 4,824 | 2.9% |
| Liver Disease | 4,137 | 2.5% |
| **Homicide** | **3,465** | **2.1%** |
| Cerebrovascular | 3,344 | 2.0% |
| All Others | 41,013 | 24.5% |

Download Results in a Spreadsheet (CSV) File

Terms for Causes of Death

Help with Download

**Produced By:** **National Center for Injury Prevention and Control, CDC**
**Data Source:** **National Center for Health Statistics (NCHS) Vital Statistics System.**

## Russell Frandsen

**From:** Kevin Burt <kburt@utah.gov>
**Sent:** Thursday, May 13, 2021 9:26 AM
**To:** Kimberly Madsen; Russell Frandsen
**Cc:** Dan Schuring; Paras, Greg; Nate McDonald
**Subject:** Re: experience adding a chat option for eligibility services?

Russell,

With Kathy changing jobs, I will now be handling legislative affairs for DWS so please add me to all of your DWS email lists. Here is the information you requested.

The Eligibility Services Division (ESD) began using a chat feature in December 2013.

Here's an outline of the cost to add the feature and maintain licensing.

- The chat feature was already provided with our telephony system at the time, so the additional cost was licensing and maintenance.
- A license allows for multiple/variety of interactions per agent - so they have the ability to do calls, chats, emails, etc.
- The sale price for each license was $767.50 in 2013
- There is also a yearly maintenance charge per license. Each year, there is a slight increase. Currently, it is $332 per license.
- It is important to note that ESD is not using chat for eligibility questions rather is using chats to assist with customers accessing us online
- There were no staffing costs for DTS or DWS to set this up.

Additional information:

- We currently average about 1,600 chats per month (again for online support)
- Typically 5-7 staff are assigned to chat on a typical day, dependent upon volume.

Please let me know if you need anything else, and thanks!

**Kevin Burt**
**Assistant Deputy Director**
**P:** (801) 526-9575
140 East 300 South, Salt Lake City, Utah 84111
jobs.utah.gov

UTAH DEPARTMENT OF WORKFORCE SERVICES

On Wed, May 5, 2021 at 1:40 PM Russell Frandsen <rfrandsen@le.utah.gov> wrote:

Hi Kathy,

I am sorry to bother you now that the very capable Kimberly is helping oversee DWS' budget, but could you tell me some time in May what DWS' experience was in terms of cost and time demands on staff to add an online chat feature for clients asking about eligibility? Thanks for your consideration.

Russell Frandsen

Finance Officer

Office of the Legislative Fiscal Analyst

State of Utah

Phone 801-538-1034

Fax 801-538-1692

rfrandsen@le.utah.gov

http://budget.utah.gov/

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue | FY21 Fee Revenue |
|---|---|---|---|---|---|
| LEE | | | | | |
| Out-of-state laboratories | $ 40,000 | $ 65,000 | $ 65,000 | $ 65,000 | $ 72,000 |
| Volatile | $ 23,500 | $ 45,000 | $ 45,000 | $ 45,000 | $ 61,000 |
| Inductively Coupled Plasma Mass Spectrometry | $ 26,500 | $ 51,500 | $ 51,500 | $ 51,500 | $ 56,000 |
| Utah laboratories | $ 37,125 | $ 34,650 | $ 34,650 | $ 34,650 | $ 53,000 |
| Inductively Coupled Plasma Metals Analysis | $ 26,400 | $ 38,400 | $ 38,400 | $ 38,400 | $ 47,600 |
| Semivolatile | $ 19,500 | $ 30,500 | $ 30,500 | $ 30,500 | $ 38,000 |
| Atomic Absorption/Atomic Emission | $ 22,200 | $ 28,500 | $ 28,500 | $ 28,500 | $ 36,000 |
| National Environmental Accreditation Program (NELAP) recognition | $ 28,875 | $ 35,475 | $ 35,475 | $ 35,475 | $ 36,000 |
| Simple | $ 20,100 | $ 24,900 | $ 24,900 | $ 24,900 | $ 29,700 |
| Spectrometry | $ 15,000 | $ 23,400 | $ 23,400 | $ 23,400 | $ 28,800 |
| Ion Chromatography | $ 14,800 | $ 18,600 | $ 18,600 | $ 18,600 | $ 21,800 |
| Radiological chemistry - Gas Proportional Counter | $ 7,000 | $ 8,000 | $ 8,000 | $ 8,000 | $ 18,600 |
| Complex | $ 19,800 | $ 22,800 | $ 22,800 | $ 22,800 | $ 18,600 |
| Radiological chemistry - Beta | $ 1,800 | $ 5,800 | $ 5,800 | $ 5,800 | $ 14,400 |
| High Pressure Liquid Chromatography | $ 10,200 | $ 12,300 | $ 12,300 | $ 12,300 | $ 14,400 |
| Ion Selective Electrode base methods | $ 10,000 | $ 12,100 | $ 12,100 | $ 12,100 | $ 14,000 |
| Radiological chemistry - Gamma | $ 3,800 | $ 5,200 | $ 5,200 | $ 5,200 | $ 12,600 |
| Radiological chemistry - Alpha spectrometry | $ 5,800 | $ 8,000 | $ 8,000 | $ 8,000 | $ 12,300 |
| Gravimetric | $ 8,900 | $ 10,500 | $ 10,500 | $ 10,500 | $ 11,900 |
| Radiological chemistry - Liquid Scintillation | $ 4,000 | $ 6,600 | $ 6,600 | $ 6,600 | $ 11,100 |
| Physical Properties | $ 6,900 | $ 8,500 | $ 8,500 | $ 8,500 | $ 10,200 |
| Toxicity/Synthetic Extractions Characteristics Procedure | $ 7,400 | $ 8,200 | $ 8,200 | $ 8,200 | $ 10,000 |
| Organic Extraction | $ 3,100 | $ 6,000 | $ 6,000 | $ 6,000 | $ 9,400 |
| Titrimetric | $ 7,000 | $ 8,000 | $ 8,000 | $ 8,000 | $ 8,300 |
| Complex Microbiological Testing | $ 4,200 | $ 7,800 | $ 7,800 | $ 7,800 | $ 6,900 |
| Simple Microbiological Testing | $ 3,500 | $ 4,300 | $ 4,300 | $ 4,300 | $ 6,800 |
| While Effluent Toxicity | $ 2,400 | $ 4,800 | $ 4,800 | $ 4,800 | $ 6,000 |
| Organic Clean Up | $ 1,900 | $ 2,500 | $ 2,500 | $ 2,500 | $ 5,800 |
| Metals Digestion | $ 3,500 | $ 4,200 | $ 4,200 | $ 4,200 | $ 5,500 |
| Calculation of Analytical Results | $ 1,450 | $ 2,150 | $ 2,150 | $ 2,150 | $ 2,600 |
| Certification change | $ 1,000 | $ 900 | $ 900 | $ 900 | $ 2,500 |
| Primary Method Addition for Recognition Laboratories | $ 2,000 | $ 1,000 | $ 1,000 | $ 1,000 | $ 500 |

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue | FY21 Fee Revenue |
|---|---|---|---|---|---|
| Performance Based Method Review | $ 250 | $ 250 | $ 250 | $ 250 | $ 250 |
| Organic Wet Chemistry | $ - | $ - | $ - | $ - | $ 200 |
| Certification Clarification | $ - | $ - | $ - | $ - | $ - |
| **LEE Total** | **$ 389,900** | **$ 545,825** | **$ 545,825** | **$ 545,825** | **$ 682,750** |

| Row Labels | FY22 Fee Revenue | FY22 - FY17 Fee Increase/(Decrease) | FY22 - FY17 Fee % Change |
|---|---|---|---|
| LEE | | | |
| Out-of-state laboratories | $ 72,000 | $ 32,000 | 80% |
| Volatile | $ 61,000 | $ 37,500 | 160% |
| Inductively Coupled Plasma Mass Spectrometry | $ 56,000 | $ 29,500 | 111% |
| Utah laboratories | $ 53,000 | $ 15,875 | 43% |
| Inductively Coupled Plasma Metals Analysis | $ 47,600 | $ 21,200 | 80% |
| Semivolatile | $ 38,000 | $ 18,500 | 95% |
| Atomic Absorption/Atomic Emission | $ 36,000 | $ 13,800 | 62% |
| National Environmental Accreditation Program (NELAP) recognition | $ 36,000 | $ 7,125 | 25% |
| Simple | $ 29,700 | $ 9,600 | 48% |
| Spectrometry | $ 28,800 | $ 13,800 | 92% |
| Ion Chromatography | $ 21,800 | $ 7,000 | 47% |
| Radiological chemistry - Gas Proportional Counter | $ 18,600 | $ 11,600 | 166% |
| Complex | $ 18,600 | $ (1,200) | -6% |
| Radiological chemistry - Beta | $ 14,400 | $ 12,600 | 700% |
| High Pressure Liquid Chromatography | $ 14,400 | $ 4,200 | 41% |
| Ion Selective Electrode base methods | $ 14,000 | $ 4,000 | 40% |
| Radiological chemistry - Gamma | $ 12,600 | $ 8,800 | 232% |
| Radiological chemistry - Alpha spectrometry | $ 12,300 | $ 6,500 | 112% |
| Gravimetric | $ 11,900 | $ 3,000 | 34% |
| Radiological chemistry - Liquid Scintillation | $ 11,100 | $ 7,100 | 178% |
| Physical Properties | $ 10,200 | $ 3,300 | 48% |
| Toxicity/Synthetic Extractions Characteristics Procedure | $ 10,000 | $ 2,600 | 35% |
| Organic Extraction | $ 9,400 | $ 6,300 | 203% |
| Titrimetric | $ 8,300 | $ 1,300 | 19% |
| Complex Microbiological Testing | $ 6,900 | $ 2,700 | 64% |
| Simple Microbiological Testing | $ 6,800 | $ 3,300 | 94% |
| While Effluent Toxicity | $ 6,000 | $ 3,600 | 150% |
| Organic Clean Up | $ 5,800 | $ 3,900 | 205% |
| Metals Digestion | $ 5,500 | $ 2,000 | 57% |
| Calculation of Analytical Results | $ 2,600 | $ 1,150 | 79% |
| Certification change | $ 2,500 | $ 1,500 | 150% |
| Primary Method Addition for Recognition Laboratories | $ 500 | $ (1,500) | -75% |

| Row Labels | FY22 Fee Revenue | FY22 - FY17 Fee Increase/(Decrease) | FY22 - FY17 Fee % Change |
|---|---|---|---|
| Performance Based Method Review | $ 250 | $ - | 0% |
| Organic Wet Chemistry | $ 200 | $ 200 | 0% |
| Certification Clarification | $ - | $ - | 0% |
| **LEE Total** | **$ 682,750** | **$ 292,850** | **75%** |

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue |
|---|---|---|---|---|
| LED | | | | |
| Laboratory Testing and Follow-up Services | $ 5,720,160 | $ 5,720,160 | $ 5,868,570 | $ 5,841,000 |
| Chlamydia trachomatis and Neisseria gonorrhoeae detection by nucleic acid testing | $ 537,500 | $ 615,475 | $ 1,028,820 | $ 963,332 |
| Legionella Standard Methods 9260J | $ 141,680 | $ 76,370 | $ 60,060 | $ 61,070 |
| 1/2 and O, Antigen/Antibody Combo | $ 70,000 | $ 54,565 | $ 62,685 | $ 33,750 |
| Herpesvirus (Herpes Simplex Virus-1, Herpes Simplex Virus-2, Varicella Zoster Virus) Detection and Differentiation by Polymerase Chain Reaction | $ 48,035 | $ 30,030 | $ 33,540 | $ 37,638 |
| Immunoglobulin G (IgG) Antibody (including reflex Rapid Plasma Reagin titer) | $ 52,637 | $ 31,434 | $ 47,242 | $ 37,220 |
| Total Coliforms/Escherichia coli | $ 40,140 | $ 10,100 | $ 32,000 | $ 28,500 |
| Mycoplasma Genitalium Detection by Nucleic Acid Testing | $ - | $ - | $ - | $ - |
| QuantiFERON Gold | $ 62,937 | $ 81,018 | $ 125,000 | $ 73,150 |
| Haloacetic Acids Method 6251B | $ 26,400 | $ 11,385 | $ 17,160 | $ 21,190 |
| Zika Immunoglobulin M | $ - | $ - | $ - | $ - |
| Hepatitis C Virus (HCV) detection by quantitative Nucleic Acid Amplification Test | $ - | $ - | $ - | $ - |
| C (Anti-Hepatitis C Virus) Antibody | $ 13,944 | $ 9,940 | $ 18,144 | $ 10,534 |
| TrioPlex Polymerase Chain Reaction | $ - | $ - | $ - | $ - |
| Environmental Protection Agency 524.2 Trihalomethanes | $ 13,149 | $ 8,353 | $ 7,526 | $ 10,546 |
| BioFire FilmArray Gastrointestinal Panel | $ - | $ - | $ - | $ - |
| Anatoxin by Enzyme-Linked Immunosorbent Assay | $ - | $ - | $ - | $ 7,257 |
| Cylindrospermopsin by Enzyme-Linked Immunosorbent Assay | $ - | $ - | $ - | $ 7,167 |
| Anti-Hepatitis B Antigen | $ 5,038 | $ 2,134 | $ 3,230 | $ 2,282 |
| TP-PA (Treponema Pallidum - Particle Agglutination) Confirmation | $ 12,324 | $ 3,744 | $ 3,692 | $ 6,204 |
| Bacterial Sequencing, Identification, Analysis | $ - | $ - | $ 6,122 | $ 6,100 |
| Bacterial Sequencing and Identification | $ - | $ - | $ 5,430 | $ 5,400 |
| Anti-Hepatitis B Antibody | $ 5,830 | $ 3,410 | $ 9,531 | $ 5,499 |
| Rabies - Not epidemiological indicated or pre-authorized | $ 4,500 | $ 2,700 | $ 3,960 | $ 8,640 |
| Identification and Susceptibility by GeneXpert | $ 40,000 | $ 100 | $ 673 | $ 5,670 |
| Supplemental Testing (HIV-1/HIV-2 differentiation) | $ 89 | $ 3,026 | $ 2,520 | $ 294 |
| Environmental Protection Agency 200.8 Lead | $ 2,509 | $ 2,340 | $ 1,446 | $ 768 |
| Chlorophyll-A by High Performance Liquid Chromatography | $ - | $ - | $ - | $ 2,514 |
| Environmental Protection Agency 180.1 Turbidity | $ 1,265 | $ 1,298 | $ 1,309 | $ 1,326 |
| Environmental Protection Agency 353.2 Nitrate | $ - | $ - | $ - | $ - |

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue |
|---|---|---|---|---|
| Environmental Protection Agency 524.2 | $ 14,421 | $ 3,971 | $ 4,180 | $ 2,080 |
| Environmental Protection Agency 375.2 Sulfate | $ 1,155 | $ 1,749 | $ 1,700 | $ 713 |
| Environmental Protection Agency Sodium 200.8 | $ 1,040 | $ 1,890 | $ 497 | $ 1,824 |
| Cyanide, Total 335.4 | $ 3,000 | $ 2,000 | $ 2,050 | $ 1,900 |
| Environmental Protection Agency 200.8 Calcium | $ 610 | $ 1,630 | $ 15 | $ 1,356 |
| Environmental Protection Agency 200.8 - Magnesium | $ - | $ - | $ 1,506 | $ 1,380 |
| Environmental Protection Agency 353.2 Nitrate + Nitrite | $ 2,653 | $ 3,076 | $ 3,485 | $ 2,552 |
| Environmental Protection Agency 200.8 - Potassium | $ - | $ - | $ 346 | $ 1,332 |
| Environmental Protection Agency 200.8 Copper | $ 2,470 | $ 1,859 | $ 783 | $ 516 |
| Alkalinity (Total) Standard Method 2320B | $ 650 | $ 1,420 | $ 1,680 | $ 1,136 |
| Mercury 245.1 | $ 2,613 | $ 2,118 | $ 2,063 | $ 624 |
| Environmental Protection Agency 200.8 Arsenic | $ 1,807 | $ 1,885 | $ 1,611 | $ 960 |
| Nitrogen, Total Standard Method 4500-N (Lachat) | $ - | $ - | $ 5,225 | $ 2,052 |
| Cyanotoxin Quantitative Polymerase Chain Reaction Method | $ - | $ - | $ - | $ 750 |
| Environmental Protection Agency 300.1 Sulfate | $ 1,403 | $ 893 | $ 38 | $ 926 |
| BioFire FilmArray Respiratory Panel | $ - | $ - | $ - | $ - |
| Environmental Protection Agency 200.8 Selenium | $ 1,027 | $ 962 | $ 949 | $ 600 |
| Heterotrophic Plate Count by 9215 B Pour Plate | $ 442 | $ 130 | $ 403 | $ 39 |
| Rush Fee | $ - | $ - | $ - | $ - |
| Environmental Protection Agency 200.8 - Iron | $ - | $ - | $ 663 | $ 480 |
| Environmental Protection Agency 300.0 Fluoride | $ 1,178 | $ 1,007 | $ 38 | $ 703 |
| Chain of Custody Request Fee | $ - | $ - | $ - | $ - |
| Periphyton | $ - | $ - | $ - | $ 480 |
| Environmental Protection Agency 200.8 Cadmium | $ 1,417 | $ 1,170 | $ 1,431 | $ 552 |
| Environmental Protection Agency 200.8 Barium | $ 1,040 | $ 598 | $ 738 | $ 516 |
| Environmental Protection Agency 200.8 Antimony | $ 793 | $ 507 | $ 783 | $ 492 |
| Environmental Protection Agency 200.8 Nickel | $ 1,222 | $ 897 | $ 1,130 | $ 480 |
| Environmental Protection Agency 200.8 Chromium | $ 1,404 | $ 884 | $ 1,160 | $ 468 |
| Culture | $ 40,700 | $ 36,300 | $ 41,600 | $ 63,423 |
| Environmental Protection Agency 200.8 Beryllium | $ 793 | $ 520 | $ 753 | $ 456 |
| Environmental Protection Agency 200.8 Thallium | $ 793 | $ 598 | $ 693 | $ 456 |
| Environmental Protection Agency 200.8 Digestion | $ - | $ - | $ 181 | $ 264 |

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue |
|---|---|---|---|---|
| Environmental Protection Agency 537.1 - Per-and Polyfluoroalkyl Substances | $ - | $ - | $ - | $ - |
| Environmental Protection Agency 200.8 Aluminum | $ 455 | $ 325 | $ 316 | $ 192 |
| Laboratory Testing of Public Health Significance | $ - | $ - | $ - | $ 200 |
| Microbial Source Tracking (via shotgun metagenomics sequencing) | $ - | $ - | $ - | $ 194 |
| Mycobacterium tuberculosis susceptibilities (send out) | $ 4,250 | $ 4,250 | $ 4,375 | $ 175 |
| Microbial Source Tracking (via culture based) | $ - | $ - | $ - | $ 150 |
| Influenza PCR (Polymerase Chain Reaction) | $ 30,000 | $ 150 | $ 150 | $ 150 |
| pH (Test of acidity or alkalinity) 150.1 | $ 330 | $ 484 | $ 451 | $ 30 |
| Environmental Protection Agency 200.8 Manganese | $ 624 | $ 429 | $ 572 | $ 120 |
| Out of State Screening | $ - | $ - | $ - | $ 116 |
| Bacterial Sequencing | $ - | $ - | $ 107 | $ 107 |
| Total Microcystins & Nodularins by Enzyme-Linked Immunosorbent Assay | $ - | $ - | $ 7,936 | $ 7,167 |
| Organic Carbon, Total  Standard Method 5310B | $ - | $ - | $ 1,320 | $ 51 |
| Environmental Protection Agency 200.8 Zinc | $ 481 | $ 507 | $ 557 | $ 48 |
| Perchlorate 314.0 | $ 1,100 | $ 165 | $ 165 | $ 55 |
| Chromium (Hexavalent) Environmental Protection Agency 218.7 | $ 1,210 | $ 165 | $ 55 | $ 55 |
| Environmental Protection Agency 200.8 - Strontium | $ - | $ - | $ 45 | $ 36 |
| Environmental Protection Agency 376.2 Sulfide | $ 88 | $ 176 | $ 440 | $ 44 |
| Carboxylic Acids (Oxalate, Formate, Acetate) | $ 5,250 | $ 5,376 | $ 1,722 | $ 42 |
| Bacterial Sequencing Analysis | $ - | $ - | $ 17 | $ 40 |
| Hantavirus | $ 400 | $ 560 | $ 760 | $ 40 |
| Chloride Environmental Protection Agency 300.0 | $ 912 | $ 912 | $ 19 | $ 35 |
| Legiolert | $ - | $ - | $ - | $ 34 |
| Standard Method 5210B Carbonaceous Biochemical/Soluble Oxygen Demand | $ - | $ - | $ 1,122 | $ 33 |
| Organic Constituents, Ultra Violet-Absorbing Standard Method 5910B | $ 2,024 | $ 1,760 | $ 1,386 | $ 33 |
| Environmental Protection Agency 353.2 Nitrite | $ - | $ - | $ - | $ - |
| Selenium by Selenium Hydride - Atomic Absorption - Standard Method 3114C | $ 588 | $ 210 | $ 420 | $ 32 |
| Environmental Protection Agency 300.1 Bromide | $ - | $ - | $ 1,650 | $ 28 |
| Odor, Environmental Protection Agency 140.1 | $ - | $ - | $ - | $ 28 |
| Bromate Environmental Protection Agency 300.1 | $ 165 | $ 110 | $ 28 | $ 28 |
| Chlorate Environmental Protection Agency 300.1 | $ 165 | $ 110 | $ 28 | $ 28 |
| Chlorite Environmental Protection Agency 300.1 | $ 165 | $ 110 | $ 28 | $ 28 |

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue |
|---|---|---|---|---|
| Biochemical Oxygen Demand 5 day test Standard Method 5210B | $ 495 | $ 66 | $ 33 | $ 546 |
| Environmental Protection Agency 200.8 Cobalt | $ - | $ - | $ 45 | $ 12 |
| Environmental Protection Agency 200.8 Copper and Lead | $ - | $ - | $ - | $ - |
| Environmental Protection Agency 200.8 Boron | $ 170 | $ 200 | $ 15 | $ 12 |
| Environmental Protection Agency 200.8 Silver | $ 455 | $ 130 | $ 166 | $ 12 |
| Ammonia Environmental Protection Agency 350.1 | $ 572 | $ 1,210 | $ 1,921 | $ 735 |
| Chlorophyll A Standard Method 10200H - Chlorophyll-A | $ 110 | $ 66 | $ 902 | $ 901 |
| Solids, Total Volatile, Environmental Protection Agency 160.4 | $ 3,069 | $ 2,492 | $ 50 | $ 17 |
| Silica 370.1 | $ 215 | $ 149 | $ 215 | $ 63 |
| Phosphorus, Total 365.1 | $ 1,600 | $ 1,160 | $ 6,580 | $ 2,961 |
| Solids, Total Dissolved Standard Method 2540C | $ - | $ - | $ 3,581 | $ 3,366 |
| Solids, Total Suspended Standard Method 2540D | $ 2,921 | $ 3,036 | $ 132 | $ 3,761 |
| Environmental Protection Agency 200.8 Tin | $ - | $ - | $ 45 | $ 12 |
| Environmental Protection Agency 200.8 Vanadium | $ - | $ - | $ 45 | $ 12 |
| Environmental Protection Agency Method 200.8 Zirconium | $ - | $ - | $ 151 | $ 12 |
| Standard Method 2120B Color | $ - | $ - | $ 84 | $ 12 |
| Environmental Protection Agency 200.8 Molybdenum | $ 351 | $ 65 | $ 30 | $ 12 |
| Specific Conductance 120.1 | $ 650 | $ 1,100 | $ 30 | $ 891 |
| Environmental Protection Agency 325.2 Chloride | $ - | $ - | $ 540 | $ 14 |
| Hardness (Requires Calcium & Magnesium tests) | $ - | $ - | $ - | $ 6 |
| Standard Method 2330B Langelier Index | $ - | $ - | $ - | $ - |
| **LED Total** | **$ 6,939,582** | **$ 6,759,117** | **$ 7,452,588** | **$ 7,289,233** |

| Row Labels | FY21 Fee Revenue | FY22 Fee Revenue | **FY22 - FY17 Fee Increase/(Decrease)** |
|---|---|---|---|
| LED | | | |
| Laboratory Testing and Follow-up Services | $ 5,841,000 | $ 5,880,000 | $ 159,840 |
| Chlamydia trachomatis and Neisseria gonorrhoeae detection by nucleic acid testing | $ 963,355 | $ 963,355 | $ 425,855 |
| Legionella Standard Methods 9260J | $ 71,610 | $ 55,583 | $ (86,097) |
| 1/2 and O, Antigen/Antibody Combo | $ 52,299 | $ 52,299 | $ (17,701) |
| Herpesvirus (Herpes Simplex Virus-1, Herpes Simplex Virus-2, Varicella Zoster Virus) Detection and Differentiation by Polymerase Chain Reaction | $ 41,820 | $ 41,820 | $ (6,215) |
| Immunoglobulin G (IgG) Antibody (including reflex Rapid Plasma Reagin titer) | $ 37,220 | $ 37,220 | $ (15,417) |
| Total Coliforms/Escherichia coli | $ 33,377 | $ 25,456 | $ (14,684) |
| Mycoplasma Genitalium Detection by Nucleic Acid Testing | $ - | $ 24,000 | $ 24,000 |
| QuantiFERON Gold | $ 21,125 | $ 21,125 | $ (41,812) |
| Haloacetic Acids Method 6251B | $ 18,647 | $ 18,647 | $ (7,753) |
| Zika Immunoglobulin M | $ 15,120 | $ 15,120 | $ 15,120 |
| Hepatitis C Virus (HCV) detection by quantitative Nucleic Acid Amplification Test | $ 15,000 | $ 15,000 | $ 15,000 |
| C (Anti-Hepatitis C Virus) Antibody | $ 11,868 | $ 11,868 | $ (2,076) |
| TrioPlex Polymerase Chain Reaction | $ 11,700 | $ 11,700 | $ 11,700 |
| Environmental Protection Agency 524.2 Trihalomethanes | $ 9,263 | $ 9,263 | $ (3,887) |
| BioFire FilmArray Gastrointestinal Panel | $ 9,250 | $ 9,250 | $ 9,250 |
| Anatoxin by Enzyme-Linked Immunosorbent Assay | $ 8,574 | $ 8,574 | $ 8,574 |
| Cylindrospermopsin by Enzyme-Linked Immunosorbent Assay | $ 8,081 | $ 8,081 | $ 8,081 |
| Anti-Hepatitis B Antigen | $ 6,825 | $ 6,825 | $ 1,787 |
| TP-PA (Treponema Pallidum - Particle Agglutination) Confirmation | $ 6,556 | $ 6,556 | $ (5,768) |
| Bacterial Sequencing, Identification, Analysis | $ 6,100 | $ 6,100 | $ 6,100 |
| Bacterial Sequencing and Identification | $ 5,400 | $ 5,400 | $ 5,400 |
| Anti-Hepatitis B Antibody | $ 5,129 | $ 5,129 | $ (702) |
| Rabies - Not epidemiological indicated or pre-authorized | $ 3,600 | $ 3,600 | $ (900) |
| Identification and Susceptibility by GeneXpert | $ 3,528 | $ 3,528 | $ (36,472) |
| Supplemental Testing (HIV-1/HIV-2 differentiation) | $ 3,444 | $ 3,444 | $ 3,355 |
| Environmental Protection Agency 200.8 Lead | $ 3,313 | $ 3,313 | $ 804 |
| Chlorophyll-A by High Performance Liquid Chromatography | $ 2,765 | $ 2,765 | $ 2,765 |
| Environmental Protection Agency 180.1 Turbidity | $ 2,646 | $ 2,646 | $ 1,381 |
| Environmental Protection Agency 353.2 Nitrate | $ 2,464 | $ 2,464 | $ 2,464 |

| Row Labels | FY21 Fee Revenue | FY22 Fee Revenue | **FY22 - FY17 Fee Increase/(Decrease)** |
|---|---|---|---|
| Environmental Protection Agency 524.2 | $ 2,059 | $ 2,059 | $ (12,362) |
| Environmental Protection Agency 375.2 Sulfate | $ 1,843 | $ 1,843 | $ 688 |
| Environmental Protection Agency Sodium 200.8 | $ 1,835 | $ 1,835 | $ 795 |
| Cyanide, Total 335.4 | $ 1,540 | $ 1,540 | $ (1,460) |
| Environmental Protection Agency 200.8 Calcium | $ 1,465 | $ 1,465 | $ 855 |
| Environmental Protection Agency 200.8 - Magnesium | $ 1,452 | $ 1,452 | $ 1,452 |
| Environmental Protection Agency 353.2 Nitrate + Nitrite | $ 1,376 | $ 1,376 | $ (1,277) |
| Environmental Protection Agency 200.8 - Potassium | $ 1,373 | $ 1,373 | $ 1,373 |
| Environmental Protection Agency 200.8 Copper | $ 1,241 | $ 1,241 | $ (1,229) |
| Alkalinity (Total) Standard Method 2320B | $ 1,170 | $ 1,170 | $ 520 |
| Mercury 245.1 | $ 963 | $ 963 | $ (1,650) |
| Environmental Protection Agency 200.8 Arsenic | $ 950 | $ 950 | $ (857) |
| Nitrogen, Total Standard Method 4500-N (Lachat) | $ 836 | $ 836 | $ 836 |
| Cyanotoxin Quantitative Polymerase Chain Reaction Method | $ 825 | $ 825 | $ 825 |
| Environmental Protection Agency 300.1 Sulfate | $ 805 | $ 805 | $ (598) |
| BioFire FilmArray Respiratory Panel | $ 800 | $ 800 | $ 800 |
| Environmental Protection Agency 200.8 Selenium | $ 766 | $ 766 | $ (261) |
| Heterotrophic Plate Count by 9215 B Pour Plate | $ 157 | $ 701 | $ 259 |
| Rush Fee | $ 700 | $ 700 | $ 700 |
| Environmental Protection Agency 200.8 - Iron | $ 647 | $ 647 | $ 647 |
| Environmental Protection Agency 300.0 Fluoride | $ 611 | $ 611 | $ (568) |
| Chain of Custody Request Fee | $ 540 | $ 540 | $ 540 |
| Periphyton | $ 528 | $ 528 | $ 528 |
| Environmental Protection Agency 200.8 Cadmium | $ 475 | $ 475 | $ (942) |
| Environmental Protection Agency 200.8 Barium | $ 462 | $ 462 | $ (578) |
| Environmental Protection Agency 200.8 Antimony | $ 436 | $ 436 | $ (357) |
| Environmental Protection Agency 200.8 Nickel | $ 422 | $ 422 | $ (800) |
| Environmental Protection Agency 200.8 Chromium | $ 422 | $ 422 | $ (982) |
| Culture | $ 405 | $ 405 | $ (40,295) |
| Environmental Protection Agency 200.8 Beryllium | $ 396 | $ 396 | $ (397) |
| Environmental Protection Agency 200.8 Thallium | $ 396 | $ 396 | $ (397) |
| Environmental Protection Agency 200.8 Digestion | $ 363 | $ 363 | $ 363 |

| Row Labels | FY21 Fee Revenue | FY22 Fee Revenue | **FY22 - FY17 Fee Increase/(Decrease)** |
|---|---|---|---|
| Environmental Protection Agency 537.1 - Per-and Polyfluoroalkyl Substances | $ 290 | $ 290 | $ 290 |
| Environmental Protection Agency 200.8 Aluminum | $ 238 | $ 238 | $ (217) |
| Laboratory Testing of Public Health Significance | $ 200 | $ 200 | $ 200 |
| Microbial Source Tracking (via shotgun metagenomics sequencing) | $ 194 | $ 194 | $ 194 |
| Mycobacterium tuberculosis susceptibilities (send out) | $ 175 | $ 175 | $ (4,075) |
| Microbial Source Tracking (via culture based) | $ 150 | $ 150 | $ 150 |
| Influenza PCR (Polymerase Chain Reaction) | $ 150 | $ 150 | $ (29,850) |
| pH (Test of acidity or alkalinity) 150.1 | $ 132 | $ 132 | $ (198) |
| Environmental Protection Agency 200.8 Manganese | $ 132 | $ 132 | $ (492) |
| Out of State Screening | $ 116 | $ 116 | $ 116 |
| Bacterial Sequencing | $ 107 | $ 107 | $ 107 |
| Total Microcystins & Nodularins by Enzyme-Linked Immunosorbent Assay | $ 7,785 | $ 99 | $ 99 |
| Organic Carbon, Total  Standard Method 5310B | $ 94 | $ 94 | $ 94 |
| Environmental Protection Agency 200.8 Zinc | $ 79 | $ 79 | $ (402) |
| Perchlorate 314.0 | $ 61 | $ 61 | $ (1,040) |
| Chromium (Hexavalent) Environmental Protection Agency 218.7 | $ 61 | $ 61 | $ (1,150) |
| Environmental Protection Agency 200.8 - Strontium | $ 53 | $ 53 | $ 53 |
| Environmental Protection Agency 376.2 Sulfide | $ 387 | $ 48 | $ (40) |
| Carboxylic Acids (Oxalate, Formate, Acetate) | $ 46 | $ 46 | $ (5,204) |
| Bacterial Sequencing Analysis | $ 40 | $ 40 | $ 40 |
| Hantavirus | $ 40 | $ 40 | $ (360) |
| Chloride Environmental Protection Agency 300.0 | $ 39 | $ 39 | $ (873) |
| Legiolert | $ 37 | $ 37 | $ 37 |
| Standard Method 5210B Carbonaceous Biochemical/Soluble Oxygen Demand | $ 726 | $ 36 | $ 36 |
| Organic Constituents, Ultra Violet-Absorbing Standard Method 5910B | $ 36 | $ 36 | $ (1,988) |
| Environmental Protection Agency 353.2 Nitrite | $ 35 | $ 35 | $ 35 |
| Selenium by Selenium Hydride - Atomic Absorption - Standard Method 3114C | $ 35 | $ 35 | $ (553) |
| Environmental Protection Agency 300.1 Bromide | $ 30 | $ 30 | $ 30 |
| Odor, Environmental Protection Agency 140.1 | $ 30 | $ 30 | $ 30 |
| Bromate Environmental Protection Agency 300.1 | $ 30 | $ 30 | $ (135) |
| Chlorate Environmental Protection Agency 300.1 | $ 30 | $ 30 | $ (135) |
| Chlorite Environmental Protection Agency 300.1 | $ 30 | $ 30 | $ (135) |

| Row Labels | FY21 Fee Revenue | FY22 Fee Revenue | **FY22 - FY17 Fee Increase/(Decrease)** |
|---|---|---|---|
| Biochemical Oxygen Demand 5 day test Standard Method 5210B | $ 572 | $ 29 | $ (466) |
| Environmental Protection Agency 200.8 Cobalt | $ 26 | $ 26 | $ 26 |
| Environmental Protection Agency 200.8 Copper and Lead | $ 26 | $ 26 | $ 26 |
| Environmental Protection Agency 200.8 Boron | $ 26 | $ 26 | $ (144) |
| Environmental Protection Agency 200.8 Silver | $ 26 | $ 26 | $ (429) |
| Ammonia Environmental Protection Agency 350.1 | $ 866 | $ 19 | $ (553) |
| Chlorophyll A Standard Method 10200H - Chlorophyll-A | $ 823 | $ 19 | $ (91) |
| Solids, Total Volatile, Environmental Protection Agency 160.4 | $ 2,886 | $ 18 | $ (3,051) |
| Silica 370.1 | $ 69 | $ 17 | $ (197) |
| Phosphorus, Total 365.1 | $ 2,336 | $ 17 | $ (1,583) |
| Solids, Total Dissolved Standard Method 2540C | $ 3,157 | $ 14 | $ 14 |
| Solids, Total Suspended Standard Method 2540D | $ 3,115 | $ 14 | $ (2,906) |
| Environmental Protection Agency 200.8 Tin | $ 13 | $ 13 | $ 13 |
| Environmental Protection Agency 200.8 Vanadium | $ 13 | $ 13 | $ 13 |
| Environmental Protection Agency Method 200.8 Zirconium | $ 13 | $ 13 | $ 13 |
| Standard Method 2120B Color | $ 53 | $ 13 | $ 13 |
| Environmental Protection Agency 200.8 Molybdenum | $ 13 | $ 13 | $ (338) |
| Specific Conductance 120.1 | $ 955 | $ 9 | $ (641) |
| Environmental Protection Agency 325.2 Chloride | $ 862 | $ 8 | $ 8 |
| Hardness (Requires Calcium & Magnesium tests) | $ 6 | $ 6 | $ 6 |
| Standard Method 2330B Langelier Index | $ 6 | $ 6 | $ 6 |
| **LED Total** | **$ 7,276,791** | **$ 7,292,153** | **$ 352,572** |

| Row Labels | FY22 - FY17 Fee % Change |
|---|---|
| LED | |
| Laboratory Testing and Follow-up Services | 3% |
| Chlamydia trachomatis and Neisseria gonorrhoeae detection by nucleic acid testing | 79% |
| Legionella Standard Methods 9260J | -61% |
| 1/2 and O, Antigen/Antibody Combo | -25% |
| Herpesvirus (Herpes Simplex Virus-1, Herpes Simplex Virus-2, Varicella Zoster Virus) Detection and Differentiation by Polymerase Chain Reaction | -13% |
| Immunoglobulin G (IgG) Antibody (including reflex Rapid Plasma Reagin titer) | -29% |
| Total Coliforms/Escherichia coli | -37% |
| Mycoplasma Genitalium Detection by Nucleic Acid Testing | 0% |
| QuantiFERON Gold | -66% |
| Haloacetic Acids Method 6251B | -29% |
| Zika Immunoglobulin M | 0% |
| Hepatitis C Virus (HCV) detection by quantitative Nucleic Acid Amplification Test | 0% |
| C (Anti-Hepatitis C Virus) Antibody | -15% |
| TrioPlex Polymerase Chain Reaction | 0% |
| Environmental Protection Agency 524.2 Trihalomethanes | -30% |
| BioFire FilmArray Gastrointestinal Panel | 0% |
| Anatoxin by Enzyme-Linked Immunosorbent Assay | 0% |
| Cylindrospermopsin by Enzyme-Linked Immunosorbent Assay | 0% |
| Anti-Hepatitis B Antigen | 35% |
| TP-PA (Treponema Pallidum - Particle Agglutination) Confirmation | -47% |
| Bacterial Sequencing, Identification, Analysis | 0% |
| Bacterial Sequencing and Identification | 0% |
| Anti-Hepatitis B Antibody | -12% |
| Rabies - Not epidemiological indicated or pre-authorized | -20% |
| Identification and Susceptibility by GeneXpert | -91% |
| Supplemental Testing (HIV-1/HIV-2 differentiation) | 3770% |
| Environmental Protection Agency 200.8 Lead | 32% |
| Chlorophyll-A by High Performance Liquid Chromatography | 0% |
| Environmental Protection Agency 180.1 Turbidity | 109% |
| Environmental Protection Agency 353.2 Nitrate | 0% |

| Row Labels | FY22 - FY17 Fee % Change |
|---|---|
| Environmental Protection Agency 524.2 | -86% |
| Environmental Protection Agency 375.2 Sulfate | 60% |
| Environmental Protection Agency Sodium 200.8 | 76% |
| Cyanide, Total 335.4 | -49% |
| Environmental Protection Agency 200.8 Calcium | 140% |
| Environmental Protection Agency 200.8 - Magnesium | 0% |
| Environmental Protection Agency 353.2 Nitrate + Nitrite | -48% |
| Environmental Protection Agency 200.8 - Potassium | 0% |
| Environmental Protection Agency 200.8 Copper | -50% |
| Alkalinity (Total) Standard Method 2320B | 80% |
| Mercury 245.1 | -63% |
| Environmental Protection Agency 200.8 Arsenic | -47% |
| Nitrogen, Total Standard Method 4500-N (Lachat) | 0% |
| Cyanotoxin Quantitative Polymerase Chain Reaction Method | 0% |
| Environmental Protection Agency 300.1 Sulfate | -43% |
| BioFire FilmArray Respiratory Panel | 0% |
| Environmental Protection Agency 200.8 Selenium | -25% |
| Heterotrophic Plate Count by 9215 B Pour Plate | 59% |
| Rush Fee | 0% |
| Environmental Protection Agency 200.8 - Iron | 0% |
| Environmental Protection Agency 300.0 Fluoride | -48% |
| Chain of Custody Request Fee | 0% |
| Periphyton | 0% |
| Environmental Protection Agency 200.8 Cadmium | -66% |
| Environmental Protection Agency 200.8 Barium | -56% |
| Environmental Protection Agency 200.8 Antimony | -45% |
| Environmental Protection Agency 200.8 Nickel | -65% |
| Environmental Protection Agency 200.8 Chromium | -70% |
| Culture | -99% |
| Environmental Protection Agency 200.8 Beryllium | -50% |
| Environmental Protection Agency 200.8 Thallium | -50% |
| Environmental Protection Agency 200.8 Digestion | 0% |

| Row Labels | FY22 - FY17 Fee % Change |
|---|---|
| Environmental Protection Agency 537.1 - Per-and Polyfluoroalkyl Substances | 0% |
| Environmental Protection Agency 200.8 Aluminum | -48% |
| Laboratory Testing of Public Health Significance | 0% |
| Microbial Source Tracking (via shotgun metagenomics sequencing) | 0% |
| Mycobacterium tuberculosis susceptibilities (send out) | -96% |
| Microbial Source Tracking (via culture based) | 0% |
| Influenza PCR (Polymerase Chain Reaction) | -100% |
| pH (Test of acidity or alkalinity) 150.1 | -60% |
| Environmental Protection Agency 200.8 Manganese | -79% |
| Out of State Screening | 0% |
| Bacterial Sequencing | 0% |
| Total Microcystins & Nodularins by Enzyme-Linked Immunosorbent Assay | 0% |
| Organic Carbon, Total  Standard Method 5310B | 0% |
| Environmental Protection Agency 200.8 Zinc | -84% |
| Perchlorate 314.0 | -95% |
| Chromium (Hexavalent) Environmental Protection Agency 218.7 | -95% |
| Environmental Protection Agency 200.8 - Strontium | 0% |
| Environmental Protection Agency 376.2 Sulfide | -45% |
| Carboxylic Acids (Oxalate, Formate, Acetate) | -99% |
| Bacterial Sequencing Analysis | 0% |
| Hantavirus | -90% |
| Chloride Environmental Protection Agency 300.0 | -96% |
| Legiolert | 0% |
| Standard Method 5210B Carbonaceous Biochemical/Soluble Oxygen Demand | 0% |
| Organic Constituents, Ultra Violet-Absorbing Standard Method 5910B | -98% |
| Environmental Protection Agency 353.2 Nitrite | 0% |
| Selenium by Selenium Hydride - Atomic Absorption - Standard Method 3114C | -94% |
| Environmental Protection Agency 300.1 Bromide | 0% |
| Odor, Environmental Protection Agency 140.1 | 0% |
| Bromate Environmental Protection Agency 300.1 | -82% |
| Chlorate Environmental Protection Agency 300.1 | -82% |
| Chlorite Environmental Protection Agency 300.1 | -82% |

| Row Labels | FY22 - FY17 Fee % Change |
|---|---|
| Biochemical Oxygen Demand  5 day test Standard Method 5210B | -94% |
| Environmental Protection Agency 200.8 Cobalt | 0% |
| Environmental Protection Agency 200.8 Copper and Lead | 0% |
| Environmental Protection Agency 200.8 Boron | -84% |
| Environmental Protection Agency 200.8 Silver | -94% |
| Ammonia Environmental Protection Agency 350.1 | -97% |
| Chlorophyll A Standard Method 10200H - Chlorophyll-A | -83% |
| Solids, Total Volatile, Environmental Protection Agency 160.4 | -99% |
| Silica 370.1 | -92% |
| Phosphorus, Total 365.1 | -99% |
| Solids, Total Dissolved Standard Method 2540C | 0% |
| Solids, Total Suspended Standard Method 2540D | -100% |
| Environmental Protection Agency 200.8 Tin | 0% |
| Environmental Protection Agency 200.8 Vanadium | 0% |
| Environmental Protection Agency Method 200.8 Zirconium | 0% |
| Standard Method 2120B Color | 0% |
| Environmental Protection Agency 200.8 Molybdenum | -96% |
| Specific Conductance 120.1 | -99% |
| Environmental Protection Agency 325.2 Chloride | 0% |
| Hardness (Requires Calcium & Magnesium tests) | 0% |
| Standard Method 2330B Langelier Index | 0% |
| **LED Total** | **5%** |

| Row Labels | FY17 Fee Revenue | FY18 Fee Revenue | FY19 Fee Revenue | FY20 Fee Revenue |
|---|---|---|---|---|
| LEK | | | | |
| Review and authorize cremation permits. | $ 783,900 | $ 863,000 | ######### | ######### |
| Bone | $ 40,113 | $ 40,113 | $ 32,675 | $ 49,145 |
| All other requestors. | $ 2,625 | $ 2,625 | $ 2,625 | $ 10,150 |
| Autopsy, full or partial | $ 5,000 | $ 5,000 | $ 5,000 | $ 15,000 |
| Eye | $ 7,588 | $ 7,588 | $ 6,064 | $ 16,182 |
| Criminal cases, out of state | $ 1,500 | $ 1,500 | $ 1,500 | $ 7,500 |
| Non-jurisdictional criminal and all civil cases | $ 1,500 | $ 1,500 | $ 1,500 | $ 7,500 |
| Copies for immediate relative or legal representative as outlined in UCA 26-4-17(2)(a)(i)-(ii). | $ 50 | $ 50 | $ 50 | $ 210 |
| Consultation on non-Medical Examiner cases | $ 1,500 | $ 1,500 | $ 1,500 | $ 5,000 |
| Skin Graft | $ 1,328 | $ 1,328 | $ 1,328 | $ 2,258 |
| Heart Valve | $ 1,386 | $ 1,386 | $ 1,386 | $ 1,802 |
| Saphenous vein | $ 970 | $ 970 | $ 1,040 | $ 1,733 |
| Use of facilities only for autopsy or examination | $ - | $ - | $ - | $ - |
| External Examination | $ 500 | $ 500 | $ 500 | $ 2,000 |
| Glass slides - Immunohistochemical stains per slide | $ - | $ - | $ - | $ - |
| Use of facilities and staff for autopsy | $ 1,000 | $ 1,000 | $ 1,000 | $ 3,000 |
| Return request by immediate relative as defined in code UCA 26-4-2(3) | $ - | $ - | $ - | $ - |
| Histochemical stains per slide | $ - | $ - | $ - | $ - |
| Glass Slides (re-cuts, routine stains) per slide | $ 40 | $ 40 | $ 40 | $ 240 |
| Handling and storage of requested samples by outside sources. Annual Fee | $ - | $ - | $ - | $ - |
| Handling of requested samples for shipping to outside lab. | $ 450 | $ 450 | $ 450 | $ 425 |
| Daily charge for use of Medical Examiner Storage Facilities | $ 120 | $ 120 | $ 120 | $ 240 |
| Use of facilities and staff for external examinations | $ 300 | $ 300 | $ 300 | $ 300 |
| Digital X-ray images from Digital Source (DICOM). | $ 20 | $ 20 | $ 60 | $ 120 |
| Copied from color slide negatives. | $ 10 | $ 10 | $ 10 | $ 5 |
| Copies for law enforcement, physicians, attorneys and government entities as outlined in UCA 26-4-17(2)(a)(iii)-(iv), and 26-4-17(2)(b)(i)-(iv). | $ 1,750 | $ 1,750 | $ 1,750 | $ 840 |
| **LEK Total** | **$ 851,651** | **$ 930,751** | ######### | ######### |

| Row Labels | FY21 Fee Revenue | FY22 Fee Revenue | **FY22 - FY17 Fee Increase/(Decrease)** |
|---|---|---|---|
| LEK | | | |
| Review and authorize cremation permits. | ######### | ######### | $ 536,100 |
| Bone | $ 53,200 | $ 53,200 | $ 13,087 |
| All other requestors. | $ 21,000 | $ 21,000 | $ 18,375 |
| Autopsy, full or partial | $ 17,500 | $ 17,500 | $ 12,500 |
| Eye | $ 17,500 | $ 17,500 | $ 9,912 |
| Criminal cases, out of state | $ 7,500 | $ 7,500 | $ 6,000 |
| Non-jurisdictional criminal and all civil cases | $ 7,500 | $ 7,500 | $ 6,000 |
| Copies for immediate relative or legal representative as outlined in UCA 26-4-17(2)(a)(i)-(ii). | $ 6,150 | $ 6,150 | $ 6,100 |
| Consultation on non-Medical Examiner cases | $ 5,000 | $ 5,000 | $ 3,500 |
| Skin Graft | $ 2,660 | $ 2,660 | $ 1,332 |
| Heart Valve | $ 2,100 | $ 2,100 | $ 714 |
| Saphenous vein | $ 1,750 | $ 1,750 | $ 780 |
| Use of facilities only for autopsy or examination | $ 1,600 | $ 1,600 | $ 1,600 |
| External Examination | $ 1,000 | $ 1,000 | $ 500 |
| Glass slides - Immunohistochemical stains per slide | $ 1,000 | $ 1,000 | $ 1,000 |
| Use of facilities and staff for autopsy | $ 1,000 | $ 1,000 | $ - |
| Return request by immediate relative as defined in code UCA 26-4-2(3) | $ 825 | $ 825 | $ 825 |
| Histochemical stains per slide | $ 600 | $ 600 | $ 600 |
| Glass Slides (re-cuts, routine stains) per slide | $ 400 | $ 400 | $ 360 |
| Handling and storage of requested samples by outside sources. Annual Fee | $ 375 | $ 375 | $ 375 |
| Handling of requested samples for shipping to outside lab. | $ 375 | $ 375 | $ (75) |
| Daily charge for use of Medical Examiner Storage Facilities | $ 300 | $ 300 | $ 180 |
| Use of facilities and staff for external examinations | $ 300 | $ 300 | $ - |
| Digital X-ray images from Digital Source (DICOM). | $ 150 | $ 150 | $ 130 |
| Copied from color slide negatives. | $ 25 | $ 25 | $ 15 |
| Copies for law enforcement, physicians, attorneys and government entities as outlined in UCA 26-4-17(2)(a)(iii)-(iv), and 26-4-17(2)(b)(i)-(iv). | $ 200 | $ - | $ (1,750) |
| **LEK Total** | ######### | ######### | **$ 618,159** |

| Row Labels | FY22 - FY17 Fee % Change |
|---|---|
| LEK | |
| Review and authorize cremation permits. | 68% |
| Bone | 33% |
| All other requestors. | 700% |
| Autopsy, full or partial | 250% |
| Eye | 131% |
| Criminal cases, out of state | 400% |
| Non-jurisdictional criminal and all civil cases | 400% |
| Copies for immediate relative or legal representative as outlined in UCA 26-4-17(2)(a)(i)-(ii). | 12200% |
| Consultation on non-Medical Examiner cases | 233% |
| Skin Graft | 100% |
| Heart Valve | 52% |
| Saphenous vein | 80% |
| Use of facilities only for autopsy or examination | 0% |
| External Examination | 100% |
| Glass slides - Immunohistochemical stains per slide | 0% |
| Use of facilities and staff for autopsy | 0% |
| Return request by immediate relative as defined in code UCA 26-4-2(3) | 0% |
| Histochemical stains per slide | 0% |
| Glass Slides (re-cuts, routine stains) per slide | 900% |
| Handling and storage of requested samples by outside sources. Annual Fee | 0% |
| Handling of requested samples for shipping to outside lab. | -17% |
| Daily charge for use of Medical Examiner Storage Facilities | 150% |
| Use of facilities and staff for external examinations | 0% |
| Digital X-ray images from Digital Source (DICOM). | 650% |
| Copied from color slide negatives. | 150% |
| Copies for law enforcement, physicians, attorneys and government entities as outlined in UCA 26-4-17(2)(a)(iii)-(iv), and 26-4-17(2)(b)(i)-(iv). | -100% |
| **LEK Total** | **73%** |

# Disabilities and Health in Utah

**October 2020**

UTAH DEPARTMENT OF HEALTH

## Acknowledgments

This report was prepared by the following Utah Department of Health staff:

◇ Stephanie George, MPH, Epidemiologist, Utah Disability and Health Program

◇ Shelly Wagstaff, BS, Statistician, Bureau of Health Promotion

◇ Anna Braner, BS, Coordinator, Utah Disability and Health Program

◇ Kathy Paras, MS, Bureau of Health Promotion, Assistant Director

◇ Celsa Bowman, MS, Coordinator, Utah Arthritis Program

Note: This report is not a replacement for individualized medical care. Consult with your provider for medical treatment.

## Table of Contents

## Utah Disability Advisory Committee (UDAC)

We thank our partners for working to improve the lives of people with disabilities.

Alzheimer's Disease and Related Dementias Program, Utah Department of Health

Association for Utah Community Health

Bureau of Health Promotion, Utah Department of Health

Huntsman Cancer Institute, Center for Health Outcomes & Population Equity (HOPE)

Centers for Independent Living

Center for Persons with Disabilities, Utah State University

Comagine Health

Community Health Workers

Department of Human Services

Disability Health Program, Utah Department of Health

Disability Law Center

Disabled Rights Advocacy Committee (DRAC)

Division of Services for People with Disabilities (DSPD), Utah Department of Human Services

Family Health Services

Healthy Living Through Environment, Policy, and Improved Clinical Care Program (EPICC), Utah Department of Health

Utah Department of Health, Medicaid

National Ability Center

OPTIONS for Independence

Salt Lake County Health Department

Select Health

Self-advocates

Source America

Tobacco Prevention and Control Program, Utah Department of Health

University of Utah Neurobehavior Home Program

Utah Arthritis Program, Utah Department of Health

Utah Developmental Disabilities Council (UDDC)

Utah County Health Department

Utah Statewide Independent Living Council

Violence and Injury Prevention Program, Utah Department of Health

Weber Human Services

Weber-Morgan Health Department

Utah Transit Authority (UTA)

# Introduction

## Perspectives on Disability

Better data has improved understanding about the disparities that people with disabilities experience. This report is intended to increase public awareness of the prevalence of disabilities and the magnitude of the health differences between those with and without disabilities. It is intended to address these disparities by promoting access and inclusion for people with disabilities.

Traditionally, disability has been viewed as a negative health outcome. Now, a greater understanding of the nature of disability (including the social and cultural contexts which shape disability) has led to a more comprehensive view that "disability" is a social experience encountered by everyone within their lifespan.[1] Persons with disabilities represent a diverse group of people, cutting across boundaries of age, race, sex, and socioeconomic status with wide-ranging needs.[2] Disabilities will always be found in society. Therefore, public health's understanding of their responsibility has shifted from a mindset of preventing disability to promoting "the health and improv[ing] the quality of life of persons who already experience disability."[3]

People with disabilities are more likely to experience significant differences in their health behaviors and health outcomes than those without a disability. Costly health events and chronic conditions such as stroke, asthma, heart disease, diabetes, and cancer, are all more common for those with disabilities, and essential preventive services such as cancer screenings and dental screenings are less common.[4] While it is true the nature of disability itself can be the reason for these observed differences, it is important to understand that many of these differences and the size of these differences are avoidable and societal-based and not solely due to the nature of disability itself.[2] For example, even the lack of familiarity with disabilities among primary care doctors and lack of comfort with primary care among disability specialists can play a role in these differences.

As stated by Healthy People 2020, "to be healthy, all individuals with or without disabilities must have opportunities to take part in meaningful daily activities that add to their growth, development, fulfillment, and community contribution." This objective will require all public health programs, organizations, and communities to find ways to include people with disabilities.[6]

# Disability Models and Definitions

## Disability Defined

In the **Medical Model**, disability is the consequence of a health condition and places the focus of treatment on preventing, treating, or curing disability. In contrast, the **Social Model** views people as being disabled by society rather than their bodies.[7] The World Health Organization (WHO) prefers to view disability not as one or the other but, rather, a mix between the two.[7] In the WHO model (also called ICF), disability arises from the interaction between someone with a condition-based limitation and barriers within their social and physical environment.[2,7]

## Social Model

- The "problem" of disability is located within society, not the individual
- Disability is a societal issue
- Focuses on approaches such as barrier removal and anti-discrimination laws

## Medical Model

- Disability is a problem within the individual
- It is a personal problem
- Focuses on treating or curing
- Common in the United States

## Disability Surveillance

Prior to the last decade, disability was defined in hundreds of ways by various federal agencies and national surveys.[2] After the Affordable Care Act called for the standardization of disability status on all U.S. Health and Human Services (HHS) surveys, six standard questions for disability types were established.[2] The Behavior and Risk Factor Surveillance System (BRFSS) incorporated five of the six questions into its core questionnaire in 2013 and added the final question regarding hearing disability in 2016. A response of "Yes" to any of the following is considered a disability:

1. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
2. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
3. Do you have serious difficulty walking or climbing stairs?
4. Do you have difficulty dressing or bathing?
5. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
6. Are you deaf or do you have serious difficulty hearing?

# What does inclusion mean?

## Inclusion means all community members:

1. Are presumed competent
2. Are welcome as valued members of their community
3. Fully participate and learn with their peers
4. Experience reciprocal relationships[8]

## General Prevalence

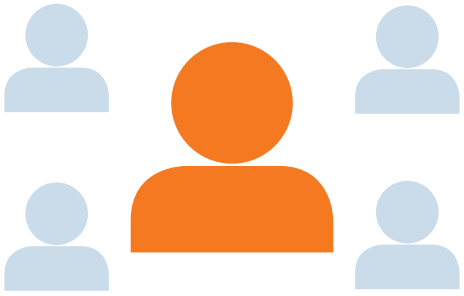
# How Common are Disabilities?

It is not uncommon for everyone to experience a disability at some point in their life. While most people will experience a disability for at least a short time, many people have a disability for most of their life.

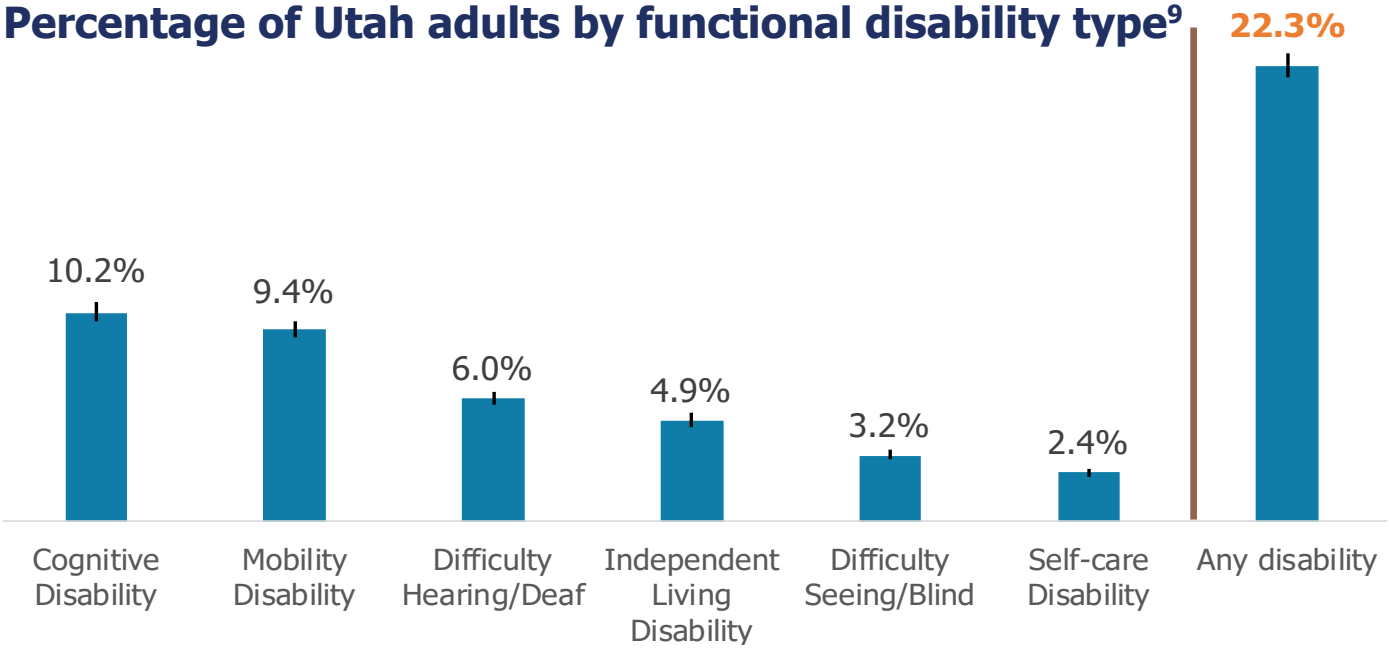
One in every five Utah adults (**22.3%**)[9] has one or more disabilities. This represents roughly **500,000 Utah adults.**[10]

**1 in 5**

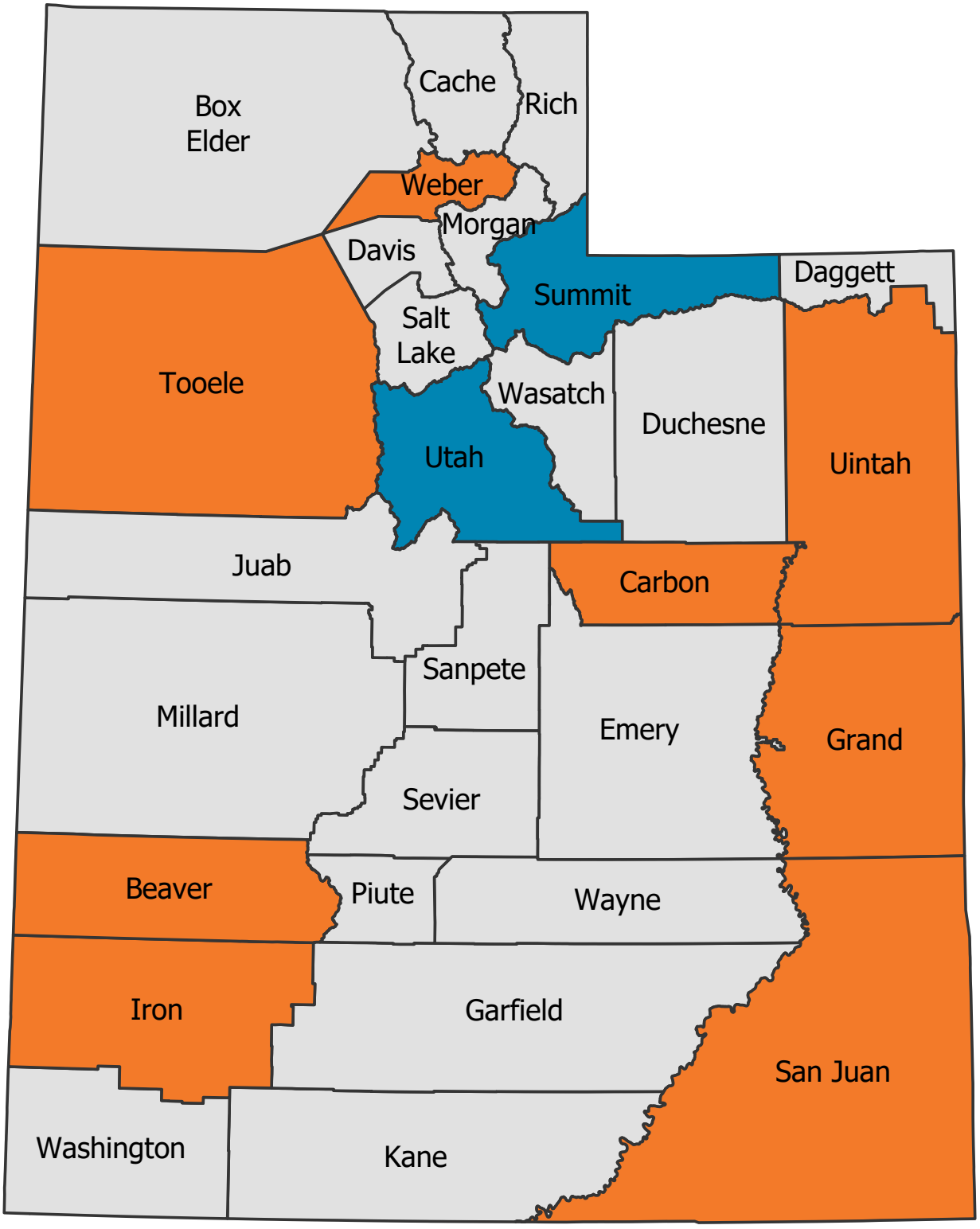
Utah adults have a disability



**Percentage of Utah adults by functional disability type[9]**



## Disability rates higher, the same, and lower than the state rate by county[9]



# Who is most likely to have a disability in Utah?

## Age and Sex[11]

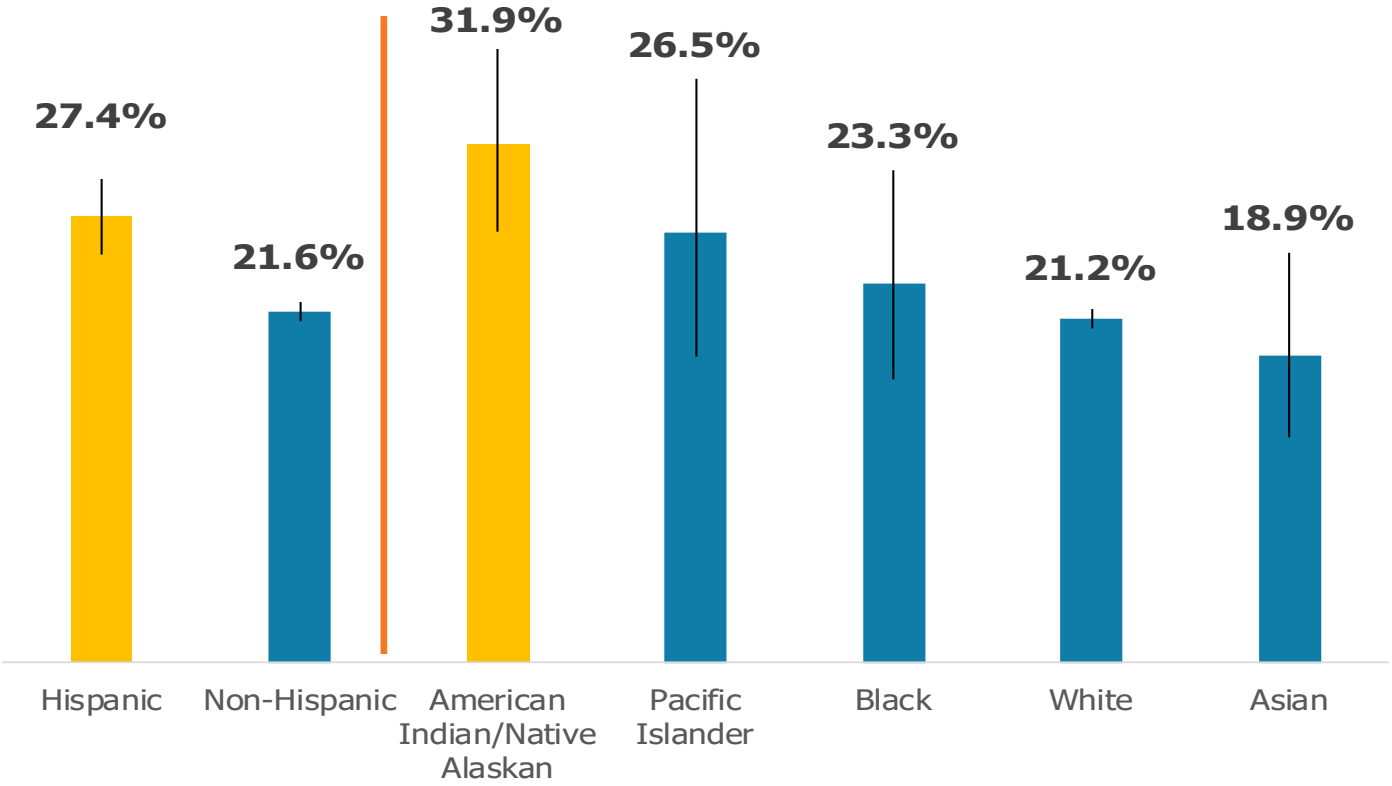
Two general patterns (and two exceptions) emerged from the data:

- **Women** report disability more frequently than men do, except men are more likely to be deaf or hard of hearing.
- The percent of people reporting **disability increases as they age**, especially for those with a mobility disability or are hard of hearing. However, the percent of people with cognitive disabilities are roughly the same across age groups.

## Ethnicity and Race[9]

- People who are **Hispanic** are more likely than non-Hispanics to have a disability.
- People who are **Native Americans/ Alaska Natives** are significantly more likely to have a disability (**31.9%**) than all races combined (**22.3%**).

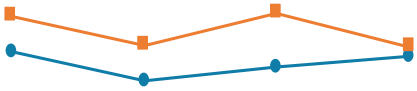
### Percent of Utah adults with disabilities by ethnicity and race[9]




*Native Americans/Alaska Natives are often underrepresented and oversampled.

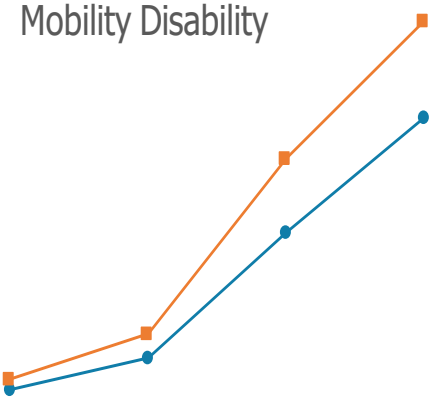
# Disability Type by Age and Sex[11]

## Cognitive Disability



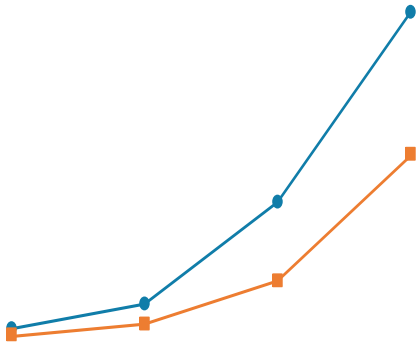
| | 18-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|
| Male | 9.8 | 7.9 | 8.8 | 9.5 |
| Female | 12.3 | 10.3 | 12.5 | 10.2 |

## Mobility Disability



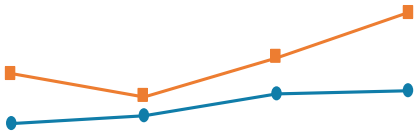
| | 18-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|
| Male | 1.7 | 3.9 | 12.5 | 20.4 |
| Female | 2.4 | 5.5 | 17.6 | 27.1 |

## Deaf or Hearing Disability



| | 18-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|
| Male | 1.7 | 3.4 | 10.2 | 22.9 |
| Female | 1.2 | 2.0 | 4.9 | 13.3 |

## Independent Living Disability



| | 18-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|
| Male | 2.5 | 3.0 | 4.5 | 4.7 |
| Female | 5.8 | 4.3 | 6.9 | 9.9 |

## Blind or Vision Disability

| | 18-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|
| Male | 1.9 | 2.0 | 3.8 | 5.5 |
| Female | 2.3 | 2.0 | 4.8 | 6.2 |

## Self-care Disability

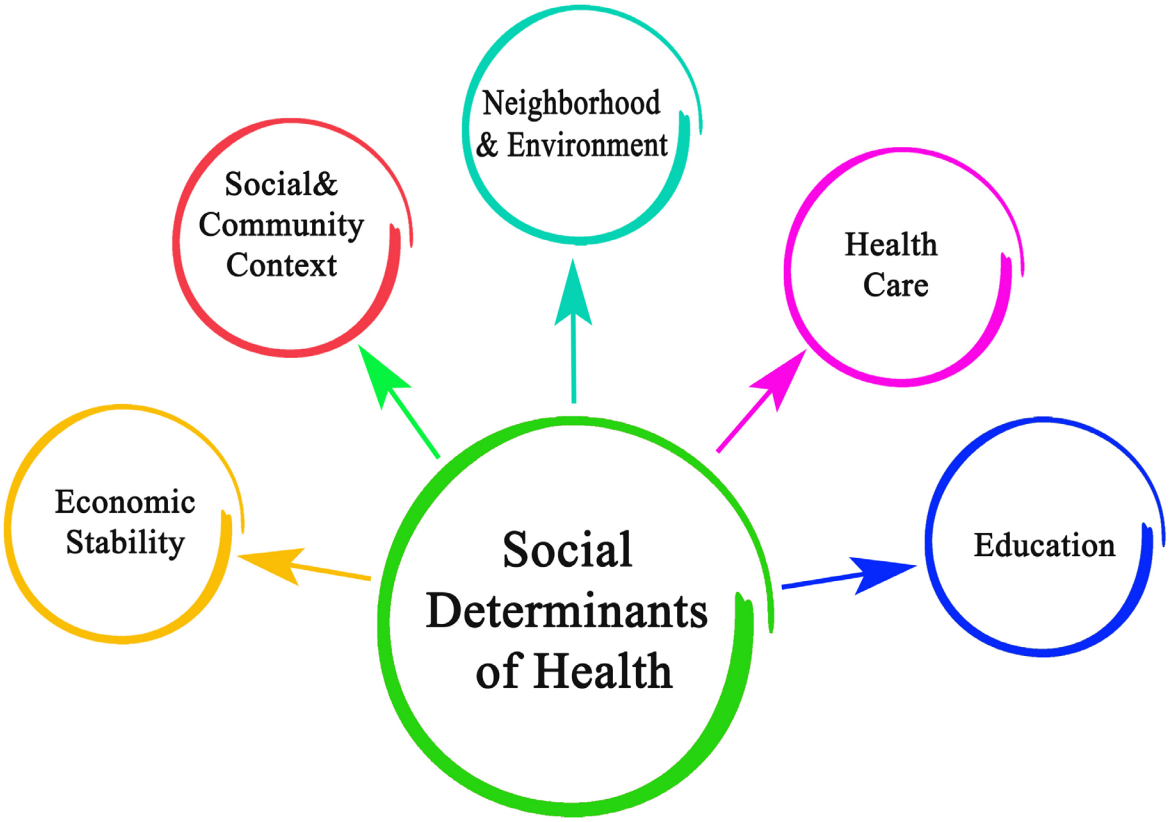
| | 18-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|
| Male | 0.7 | 1.3 | 4.7 | 3.9 |
| Female | 0.9 | 1.8 | 3.7 | 4.6 |

## Social Determinants of Health

# How does social status relate to health?

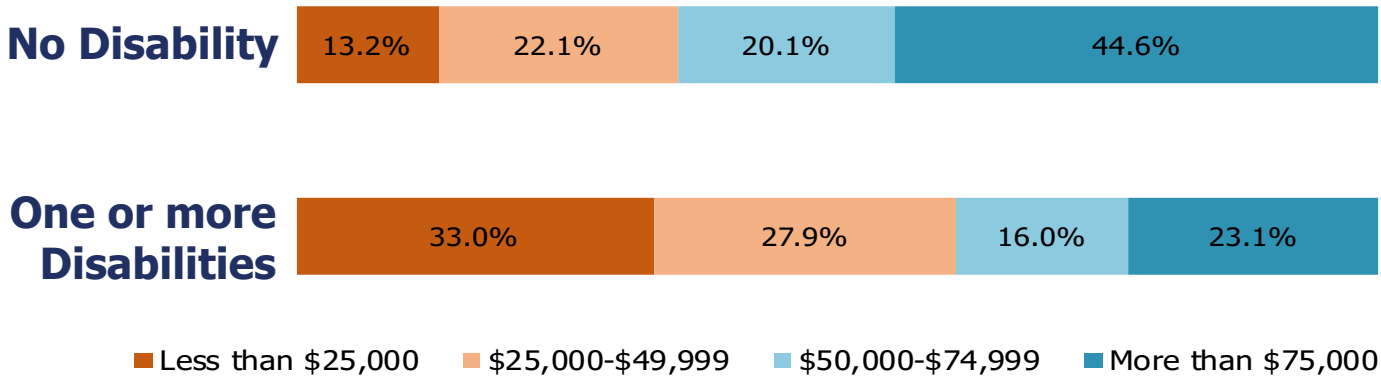
Health outcomes and health behaviors are strongly influenced by socioeconomic status. Research has consistently shown that disease (both its frequency and severity) is shaped by one's income, education, stress, employment, social support, and other "social determinants of health" (SDOH).[12] In other words, a person's social standing and environment can greatly impact their health behaviors and their health outcomes, with those in lower socioeconomic groups experiencing the poorest health outcomes.

As shown in the following graphs, Utah adults with disabilities are disproportionately disadvantaged. Social circumstances put them at greater risk for poor health outcomes than the general population.

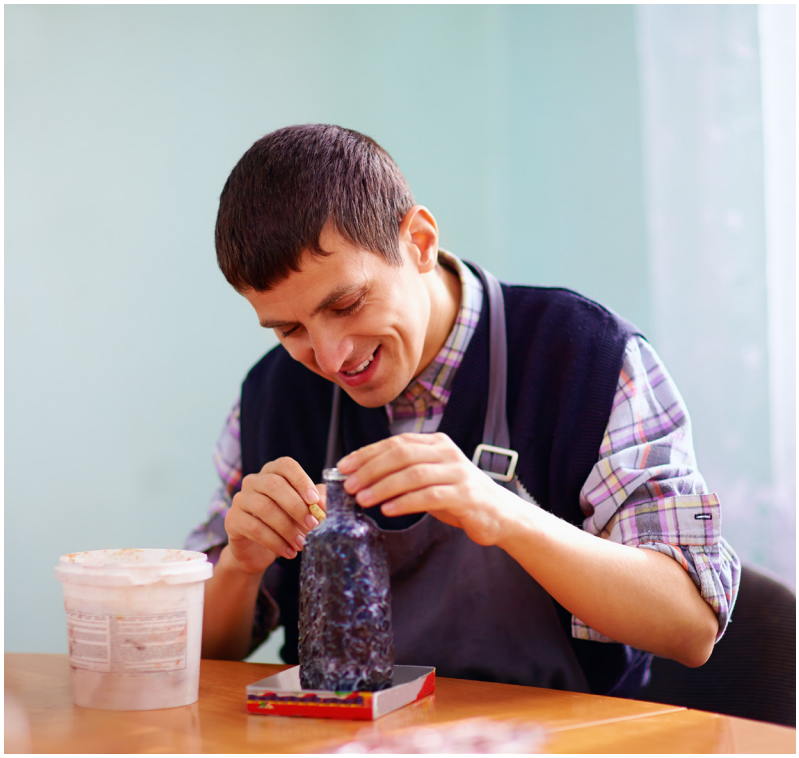


## Income[9]

Among Utah adults older than age 25, the majority (61%) of people with disabilities **make less than $50,000 per year** whereas the majority (65%) of people without a disability **make more than $50,000 in a year**. Furthermore, 33% of persons with disabilities make less than $25,000 per year compared with 13.2% of people without a disability.




## What are some reasons for the gap in income?

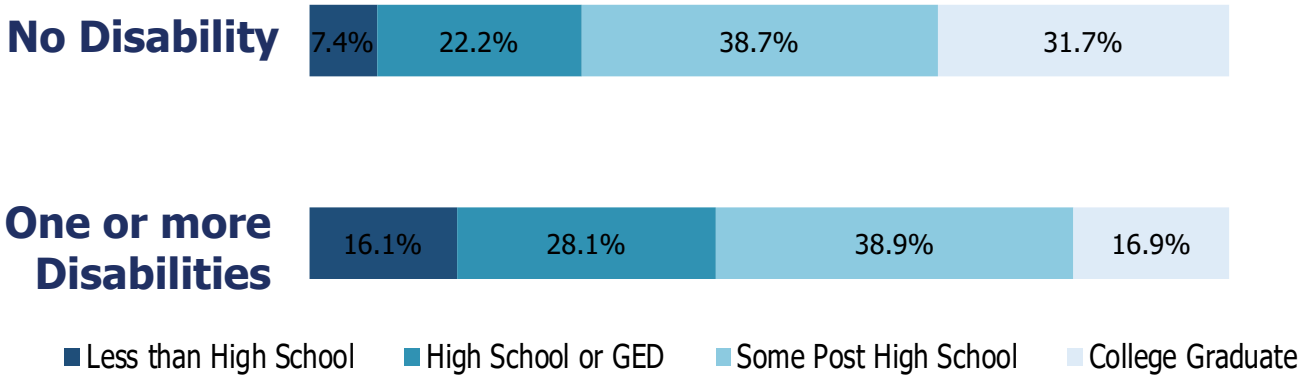


*"Workplace discrimination, physical barriers, problems with health insurance, inadequate education, or career training are some of the disability-specific challenges associated with employment and working conditions. Relative and absolute income for people with disabilities are often complicated by medical and health insurance costs, employment issues, and sometimes by income-based eligibility rules for assistance with health care services, equipment, and other costs."*[1]

# Social Determinants of Health

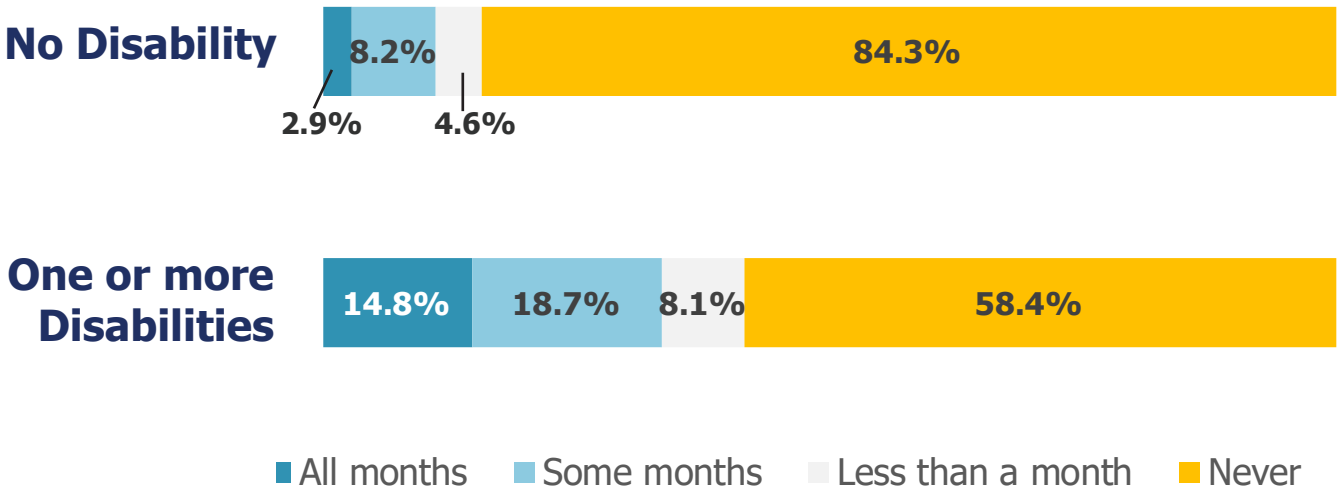
## Education[9]

People with disabilities are significantly **less likely to graduate from high school or to receive a college education** than those without a disability. About 16% of people with disabilities, and only 7.4% of people without a disability, do not graduate from high school. Alternatively, 31.7% of people without a disability graduate from college as compared with 16.9% of those with a disability.




## Food Security[13]

When asked how often they have been "worried or stressed about having enough money to buy nutritious meals" in the past 12 months (i.e., food insecurity), **41.6% of people with disabilities reported food insecurity** as compared with only **15.7% of people without a disability.**[13]



## Inability to get care due to cost[9]

Utah adults with disabilities are three times more likely than those without a disability (9.1% vs. 27.1%) to say they could not get medical care due to the cost (see chart below).

Among those with disabilities, adults with a self-care or independent living disability were the most likely to not get care due to cost (35%), and deaf adults were the least likely to not get care due to its cost (20.8%). These are all significantly higher than the percent of those living without any type of disability.

**People with disabilities are more likely to report not receiving medical care due to cost than people without disabilities.[9]**

| | |
|---|---|
| **Self-care disability** | **35.1%** |
| **Independent Living** | **35.0%** |
| **Blind** | **33.1%** |
| **Mobility Disability** | **31.5%** |
| **Cognitive Disability** | **31.3%** |
| **Hearing Disability** | **20.8%** |
| **No Disability** | **9.1%** |

## Insurance[9]

Utah adults with disabilities were also significantly less likely to have insurance than those without a disability (17.9% vs. 10.6% without insurance). This may be one of the factors that influences their ability to get needed medical care.

## Health Behaviors and Conditions

# What are some differences in health for people with disabilities?

Despite progress in the treatment of people with disabilities, significant differences between their health behaviors and their overall health compared with adults without disabilities still exist. Utah adults with a disability are **more likely to report engaging in behaviors that are harmful to their health**, such as smoking, eating fewer fruits and vegetables on a daily basis, and getting less exercise than adults without a disability. One in every three people with a disability report being obese compared with one in every four people without a disability.[9] Persons with disabilities are also much more likely to have been prescribed pain medications.[9] On the other hand, people with disabilities are more likely to attempt to quit smoking than people without disabilities.[9]

| Any Disability | | No Disability |
|---|---|---|
| 17.6% | Current smoker[9] | 6.9% |
| 9.7% | Current E-cig Use[9] | 4.0% |
| 62.7% | Smoking Cessation Attempt[9] | 55.7% |
| 13.1% | Binge Drinking[9] | 11.1% |
| 30.0% | Physically Inactive[9] | 14.7% |
| 36.3% | Obese[9] | 24.3% |
| 31.2% | Eats 2 or more servings of fruit each day[14] | 35.6% |
| 11.7% | Eats 3 or more servings of vegetables each day[14] | 14.0% |
| 28.9% | Prescribed pain medications by doctor[13] | 11.4% |

## Chronic Conditions

**Costly and debilitating health events and chronic conditions are also more common for persons with disabilities.**[9] They are about three times more likely to have a heart attack, almost twice as likely to have been diagnosed with cancer (not including skin cancer), and more than twice as likely to have asthma or arthritis than those without a disability.[9]

The differences in health between people with and without disabilities are not always due to the nature of disability itself, but they arise for a variety of reasons, which may be related or unrelated to the underlying disability.[1,2] Environments are crucial in disabling (through barriers) or enabling (through supports) access to health care and health promotion opportunities. Environmental barriers or supports also impact the social circumstances of people with disabilities which in turn impact their health."[1]

| | Any Disability | No Disability |
|---|---|---|
| Asthma | 15.0% | 7.3% |
| Arthritis | 37.6% | 16.8% |
| Cancer | 8.7% | 5.3% |
| COPD | 9.5% | 2.5% |
| Diabetes | 12.7% | 6.2% |
| Heart Attack | 5.2% | 2.1% |
| Heart Disease | 4.8% | 1.8% |
| Kidney Disease | 5.8% | 1.9% |
| Stroke | 5.7% | 1.3% |

## Mental and Physical Health

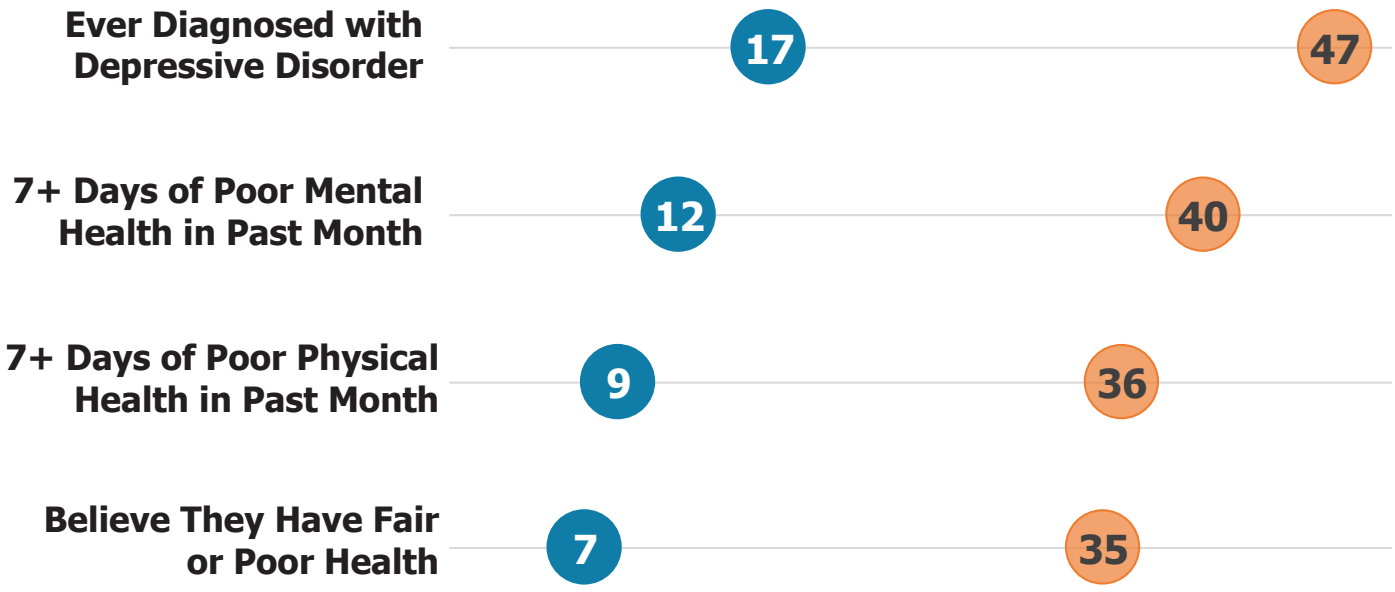
# What about mental and overall health?

Nearly half of Utah adults with disabilities have been diagnosed with a depressive disorder compared with 17% among adults without a disability.[9]

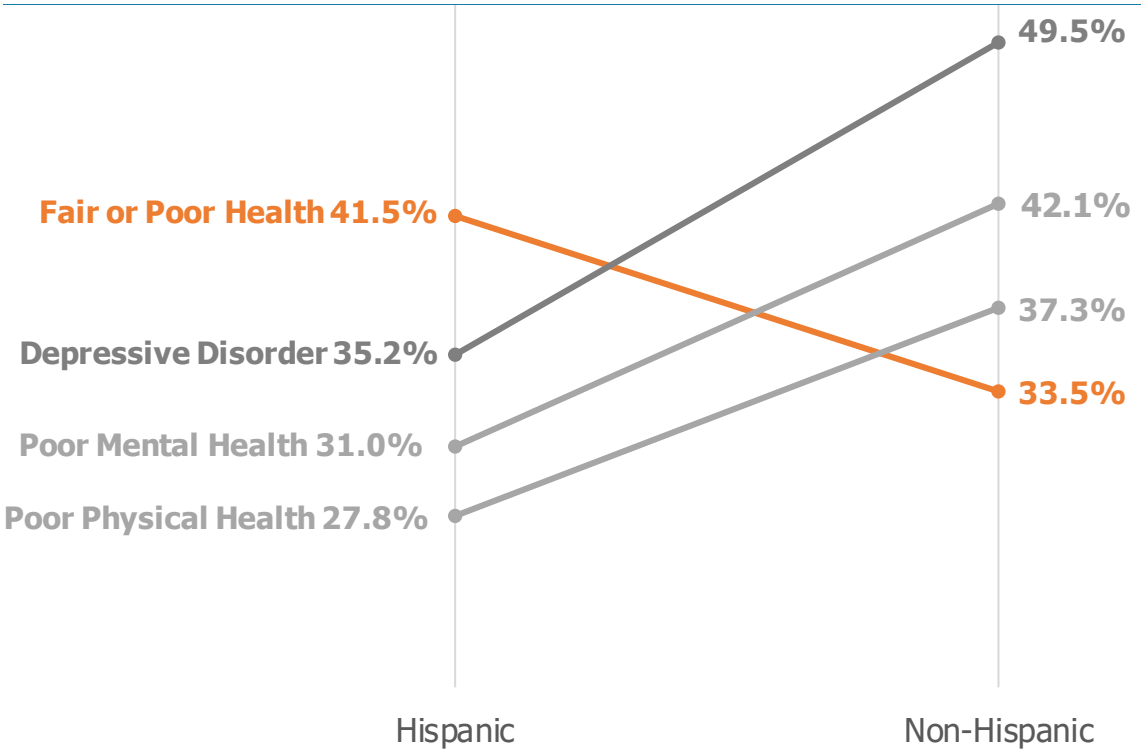
When thinking about a 30-day span in time, about 40% of persons with disabilities report having more than 7 days of poor mental health compared with 12% for persons without a disability.[9] Almost 40% of persons with disabilities also report having more than 7 days of poor physical health whereas 9% of those without a disability report the same.[9]

Among Utah adults, more than one-third of persons with disabilities rate their health as "fair" or "poor." This is five times higher than the amount of persons without disabilities who say their health is fair or poor.

The percent of **people with disabilities** that report poor physical or mental health is significantly higher than the percent reported by **people without disabilities**.[9]



Diving Deeper

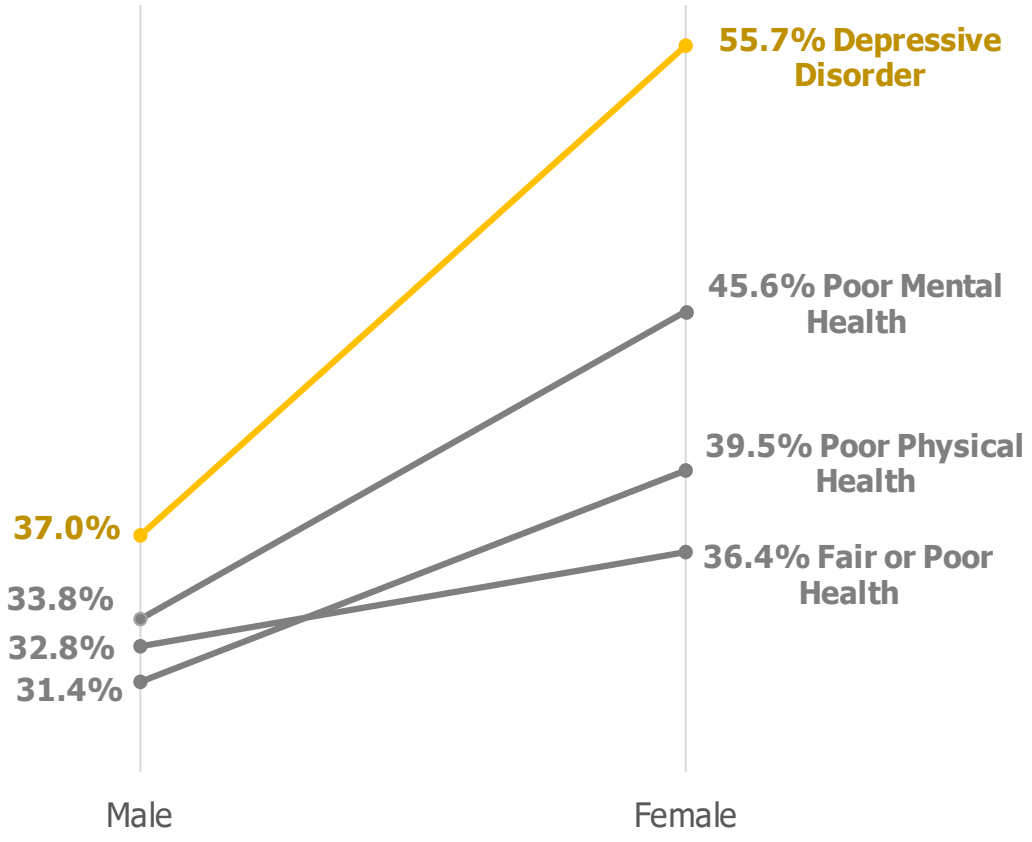



# Ethnicity

Among people with disabilities, people who are **Hispanic** are more likely than non-Hispanics to report they have **fair or poor health** but less likely to report having 7 or more days of poor mental or poor physical health in the past 30 days. They are also significantly less likely to report ever being diagnosed with a depressive disorder.[9]

# Sex

Among people with disabilities, **women** are more likely than men are to report poor mental or physical health.[9]



# Guidelines, Recommendations, Adaptations, Including Disability (GRAIDs)

## How do programs, organizations, and communities become more accessible and inclusive?

A gap in the availability and accessibility of evidence-based programs led to the development of the GRAIDs framework by the National Centers on Health, Physical Activity and Disability (NCHPAD). The GRAIDs are an evidence-based method to adapt programs to be more inclusive of individuals with disabilities. The GRAIDs framework is applicable across programs, settings, sectors, and organizations. Applying the five GRAIDs domains will ensure accessibility and inclusion for individuals with disabilities in communities, programs, services, and organizations.

**Built Environment:** The structural features of a building or community.[15]

| Examples | Resources |
|---|---|
| Ramps, signage, clear paths and sidewalks, hard floor surfaces, curb cuts, park play equipment, spacing between tables or aisles in a conference room setup. | Community Health Inclusion Index (CHII) macro community assessment and on-site assessment.<br>ADA checklist for exiting facilities https://www.adachecklist.org/ |

**Policy:** Laws, regulations, rules, protocols, and procedures designed to guide or influence behavior. Policies can be either legislative or organizational in nature. This means you do not have to wait for state legislation to implement policies to improve accessibility and inclusion.[15]

| Examples | Resources |
|---|---|
| Policies to make reasonable accommodations for client appointments or large events, requiring a new employee disability training, and state level policies for employment initiatives. | The Utah Policy Database allows users to quickly find or add policies on a range of topics and within various settings https://utahhpts.org/.<br>Check out the Healthy Communities Policy Guide for more policy ideas. |

**Services:** Person-to-person assistance or other assistance that increases participation.[15]

| Examples | Resources |
|---|---|
| Transportation services, a personal shopping aide, a peer assistant in a physical activity program, and inclusive advertisements or communication. | The Utah Parent Center compiled a list of services available in Utah.<br>Webinar platforms have additional accessibility options: closed captioning, transcripts, screen reader support, or keyboard accessibility options. This accessible meetings checklist can help agencies prepare accommodations and services. |

**Instruction:** Training and education techniques used to enhance learning for the staff within an organization or for the individual with a disability and their family members or caregivers.[15]

| Examples | Resources |
|---|---|
| Webinars, lunch and learns, in-service training, seminars, group or individual classes. | Check out the NACCHO Disability and Health 101 Training or their Five Steps for Inclusive Communication Fact Sheet. |

**Equipment and Technology:** Products or tools used to promote and allow for participation.[15]

| Examples | Resources |
|---|---|
| Adaptive workout equipment, automatic sliding doors, portable wheelchair scales, closed captioning or screen readers, and video conferencing options. | The Utah Assistive Technology Program can help people with disabilities get assistive technology, see http://www.uatpat.org/. |

# Stepping up: Examples in Utah

## Disability 101 Training Policy

The Utah Department of Health Disability and Health Program (DHP) partnered with the Utah Developmental Disabilities Council (UDDC) to adapt the Disability and Health 101 training originally created by the National Association of City and County Health Officials (NACCHO). The purpose of the Disability 101 training is to educate state of Utah employees about federal requirements for employment and public services (e.g., ADA Title I & Title II), as well as the benefits of including people with disabilities and practical information about how to do so. Disability 101 is an interactive training product that will improve interactions between employees and their coworkers, customers, and managers.

## Inclusivity training for staff implementing chronic disease programs

DHP and EPICC collaborated with NCHPAD to develop training for Diabetes Prevention Program (DPP) Lifestyle Coaches and other self-management program coaches across the state. The content focused on foundation-level knowledge, skills, and abilities to adapt disease management programs in-person curricula to include participants with disabilities.

The DHP and NCHPAD also collaborated on a second training targeting upper management for organizational change for inclusion of people with disabilities. The content included approaches, tools, and resources that create policy, programs, systems, and environmental changes to include people with disabilities.

Evaluation from these trainings showed increased knowledge of the needs of persons with disabilities, increased understanding of disability inclusion and accessibility, increased proficiency in providing accommodations to persons with disabilities, and increased confidence in the organization's ability to deliver inclusive services to persons with disabilities.

Three local health departments in attendance created action plans outlining steps they would take to increase inclusion in their organizations and programs. One of the local health departments in attendance will implement an inclusive Diabetes Prevention Program and will work closely with the DHP on promotion and resources for their program, including the use of a portable wheelchair scale.

## Adaptation of the Top Star Program

In 2018, the DHP conducted site visits to determine the capacity of adult day programs to implement environmental and policy changes. Site visits were comprised of staff and clients in adult day programs in two different geographic regions of the state. Results pointed to their strong desire to increase opportunities for good nutrition and physical activity. Providers also reported the need for additional education and guidance. Recognizing the importance of addressing these issues, the UDOH partnered with the UDAC to develop an intervention to help adult day program providers develop policies for inclusive nutrition and physical activity environments. The intervention, Teaching Obesity Prevention (TOP) Star, was modeled after a successful childcare setting intervention and was piloted in two adult setting sites in 2019. The UDOH provided technical assistance for action planning and policy development. Staff received training through four learning modules that covered inclusive strategies to increase opportunities for clients to eat well and be physically active. Check-ins were held with day program administrators to identify challenges and make modifications to improve the intervention. Additionally, an endorsement process was created for settings that meet the TOP Star requirements of training, goal setting, and action plan completion.

## More accessible websites, reports, and data

As part of the Utah Department of Health's commitment to inclusion and accessibility, department websites and reports use alternate communication formats and follow website accessibility guides. Utah's coronavirus website is an example of utilizing various visuals and communication formats in order to increase the reach and use of coronavirus messages among all Utahns, and this report was designed with the option to be read aloud by a screen reader.

## Additional Tools and Resources:

- The Community Health Inclusion Index (CHII) is a set of survey tools developed by the National Center on Health, Physical Activity, and Disability (NCHPAD) which are used to assess the extent to which a neighborhood, worksite, or organization are inclusive of all ability types.
- The W3C Web Accessibility Initiative (WAI) has guides and resources to help you understand and implement accessible websites, see https://www.w3.org/WAI/.
- NCHPAD has many disability education guides on disability etiquette for public health professionals or healthcare providers, see https://www.nchpad.org/.
- The National Association of City and County Health Officials (NACCHO) has more trainings and fact sheets to help increase local health department inclusivity of people with disabilities.
- Utah's data on persons with disabilities can be accessed online at https://ibis.health.utah.gov/ibisph-view/indicator/complete_profile/Dis.html

# Next Steps

# So what can you do?

## Public Health Can

- ◇ Increase health promotion opportunities for persons with disabilities.
- ◇ Support health promotion programs, health education workshops, and screenings. See http://livingwell.utah.gov/ for more information on these programs.
- ◇ Raise awareness of health promotion and health-related disability policy initiatives.
- ◇ Invite disability advisors and persons with disabilities to participate in program planning groups.
- ◇ Train staff and community partners on disability literacy, inclusion strategies relating to inclusive meetings, communications, accessibility, and health promotion.

## Healthcare Providers Can[16]

- ◇ Educate patients with disabilities about health screenings and provide health screenings.
- ◇ Urge and educate patients with disabilities to make positive lifestyle changes and avoid risky health behaviors like smoking, poor nutrition, unhealthy sexual relationships, and sedentary lifestyles.
- ◇ Avoid making assumptions about a person's abilities.
- ◇ Modify communication strategies to meet the needs and abilities of the patient.
- ◇ Include quality of life in the care of persons with disabilities, which addresses social, economic, and environmental issues.
- ◇ Recognize that persons with disabilities experience the same conditions as persons without disabilities, but an individual's disability may impact signs, symptoms, and diagnoses.
- ◇ Recommend and refer patients to Living Well Utah programs to help manage their condition when appropriate (http://livingwell.utah.gov/).

## State officials and community leaders can

- ◇ Support improvements for more walkable community areas to increase opportunities for physical activity.

- ◇ Provide environmental support, including transportation to evidence-based programs.
- ◇ Offer funding stability.
- ◇ Improve organizational capacity to deliver or support evidence-based programs.
- ◇ Support evaluation.

## Adults with Disabilities Can[17]

- ◇ Be a part of your health care team by asking questions about your health and sharing your feelings and concerns. Write down questions before going to the doctor.
- ◇ Take someone you trust with you to help ask questions or tell the doctor your concerns. They can also help you understand the information you are given or can write down what the doctor says. Do not take someone who will talk with the doctor like you are not there, ignores what you want, or makes decisions for you. It is your body and your health.
- ◇ Talk to your doctor or health care provider about healthy lifestyle changes including exercise, healthy eating, and quitting tobacco products.
- ◇ Talk to your doctor or health care provider about managing pain, stress, anxiety, and depression.
- ◇ Talk to your doctor or health care provider about routine and preventive health screenings.
- ◇ Participate in a Living Well Utah workshop to manage chronic conditions with a supportive peer group (http://livingwell.utah.gov/).
- ◇ Ask questions about healthy lifestyle changes when talking to trusted friends, family, support staff, or your health care team.
- ◇ Advocate for better health. Talk with your state and local government about ways to improve health for persons with disabilities.
- ◇ Participate on committees and coalitions related to health.

# References

1. Drum CE, Krahn GL, Peterson JJ, Horner-Johnson W, Newton K. Chapter 8: **Health of People with Disabilities: Determinants and Disparities.** In: Disability and Public Health. Washington, D.C.: American Public Health Association; 2009:125-144.

2. Krahn GH, Walker DK, Correa-De-Araujo R. **Persons with disabilities as an unrecognized health disparity population.** AJPH. 2015;105:S198–S206. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/

3. Drum CE, Krahn GL, Bersani HA. Chapter 1: **An Introduction to Disability and Public Health**. In: Disability and Public Health. Washington, D.C.: American Public Health Association; 2009:1.

4. **Utah Department of Health.** Behavioral Risk Factor Surveillance System (BRFSS), Salt Lake City: Utah Department of Health, Center for Health Data

5. Courtney-Long EA, Stevens AC, Carroll DD, Griffin-Blake S, Omura JD, Carlson SA. **Primary Care Providers' Level of Preparedness for Recommending Physical Activity to Adults With Disabilities**. Prev Chronic Dis 2017;14:170328. DOI: http://dx.doi.org/10.5888/pcd14.170328external icon

6. **Healthy People 2020.** Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Cited 7/2/2020. Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health.

7. World Health Organization & World Bank. (2011). **World report on disability 2011**. World Health Organization. https://apps.who.int/iris/handle/10665/44575

8. **Definition of Inclusion**. National Center on Health, Physical Activity, and Disability. Accessed 7/2/2020.

9. **Utah Department of Health**. Behavioral Risk Factor Surveillance System (BRFSS) 2016-2018 combined data, Age-adjusted to the 2000 standard population using five age groups, 18-24, 25-34, 35-44, 45-64, and 65+. Salt Lake City: Utah Department of Health, Center for Health Data.

10. **Utah Department of Health**. IBIS Version 2018 Population Estimates from the National Center for Health Statistics through a collaborative agreement with the U.S. Census Bureau.

11. **Utah Department of Health**. Behavioral Risk Factor Surveillance System (BRFSS) 2016-2018 combined, crude data. Salt Lake City: Utah Department of Health, Center for Health Data.

12. Cockerham WC, Hamby BW, Oates GR. **The Social Determinants of Chronic Disease**. Am J Prev Med. 2017;52(1S1):S5-S12. doi:10.1016/j.amepre.2016.09.010

13. **Utah Department of Health**. Behavioral Risk Factor Surveillance System (BRFSS) 2018 data, Age-adjusted to the 2000 standard population using five age groups, 18-24, 25-34, 35-44, 45-64, and 65+. Salt Lake City: Utah Department of Health, Center for Health Data.

14. **Utah Department of Health**. Behavioral Risk Factor Surveillance System (BRFSS) 2017 data, Age-adjusted to the 2000 standard population using five age groups, 18-24, 25-34, 35-44, 45-64, and 65+. Salt Lake City: Utah Department of Health, Center for Health Data.

15. National Center on Health, Physical Activity and Disability (NCHPAD). **GRAIDs: Guidelines, Recommendations, Adaptations, Including Disability.** https://www.nchpad.org/fppics/NCHPAD_GRAIDs_Flyer_final.pdf

16. **Core Competencies on Disability for Health Care Education**. Alliance for Disability in Health Care Education. Published August 2016.

17. Roberson, K. **Being a Healthy Adult: How to Advocate for Your Health and Health Care.** Elizabeth M. Boggs Center on Developmental Disabilities at the University of Medicine and Dentistry of New Jersey. 2010.

18. Cover photo by SoloTravelGoals on Unsplash.

19. Icons on page 14 came from Piktochart.

UTAH DEPARTMENT OF HEALTH

| Recipient | Strategy | ObjNumber | PeopleBaseline | PeopleTarget | PeopleDescrip | People_Actual as of 6/30/2020 | UnitBaseline | UnitTarget | UnitDescription | Unit_Actual as of 6/30/2020 | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Utah | Capacity Building | Capacity 5 | 0 | 24 | Number of partners who access the systems | 0 | 0 | 3 | Data management systems | 3 | This unit target was changed to 1 website in YR 5. |
| Utah | Dissemination and Communication | Comm 3 | 2051 | 2251 | People who attend, receive or access resources | 6097 | 4 | 12 | Number of unique communication products disseminated | 9 | |
| Utah | Partnerships | Partner 4 | 35 | 40 | Utah Disabilities Advisory Committee Members | 41 | 1 | 1 | Utah Disabilities Advisory Committee | 1 | |
| Utah | Programmatic, Policy, Systems, and Environmental Changes | PPSE 4 | 599 | 750 | Persons with Disabilities referred to the Quit Line | 1163 | 1 | 1 | Utah Tobacco Quit Line | 1 | |
| Utah | Programmatic, Policy, Systems, and Environmental Changes | PPSE 6 | 0 | 35 | Number of subcontractor partners receiving the training | 0 | 0 | 1 | Number of policies requiring contract language | 0 | Policy efforts delayed due to COVID-19 response |
| Utah | Programmatic, Policy, Systems, and Environmental Changes | PPSE 7 | 133 | 175 | People with disabilities who participate in interventions | 571 | 5 | 7 | Organizations that host the intervention | 33 | |
| Utah | Technical Assistance and Training | TA1 | 152 | 227 | People receiving technical assistance | 241 | 20 | 120 | Hours | 160 | |

# Disability & Health Program

**May 27, 2021**

**Acronyms:**
**ADA**: Americans with Disabilities Act
**APCD**: All-Payer Claims Data
**BHP**: Bureau of Health Promotion
**BRFSS**: Behavioral Risk Factor Surveillance Survey
**CDC**: Centers for Disease Control
**DHP**: Disability and Health Program
**DPP**: Diabetes Prevention Program
**EPICC**: Healthy Living through Environment, Policy and Improved Clinical Care Program
**IDD**: Intellectual Disabilities and Developmental Disabilities
**LHD:** Local Health Departments
**ML**: Mobility Limitation
**NCHPAD**: National Center on Health, Physical Activity and Disability
**OHCS**: Office of Health Care Statistics
**PSE**: Policy, System and Environmental Changes
**QL**: Quit Line
**TPCP**: Tobacco Prevention and Control Program
**UDAC**: Utah Disabilities Advisory Committee
**UDDC**: Utah Developmental Disabilities Council

**Background**
One in five (22.3%) of Utah adults are living with a disability. Adults with disabilities experience significant differences in their health behaviors and overall health compared with adults without disabilities. People with disabilities are more likely to engage in unhealthy behaviors like inactivity and tobacco usage and experience a higher incidence of chronic health conditions like diabetes and obesity. Many of the health outcomes that persons with disabilities are more likely to experience contribute to the top causes of death or are one of the leading causes of death in the U.S. These significant health differences can often be dismissed by arguments that the observed differences are inherent to the nature of disability itself or that poor health leads to disability. While both scenarios can be valid, they do not represent all reasons for the large gap in health between people with and without disabilities. It is important to understand that many of these differences and the size of those differences are avoidable and societal-based.

**1. What does your office do?**

The Utah Disability and Health Program (DHP) works to improve health and quality of life among adults with mobility limitations (ML) and intellectual/developmental disabilities (IDD) through the adaptation and implementation of evidence-based strategies in their communities. Specifically, we are work to develop and strengthen capacity to:

- Improve knowledge and awareness about the usefulness and effectiveness of programmatic, policy, systems, and environmental changes for people with select functional disability types (i.e., ML and IDD) and

- Support programs to plan, implement, evaluate, and disseminate non-research activities to promote inclusion and accessibility and reduce health disparities between people with and without disabilities.

Our program is committed to improving the health of persons with disabilities by improving access and inclusion of persons with disabilities in health promotion programs such as physical activity and nutrition, diabetes prevention and self-management, and ending tobacco use. Utahns of all abilities will have more opportunities to adopt healthy lifestyles, prevent and manage chronic diseases and be more integrated into the communities in which they live. The DHP is guided by the Utah Disability Advisory Committee (UDAC), which includes people with disabilities and representatives from disability organizations, advocacy groups, and public health organizations. The UDOH DHP program is the backbone organization of the UDAC and convenes the UDAC meetings.

2. How are you organized?

We are located in the Bureau of Health Promotion (BHP). We have a program coordinator (1 FTE) and a part-time epidemiologist (.35 FTE).

3. Which personnel do which tasks?

**Anna Braner, Program Coordinator (1 FTE)** This position directs the day-to-day operations of the grant, coordinates grant activities, oversees all contracts, conducts project meetings, and is responsible for coordinating overall project evaluation. This position is responsible for ensuring that necessary reports and documentation are submitted to Centers for Disease Control (CDC).

**Stephanie George, Epidemiologist (.35 FTE)** This position collaborates with the staff of Utah's major surveillance systems, analyzing Behavioral Risk Factor Surveillance Survey (BRFSS) data, overseeing and assisting with the analysis interpretation, reporting, dissemination, and use of disability and health data. Assist with gathering and compiling data for the needs assessment and data summaries.

4. How do you measure success?

We measure success through various performance measures. These include measuring reach, the number of partnerships, participant-level data, changes in knowledge and behaviors, and increases in policy, system, and environmental changes (PSEs).

5. What have been the results of your success measuring the last few years?

-Increased **program capacity** in our partnerships with over 30 organizations and good representation from individuals with disabilities on our UDAC. We also have good collaboration with our fellow UDOH BHP programs.

-Implementation of several **PSE strategies** to increase opportunities for access and inclusion and overall better health outcomes

**TOP (Teaching Obesity Prevention) Star for Adults with Disabilities**: We collaborated with the UDAC and BHP EPICC program to adapt and implement a physical activity and nutrition program targeting PSEs in Adult Day Program facilities. We piloted the program in two Adult Day Program facilities in late 2019, early 2020. Rigorous evaluation of the intervention included measuring

changes in knowledge, attitudes, and behaviors and changes in the policies, practices, and environments at each adult day program. The improvements were remarkable! The two settings exceeded expectations by implementing nine new nutrition and physical activity policies each. Additional feedback indicated the training was a valuable use of staff time, and it was overwhelmingly well-received. Additionally, we worked with the Department of Administrative Services/Utah Learning Portal Administrator to load the staff training component of the program into the Utah Learning Portal. We are currently in the process of building the microsite to allow external partners access to the content.

We collaborated with the Department of Human Services-Utah Developmental Disabilities Council (UDDC) on content development of a **Disability 101 staff training** for state employees to highlight practical ways to increase access and inclusion of people with disabilities in state and local government services. The training is inclusive and is co-narrated by an adult with an intellectual disability. Our program worked with the Department of Administrative Service/Utah Learning Portal Administrator to load the training into the Utah Learning Portal/SABA to make the training accessible to all state employees, and created a microsite to provide access to our external partners (e.g., our UDAC partners, Local Health Departments (LHDs) and disability organizations). We also worked with our BHP Administration to develop and implement a policy in January 2021, which requires all UDOH Bureau of Health Promotion Staff to complete the training every other year (and at initial onboarding). To date, 98 BHP employees have completed the training.

We hosted **"Inclusive workshops/training"** conducted by the National Center on Physical Activity, Health and Disability (NCHPAD). We collaborated with NCHPAD and the BHP EPICC program (Diabetes Prevention Program) to develop and implement training **for Diabetes Prevention Program (DPP) Lifestyle Coaches and other self-management program coaches across the state**.

- The training participants included 32 lifestyle coaches, 2 master trainers, 3 dietitians, and 3 registered nurses. Participants represented geographic areas across the state and various organizations, including higher education, health systems, local health departments, aging and adult services, and Indian Health Services. The training approach centered on working with lifestyle coaches and other self-management program facilitators to use inclusive practices for their programs. The content focused on foundation-level knowledge, skills, and abilities to adapt the NDPP and other lifestyle management programs in-person curricula to include participants with disabilities.
- Evaluation of the training showed a significant increase in participants' knowledge around providing accommodations, locating resources for inclusion, and their belief in their organization's ability to deliver inclusive services to persons with disabilities. Additionally, three local health departments created action plans outlining steps to increase inclusion in their organizations and programs.

The DHP and NCHPAD also collaborated on a second training targeting **organizational change for the inclusion of people with disabilities**. Planning efforts included identifying accommodations needed for participants through the registration process, accessibility for space and set-up using the Americans with Disabilities Act (ADA) guide, and accessibility for participants in remote and rural areas with Zoom.

- Approximately 50 participants attended. Participants included Executive Leadership from the UDOH and program leadership from various divisions, including Maternal and Child Health, Emergency Preparedness, Disease Control and Prevention, Medicaid, Office of Health Disparities, and Office of Health Care Data and Statistics (OHCS). UDAC partner organizations represented the Utah Transit Authority, UDDC, LHDs, Huntsman Cancer Institute, and Medicaid Managed Care Organizations. The content covered the historical perspective and population data and an overview of approaches, tools, and resources that create policy, programs, systems, and environmental changes to include people with disabilities. Evaluation from this training session showed increased knowledge of participant awareness regarding the needs of persons with disabilities, increased understanding of disability inclusion and accessibility, increased proficiency in providing accommodations to persons with disabilities, and increased confidence in the organization's ability to deliver inclusive services to persons with disabilities. Additionally, participants indicated an increase in knowledge of where to find resources, how to use those resources, and an increase in awareness of disability organization partners. Participants felt strongly that the training was a good use of time and applicable in their daily work.

-**Data**: We added questions to the BRFSS to understand disability rates across chronic disease programs.

- In 2019, our DHP epidemiologist worked with partner programs across the BHP to add disability indicators to their BRFSS data sets. As a program, we approached our BHP Director and our Division Director to approve the new indicators and received the approval in October 2019. The updates to the data sets for diabetes, physical activity and nutrition, cancer prevention and screenings, heart disease and blood pressure, tobacco prevention and control, and violence and injury prevention can be viewed by the public here https://ibis.health.utah.gov/ibisph-view/indicator/complete_profile/Dis.html
- Additionally, our DHP and UDAC have worked with the UDOH Office of Health Care Statistics (OHCS) to create "data-byte" reports using All-Payer Claims Data (APCD) in addition to other data sources to highlight disability and health issues, such as depression rates among adults with autism.
- We worked with the BHP Tobacco Prevention and Control program (TPCP) to add disability status questions to the Quit Line (Q.L.) intake form to track the number of referrals and number of individuals with IDD/ML that enroll in the cessation services offered. The number of individuals with disabilities who have accessed the Q.L. has exceeded our goal for referrals every year. Additionally we worked with the TPCP to create a data brief on tobacco use and e-cigarette use rates among adults with disabilities based on BRFSS data.

6. How are you funded?

The Centers for Disease Control funded the DHP in July 2016 as a capacity-building grant. Our five-year grant cycle ends on June 30, 2021. We are currently in the process of applying for the new five-year funding opportunity.

When will you find out if you were approved for another five years? End of June

Why are you funded that way?

We were funded as a capacity-building grant since it was a new program.

a. Since you are primarily federally-funded, what are the main options/flexibility/choices we have as the grant administrators?
    i. Not allowed to do research
    ii. There are core activities required to do

7. When was the last time that you had a major problem?

June 2019. Once we finalized the curriculum for the TOP Star staff training for the adult day programs and the Disability 101 product, our approach to ensure sustainability was to house the training products in the Utah Learning Portal/Saba. We quickly realized the lack of experience/expertise with converting a PowerPoint product into interactive training compatible with a learning management system.

How did you identify it?

Once we received an overview of the Learning Management System requirements for interactive training, we knew we could not simply insert a PowerPoint presentation. We purchased an Adobe Captivate license to make the product more compatible but quickly realized we did not have the skill set to transition the content.

What was the solution that you implemented?

With minimal funds, we bid the work out to convert the PowerPoint product to Adobe Captivate format. We then worked with the Department of Administrative Services to load the product into the Utah Learning Portal/Saba.

8. When was the last major change in your office?

March 2020

What was it?

COVID-19

How did it change your workflow?

Other duties were assigned that stretched our program's capacity/bandwidth very thin. COVID-19 also affected external partner capacity and interrupted some of the work from moving forward. Technology has helped immensely and has facilitated increased participation from partners in some ways.

9. Do you seek for and receive private contributions to involve the community in the solution? If not, why?

No, at this time, we do not have the capacity to seek private contributions. We involve the community in the solution through our many partnerships and the UDAC, which

guides our efforts. In the disability community, there is a saying, "Nothing about us, without us," and we always consider that perspective in our programmatic strategies and approach.

10. How much do you spend on services versus program administration?

Our grant is very small, $165,000 per year. About 85% of our budget supports program administration costs for the program coordinator (1 FTE), part-time epidemiologist (.35 FTE), and finance (.05 FTE). The remaining budget supports the PSE activities we work to support and implement.

11. How do you emphasize preventative measures rather than reactive measures, such as:
- Encouraging good nutrition and exercise?

Policy, system, and environmental change approaches to increase opportunities for inclusive and accessible health promotion. Inclusive programs for nutrition and physical activity.

- Treating the underlying issue (e.g., mental health, substance abuse)?

Stigma and exclusion are huge issues for the disability community. We are working to address this by increasing knowledge and awareness, adapting programs through the provision of technical assistance and support, improving our partnerships, and increasing policy, system, and environmental changes to create more inclusive and accessible opportunities for good health for ALL Utahns.

- Educating in a way that helps individuals desire and realize change?

We focus on helping individuals see the barriers to healthy choices and work to increase inclusive, accessible opportunities for health promotion.

12. What would you do with more funding?

Hire more staff to increase programmatic capacity to leverage existing partnership opportunities and provide more technical assistance and training. We would use more funding to support program strategies to scale out adapted programs and support organizations implementing them.

13. What would you do with less funding?

Continue to try to leverage resources across partnerships to move the work forward.

14. Are there any areas where you would like to know what other states are doing to address specific issues (I can ask my national support organization)?

We would like to know if/how other States have implemented standard operating procedures across their state agencies to address inclusion for individuals with disabilities in the 1) built environment in state government buildings, 2) staff training and education for contractors and state employees, 3) services provided by the State or contractors, 4) equipment and technology (e.g. – in clinics, gyms, water fountains), and 5) organizational policies.

1. What are your (budget/legal) suggestions for improvements? Would require all state employees to take the disability sensitivity training.

**Sources:**

1. **From:** Anna Braner <aBraner@utah.gov>
   **Sent:** Tuesday, May 25, 2021 9:02 AM
   **To:** Russell Frandsen <rfrandsen@le.utah.gov>
   **Cc:** Brandi Frandsen <btfrands@utah.gov>; Stephanie George <sgeorge@utah.gov>; Traci Barney <tabarney@utah.gov>; Teresa Brechlin <tbrechlin@utah.gov>
   **Subject:** Re: UDOH Disability & Health Program Mtg. with Russell Frandsen
2. Disability & Health Program Meeting on May 27, 2021

## Russell Frandsen

**From:** Kevin Burt <kburt@utah.gov>
**Sent:** Tuesday, May 25, 2021 4:43 PM
**To:** Russell Frandsen
**Cc:** Casey Cameron (caseycameron@utah.gov); Greg Paras; Jennifer Roth; Kathy Bounous; Kim Beck; Nate McDonald; Nathan Harrison; Schuring, Dan; Shelle Allinson; Stacey Cummings; Trudy Ellis; Kimberly Madsen
**Subject:** Re: does DWS collect any information on food insecurity?

Russell,

DWS does not collect information on food insecurity in the State. However, the USDA does collect food security information and at least some of it is broken out by state. Here's a general food security web page of theirs with links to other pages for reports, charts, and other information.
https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/

Hope that helps,

**Kevin Burt**
**Assistant Deputy Director**
**P:** (801) 526-9575
140 East 300 South, Salt Lake City, Utah 84111
jobs.utah.gov


On Tue, May 25, 2021 at 12:10 PM Russell Frandsen <rfrandsen@le.utah.gov> wrote:

> Hi Kevin,
>
> Could you please tell me by the end of Monday, June 7th, what data (if any) DWS collects on food insecurity in Utah? If yes, then what data are you collecting and what have the results been?
>
> Thanks for your time.
>
> Russell Frandsen
>
> Finance Officer

Office of the Legislative Fiscal Analyst

State of Utah

Phone 801-538-1034

Fax 801-538-1692

rfrandsen@le.utah.gov

http://budget.utah.gov/

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May 20, 2021

**To:** Russell Frandsen
Finance Officer, Office of the Legislative Fiscal Analyst
State of Utah
rfrandsen@le.utah.gov

**From:** Kate Bradford
Research Analyst, NCSL Health Program
kate.bradford@ncsl.org | 303.856.1446



**Subject:** Funding Sources for Spinal Cord and Brain Injury Programs

Dear Russell,

Thank you for reaching out with your question about funding sources for spinal cord and brain injury or similar programs in other states. Below you will find several examples of related funds established through state statute and, when available, the amount of funds collected by each source. An additional resource is included at the end.

*Please note that NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.*

**State Examples**

- **Colorado** – Brain Injury Trust Fund Board
  - Colo. Rev. Stat. § 26-1-302 created the Colorado brain injury trust fund board within the department of human services and § 26-1-309 established the Colorado brain injury trust fund, which consists of money collected pursuant to sections 30-15-402(3), 42-4-1307(10)(c), and 42-4-1701(4)(e):
    - § 30-15-402 (3): $20 fee from convictions of operating a vehicle in excess of the speed limit established by a local ordinance pursuant to § 30-15-401 (1)(h)
    - § 42-4-1307 (10)(c): $25 fee from convictions of driving under the influence
    - § 42-4-1701 (4)(e):
      - $20 fee for speeding violations pursuant to (4)(a)(I)(L) of this section
      - $20 fee for a violation of a traffic regulation pursuant to (4)(a)(I)(c) of this section
      - $20 for a motorcycle violation pursuant to (4)(a)(I)(o) of this section
- **Louisiana** – Traumatic Head and Spinal Cord Injury Trust Fund
  - La. Stat. Ann. § 46: 2633 established the Traumatic Head and Spinal Cord Injury Trust Fund, which consists of funds collected from additional fees imposed on all motor vehicle violations for driving

under the influence, reckless operation and speeding in the state. In addition, the legislature may make annual appropriations to the trust fund to the extent that state funds are available.
    - Sources for the trust fund pursuant to § 46: 2633 (B) include:
        - $5 fee for reckless driving offenses
        - $5 fee for speeding offenses
        - $25 fee for first convictions of operating a vehicle while intoxicated offenses
        - $50 fee for second convictions of operating a vehicle while intoxicated offenses
        - $100 fee for third convictions of operating a vehicle while intoxicated offenses
        - $250 fee for fourth or subsequent convictions of operating a vehicle while intoxicated offenses
- **Indiana** – Spinal Cord and Brain Injury Fund Research Grant Program
    - Ind. Code § 16-41-42.2-3 established the spinal cord and brain injury fund, which consists of appropriations, gifts and bequests, certain motor vehicle registration fees (30 cents) under Ind. Code § 9-18.1 et seq., and grants received from the federal government and private sources.
    - According to their website, the fund is expected to generate approximately $1.6 million per year, with the majority of money generated to be allocated to research projects. Their most recent annual report (submitted in January 2020) showed the program revenues collected during FY19 were $1,774,739.
- **Minnesota** – Spinal Cord Injury and Traumatic Brain Injury Research Grant Program
    - Minn. Stat. § 136A.901 established the Spinal Cord Injury and Traumatic Brain Injury Grant Program, which consists of funding appropriated from the legislature and additional funds from private and public sources. According to their website, the legislature appropriates $500,000 per year, which is split equally between spinal cord injuries and traumatic brain injuries.
- **New York** – Spinal Cord Injury Research Board
    - N.Y. McKinney's Public Health Law § 250 established a spinal cord injury research board, which is in charge of administering the spinal cord injury trust fund created in N.Y. McKinney's State Finance Services Law § 99-f:
        - The fund shall consist of funding in an amount not to exceed $8.5 million collected by the mandatory surcharges imposed pursuant to subdivision one of § 1809 of the vehicle and traffic law:
            - $5 crime victim assistance fee and a $25 mandatory surcharge in the conviction of certain traffic infractions pursuant to § 1192 – Operating a motor vehicle while under the influence of alcohol or drugs.
            - $25 crime victim assistance fee for a misdemeanor or felony pursuant to § 1192 – Operating a motor vehicle while under the influence of alcohol or drugs and either a $300 mandatory surcharge for a person convicted of a felony or a $75 mandatory surcharge for a person convicted of a misdemeanor.
        - According to their 2018 annual report, in FY18-FY19 the fund consisted of $8.5 million.

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- **New Jersey** – Commission on Spinal Cord Research
  - N.J. Rev. Stat § 52:9E-3 established the New Jersey Commission on Spinal Cord Research and § 52:9E-9 created the New Jersey Spinal Cord Research Fund, which is the repository for the funds provided in subsection e. of § 39:5-41:
    - $1 added to the amount of each fine and penalty for any violation of the provisions of Title 39 or any other motor vehicle or traffic violation in the state.
- **Virginia** – Commonwealth Neurotrauma Initiative
  - Va. Code Ann. § 51.5-179 established the Commonwealth Neurotrauma Fund, which consists of grants, donations, and bequests from public and private sources and funds collected pursuant to § 46.2-411:
    - $25 charge when a person's driver's license or registration card, license plate or other privilege to drive or to register motor vehicles is revoked and the revocation results from one of several convictions including but not limited to involuntary manslaughter pursuant to § 18.2-36.1, unreasonable refusal to submit to drug or alcohol testing in violation of § 18.2-268.2, conviction of eluding police in violation of § 46.2-817, or conviction of a hit and run in violation of § 46.2-894.

**Additional Resources**

*Please note: NCSL provides links to other websites for information purposes only. Providing these links does not indicate NCSL's support or endorsement of the site.*

- Spinal Cord Injury: Progress, Promise, and Priorities, National Academies of Sciences, Engineering, and Medicine (2005)
  - You can download Chapter 8, "State Programs in Spinal Cord Injury", for free as a guest. This chapter examined the structure of state spinal cord injury research programs, including some funding sources.

I hope this information is helpful. Please do not hesitate to reach out if you have any further questions.

Sincerely,

Kate Bradford

**Healthy Living through Environment, Policy, and Improved Clinical Care**

**May 25, 2021**

## P: DWS data from SNAP on any general food insecurity questions (federal requirements)

# EPICC

1. What does your office do?

The Healthy Living through Environment, Policy, and Improved Clinical Care Program (EPICC) is a program resulting from the consolidation of three programs (Diabetes Prevention and Control Program, Heart Disease and Stroke Prevention Program, and the Physical Activity, Nutrition and Obesity Program). The consolidation of the three programs into one was designed to assist in the coordination of activities to ensure a productive, collaborative and efficient program focused on health outcomes. The program aims to reduce the incidence of diabetes, heart disease, and stroke by targeting risk factors including reducing obesity, increasing physical activity and nutritious food consumption, and improving diabetes and hypertension control.

2. How are you organized?

The EPICC Program was formed in July, 2013 through the merging of three existing programs; Heart Disease and Stroke, Diabetes Prevention and Control and Physical Activity, Nutrition and Obesity. Currently, the program is organized by social determinants of health focused on healthcare access, education, social and community context, built environment, economics, and education. Additionally, the program is organized by grant workplans, strategies and activities.

***Could you tell me more about the merger and the reasons for combining and how that has impacted reaching of goals please?***

3. Which personnel do which tasks?

a. Health Program Manager II, Linnea Fletcher: This position manages and oversees grant implementation, directs the day-to-day operations of the grants, oversees budgets and procurement, including revenues, expenditures, and budget projections. This position supervises staff, implements federal and state grant activities, serves as the liaison with other states, conducts project meetings and convenes partners, and is responsible for overall project evaluation. This position is responsible for ensuring that necessary reports and documentation are submitted for state and federal reporting requirements. Plans and allocates resources to ensure agency policies and state statutes are fully implemented. This position is responsible for developing and coordinating plans and policies, resources, and mission as well as goals, vision, and expectations of agency or program; prepares and updates plans and priorities.

b. Health Program Manager I, Rebecca Fronberg: This position is responsible for overseeing coordination of grant activities and ensuring all grant objectives are met. This position is responsible for supervising and overseeing staff activities. This position is also responsible for fostering and improving relationships with partners to support Community Health Workers, school and early childhood settings and breastfeeding.

c. Health Program Manager I, John Stuligross: This position is responsible for overseeing coordination of grant activities and ensuring all grant objectives are met. This position is responsible for supervising and overseeing staff activities. This position is also responsible for fostering and improving relationships with partners to support the improved access to health care and the built environment.

d. Health Program Manager I, McKell Drury: This position is responsible for overseeing coordination of all contracts for sub-awardees and contractors work, activities and deliverables for all state and federal workplans and budgets. This position will oversee communication efforts to reach target populations for program messaging.

e. Epidemiology Manager I, Brittany Brown: This position is responsible for overseeing Epidemiology/Evaluation staff activities. They are responsible for collaborating with staff of Utah's major surveillance systems, overseeing development and implementation of the evaluation plan, reporting, disseminating and use of relevant data, assisting with evaluation training for staff and partners, advising program manager of mid-course adjustments that may need to be made based on data and evaluation results, and is responsible for yearly surveillance and evaluation reports.

f. Administrative Secretary, Carolyn Croxall: This position provides secretarial support to all program staff in organizing, coordinating and maintaining program efforts, including organizing partner meetings, taking meeting minutes, coordinating meeting logistics, ordering program materials, preparing mailings, making copies, and other similar duties as requested.

g. Epidemiologist II, Brenda Ralls: This position provides epidemiology and evaluation support for Environmental Approaches that Promote Health.

h. Epidemiologist II, Caitlyn Jasumback: This position provides epidemiology and evaluation support for diabetes prevention and management.

i. Epidemiologist II, Taylor Hoj: This position provides epidemiology and evaluation support for heart disease, stroke, and cholesterol.

j. Health Program Specialist III, Brett McIff: This position is the lead over all built environment and active transportation activities that support linking people with places and increasing physical activity.

k. Health Program Specialist III, Brittany Ly: This position is responsible for all things Diabetes Self-Management Education.

l. Health Program Specialist III, Josh (Antony) Pittman: This position provides support to policy efforts around the Chronic Disease Reporting Rule, Medicaid expansion for National DPP, clinic policy, breastfeeding, worksites, etc.

m. Health Program Specialist III, Judith Harris: This position is a nutritionist and International Board Certified Lactation Consultant (IBCLC), over all of the nutrition and physical activity activities in Early Care and Education (ECE). This position serves as the lead for all breastfeeding activities.

n. Health Program Specialist III, Karlee Walker: This position is responsible for the statewide strategic plan. This position is responsible for other special projects.

o. Health Program Specialist III, Kevin Nguyen: This position is responsible for supporting CHWs, building infrastructure to the state, supporting CHW core skills training, instruction, management, etc.
p. Health Program Specialist III, Natalie Klein: This position is responsible for the National Diabetes Prevention Program Activities. This position also provides technical assistance as a liaison to local health departments, managing and coordinating contract activities and reporting.
q. Health Program Specialist III, Rachel Black: This position is responsible for CHW training and certification training program.
r. Health Program Specialist III, Sarah Roundy: This position is the School Health Coordinator and is paid from Maternal and Child Health Block Grant funding. This position also provides technical assistance as a liaison to local health departments, managing and coordinating contract activities and reporting.
s. Health Program Specialist III, Tara Ross: This position is responsible for the Utah Million Hearts Coalition and Self Measured Blood Pressure Collaborative.
t. Health Program Specialist III, Verena de Havenon: This position supports hypertension efforts for telehealth and other special projects such as health equity.
u. Health Program Specialist II, Aashima Acharya: This position is a Community Health Worker responsible for supporting statewide Community Health Worker efforts with building infrastructure to the state, supporting CHW core skills training and instruction.
v. Public Health Nutritionist, Laura Holtrop-Kohl: This position is a registered dietitian and responsible for all of the food service guidelines nutrition activities.
w. Senior Registered Nurse, BettySue Hinkson: This position serves as a consultant on school health issues between the Utah Department of Health and Utah State Board of Education. This position promotes coordination of school nursing services and school health programs amongst a diverse range of partners. This position provides guidance in school health services program development and planning. This position serves as a liaison and resource expert in school nursing practice and school health programming.
x. Senior Business Analyst, Ryan Christenson: This position is responsible for navigating technical details of acquiring clinical health data, including data-sharing agreements, computer systems, database management, etc. in order to get data in a format that can be used to construct indicators and do public health surveillance and evaluation. This position helps evaluate the quality of cHIE data by comparing cHIE data to EHR data, cleaning at the data as it comes into the cHIE, validating patients and the cHIE, and help identify an infrastructure for data in our hypertension and diabetes surveillance system project.
y. Information Specialist, Dave Mecham: This position is responsible for coordinating all of the communications activities in each federal and statewide strategy and ensures that success stories receive media exposure.
z. Intern, Spencer Denison: This position provides support on grant projects and activities related to heart disease and diabetes.

aa. Intern, McKayla McConkie: This position provides support on grant projects and activities related to physical activity and nutrition.
bb. Additional positions supported by EPICC: The EPICC Program supports Michael Friedrichs in the role as state chronic disease epidemiologist, Angela Dunn in her role as the state infectious disease epidemiologist, and Theron Jeppson in his role as an informaticist.

4. How do you measure success?

The EPICC Program measures success by using the CDC Performance Measures and evaluation plans that supports continuous monitoring for program goals, strategies and outcomes. Information is provided to CDC through monthly and annual reports.

1. Heart Disease
    1. Proportion of patients within high burden subpopulations with known high blood pressure who have achieved blood pressure control based on improved clinical quality measurement, innovative approaches to engage non-physician team members in hypertension management in clinical settings and manage their cholesterol with statin therapy based on improved clinical quality measurement
    2. # and % of providers with a protocol for identifying patients with undiagnosed hypertension
    3. # and % of clinics or health care system sites that use standardized clinical quality measures to track differences in blood pressure and cholesterol control in high burden subpopulations compared to overall populations
    4. # and % of community pharmacies that provide MTM services for the purpose of managing high blood pressure and/or high blood cholesterol
    5. # of patients within clinical and/or community settings that engage with CHWs or community navigators who link patients to community resources that promote management of high blood pressure
    6. # and % of patients in the selected clinical or community settings with hypertension who use telehealth technologies to manage their blood pressure
2. Diabetes
    1. # of patients served and health care systems that use bi-directional e-referral systems to exchange information with National Diabetes Prevention Programs (DPP)
    2. # of new National DPPs established during the reporting period
    3. Total # of participants enrolled in prediabetes and diabetes programs in person or via telehealth
    4. Number of people reached by tailored communication/messaging to increase awareness of prediabetes and the National DPP
    5. # of new telehealth sites established in underserved areas to increase access to prediabetes and diabetes programs
    6. # of diabetic retinopathy screening sites established in underserved areas and connected to a telemedicine reading center
    7. # of health care systems using clinical decision support within the EHR to promote early detection of chronic kidney disease in people with diabetes
    8. # of academic and other institutions offering CHW core competency training and number of CHWS who have received core competency training

9. # of CHWS in the state who are paid from sustainable payment mechanisms
10. During April 2020 through 2021 800+ able to get training during rapid switch to online training (previously trainings were all in person)

3. Physical Activity and Nutrition
    1. # of births potentially impacted by hospitals that have implemented at least six of the evidence-based maternity care practices and policies
    2. # of employees potentially impacted by the full implementation of the federal lactation accommodation law in worksites
    3. # of hospitals that have implemented at least six of the evidence-based maternity care practices and policies
    4. # of facilities potentially impacted by system-level supports in state Early Childhood Education Spectrum Areas.
    5. # of employees potentially impacted by implemented food service guidelines in worksites including number of venues and community sites
    6. # of potential and actual linear miles, connecting everyday destinations, which have been addressed by new or improved policies and plans.
    7. # of people potentially impacted by new or improved active transportation policies and plans.

5. What have been the results of your success measuring the last few years?
***What are the recent results of the most important measures? Is the overall performance measure trend positive or negative for what the program is addressing?***

Performance measure data that has been collected over the past few years has allowed the EPICC Program to be awarded funds for continued efforts around chronic disease prevention. Staff have been able to work with partners to expand the number of prediabetes and diabetes programs in the state of Utah and have an increased number of participants. There has been an increased number of clinics that have applied for and been awarded the Million Hearts award for their controlled hypertension rates. The CHW Core Skills Training has been implemented and over the past year over 60 CHWs have completed the training. Staff have worked with ECE to implement TOP Star to increase physical activity and provide good nutrition for young children. Safe Routes to School and school breakfast initiatives passed during the 2020 legislative session. There have been an increased number of cities and counties working on active transportation. Additionally, Utah has been recognized nationally as a progressive state in their efforts.

6. How are you funded? Why are you funded that way?

a. Currently all payers pay for diabetes management programs once you have diabetes. What is not covered are classes for pre-diabetic clients.

b. CDC Grant 1815 - Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease, and Stroke

c. CDC Grant 1817- Innovative State and Local Public Health Strategies Through the Prevention and Management of Diabetes, Heart Disease and Stroke

d. CDC Grant 1807- State Physical Activity and Nutrition Program (SPAN)

e. National Association of Chronic Disease Directors (NACDD) Building Resilience Inclusive Communities (one year, one time funding)

f. State Funds for heart disease, obesity prevention and school nursing efforts including: asthma, seizure rescue medications, vision screening

***g. If you are primarily federally-funded, then what are the main options/flexibility/choices we have as the grant administrators?***

***h. How is the Community Health Worker initiative funded?***

7. When was the last time that you had a major problem? How did you identify it? What was the solution that you implemented?

During contract negotiations of 2018, LHDs identified that the meeting attendance requirement for coalition and workgroup meetings was not sustainable for them. The intent of having an 80% meeting attendance requirement was a simple way to measure LHD participation in grant work and activities. The LHDs, as valued partners, brought the concerns to the BHP director during their quarterly Utah Local Association for Community Health Education Specialists (ULACHES) meeting. Over the course of one year, the EPICC Program leadership team met with ULACHES representatives to evaluate organizational performance across all LHD and UDOH teams. The EPICC Program staff and ULACHES representatives' utilized collective knowledge to identify relevant performance metrics, define those performance metrics, and identify timeframes for adoption. Performance metrics that were identified were timeliness of reporting, quality of reporting, spending out of current funds, and identifying core activities for all LHDs. Quarterly meetings allowed for check ins of the performance measures as well as annual contract negotiations.

8. When was the last major change in your office? What was it? How did it change your workflow?

The EPICC Program was tasked with creating a strategic plan to guide their work by leadership as well as Local Health Officers (LHO). As part of the strategic planning process, the EPICC Program contracted with consultants ChangeLab Solutions to support their efforts to focus upstream to address the social determinants of health and advance health equity across the state of Utah. ChangeLab Solutions produced a suite of memos that incorporate feedback from consultations led by ChangeLab Solutions and/or a program consultant with program leadership, EPICC staff, LHDs, and select program partners over the course of six months (January – June 2020) to address the following topics: 1) overlaps and gaps in the EPICC program activities; 2) recommendations for new program vision, mission, and goals language; 3) recommendations for the strategic planning process and structures for the program model, 4) evidence-based strategies being utilized by other states, 5) a preemption analysis on potential policy strategies that the EPICC Program may be interested in working on in the future. To achieve the desired goal of addressing social determinants of health and health equity, an additional memo on health equity provides recommendations for creating an equity action plan that is aligned with the new strategic plan and provided the EPICC Program with guidance on how to center an equity approach in their work first internally and then externally with partners. In January of 2020, the EPICC Program convened their partners to gather input and to solicit feedback. Following that original kickoff meeting ChangeLab Solutions and program consultant met with the EPICC Program staff, partners to do one on one and team interviews to gather input to be used in memo development as well as guide the strategic planning process.

In November 2020, the EPICC Program formed three workgroups (Healthy People, Healthy Communities and Equitable Society) made up of staff, LHD partners, and external partners to provide input on workplan activities, strategies and goals. The three workgroups were formed

based on the new program model being adopted by the program and each was led by a member of the leadership team. In March 2021, the EPICC Program was restructured based on recommendations from ChangeLab Solutions to be more upstream and focused on social determinants of Health. Some members of the leadership team's roles and responsibilities and supervisory of specific staff changed based on the new program implementation.

9. Do you seek for and receive private contributions to involve the community in the solution? If not, why?
The EPICC Program does not seek private monetary contributions from the community. As part of current grant funds, the EPICC Program partners all 13 local health departments, community based organizations, health systems, community health workers, etc. in their efforts around heart disease, diabetes, physical activity, and nutrition.

10. How much do you spend on services versus program administration?
a. CDC Grant 1815 - Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease, and Stroke - 58% Program Administration
b. CDC Grant 1817- Innovative State and Local Public Health Strategies Through the Prevention and Management of Diabetes, Heart Disease and Stroke - 20% Program Administration
c. CDC Grant 1807- State Physical Activity and Nutrition Program (SPAN) - 46% Program Administration
d. National Association of Chronic Disease Directors (NACDD) Building Resilience Inclusive Communities (one year, one time funding) - 32% Program Administration
e. State Funds for heart disease (50% Program Administration), obesity prevention (50% Program Administration) and school nursing efforts including: asthma, seizure rescue medications, vision screening (95% Services)

***Some of these admin percentages could seem a little high to those reviewing them. Could you please provide more context and justification for the highest admin percentages?***

11. How do you emphasize preventative measures rather than reactive measures, such as:
- Encouraging good nutrition and exercise?
- Treating the underlying issue (e.g., mental health, substance abuse)?

***You are working to help clinicians update to best practices for heart health, this is probably a broader problem with many diseases/issues. What is being done to address the broader issue?***

- Educating in a way that helps individuals desire and realize change?

The EPICC Program encourages all Utahns to eat healthy and be physically active and is an integral part of all program goals, strategies and activities. This is done through prevention efforts through coalition work with partners like the Diabetes Coalition, Million Hearts Coalition, Eat Well Utah, and others. Efforts are being made to make changes through policies, systems, and the environment. Various settings where staff are working with partners to encourage prevention efforts around physical activity and nutrition are happening at settings like hospitals and clinics, schools, early childhood centers, worksites, community centers, parks, trails, grocery stores, pharmacies, healthcare payers, community health workers etc. The EPICC Program provides education to healthcare providers, ECE providers, decision makers, etc. to provide access to healthy eating and nutritious foods. Additionally the EPICC Program supports

diabetes and prediabetes programs that helps educate individuals to change their behavior and reduce their risk of diabetes.

12. What would you do with more funding?
If the EPICC Program had additional funding, the funds would be used to support the statewide chronic disease monitoring and surveillance system. This would allow the department access to utilize population based chronic disease data, providing the opportunity to better utilize CDC and state funds for the program activity implementation and evaluation. Additionally, the EPICC Program is unable to purchase equipment or provide certain direct services with CDC funds. Funds could be used for services however some are not allowed with the budgets based on CDC restrictions.

13. What would you do with less funding?
The number of Utahns with heart disease, diabetes and obesity would have less access to services, physical activity and nutrition opportunities. Staff that are currently working on these efforts would be let go.

Are there any areas where you would like to know what other States are doing to address certain issues (I can ask my national support organization)?
The EPICC Program meets monthly with three different CDC project officers and receives technical support with grant activities. Staff meet frequently with other states through webinars, collaboration calls, annual grantees meetings, and national coalitions and workgroups as participants and leaders. Through recent strategic planning efforts, Utah connected with other states to learn best practices and evidence based strategies to better improve program activities and utilize resources in a more efficient way.

1. ***What are your legal/budgetary suggestions for improvements?***

**Original Source for Most of Data (LFA added some notes):**

**From:** Linnea Fletcher <linneafletcher@utah.gov>
**Sent:** Tuesday, May 25, 2021 9:12 AM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** Re: EPICC (Healthy Living through Environment, Policy, and Improved Clinical Care) Collaboration Group

| Individuals with Immunizations in Information Registries in 2019 (2+ records for youth and 1+ for adults) | | | | | | |
|---|---|---|---|---|---|---|
| **State/City** | **Children (< 6) %** | **Rank of 54** | **Adolescents (11-17) %** | **Rank of 54** | **Adults %** | **Rank of 54** |
| **Alabama** | 87% | 49 | 77% | 43 | 37% | 46 |
| **Alaska** | 91% | 46 | 76% | 45 | 64% | 31 |
| **Arizona** | 103% | 14 | 98% | 9 | 57% | 39 |
| **Arkansas** | 103% | 14 | 99% | 8 | 80% | 18 |
| **California** | 92% | 45 | 77% | 44 | 69% | 27 |
| **Chicago, IL** | 103% | 13 | 96% | 10 | 61% | 35 |
| **Colorado** | 101% | 21 | 88% | 26 | 78% | 19 |
| **Connecticut** | 80% | 53 | 8% | 54 | 1% | 53 |
| **DC** | 94% | 39 | 83% | 36 | 37% | 47 |
| **Delaware** | 103% | 11 | 92% | 15 | 73% | 24 |
| **Florida** | 99% | 32 | 74% | 47 | 60% | 36 |
| **Georgia** | 110% | 2 | 103% | 6 | 91% | 9 |
| **Houston, TX** | 138% | 1 | 118% | 1 | 5% | 50 |
| **Idaho** | 100% | 24 | 83% | 35 | 70% | 26 |
| **Illinois*** | 95% | 36 | 89% | 23 | 64% | 32 |
| **Indiana** | 104% | 10 | 104% | 5 | 97% | 5 |
| **Iowa** | 103% | 12 | 91% | 17 | 95% | 6 |
| **Kansas** | 85% | 51 | 63% | 52 | 72% | 25 |
| **Kentucky** | 94% | 43 | 80% | 38 | 59% | 38 |
| **Louisiana** | 106% | 5 | 102% | 7 | 62% | 34 |
| **Maine** | 94% | 40 | 90% | 19 | 43% | 42 |
| **Maryland** | 98% | 34 | 85% | 32 | 67% | 29 |
| **Massachusetts** | 94% | 43 | 87% | 28 | 87% | 10 |
| **Michigan** | 99% | 31 | 90% | 18 | 83% | 16 |
| **Minnesota** | 99% | 28 | 89% | 20 | 110% | 1 |
| **Mississippi** | 106% | 6 | 89% | 25 | 54% | 40 |
| **Missouri** | 78% | 54 | 50% | 53 | 41% | 45 |
| **Montana** | 100% | 22 | 84% | 34 | 75% | 22 |
| **Nebraska** | 94% | 40 | 80% | 39 | 84% | 15 |
| **Nevada** | 100% | 22 | 84% | 33 | 85% | 13 |
| **New Jersey** | 91% | 46 | 80% | 40 | 11% | 49 |
| **New Mexico** | 103% | 14 | 93% | 14 | 84% | 14 |
| **New York*** | 105% | 8 | 89% | 24 | 41% | 43 |
| **New York City, NY** | 110% | 3 | 117% | 2 | 41% | 44 |
| **North Carolina** | 103% | 17 | 89% | 21 | 46% | 41 |
| **North Dakota** | 94% | 42 | 87% | 30 | 99% | 3 |
| **Ohio** | 95% | 38 | 79% | 41 | 63% | 33 |
| **Oklahoma** | 91% | 48 | 71% | 50 | 28% | 48 |
| **Oregon** | 100% | 24 | 85% | 31 | 98% | 4 |
| **Pennsylvania*** | 86% | 50 | 73% | 48 | 74% | 23 |
| **Philadelphia, PA** | 108% | 4 | 104% | 4 | 75% | 21 |
| **Rhode Island** | 102% | 20 | 95% | 12 | No Data | ##### |
| **San Antonio, TX** | 100% | 27 | 75% | 46 | 5% | 51 |

| Individuals with Immunizations in Information Registries in 2019 (2+ records for youth and 1+ for adults) | | | | | | |
|---|---|---|---|---|---|---|
| **State/City** | **Children (< 6) %** | **Rank of 54** | **Adolescents (11-17) %** | **Rank of 54** | **Adults %** | **Rank of 54** |
| **South Carolina** | 96% | 35 | 72% | 49 | 59% | 37 |
| **South Dakota** | 99% | 33 | 92% | 16 | 92% | 7 |
| **Tennessee** | 100% | 24 | 78% | 42 | 65% | 30 |
| **Texas*** | 84% | 52 | 65% | 51 | 4% | 52 |
| **Utah** | 102% | 18 | 87% | 29 | 82% | 17 |
| **Vermont** | 104% | 9 | 94% | 13 | 92% | 8 |
| **Virginia** | 102% | 19 | 108% | 3 | 85% | 12 |
| **Washington** | 99% | 29 | 96% | 11 | 86% | 11 |
| **West Virginia** | 95% | 37 | 82% | 37 | 68% | 28 |
| **Wisconsin** | 99% | 29 | 89% | 22 | 101% | 2 |
| **Wyoming** | 106% | 7 | 88% | 27 | 75% | 20 |
| **Average** | **99%** | | **85%** | | **65%** | |

**Source & Notes:**

https://www.cdc.gov/vaccines/programs/iis/annual-report-iisar/2019-data.html

"* City-based IIS participation rates are reported separately from their respective states; state rates do not include city data in their values."

1) Hawaii and New Hampshire had no data for any category and were deleted.

Iowa Administrative Code Currentness
Agency 641 Public Health Department
Chapter 56 Brain Injury Services Program (Refs & Annos)

Iowa Admin. Code 641-56.4(135)

# 641-56.4(135) Cost-share component.

Persons determined ineligible for the brain injury services waiver, due to fiscal or functional criteria, or persons who are eligible for the waiver but for whom funding was not authorized or available to provide waiver eligibility are eligible for the cost-share component of the brain injury services program.

**56.4(1)** An individual must meet all of the following requirements:

*a.* The individual is aged one month through 64 years.

*b.* The individual has a diagnosed brain injury as defined in Iowa Code section 135.22.

*c.* The individual is a resident of Iowa and either a United States citizen or a qualified alien as defined in 8 U.S.C. Section 1641.

*d.* The individual must meet the cost-share component's financial eligibility requirements and be willing to pay a cost share for the cost-share component.

**56.4(2)** Cost-share financial eligibility. Countable income shall be used when determining initial and ongoing eligibility for the program. All of the following criteria must be met.

*a.* Individuals who are at 300 percent or below the federal poverty level for a family of the same size will not be assessed a cost share.

*b.* Individuals whose countable income is between 301 percent and 350 percent of the federal poverty level for a family of the same size will be assessed a 10 percent cost share for services that will be payable to the service provider.

*c.* Individuals whose countable income is between 351 percent and 400 percent of the federal poverty level for a family of the same size will be assessed a 20 percent cost share for services that will be payable to the service provider.

*d.* Individuals whose countable income is above 400 percent of the federal poverty level for a family of the same size will be assessed a 30 percent cost share for services that will be payable to the service provider.

**56.4(3)** The cost-share component must be the source of last resort for payment; the program shall not pay for services when the provision of those services is mandated by law or administrative rule to be the responsibility of another governmental unit, private agency or program. Brain injury cost-share services are not available to an individual who receives services or funding under any type of medical assistance home- and community-based services waiver.

These rules are intended to implement Iowa Code section 135.22B.

[Filed emergency 5/9/07—published 6/6/07, effective 5/9/07]

[Filed 7/13/07, Notice 6/6/07—published 8/1/07, effective 9/5/07]

Current through January 12, 2021.

Iowa Admin. Code 641-56.4(135), IA ADC 641-56.4(135)

**End of Document**

# GRAIDs:

## *Guidelines, Recommendations, Adaptations, Including Disability*

## *What are the GRAIDs?*

A tool and framework used to adapt evidence-based health promotion programs to be inclusive of people with disabilities. The GRAIDs are broken down by potential changes in 5 inclusion domains.

**Inclusion Domains:** A common set of items used to ensure participation by individuals with disabilities in an existing health promotion program or strategy. The five inclusion domains are: Built Environment, Services, Instruction, Equipment & Technology, and Policy.

**Built Environment:** Structural features.

a. Examples include: ramps, signage, clear paths/sidewalks, curb cuts, hard floor surfaces, park play equipment, adequate temperature and lighting.

**Service:** Person-to-person assistance or other assistance that increases participation.

a. Examples: providing transportation, a personal shopping aide for a person with a disability, a peer assistant in a physical activity program, and inclusive advertisement or communication.

**Instruction:** (Training & Education) Technique(s) used to enhance learning for the staff within an organization or for the individual with a disability and their family members or caregivers.

a. Examples: webinars, lunch and learns, in-service trainings, seminars

**Equipment & Technology:** Products or tools used to promote and allow for participation.

a. Examples: sports-related products, utensils, automatic sliding doors, bus lifts, communication devices.

**Policy:** Laws, regulations, rules, protocols, and procedures designed to guide or influence behavior. Policies can be either legislative or organizational in nature.

# GRAIDs:

## *Guidelines, Recommendations, Adaptations, Including Disability*

## *Two ways to use the GRAIDs:*

**1**

GRAIDs as a tool:

Apply existing nutrition and physical activity recommendations and adaptations.

a. Use the existing recommendations and adaptations to make inclusive changes to a program
b. Adapt recommendations and adaptations to fit the needs of your program or service
c. These recommendations and adaptations can be found at www.new.reduceobesity.org

**2**

GRAIDs as a Framework:

Adapt programs and services using the five inclusion domains.

a. Apply each of the five domains to the program or service to ensure it is inclusive of people with disabilities
b. Identify strategies that address areas that are not inclusive of people with disabilities
c. Implement inclusive changes to your program or service

## *Remember:*

**1**

Conduct assessments (e.g., Community Health Inclusion Index) to identify where there are gaps in disability inclusion or accessibility then use the GRAIDs tool and/or framework to identify solutions.

**2**

Include people with disabilities in the process when adapting your program and services.

**From:** Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>
**Sent:** Wednesday, April 1, 2020 1:56 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Karmen Hanson <karmen.hanson@ncsl.org>; Tahra Johnson <Tahra.Johnson@ncsl.org>
**Subject:** RE: information request help by the end of March please

Good Afternoon Russell,

I apologize for my delayed response; I was out of the office sick yesterday. Attached you will find a memo as it relates to your question, *deterring youth vaping utilization*.

While we can't determine if any of these policies are the most effective for deterring youth utilization at this time, the memo contains the most common forms of legislative action we have tracked so far in this session and last session. We anticipate learning more about these actions and their effectiveness over the coming months and years and would be more than happy to follow-up with you in the future.

In addition to this memo, we have seen a number of PSAs from the CDC and state health departments (e.g. AZ and MN) and that may also be worth looking into.

Please let us know if you have any additional questions at this time.

Thank you for reaching out to NCSL.

Best,

**Tammy Jo Musgraves**
National Conference of State Legislatures
Policy Specialist, Health Program
303.856.1459 (o)


**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Tuesday, March 17, 2020 8:07 AM
**To:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Cc:** Stacy Householder <Stacy.Householder@ncsl.org>; Doug Farquhar <doug.farquhar@ncsl.org>; Karmen Hanson <karmen.hanson@ncsl.org>; Erik Skinner <Erik.Skinner@ncsl.org>; Charlie Severance-Medaris <charlie.severance@ncsl.org>; Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>; Noah Cruz <noah.cruz@ncsl.org>; Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** [EXTERNAL] RE: information request help by the end of March please

Many email work fine for the requested responses. Thanks for your help.

**From:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Sent:** Monday, March 16, 2020 5:00 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Stacy Householder <Stacy.Householder@ncsl.org>; Doug Farquhar <doug.farquhar@ncsl.org>; Karmen Hanson <karmen.hanson@ncsl.org>; Erik Skinner <Erik.Skinner@ncsl.org>; Charlie Severance-Medaris <charlie.severance@ncsl.org>; Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>; Noah Cruz <noah.cruz@ncsl.org>; Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** RE: information request help by the end of March please

Hi Russell,

I hope you are staying well! Stacy passed your research request along. We have a variety of staff that work on these issues and splitting up the research. Please note, you'll receive responses from the policy experts by the end of the month, as they are answered. If you prefer to get it all at once on March 30th, we can do that too.

Best,

Tahra

**Tahra Johnson, MPH**
National Conference of State Legislatures
Program Director, Public Health and Maternal & Child Health
303.856.1389 (o) | 720.447.3775 (m)


**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Monday, March 16, 2020 10:14 AM
**To:** Stacy Householder <Stacy.Householder@ncsl.org>
**Subject:** [EXTERNAL] information request help by the end of March please

Hi Stacy,

Utah does an annual accountable base budget review process. Could NCSL help provide answers to the questions below by the end of March please? Since I am a financial analyst, my starting perspective is from the budget angle.

1) Disease Control and Prevention questions
    a. Clinical and Environmental Lab Certification Programs

i. Are there any states that are well know for having really effective lab certification programs? If yes, then what specific actions are they taking?
ii. Utah annually charges for chemistry and/or microbiology private laboratories a $1,000 certification fee for in-state labs and $3,000 plus travel expenses for out-of-state labs, how does this compare to Utah's neighboring states (Idaho, Wyoming, Colorado, Nevada, Arizona and New Mexico)?

b. Epidemiology
   i. Are any states/localities known for having a really effective response to disease outbreaks and controlling other disease (HIV/AIDS, sexually transmitted disease, hepatitis, etc.)? If yes, then what are those entities doing?
   ii. Which states have the most effective immunization registry system (to know who has already received which immunizations)? What are those states doing?
      1. Do any states use alternative funding sources to fund their systems? If yes, then what states, what funding source, and what percentage of the total cost is funded with alternative sources?

c. Health Promotion
   i. Which states have the lowest rates of premature death and disability? What interventions are those states using to achieve those results?
   ii. Have any states implemented effective interventions to lower the youth utilization rate of electronic cigarettes?
   iii. What strategies to reduce opioid overuse are other states successfully using that Utah is not?

d. Utah Public Health Laboratory
   i. Do any states rely exclusively on private labs for certain public health laboratory testing functions? If yes, then which states for which functions and why?
      1. Do any states have a process to determine whether the public vs private labs should be providing certain tests?
   ii. Do any other states have their lab technicians primarily testify in court cases via technology? If yes, then what changes were made to achieve that?

e. Office of the Medical Examiner
   i. Are any states/localities known for having a really effective medical examiner system? If yes, then what are those entities doing?

2) Medical cannabis
   a. Which states are recognized as having a well-run medical cannabis program and what specific things are they doing to be successful?
3) Vaccine commodities
   a. Which states are recognized for having the most successful federally-funded Vaccines for Children Program? What specific things are those states doing to be successful?
4) Spinal Cord and Brain Injury Rehabilitation Fund & Traumatic Brain Injury Fund

a. What are the most effective approaches for individuals who need more therapy services than are provided by their insurance to restore as many functions as possible after a traumatic event?

Thanks for your time and help.

Russell Frandsen
Finance Officer
Office of the Legislative Fiscal Analyst
State of Utah
Phone 801-538-1034
Fax 801-538-1692
rfrandsen@le.utah.gov
http://budget.utah.gov/

**From:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Sent:** Thursday, April 2, 2020 2:43 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** RE: information request help by the end of March please

Good Afternoon Russell,

I hope you are healthy and well. By now you should have received answers to all of your questions from our staff, except the ones below related to laboratories. My colleague Doug Farquhar compiled these resources with APHL and shared the information with me. He recently left NCSL for a new job, so if you have questions, please let me know and we'll do our best to get you answers.

Question: Clinical and Environmental Lab Certification Programs. Are there any states that are well known for having really effective lab certification programs? If yes, then what specific actions are they taking?

**Clinical laboratory certification: The UT PHL is a CLIA-certified laboratory and the Utah Department of Health contracts with the federal government inspecting clinical laboratories within the state. Facilities performing any testing of human samples for the purpose of assessing a condition or diagnosing an illness are considered a laboratory and are subject to these regulations. This is the most common situation across the states.**

**Two states have their own certification programs, Washington and New York state:**
**https://www.wadsworth.org/regulatory/clep**
**https://ecology.wa.gov/Regulations-Permits/Permits-certifications/Laboratory-Accreditation**
**The rest of the state public health labs rely on the Federal laboratory certification program, CLIA: https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA**

**Environmental Laboratory Accreditation: Utah is one of fourteen states recognized by the National Environmental Laboratory Accreditation Program (NELAP) as a primary accrediting authority; the purpose of NELAP is to establish and implement a program for the accreditation of environmental laboratories. Environmental Laboratories in Utah requesting certification must complete an application with the state, participate in proficiency testing programs, and meet state laboratory standards.**
**https://nelac-institute.org/index.php**

**The Association of Public Health Laboratories (APHL) urges states to continue designating state laboratories as their principal drinking water laboratory under the Safe Drinking Water Act, "The purpose of governmental laboratories is to provide services to protect public health and safety."**
**https://www.aphl.org/policy/Position_Documents/Final_State%20PHL%20should%20be%20Principal%20Water%20Lab.pdf**

Questions: Utah Public Health Laboratory. Do any states rely exclusively on private labs for certain public health laboratory testing functions? If yes, then which states for which functions and why? Do any states have a process to determine whether the public vs private labs should be providing certain tests?

**Here are some links that help explain the unique role and function of public health laboratories.**

**https://www.aphl.org/aboutAPHL/Pages/aboutphls.aspx**
https://www.cdc.gov/training/publichealth101/documents/introduction-to-public-health-laboratories.pdf
**https://www.aphl.org/policy/Position_Documents/Final_State%20PHL%20should%20be%20Principal%20Water%20Lab.pdf**
**APHL created two videos that will be helpful, titled What is a public health laboratory? And What is environmental testing?**

Question: Do any other states have their lab technicians primarily testify in court cases via technology? If yes, then what changes were made to achieve that?

***Melendez-Diaz v. Massachusetts*, 557 U.S. 305 (2009), is a United States Supreme Court case in which the Court held that it was a violation of the Sixth Amendment right of confrontation for a prosecutor to submit a chemical drug test report without the testimony of the person who performed the test.**

Please let me know if you haven't received answers to any of your additional questions yet.

Best,

Tahra

**Tahra Johnson, MPH**
National Conference of State Legislatures
Program Director, Public Health and Maternal & Child Health
303.856.1389 (o) | 720.447.3775 (m)

**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Tuesday, March 17, 2020 8:07 AM
**To:** Tahra Johnson <Tahra.Johnson@ncsl.org>
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Medaris <charlie.severance@ncsl.org>; Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>; Noah Cruz <noah.cruz@ncsl.org>; Matt Schmidt <matt.schmidt@ncsl.org>
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National Conference of State Legislatures
Program Director, Public Health and Maternal & Child Health
303.856.1389 (o) | 720.447.3775 (m)

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**Sent:** Monday, March 16, 2020 10:14 AM
**To:** Stacy Householder <Stacy.Householder@ncsl.org>
**Subject:** [EXTERNAL] information request help by the end of March please

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        ii. Utah annually charges for chemistry and/or microbiology private laboratories a $1,000 certification fee for in-state labs and $3,000 plus travel expenses for out-of-state labs, how does this compare to Utah's neighboring states (Idaho, Wyoming, Colorado, Nevada, Arizona and New Mexico)?
    b. Epidemiology

i. Are any states/localities known for having a really effective response to disease outbreaks and controlling other disease (HIV/AIDS, sexually transmitted disease, hepatitis, etc.)? If yes, then what are those entities doing?
ii. Which states have the most effective immunization registry system (to know who has already received which immunizations)? What are those states doing?
    1. Do any states use alternative funding sources to fund their systems? If yes, then what states, what funding source, and what percentage of the total cost is funded with alternative sources?

c. Health Promotion
    i. Which states have the lowest rates of premature death and disability? What interventions are those states using to achieve those results?
    ii. Have any states implemented effective interventions to lower the youth utilization rate of electronic cigarettes?
    iii. What strategies to reduce opioid overuse are other states successfully using that Utah is not?
d. Utah Public Health Laboratory
    i. Do any states rely exclusively on private labs for certain public health laboratory testing functions? If yes, then which states for which functions and why?
        1. Do any states have a process to determine whether the public vs private labs should be providing certain tests?
    ii. Do any other states have their lab technicians primarily testify in court cases via technology? If yes, then what changes were made to achieve that?
e. Office of the Medical Examiner
    i. Are any states/localities known for having a really effective medical examiner system? If yes, then what are those entities doing?

2) Medical cannabis
    a. Which states are recognized as having a well-run medical cannabis program and what specific things are they doing to be successful?
3) Vaccine commodities
    a. Which states are recognized for having the most successful federally-funded Vaccines for Children Program? What specific things are those states doing to be successful?
4) Spinal Cord and Brain Injury Rehabilitation Fund & Traumatic Brain Injury Fund
    a. What are the most effective approaches for individuals who need more therapy services than are provided by their insurance to restore as many functions as possible after a traumatic event?

Thanks for your time and help.

Russell Frandsen
Finance Officer

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To: Russell Frandsen
Finance Officer
Office of Legislative and Fiscal Analysis
State of Utah

From: Erik Skinner
NCSL Health Program
Erik.Skinner@ncsl.org
(303) 856-1461

Date: 3/31/2020

Subject: Immunization Information Systems and Child Vaccine Coverage

Dear Mr. Frandsen,

Thank you for reaching out to NCSL for information about immunization information systems (IIS) and child vaccination programs.

1. Which states have the most effective immunization registry system (to know who has already received which immunizations)? What are those states doing?

I reached out to the American Immunization Registries Association (AIRA) for some insight on this question. They suggested starting with this CDC resource on IIS Functional Standards. They noted that they don't think of IISs as more or less effective, but rather whether an individual IIS is achieving what it was designed to do. To that end, the "General Considerations", "Programmatic Goals" and "Functional Standards by Program Goal" may be helpful for states evaluating their IIS.

CDC also has an annual report that each state/jurisdiction completes and is centered around answering how well a system has implemented the functional standards. All states are expected to adhere to the functional standards, but there is variability. AIRA also has a Measurement and Improvement initiative that independently assesses some functionality, but not all components. The results are listed on the AIRA website. They also wanted to note that functionality is only a piece of the puzzle. What generally creates a good system are the policies that support the use of the system coupled with provider recruitment and data use. You can have the best system but if no one is using it, it won't work. An example of a policy that supports good data capture is data sharing between vital records and an IIS for births and deaths. This helps populate an IIS with population-level information.

2. Vaccine commodities
    a. Which states are recognized for having the most successful federally-funded Vaccines for Children Program? What specific things are those states doing to be successful?

For this question, I reached out to the Association of Immunization Managers (AIM). They said it would be difficult to say what would make one VFC program more successful than another. Every state meets the requirements of the VFC, some have additional requirements that go above and beyond. For example, some states require providers in the VFC program to report all doses administered in the immunization information system (IIS). Every state requires providers to use digital data loggers to monitor temperatures in refrigerators storing vaccines, but some states require the data loggers to electronically report temps to the state. Some states require providers to pay for vaccine that is wasted. Some states complete the minimum number of provider site visits (50% of providers annually), some do more. But this may not make one program more successful than another.

Some states have more provider density so that they can require more without as much worry that providers will drop out. Other states have areas, especially rural areas, where they need providers. States like Texas are trying to recruit providers.

Similar to AIRA, AIM also noted the importance of provider participation. They highlighted requiring VFC providers to report to IIS as an important component. Some states have legislation requiring providers to report to IIS, but states without that can at least require VFC providers to report statistics.

**Reporting Requirements**

The common theme from both organizations was that participation and reporting are crucial to the functions of tracking and administering vaccines. It is important to note that many states make these requirements through the Board of Health and administrative rules. For example, Colorado Board of Health rule 6 CCR 1009-2 requires most schools and licensed child care facilities to report aggregate immunization and exemption data to the Colorado Department of Public Health and Environment annually. The CDC Survey of State Immunization Information System Legislation allows you to explore state policies and requirements.

This study from the Journal of Public Health Management and Practice provides analysis of state laws related to IIS, including reporting requirements.



I hope this information is helpful. Please do not hesitate to reach out if you have any further questions or clarification.

Best regards,

Erik Skinner, MPH
Policy Associate
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National Conference of State Legislatures
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To: Russell Frandsen, Product Manager, Utah
Clare Lence, Fiscal Analyst, Utah
Maddy Oritt, Fiscal Analyst, Utah

From: Samantha Scotti
Policy Specialist, NCSL Health Program
Sam.Scotti@NCSL.org
303.856.1440

Date: January 18, 2019

Subject: sexually transmitted disease

## Lowering the rates of gonorrhea - strategies successfully used?  Funding sources?

### Screening Programs

Many men and women with gonorrhea are asymptomatic. This means that without testing, asymptomatic individuals could pass the disease to new partners without even knowing their partners were at risk. The CDC specifically recommends that all sexually active women under age 25 undergo gonorrhea screening at least once a year. In one health plan, after introduction of a new performance measure focused on screening young women for chlamydia, screening of eligible women increased from 55% in 1998–99 to 72% in 2000–01.

### Access to Confidential STD Services

Because many new cases of gonorrhea and other STDs are found among young adults and adolescents who may remain on their parents' insurance plans, confidentiality of screening and treatment records remains a concern to public health officials. Studies have shown that adolescents and young adults may avoid or delay seeking healthcare for sensitive services to ensure that their illness remains private. Although the Health Insurance Portability and Accountability Act and other laws provide guidelines for confidential care to minors, providers may not be aware of these provisions. Physician assurances of confidentiality increase young adults and adolescents' willingness to disclose sensitive health information, but these assurances are rarely given.

### Expedited Partner Therapy

Expedited Partner Therapy (EPT) is a strategy that relies on patients to deliver treatment to partners who may also be infected. Research has demonstrated that this strategy is effective at reducing reinfection. A frequently encountered barrier to implementing EPT is concern from health care providers regarding the legality of the practice, including

privacy concerns and liability concerns for providers that prescribe and provide treatment without physical examination. Research has demonstrated that supportive policies alleviating these concerns is correlated with increased use of EPT.

### CDC's Community Approaches to Reducing Sexually Transmitted Diseases (CARS)

The CDC's Community Approaches to Reducing Sexually Transmitted Diseases (CARS) project is designed to use community engagement methods to build the capacity of communities around STD prevention. Approaches taken by awardees included opening STD screening and clinical resource centers in at-risk communities, conducting testing via mobile units in communities facing high rates of STD prevalence and offering advancement opportunities including job readiness trainings, GED and SAT prep classes. Early successes in the program include increased screening rates in low-income communities and an increased sense among community stakeholders that their voices were being listened to by policy makers.

## Other Resources

### CDC Gonorrhea Resources

The CDC maintains a landing page of gonorrhea resources including resources for individuals, physicians and policy makers.

### CDC Screening Recommendations

The CDC provides guidelines for who should be screened for STDs and how often.

### Strengthening STD Prevention and Control for Health Departments

This competitive award opportunity provides funding for health departments to strengthen STD prevention and control programs for chlamydia, gonorrhea, and syphilis. The opportunity supports strategies and activities to: eliminate congenital syphilis; prevent antibiotic resistant gonorrhea; reduce primary and secondary syphilis; prevent STD-related pelvic inflammatory disease, ectopic pregnancy, and infertility; address STD-related outbreaks; and reduce STD-related health disparities.

### Gonococcal Isolate Surveillance Project (GISP)

Antibiotic resistance (AR) is the ability of bacteria to resist the effects of all of the drugs used to treat them. This means the germs are not killed and they will continue to reproduce. *Neisseria gonorrhoeae*, the bacterium that causes the sexually-transmitted disease gonorrhea, has developed resistance to nearly all of the antibiotics used for gonorrhea treatment. The Gonococcal Isolate Surveillance Project (GISP) was established in 1986 to monitor AR trends in *N. gonorrhoeae* bacteria in the United States. GISP is a collaborative project among selected STD clinics and their state or local public health authorities, GISP regional laboratories, and CDC. Public health officials and healthcare providers use the data collected in GISP to ensure that gonorrhea is successfully treated with the right antibiotic.

### CDC Effective Interventions Toolkit

CDC's Division of STD Prevention and partners published evidence for the effectiveness of various STD control interventions for today's STD program staff. In a time with fewer resources and more prevention options than ever before, this information offers a menu of options to help programs identify which interventions best meet their needs.

### Healthy People 2020 Database of Evidenced-Based Interventions and Resources

The Healthy People 2020 database includes only programs with high quality evidence evaluating their effectiveness.

### Sexually Transmitted Disease Surveillance Utah 2007-2016

A comprehensive look at the rates of gonorrhea transmission and other STDs in Utah.

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To: Russell Frandsen
Utah Office of the Legislative Fiscal Analyst
Finance Officer
rfrandsen@le.utah.gov

From: Matt Schmidt
National Conference of State Legislatures
Health Program Intern
Matt.schmidt@ncsl.org

Date: March 31, 2020

Subject: State Medical Examiner Systems

Dear Russell,

Thank you for contacting NCSL. Below, you will find information on death investigation systems, including state examples for each. While we are unable to measure the overall effectiveness of any one state's medical examiner system, we do know states differ in the organization of these systems and the qualifications required to perform death investigations. There are resources at the end of this memo that share advantages and disadvantages of the medical examiner systems in states.

We hope you find this information useful, please do not hesitate to reach out with any further inquiries.

**Background**

Death investigation systems, medical examiners and coroners, are defined individually by state statutes. Statute determines which entity delivers death investigation services for each state. Medical examiners are, by definition, board-certified in a medical specialty. They are appointed to a position in a state medical examiner system and are often forensic pathologists. Coroners are often elected laypeople. States with coroner systems do not typically specify a degree or specialty requirement. According to the Center for Disease Control and Prevention (CDC), 16 states have a centralized medical examiner system. Other states have a county/district-based coroner or medical examiner.

**Central administration of state medical examiners**

Central administration, currently in 16 states, creates a uniformed system for reporting deaths. A chief medical examiner oversees all death investigations in these states and supervises any county, district, or local medical examiner. Centralization and oversight foster technology and best practices to be shared among experts in the state.

State examples

Virginia

§ 32.1-277 of the Virginia Code establishes the Office of the Chief Medical Examiner in the Virginia Department of Health. The chief medical examiner supervises each district office of medical examiners in the state. Each

district office is required to have adequate professional, technical, and medical personnel including a county medical examiner.

Utah

§ 26-4-4 of the Utah code requires the appointment of a chief medical examiner. This appointee must be a forensic pathologist certified by the American Board of Pathologists. The position of county medical examiner may be created by each county executive and legislative authority and is overseen by the chief medical examiner.

**County/district medical examiner systems**

Some states have county or district medical examiners that perform death investigations without oversight from a chief medical examiner. County and district medical examiners are required to be pathologists. Currently, six states have county/district-based medical examiners without a central authority.

State example

Arizona

§ 11-592 of the Arizona Revised Statutes permits the county board of supervisors to appoint a forensic pathologist as the county medical examiner. If the board of supervisors disagree on an appointment of a medical examiner, the board must designate one or more alternate medical examiners that do not need to be residents of the county. In this case, alternate medical examiners are notified of a death investigation by the county sheriff and are required to perform the investigation thereafter.

**County/district coroner systems**

A decentralized system of county or district coroners currently exists in 14 states. In this system, there is typically no central medical examiner or coroner and unlike medical examiners, coroners are not always required to hold medical licensure or degrees to perform autopsies.

State examples

Colorado

§ 30-10-601 of the Colorado Revised Statutes summarizes the qualifications and duties of coroners in Colorado and creates the Colorado Coroners Standards and Training Board (C.C.S.T.) in the Colorado Department of Public Health and Environment. County coroners are required to hold a high school diploma and receive approval and curriculum from the C.C.S.T.

South Carolina

§ 17-5-5 of the South Carolina Code requires each county to have a qualified coroner elected. The qualifications include a high school diploma and relevant experience in death investigations or education in a related field. In addition, a county with a population of over 100,000 residents may, if deemed necessary by county authority, form a medical examiner commission. This commission must employ at least one forensic pathologist. In counties with both coroners and medical examiners, coroners have responsibility for carrying out the duties of death investigation.

**Additional Resources**

The CDC Coroner/Medical Examiner Laws by State is an interactive map that provides a state profile for each state, including laws related to death investigation.

The National Academies of Science, Institute of Medicine: Comparing Medical Examiner and Coroner Systems. The US Department of Justice's National Institute of Justice asked the Institute of Medicine to conduct a workshop that would

examine the interface of the medicolegal death investigation system and the criminal justice system. This chapter of the workshop outlines the advantages and disadvantages of the medical examiner system used in states.

***Please note: NCSL links to outside organizations and websites for information purposes only. Links to outside content do not indicate support from NCSL.***

Again, I hope you find this information useful. Please feel free to contact NCSL with any follow-up questions related to medical examiner systems.

Matt

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**From:** Karmen Hanson <karmen.hanson@ncsl.org>
**Sent:** Wednesday, March 25, 2020 7:20 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** RE: Medical marijuana request

Hi Russell!

I haven't forgotten about you! I've been digging through multiple resources for a solid way to "recommend" a way for you to analyze the UT medical MJ program compared to others. As you know, it's tough to find someone out there that "grades" programs without an advocacy slant of some sort.

One source of "grades" for MMJ programs is from Americans for Safe Access, which is a pro-medical marijuana access advocacy group. So take their evals with a grain of salt, but you WILL see the way that they score programs, which included a wide variety of regulations and controls. Not much with a fiscal angle, but you will at least see what THEY are looking for in a "good" program, which is the patient experience.
https://american-safe-access.s3.amazonaws.com/sos2019/sos19web.pdf

This journal article from 2016 also tries to compare medical programs as of 2015. Doesn't necessarily rank them, but again, you'll see some interesting comparisons.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4845727/

An analysis of the Washington D.C. medical program by UCLA:
https://luskin.ucla.edu/sites/default/files/5%20-%20Marijuana%20Washington%20DC_0.pdf

Another way to think about areas included in "comprehensive" regulations include Colorado's medical regulation sections. It may not look the same in each state, or sections may be missing, but CO is highly regulated compared to some other medical programs. It MAY be because of our adult-use implementation showed some differences between medical and adult-use programs, so everything was fine-tuned to be roughly the same as far as packaging requirements, etc…
Here are the CO medical statutes. You can click this or look up C.R.S. 25-1.5-106
OR… this link should work, too.
https://advance.lexis.com/documentpage/?pdmfid=1000516&crid=915fd5f7-69c8-486f-8949-388051781e86&nodeid=AAZAABAACAABAAG&nodepath=%2FROOT%2FAAZ%2FAAZAAB%2FAAZAABAAC%2FAAZAABAACAAB%2FAAZAABAACAABAAG&level=5&haschildren=&populated=false&title=25-1.5-106.+Medical+marijuana+program+-+powers+and+duties+of+state+health+agency+-+rules+-+medical+review+board+-+medical+marijuana+program+cash+fund+-+subaccount+-+created+-+%22Ethan%27s+Law%22+-+definitions+-+repeal&config=014FJAAyNGJkY2Y4Zi1mNjgyLTRkN2YtYmE4OS03NTYzNzYzOTg0OGEKAFBvZENhdGFsb2d592qv2Kywlf8caKqYROP5&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A5XPN-KFB1-JP9P-G0BK-00008-00&ecomp=t58_9kk&prid=5939ddcd-3dd2-4d14-a331-91f99edab0ee

My only other idea is a fiscal note example from Nebraska's medical marijuana program bill.
https://nebraskalegislature.gov/FloorDocs/106/PDF/FN/LB110_20190125-081503.pdf

I really hope these work for you. If not, I can dig up more fiscal notes for recent bills to establish new programs or go back to fiscal notes from states similar to Utah and see what they require and costs associated with them.

Let me know what you think and I'll be on it!
Thanks, Russell! Stay safe!
KARMEN

**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Tuesday, March 17, 2020 8:06 AM
**To:** Karmen Hanson <karmen.hanson@ncsl.org>
**Subject:** [EXTERNAL] RE: Medical marijuana request

Hi Karmen,

Greetings from one of many Utah legislative staffers scattered throughout the State working from home! The first one about effective regulatory systems for medical cannabis in other states would be best. We are just getting our medical cannabis program operational and my office is being asked to review it for performance and finances. Thanks.

Russell Frandsen
Finance Officer
Office of the Legislative Fiscal Analyst
State of Utah
Phone 801-538-1034
Fax 801-538-1692
rfrandsen@le.utah.gov
http://budget.utah.gov/

**From:** Karmen Hanson <karmen.hanson@ncsl.org>
**Sent:** Monday, March 16, 2020 5:46 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** Medical marijuana request

Hi Russell!
Howdy from the teleworking NCSL office!
I have your question re: "well run medical cannabis programs" and that's a bit of a value judgment. If you mean they run as intended, provides access to what patients need/want, relatively more regulation, I can probably find some examples for you.
If you want a model of something that might work well in Utah, given the local climate and existing medical (low-THC) program, I can send other examples. It's a little tough to judge programs, since NCSL doesn't do that, but I can look for overall "well-regulated" programs.
Which do you think works best? Either one or combo of both?
Thanks-
KARMEN

**Karmen Hanson, MA**
National Conference of State Legislatures
Program Director-Behavioral Health & Pharmaceuticals
North Dakota Legislative Assembly Liaison
karmen.hanson@ncsl.org
303.856.1423 (o)

**From:** Matt Schmidt <matt.schmidt@ncsl.org>
**Sent:** Tuesday, March 31, 2020 11:46 AM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Tahra Johnson <Tahra.Johnson@ncsl.org>; Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>; Kate Bradford <kate.bradford@ncsl.org>
**Subject:** Re: [EXTERNAL] RE: information request help by the end of March please

Hi again Russell,

Thank you for your question related to premature death in the United States. Below you will find resources that explore premature death and injury prevention in each state.

> According to the Centers for Disease Control and Prevention (CDC), premature death is defined as the measure of potential years of life lost (YPLL) due to death occurring before the age of 75 years. Deaths at younger ages contribute more to the premature death rate than deaths occurring closer to age 75. For example, a person dying at age 70 would lose five years of potential life, whereas a child dying at age five would lose 70 years of potential life. The CDC's Years of Potential Life Lost (YPLL) Report (1981-2018) identifies cancer, unintentional injury, heart disease, suicide, perinatal death and homicide as the leading causes of premature death. Several of these causes of death are considered preventable through programs addressing smoking cessation, mental health, promoting healthy behaviors, and many others.
>
> America's Health Rankings by the United Health Foundation uses CDC mortality data to determine the cause of death and age of the deceased. Years of potential life lost (YPLL) per 100,000 can be determined for each state which provides a measure of premature death. Additionally, America's Health Rankings explores public health funding for each state, including an estimation of how many state and federal dollars are allocated to public health per person. For example, Hawaii ranks in the top 10 of both measures. Hawaii is a state with one of the lowest rates of premature death and ranks third among the states for state dollars and federal funds dedicated to public health per person. This resource may help identify premature death statistics in each state in the context of funding they receive.
>
> **Additional Resources**
> The CDC provides funding to states through the State Violence and Injury Prevention Program (SVIPP). This webpage provides information on states receiving awards for such programs.
>
> NCSL Blog relating to state information on premature death

We hope that this information is useful. Please feel free to reach out with further questions or clarification.

Best,
Matt

Matt Schmidt
National Conference of State Legislatures

Health Program Intern
Matt.schmidt@ncsl.org

**From:** Matt Schmidt <matt.schmidt@ncsl.org>
**Date:** Tuesday, March 31, 2020 at 10:04 AM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Kate Bradford <kate.bradford@ncsl.org>, Tahra Johnson <Tahra.Johnson@ncsl.org>, Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>
**Subject:** RE: [EXTERNAL] RE: information request help by the end of March please

Hi Russell,

Thank you for reach out to NCSL with your question regarding medical examiner systems in the United States. In the attached memo, you will find an overview of death investigation systems that states use in addition to resources comparing the effectiveness of them.

Please do not hesitate to reach out with any further questions.

Matt

Matt Schmidt
National Conference of State Legislatures
Health Program Intern
Matt.schmidt@ncsl.org

**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Date:** Tuesday, March 17, 2020 at 8:07 AM
**To:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Cc:** Stacy Householder <Stacy.Householder@ncsl.org>, Doug Farquhar <doug.farquhar@ncsl.org>, Karmen Hanson <karmen.hanson@ncsl.org>, Erik Skinner <Erik.Skinner@ncsl.org>, Charlie Severance-Medaris <charlie.severance@ncsl.org>, Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>, Noah Cruz <noah.cruz@ncsl.org>, Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** [EXTERNAL] RE: information request help by the end of March please

Many email work fine for the requested responses. Thanks for your help.

**From:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Sent:** Monday, March 16, 2020 5:00 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Stacy Householder <Stacy.Householder@ncsl.org>; Doug Farquhar <doug.farquhar@ncsl.org>;

Karmen Hanson <karmen.hanson@ncsl.org>; Erik Skinner <Erik.Skinner@ncsl.org>; Charlie Severance-Medaris <charlie.severance@ncsl.org>; Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>; Noah Cruz <noah.cruz@ncsl.org>; Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** RE: information request help by the end of March please

Hi Russell,

I hope you are staying well! Stacy passed your research request along. We have a variety of staff that work on these issues and splitting up the research. Please note, you'll receive responses from the policy experts by the end of the month, as they are answered. If you prefer to get it all at once on March 30th, we can do that too.

Best,

Tahra

**Tahra Johnson, MPH**
National Conference of State Legislatures
Program Director, Public Health and Maternal & Child Health
303.856.1389 (o) | 720.447.3775 (m)

**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Monday, March 16, 2020 10:14 AM
**To:** Stacy Householder <Stacy.Householder@ncsl.org>
**Subject:** [EXTERNAL] information request help by the end of March please

Hi Stacy,

Utah does an annual accountable base budget review process. Could NCSL help provide answers to the questions below by the end of March please? Since I am a financial analyst, my starting perspective is from the budget angle.

1) Disease Control and Prevention questions
    a. Clinical and Environmental Lab Certification Programs
        i. Are there any states that are well know for having really effective lab certification programs? If yes, then what specific actions are they taking?
        ii. Utah annually charges for chemistry and/or microbiology private laboratories a $1,000 certification fee for in-state labs and $3,000 plus travel expenses for out-of-state labs, how does this compare to Utah's neighboring states (Idaho, Wyoming, Colorado, Nevada, Arizona and New Mexico)?

b. Epidemiology
    i. Are any states/localities known for having a really effective response to disease outbreaks and controlling other disease (HIV/AIDS, sexually transmitted disease, hepatitis, etc.)? If yes, then what are those entities doing?
    ii. Which states have the most effective immunization registry system (to know who has already received which immunizations)? What are those states doing?
        1. Do any states use alternative funding sources to fund their systems? If yes, then what states, what funding source, and what percentage of the total cost is funded with alternative sources?
c. Health Promotion
    i. Which states have the lowest rates of premature death and disability? What interventions are those states using to achieve those results?
    ii. Have any states implemented effective interventions to lower the youth utilization rate of electronic cigarettes?
    iii. What strategies to reduce opioid overuse are other states successfully using that Utah is not?
d. Utah Public Health Laboratory
    i. Do any states rely exclusively on private labs for certain public health laboratory testing functions? If yes, then which states for which functions and why?
        1. Do any states have a process to determine whether the public vs private labs should be providing certain tests?
    ii. Do any other states have their lab technicians primarily testify in court cases via technology? If yes, then what changes were made to achieve that?
e. Office of the Medical Examiner
    i. Are any states/localities known for having a really effective medical examiner system? If yes, then what are those entities doing?

2) Medical cannabis
    a. Which states are recognized as having a well-run medical cannabis program and what specific things are they doing to be successful?
3) Vaccine commodities
    a. Which states are recognized for having the most successful federally-funded Vaccines for Children Program? What specific things are those states doing to be successful?
4) Spinal Cord and Brain Injury Rehabilitation Fund & Traumatic Brain Injury Fund
    a. What are the most effective approaches for individuals who need more therapy services than are provided by their insurance to restore as many functions as possible after a traumatic event?

Thanks for your time and help.

Russell Frandsen

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**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Date:** Tuesday, March 17, 2020 at 8:07 AM
**To:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Cc:** Stacy Householder <Stacy.Householder@ncsl.org>, Doug Farquhar <doug.farquhar@ncsl.org>, Karmen Hanson <karmen.hanson@ncsl.org>, Erik Skinner <Erik.Skinner@ncsl.org>, Charlie Severance-Medaris <charlie.severance@ncsl.org>, Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>, Noah Cruz <noah.cruz@ncsl.org>, Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** [EXTERNAL] RE: information request help by the end of March please

Many email work fine for the requested responses. Thanks for your help.

**From:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Sent:** Monday, March 16, 2020 5:00 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Stacy Householder <Stacy.Householder@ncsl.org>; Doug Farquhar <doug.farquhar@ncsl.org>; Karmen Hanson <karmen.hanson@ncsl.org>; Erik Skinner <Erik.Skinner@ncsl.org>; Charlie Severance-Medaris <charlie.severance@ncsl.org>; Tammy Jo Musgraves <tammyjo.musgraves@ncsl.org>; Noah Cruz <noah.cruz@ncsl.org>; Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** RE: information request help by the end of March please

Hi Russell,

I hope you are staying well! Stacy passed your research request along. We have a variety of staff that work on these issues and splitting up the research. Please note, you'll receive responses from the policy

experts by the end of the month, as they are answered. If you prefer to get it all at once on March 30th, we can do that too.

Best,

Tahra

**Tahra Johnson, MPH**
National Conference of State Legislatures
Program Director, Public Health and Maternal & Child Health
303.856.1389 (o) | 720.447.3775 (m)

**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Monday, March 16, 2020 10:14 AM
**To:** Stacy Householder <Stacy.Householder@ncsl.org>
**Subject:** [EXTERNAL] information request help by the end of March please

Hi Stacy,

Utah does an annual accountable base budget review process. Could NCSL help provide answers to the questions below by the end of March please? Since I am a financial analyst, my starting perspective is from the budget angle.

1) Disease Control and Prevention questions
    a. Clinical and Environmental Lab Certification Programs
        i. Are there any states that are well know for having really effective lab certification programs? If yes, then what specific actions are they taking?
        ii. Utah annually charges for chemistry and/or microbiology private laboratories a $1,000 certification fee for in-state labs and $3,000 plus travel expenses for out-of-state labs, how does this compare to Utah's neighboring states (Idaho, Wyoming, Colorado, Nevada, Arizona and New Mexico)?
    b. Epidemiology
        i. Are any states/localities known for having a really effective response to disease outbreaks and controlling other disease (HIV/AIDS, sexually transmitted disease, hepatitis, etc.)? If yes, then what are those entities doing?
        ii. Which states have the most effective immunization registry system (to know who has already received which immunizations)? What are those states doing?

1. Do any states use alternative funding sources to fund their systems? If yes, then what states, what funding source, and what percentage of the total cost is funded with alternative sources?

c. Health Promotion
   i. Which states have the lowest rates of premature death and disability? What interventions are those states using to achieve those results?
   ii. Have any states implemented effective interventions to lower the youth utilization rate of electronic cigarettes?
   iii. What strategies to reduce opioid overuse are other states successfully using that Utah is not?

d. Utah Public Health Laboratory
   i. Do any states rely exclusively on private labs for certain public health laboratory testing functions? If yes, then which states for which functions and why?
      1. Do any states have a process to determine whether the public vs private labs should be providing certain tests?
   ii. Do any other states have their lab technicians primarily testify in court cases via technology? If yes, then what changes were made to achieve that?

e. Office of the Medical Examiner
   i. Are any states/localities known for having a really effective medical examiner system? If yes, then what are those entities doing?

2) Medical cannabis
   a. Which states are recognized as having a well-run medical cannabis program and what specific things are they doing to be successful?

3) Vaccine commodities
   a. Which states are recognized for having the most successful federally-funded Vaccines for Children Program? What specific things are those states doing to be successful?

4) Spinal Cord and Brain Injury Rehabilitation Fund & Traumatic Brain Injury Fund
   a. What are the most effective approaches for individuals who need more therapy services than are provided by their insurance to restore as many functions as possible after a traumatic event?

Thanks for your time and help.

Russell Frandsen
Finance Officer
Office of the Legislative Fiscal Analyst
State of Utah
Phone 801-538-1034
Fax 801-538-1692
rfrandsen@le.utah.gov
http://budget.utah.gov/

## Disclaimer

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To: Russell Frandsen
Finance Officer, Office of the Legislative Fiscal Agent
rfrandsen@le.utah.gov

From: Tammy Jo Musgraves, MPP
Policy Specialist, Health Program
TammyJo.Musgraves@ncsl.org

Date: March 31, 2020

Subject: Reducing Youth Utilization of Vaping Products

Dear Russell Frandsen,

Thank you for reaching out to NCSL. Below are resources addressing the challenges related to youth vaping. At this time, state legislatures have introduced several bills regarding,

- Taxation of electronic nicotine devices
- Increasing the retail price of these products
- Reducing or banning online and telephonic sales to youth
- Updates to policies and regulatory language to define electronic nicotine devices as a tobacco product; allowing states to regulate products within their Tobacco Control Departments; and
- Amendments to existing regulations for compliance with the **federal purchasing age**.

With this, some states have or are considering banning the sale of online and telephonic sales to reduce the amount of potential retailers within their states and changing the type of retail license requirements needed to operate within their states.

Below you will find several examples of these different approaches. We anticipate the regulation of electronic nicotine devices to be a continued area of interest for states throughout this session. We would recommend following the NCSL Alternative Nicotine Products **webpage** for the latest updates.

We hope the included information is useful. Please do not hesitate to reach out if you have other questions or would like additional research.

Warm regards,

Tammy Jo

***Please note: NCSL links to outside organizations and websites for information purposes only. Links to outside content do not indicate support from NCSL.***

**General Resources: Taxation and Online and Telephonic Sales**

- **The National Law Review**
  - **What will "heighted" online-age verification look like? FDA forthcoming online age verification requirements for vapor products may mirror California rules.**
  - FDA would seek to limit the sale of flavored e-cigarettes (excluding tobacco, mint and menthol flavored products) to
    (1) brick-and-mortar retailers that permit entry only to adults (18+), or that have a walled-off adult-only section where flavored products can be viewed and purchased; and
    (2) in online stores that implement soon-to-be-announced "heightened" age-verification measures.
  - Enforcement of **California's STAKE Act**
    - Through warning letters from the state Department of Justice and legal action
      - Warning letter reminds recipients, "Section 22963 [the STAKE Act] provides for civil penalties of up to $2,000 for the first violation of its requirements, $3,500 for the second violation, $5,000 for the third violation, $6,500 for the fourth violation, and $10,000 for each subsequent violation in a five-year period."
- **Federal Drug Administration**
  **Enforcement Priorities for Electronic Nicotine Delivery Systems (ENDS) and Other Deemed Products on the Market Without Premarket Authorization**
  - Describes how the FDA intends to prioritize enforcement resources with regard to the marketing of certain deemed tobacco products that do not have premarket authorization.
    - For ENDS products marketed without FDA authorization, FDA intends to prioritize enforcement against:
      - Any flavored, cartridge-based ENDS product (other than a tobacco- or menthol-flavored ENDS product);
      - All other ENDS products for which the manufacturer has failed to take (or is failing to take) adequate measures to prevent minors' access; and
      - Any ENDS product that is targeted to minors or whose marketing is likely to promote use of ENDS by minors.3

  **Vaporizers, E-Cigarettes and other Electronic Nicotine Delivery Systems (ENDS)**
  - Last updated in January 2020, the FDA provides updates to their regulations, including manufacturing, advertising and warnings on packages.
    - **Federal manufacture requirements**
    - **Federal advertisements and warning on package requirements**
  - FDA does have a **list of all the entities it contracts** with to do FDA age-checks throughout the country These age checks are not enforcement checks, they are Synar compliance checks where an underage person makes a purchase attempt and violations get logged for a state's compliance numbers
- **The Public Health and Law Center**
  **U.S. E-Cigarette Regulations – 50 State Review (2019)**
  - Provides a 50-state review of definitions of tobacco product, **taxation**, **product packaging**, youth access/other retail restrictions, licensure and smoke-free legislation.
  - **Online E-Cigarette Sales and Shipment to Consumers, State Laws Prohibiting Them**
  - Age in which **Youth Access to E-Cigarettes** by state
  - **States and Tribes Stepping in to Protect Youth from the Dangers of E-Cigarettes: Actions and Options**
    - Last updated February 4, 2020
    - 10 states and 7 tribes reacted with bans and additional regulation

- **NCSL** **E-Cigarette & Vaping Product Taxes**

- **Centers for Disease Control and Prevention**
  **E-Cigarette Ads and Youth**
  - Vital signs information page of the CDC. This page provides overview information, the problem states and communities are facing, infographics, recommendations and issue details.

**State Examples – General Session 2019**

- **Alabama** 2019, **Act No. 2019-233** legislation requiring vape shops to have a tobacco permit; prohibits advertising vape and other alternate nicotine products as cessation devices or healthy alternatives to smoking and, among other provisions; and requires the Alcoholic Beverage Control Board to regulate e-cigarettes and vape products." Effective August 1, 2019.
- **Arkansas** 2019, **2019 HB 1763** Transformation and Efficiencies Act, among other things, this act mandates copies of all invoices for the purchase or sale of any tobacco products, vapor products, alternative nicotine products, or e-liquid products shall be retained by each manufacturer, wholesaler, vendor, and retailer for a period of three (3) years subject to examination by the Secretary of the Department of Finance and Administration and the Director of Arkansas Tobacco Control or their authorized agents upon demand at any time during regular business hours.
- **Maine** 2019, **2019 SB 364** Provides that a person is guilty of endangering the welfare of a child if the person knowingly sells, furnishes, gives away or offers to sell, furnish or give away a tobacco product to a child under a specific age. Adds the definition of electronic smoking device, "means a device used to deliver nicotine or any other substance intended for human consumption that may be used by a person to simulate smoking through inhalation of vapor or aerosol from the device, including, without limitation, a device manufactured, distributed, marketed or sold as an electronic cigarette, electronic cigar, electronic pipe, electronic hookah or so-called vape pen. "Electronic smoking device" includes any component, part or accessory of such a device, whether or not sold separately, and includes any substance intended to be aerosolized or vaporized during the use of the device. "Electronic smoking device" does not include drugs, devices or combination products authorized for sale by the United States Food and Drug Administration, as those terms are defined in the Federal Food, Drug, and Cosmetic Act" and expands the definition of tobacco or cigar to be an all encompassing term, "tobacco product."
- **Michigan** 2019, **2019 SB 155** "A person shall not sell in this state a liquid nicotine container unless the liquid nicotine container meets the child-resistant effectiveness standards of 16 CFR 1700.15(b). Liquid nicotine" means a liquid or other substance containing nicotine in any concentration that is sold, marketed, or intended for use in a noncombustible product that employs a heating element, power source, electronic circuit, or other electronic, chemical, or mechanical means, regardless of shape or size, that can be used to produce vapor from nicotine or any other substance, and the use or inhalation of which simulates smoking. Liquid nicotine container" means a bottle or other container holding liquid nicotine in any concentration but does not include a cartridge containing liquid nicotine if the cartridge is prefilled and sealed by the manufacturer of the cartridge and is not intended to be opened by the consumer. A person who sells vapor products or alternative nicotine products at retail shall not display for sale in this state a vapor product unless the vapor product is stored for sale behind a counter in an area accessible only to employees or within a locked case.
    - **2019 SB 106** Prohibits the selling, giving, or furnishing of tobacco products, vapor products, and alternative nicotine products to minors; prohibits the purchase, possession, or use of tobacco products, vapor products, and alternative nicotine products by minors; regulates the retail sale of tobacco products, vapor products, alternative nicotine products, and liquid nicotine containers.
- **Virginia** 2019, **2019 SB 263** An Act relating to public health; requiring that certain vapor products and alternative nicotine products be taxed and regulated as other tobacco products; revising provisions related to the areas in which smoking is prohibited; revising provisions pertaining to the sale or distribution of cigarettes, cigarette paper, tobacco, products made or derived from tobacco, vapor products and alternative nicotine products to persons under the age of 18 years; providing penalties; making appropriations; and providing other matters properly relating thereto.
- **Vermont** 2019, **2019 HB 6** An act relating to restricting retail and Internet sales of electronic cigarettes, liquid **nicotine,** and tobacco paraphernalia in Vermont. No person shall engage in the retail sale of tobacco products, tobacco substitutes, substances containing **nicotine** or otherwise intended for use with a tobacco substitute, or tobacco paraphernalia in the State unless the person is a licensed wholesale dealer

**From:** Michael Hartman <michael.hartman@ncsl.org>
**Sent:** Tuesday, April 20, 2021 12:45 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** RE: information request help by the end of March please

Hello Mr. Frandsen,

My name is Michael Hartman, and I am part of the Civil & Criminal Justice program here at NCSL. I was forwarded your information request below. The case mentioned below specifically deals with whether lab analysts' certificates of analysis fell within the protections afforded by the confrontation clause. Justice Scalia confirmed that analyst reports were within the scope of the confrontation clause.

It is important to note that the Supreme Court has not decided to blanket allow/ban remote testimony – even when it is analysts' certificates of analysis (or other lab report). They elaborate on the strength of the confrontation clause test in *Coy v. Iowa*, 108 S.Ct. 2798 (1988) where Justice Scalia held that: (1) confrontation clause provides criminal defendant right to "confront" face-to-face witnesses giving evidence against him at trial, and (2) placement of screen between defendant and child sexual assault victims during testimony against defendant violated defendant's confrontation clause rights. In contrast, in *Maryland v. Craig*, 497 U.S. 836, 837 (1990), the court decided Maryland's interest in protecting child witnesses from the trauma of testifying in a child abuse case is sufficiently important to justify the use of its special procedure, provided that the State makes an adequate showing of necessity in an individual case.

For a lot more information – especially in relation to the confrontation clause and current events – I would recommend the University of North Carolina's Covid-19 and Remote Testimony in Criminal Trials piece written December 2020.

In the early 2000's there was a movement to have the Federal Rules of Criminal Procedure mirror the remote witness language that is currently in the Federal Rules of Civil Procedure 43(a). These failed and the proposed rule 26(b) was never enacted. See here for more information.

Within the guidance of the Supreme Court, states (primarily through judicial discretion) may take the approach that they see fit. For example, in *Harrell v. State*, 709 So.2d 1364 (1998), the Florida Supreme court held as a matter of first impression that the admission of trial testimony through the use of a live satellite transmission when a witness resides in a foreign country and is unable to appear in court does not violate the federal or state Confrontation Clauses.

I hope this information is helpful. Please reach out with any follow-questions you might have.

Best Regards,
Michael Hartman

**From:** Russell Frandsen <rfrandsen@le.utah.gov>
**Sent:** Friday, April 16, 2021 7:32 AM
**To:** Tahra Johnson <Tahra.Johnson@ncsl.org>
**Cc:** Matt Schmidt <matt.schmidt@ncsl.org>
**Subject:** [EXTERNAL] RE: information request help by the end of March please

Hi Tahra,

Good morning from Utah! With your comment below, is the Supreme Court not allowing/counting remote testimony by lab technicians as right of confrontation? Have any states found a way to allow for remote participation by lab technicians in court cases? Anything that you could provide by the end of April would be most helpful. Thanks for your time.

Question: Do any other states have their lab technicians primarily testify in court cases via technology? If yes, then what changes were made to achieve that?

> ***Melendez-Diaz v. Massachusetts*, 557 U.S. 305 (2009), is a United States Supreme Court case in which the Court held that it was a violation of the Sixth Amendment right of confrontation for a prosecutor to submit a chemical drug test report without the testimony of the person who performed the test.**

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**Robin Vos**
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Wisconsin
President, NCSL

**Martha R. Wigton**
Director
House Budget & Research Office
Georgia
Staff Chair, NCSL

**Tim Storey**
Executive Director

To: Russell Frandsen
Finance Officer, Office of the Legislative Fiscal Analyst
State of Utah

From: Samantha Scotti and Emily Blanford
National Conference of State Legislatures

Date: March 30, 2020

Subject: State approaches to providing spinal cord injury and TBI services

Dear Russell:

Thanks for reaching out with your question on state approaches to providing spinal cord injury and TBI services. While we can't identify one approach as the most effective approach, in this memo, we have included background information on how states provide these services as well as some state examples. Please don't hesitate to let us know if you'd like additional information.

**Background:**

According to the National Association of State Head Injury Administrators (NASHIA):

*Beginning in the 1980s, States began responding to families calling for services and assistance to address the unique cognitive and behavioral needs of individuals with traumatic brain injury (TBI). Often, these individuals found that their insurance coverage was insufficient to cover the array of short-term and long-term rehabilitation care and community supports. States began developing infrastructure and capacity for addressing these complex, unique needs associated with TBI-related disabilities. States use a combination of funding streams to support an array of services, including State revenue, dedicated funding (trust fund), usually from traffic fines, Vocational Rehabilitation, federal grants, and Medicaid.*

This resource categorizes the state programs in three groups (based off funding sources): states with trust fund program/dedicated funding only, states using Medicaid HCBS Waiver Program or 1115 Demonstration Program only, and states that use a combination of those two sources. While the map categorizing the states is from 2015, it provides a helpful overview of how states fund these services.

**Trust Fund Programs:**

According to NASHIA as of 2015,

*Twenty-three (23) States have enacted legislation designating funding, usually associated with traffic fines and/or surcharges to vehicle registration and motor vehicle licenses, for an array of programs and services for individuals with TBI and their families. The revenue is usually collected by county clerks and forwarded to the State treasurer to be placed in a non-reverting account. The legislation designates a State agency to administer the funds. Most States established an advisory body to provide input and oversee the fund. There is variability with regard to the amount generated and how the funds are used. States may use funding to support a registry; public education and awareness; prevention; rehabilitation; case management or service coordination; family education; and an array of rehabilitation and community services and supports.*

**State Examples:**

- Georgia Section 15-21-148. Creation of the Brain and Spinal Injury Trust Fund creates the Brain and Spinal Injury Trust Fund as a separate fund in the state treasury. It states the commission may authorize the disbursement of available money from the trust fund, after appropriation thereof, for purposes of providing care and rehabilitative services to citizens of the state who have survived neurotrauma with head or spinal cord injuries, to a person, entity, or program eligible pursuant to criteria to be set by such commission.
- Virginia Section 51.5-179. Commonwealth Neurotrauma Initiative Trust Fund established states that for the purpose of preventing traumatic spinal cord or brain injuries and improving the treatment and care of Virginians with traumatic spinal cord or brain injuries, there is hereby created in the state treasury a special nonreverting fund to be known as the Commonwealth Neurotrauma Initiative Trust Fund.

**Medicaid Programs:**

Some Medicaid programs offer some sort of complementary or integrative health services like chiropractic, massage therapy or acupuncture services. At least 25 states use waivers, in particular Home and Community-Based Services (HCBS) waivers, to provide services designed uniquely for individuals with spinal cord injury and brain injury. This NASHIA report outlines services offered in HCBS waivers for individuals with brain injury, by state.

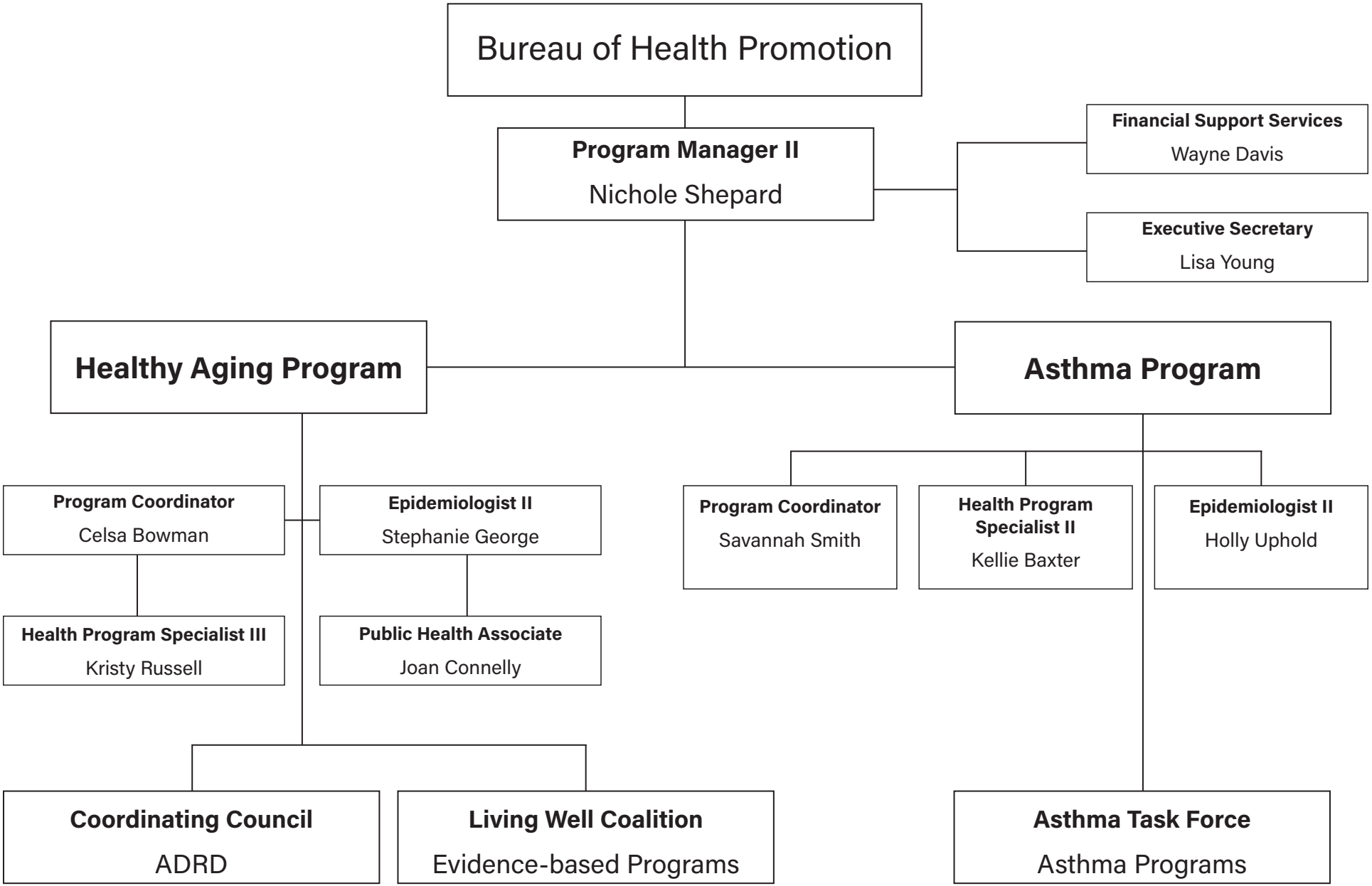
This report, from the Steadman Group completed in 2017 for Colorado's Medicaid agency, summarizes much of the evidence available regarding the cost-effectiveness of complementary and integrated services for spinal cord injury. From this report, it appears that the evidence regarding the cost-effectiveness of complementary or integrative services is limited:

*A health care intervention is cost effective when it achieves the desired health impact and costs less than other treatments. If a therapy costs less but does not achieve the desired end, it is not cost effective. The efficacy of complementary and integrative therapies has not yet been established for the type of pain management needed for persons with SCI, so it is not possible to conclusively state that these therapies are cost effective (page 15).*

This report, completed by National Research Center, Inc. for Colorado's Medicaid agency, specifically evaluates the costs of services provided in Colorado's HCBS waiver serving individuals with spinal cord injury. The report concludes that the waiver services may decrease, but do not increase, overall expenditures in the Medicaid program.

This report, from Bailit Health, discusses other state examples providing Medicaid waiver services to treat both brain injury and spinal cord injury. This report does not have much information regarding cost-effectiveness, but includes additional details regarding the design of programs in Florida, South Carolina and Mississippi.

UTAH DEPARTMENT OF HEALTH
Healthy Aging Program



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May 7, 2021

**To:** Russell Frandsen, finance officer
Office of the Legislative Fiscal Analyst
State of Utah
rfrandsen@le.utah.gov

**From:** Erik Skinner
NCSL Health Program
Erik.Skinner@ncsl.org
(303) 856-1461



**Subject:** Public Health Laboratory Funding and Priorities

Dear Mr. Frandsen:

Thank you for reaching out to NCSL with your question about public health laboratory funding and priorities.

1. What significant non-General Fund, non-federal fund sources do other states use to fund their public health laboratory operations? I would also exclude traditional fees charged to users for laboratory testing (unless the fees are creative or charged on a non-traditional source/user) from this request.

The Association of Public Health Laboratories (APHL) collects NBS funding/fee information in the NewSTEPs State Profiles. We have pulled that data in the excel document which includes information for all states (+ DC, PR, Guam) on Newborn Screening Funding Source, Fee Collection Methods, Fee Holding Location, Initial Screen Fee, Repeat Screen Fee (where applicable), Second Screen Fee (where applicable) and Fee related notes. As a caveat, the newborn screening fee is not necessarily representative of the cost incurred to the program for performing the screening, and varies greatly by state. Some programs, for example Kansas, charge no fee for newborn screening to the family/hospital and as such, all costs incurred to the laboratory (including instrument procurement/maintenance) for performing the screening are received from a special, dedicated NBS fund within the health department.

The 2019 Annual Report linked here also sheds some light on the public health laboratory

newborn screening programs' funding sources, specifically on pp. 9-10 (stratified by NBS fees, General Funds, Title V funds, Insurance, State NBS funds, Grants, Federal funds, Special Revenue Accounts, Agency Funds).

2. Could you provide some state public health laboratory examples and how financially stable the lab is as well as funding by source type for a state that has (1) not created any/many requirements for users to get a specific service from the public health lab and (2) have many monopolies for the public health laboratory for certain tests?

The attached excel document (fee information from the NewSTEPs State and Profiles) and the NewSTEPs State Profiles provide state examples of public health laboratory fees. APHL declined to comment on the fiscal health of each program and NCSL has not found information that analyzes fiscal health of public health laboratories.

Explain RUSP?

3. Do any states have a good system for paying for regular equipment replacement for their public health labs?

The Competency Guidelines for Public Health Laboratory Professionals: CDC and the Association of Public Health Laboratories provides guidance for equipment selection, maintenance, installation and trouble shooting. Quality Management System 6.00 (QMS 6.00) covers equipment considerations and includes a table (Table 1). The guidelines were developed by CDC, APHL and state and local public health lab directors.

On the clinical side, many states obtain licensure for their state laboratories through the Clinical Laboratory Improve Act. §493.1252 covers test systems, equipment, instruments, etc.

Of the state reports on public health laboratories, we did not find information about equipment replacement. Here are reports from Minnesota and Florida, for reference.

*Please note that NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.*

Thank you!

Sincerely,

**Erik Skinner**
National Conference of State Legislatures
Health Program
erik.skinner@ncsl.org

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May 7, 2021

**To:** Russell Frandsen, Financial Officer, Office of the Legislative Fiscal Analyst, Utah
**From:** NCSL Health Program
**Subject:** Public Health and Public Service Programs



Dear Russell,

Thank you for reaching out to NCSL with your questions around health. Several NCSL staff answered your question and I compiled them into one memo for ease. Please contact the subject matter expert identified by each section if you have further questions. *Please note that this may not be a comprehensive list. Please also note that NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL endorse any third-party publications; resources are cited for informational purposes only.*

**Question: Have any states successfully implemented a give back/work requirement/cost sharing with any clients for any public service program besides Medicaid?**

*Contacts:*
*Charlie Severance-Medaris, policy specialist, Charlie.severance@ncsl.org, Ryan White*
*Emily Blanford, program principal, Emily.blandford@ncsl.org, Medicaid, TBI and SCI*
*Erik Skinner, policy associate, erik.skinner@ncsl.org, WIC and SNAP*
*Karmen Hanson, program director, Karmen.hanson@ncsl.org, Cancer*
*Tammy Jo Hill, policy specialist, tammyjo.hill@ncsl.org, Tobacco Cessation*

**Cancer**

Karmen did not find any type of client give-back/payback requirement for any cancer-related screenings under Medicaid. The national breast and cervical cancer screening program is funded by the CDC through providers in all 50 states and provides access to screening and treatment through Medicaid for anyone qualified through the program. Karmen's read of that means CDC is reimbursing Medicaid for the costs. Similarly, the National Colorectal Cancer Control Screening Program provided screening for a limited number of people who qualify- reimbursed by CDC.

According to our contact at the American Cancer Society and NCSL's research, some states are looking at requiring cost-share, volunteer hours, work, etc. for Medicaid expansion, but none currently do for any cancer-related screenings or treatment.

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**Ryan White Program**

Charlie did not find any states that have work requirements as part of their Ryan White programs. Eligibility is determined by three things 1) proof of HIV status 2) income as a percentage of the federal poverty rate 3) proof of residence. States have their own flexibility to set income limits (it's 250% in Utah and 400% in Fulton County, GA, for instance).

Under federal law, Ryan White has to be the payer of last resort. This means that potential clients are required by states to provide proof that they are enrolled in other assistance programs (like Medicaid) or have applied for these programs to receive assistance from the Ryan White program. This means that states can set eligibility requirements around work requirements in other programs, like Medicaid, that would impact eligibility for Ryan White. For instance, in Utah already, clients who are Medicaid eligible through spend down requirements who do not pay that spend down cannot be eligible for Ryan White.

In effect, even though we were unable to identify any states that have employment eligibility criteria explicitly for Ryan White, a state can deny an application for Ryan White if the applicant is eligible for other forms of assistance but chooses not to participate.

**SNAP**

SNAP Work Requirements – There are work requirements for certain individuals. For people 16-59 that are able to work, which include registering for work, participating in SNAP Employment and Training (E&T) or workfare (if assigned by state SNAP agency), taking a suitable job if offered and avoiding reducing work hours to below 30 hours a week without a good reason. There are separate work requirements for able bodied adults without dependents.

Colorado Employment First – This is the E&T program for Colorado's SNAP program and provides guidance on eligibility criteria and employment services that can help enrollees fulfill their work requirement.

Minnesota SNAP E&T Guide – This guide provides a high-level overview of the roles and responsibilities of participants, primary and secondary providers, and the state for work requirements in the E&T program.

Tennessee SNAP E&T Program Manual – The stated purpose of the E&T program is:

To assist participants in finding a career that pays a self-sustaining wage and allows SNAP recipients to become totally independent of government assistance. The Food and Nutrition Act requires all states to provide employment and/or training opportunities for individuals receiving SNAP. In Tennessee SNAP E&T is operated as a joint partnership between the Department of Human Services (TDHS) and the Department of Labor and Workforce Development (TDLWD) through a grant from United States Department of Agriculture (USDA).

Texas Supplemental Nutrition Assistance Program Employment and Training Guide – The Texas training guide provides comprehensive policy background, explanation and application related to their SNAP program's E&T requirement. Texas started a new E&T program that incorporates the activities from the 2014 Farm Bill Pilots that the Federal Nutrition Service determined to have the most demonstrable impact on an individual's ability to find and retain employment, and that lead to increased household income and reduced reliance on public assistance.

**Tobacco Cessation**

As for your inquiry of "client give back/work requirements," related to tobacco cessation programs or policies, this is not something we see legislative branch or executive agencies enforcing at this time. However, Tammy Jo provided a few general resources related to incentive programs to quit smoking and a snapshot of state legislative trends we have seen this year related to tobacco cessation.

***General Resources***

- Baby and Me Tobacco Free is an evidence based smoking cessation program created to reduce the burden of tobacco on the pregnant and postpartum population. The program currently operates in 19 states and offers diaper vouchers to women who participate in the cessation counseling sessions and receive education and support to quit smoking.
- The Commonwealth Fund studied What Happened When GE Paid Employees to Quit Smoking? This article will provide background related to the study and incentive mechanisms the company employed.
    - Lessons learned include:
        - Sufficient incentives can help encourage smokers to quit.
        - Incentives can save employers money.
        - Timing is critical, the incentive should be long enough to

encourage behavior change.
        - Incentives aren't sufficient on their own, other approaches may consider cultural changes and specific medication or other interventions to support quitting.
- Medi-Cal Incentives to Quit Smoking, led by California's Medicaid program, conducted a program from 2011-2015 to encourage Medicaid recipients to quit smoking. Much like the findings from general electric, the state reported mixed reviews.
    - Lessons learned include:
        - The target population should be a major focus of state tobacco control efforts.
        - There is no magic bullet to reduce smoking levels. Thus, it is important to apply both policy and clinical interventions.
        - Although the results of individual policy and clinical interventions may be relatively modest, each contributes to driving down smoking rates and saving lives.

For a look at what states are discussing this year, we have tracked approximately 127 bills across 30 states related to smoking cessation so far. Of these 127, nine have been enacted, generally relating to budget appropriations. However, we have provided two program related bills below and one bill related to increasing community awareness of cardiovascular disease and its causes.

**Arizona** SB 1170 enacted April 2021, updated prescribing authority for pharmacies related to tobacco cessation drug therapies.

- 32-1979.03. Tobacco cessation drug therapies; prescription authority; requirements; definition

**Mississippi** SB 2799 enacted April 2021, relates to updates of the state Medicaid program.

- *(43) The division shall provide reimbursement, according to a payment schedule developed by the division, for smoking cessation medications for pregnant women during their pregnancy and other Medicaid-eligible women who are of child-bearing age.*

**Wisconsin** JR 6 enacted February 2021, proclaims February 2021 to be the American Heart Month in Wisconsin.

- In an effort to decrease cardiovascular disease the state encourages community collaboration, increased awareness and education with health care providers to discuss the risk of smoking and smoking cessation, among other heart disease related causes.

**Traumatic Brain Injury and Spinal Cord Injury Programs**

Emily Blanford found an example in Iowa where they have a program for TBI with cost sharing requirements. The program is for people who cannot enroll in the Medicaid HCBS waiver for some reason (the HCBS waiver has no cost sharing requirements) and cost sharing for this program is defined in the regulations. **You can find this document attached to the email.** We did not find state Medicaid waivers that included cost sharing or "give back" requirements for TBI or SCI.

**WIC-** We did not identify any policies in the WIC program with work requirements or give backs.

We hope this information is useful. If you have follow-up questions, please do not hesitate to reach out to the team.

Thank you!

Sincerely,

Tahra Johnson
Program Director, Public Health and Maternal & Child Health
Tahra.Johnson@ncsl.org
303.856.1389 (o) or 720.447.3775 (m)

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

April 26, 2021

**To**: Russell Frandsen, Finance Officer, Office of the Legislative Fiscal Agent
**From**: Tammy Jo Hill
**Subject**: Reducing Youth Utilization of Tobacco and Vaping Products_Update



Dear Russell Frandsen,

Thank you for following-up with NCSL. As a reminder, the 2019 legislative themes related to youth prevention and cessation included,

- Taxation of electronic nicotine devices
- Increasing the retail price of these products
- Reducing or banning online and telephonic sales to youth
- Updates to policies and regulatory language to define electronic nicotine devices as a tobacco product; allowing states to regulate products within their Tobacco Control Departments; and
- Amendments to existing regulations for compliance with the **federal purchasing age.**

While many states shifted priorities and legislative agendas due to the onset of COVID-19 at the beginning of 2020 we were able to identify almost 400 bills related to tobacco and e-cigarettes during the 2020 and 2021 general session so far. About half of these bills related to or mentioned youth in some way.

Twelve different state examples can be found below, but some common legislative themes also include,

- Public health campaigns and educational campaigns aimed at youth prevention and cessation
- Regulating advertising and labeling of e-liquids or vape products to people under 21 years of age
- Updating state regulations to comply with the federal purchasing age of 21
- Regulating wholesale and distributor laws; including compliance with premarket applications
- Banning the retail sale of flavored nicotine products including liquid and e-liquid
- Regulating the potency levels of nicotine in vape products

We have also provided a few new additional resources related to youth prevention and cessation.

We hope the included information is useful. Please do not hesitate to reach out if you have other questions or would like additional research.

Warm regards,
Tammy Jo

***Please note: NCSL links to outside organizations and websites for information purposes only. Links to outside content do not indicate support from NCSL.***

NCSL
NATIONAL CONFERENCE OF STATE LEGISLATURES

**General Resources**

- Rescue, The Change Behavior Agency
  - Help government agencies and nonprofits create campaigns that drive health behavior change through research and strategy, media, community engagement and creative development. They help with health behaviors in areas related to tobacco, opioids, marijuana, nutrition, alcohol and sexual health.
  - Teen Vaping Prevention Resource Library

- **Federal Drug Administration**
  FDA's Youth Tobacco Prevention Plan
  - Preventing youth access, curbing marketing of tobacco products aimed at youth and educating teens about the dangers of using tobacco products including e-cigarettes.

  Vaporizers, E-Cigarettes and other Electronic Nicotine Delivery Systems (ENDS)
  - Last updated in September 2020, the FDA provides updates to their regulations, including manufacturing, advertising and warnings on packages.
    - Federal manufacture requirements
    - Federal advertisements and warning on package requirements
  - FDA does have a list of all the entities it contracts with to do FDA age-checks throughout the country These age checks are not enforcement checks, they are Synar compliance checks where an underage person makes a purchase attempt and violations get logged for a state's compliance numbers

- **The Public Health and Law Center**
  U.S. E-Cigarette Regulations – 50 State Review (2021)
  - Provides a 50-state review of definitions of tobacco product, taxation, product packaging, youth access/other retail restrictions, licensure and smoke-free legislation.

- **Centers for Disease Control and Prevention**
  Youth Tobacco Prevention
  - Links to data, infographics, reports and other resources.

  E-Cigarette Ads and Youth
  - Vital signs information page of the CDC. This page provides overview information, the problem states and communities are facing, infographics, recommendations and issue details.

NATIONAL CONFERENCE OF STATE LEGISLATURES

**2020-2021 Legislative Action**

**California**,

- SB 487 Pending, 2021
  - Among other things, *104370. The committee shall be advisory to the department, the University of California, and State Department of Education for the following purposes:*
  - *(a) Evaluation of research, school- and community-based programs funded under this article as necessary in order to assess the overall effectiveness of efforts made by the programs to reduce the use of tobacco products. In order to evaluate tobacco education, research, and cessation programs, the committee shall seek the cooperation and assistance of the department, the State Department of Education, county offices of education, local lead agencies, administrative representatives, target populations, school officials, and researchers. A principal measurement of effectiveness shall be reduction of smoking rates among a given target population. population, including reduction of electronic cigarette use among school age youth.*
- SB 683 Pending, 2021
  - The bill would require California Health and Human Services Agency, in collaboration with the departments under its purview and other specified entities, to develop and implement a plan, as specified, that establishes targets to reduce racial disparities in health outcomes by 50% by December 31, 2030, in chronic conditions affecting children, including, but not limited to, asthma, diabetes, dental caries, depression, and vaping-related diseases. The bill would require the agency to submit the plan to the Legislature and post the plan on its internet website on or before January 1, 2023, and to commence implementation of the plan no later than June 30, 2023. The bill also makes related findings and declarations.
- AB 46 Pending, 2021
  - Creates the California Youth Empowerment Act to address, among other issues, the growing need to engage youth directly with policymakers. Establishes the California Youth Empowerment Commission in state government consisting of 25 voting commissioners between 14 and 25 years of age and meeting specified requirements. Establishes the commission to be advisory in nature, for the main purpose of providing meaningful opportunities for civic engagement to improve the quality of life for disadvantaged youth.
  - The group will advise and make recommendations to the Legislature, Superintendent of Public Instruction and the Governor on specific legislative and fiscal issues effecting youth, including but not limited to substance abuse and vaping.

**Hawaii**,

- SB 63 Pending, 2021
  - The legislature has determined that comprehensive regulatory action on tobacco products in Hawaii is necessary to reduce tobacco-related health disparities and end the youth vaping epidemic.
    - *Accordingly, the purpose of this Act is to:*

*(1) Make unlawful the sale of flavored tobacco products, mislabeling of e-liquid products containing nicotine, and sale of tobacco products other than through retail sales via in-person exchange;*
*(2) Include e-liquid and electronic smoking devices in the definition of "tobacco products" for purposes of the cigarette tax and tobacco tax law;*
*(3) Increase the license fee for wholesalers and dealers of tobacco products and retail tobacco permit fee;*
*(4) Require retailers to pay an additional excise tax on the gross receipts from the retail sale of electronic smoking devices on and after July 1, 2021;*
*(5) Direct a certain percentage of moneys received from the cigarette tax and tobacco tax to the Hawaii tobacco prevention and control trust fund to establish and fund a comprehensive youth tobacco cessation program;*
*(6) Repeal the electronic smoking device retailer registration unit; and*
*(7) Repeal provisions relating to delivery of sales under the cigarette tax and tobacco tax law.*

- HR 67 Adopted, 2021
  - Premarket Tobacco Product Application. Requests the United States food and drug administration to promote transparency and enforcement by immediately publishing premarket tobacco product applications.

**Illinois,**

- HB 2579 Pending, 2021
  *reintroduced from 2020 session
  - Would have created the Electronic Cigarette Youth Protection Act. *Providing that a person who sells an electronic cigarette without a proper license under the Tobacco Products Tax Act of 1995 shall be subject to specified additional civil penalties. Prohibits manufacturers, distributors, or retailers of electronic cigarettes from selling, offering for sale, or distributing any electronic cigarette with labeling or packaging intended to be attractive to persons under 21 years of age and provides criteria to determine whether packaging or labeling is attractive to such persons. Requires all labeling and packaging of electronic cigarettes to include nicotine warning statements. Provides that manufacturers, distributors, or retailers of electronic cigarettes shall not sell, advertise, or market an electronic cigarette unless specified conditions have been met. Prohibits: (1) electronic cigarettes from containing more than 25 milligrams per milliliter of nicotine; and (2) vitamin E acetate from being added to a flavored solution or substance intended for use with an electronic cigarette. Prohibits a retailer serving persons under 21 years of age from selling a flavored solution or substance intended for use with an*

*electronic cigarette. Requires a retailer to perform age verification. Provides that failure to comply with the Act's requirements or prohibitions is punishable by a civil penalty. Provides that specified provisions do not apply to any noncommercial speech. Requires moneys collected from civil penalties to be deposited into the Common School Fund. Amends the Prevention of Tobacco Use by Persons under 21 Years of Age and Sale and Distribution of Tobacco Products Act. Provides that no person under 21 years of age shall possess any cigar, cigarette, smokeless tobacco, or tobacco in any of its forms.*

- SB512 Pending, 2021
    - Preventing Youth Vaping Act. Provides that it is unlawful for a person to sell or distribute specified electronic cigarettes and electronic cigarette packaging. Creates advertising and manufacturing requirements while providing civil and criminal penalties. Give the Department of Agriculture, Department of Revenue, Department of Public Health, and State Police equal and joint authority to administer and enforce the Act.

**Minnesota,**

- SB 961 Pending, 2021
    - A bill for an act relating to taxation. This bill proposes Minnesota's COVID-19 recovery budget which would raise revenue for strategic investments in our economy, supporting working families, and combating youth smoking and nicotine addiction. It will modify individual income taxes, estate taxes, corporate franchise taxes, tobacco taxes, sales and use taxes, property taxes, local government aids, special taxes and other miscellaneous taxes and tax provision.

**North Carolina,**

- SB 503 Pending, 2021
    - End the Youth Nicotine Dependence Act or End Act. This Act will create the Tobacco Use Prevention Fund with the department of health and human services, division of public health. This fund will help local health departments through a regional infrastructure to provide community-based education and training of youth leaders, schools, and local agencies regarding Centers for Disease Control and Prevention evidence-based tobacco use prevention and cessation interventions, including interventions addressing e-cigarettes. The Act will also,
        - *For evidence-based media and education campaigns on the health risks of tobacco use, including e-cigarettes.*
        - *To increase military readiness of active-duty military in North Carolina through tobacco use prevention and cessation policy, systems, and environmental change.*
        - *For grants to community colleges to support a healthy, tobacco-free campus.*
        - *To track tobacco use and exposure, including exposure to e-cigarettes and emerging tobacco products, among young people and populations most at risk for tobacco use.*

- *To provide technical assistance and oversight of regional tobacco use prevention programs.*
- *To conduct an independent evaluation of the reach and effectiveness of the State's tobacco use prevention programs.*

**New Jersey,**

- AR 119 Pending, 2020
  - *Urges the enactment of the "Reversing the Youth Tobacco Epidemic Act of 2019" (H.R.2339) in order to address the current youth electronic cigarette epidemic threatening to undermine the progress that has been made in reducing youth cigarette use, and to reduce and prevent youth from using other tobacco products.*

**New York,**

- SB 551 Pending, 2021
  - Standardized Vaping School Guidelines. Requires the commissioner of education and the commissioner of public health to develop standardized vaping and e-cigarette school guidelines to assist school districts when they are developing their own policies.

**South Carolina,**

- HB 3754 Pending, 2021
  - Youth Tobacco Access Prevention. Requires tobacco retailers to obtain a license to sell tobacco products and to establish associated fees and penalties. Would redefine the term tobacco products and requires the state department of revenue to conduct at least two minimum age sales compliance checks annually of tobacco retail establishments. Also includes mandatory public school comprehensive tobacco free campus policy.

**Virginia**,

- HB 30 Enacted, 2020
  - Budget bill. *The Virginia Foundation for Healthy Youth shall prioritize in its marketing and education efforts information regarding the health effects of vaping by teens and young adults. The foundation shall include such information in marketing materials, advertising, outreach, and social media channels.*

**Vermont**,

- SB 24 Pending, 2021
  - Flavored Tobacco Product Ban. *This bill proposes to ban the retail sale of flavored cigarettes, e-cigarettes, and e-liquids. It would eliminate the existing ban on and penalty for possession of cigarettes, e-cigarettes, and tobacco paraphernalia by individuals under 21 years of age and expand the applicability of provisions for the seizure and destruction of contraband tobacco products to include contraband e-cigarettes, e-liquids, and tobacco paraphernalia. The bill would also direct the Office of the Attorney General to report on the extent to which Vermont may legally restrict advertising and regulate labels for e-cigarettes and other vaping-related products.*

**Washington,**

- SB 5366 Pending, 2021
  - Regulation of Products Sold to Adults. Concerning the addictive nature of nicotine and the under regulated nicotine levels in vapor products, this bill intends to ban the sale of flavored vapor products and enact additional regulatory protections to protect the health of youth and young adults in Washington state.
- HB 1550 Pending, 2021
  - Nicotine Addiction. To prevent nicotine addiction with an emphasis on youth and persons under 21 years of age through funding for prevention, cessation and public health services through the taxation of vapor and tobacco products containing nicotine.

**Wisconsin**,

- SB 111 Pending, 2021
  - State Budge Act. Includes,
    - *Section 2596. 255.15 (3) (d) of the statutes is created to read:*
    - *255.15 (3) (d) From the appropriation under s. 20.435 (1) (fm), the department may develop and implement a public health campaign aimed at the prevention of initiation of tobacco and vapor product use and may award grants for local and regional organizations working on youth vaping and providing cessation services.*

## Russell Frandsen

**From:** maggie.ferguson@idph.iowa.gov on behalf of Injury, Brain <brain.injury@idph.iowa.gov>
**Sent:** Thursday, May 20, 2021 6:35 AM
**To:** Russell Frandsen
**Subject:** Re: cost of TBI cost sharing vs revenues (request for help from Utah please)

Good morning,
Unfortunately, the program was never implemented.

Feel free to reach me on my personal work email at maggie.ferguson@idph.iowa.gov if you have any other questions.

On Thu, May 13, 2021 at 8:46 AM Russell Frandsen <rfrandsen@le.utah.gov> wrote:

> Thanks for responding and for the suggestion. Have you implemented the cost sharing? If yes, then do you have any information on how much revenue you have collected in any given year from clients with incomes over 300% FPL?
>
> Russell Frandsen
>
> Finance Officer
>
> Office of the Legislative Fiscal Analyst
>
> State of Utah
>
> Phone 801-538-1034
>
> Fax 801-538-1692
>
> rfrandsen@le.utah.gov
>
> http://budget.utah.gov/

---

**From:** maggie.ferguson@idph.iowa.gov <maggie.ferguson@idph.iowa.gov> **On Behalf Of** Injury, Brain
**Sent:** Thursday, May 13, 2021 7:41 AM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** Re: cost of TBI cost sharing vs revenues (request for help from Utah please)

Thanks for reaching out. While there is information regarding cost sharing in Iowa Administrative Code, it is an unfunded mandate. As a result, we do not have any data that you would be able to present to your colleagues in Utah.

You may want to consider asking the National Association of State Head Injury Administrators (NASHIA) if they know of any states with an active cost share program.

respectfully,

On Tue, May 11, 2021 at 8:57 AM Russell Frandsen <rfrandsen@le.utah.gov> wrote:

> Good morning from Utah! Do you have data/estimates to show much it costs to do your cost sharing vs revenues collected for TBI clients with incomes over 300% FPL that you could share some time in May please? The Utah Legislature is doing an accountable base budget review of its TBI program this year. Thanks for your consideration.
>
> Russell Frandsen
>
> Finance Manager
>
> Office of the Legislative Fiscal Analyst
>
> State of Utah
>
> Phone 801-538-1034
>
> Fax 801-538-1692
>
> rfrandsen@le.utah.gov
>
> http://budget.utah.gov/

--

**Maggie Ferguson, MS, CRC, CBIS**

Brain Injury and Disability Program Manager

Office of Disability, Injury, and Violence Prevention | Division of Behavioral Health | Iowa Department of Public Health | 321 E. 12th St | Des Moines, IA 50319-0075 |office: 515-281-8465 | Maggie.Ferguson@idph.iowa.gov

*Promoting and Protecting the Health of Iowans*



--

**Maggie Ferguson, MS, CRC, CBIS**

Brain Injury and Disability Program Manager

Office of Disability, Injury, and Violence Prevention | Division of Behavioral Health | Iowa Department of Public Health | 321 E. 12th St | Des Moines, IA 50319-0075 |office: 515-281-8465 | Maggie.Ferguson@idph.iowa.gov

*Promoting and Protecting the Health of Iowans*

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Spinal Cord and Brain Injury Rehabilitation Fund

| Sources of Finance | 2016 Actual | 2017 Actual | 2018 Actual | 2019 Actual | 2020 Actual | 2021 Est. | 2022 Est. |
|---|---|---|---|---|---|---|---|
| Dedicated Credits Revenue | $ 163,200 | $ 144,600 | $ 234,300 | $ 352,500 | $ 435,700 | $ 352,500 | $ 352,500 |
| Beginning Fund Balance | $ 413,400 | $ 334,300 | $ 310,800 | $ 449,400 | $ 612,100 | $ 789,100 | $ 789,100 |
| Closing Fund Balance | $ (334,300) | $ (310,800) | $ (449,400) | $ (612,100) | $ (789,100) | $ (789,100) | $ (789,100) |
| **Total** | **$ 242,300** | **$ 168,100** | **$ 95,700** | **$ 189,800** | **$ 258,700** | **$ 352,500** | **$ 352,500** |
| Monthly Spending Per Client | $ 262 | $ 206 | $ 117 | $ 288 | $ 308 | $ 210 | $ 210 |
| Monthly Caseload | 77 | 68 | 68 | 55 | 70 | 140 | 140 |
| Fee Revenues to the Fund | | | | | | | |
| - administrative impound fee $20 | $ 163,200 | $ 144,600 | $ 156,500 | $ 158,300 | $ 163,000 | $ 166,000 | $ 168,000 |
| - motorcycle registration $0.50 (started in January 2018) | N/A | N/A | $ 77,700 | $ 194,300 | $ 50,000 | $ 48,000 | $ 51,000 |
| - off-highway vehicle registration $1 ($0.50 in January 2018, $1 in January 2019) | N/A | N/A | | | $ 223,000 | $ 212,000 | $ 222,000 |
| Total Fee Revenues to the Fund | $ 163,200 | $ 144,600 | $ 234,200 | $ 352,600 | $ 436,000 | $ 426,000 | $ 441,000 |
| Revenues Over/(Under) Expenses | $ (79,100) | $ (23,500) | $ 138,500 | $ 162,800 | $ 177,300 | $ 73,500 | $ 88,500 |
| Any plans to use the fund balance? | Health: "With a new provider onboarded, the balance has been obligated in existing contracts." | | | | | | |

The monthly caseload is the number of physical, speech or occupational therapy services provided. Explanation of caseload trend by agency: "This number is low due to Covid-19 and the new contractor not participating at of the end of the SFY due to their internal processes. These are being worked on so these numbers will increase next year as long as they are able to start providing services soon." The dedicated credits are from a portion of the vehicle impound fees and part of the motor-cycle and off-highway vehicle

Traumatic Brain Injury Fund

| Sources of Finance | 2016 Actual | 2017 Actual | 2018 Actual | 2019 Actual | 2020 Actual | 2021 Est. | 2022 Est. |
|---|---|---|---|---|---|---|---|
| General Fund | $ 200,000 | $ 200,000 | $ 200,000 | $ 200,000 | $ 200,000 | $ 200,000 | $ 200,000 |
| General Fund, One-Time | $ - | $ - | $ - | $ - | $ (50,000) | $ 50,000 | $ - |
| Dedicated Credits Revenue | $ - | $ - | $ - | $ 100 | $ - | $ - | $ - |
| Transfers | $ 52,400 | $ - | $ 527,700 | $ 200,000 | $ - | $ - | $ - |
| Beginning Fund Balance | $ 122,400 | $ 162,400 | $ 137,900 | $ 756,700 | $ 733,000 | $ 698,400 | $ 582,200 |
| Closing Fund Balance | $ (162,200) | $ (137,900) | $ (610,200) | $ (932,900) | $ (679,200) | $ (582,200) | $ (416,000) |
| **Total** | **$ 212,600** | **$ 224,500** | **$ 255,400** | **$ 223,900** | **$ 203,800** | **$ 366,200** | **$ 366,200** |
| Monthly Spending Per Client | $ 101 | $ 82 | $ 109 | $ 83 | $ 143 | $ 102 | $ 102 |
| Monthly Caseload | 176 | 228 | 195 | 226 | 119 | 300 | 300 |
| Any plans to use the fund balance? | Health: "Balance has been budgeted in FY21 and FY22 and approved by [Traumatic Brain Injury] Advisory Committee with an increase in virtual outreach and training and implementation of a RFP for community health workers and independent living centers to train as brain injury specialists." | | | | | | |

The monthly caseload is the number of clients that received an intake assessment. Explanation of caseload trend by agency: "These numbers are low due to Covid-19 and [Brain Injury Association of Utah] had a loss in staff due to budget constraints at the organization."

The fund received one-time transfers via intent language from unspent funds in other areas of Health in FY 2016 and FY 2018.

**Sources:**
https://cobi.utah.gov/2021/266/financials
https://cobi.utah.gov/2021/265/financials
https://cobi.utah.gov/fund/2250
https://cobi.utah.gov/fund/2251
Tax Commission May 19, 2021 personal email

## Spinal Cord and Brain Injury Rehabilitation Fund

| | FY 2012 | FY 2013 | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | Forecast FY 2021 | Forecast FY 2022 | Forecast FY 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DUI Impound Fees | 28,360 | 188,760 | 170,434 | 169,342 | 163,239 | 144,588 | 156,470 | 158,342 | 163,493 | 165,945 | 168,434 | 170,961 |
| Tax registration Fees | | | | | | | 77,753 | 194,249 | 272,220 | 259,971 | 272,969 | 277,064 |
| TOTAL - Spinal Cord & Brain Injury Rehab. Fund | 28,360 | 188,760 | 170,434 | 169,342 | 163,239 | 144,588 | 234,223 | 352,590 | 435,713 | 425,915 | 441,403 | 448,024 |

$20 administrative impound fee
January 1, 2018 ($.50 motorcycle registration, $.50 OHV registration)
January 1, 2019 ($.50 motorcycle registration, $1.00 OHV registration)

**Source**
**From:** Jacoba Ellyn Larsen <jelarsen@utah.gov>
**Sent:** Wednesday, May 19, 2021 3:45 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Leslee Katayama <lkatayama@utah.gov>
**Subject:** Re: Brain Injury Spinal Cord Fund

# Registrations

| | Standard Motorcycles | Off Road | | | | LFA Addition Motorcycles $ 0.50 | % | Off Road $ 1.00 | % |
|---|---|---|---|---|---|---|---|---|---|
| 2015 | 73,606 | 187,538 | 261,144 | 28.2% | | | | | |
| 2016 | 71,760 | 186,878 | 258,638 | 27.7% | | | | | |
| 2017 | 70,929 | 186,006 | 256,935 | 27.6% | | | | | |
| 2018 | 71,523 | 180,514 | 252,037 | 28.4% | | | | | |
| 2019 | 78,155 | 179,232 | 257,387 | 30.4% | | | | | |
| 2020 | 79,676 | 179,573 | 259,249 | 30.7% | | $39,838 | 18% | $179,573 | 82% |
| 2021 | 81,680 | 180,502 | 262,182 | 31.2% | | $40,840 | 18% | $180,502 | 82% |
| 2022 | 83,314 | 181,856 | 265,169 | 31.4% | *Forecast | $41,657 | 19% | $181,856 | 81% |
| 2023 | 84,980 | 183,220 | 268,200 | 31.7% | *Forecast | $42,490 | 19% | $183,220 | 81% |
| 2024 | 86,679 | 184,594 | 271,273 | 32.0% | *Forecast | $43,340 | 19% | $184,594 | 81% |

**Source**

**From:** Jacoba Ellyn Larsen <jelarsen@utah.gov>
**Sent:** Wednesday, May 19, 2021 3:45 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Cc:** Leslee Katayama <lkatayama@utah.gov>
**Subject:** Re: Brain Injury Spinal Cord Fund

**Disability and Health Promotion Branch: State Annual Progress Report Year 4**

**AWARDEE NAME:** Utah
**GRANT NUMBER:** NU27DD000003

Please fill out the tables that follow based on your submitted Year 4 Annual Objectives (one table per AO). Some of the fields have been populated for you based on the information you submitted in your last work plan – **this information should not be changed.** Please fill out new information only in the appropriate fields.

**SAVING THE ANNUAL PROGRESS REPORT:** When saving your annual progress report (APR) template, please follow the designated naming convention.

**File Naming Convention:** Project Narrative _ Progress Report

**Common Abbreviations for Strategies**

- Capacity Building (Capacity)
- Partnerships (Partner)
- Programmatic, Policy, Systems, and Environmental Changes (PPSE)
- Dissemination and Communication (Comm)
- Technical Assistance and Training (TA)
- Date/HealthCare Utilization (Data)

If you have any questions about completing this template, please reach out to your Project Officer.

**STRATEGY:** Capacity Building

| **Capacity 5** | | | | |
|---|---|---|---|---|
| By June 30, 2020, increase the number of data management systems that support active participation of disability partners from 0 to 3. | | | | |
| **Status (Select One)** | | | | |
| ☐ Met ☒ In Progress | | | | |
| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
| People | 0 | 24 | Number of partners who access the systems | 0 |
| Unit | 0 | 3 | Data management systems | 3 |
| **Instructions** | | | | |
| For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items. | | | | |
| **Successes** | | | | |
| We tested/piloted the three different data management systems using Google Sheets and Google Forms and received feedback from stakeholders that a website would be a much easier way to support participation of disability partners. A website has been developed to incorporate the three data management systems into one place for the purpose of supporting partners and collecting and sharing data. | | | | |
| **Challenges** | | | | |
| Time to develop website and train partners on using the site. We expect to train at least 24 partners by the end of the grant year. | | | | |
| **Evaluation Results** | | | | |
| Moving forward the unit measure should be changed to 1 data management system (website) to support active participation of disability partners. | | | | |

**STRATEGY:** Dissemination and Communication

| **Comm 3** | | | | |
|---|---|---|---|---|
| By June 30, 2020 increase the number of unique communication products disseminated that highlight disability-related health information from 4 to 12. | | | | |
| **Status (Select One)** | | | | |
| ☐ Met ☒ In Progress | | | | |
| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
| People | 2051 | 2251 | People who attend, receive or access resources | 6097 |
| Unit | 4 | 12 | Number of unique communication products disseminated | 9 |
| **Instructions** | | | | |
| For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items. | | | | |
| **Successes** | | | | |
| Although we've had fewer products than we expected, we reached far more people through the products we have developed, than planned. | | | | |
| **Challenges** | | | | |
| Time and resources for product development | | | | |
| **Evaluation Results** | | | | |
| People: Disability Day at the Capitol (50), NCHPAD workshops (approx. 32 (day 1), approx. 50 (day 2), Social media engagement (1,113 FB engagement, Twitter: 4839 impressions), TPCP presentation attendees (13), tobacco data brief recipients<br>Unit: NCHPAD Inclusion Action Plans (via Google Forms) = 2; NCHPAD training for inclusion= 2; Social Media (World Diabetes Day, Great American Smokeout)=2; UDAC Overview/Recruitment one-pager=1; TPCP Presentation with Sydney=1; Tobacco Data Brief=1 | | | | |

**STRATEGY:** Partnerships

| **Partner 4** | | | | |
|---|---|---|---|---|
| By June 30,2020, increase the number of members serving on the Utah Disabilities Advisory Committee from 35 to 40. | | | | |
| **Status (Select One)** | | | | |
| ☒ Met ☐ In Progress | | | | |
| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
| People | 35 | 40 | Utah Disabilities Advisory Committee members | 41 |
| Unit | 1 | 1 | Utah Disabilities Advisory Committee | 1 |
| **Instructions** | | | | |
| For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items. | | | | |
| **Successes** | | | | |
| Utah Disabilities Advisory Committee Membership workgroup Chair and the Disability and Health Program Coordinator worked together to identify membership recruitment strategies and reached out to potential new members to encourage their involvement. We started offering Zoom for all of the meetings in January and expect to see more participation from all members in 2020. | | | | |
| **Challenges** | | | | |
| Membership engagement remains a bit challenging for the different workgroups. | | | | |
| **Evaluation Results** | | | | |
| People: new members: self-advocates (2); UTA ADA compliance director; local health departments (WMHD and Utah County HD) (2), Utah State Office of Rehabilitation (1) | | | | |

**STRATEGY:** Programmatic, Policy, Systems, and Environmental Changes

| **PPSE 4** | | | | |
|---|---|---|---|---|
| By June 30, 2020, increase the number of people with disabilities referred to the Utah Tobacco Quit Line from 599 to 750. | | | | |
| **Status (Select One)** | | | | |
| ☒ Met ☐ In Progress | | | | |
| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
| People | 599 | 750 | Persons with Disabilities referred to the Quit Line | 986 |
| Unit | 1 | 1 | Utah Tobacco Quit Line | 1 |

**Instructions**

For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items.

**Successes**

Additional question was added to the Quit Line intake process to better identify persons with intellectual disabilities calling for assistance. Referrals of persons with disabilities exceeded target. Partnership with Tobacco Prevention and Control Program (TPCP) is strong. The Disability and Health Program have facilitated several collaboration meetings with the TPCP media coordinator to update materials like social media posts and a data brief highlighting the health disparities among people with disabilities and the importance of being inclusive in cessation approaches. Utah Disabilities Advisory Committee members were included in this collboration and are sharing this resource. Social media and data brief highlighted this issue with a call to action to refer to quitline.

**Challenges**

New Quit Line vendor took a while to get disability questions added to the intake form.

**Evaluation Results**

People: YR 3 Actual was 767, new QL vendor National Jewish did not include numbers until December. Most recent numbers are 219 (December-January) from National Jewish (134 answered "yes" to difficulty concentrating/memory/decisions and 85 answered "yes" to difficulty walking/climbing stairs)This equates to 38% and 23% of Quit Line registrants, respectively.

**STRATEGY:** Programmatic, Policy, Systems, and Environmental Changes

**PPSE 6**

By June 30, 2020, increase the number of policies requiring annual disability and health inclusion training for subcontractors from 0 to 1.

**Status (Select One)**

☐ Met ☒ In Progress

| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
|---|---|---|---|---|
| People | 0 | 35 | Number of subcontractor staff receiving the training | 0 |
| Unit | 0 | 1 | Number of policies requiring contract language | 0 |

**Instructions**

For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items.

**Successes**

Policy has been drafted and has support from Executive Leadership Team at Utah Department of Health. Program Coordinator presented an overview of the training and policy to the Utah Department of Health Executive Leadership Team in October 2019. The policy and training have support from the Executive Leadership Team. The policy draft is now en route to an internal Operations Communications workgroup for approval. We have piloted the training with our Utah Department of Heatlh Resource Line employees and other stakeholders. The final 30-minute training product will be loaded into our state Learning Management System. The training will be required of all Utah Department of Health employees at onboarding and every other year after. The training content was developed in partnership with our Utah Developmental Disabilities Council and the training is co-narrated by a self-advocate with an intellectual disability. We intend to pursue a policy requiring this training for subcontractors within the Bureau of Health promotion as well.

**Challenges**

It has taken a lot of time to gather input and consensus from stakeholders and make edits to the training product. Our Utah Department of Health leadership has experienced several pressing issues that have pushed policy approval further down the priority list. However, we do anticipate the training and policy will be in place by the end of May.

**Evaluation Results**

Need to update the SMART Objective and people target to include state agencies/employees, instead of just subcontractors.

**STRATEGY:** Programmatic, Policy, Systems, and Environmental Changes

| **PPSE 7** | | | | |
|---|---|---|---|---|
| By June 30, 2020, increase the number of organizations that host evidence-based interventions on physical activity, nutrition, and diabetes from 5 to 7. | | | | |
| **Status (Select One)** | | | | |
| ☒ Met ☐ In Progress | | | | |
| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
| People | 133 | 175 | People with disabilities who participate in interventions | 571 |
| Unit | 5 | 7 | Organizations that host the intervention | 33 |
| **Instructions** | | | | |
| For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items. | | | | |
| **Successes** | | | | |
| The National Center on Health, Physical Activity and Disability hosted a workshop for coaches of lifestyle management programs (including Diabetes Prevention Program lifestyle coaches, Living Well leaders, ) that focused on increasing inclusion in chronic disease self-management programs. Three local health departments created inclusive action plans based on this workshop, to make all of their health promotion programs more inclusive. The Bear River Health Department in Logan will begin offering Inclusive Diabetes Prevention Program by the end of the grant year. The Disability and Health Program purchased a portable wheelchair scale that will be loaned to them for use during their program. | | | | |
| **Challenges** | | | | |
| Scaling the TOP Star program for AWD has been a challenge due to time constraints of staff involved and implementation of action plans at pilot sites. Both pilot sites will receive a co-endorsement for completion of the program criteria (e.g. self-assesement, staff training, action plans, implemenation of policy and environmental changes and improvement in baseline assessment/completion of action plan). Recruitment of host organizations for Living Well in the Community has also been a challenge. | | | | |
| **Evaluation Results** | | | | |
| Reach to people with disabilities by program type: TOP Star for AWD at two pilot sites= 112, Chronic Disease Self-management Program=76, Chronic Pain Self-Management Program=203, Diabetes Self-Management Program=55, Programa de Manejo de la Diabetes=6, Tomando Control de su Salud (Spanish CDSMP), Walk with Ease=1, EnhanceFitness=113<br>Unit target: 2 TOP Star for AWD organizations and 33 host organizations implementing National Diabetes Prevention Program (currently no metrics on reach to people with disabilities though), CDSMP, DSMP, CPSMP, Spanish DSMP, Spanish CDSMP, WWE, and/or EF. | | | | |

**STRATEGY:** Technical Assistance and Training

| **TA 1** | | | | |
|---|---|---|---|---|
| By June 30, 2020 increase the number of technical assistance and mentoring hours provided to partners from 20 to 120 hours. | | | | |
| **Status (Select One)** | | | | |
| ☒ Met ☐ In Progress | | | | |
| Reach | Baseline | Target | Description | Actual (7/1/19 – 3/31/20) |
| People | 152 | 227 | people receiving technical assistance | 227 |
| Unit | 20 | 120 | hours | 160 |
| **Instructions** | | | | |
| For the Successes, Challenges, and Evaluation Results, please use dashes to indicate separate items. | | | | |
| **Successes** | | | | |
| The number of hours and people we are reaching show us our capacity-building efforts are working. | | | | |
| **Challenges** | | | | |
| Tracking number of hours is still a challenge, even with a tracking spreadsheet. | | | | |
| **Evaluation Results** | | | | |
| People (51 internal to UDOH): BHP programs (SEED and programs that updated their indicators on IBIS); BHP policy coordinator (101 training), Utah Department of Health Executive Leadership (101 training), EPICC program (TOP Star; DPP and NCHPAD workshop planning), TPCP program (disability data brief, social media messages, quit line intake, TPCP conference); VIPP (Sexual violence collaboration/partners); Office of Health Care Statistics (Disability DataByte); Medicaid (connecting waiver program to partners); Office of Health Disparities (accessible communication strategies, inclusive training); Health Resource Center (101 pilot);<br><br>other partners (24): Utah Developmental Disabilities Council (1) (connecting to partners, leveraging resources, developing training and policy); UTA ADA coordinator (1) (connecting to resources, recruiting to UDAC); media (2) : connecting to resources/IBIS data; Independent Living Centers (2): connecting to data; local health departments (5): providing information on inclusion best practices, connecting to disability organizations, training (NCHPAD); Utah State Office of Rehabilitation (1) (connecting to resources, recruiting to UDAC); Division of Services for People with Disabilities (1) (connecting to resources and partners), disability organizations (9) at Capitol event (Disability Day), general public inquiries (6) connecting to resources, non-profit organizations (2) Multiple Sclerosis, Epilepsy foundation<br><br>Unit: Program Coordinator: approx 110 hours spent in meetings, presentations, collaboration, strategic planning providing technical assistance and training.<br>Epi: approx. 30 hours | | | | |

# Logic Model

| Logic Model: Utah Disability and Health Program | | | |
|---|---|---|---|
| **Strategies and Activities** | **Short-Term Outcomes** | **Intermediate Outcomes** | **Long-Term Outcomes** |
| **Overarching Strategy**<br>Improve inclusion and accessibility and reduce health disparities for people with intellectual disabilities (ID) and/or mobility impairments (MI) in Utah's public health programs<br>• Develop internal capacity of the Bureau of Health Promotion (BHP)<br>• Enhance and expand partnerships with state and community partners serving/supporting individuals with ID or MI organizations<br>• Assess, develop, and disseminate health promotion resources, tools, and inclusion strategies with adaptations needed to meet the needs of Utahns with ID and/or ML.<br>• Deploy evidence-based and innovative, programmatic, policy, systems, and environmental changes<br>• Provide training and | • Increased knowledge and awareness of health risk factors<br>• Improved collaboration with partners<br>• Improved data collection methods with BRFSS call-back surveys and project specific surveys and pre-post assessments.<br>• Increased availability and use of health promotion resources, tools, and inclusion strategies<br>• Implementation of evidence-based health promotion programs with the targeted populations. | • Improved organizational capacity of BHP and UDAC partner organizations<br>• Improved monitoring of health and health care utilization of individuals with ID and/or ML in Utah<br>• Increased participation in evidence-based and innovative health promotion programs by participants with ID and/or ML.<br>• Increased use of programmatic, policy, systems, and environmental changes with the BHP and the Utah Health and Disability Program.<br>• Improved evidence-base for health promotion programs | • Increased healthy behaviors in individuals with ID and/or ML in Utah<br>• Decreased prevalence of chronic disease risk factors<br>• Decreased prevalence of chronic diseases<br>• Improved sustainability of programmatic, policy, systems, and environmental improvements |

| | | | |
|---|---|---|---|
| education to project staff, and UDAC members,<br>• Provide technical assistance<br>• Enhance and utilize data to identify patterns of health and health care utilization<br>• Evaluate program impact | | | |

**Upstanding: Bystander Intervention Program**

Upstanding bystander intervention educates participants with knowledge, skills, and experience with how to intervene in everyday situations to prevent and interrupt harm and violence that they witness. Bystander intervention approaches are currently one of the most effective approaches to prevention of harm, violence, and cultural change to a less violent community/environment/population. Bystander intervention is shown to decrease rape and sexual assault, harassment, and binge drinking. The program is to increase the willingness of bystanders to intervene. This is accomplished through teaching skills and then practicing those skills. This builds skill development but also builds self-efficacy in participants with makes participants more likely to intervene and more likely to have effective interventions.

VIPP trains prevention specialists across Utah to deliver the program. The program is tailored to the general community, community-based organization staff, and middle and high school students. Upstanding resources include a training manual and ongoing technical assistance on bystander intervention.

The program is free. The materials, resources, and training sessions are all provided without cost by VIPP through the Rape Prevention and Education Grant from the Centers for Disease Control and Prevention.

**DCFS/VIPP Media Campaign**

DCFS, VIPP and The Division of Substance Abuse and Mental Health (DSAMH) worked together to braid funding to develop a new campaign to support parents and positive parenting that will kick off in 2021.

The DCFS Prevention Services Administrator met with the DHS Communications Division in March to begin the planning process for this campaign. The Communication Division feels like this campaign can mostly be supported with internal agency resources rather than contracting with an outside media agency to create content. Currently, the plan is to use the braided funding for media spots once the campaign has been created internally.

In order to prepare the media content, DCFS has been meeting with other states who have launched successful parenting campaigns. The goal of the campaign is to increase parental help seeking. DCFS and VIPP are trying to learn more about parent-help seeking behavior in Utah in order to tailor the message appropriately. VIPP contacted the CDC for help conducting a literature review to hone in on messaging that may improve parent help-seeking. The group is also considering conducting parent focus groups to learn more about parenting needs in the state.

Throughout April, DCFS and VIPP prioritized media messaging for Child Abuse Prevention Month. The larger positive parenting campaign will be a continuation of the messaging that was created in April.

# VIPP

1. What does your office do?

VIPP's mission is to provide trusted data, comprehensive resources, valued community engagement, and strategic partnerships that prioritize comprehensive strategies and policies to prevent violence and injury in Utah communities. VIPP focuses its efforts on the primary prevention of injury and violence. Primary prevention aims to prevent injury and violence before it ever occurs. This is done by minimizing the known risks of injury and violence and by altering unhealthy or unsafe behaviors that lead to injury and violence. VIPP focuses on shared risk and protective factors or factors that influence more than one type of injury or violence. For example, one of VIPP's goals is to "Improve the socioeconomic conditions for Utahns". Poverty is a risk factor for mental illness, child maltreatment, suicide, youth violence, intimate partner violence, and obesity, just to name a few. By focusing on improving economic conditions for Utahns we can affect numerous health outcomes.

Program Goals:

- Build program capacity to include a learning culture for staff to advance health equity and a trauma-informed approach across Utah's population
- Provide awareness, support, education, training, and technical assistance on injury and violence prevention, shared risk and protective factors of injury and violence, and on populations disproportionately affected by injury and violence, to partners and grantees
- Intervene to lessen risks and the harmful outcomes of injury and violence and to reduce their occurrence among Utahns
- Improve the socioeconomic conditions for Utahns, disproportionately affected by poverty
- Promote individual, family, and community connectedness to decrease isolation and loneliness among Utahns
- Encourage social norms shown to promote safety and health among Utahns
- Encourage enhancement of Utahns physical environment to improve safe and healthy living
- Improve access to and utilization of healthcare, including behavioral healthcare
- Collect and disseminate accurate, timely, and comprehensive data on injury and violence, on the risk factors for injury and violence, and on the populations that are disproportionately affected by violence and injury in Utah
- Conduct evaluation of VIPP's prevention and surveillance activities to inform data-driven decision-making and continuous quality programmatic improvement

2. How are you organized?

We have a program manager and an assistant program manager, an epidemiology team (13 staff), a prevention team (10 staff), a marketing team (2 staff), and administrative support team (3 staff). VIPP also partially funds 34 health department staff in other programs, bureau's and divisions, most notably the Center for Health Data and Informatics, the Utah Public Health Lab and the Office of the Medical Examiner.

3. Which personnel do which tasks?

| Name/Title | Job Description |
|---|---|
| Teresa Brechlin, Program Manager | Teresa is responsible for the overall development, management and coordination of resources required to maintain the VIPP. This includes staff supervision, budget preparation and monitoring, coordination and monitoring of grant applications and state plans, and collaborating with other state and county agencies, programs, providers, community-based organizations and public and private health care providers. |
| Gary Mower, Assistant Program Manager | Gary assists with management of the VIPP and oversees the contract process for the many VIPP contracts. Gary manages the National Violent Death Reporting System, Enhanced Surveillance of Opioid Morbidity and Mortality, and Alcohol Epidemiology grants. |
| **Administrative Support Team** | |
| Melissa Leak, Administrative Secretary | Missi is responsible for managing the day-to-day operations of the program (mailing out materials to community partners, coordinating meetings, processing invoices, ordering materials, etc.). |
| Karla Matheson, Law Enforcement Liaison | Karla requests police reports from all agencies in Utah for data entry into various violence and injury surveillance systems. She also provides administrative assistance for the program. In addition, she assists with the Student Injury Reporting System. |
| Vanonda Kern, Contracts Coordinator | Vanonda coordinates the processing of all VIPP grants and contracts which includes reviewing Federal, State, Department and/or Division requirements and ensuring compliance with those requirements. |
| **Epidemiology Team** | |
| Vacant, Epidemiology Manager | |
| Meghan Balough, Epidemiologist Supervisor | Meghan is the opioid prevention specialist and oversees the program and policy evaluation for several injury and violence topics. |
| Deanna Ferrell, Epidemiologist/ Evaluator Supervisor | Deanna coordinates the data abstraction team and VIPP's data surveillance projects. She also develops evaluation activities and completes data requirements for multiple intentional and unintentional injuries, including sexual violence, intimate partner violence, child abuse and neglect, traumatic brain injury, and motor vehicle crashes. Additionally, she focuses on strategic planning around shared risk and protective factors. |

| | |
|---|---|
| Akanksha Acharya, Epidemiologist | Akanksha is the non-fatal suicide epidemiologist. She conducts analysis from the Violent Death Reporting System for reports, fact sheets, and other projects to support the data needs of VIPP's partners in prevention. |
| Wei Beadles, Epidemiologist | Wei is an Alcohol Epidemiologist. She is responsible for studying Utahns drinking behaviors, and what it does to their health. She also has the responsibility of collaborating with community partners in alcohol policy and prevention efforts, identifying new binge and chronic drinking trends, and writing reports on her findings. |
| Jerry Nelson, Epidemiologist | Jerry is responsible for analyzing nonfatal firearm injury data from syndromic surveillance and other emergency department data sources. He tracks performance measures, prepares reports, fact sheets, and articles related to the FASTER (Firearm Injury Surveillance Through Emergency Rooms) grant. He is also responsible for implementing the evaluation performance and management plan. |
| Nathan Malan, Epidemiologist | Nathan is responsible for the Essentials for Childhood and Sudden Unexpected Infant Death/Sudden Death in the Young Grant data. He works with members of the Utah Coalition for Protecting Childhood to improve data collection and better guide prevention efforts of intentional and unintentional child death and injury. He also conducts analysis for report and fact sheet creation and oversees evaluation of those grant project efforts. |
| Sophie Luckett-Cole, Epidemiologist | Sophie is responsible for analyzing non-fatal drug overdoses data from syndromic surveillance and other emergency department data sources. She tracks performance measures, prepares graphs and reports, and fact sheets. |
| **Epidemiology Abstraction Team** | |
| Jason Clark, Research Analyst | Jason is responsible for abstracting drug overdose data from medical examiner and police reports into the State Unintentional Drug Overdose Reporting System. He also collects data for the Opioid Fatality Review Committee |
| Trish Maloney, Research Analyst | Trish is responsible for abstracting drug overdose data from medical examiner and police reports and inputting data into the State Unintentional Drug Overdose Reporting System (SUDORS). |
| Ynhi Nguyen, Research Analyst | Ynhi is responsible for abstracting Traumatic Brain Injury (TBI) Data for the TBI surveillance database. She also does abstractions for accidental overdoses in NVDRS as well as police reports for SUDORS cases. |
| Cristy Sneddon, Senior Research Analyst | Cristy is responsible for training related to data abstractions in VIPP's various surveillance systems. She works with the epidemiologists to ready data and coordinate abstraction projects. She is abstracts data for the National Violent Death Reporting System (NVDRS) gathering information for homicides, suicides, deaths of undetermined manner and accidental firearm deaths. |

| | |
|---|---|
| Hillary Campbell, Research Analyst | Hillary oversees and manages the student injury reporting system. She is responsible for quality assurance and training of new users who work with student services at the district level. |
| **Prevention Team** | |
| Vacant, Policy and Prevention Manager | |
| Amy Mikkelsen, Primary Prevention Coordinator Supervisor | Amy works with partners to provide guidance, support, and technical assistance in their suicide prevention efforts. Amy participates on multiple coalitions and workgroups providing her expertise in suicide prevention principles and evidence based strategies. She works with other state agencies to ensure both a comprehensive and collaborative approach to suicide prevention is implemented at the state level. |
| Traci Barney, Prevention Coordinator Supervisor | Traci coordinates the Utah Brain Injury Council, Utah's TBI Advisory Board, the TBI Fund Advisory Committee and the SCI/BI Rehabilitation Fund Advisory Committee. She oversees the Utah TBI Fund and the Utah SCI/BI Rehabilitation Fund. She also manages a federal TBI Partnership grant and is a member of the National Association of State Head Injury Administrators and the State representative for TBI and SCI. |
| Lauren Radcliffe, Overdose Prevention Specialist | Lauren is responsible for working with local communities and providing technical assistance and guidance in their prevention efforts. She provides expertise in the opioid media campaigns and works with healthcare, law enforcement, treatment, recovery, and community partners to identify and implement evidence-informed strategies to address opioid abuse, misuse and overdose. She is also the Local Health Department Liaison and helps facilitate work and contracts. |
| Joey Thurgood, Adverse Childhood Experiences Coordinator | Joey Thurgood is the ACEs subject matter expert and serves as the Utah Essentials for Childhood (EfC) Coordinator. EfC is a CDC program focused on primary prevention of child maltreatment through focus on Social Determinants of Health. |
| Hailey Hadean, Healthy Aging Specialist | Hailey is over the falls prevention program and also works on opioid overdose, motor vehicle crash, and suicide prevention within Utah's aging population. |
| Marty Liccardo, Community Outreach Specialist | Marty increases males involvement in violence prevention, particularly sexual violence prevention. Marty works with community and state partners on sexual violence work and specifically coordinates efforts with the Men's Anti-violence Network of Utah. He works on the Rape Prevention and Education grant and develops programming, technical assistance, and resources for Utah communities; including implementation of the Upstanding bystander intervention program. |

| | |
|---|---|
| Kacy Robinson, Fatality Review Specialist | Kacy coordinates the three Fatality Review Committees. She coordinates the Sudden Death in the Young Advanced Clinical Review Team. As coordinator, she is responsible for identifying cases for review; performing all research and record collection for review cases; meeting facilitation and collection of recommendations, which identify service gaps and populations vulnerable to violence/injury; and promote health and wellbeing for all Utahns. |
| Corryn Wermel, Safe Kids Coordinator | Corryn coordiantes comprehensive childhood injury prevention programs designed to prevent death and injury among children ages 0-14 throughout Utah. She provides direction to the 14 local Safe Kids Utah Chapters and Coalitions with funding, assessing needs and designing actions to meet those needs. Corryn assists with statewide community outreach, provides education and training on childhood injury prevention issues, and coordinates the statewide campaigns |
| **Media/Public Information Team** | |
| Katie McMinn, Media Coordinator Supervisor | Katie oversees the communication efforts of the VIPP; managing the media contracts; coordinating the prescription drug overdose media campaign; creating and publishing public educational material; and maintaining the VIPP, naloxone, Utah Coalition for Opioid Overdose Prevention, and Stop the Opidemic websites |
| Tom Schleiffarth, Media Specialist | Tom creates all of the digital media content for the VIPP. This includes developing social media posts, visual website content, live event coverage, as well video to be shared through multiple online channels. |

4. How do you measure success?

Successful injury and violence prevention employs a systematic process called the public health approach. This approach has four steps: define the problem, identify risk and protective factors, develop and test prevention strategies, and assure widespread adoption of effective injury prevention principles and strategies. VIPP works on numerous injury and violence topics. Each of these projects have different measures of success. VIPP staff conduct evaluation of its numerous projects and have developed indicators to measure success. Injury indicators are used to estimate the scale of injuries and their long-term effects. They can help compare injury levels in different counties, health districts, and small-areas and are used to help measure the effectiveness of VIPP's prevention strategies. Long-term effects of primary prevention strategies may take years or even decades to prove so shorter term indicators that reflect changes in risk and protective factors are used by VIPP to measure success. A few of the measures that VIPP uses to measure success are:

Short-term measures:

- Increasing access of timely and actionable data
- Increasing coordination and collaboration with partners
- Increasing the uptick of Utahns filing for the Earned Income Tax Credit
- Increasing the distribution of naloxone

Increasing the understanding of Adverse Childhood Experiences
Increased number of partners working on VIPP's strategic goals
Increasing the number of days that a family eats together

Long-term measures:

Decreasing the proportion of deaths due to injury
Decreasing the number of preventable hospital admissions due to injury or violence
Decreasing the number of injury and violence-related deaths
Decreasing the rate of sexual assault
Decreasing the rate of overdose deaths
Decreasing the number of non-fatal injuries
Decreasing the rate of suicide
Decreasing the number of violent crime per 100,000 people
Decreasing the proportion of Utah children living below the poverty level
Decreasing the proportion of households with food insecurity
Decreasing the number of reported poor mental health days in the past 7 days
Increasing the percentage of registered voters voting in the last election
Decreasing the percentage of children who report neglect or physical/ sexual abuse

5. What have been the results of your success measuring the last few years?

VIPP has successfully worked with public and private partners to braid funding, collaborate on strategies, and implement innovative data projects. Some of these accomplishments include:

- Through VIPP, with support from the Intergenerational Poverty Commission, and in partnership with Utah Tax Help, UCPC developed and carried out a multimedia awareness campaign focused on improving Utah's uptake of the Federal Earned Income Tax Credit (EITC), and held an EITC Awareness Day Event with special remarks from then Lieutenant Governor Spencer Cox. IRS data takes years to be released. Once we have updated data for 2020 and 2021 we will be able to evaluate the campaign.
- DCFS, VIPP and The Division of Substance Abuse and Mental Health (DSAMH) worked together to braid funding to develop a new campaign to support parents and positive parenting that will kick off in 2021.
- After serving on the Intergenerational Welfare Poverty Commission's trauma workgroup, Resilient Utah, VIPP provided much needed funding and support to efforts to create a Center for a Trauma Informed Utah. An advisory board was developed and the Center for a Trauma Informed Utah is in the process of becoming a nonprofit organization.

Some longer-term measures are reflected below.

The injury rate has been decreasing since 2017

| Year | Injury Death Rate |
|---|---|
| 2017 | 67.3 |

| | |
|---|---|
| 2018 | 66.59 |
| 2019 | 65.85 |

Injury hospitalizations decreased in 2017 and 2018 but increased slightly in 2019

| Year | Hospitalization Rate |
|---|---|
| 2016 | 41.87 |
| 2017 | 40.14 |
| 2018 | 38.06 |
| 2019 | 38.86 |

6. How are you funded? Why are you funded that way?

VIPP is funded through:
68% federal funding obtained through a competitive application process
10% federal block grant funding
5% federal formula funding
8% state funding
9% legislative appropriation of TANF funds

7. When was the last time that you had a major problem? How did you identify it? What was the solution that you implemented?

Covid-19 sent the program into a bit of a tailspin. All at once we were required to work from home and come up with processes and procedures to continue working with the elevated workload of responding to Covid-19. Fortunately, VIPP staff are patient and flexible and before long we had everything up and running. Staff worked a lot of overtime to aid with contact tracing, staffing the webchat, doing covid investigations, and helping with vaccine preparation and distribution.

8. When was the last major change in your office? What was it? How did it change your workflow?

Our program manager left in November to become the bureau director of Health Promotion. This was at the end of a pretty tumultuous year responding to Covid-19. The position was vacant for a couple of months but was filled by Teresa Brechlin who has been with VIPP since 2003. Once again VIPP staff were patient and flexible and barely a beat was missed.

9. Do you seek for and receive private contributions to involve the community in the solution? If not, why?

We seek opportunities for private funding that align with VIPP priorities when they arise and in the past have been successful in obtaining funding. Currently, we do not receive private funding but we do have a lot of in-kind donations of time by our partners, many of whom work in the private sector.

10. How much do you spend on services versus program administration?

VIPP, for the most part, does not do direct services. However the majority of the funding is used to service the population of Utah through data collection and surveillance, prevention strategies, and evaluation of our programs.

- 49% of funding is contracted out to LHD's and other CBO's
- 3% of funding is spent on administration of the program
- 48% of funding is used to service the population of Utah

11. How do you emphasize preventative measures rather than reactive measures, such as:

VIPP focuses its efforts on the primary prevention of injury and violence. Primary prevention aims to prevent injury and violence before it ever occurs. This is done by minimizing the known risks of injury and violence and by altering unhealthy or unsafe behaviors that lead to injury and violence. VIPP focuses on shared risk and protective factors or factors that influence more than one type of injury or violence. For example, one of VIPP's goals is to "Improve the socioeconomic conditions for Utahns". Poverty is a risk factor for mental illness, child maltreatment, suicide, youth violence, intimate partner violence, and obesity, just to name a few. By focusing on improving economic conditions for Utahns we can affect numerous health outcomes.

12. What would you do with more funding?

Provide more support, technical assistance, and funding to communities to work on local implementation of violence and injury primary prevention.

13. What would you do with less funding?

Scale back reach and saturation of programs. Decrease surveillance of injury and violence and risk factors.

Are there any areas where you would like to know what other States are doing to address certain issues (I can ask my national support organization)?

**Source**
**From:** Teresa Brechlin <tbrechlin@utah.gov>
**Sent:** Tuesday, April 27, 2021 1:35 PM
**To:** Russell Frandsen <rfrandsen@le.utah.gov>
**Subject:** VIPPs response

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