Maternal and Child Health Services Title V Block Grant

Utah

FY 2020 Application/ FY 2018 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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State of Utah

GARY R. HERBERT
Governor

SPENCER I. COX
Lieutenant Governor

July 12, 2019

Michele Lawler
Director, Division of State and Community Health
Maternal & Child Health Bureau
Health Resources and Services Administration
5600 Fisher Lane, Room 18-3
Rockville, MD 20857

Dear Ms. Lawler:

We are pleased to submit Utah's Maternal and Child Health Block Grant Application for Fiscal Year 2020 and the Annual Report for Fiscal Year 2018.

The 2020 application includes the needs assessment, the annual plan for the National and the State Performance Measures which includes the evidence based strategy measures. The Annual Report for the FFY 2017 provides the results of our planned efforts completed during this time period.

We are excited to move towards implementing specific plans to address the National and State Performance Measures over the next twelve months.

Sincerely,

Lynne Nilson, MPH, MCHES
Director, Title V and Bureau of
Maternal & Child Health

Noel Taxin
Director, Bureau of Children With
Special Health Care Needs

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

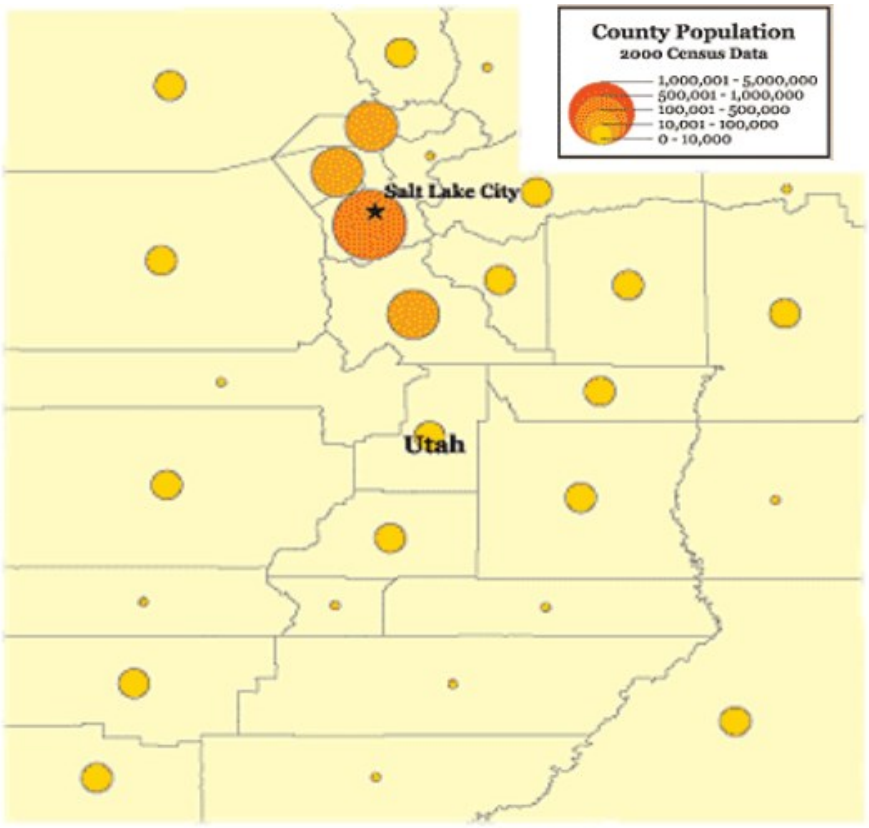
The Utah Department of Health (UDOH) is pleased to submit the Title V Maternal and Child Health Services Block grant plan for FFY 2020 and annual report for FFY 2018. The Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Bureaus are the lead agencies in the UDOH responsible for the work of this grant. Included in this report is an overview of highlights, accomplishments and challenges as the work progresses to move the needle for women, infants, children and children with special health care needs.

The UDOH has a specific Vision, Mission and Strategic Priorities. UDOH Vision: for Utah to be a place where all people can enjoy the best health possible, where all can live, grow and prosper in healthy and safe communities. UDOH Mission: is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care and promoting healthy lifestyles. Strategic Priorities: Healthiest People, Optimize Medicaid and A Great Organization. The work of Title V in Utah aligns well with the UDOH.

Title V Leadership - The Maternal & Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Bureaus

Utah's MCH and CSHCN Bureaus work collaboratively to improve the health status of MCH/CSHCN populations and are the lead agencies accountable for implementation of Title V Block Grant activities. Both Bureaus reside in the Division of Family Health and Preparedness (DFHP) at the UDOH. Leadership meet on a regular basis to manage and assure programs are functioning at the highest capacity possible. The MCH Bureau consists of six programs - Maternal & Infant Health, Integrated Services, Family Youth & Outreach (which includes: Oral Health, Pregnancy Risk Line, Early Childhood Utah), Data Resources, Office of Home Visiting (MIECHV) and Women, Infant & Children (WIC). The CSHCN Bureau consists of 14 Programs. Of the 14 the following four are funded to work specifically on Block Grant Activities-Utah Birth Defects Network, Autism System Development, Early Hearing Detection and Intervention (EHDI), and Child Health Advanced Records Management (CHARM). In addition the MCH/CSHCN Bureaus work in partnership with the Bureau of Health Promotion (housed in the Division of Disease Control & Prevention). The Programs in this Bureau that work serve MCH populations includes: Violence and Injury Prevention, Baby Your Baby and EPICC (Environment, Policy and Improved Clinical Care). Efforts in the EPICC Program include policies and interventions for physical activity and healthy lifestyles.

Utah Geography and Demographics



Utah is the thirteenth largest state in the nation and is a largely rural and frontier state. The majority of the population resides along the Wasatch Front, a 75-mile strip running from Ogden to Provo, with Salt Lake City, the state's Capital, in between. The Wasatch Front comprises only 4% of the state's land mass, but 75% of the population. Utah's 2018 population count is estimated at 3,161,105. Utah is known for its signature demographics, which include the youngest population, largest household sizes, and one of the most rapidly growing populations.

The population of Utah is primarily white and non-Hispanic with the overall minority share of the population much lower than the national average. However, linguistic demographics are rapidly evolving, with approximately one in seven Utah residents older than age five speaking a language other than English at home. The population of every racial and ethnic group is growing at a faster rate than whites and the overall state population. Historically, Utah has claimed the highest general fertility rate in the nation, however in 2017, Utah's fertility rate fell below that of both North and South Dakota (72.0 Utah live births per 1,000 vs. 60.3 U.S.). Utah continues to have the highest birth rate in the nation (15.8 Utah vs. 11.8 U.S.).

Public Health System

The public health system is comprised of 14 health departments, the UDOH and 13 local health departments (LHDs). Approximately half of the LHDs are multi-county districts covering large geographic areas that include both rural and frontier areas within their service region. While the LHDs in all of these areas receive Title V funds, demand for services often far outpaces funding. In addition, many have been gradually moving away from direct services, recognizing they do not have the capacity to provide primary care in their communities and are not a true medical home. New this past year, four of the LHDs are providing care coordination services for children with special health care needs.

A Local Health Department/District is the "boots on the ground" agency where public health programs are implemented and key collaborations/partnerships happen. Approximately half of Utah's LHDs are multi-county districts covering large geographic areas. Many include both rural and frontier areas within their service region.

A strong partnership exists between the UDOH and LHDs. The MCH Director meets at least six times per year with the LHD Nursing Directors to develop objectives and implement strategies that reach MCH/CSHCN populations specific to the need in their respective areas. This past year services for women/infants, provided by the LHDs included: maternal mental health/depression screening and referral (including telemental health), home visiting services, family planning, and breastfeeding support (resources, information and policies). Services for Children included: clinical services and care coordination for CSHCN in four rural/frontier LHDs, violence and injury prevention programs for children ages 1 to 19, suicide prevention, physical activity programs, autism screening and education, developmental screening, oral health/sealants, vision/hearing screening, etc.

Health Care/Health Insurance

Access to low-cost maternal and child health care services provided by community health centers is problematic in rural/frontier areas of the state as they span large geographic areas. Community health centers opened in some of the more rural areas of the state yet the need in rural/frontier remains high. For instance, American Indian women and children in Southeastern Utah may need to travel to Tuba City, Arizona or to Blanding, Utah for services if Indian Health Services is not able to pay.

While health insurance coverage rates improved for many Utahns under the Affordable Care Act (ACA), some still do not have adequate coverage. The rates of no health insurance coverage declined from 2013-2016 but rose in 2017, making Utah's uninsured rate of 9.2% higher than the U.S. average of 8.6%. For Utah's CSHCN populations, some services are not covered under the ACA, leaving families with high out-of-pocket expenses. The 2017 National Survey of Children's Health found that 6.2% of children were uninsured, an increase from the 2016 rate of 5.8%.

Indicator 3.1: Is this child currently covered by health insurance or health coverage plan?

		Insured at time of survey	Not insured at time of survey	Total %
Utah	%	93.8	6.2	100.0
	C.I.	89.2 - 96.5	3.5 - 10.8	
	Sample Count	418	22	
	Pop. Est.	856,470	56,683	
Nationwide	%	93.8	6.2	100.0
	C.I.	92.8 - 94.6	5.4 - 7.2	
	Sample Count	20,675	844	
	Pop. Est.	68,446,204	4,540,903	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.

Utah's Medicaid program is administered by the UDOH and is an advocate for supporting MCH/CSHCN populations in the state. The CSHCN Bureau and Integrated Services Program in the MCH Bureau are partners in providing care coordination, explaining benefits, eligibility and services for select Medicaid clients. Earlier this year Utah expanded Medicaid coverage to approximately 70,000-90,000 adults who earn up to 100% of the federal poverty level (about $12,492 for an individual or $25,752 for a family of four). The federal government covers approximately 70% of the costs associated with caring for these newly eligible adults, with the state covering the remaining 30%. More than 31,000 Utah adults are already enrolled in the expanded Medicaid program.

The UDOH is implementing the requirements outlined in Senate Bill 96 (2019 Utah General Legislative Session), which directs how Medicaid expansion will occur in the state. Known as the 'per-capita cap,' the proposal seeks to increase federal cost sharing to 90%. It also allows the federal government to cap the amount of money it will direct to the state to cover the newly eligible adults. Other elements of the proposal include a self-sufficiency requirement, the ability to provide housing supports, an option to lockout individuals who deliberately violate program requirements, and allowing up to 12 months of continuous eligibility.

Family Centered Services

Utah places a high value on family centered partnerships and collaboration. A few examples include UDOH's partnership with Utah Family Voices. Utah Family Voices supports family centered care for all children and youth with special health care needs and/or disabilities. Both CSHCN and MCH partner and work closely with this group.

The CSHCN Advisory Committee is comprised of family members and individuals with special health care needs. This committee advises the Bureau on the family/parent perspective regarding issues, needs, and services, influences the direction of policies, contributes to program improvement, and ensures a voice for families and individuals with special health care needs to improve the system of care. The Bureau of CSHCN has both parents and individuals with special health care needs employed. Also, the Integrated Services Program in the Bureau of MCH connects regularly with families to provide care coordination to children with special health care needs.

Title V Partnerships

MCH/CSHCN have established partnerships that help expand the work of reaching women, infants, children (including CSHCN), and families. Federal and non-federal funds are leveraged to deliver programs and services in the state. MCH/CSHCN staff maintain working relationships with Title V and non-Title V Programs to create a statewide system of collaboration. The levels of cooperation with various partners and partnerships can include networking (information sharing), linkages (agreements which include referrals, intake, interagency consultations, monitoring referral outcomes, participation in joint planning meetings (which usually do not involve the sharing of funds), collaboration (specific formal agreement to accomplish common purposes including specific allocations of staff time and funds, quantities of services, timeline, use of each other's sites, joint staff trainings and co-sponsorship of events), and integration (formal horizontal or vertical affiliation or merger of agencies with resultant structural and leadership changes). A small example of Utah Title V partnerships include: health care systems (University of Utah, Intermountain Healthcare, Community Health Centers), non-profit agencies (YWCA, Utah Family Voices, Help Me Grow, Utah Parent Center, Utah Maternal Mental Health Collaborative), advisory groups (Newborn Screening, Autism Initiative, CSHCN Advisory Committee, Newborn Hearing Screening), other public health systems and programs (Local Health Departments, Indian Health Board, Home Visiting-MIECHV, Child Development), etc.

Priorities and Progress

Utah continues to implement a variety of methods to ensure resources and programs are reaching vulnerable MCH/CSHCN populations. Ongoing needs assessments, surveys, and program evaluations are implemented throughout the year, in addition to the required every five year comprehensive needs assessment. Data received from these assessments and evaluations provide direction and information to leadership regarding progress in reaching goals which allows for timely "course corrections/adjustments" as needed. MCH/CSHCN produce reports to evaluate and educate on issues related to Title V populations. For example, articles are published in the Utah Health Status Update, which is published monthly by the UDOH Center for Health Data and Informatics.

Utah aligns its programs and activities with the "10 Essential Public Health Services to Promote Maternal and Child Health" framework. This model provides a well-rounded strategy which allows Utah to incorporate assessment, policy development, and assurance components within all of its programs. Utah ensures that the State Action plan activities are linked to the 10 Essential MCH Public Health Services. Utah is stronger in some of the areas, but we are working to improve and become equally aligned across all services.

Utah aligns its CSHCN services with the AMCHP's National Consensus Standard for Systems of Care for CYSHCN. Utah supports a coordinated care model which is inclusive of the family. Utah continues to struggle with agencies operating in silos and being open to reducing duplication of services and processes. Utah uses evidence based approaches and values data in supporting initiatives to ensure a robust foundation and solid system.

Five-Year MCH Needs Assessment

In 2015, Utah completed a comprehensive needs assessment process to identify priorities for the 2016-2020 MCH Block Grant Cycle. The table below shows the health needs that were identified during this process and the associated State Priorities and National Performance Measures (NPM) and State Performance Measures (SPM) that were selected to address these needs.

The selected NPMs and SPMs are as follows:

- Women/Maternal Health - NPM 1 Well-Woman Visit and NPM 13A Oral Health for Pregnant Women

- Perinatal/Infant Health - NPM 3 Perinatal Regionalization, NPM 4 Breastfeeding, and SPM 1 Preterm Birth
- Child Health - NPM 6 Developmental Screening and SPM 3 Child Injury
- Adolescent Health - NPM 8 Adolescent Physical Activity, NPM 13b Oral Health – Children, and SPM 4 Adolescent Suicide
- Children with Special Health Care Needs - NPM 11 Medical Home, NPM 12 Transition, and SPM 2 CSHCN in Rural Areas

State Health Needs, Priorities, and Performance Measures, Utah, 2015

MCH Population Domain	Identified Health Needs	2015 Selected State Priorities	Selected Performance Measures NPMs/SPMs
Women/ Maternal Health	• Adequate insurance coverage • Awareness of importance of preventive care • Depression/mental health • Diabetes prevention • Domestic violence • Family planning/unintended pregnancy • Healthy weight maintenance • Male/father involvement • Prenatal care/multivitamin use • Substance abuse	• Preconception and interconception care	**NPM 1 – Well-woman visit** Percent of women with a past-year preventive medical visit
Perinatal/ Infant Health	• Adequate insurance coverage • Developmental delays • Immunizations • Injury prevention • Lack of quality child care • Low breastfeeding prevalence/poor infant nutrition • Parenting knowledge • Premature/low-birth-weight babies • Safe sleep	• Breastfeeding promotion • Preterm and low-birth-weight babies/NICU	**NPM 3 – Perinatal regionalization** Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) **NPM 4 – Breastfeeding** A - Percent of infants who are ever breastfed B - Percent of infants breastfed exclusively through 6 months **SPM 1—Preterm births** Percent of live births occurring before 37 completed weeks of gestation
Child Health	• Adequate insurance coverage • Developmental delays • Immunizations • Injury prevention • Lack of quality child care/after-school supervision • Maintenance of healthy weight/physical activity • Mental health	• Developmental screening • Injury and injury-related deaths	**NPM 6 – Developmental screening** Percent of children, ages 10–71 months, receiving a developmental screening using a parent-completed screening tool **SPM 3—Child injury deaths** The rate (per 100,000) of injury deaths among children aged 1–19
Adolescent Health	• Adequate insurance coverage • Comprehensive sexual health education/sexually- transmitted infections • Depression/mental health/suicide • Immunizations • Injury prevention • Lack of after-school supervision • Maintenance of healthy weight/physical activity • Substance abuse • Teen pregnancy/access to contraceptives	• Prevention of unhealthy weight (overweight/obese) among children and adolescents • Suicide, mental health issues, and access to mental health services	**NPM 8 – Adolescent physical activity** A - Percent of adolescents ages 12 through 17 who are physically active at least 60 minutes per day B - Percent of adolescents in grades 9 through 12 who report being physically active at least 60 minutes per day in the past week **SPM 4—Adolescent suicide** The rate (per 100,000) of suicide deaths among youths aged 15–19
Children with Special Health Care Needs (CSHCN)	• Adequate insurance coverage • Availability of specialized services • Cost of care/financial stability • Income-based eligibility/waiting list for public programs • Lack of support for rural families • Medical home/service coordination • Recreational/social activities • Relevant community services and resources • Respite care • Transition to adulthood	• -Out-of-pocket costs/ financial challenges faced by CSHCN parents • Specialty service availability in rural areas and improved care coordination for children with special needs	**NPM 11 – Medical home** Percent of children with special health care needs having a medical home **NPM 12 – Transition** Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care **SPM 2—CSHCN rural clinical services** Percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program
Cross-Cutting/ Life Course	• Adequate insurance coverage • Cost of care/financial stability • Family planning/unintended pregnancy • Immunizations • Lack of support for rural families • Maintenance of healthy weight • Medical home/service coordination • Mental health • Substance abuse • Violence	• Adequate insurance coverage	**NPM 13 – Oral health** A - Percent of women who had a dental visit during pregnancy B - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Accomplishments Related to the Performance Measures (NPMs and SPMs) During FY18

The tables below show Utah's progress during the past year on achieving the National and State Performance measures.

New National Performance Measure Accomplishments: Progress on "Moving the Needle"

Women/Maternal Health

NPM 1 – Well-Woman Visit: (Percent of women with a past-year preventive medical visit)

- Relationships with two local universities has allowed the MIHP to reach college-aged women with education and information about the importance of routine preventive care.
- Conducted focus groups with women to assess their knowledge, perceptions, and beliefs and barriers associated with the well-woman exam. A final report was developed with recommendations for future activities.

NPM 13A – Oral Health-Pregnant Women: (Percent of women who had a dental visit during pregnancy)

- The Oral Health Program (OHP) intern worked with the MotherToBaby Program on their oral health questions data. She also worked with WIC comparing our pilot data from Ogden and Provo WIC clinics. Using these two data sets, along with PRAMS, she assessed oral health needs and barriers to care for pregnant women.
- The OHP intern presented a poster at the Utah Public Health Association (UPHA) for the MTB Program. She submitted a proposal on her research to speak at the 26th International Conference on Advanced Dental Care in Moscow. Her BYU Professor presented her report.
- The OHS provided an in-service presentation called Strategies for Promoting Oral Health for Pregnant Women, Infants, and Children to Cedar City EHS/HS staff. A four-minute long video segment on oral health for pregnant mothers and infants was made to share with staff.
- The OHS continued to coordinate KUTV Baby Your Baby segments with topics of oral health and pregnancy, baby bottle use, and other oral health topics.
- The OHP published and disseminated two Oral Health Outreach Reports.
- The OHP continued using the "12 Oral Health Messages" created for pregnant mothers and children.

Perinatal/ Infant Health

NPM 3 – Perinatal Regionalization: (Percent of very low-birth-weight infants born in a hospital with a Level III+ Neonatal Intensive Care Unit)

- Utah completed data collection and assessment of the Level of Care Assessment Tool (LOCATe).
- The Maternal and Infant Health Program (MIHP) discussed LOCATe level of care discrepancies with participating hospitals and come to a consensus on levels.
- Worked with the CDC on a multi-jurisdictional analysis to compile LOCATe data by outcomes and levels of care will provide insights on perinatal regionalization.

NPM 4 – Breastfeeding: 4A (Percent of infants who are ever breastfed) & 4B (Percent of infants breastfed exclusively through 6 months)

- Intermountain Healthcare has endorsed the Stepping Up for Utah Babies program and has recommended that all hospitals in their system implement the program. Nineteen out of twenty-one Intermountain Healthcare Hospitals have been trained and have created a breastfeeding policy that address implementation of all ten steps.
- Three local WIC agencies were awarded national awards for their Breastfeeding Peer Counseling Programs.
- Local WIC agencies expanded the reach of the Peer Counseling Program significantly through creating Breastfeeding Support Groups for the community, expanding communication channels to include at-home visits and texting, collaborating with local physician's offices to improve community referrals to WIC Peer Counseling services, and utilizing the Breastfeeding Attrition Prediction Tool to provide targeted breastfeeding education and counseling to participants.
- The Utah Healthy Living through the EPICC program assisted worksites to develop a lactation policy that complies with national and state laws. Twenty-five worksites created a policy, 77 worksites provided a private space for employees to express milk, 77 worksites provide flexible break times to allow mothers to breastfeed and/or pump and 75 worksites provided on-site refrigerated space for breast milk storage.

SPM 1 – Preterm Birth: (Percent of live births occurring before 37 completed weeks of gestation)

- Creating and reviewing 17-P utilization run charts for individual hospitals and for statewide tracking has helped to visualize the baseline and have discussions with hospitals on how they can improve the number of eligible women who they are having a discussion about 17-P to reduce their risk.
- The University of Utah created a spontaneous PTB section in their Electronic Medical Record (EMR) EPIC which captures patient history of singleton spontaneous PTB, whether 17-P was offered, if the patient took 17-P injections and if so, when they were started. A data sharing agreement was executed to share this data with MIHP, which will help to establish a baseline and identify potential barriers to optimal treatment.
- A new variable on progesterone use on the Utah birth certificate has allowed us to establish a baseline from which we are creating run charts and discussing with hospitals.

Child Health

NPM 6 – Developmental Screening: (Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool)

- Throughout FY18, 6,649 children ages 9-35 months received an age aligned developmental health screen through the UDOH ASQ online account.
- Among those screened, 85.5% were above cutoff or in the monitoring zone.
- From 2015 to 2018, Help Me Grow Utah facilitated 10,509 age aligned developmental screens.

SPM 3 – Child Injury: (Rate of injury deaths among children 1-19)

- LHDs collaborated with school districts to support and coordinate activities with local hope squads.
- LHDs distributed 810 gun locks to residents in their communities.
- VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens.
- To increase awareness of violence and injury impacting youth, VIPP took the lead in developing the 2017 Utah Adolescent Health Report using data from the Prevention Needs Assessment.

Adolescent Health

NPM 8 – Adolescent Physical Activity: (Percent of adolescents in grades 9 through 12 who report being physically active at least 60 minutes per day in the past week)

- EPICC staff partnered with the State Board of Education and SHAPE Utah to provide PE/PA professional development opportunities.
- Partnered with SHAPE Utah and USBE to conduct work statewide conferences.

NPM 13B – Oral Health-Children: (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)

- The Oral Health Program (OHP) staff attended each of the Migrant Head Start locations to conduct physical assessments, oral health risk assessments, and applied fluoride varnish.
- OHP staff visited the Ute Tribe Head Start (UTHS) provide physical assessments, oral health risk assessments, applied fluoride varnish and made appropriate referrals.
- The Oral Health Specialist worked with a National Oral Health Initiative to help eradicate dental disease in children.
- The OHP published and disseminated two oral health outreach reports with stakeholders and other partners.

SPM 4 – Adolescent Suicide: (The rate of suicide deaths among youths aged 15-19)
• Suicide prevention activities were emphasized in local health department contracts. As a result, there was an increase in individuals reached through suicide prevention activities in local communities. • LHDs collaborated with school districts to support and coordinate activities with local hope squads. • LHDs distributed 810 gun locks to residents in their communities. • VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens. • The VIPP requested epidemiological assistance from the Centers for Disease Control and Prevention (CDC) in 2017. Youth suicide data was analyzed to determine trends, common precipitating factors for suicide, and risk and protective factors for suicidal behaviors unique to Utah youth. Their findings were reported to the Utah Department of Health in November 2017. • Governor Herbert created a Youth Suicide Task Force in January 2018. The report from this task force was submitted to the Governor in February 2018. • The Youth Suicide Task Force report led to several suicide prevention bills and funding allocation from the Utah State Legislature. Unfortunately, the legislature has not allocated any funding to primary prevention of suicide.
Children with Special Health Care Needs
NPM 11 – Medical Home: (Percent of children with special health care needs having a medical home)
• The Integrated Services Program worked with partners to implement shared plans of care for families and professionals regarding needs for CSHCN. • The Integrated Services Program and its partners educated professionals about the components of a medical home through four quarterly Utah Chapter of the American Academy of Pediatrics' Growing Times newsletter articles. • MCH Bureau funded enhancements to the medical home portal including adding content, adding customizable lists for users, expanding local services listings, adding a live-help telephone support process, and adding partners.
NPM 12 – Transition: (Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care)
• Participating primary care practices who provide care coordination are communicating with schools around care and accommodations for their patients. • The Medical Home Portal / Shared Resource is well utilized both in Utah and in other states and is providing information that is needed by families and providers including resources for families and providers regarding transition to adulthood. • Coordinating Council for Persons with Disabilities (CCPD) conducted discussions regarding a communication platform that could jointly serve their service users.
SPM 2 – CSHCN in Rural Areas: (Percent of CSHCN in the rural areas of the state receiving direct clinical services through the state CSHCN program)
• ISP established a MOU with University of Utah's Pediatric Orthopedic group to continue to fund air travel, clinical space rental, and ground transportation for twelve rural clinics per year. • Care Coordinators were hired at four LHDs, and in depth training was provided by ISP and the Utah Children's Care Coordination Network. • Full-time clinical staff, am APRN and a Pediatric Nurse Practitioner, were hired for rural and Wasatch Front clinics, part-time staff, and OT, PT, SLP, and Audiologist, were hired to cover rural traveling clinics. • Direct clinical and care coordination services provided to 533 unique patients in rural Utah. • Statewide, 833 unique patients served through clinical services (including pediatric orthopedics) and care coordination, with 1688 patient encounters.

Achievements Related to the Performance Measures (NPMs and SPMs) During FY18

The table below illustrates Utah's progress during the past year on achieving the National and State Performance measures.

2018 Block Grant Performance Measure Objective Achievement Status				
Population Domain	Performance Measures	Achieved	Objective	Utah Data
Women/Maternal Health	**NPM 1**- Well-Women Visit: Percent of women with a past-year preventive medical visit	No	57.0	54.6
	NPM 13A- Oral Health-Pregnant Women: Percent of women who had a dental visit during pregnancy	No	56.9	53.6
Perinatal/Infant Health	**NPM 3**- Perinatal Regionalization: Percent of very low-birth-weight infants born in a hospital with a Level III+ Neonatal Intensive Care Unit	No	91.7	89.1
	NPM 4A- Breastfeeding: Percent of Infants who are ever breastfed	Yes	88.6	89.7
	NPM 4B- Percent of infants breastfed exclusively through 6 months	Yes	26.9	27.8
	SPM 1- Preterm Birth: Percent of live births occurring before 37 completed weeks of gestation	Yes	9.4	9.4
Child Health	**NPM 6**- Developmental Screening: Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool	No	33.2	32.6
	SPM 3- Child Injury: Rate of injury deaths among children 1-19	No	15.1	15.7
Adolescent Health	NPM 8- Adolescent Physical Activity: Percent of adolescents in grades 9 through 12 who report being physically active at least 60 minutes per day in the past week	Yes	18.9	19.1
	NPM 13B- Oral Health-Children: Percent of Children, ages 1 through 17, who had a preventive dental visit in the past year	Yes	80.3	82.4
	SPM 4- Adolescent Suicide: The rate of suicide deaths among youths aged 15-19	No	16.7	21.5
Children with Special Health Care Needs	**NPM 11**- Medical Home: Percent of children with special health care needs having a medical home	No	50.4	43.9
	NPM 12- Transition: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care	Yes	18.4	20.2
	SPM 2- CSHCN in Rural Areas: Percent of CSHCN in the rural areas of the state receiving direct clinical services through the state CSHCN program	Not	2.0	1.6

The Title V Block Grant application for Utah represents a comprehensive effort to move the needle for improved health outcomes for women, children and infants. The National and State Performance Measures are a reflection of the important issues we face in our state. There are also emerging issues that raise concerns and require action.

Utah has seasoned and qualified staff that administer and implement the Title V Block Grant. As such Utah continues to be a leader and example for “moving the needle” for the health of women, infants and children. This application reflects the commitment and efforts of MCH/CSHCN and other UDOH staff and community partners working together to achieve the goals and strategies outlined hereafter.

III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V funds support many MCH/CSHCN efforts across the state. One of the challenges is distributing limited state and federal dollars among populations with the greatest need. Needs assessments, surveys, data collection and reports are the best way to identify Title V population needs. The budget outlines where Block Grant dollars are distributed. MCH/CSHCN continue to evaluate the effectiveness of the programs it funds and is looking forward to the needs assessment feedback and setting goals to meet community needs in FY2020. With the transformation of the Block Grant, changes in grant requirements and consideration of "historical" funding patterns distribution of dollars is being reviewed and justified. It is anticipated a reallocation of funds, and associated changes will be put into effect October 1, 2020.

Block Grant funds are distributed as follows: Bureau of Maternal and Child Health: Programs - Maternal Infant Health, Integrated Services, Family Youth & Outreach (Adolescent/Child, Oral Health, Pregnancy Risk Line/MotherToBaby), Home Visiting, Early Childhood Utah and Data Resources; Bureau of Children with Special Health Care Needs: Programs - Autism System Development, Birth Defects Network, Early Hearing, Detection and Intervention Program Child Health Advanced Records Management); Bureau of Health Promotion: Programs - Violence and Injury Prevention, Physical Activity, Baby Your Baby; and 13 Local Health Departments.

III.A.3. MCH Success Story

Utah EHDI Success Story
For 2019, the Utah EHDI team is working on creating more opportunities for families of children who are deaf or hard of hearing (DHH) to learn about available resources. We planned 3 events:

Our first event for families was planned in conjunction with DSDHH (Division of Services for the Deaf and Hard of Hearing). The DSDHH hosted our event at their location in St. George, Utah and provided marketing support in addition to our own efforts to make sure we had as many families invited. We simultaneously live-streamed the presentation onto our Facebook page. This was also recorded for anyone unable to participate in person or via live stream, available on our Facebook page, Utah EHDI Family Support and Information (@UtahEHDI).

Justin Osmond, nephew to Donny and Marie Osmond, presented at this event for parents, DHH children and adults, and our Facebook audience about overcoming adversity, accepting yourself, and finding a purpose. The theme of his presentation was "I May Have a Hearing Loss, but My Hearing Loss Doesn't Have Me." We had 30 attendees in person and almost 500 views so far on our FB page.

Our next two events featured Aimee Walker-Pond, the only Deaf Gymnast to compete at an Elite level; and Rachel Coleman, President of the ASDC (American Society of Deaf Children) and creator of the critically acclaimed PBS series "Signing Time" and the "SignIt" video series which are both excellent ASL (American Sign Language) resources for families.


UTAH DEPARTMENT OF
HEALTH
Early Hearing Detection & Intervention
Justin Osmond

For Parents of Children who are Deaf or Hard of Hearing:

An Evening With Justin Osmond

www.justinosmond.com

"I may have a Hearing Loss, but my Hearing Loss does not have me."

Thursday February 7th, 2019

6:30 pm-8:00 pm

Pre-registration requested and appreciated.

Register at:
https://conta.cc/2FThsD6

Southern Utah Deaf and Hard of Hearing Program
1067 E. Tabernacle, Ste 10, St. George, UT
and LIVE on Facebook @utahehdi

Valentine Activities for children provided!

Utah Parent Center
Special needs, extraordinary potential

UTAH DEPARTMENT OF HEALTH
Early Hearing Detection and Intervention

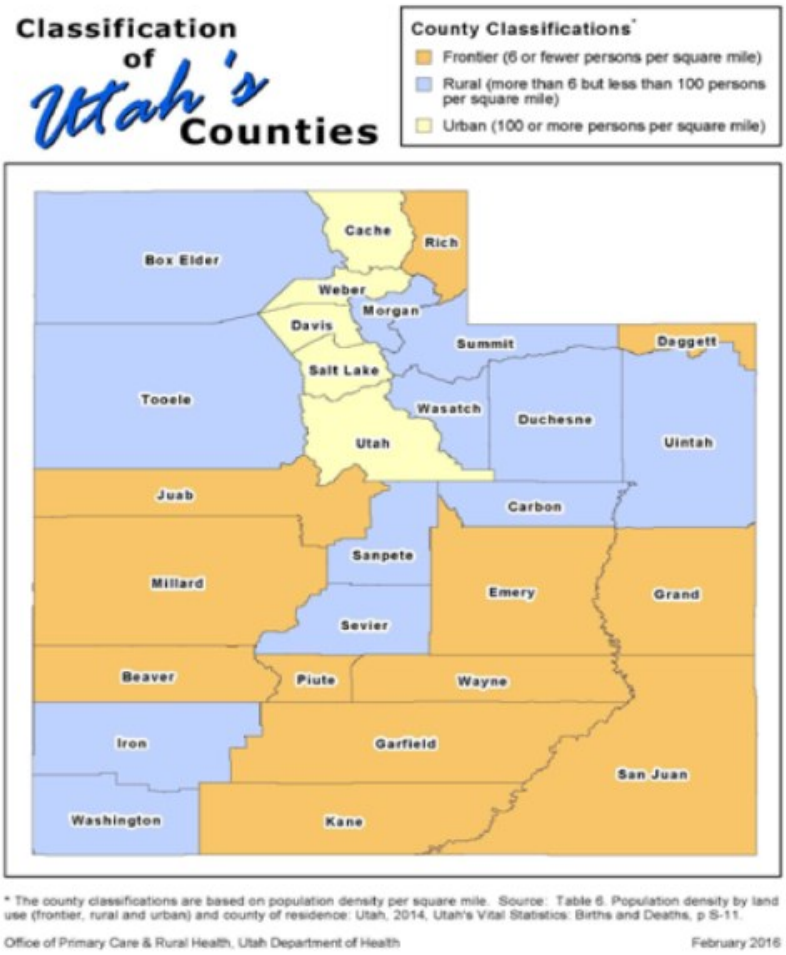
DSDHH


2019 NATIONAL EHDI MEETING
WEBSITE OF THE YEAR
HEALTH
Children With Special Health Care Needs
Early Hearing Detection and Intervention (EHDI)
Presented to:
UTAH DEPARTMENT OF HEALTH
EHDI
18TH ANNUAL EARLY HEARING DETECTION & INTERVENTION MEETING

III.B. Overview of the State

Population Demographics

Utah is geographically the thirteenth largest state and is a largely rural and frontier state. Thirty-seven percent of the State's population resides in a single county, Salt Lake County, which comprises one percent of the State's land mass. Utah has 5 urban, 12 rural, and 12 frontier counties. Utah's average population density is 35.9 persons per square mile, compared to 91.0 persons per square mile nationally. Sixty-seven percent of Utah's lands are under federal ownership, with 22% privately owned, 7% by the State and 4% by Utah's tribes.



* The county classifications are based on population density per square mile. Source: Table 6. Population density by land use (frontier, rural and urban) and county of residence: Utah, 2014, Utah's Vital Statistics: Births and Deaths, p S-11.

Office of Primary Care & Rural Health, Utah Department of Health February 2016

Utah's 2018 population was estimated at 3,161,105. From 7/1/17 to 6/30/18, Utah's population grew by 1.9 percent, an increase of 59,292 people. Most growth comes from migration to the State.

Historically, Utah has claimed the highest general fertility rate in the nation, however in 2017, Utah's fertility rate fell below that of both North and South Dakota. Utah's fertility rate was 72.0 live births per 1,000 women in 2017 compared to 60.3 nationally. Utah continued to have the highest birth rate in the U.S. (15.8 Utah vs.11.8 U.S.). Utah's birth numbers declined for the third consecutive year with 48,578 live births to Utah residents in 2017.

Population estimates for 2017 detail Utah's racial/ethnic populations:

Race	Non-Hispanic		Hispanic		Total	
	Number	Percent	Number	Percent	Number	Percent
White	2,494,166	78.3%	399,778	12.5%	2,893,944	90.8%
Black	50,068	1.6%	13,416	0.4%	63,484	2.0%
American Indian/ Alaskan Native	44,500	1.4%	25,824	0.8%	70,324	2.2%
Asian	103,551	3.2%	7,644	0.3%	111,195	3.5%
Native Hawaiian/ Pacific Islander	44,224	1.4%	7,644	0.1%	48,371	1.5%
Total	2,736,509	85.9%	450,809	14.1%	**3,187,318**	

The predominant religion in Utah is the Church of Jesus Christ of Latter Day Saints (LDS), also known as the Mormon faith. The Pew Research Center reports that 55% of Utahns are of the LDS faith. Eighteen percent are of other Christian faiths (Protestant, Catholic, Jehovah's Witness), four percent are of non-Christian faiths (Jewish, Muslim, Buddhist, Hindu), 22% are unaffiliated (agnostic or atheist) and 1% are undecided. Religious entities are invited to advisory committees and their input is sought out and valued. While these efforts occur, challenges arise with different systems and policies with each denomination.

There are eight sovereign tribal governments within Utah: Confederated Tribes of the Goshute Reservation, Navajo Nation, Northwestern Band of Shoshone Nation, Paiute Indian Tribe of Utah, San Juan Southern Paiute, Skull Valley Band of Goshute, Ute Mountain Ute Tribe, and Ute Indian Tribe. Census data shows the largest tribal communities indigenous to Utah are the Navajo Nation, Ute Indian Tribe, and Paiute Indian Tribe of Utah. Close to one-third of Utah's American Indian population speak a language other than English at home. After English, Navajo is the fourth-most spoken language in Utah.

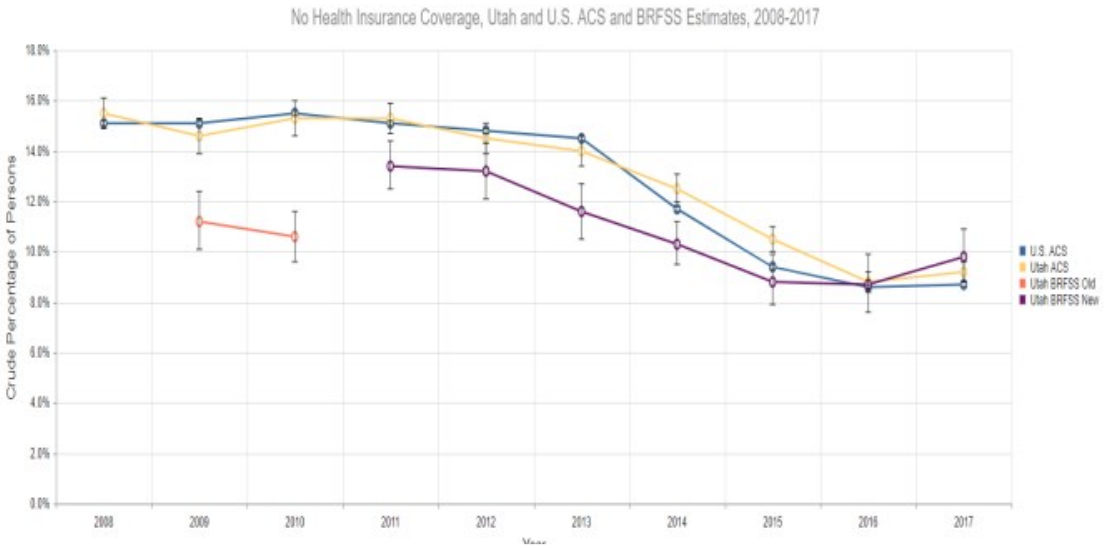
In Utah, life expectancy at birth was 78.0 years for males and 81.8 years for females in 2017. The median age of Utah's population is 30.5 years, versus 37.8 in the U.S., ranking the state youngest in the nation. The 2013-2017 American Community Survey (ACS) estimates note that 41.8% of Utah's population is under the age of 24, compared with 32.7% nationwide.

Utah's Economy

The Bureau of Labor Statistics notes that the 2017 unemployment rate in Utah was 3.3 compared to 4.4 for the nation. Utah's median household income, $65,325, was higher compared to the U.S. at $57,652. However, Utah's households are also large, resulting in a significantly lower per capita income ($26,907 vs. $31,177). There is also variation by race with the median income ranging from $67,070 for white Utahns to $40,536 for Black Utahns. According to the 2013-2017 ACS 5-Year estimates, the percentage of individuals with incomes below the federal poverty level is 11.0% in Utah vs. 14.6% in the U.S. For children living in poverty, Utah's 12.5% is below the national average of 20.3%. Poverty rates also range widely, depending on county of residence. 2017 poverty rates are lowest in Morgan County (4.1%) and highest in San Juan County (25.9%), with a statewide mean of 9.7%.

Health Insurance

The rates of no health insurance coverage declined from 2013-2016, regardless of data source. However, rates of no insurance increased in 2017. Estimates of no health insurance coverage among adults in 2017 were slightly higher in the BRFSS (9.8%) than the ACS (9.2%), but both rates are now higher than the U.S. rate of 8.6% (ACS).



Education

Based on the 2013-2017 ACS, Utah had a higher percentage of residents with a high school diploma, at 91.8% vs. 87.3% nationally among those aged 25 years and older. Utah's population 25 years and older with a Bachelor's degree is higher than the U.S. (21.5% vs 19.1%) and similar to the U.S. for those with graduate degrees (11.0% vs 11.8%). According to the 2018 Kids Count report, Utah has a higher percentage of children ages 3-4 who are not in school compared to the nation (58% vs 52%). Utah is doing better than the national average for the proportion of fourth graders not proficient in reading (59% vs. 65%). The National Education Association reports Utah having the second-lowest per-student expenditure at $7,187, compared to the national average of $12,602.

Household and Family

Utah has the largest household size in the country at 3.1 persons per household compared to 2.6 nationally. The percent of Utah family households with children is also higher at 39.5% vs. 28.8% nationally.

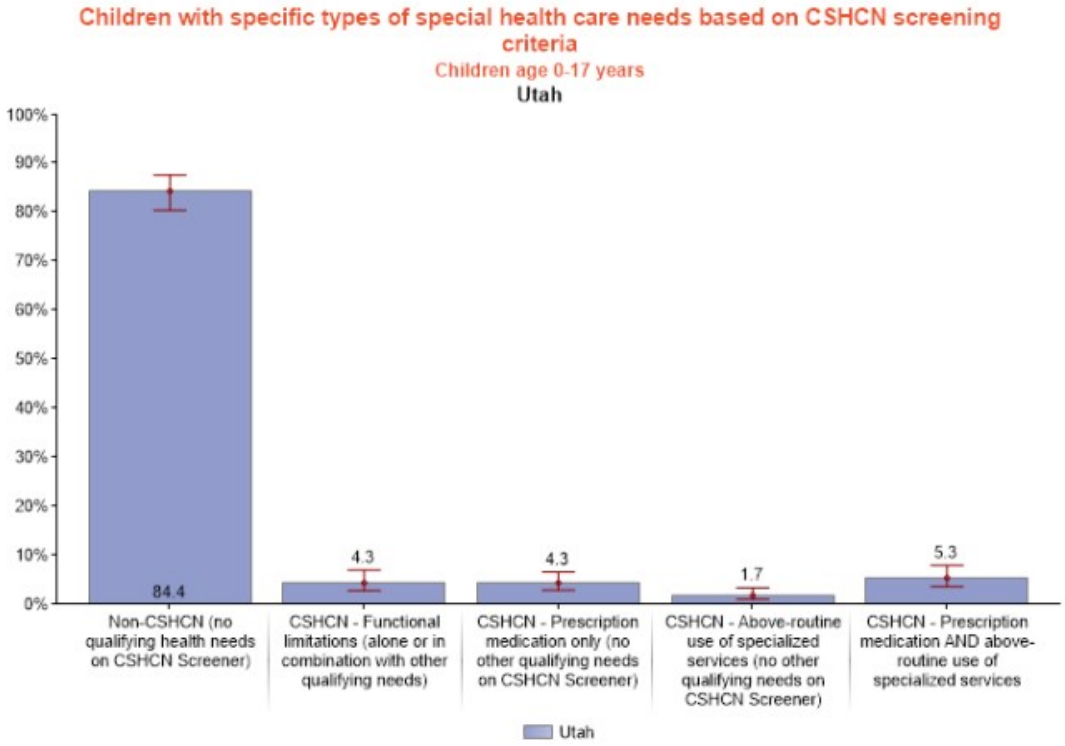
2016 National Survey of Children's Health data illustrate many areas where Utah's children differ:

	Utah %	U.S. %
Race/Ethnicity		
Hispanic	17.3	24.9
White Non-Hispanic	73.2	51.0
Black Non-Hispanic	0.5	13.4
Asian Non-Hispanic	1.8	4.7
Other Non-Hispanic	7.2	6.1
Primary language spoken in home		
English	89.3	85.2
Non-English	10.7	14.8
Highest Education in Household		
Less than High School	4.7	8.5
High School	14.5	19.6
Some College	21.7	22.3
College Graduate	59.1	49.5
Family Structure		
Two parent, currently married	85.0	68.1
Two parent, not currently married	3.9	8.7
Single parent	8.5	16.9
Other family type	2.6	6.3
Not insured at time of NCHS survey	6.2	6.2
Current insurance not adequate	39.3	26.5
2 or more adverse childhood events	18.3	19.3

Children with Special Health Care Needs (CSHCN)

Data from the 2017 National Survey of Children's Health (NSCH) found 19.4% of Utah children have one or more functional difficulties, an increase from 15.5% in 2016. The NSCH data also found that 15.6% of Utah children have a special health care needs, ranking Utah as the sixth lowest in the nation.

2016-2017 NSCH data shows that Utah's rate of children ages 3-17 diagnosed with autism is 2.5% and is very similar to the U.S. rate of 2.8%. Utah's percentage of children diagnosed with autism at 5 years or older is higher than the U.S. (35.9% vs 31.5%). NSCH data also finds that children in Utah with autism are more often diagnosed by a psychologist or psychiatrist (55.5%) than the U.S. (39.1%).



Utah Title V Capacity

The Department of Health's and Utah's Title V unified vision is "A place where all people can enjoy the best health possible, where all can live, grow and thrive in healthy and safe communities." The Utah Department of Health (UDOH) is accredited by the Public Health Accreditation Board (PHAB) and continues to work on maintaining this credential.

Utah Code 26-10-1 through 26-10-7 provides statutory authority for Title V. Two bureaus within the Division of Family Health and Preparedness (DFHP) collaborate to serve mothers, infants, teens, children and children with special health care needs: Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN). The Bureau of Health Promotion also collaborates and contributes to the Title V work.

Title V staff work to identify the needs of underserved mothers, children, and children with special health care needs to prioritize allocation of resources. Staff weigh factors that limit access to, or availability of, services across the state in partnership with community organizations and other interested parties. Staff develop plans and interventions to support health needs. Division staff review and analyze MCH/CSHCN data and educate the public through marketing and educational sessions, produce reports, fact sheets, abstracts, and articles in peer reviewed journals with UDOH staff as authors.

Each program which addresses the health of mothers and children has a specific plan identifying goals, objectives and activities. The FHP Division has been in the process of reviewing, updating and improving all Bureau and Programs missions and strategic plans to ensure they are meaningful and useful to the individuals we serve. Program staff within DFHP are assigned responsibility for one or more National/State Performance measures. For programs outside of the Division, each is assigned responsibility for the related measures in their program plans. Additional goals and objectives are developed by each program as issues arise. Annually, each program reviews the previous year's accomplishments, as well as strategies and needs for the future. Based on these discussions, program managers amend program plans as needed. The Block Grant annual report and application process provides an opportunity for each program to review its accomplishments and to amend plans as needed based on its achievement of the assigned measures.

The Bureau of Maternal and Child Health oversees eight programs that focus on improving the health of MCH populations; Maternal and Infant Health; Integrated Services (care coordination, transition, medical home, and direct

evaluative and diagnostic clinical services); Family and Youth Outreach (Adolescent/Child, Oral Health, Mother to Baby Utah); Office of Home Visiting (MIECHV); Early Childhood Utah (ECU) which includes the Early Childhood Integrated Data System (ECIDS); Women Infants and Children (WIC) Program; and the Data Resources Program. The MCH Bureau also oversees 13 local health department contracts for services to mothers, children and adolescents.

The CSHCN Bureau oversees fourteen programs that focus on improving the statewide system of care for CSHCN and their families: Autism Systems Development Program; Baby Watch Early Intervention Program; Child Health Advanced Records Management (CHARM); Critical Congenital Heart Defect Screening; Children's Hearing Aid Program (CHAP); Cytomegalovirus Public Education and Testing (CMV); Early Hearing Detection and Intervention (EHDI); Fostering Healthy Children Program; Kurt Oscarson Children's Organ Transplant Fund; Organ Donations; Technology Dependent Waiver Program (contract from Medicaid to administer program ended 2/1/19, program combined with other waiver programs within Medicaid); Utah Birth Defects Network (including Zika Surveillance Intervention and Referral Program); and Utah Family Voices.The CSHCN Bureau improves the quality of life for families and children with special health care needs by monitoring occurrence, early screening, education, care coordination, transition and intervention to reach optimal health. For a more comprehensive description of Title V programs, please see Appendix A.

The CSHCN Bureau programs strive to coordinate care for the children and families served throughout the State. The Bureau has internal communication methods to encourage care coordination and transition for the populations served, monthly meetings, data sharing agreements, CHARM and shared resources to create a system which flows smoothly for Bureau employees. The Bureau also has external partnerships with other State agencies which are working toward reducing redundancies, creating data sharing agreements, utilizing CHARM, quarterly meetings and working towards utilizing the cHIE electronic record in sharing records in a one stop shared resource. Internally within the DFHP, the Integrated Services Program (ISP) collaborates with the CSHCN Bureau and shares an electronic record called CaduRx which allows sharing of patient records in one system to ensure clear communication and follow through methods to reduce loss to follow up.

The DFHP collaborates across the UDOH to ensure integrated use of data and population assessment. UDOH data capacity is very strong and focused around the Center for Health Data (CHD), which serves as the central point for state health data. CHD includes the Office of Vital Records and Statistics, the Office of Public Health Assessment (OPHA), the Office of Health Care Statistics (OHCS), and the Office of Public Health Informatics (OPHI). The CHD oversees data collection via the Behavioral Risk Factor Surveillance System (BRFSS) and the development of an Internet-based query system for health data (http://ibis.health.utah.gov/), providing access to more than 100 different indicators, as well as to data sets such as birth and death files, BRFSS, Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Surveillance System (YRBSS), hospital and emergency department data, hospital performance data, population estimates, and the Utah Cancer Registry. The OHCS is responsible for health plan surveys and reporting plan performance annually, as well as inpatient, ambulatory, and emergency room data. The DFHP has strong working relationships with the CHD.

The Utah Department of Health (UDOH) conducts a Utah Healthcare Safety Net bi-annual meeting. The meeting involves 50+ stakeholders vested in MCH and CSHCN and provides insight into legislative issues affecting healthcare and community resources and facilitates networking and collaborations with State advocates and organizations throughout the State.

Utah's Strengths and Challenges

Strengths

Utah's strengths include being one of the healthiest states in the Nation. The 2018 America's Health Rankings rank Utah as the fifth healthiest U.S. state. Utah's low rates of smoking, alcohol consumption, and obesity contribute to a healthier population. Utah's data capacity and utilization is high, which allows us to act quickly on emerging issues and make data driven decisions. Utah's Title V programs use social media for health education and are using technology to engage families and partners. Utah has strong collaboration efforts with stakeholders and utilizes the advice of our peers to develop, implement, and evaluate programs for women, children, and families.

Challenges

The geographic distribution of the state's population presents significant challenges for those delivering and accessing health care services, particularly in rural and frontier areas. Long travel distances and a shortage of

nearby hospital facilities and providers, particularly specialists, mean many residents must travel hundreds of miles for care. Many may be reluctant if not unwilling, to utilize certain services in their communities, such as family planning or mental health, because of concern for confidentiality and anonymity, as well as cultural beliefs in seeking these services in a very small town.

Health challenges among Utah's population include high rates of drug related deaths, primary care provider shortages, and low rates of childhood immunizations and lower than average public health spending.

Reorganization of the DFHP continued this year. A second major transition occurred in this grant period was the DFHP moving from six Bureaus to four. The Bureau of Child Development was dissolved and its three programs were split between MCH, CSHCN, and Health Facilities Licensing. Also, the DFHP moved the Health Clinics of Utah under executive leadership and the Patient Safety Director/IRB Chair was relocated to the Center for Health Data. The variety of reorganizational changes has increased the turn-over of employees which has created challenges with workloads, timeliness of rehiring, orienting and stabilizing new employees.

There remains a great need for services for children with special health care needs around the state. The CSHCN Bureau and ISP continue to research resources, make community connections, refer and brainstorm ideas for a more comprehensive and accessible service delivery system.

A challenge and opportunity arose in the month of May in which one of the largest counties, Weber, had its early intervention school district discontinue its contract June 30, 2019. The program is being transitioned in house and will be developed and managed within the CSHCN Bureau, Baby Watch Early Intervention Program. The opportunity provides for identifying inefficiencies in the early intervention system and ensuring top quality and compliance with regulations. We were able to hire almost all of the employees from the school district who provided the early intervention services which created minimal inconsistencies in service provision. Additionally, the location of the center is co-located in the same building in Ogden as the Clinics of Utah which will allow for referrals and collaboration, including coordination with ISP services.

Addressing the Needs of a Diverse Population

The Department has endeavored to include data on subpopulations in an attempt to better quantify the issues faced by various groups. The Office of Health Disparities (OHD) addresses disparities that may occur among populations whether they be defined by race, ethnicity, etc. The OHD assists the UDOH in identifying priorities and needs of specific key populations in the state, assessing the adequacy of ethnic data from common public health data sources and recommending improvements, informing ethnic communities about efforts and activities, and developing guidelines for cultural effectiveness for UDOH programs. In 2018, the OHD published "The Utah Health Improvement Index". This report measures social determinants of health and inequities and creates an index for each of Utah's 99 small geographic areas. The report presents index groupings from low to very high. The OHD works closely with Title V programs to identify opportunities to work together to address MCH needs.

The UDOH works closely with the Office of American Indian/Alaska Natives (AI/AN) Health Affairs. This office facilitates meeting with the Utah Indian Health Advisory Board (UIHAB). The purpose of this Board is to reaffirm the unique legal status of Tribal governments through the formal 'government to government' relationship and Tribal Consultation. The board provides leadership to develop collaborative efforts between and among Tribes, Tribal organizations, the Urban Indian Organization, the Indian Health Services (IHS), the UDOH and other public and private agencies addressing the health and public health of AI/AN living on and off the reservation. In addition to these roles, the Board works with Utah's Executive and Legislative leadership promoting strategies to improve health outcomes. The mission of this Office is to raise the health status of Utah's AI/AN population to that of Utah's general population.

Public Health System

MCH services, including those for children and youth with special health care needs, are provided in various settings, including medical homes/private providers, local health departments, community health centers that serve the homeless and migrant workers, and a number of free clinics.

Utah's public health system is comprised of the UDOH and 13 Local Health Departments (LHD), 3 of which are PHAB accredited. Approximately half of the LHDs are multi-county districts covering large geographic areas. Many include both rural and frontier areas within their service region.

The LHDs have SMART Objectives for Services for Women and Children which are part of their contract and work plans. The specific objectives vary by district. For Services for Women objectives include - postpartum depression education/screening, breastfeeding, family planning, home visiting, etc. For Services for Children objectives include oral health/sealants, vision/hearing screening, etc. All 13 LHDs have the same Developmental Screening objective - NPM6. Four rural LHDs are receiving funding for a CSHCN Care Coordinator and coordinate with the Integrated Services Program.

Systems of Care

The UDOH has created a safety net group of community providers who meet regularly to share their resources, coordinate services, and identify ongoing community needs. Community Health Centers (CHCs) throughout the state and the Wasatch Homeless Clinic in Salt Lake City provide primary care to underinsured and uninsured MCH populations. Utah has thirteen CHCs, with many having multiple clinic sites. The Association for Utah Community Health, the state's primary care association, works to promote the development of new or expansion of existing community health centers in Utah.

The UDOH provides primary care through the Health Clinics of Utah (HCU), which has locations in Salt Lake, Ogden, and Provo and plays a key role for the UDOH and Utah's Safety Net of providers. Medical clinics are staffed with a multidisciplinary team. The clinics provide high quality medical care at the lowest cost to clients. HCU accepts most forms of insurance including; Medicaid, the Children's Health Insurance Program (CHIP), Primary Care Network (PCN), and Medicare. Among the patients seen in these clinics in FY2017, 62% had Medicaid/Medicare, and 13% were uninsured. In addition to regular clinical services, the HCU provide immunization and health screenings for newly resettled refugees in Salt Lake and Weber counties and provide medical screenings for children in protective service care in multiple counties.

The Indian Health System in Utah consists of one IHS outpatient facility, 3 Tribal and Tribal Organization operated facilities, and one Urban Indian Organization located in Salt Lake City. Not all reservation communities have a health care facility in that community. While some Tribal programs operate health care facilities, travel time for services can be 3-4 hours each way. When accessing this system, appointments are not always the norm; it is first come first serve. This can be problematic if you live a significant distance and arrive later in the day, running the risk of not being seen and may be asked to return the next day. The Indian Health System is primarily dependent on federal funding. Each year, Congress appropriates funding for the IHS. This system is chronically underfunded, operating at approximately 54% of the level of need. Most of the Indian Health System facilities do not provide specialty care or dialysis and will refer patients to specialists outside of the system or refer them to the closest IHS Area Office or IHS hospital. Sometimes this can be in a different state.

Hospital Systems in Utah

The hospital healthcare system for MCH populations is well developed in Utah, with several large Maternal-Fetal Medicine Centers, 10 self-designated Level III NICUs, and two tertiary children's hospitals (Primary Children's Hospital and Shriners Hospital). Utah currently has 46 delivering hospitals across the state, four hospital systems, and one medical school/facility. All but 12 hospitals are part of the three hospital systems, which provides Utah a unique opportunity to build strong collaborations. Utah's hospital system is comprised largely of the Intermountain Healthcare hospitals. Intermountain has a national reputation for excellent quality improvement efforts and is a valuable resource for the state. The University of Utah Hospital is a teaching medical school providing tertiary care and services. Other hospitals are owned by several different hospital systems such as MountainStar, Steward and LifePoint or are independently owned.

Telehealth Capacity

Telehealth capacity is expanding in Utah. To reduce barriers to early diagnosis, Utah Early Hearing Detection Intervention (EHDI) purchased auditory brainstem response equipment to provide tele-audiology services for rural communities. This equipment was placed in Blanding and Richfield, Utah. In 2018-2019, EHDI has been expanding the rural tele-audiology service. Utah has a small number of infant-pediatric audiologists, all of whom reside on the Wasatch Front or in the St. George area. Oftentimes, these babies become lost-to-follow-up due to barriers of access to specialists, travel costs, inability to take time off from work, costs of testing, etc.

Tele-audiology services are hosted at the CSHCN Bureau with two pediatric audiologists on staff and a nurse at the remote site. The nurse provides direct face-to-face contact with the family and child. The nurse connects the electrodes to the baby and stays with the family throughout evaluation testing, while the audiologist remotely takes over the computer to run the testing. The testing is considered diagnostic and if a child is identified as deaf or hard of

hearing, the CSHCN Bureau helps the family with the next steps in the EHDI process, including referrals to early intervention, parent-to-parent support, and referrals to medical providers.

In 2017, the UDOH awarded a pilot grant to the University of Utah (UofU) for perinatal mental health screening and counseling via telehealth. The project is now working with four of Utah's rural health departments to screen women for postpartum depression symptoms using the Edinburgh postnatal depression scale tool, refer women who need support, and provide on-line support groups and counseling using telehealth.

Telehealth platforms are also being used to deliver educational programs. Project ECHO (Extension for Community Health-Care Outcomes), housed at the UofU, is a platform that can deliver education and interactivity through telemedicine. This platform is used to coordinate statewide implementation of maternal safety bundles, saving travel costs and facilitating greater participation.

Clinical Workforce Availability

The Utah Medical Association (UMA) reported 9,990 licensed physicians in 2015. Of the total number of licensed physicians, 6,035 (60.4%) reported providing services in the state. This provides a ratio of 198 patient care providers per 100,000 population, compared to a national average of 265.5/100,000. Family Medicine specialists are the largest group with 954 providers, followed by 445 general pediatricians, 312 OB/GYNs, 141 pediatric subspecialists, and 58 OB/GYN sub-specialists. The UMA report notes among practicing physicians, there has been a decrease in the proportion who spend 50% or more of their time in direct patient care or teaching and the number reporting a full practice that cannot accept new patients increased slightly since 2010.

A recent report from the Office of Primary and Rural Health at the UDOH noted that the distribution of healthcare providers is disproportionate to where the population resides in the state. In Utah, 21% of the population lives in rural areas, but only 11% of primary care providers, 9% of mental health providers, and 16% of dental providers work there.

The UDOH collaborates with the UofU School of Medicine to encourage educating new medical students of the needs and opportunities in serving the MCH/CSHCN population to increase capacity.

From July 1, 2017 to present, the Integrated Services Program (ISP) has contracted with four LHDs within the State. These four LHDs provide care coordination and clinical coordination for direct care services to the CSHCN population residing within their counties. This model creates a regional "hub" or main point of contact for local families of CSHCN through which they may be referred to supports, specialists, and services that may benefit their child. Over 72% of the referrals for either care coordination, direct clinical services, or both were related to autism spectrum disorder. The CSHCN specialty and subspecialty pediatric providers are mostly located along the Wasatch Front, including the state's tertiary pediatric care centers, which are the University of Utah, Primary Children's Hospital and Shriners Hospital for Children. There is one comprehensive women and children's health center located in the southern part of the state, serving a five-county rural area. The location of most pediatric specialists and subspecialists in the most populous areas of the state presents a problem for provider access for special needs children in rural Utah. Several counties have no pediatricians or sub-specialists, meaning families must drive long distances to access care for their children. In most cases, there is limited additional itinerant coverage from the private sector for these large geographic areas. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers.

Families continue to face formidable barriers in accessing services and coordinating care for their children with special health care needs. Access to pediatric specialists and subspecialists is adequate if you live along the Wasatch Front, although long waiting lists exist to see practitioners. The story is different for those living in rural/frontier areas of the state where families must drive long distances to access the same services.

Utah Medicaid

Utah's Medicaid program is administered through the UDOH. The Medicaid program is an advocate for supporting MCH/CSHCN populations throughout the State. Utah Medicaid contracts with health plans, or Accountable Care Organizations (ACO), to provide medical services to Medicaid members. Members living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties must choose an ACO. Members that live in other counties have the option to choose an ACO or the Fee for Service Network.

Each ACO is responsible to provide enrolled Medicaid members with all medical services covered by Medicaid.

Medicaid typically pays a monthly fee for each Medicaid member enrolled in an ACO. Each ACO may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits. The ACO must specify services which require prior authorization and the conditions for authorization.

Members enrolled in an ACO must receive all services through a provider on that ACO's network. The provider is paid by the ACO. Members enrolled in the Fee for Service Network may use any Utah Medicaid provider. The provider is paid by Medicaid.

The CHSCN Bureau and ISP Program in the MCH Bureau are designated by Medicaid to provide and/or oversee the following services to children with special health care needs: case management, explaining benefits, eligibility and services, and referral and assistance.

Overview/Conclusion

The directors of Title V/MCH and CSHCN work with employees at the state and local levels as well as with strategic partners to implement programs and services of the Title V Block Grants three federally defined populations.

The Title V/MCH and CSHCN Directors and staff use data, needs assessment, capacity surveys and historical experience to make determinations for program capacity, development and funding distribution.

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

MCH Ongoing Needs Assessment Activities

Utah Title V leadership staff employs various mechanisms to assess the ongoing needs of MCH populations. Some of the strategies implemented are described below:

1. Thoroughout the year, available data is assessed and reviewed related to BG performance and outcome measures. This allows for a 'mini' needs assessment annually through analysis of data trends and identification of demographic and geographic disparities within the domains. This data review process informs program planning and goal setting relative to emerging and unmet MCH/CSHCN population needs.

2. Needs assessment activities include updating MCH topic reports on Utah's Public Health Indicator-Based Information System (IBIS) and short data reports on a wide array of public health topics (topics can be found at: https://ibis.health.utah.gov/topic/Index.html). Employees are responsible for updating indicators for release to the Utah Legislature and the public. Updating these indicators enables Title V staff to stay current on data trends.

3. Collaboration and partnership with Local Health Departments (LHD) enables the State to become more aware of needs and issues affecting MCH populations at the local level and creates a unified focus for meeting MCH needs. The MCH Director meets regularly with the LHD Nursing Directors to develop objectives and implement strategies to reach MCH populations specific to the needs in their respective areas.

4. Programs within the MCH Bureau regularly collaborate to identify data gaps and to develop and conduct ongoing assessments to collect this data. Examples of assessments conducted to fill these data gaps include, but are not limited to: The Data Resources Program (DRP) collaborated with WIC to implement 2017-2018 Participant Satisfaction Survey and prepared a final report based on the survey results; DRP and the Oral Health Program (OHP) collaborated to finalize the 2020 School Dental Survey Screening questionnaire and selection of participating schools; DRP/OHP collaborated to measure the oral health knowledge and practice among Adolescents with the goal of increasing positive oral health behaviors and increasing the participation and utilization of dental services. DRP created an extensive indicator report for the 2020 MCH Needs Assessment during 2019. This indicator report included over 100 variables showing rates in Utah as well as the nation for the domains of maternal, infant, child, adolescent, and CSHCN health, as well as access to care. Staff work to identify data gaps for MCH topics, participate in several advisory committees, and propose adding new questions to fill identified data gaps. Advisory committees include the Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring Survey (PRAMS), Student Health and Risk Prevention (SHARP), and Vital Statistics.

5. The UDOH highlights leading health issues in its monthly *Utah Health Status Update* (HSU) publication. HSUs are sent to the Governor's Office and 500+ others including policy makers, health professionals and state and LHD staff. Because Title V work happens via collaboration among many programs, the HSU publication serves an important role in keeping program staff up-to-date on important and relevant issues. Last year, the MCH Bureau and other UDOH programs prepared twelve HSU articles. A list of these publications can be found in Appendix E.

6. The UDOH produces reports to evaluate and educate on Title V populations and issues. Last year, UDOH staff prepared and published more comprehensive reports that assessed populations and needs. A list of these publications can be found in Appendix E.

7. Title V staff meet with community partners to identify emerging issues. The Utah Children's Care Coordination Network, funded through Title V, convenes monthly as an educational and needs-based forum for care coordinators, commercial and public insurance providers, practice managers, and providers to discuss issues surrounding pediatric care coordination. Participants identify gaps in services for children with special health care needs then work together to problem solve and find solutions that include supports, specialists, and organizations that meet family needs. Guest speakers are invited to teach participants about special education, IEP/504, diagnosis-specific topics, legislative changes, Medicaid and CHIP, and other issues affecting care coordination.

8. The CSHCN Bureau Director is a member on the Utah Developmental Disabilities Council and a representative

on their Health Committee. Last year the Council invested in a Statewide Healthcare Needs Assessment survey and this year committees have been formed and are coordinating with local communities to increase access and resources in their regions of the State. Findings of the study are as follows and will be used to inform the Title V Block Grant Needs Assessment.

Health insurance premium costs continue to be a significant issue, but even individuals with insurance do not have access to providers in their home communities. Concerns about the future availability of affordable health insurance are common among study participants.
Lack of competition leads to significant issues around affordability and quality of care available in rural Utah.
Counties that are near more populous counties seem to invest less in healthcare infrastructure and assume that residents will travel to neighboring counties to access care.
There is a significant demand for mental health services, but individuals still struggle with issues of stigma, privacy, affordability, & coverage.
Diabetes and access to healthy food is a significant issue in rural counties.
Individuals in Piute (47%) and Rich (37%) counties report limited access to healthy food options, and both counties rank very last in Utah in access to healthy, affordable food options. (Statewide average is 6%)
Very limited access to basic information / education / assistance services for adults with disabilities and families of children with disabilities.
Providers in rural communities have very little training or capacity to meet the needs of adults and children with significant / severe disabilities.
Very few providers who provide respite, day habilitation or other supports. This means that families often send children to other counties/communities for services, or they choose to relocate.
No employment opportunities for individuals with significant disabilities, and a lack of providers to help develop employment avenues.
General accessibility concerns for people with physical disabilities came up frequently!
There is no coordinated means of reaching out to adults with disabilities or families of adult children with disabilities in rural counties.

Concerning Changes in Utah's MCH/CSHCN Populations

The infant mortality rate in Utah has been below the national average for over 30 years. While the national rate has been slowly declining, Utah's rate has seen an increase over the last three years. These trends have resulted in Utah's infant mortality rate being equal to that of the U.S. in 2017. This rising rate is of concern and efforts are underway to examine contributing factors.

From 2011 to 2013, the Violence and Injury Prevention Program (VIPP) noticed an increase in the youth suicide rate, which continued into 2015. In addition, data from the Prevention Needs Assessment showed a similar increase in suicidal ideation among youth from 2013 to 2015. As a result, VIPP requested Epidemiologic Assistance (Epi-Aid) from the Centers for Disease Control and Prevention. Additional efforts included the development of the "Utah Suicide Prevention Plan 2017-2021" focused on increasing protective factors and decreasing risk factors. In 2018, Utah Governor Gary Herbert launched the Youth Suicide Task Force to develop policy recommendations. Currently, in 2017, Utah ranks sixth in the nation in youth suicides. VIPP has hired a full-time Suicide Prevention Coordinator within the past year to implement evidence-based prevention efforts through a shared risk and protective factor lens. Through VIPP's strategic planning process using a similar lens, we expect to see decreases to Utah's youth suicide rate in the upcoming years.

Changes in Utah's Title V Capacity and Systems of Care

In January 2017, the Baby Watch Early Intervention (BWEI) Program moved from the Bureau of Child Development to CSHCN. The BWEI program is a high profile program and it demands a great deal of focused attention by UDOH/CSHCN managers. Over the past year, the Program has become stable with its structure, functions, staffing procedures and developing a new mission and goals. In May 2019, the BWEI Program was informed that the Weber County School District was not renewing their contract as of July 1, 2019. The BWEI Program will bring the program in house and is in the process of evaluating the program structure, functions, finding a service location and hiring

employees. The program believes bringing the program in house will allow for evaluation of the entire system statewide from a different lens, while keeping continuity for the families being served.

In December 2018, the Early Childhood Utah Program (ECU), which includes Early Childhood Integrated Data System (ECIDS); Early Childhood Utah Statewide Committee and Developmental Screening, moved from the Bureau of Child Development to CSHCN. The Program was evaluated on its structure, staffing, functions, mission and goals. In June 2019, after six months of being located in the CSHCN Bureau Division leadership moved the program to the MCH Bureau - Family Youth and Outreach Program. This change allows for more direct collaboration and coordination with the Integrated Services Program and the Office of Home Visiting.

The ISP team continues to work with four rural/frontier LHDs to ensure families of children and youth with special health care needs have access to local care coordinators who are able to assess and evaluate patient needs; make appropriate referrals for supports, services, and specialists; and help families create and follow through with care plans. These same care coordinators also triage patients who may have developmental delays including autism. Appropriate patients are scheduled with the ISP multidisciplinary traveling clinic staff who provide assessment, evaluation, and diagnosis. Traveling clinics are held approximately six times per year in the Southeast Health District (Moab and Price); TriCounty Health Department (held in Vernal-which reaches three rural/frontier counties); Central Utah Health District (held in Richfield-which reaches six county rural/frontier counties); and San Juan County Health Department (Blanding). ISP clinical staff fly in early morning, and fly out late afternoon on the date of service. Full-time staff include care coordination, pediatric psychologist, and pediatric nurse practitioner. Part-time staff include an occupational therapist, physical therapist, speech pathologist, and audiologist.

The full-time ISP staff provide general care coordination and evaluative and diagnostic clinical support to the densely populated Wasatch Front at Health Clinics of Utah sites located in Salt Lake City, Ogden, and Provo. Although not as multi-disciplinary in nature as the traveling clinics, ISP still provides clinical care through the care coordinator, pediatric psychologist, and pediatric nurse practitioner.

There remains a great need for services for children with special health care needs around the state. With a small clinical staff, ISP does not have the same impact on rural communities or the Wasatch Front as the much larger CSHCN clinics had in the past. ISP, MCH Bureau, and the CSHCN Bureau continue to seek ways to enhance and expand services currently available to rural and frontier Utah. ISP is currently investigating partnerships with Wasatch Front psychologists who could provide additional behavioral health evaluation and diagnosis, particularly for autism, through the current traveling clinic model.

Breadth of the State's Title V partnership and collaborations

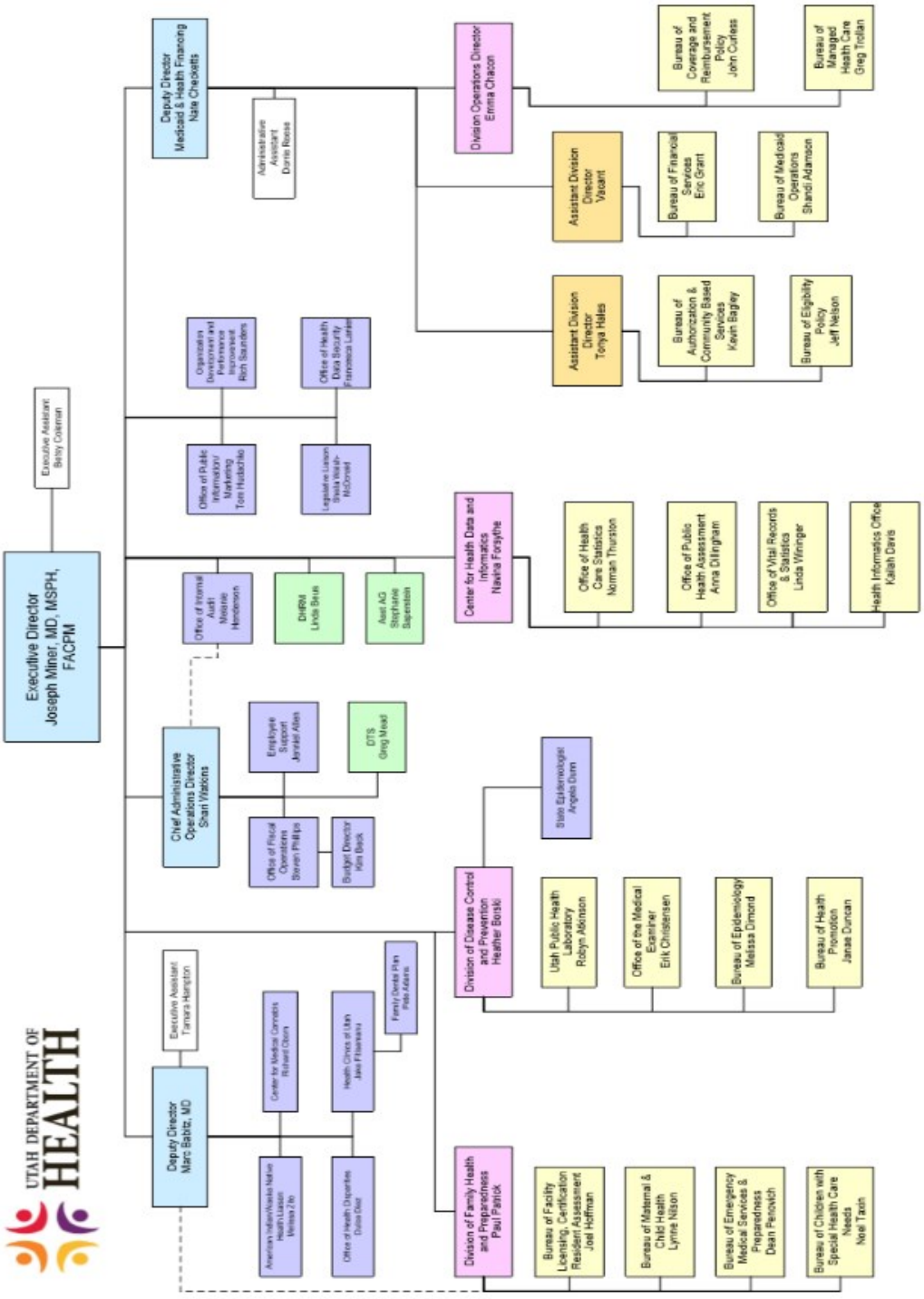
The Bureaus of MCH and CSHCN do an outstanding job collaborating with other state agencies, key partners, and private organizations on a regular basis to address ways to improve the health of women, infants, and children in the state. Staff is regularly meeting with new partners to assure the MCH/CSHCN populations are being served. A detailed (not all inclusive) document outlining Title V partnerships, collaboration and coordination is presented in Appendix E.

Efforts to operationalize the 5 Year Needs Assessment

All UDOH staff who are responsible for working and reporting on activities related to Utah's NPMs/ESMs/SPMs continue to meet on a regular basis to discuss cross collaboration and teamwork on performance measures. The CSHCN Family Partnership Advisory Committee advises the Bureau on understanding the family/parent perspective on issues, needs, and services and influence policies and program improvement. Utah is currently and actively engaging in the process for the 2020 statewide needs assessment including a strong and integrated link with the Office of Home Visiting to complete the required MIECHV Needs Assessment. The UDOH contracted with the UofU Division of Public Health to assist with the completion of both Needs Assessments, which includes: Key Informant Interviews, Discussion/Focus Groups, Stakeholder meetings and required completion of reports. Weekly and monthly meetings are being conducted to move the process forward to completion. The target completion date for both Needs Assessments is January 30, 2020.

Changes in Organizational Structure and Leadership

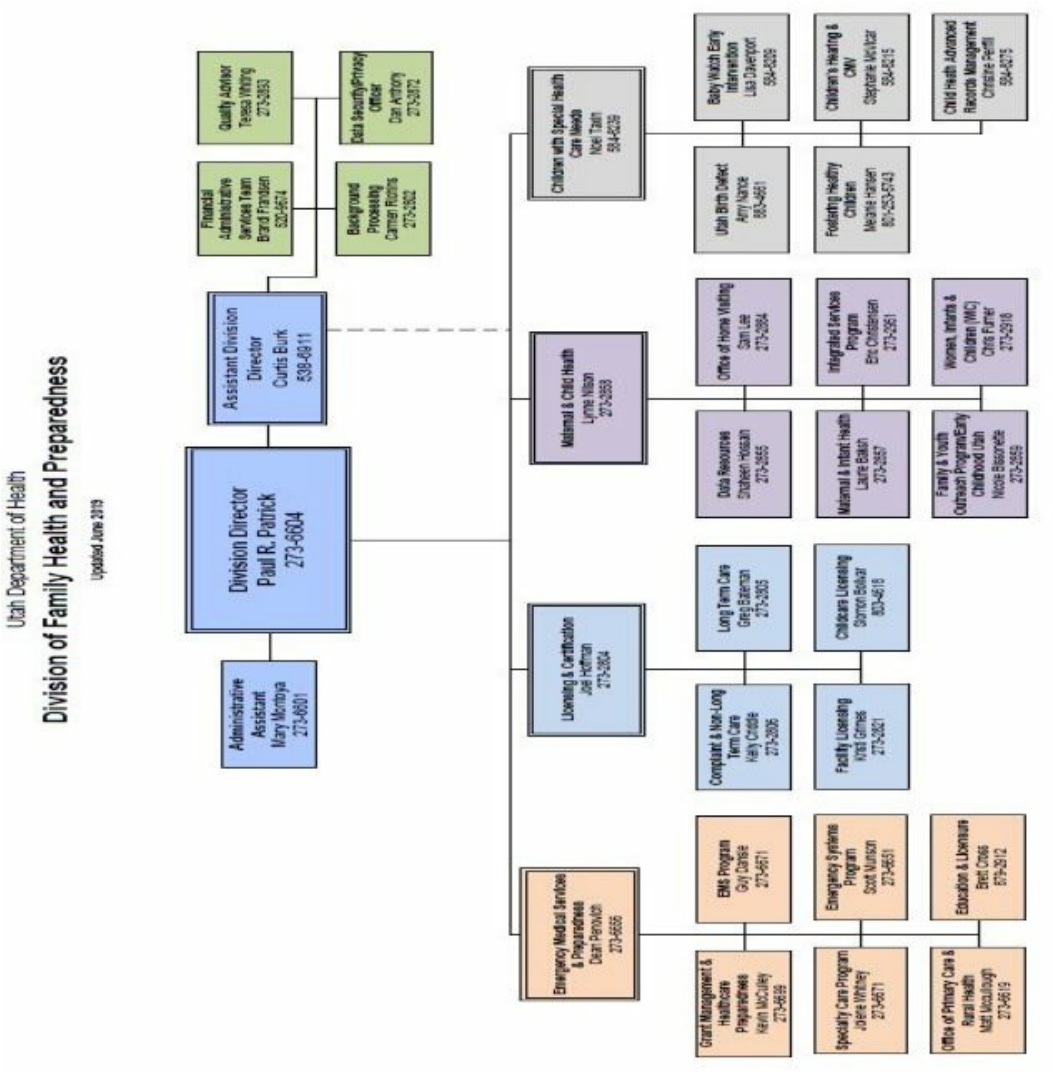
During the past year, leadership at the Utah Department of Health has remained stable. The Executive Director of the UDOH, Joseph Miner, MD reports directly to Governor Gary Herbert with Marc Babitz, MD and Nate Checketts (Medicaid Director) as Deputy Directors. The chart below outlines the Senior Level Directors and Managers of the Utah Department of Health (UDOH).



The Division of Family Health and Preparedness (DFHP) is headed by Director, Paul R. Patrick and Assistant Division, Director Curtis Burk. The Bureau of Maternal and Child Health is headed by Bureau Director, Lynne Nilson and the Children with Special Health Care Needs is headed by Bureau Director, Noël Taxin. MCH and CSHCN are the two main Bureaus that lead and direct the work of the Block Grant.

The DFHP organizational chart is shown below. There were many changes in the Division this past year. The Bureau

of Child Development was dissolved and the programs in that Bureau were moved to other Bureaus in the Division. The Office of Home Visiting (MIECHV) was moved to MCH. The Early Childhood Utah Program was originally moved to CSHCN and then later in the year to MCH. Additional moves included: Childcare Licensing to the Bureau of Facility Licensing & Certification, the Office of Primary Care and Rural Health to the Bureau of Emergency Medical Services and the Health Clinics of Utah moved under the direction of the UDOH Deputy Director. And as usual this year also brought about employees changing positions, leaving employment and retiring.



FY 2019 Application/FY 2017 Annual Report Update

MCH Ongoing Needs Assessment Activities

Utah Title V leadership staff employs various mechanisms to assess the ongoing needs of MCH populations. Some of the strategies implemented are described below:

1. Each year during the Block Grant (BG) application process, available data is assessed and reviewed related to BG performance and outcome measures. This allows for a 'mini' needs assessment annually through analysis of data trends and identification of demographic and geographic disparities within the domains. This data review process informs program planning and goal setting relative to emerging and unmet MCH/CSHCN population needs.

2. Needs assessment activities include updating MCH topic reports on Utah's Public Health Indicator-Based Information System (IBIS) and short data reports on a wide array of public health topics (topics can be found at: https://ibis.health.utah.gov/topic/Index.html). Employees are responsible for updating indicators for release to the Utah Legislature and the public. Updating these indicators enables Title V staff to stay current on data trends.

3. Collaboration and partnership with Local Health Departments (LHD) enables the State to become more aware of needs and issues affecting MCH populations at the local level and creates a unified focus for meeting MCH needs. The MCH Director meets regularly with the LHD Nursing Directors to develop objectives and implement strategies to reach MCH populations specific to the needs in their respective areas.

4. Programs within the MCH Bureau regularly collaborate to identify data gaps and to develop and conduct ongoing assessments to collect this data. Examples of assessments conducted to fill these data gaps in 2017 include, but are not limited to: the WIC Participant Satisfaction Survey, a collaboration between WIC and the Data Resources Program (DRP); the 2017 Developmental Screening Survey, conducted through a partnership between DRP and the Bureau of Child Development, to assess provider perspectives on and use of developmental screening tools; and a collaborative pilot project between WIC, Pregnancy Risk Line, Oral Health Program, and DRP that sought to assess oral health behaviors of pregnant women in Utah by asking about their dental visit history during their pregnancy. Additionally, staff work to identify data gaps for MCH topics, participate in several advisory committees, and propose adding new questions to fill identified data gaps. Advisory committees include the Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring Survey (PRAMS), Student Health and Risk Prevention (SHARP), and Vital Statistics.

5. The UDOH highlights leading health issues in its monthly *Utah Health Status Update* (HSU) publication. HSUs are sent to the Governor's Office and 500+ others including policy makers, health professionals and state and LHD staff. Because Title V work happens via collaboration among many programs, the HSU publication serves an important role in keeping program staff up-to-date on important and relevant issues. Last year, the MCH Bureau and other UDOH programs prepared eight HSU articles; Prevalence of Children with Special Health Care Needs in Utah, CDC Investigation Shows Youth Suicides in Utah Increasing, Chronic Diseases and Birth Outcomes, Maternal Anxiety and Depression, Oral Health Knowledge and Behaviors Among Utah Students, Developmental Screening Practices in Utah, Addressing Infant Mortality Disparities by Giving Utah Pacific Islander Babies the Best Chance, and Results of the 2017 WIC Participant Satisfaction Survey.

6. The UDOH produces reports to evaluate and educate on Title V populations and issues. Last year, UDOH staff prepared and published more comprehensive reports that assessed populations and needs; Severe Maternal Morbidity in Utah, Planned Out-of-Hospital Births in Utah 2013-2015, Maternal Mental Health in Utah, Adolescent Oral Health Campaign Report, Developmental Screening, Addressing Oral Health Disparities in Urban Settings, The Oral Health Status of Utah's Children, Population-Based Surveillance of Birth Defects Potentially Related to Zika Virus Infection-15 States and U.S. Territories, Critical Congenital Heart Disease Newborn Screening Implementation: Lessons Learned, and Hearing Screening (for the American Academy of Pediatrics newsletter).

7. Title V staff meet with community partners to identify emerging issues. The Utah Children's Care Coordination Network, funded through Title V, convenes monthly as an educational and needs-based forum for care coordinators, commercial and public insurance providers, practice managers, and providers to discuss issues surrounding pediatric care coordination. Participants identify gaps in services for children with special health care needs then work together to problem solve and find solutions that include supports, specialists, and organizations that meet family needs. Guest speakers are invited to teach participants about special education, IEP/504, diagnosis-specific topics, legislative changes, Medicaid and CHIP, and other issues affecting care coordination.

8. The CSHCN Bureau Director is a member on the Utah Developmental Disabilities Counsel and a representative on their Health Committee. This year the Counsel invested in a Statewide Healthcare Needs Assessment survey. The survey methods used were face-to-face interviews, focus groups and phone survey. Findings of the study are as follows and will be used to inform the Title V Block Grant Needs Assessment.

Health insurance premium costs continue to be a significant issue, but even individuals with insurance do not have access to providers in their home communities. Concerns about the future availability of affordable health insurance are common among study participants.
Lack of competition leads to significant issues around affordability and quality of care available in rural Utah.
Counties that are near more populous counties seem to invest less in healthcare infrastructure and assume that residents will travel to neighboring counties to access care.
There is a significant demand for mental health services, but individuals still struggle with issues of stigma, privacy, affordability, & coverage.
Diabetes and access to healthy food is a significant issue in rural counties.
Individuals in Piute (47%) and Rich (37%) counties report limited access to healthy food options, and both counties rank very last in Utah in access to healthy, affordable food options. (Statewide average is 6%)
Very limited access to basic information / education / assistance services for adults with disabilities and families of children with disabilities.
Providers in rural communities have very little training or capacity to meet the needs of adults and children with significant / severe disabilities.
Very few providers who provide respite, day habilitation or other supports. This means that families often send children to other counties/communities for services, or they choose to relocate.
No employment opportunities for individuals with significant disabilities, and a lack of providers to help develop employment avenues.
General accessibility concerns for people with physical disabilities came up frequently!
There is no coordinated means of reaching out to adults with disabilities or families of adult children with disabilities in rural counties.

Changes in Utah's MCH/CSHCN Populations

The focus on maternal depression and anxiety is increasing and is a pressing issue in Utah. A recent analysis of Utah PRAMS data found that 10.3% of new mothers experienced depression prior to pregnancy, 14.8% experienced anxiety prior to pregnancy and 12.2% reported symptoms of postpartum depression. The Utah Maternal Mental Health Collaborative (UMMHC) has been working to bring attention about the need to address maternal mental health before, during, and after pregnancy. The UMMHC brings together medical, mental health and allied professionals and mothers who have experienced maternal depression. The mission of the UMMHC is to exchange ideas and form relationships to increase and improve awareness, prevention, detection, and treatment of maternal mental health conditions in Utah. Their goals are to increase public awareness, increase resources, increase provider education, explore financial options, and find a legislative champion.

The need to address mental health is further supported by data from 2015-2016 maternal mortality review. One quarter of deaths reviewed were due to drug toxicity and additional 20% were due to suicide. One-third of cases reviewed had a noted mental health condition. Even if deaths were caused by obstetric or medical conditions, a significant number of those women had prior or current mental health conditions. Depression and anxiety were the predominant diagnoses.

In 2014, Utah had the seventh highest suicide rate in the U.S. for ages 10 and older. The staff in the Violence and Injury program worked with the CDC and the Governor's Task Force to analyze data on youth suicide and produce the "Utah Suicide Prevention Plan 2017-2021". Recommendations proposed in this plan include:

- Increase access to evidence-based mental health care for youth
- Strengthen family relationships
- Promote connectedness within the home, peer, school, and community environments
- Identify and provide support to youth at risk of suicidal behaviors
- Prevent other forms of violence among youth
- Reduce access to lethal means
- Teach coping and problem solving skills
- Consider comprehensive and coordinated suicide prevention programs that address multiple risk and protective factors simultaneously
- Conduct ongoing comprehensive evaluation of suicide prevention programs

Changes in Utah's Title V Capacity and Systems of Care

In January 2017, the Baby Watch Early Intervention (BWEI) Program moved from the Bureau of Child Development to CSHCN. The BWEI program is a high profile program and has the attention of the Governor, the Governor's staff, legislators, providers and advocates. As such, it demands a great deal of focused attention by UDOH/CSHCN managers. Over the past year the Program has been evaluating the Program structure, functions, and developing a new mission and goals.

In March 2017, the Integrated Services Program (ISP) moved to the MCH Bureau. One of the goals of the ISP is to create a care coordination model where rural/frontier health departments are the main point of contact for referral, resources, and services for children with special health care needs.

Since this move, ISP staff have worked to secure contracts with four rural/frontier LHDs to provide care coordination for children with special health care needs. We anticipate additional LHDs will be added over the next couple of years. An attempt was made to contract with specialty providers (APRNs, psychologists, speech pathologists, occupational and physical therapists, and audiologists) to staff rural travel clinics and team with care coordination staff at LHDs to provide services for children in hard to reach areas of the state. We were unsuccessful in finding willing contractors, so we hired in-house staff. ISP hired a full time APRN (pediatric nurse practitioner) and psychologist and is in the process of hiring a part-time occupational therapist, physical therapist, speech, and audiology staff to provide evaluative and diagnostic services. This model ensures that coordination activities take place in the rural communities where our underserved families live. It empowers the LHD to broker services for families as close to home as possible. Then, where local services do not exist, the LHD helps arrange services, supports, and specialist visits in the next closest location possible.

In an effort to expand diagnostic and evaluative services for CSHCN along the densely-populated Wasatch Front, the full-time APRN and psychologist will also see children two days per week in Salt Lake, and one day each week in Ogden and Provo. These patient encounters will take place in existing Health Clinics of Utah (HCU) sites in all three cities. This new pediatric endeavor, under the auspices of HCU, will be called *Health Clinics of Utah, Integrated Services for Children with Special Health Care Needs.* HCU, a clinical program through the UDOH Division of Family Health and Preparedness, has provided direct preventive and diagnostic family practice services to families for many years. We are excited to partner with the HCU, and feel that offering care for CSHCN families through their clinics is a logical extension of the services they offer.

As stated last year, the University of Utah Developmental Assessment Center (UDAC), in the Department of Pediatrics opted not to renegotiate the contract with UDOH for the provision of clinical services to CSHCN throughout the state (contract ended 6/30/17). The UDAC continues to see children with special health care needs without BG funding. However, it may take up to eight months for families to get an appointment for many of the services it offers. For rural/frontier areas of the state, UDAC only provides telehealth appointments, or, when telehealth is not appropriate, encourages families to travel to Salt Lake City for a face to face encounter with their staff. In reality, many rural families do not have the capacity to make the trip to Salt Lake City from remote areas of the state where travel times can exceed 5-7 hours one way. There remains a great need for services for children with special health care needs around the state.

The impact of these changes on MCH/CSHCN services delivery is dramatic. As we have worked to make these changes over the past year, hundreds of children with special health care needs have had significantly reduced access to evaluative, diagnostic, and specialty services across the state.

Other capacity building for CSHCN includes:

- Applying for supplemental grant funds to ensure programs are expanded and provided to the public.
- Focusing on helping families become more aware of services available to CSHCN.
- Ensuring children are appropriately screened for autism, heart, hearing, and other birth defects and, when indicated, diagnosing early and referring to services.
- Increasing collaboration between agencies that serve children with a goal of creating a common electronic platform for the sharing of data to improve care coordination; reducing the duplication of services; and enhancing overall care for CSHCN.

Breadth of the State's Title V partnership and collaborations

The Bureaus of MCH and CSHCN collaborate with other state agencies, key partners, and private organizations on a regular basis to address ways to improve the health of women, infants, and children in the state. The goal of ISP is to create a care coordination model where rural/frontier health departments are the main point of contact for referral, resources, and services for children with special health care needs.

A document outlining Title V partnerships, collaboration and coordination in more detail is presented in Appendix E.

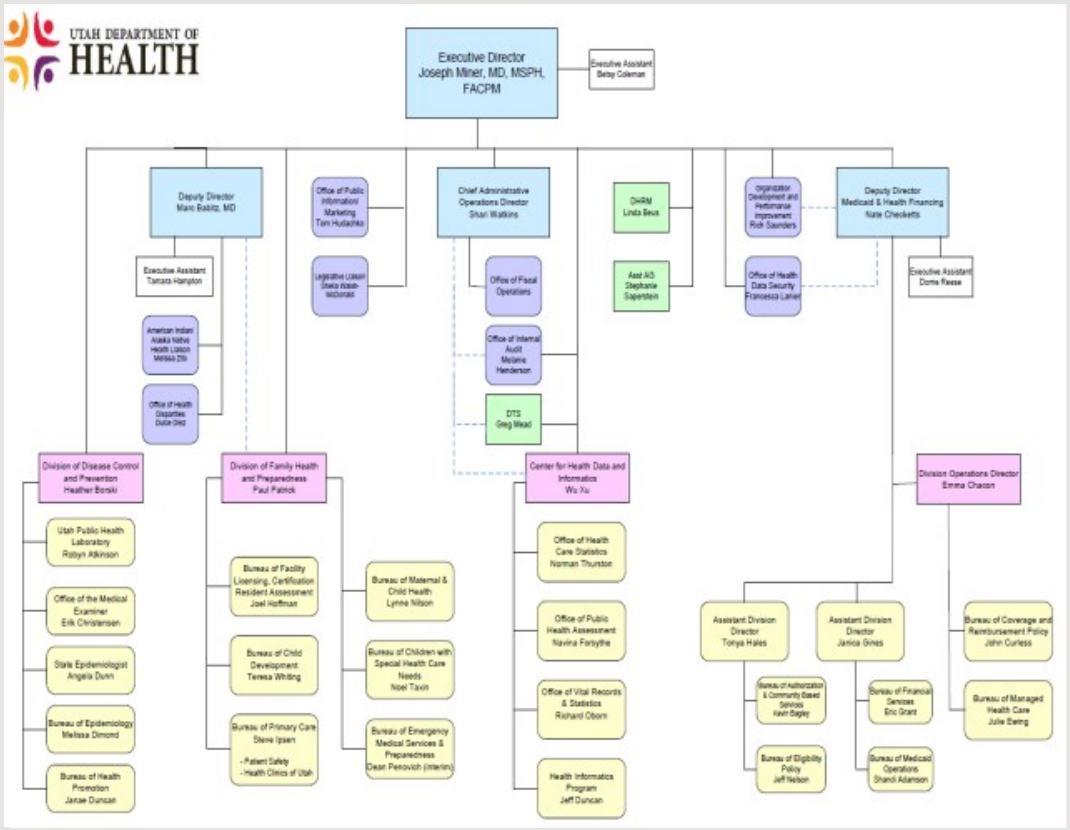
Efforts to operationalize the 5 Year Needs Assessment

All UDOH staff who are responsible for working and reporting on activities related to Utah's NPMs/ESMs/SPMs continue to meet on a regular basis to discuss cross collaboration and teamwork on performance measures. CSHCN created a Family Partnership Advisory Committee to advise the Bureau on understanding the family/parent perspective on issues, needs, and services and influence policies and program improvement.

A process for the 2020 statewide needs assessment has been developed by the MCH Needs Assessment Leadership Team which establishes activities and time frames. Monthly meetings have been scheduled to move the process forward in coming months.

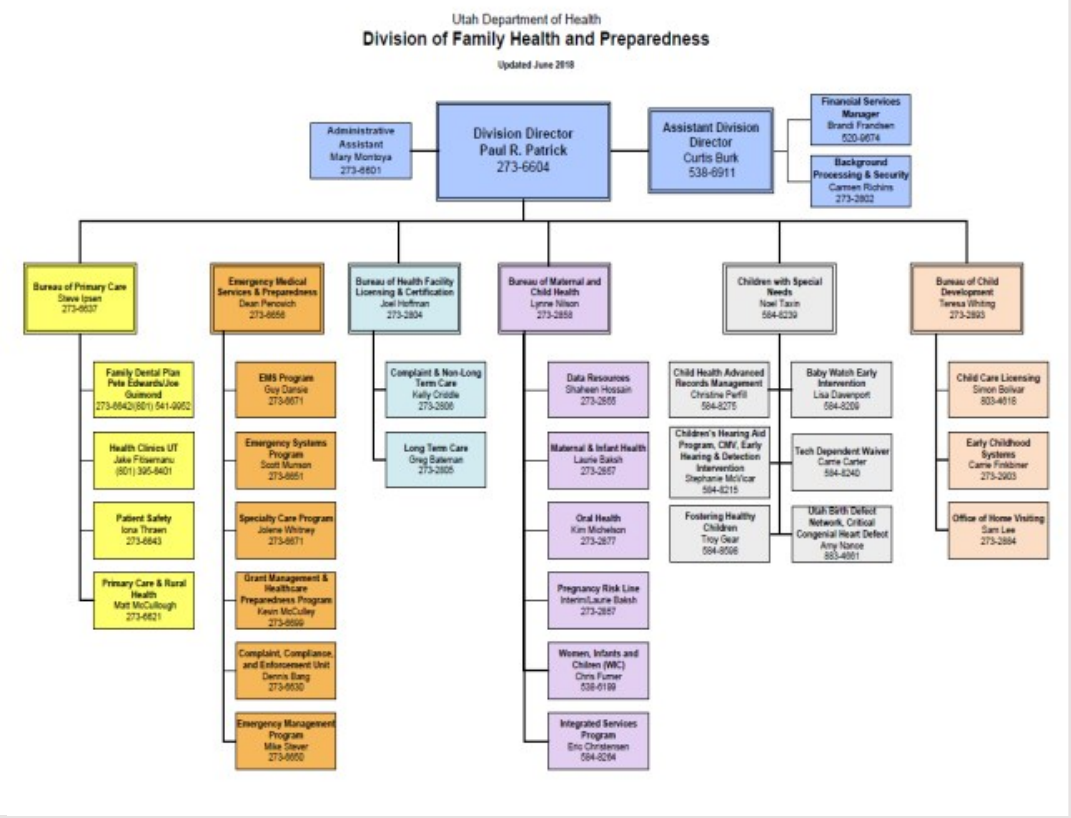
Changes in Organizational Structure and Leadership

During the past year leadership at the Utah Department of Health has remained stable. The Executive Director of the UDOH, Joseph Miner, MD reports directly to Governor Gary Herbert with Marc Babitz, MD and Nate Checketts as Deputy Directors. The chart below outlines the Senior Level Directors and Managers of the Utah Department of Health (UDOH).



The Division of Family Health Preparedness (DFHP) organizational chart is shown below. The Division Director is Paul R. Patrick and Curtis Burk is the Assistant Division Director. The Bureaus of Maternal and Child Health (Lynne Nilson) and Children with Special Health Care Needs (Noel Taxin) are the two main Bureaus that lead and direct the work of the Block Grant.

Bureau Directors and Programs within DFHP are listed below. There were no major changes that occurred over the past year for Leadership in the Division of Family Health Preparedness.


Utah Department of Health
Division of Family Health and Preparedness
Updated June 2018
Administrative Assistant
Mary Montoya
273-6601
Division Director
Paul R. Patrick
273-6604
Assistant Division Director
Curtis Burk
538-6911
Financial Services Manager
Brandi Frandsen
520-9674
Background Processing & Security
Carmen Richins
273-2802
Bureau of Primary Care
Steve Ipsen
273-6637
Emergency Medical Services & Preparedness
Dean Penovich
273-6656
Bureau of Health Facility Licensing & Certification
Joel Hoffman
273-2804
Bureau of Maternal and Child Health
Lynne Nilson
273-2858
Children with Special Needs
Noel Taxin
584-8239
Bureau of Child Development
Teresa Whiting
273-2893
Family Dental Plan
Pete Edwards/Joe Guimond
273-6642/(801) 541-9952
Health Clinics UT
Jake Fitisemanu
(801) 395-8401
Patient Safety
Iona Thraen
273-6643
Primary Care & Rural Health
Matt McCullough
273-6621
EMS Program
Guy Dansie
273-6671
Emergency Systems Program
Scott Morrison
273-6651
Specialty Care Program
Jolene Whitney
273-6671
Grant Management & Healthcare Preparedness Program
Kevin McCulley
273-6699
Complaint, Compliance, and Enforcement Unit
Dennis Bang
273-6630
Emergency Management Program
Mike Stever
273-6650
Complaint & Non-Long Term Care
Kelly Criddle
273-2806
Long Term Care
Greg Bateman
273-2805
Data Resources
Shaheen Hossain
273-2855
Maternal & Infant Health
Laurie Baksh
273-2857
Oral Health
Kim Michelson
273-2877
Pregnancy Risk Line
Interim/Laurie Baksh
273-2857
Women, Infants and Children (WIC)
Chris Furner
538-6199
Integrated Services Program
Eric Christensen
584-8254
Child Health Advanced Records Management
Christine Perfili
584-8275
Children's Hearing Aid Program, CMV, Early Hearing & Detection Intervention
Stephanie McVicar
584-8215
Fostering Healthy Children
Troy Gear
584-8598
Baby Watch Early Intervention
Lisa Davenport
584-8209
Tech Dependent Waiver
Carrie Carter
584-8240
Utah Birth Defect Network, Critical Congenial Heart Defect
Amy Nance
883-4661
Child Care Licensing
Simon Bolivar
803-4618
Early Childhood Systems
Carrie Feldsmer
273-2903
Office of Home Visiting
Sam Lee
273-2884

FY 2018 Application/FY 2016 Annual Report Update

II.B.1. Process

MCH Ongoing Needs Assessment Process
Utah Title V leadership staff employs various mechanisms to assess the ongoing needs of MCH populations. Some of the strategies implemented in the past and currently in place are described below:

1. Annual Block Grant (BG) Data Review-Each year during the BG application process, we review and assess available data related to BG performance and outcome measures. This allows for a 'mini' needs assessment annually through analysis of data trends and identification of demographic and geographic disparities within the domains. This data review process informs program planning and goal setting relative to emerging and unmet MCH population needs.

2. IBIS indicators-Needs assessment activities include updating topic reports on Utah's Public Health Indicator-Based Information System and short data reports on a wide array of public health topics. Employees are responsible for updating indicators for release to the Utah Legislature and the public. Updating these indicators enables Title V staff to stay current on data trends.

3. Collaboration with Local Health Departments (LHDs)-Collaboration and partnership with LHDs enables the State to become more aware of needs and issues affecting MCH populations at the local level and creates a unified focus for meeting MCH needs. The MCH Director met multiple times over the past year with the LHD Nursing Directors from the thirteen LHDs to solidify SMART Objectives for three contract focus areas: Services for Women, Services for Children (including CSHCN) and NPM #6.

4. Identifying Additional Data Gaps-Staff participate in the Behavioral Risk Factor Surveillance System (BRFSS) advisory group and propose questions to fill data gaps. To meet the data requirements for CoIIN project goals, the Maternal and Infant Health Program added questions on family planning/contraceptive use to the 2017 Utah BRFSS survey. The Integrated Services Program (ISP) interviewed practitioners throughout the state to assess individual office and patient needs for medical home, care coordination and transition services. Additionally, the ISP interviewed key stakeholders to assess the capacity for care coordination, coordinating efforts among agencies and ways to serve the CSHCN population.

5. State Systems Development Initiative (SSDI) Grant-Ongoing needs assessment happens through the work of the Utah SSDI team, managed by the Data Resources Program (DRP). To encourage BG contributors to assess and discuss on an annual basis the needs of disparate populations, the SSDI Technical Team (Project Director, Grant Coordinator, and DRP Web/IT Coordinator) incorporated a question about disparities into the structure of their newly revised, web-based BG data collection system (Web-Enabled Systematic Tracking Tool or WESTT). In addition, the SSDI Grant Coordinator reviews the Federally Available Data (FAD) to identify disparities among the subpopulations associated with each of the state's new NPMs/NOMs. Plans are in also in place in conjunction with the SSDI Work Plan to display stratified Minimum and Core Data Set (M/CDS) indicator data on the DRP website.

6. Operationalizing the Outcomes of the Needs Assessment - All UDOH staff who are responsible for working and reporting on activities related to Utah's NPMs/ESMs/SPMs; meet on a regular basis to discuss cross collaboration and teamwork on performance measures. CSHCN created a Family Partnership Advisory Committee to advise the Bureau on understanding the family/parent perspective on issues, needs and services and influence policies and program improvement.

7. Monthly UDOH Publication
The UDOH highlights leading health issues in its monthly *Utah Health Status Update* (HSU) publication. HSUs are sent to the Governor's Office and 500+ others including policy makers, health professionals and state and local health department staff. Because Title V work happens via collaboration among many programs, the HSU publication serves an important role in keeping program staff up-to-date on important and relevant issues. Last year, the MCH Bureau and other UDOH programs prepared ten brief HSU articles; WIC Vendor Peer Grouping, Home Birth Trends, Maternal Mortality, Clinical Congenital Heart Disease, Oral Health Status of Utah's Children, Infant Sleep Position Among Teen Mothers, Pregnancy Intention, Utilizing Commodity Supplemental Food Program, Oral health and its Impact on Diabetes, and Out of Hospital Birth Transfers.

II.B.2.Findings
II.B.2.a. MCH Population Needs

Women/Maternal Health-Utah mothers generally practice healthy behaviors reflected in pregnancy outcomes. Maternal depression has become a very pressing issue in Utah with the Utah Maternal Mental Health Collaborative and Intermountain Healthcare identifying women's mental health as a priority. We have challenges in identifying a good data source to help us better understand the reasons why women are not receiving preventive health care. The MIHP has released an RFP to conduct focus groups in Utah to collect information on this NPM. A new focus on maternal safety has gained momentum with Utah joining the Alliance for Innovation on Maternal Health and the MIHP is currently conducting an analysis on severe

maternal morbidity to assess Utah's rates.

Perinatal/Infant Health-Utah's preterm birth (PTB) rate has met the Healthy People goal and there were declines in the PTB rate through 2011; however, rates rose in 2015 and again in 2016. PTB remains the leading contributor to infant death and efforts to reduce this rate are imperative. Both the infant mortality rate and fetal mortality rate rose slightly in 2015, but not significantly.

Child Health-The National Survey of Children's Health is only available in the 2011/2012 report so it is difficult to assess changes in health status among the child health population. Local data provides a snapshot of child health in the state. Data from the UDOH oral health survey indicate 15% of Utah children had not been to a dentist in the previous year and 66% experienced caries a significant increase from the last assessment (51.7%).

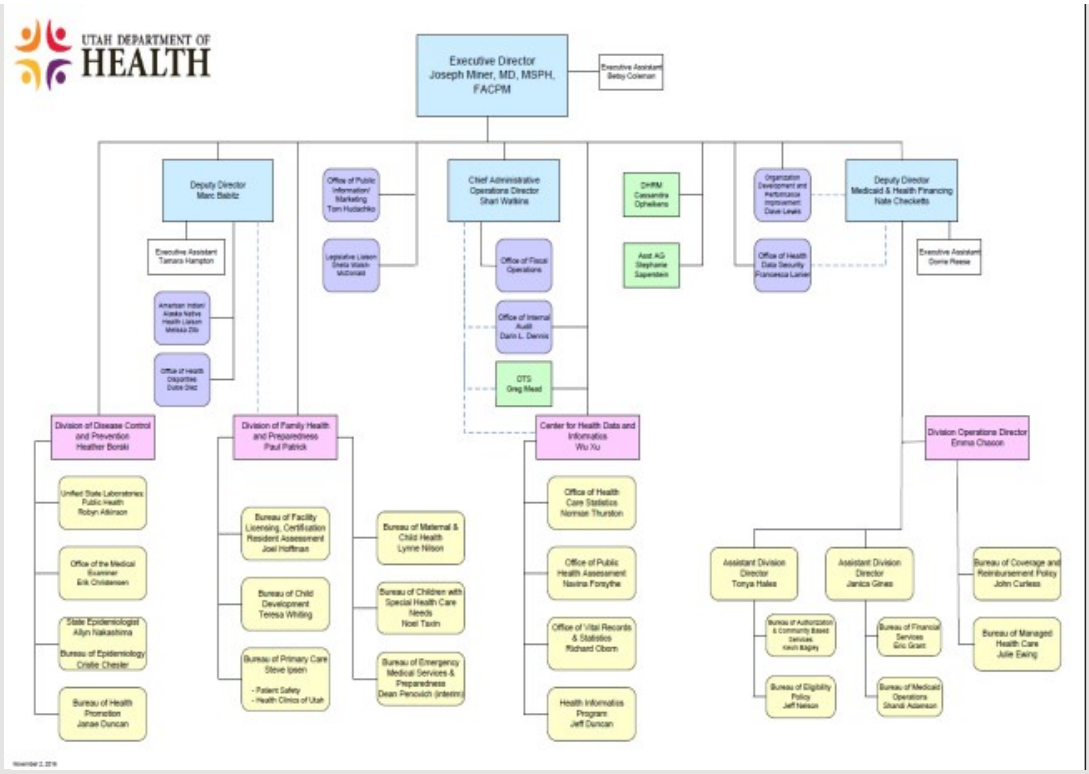
Children With Special Health Care Needs (CSHCN)-Results of a UDOH-CSHCN 2016 electronic survey of families of children with special health care needs showed approximately 80% of respondents did not have a comprehensive care plan for their child. However, of that same group, 79% replied they thought a care plan would be a useful document in the overall care of their child. Parents of young adults of transition age represented 25% of survey respondents; only 23% of those parents indicated they had a medical transition plan in place to address their child's eventual or imminent move to adult care. The ISP has been working with program participants from birth to young adulthood to provide care coordination activities in support of families, children, youth in transition, and the Medical Home. ISP partners with families to create Shared Plans of Care that have been refined to meet national standards and local guidelines.

Adolescent Health-Utah continues to see declines in the teen pregnancy rate Utah's rate continues to be lower than that of the nation but rates of teen births continue to remain higher among women who are American Indian or Hispanic. Data from Utah's Healthiest People Priorities Report (2013) show suicide is a growing concern among Utah adolescents. Utah has one of the highest age-adjusted suicide rates in the U.S. and suicide was the leading cause of death for Utahns ages 10-17 (2013, YRBS). At 5.8%, the prevalence of current use of e-cigarettes is higher among Utah students than current cigarette smoking (3.9%).

Cross Cutting/Lifecourse-Access to dental care in Utah continues to be a major issue, particularly for Medicaid participants, undocumented/uninsured, and for individuals living in rural/frontier areas of the state. The 2016 Head Start Program Information Report indicated a low rate of pregnant women and children with dental homes in four Head Start/Early Head Start sites across the state. Staff from the Oral Health Program met with health directors in these programs to discuss potential access interventions. Traditional measures of smoking during the third trimester of pregnancy are reported in 2.7% of pregnant women and there is growing concern about the use of e-cigarettes, of which we have little data for pregnant women.

II.B.2.b Title V Program Capacity
II.B.2.b.i. Organizational Structure

The Executive Director Joseph Miner reports directly to Governor Gary Herbert. The chart below outlines the Senior Level Directors and Managers of the Utah Department of Health (UDOH). This past year Marc Babitz moved from Director of the Family Health Preparedness Division (DFHP) into a Deputy Director position. For two years, prior to his promotion he served as the Title V Director in an interim capacity. This is in line with the UDOH business practice of the MCH Director designated as the Title V Director.



Another significant change since last year was the transfer of the Baby Watch Early Intervention (BWEI) Program from the Bureau of Child Development to CSHCN. The BWEI program is a high profile program and has the attention of the Governor, the Governor's staff, legislators, providers and advocates. As such, it demands a great deal of focused attention by UDOH and managers. The other big change, necessitated by the move of BWEI, is the move of ISP from CSHCN to the Bureau of MCH. These two changes represent a shift in workload among bureau directors and effected managers. For now the name of the CSHCN Bureau will remain the same, but Eric Christensen, ISP Program Manager will be the CSHCN Coordinator and Title V designee for Utah.

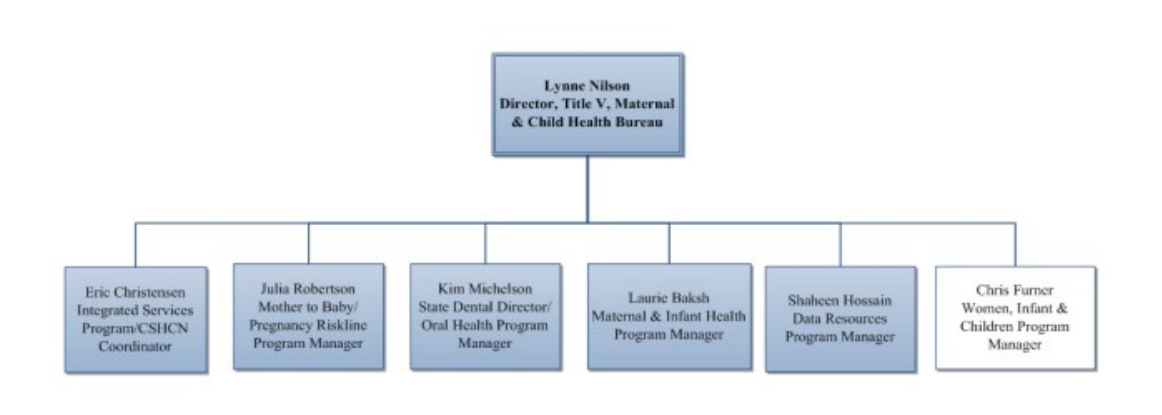
II.B.2.b.ii. Agency Capacity
The Bureau of Maternal and Child Health collaborates with other state agencies, key partners and private organizations on a regular basis to address ways to improve the health of women, infants and children in the state. The transfer of the ISP to MCH provides the perfect opportunity to take a fresh look at better ways to serve more children with special health care needs across the state. The ISP program manager, Eric Christensen is the CSHCN Coordinator for the Title V BG and links services for children with special health care needs. These linkages include the Bureaus of MCH, CSHCN, and Child Development in the UDOH, LHD's, providers, family and community partners, etc.

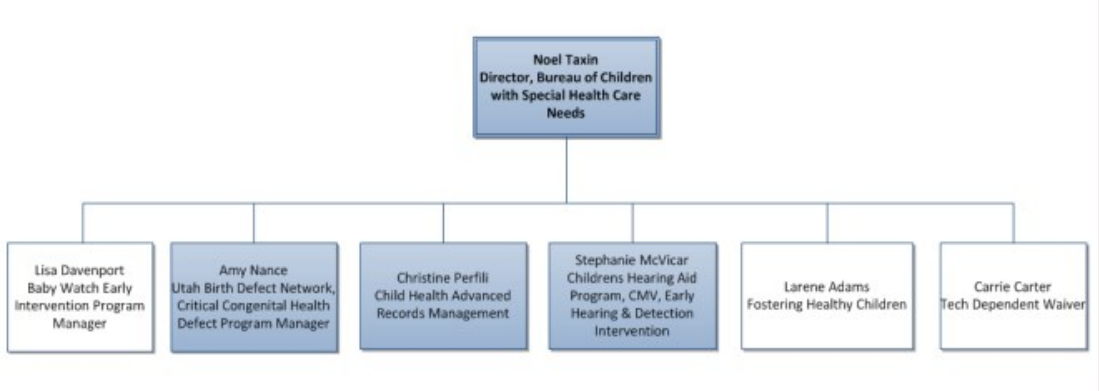
The goal of ISP is to create a care coordination model where rural/frontier health departments are the main point of contact for referral, resources, and services for children with special health care needs.

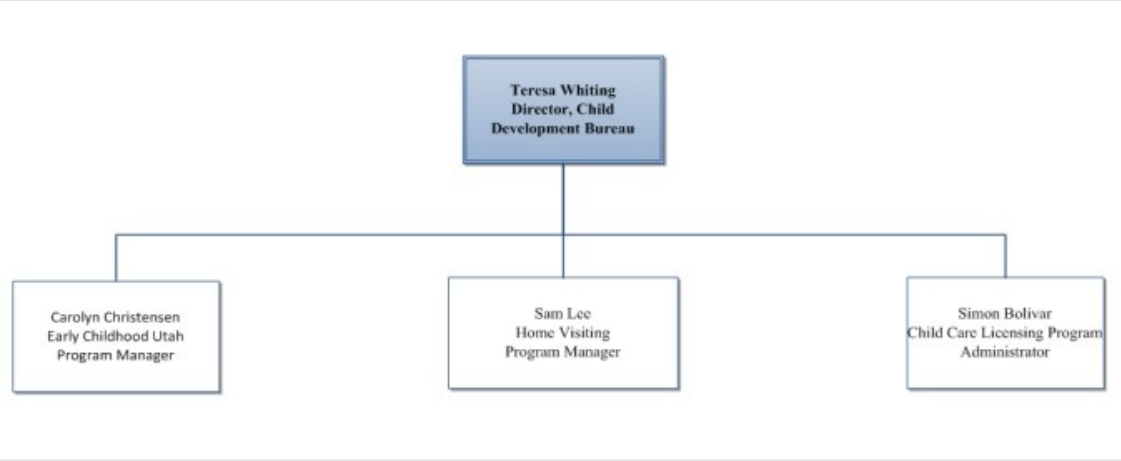
The CSHCN Bureau was awarded a grant "Enhancing the System of Services for CSHCN through Systems Integration". Now in its third, and final year, grant partnership activities focused on creating and enhancing systems to serve the CSHCN population in a more efficient and effective manner. The grant worked to increase partner communication, enhance the Medical Home Portal (Utah's shared information resource), and establish an ongoing feedback loop between referring entities and referral organizations. As grant funding ends, MCH/CSHCN Bureaus are ensuring that systems integration dialogue and action to move the Utah Integrated State Plan for CSHCN forward continues with our community partners within existing funding streams.

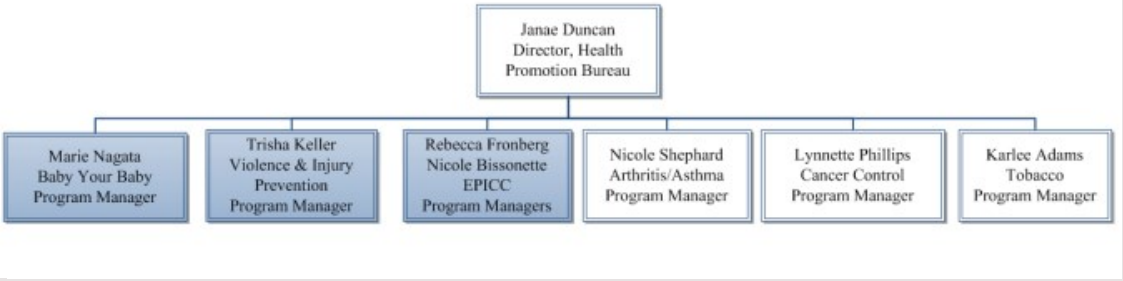
II.B.2.b.iii. MCH Workforce Development and Capacity
UDOH senior level managers lead the work of planning, implementation, evaluation and data analysis capacity. Shown below are the names, titles of the Bureau's/Programs in the DFHP and Bureau of Health Promotion who address MCH issues. A blue box indicates they receive Block Grant dollars. For the MCH Bureau, there are approximately 46 full-time employees with 22 paid with BG dollars. CSHCN has approximately 60 employees with 15 full-time employees paid with BG dollars. While each program has experienced staff turnover, all positions were filled with competent staff to meet the mission of the Division and the BG. In other UDOH Bureaus that receive BG dollars (Bureau of Child Development and Bureau of Health Promotion) there are approximately 10 employees paid with BG dollars. UDOH staff are experienced and well-seasoned

professionals, several who have worked for UDOH for many years. There are approximately 25-30 staff at the LHD level who work to improve the health of MCH/CSHCN populations.









II.B.2.c. Partnerships, Collaboration, and Coordination
Staff from MCH and CSHCN maintain working relationships with non-Title V programs in the Department to create a statewide system of collaboration.

A strong relationship exists with the MCH/CSHCN Bureaus and Utah Family Voices (UFV). The UFV Director participates, guides and provides consultation for improvements in ISP and CSHCN programs. In addition, the UFV director and other family representatives have been working with UDAC to provide direct Family to Family services at their Salt Lake clinic location.

The MCH Bureau Director is the new co-chair of the Utah Maternal Mental Health Collaborative (UMMHC). The mission of the UMMHC is to increase and improve awareness, prevention, detection, and treatment of maternal mental health conditions in Utah. The goal is to ensure every woman in Utah receives information on risk, prevention, and treatment of pregnancy and postpartum mood and anxiety disorders that affect at least 13% of Utah moms.

The CSHCN Bureau Director is the chair of the state-mandated Coordinating Council for People with Disabilities. A key topic this past year has been how electronic communication platforms, such as the designated clinical health information exchange (cHIE), could be used to share information between disparate databases and agencies, particularly around care coordination. In collaboration with DCFS, the Fostering Healthy Children Program hired an APRN and a contract psychiatrist to evaluate appropriate prescribing of psychotropic medications for children in the foster care system and recommend adjustments if needed.

The MCH Bureau Director meets at least yearly with the Indian Health Board and updates them on activities and progress of the Block Grant in regards to their population. The most recent meeting included a preliminary conversation about having tribes work collectively on NPM #6 - Developmental Screening. The Indian Health Board liaison to the UDOH is part of the DFHP and educates staff regularly on how to coordinate services with Utah tribes. In 2017, the Urban Indian Center of Salt Lake contracted with MIHP to begin implementing the Personal Responsibility Education Program curricula among American Indian youth in Utah.

CSHCN and the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) program renewed its partnership for an additional five years.

FY 2017 Application/FY 2015 Annual Report Update

II.B.1. Process

MCH Ongoing Needs Assessment Process
Utah Title V administration employs various mechanisms to assess the ongoing needs of MCH populations. Some of the strategies implemented in the past and currently in place are described below:

1. Annual Block Grant Data Review
Each year during the Block Grant application process, we review and assess available data related to Block Grant performance and outcome measures. Reviewing data allows a 'mini' needs assessment annually through analysis of data trends and identification of demographic and geographic disparities within the six MCH population health domains. This data review process informs program planning and goal setting relative to emerging and unmet MCH population needs.

2. IBIS indicators
Needs assessment activities include updating topic reports on Utah's Public Health Indicator-Based Information System and short data reports on a wide array of public health topics. Employees are responsible for updating indicators for release to the Utah Legislature and the public. Updating these indicators enables Title V staff to stay current on data trends.

3. Collaboration with Local Health Departments (LHDs)
Collaboration and partnership with LHDs enables the State to become more aware of needs and issues affecting MCH populations at the local level and creates a unified focus for meeting MCH needs at the local level. Future LHD funding can then be allocated to meet those emerging needs. The MCH Bureau Director and MCH Epidemiologist met with representatives from the thirteen Local Health Departments (LHDs) to discuss: 1) Aligning state and local MCH goals relative to the MCH 3.0 transformation; 2) Results of the 2015 service capacity survey, which was conducted to determine the services provided by LHDs to MCH populations, and: 3) Contracts between the state and LHDs that were streamlined to more closely reflect the transformation of the Block Grant and reach consensus on specific priority areas. LHDs collectively selected NPM #6 to focus on as a statewide effort during the upcoming years.

4. Identifying Additional Data Questions to Add to Surveys
Employees work to collect data that are relevant to Title V work. MCH and CSHCN staff continued to participate in the Behavioral Risk Factor Surveillance System (BRFSS) advisory group and propose questions to fill data gaps. To meet the data requirements for CoIIN project goals, the Maternal and Infant Health Program is proposing adding questions on family planning/contraceptive use to the 2017 Utah BRFSS survey. In addition, the Utah Registry of Autism and Developmental Disabilities is now asking questions on the Utah BRFSS and the data are used to verify ASD rates and improve research and access to services. The Integrated Services Program (ISP) has interviewed practitioners throughout the state to assess individual office and patient needs for medical home, care coordination and transition services. Additionally, the ISP interviewed key stakeholders to assess the capacity for care coordination, coordinating efforts among agencies and ways to serve the CSHCN population.

5. State Systems Development Initiative (SSDI) Grant
Ongoing needs assessment has been conducted through the work of the Utah SSDI team, managed by the Data Resources Program (DRP). To encourage block grant contributors to assess and discuss on an annual basis the needs of disparate populations, the SSDI Technical Team (Project Director, Grant Coordinator, and DRP Web/IT Coordinator) incorporated a question about disparities into the structure of their newly revised, web-based block grant data collection system (Web-Enabled Systematic Tracking Tool or WESTT). In addition, the SSDI Grant Coordinator reviewed the Federally Available Data (FAD) to identify disparities among the subpopulations associated with each of the state's new NPMs/NOMs. Plans are in also in place in conjunction with the SSDI Work Plan to display stratified Minimum and Core Data Set (M/CDS) indicator data on the Data Resources Program's website once the M/CDS Implementation Guide is released by HRSA and the data are compiled.

6. Monthly UDOH Publication
The UDOH highlights leading health issues in its monthly *Utah Health Status Update* (HSU) publication. HSUs are sent monthly to the Governor's Office and 500+ others including policy makers, health professionals and state and local health

department staff. Because Title V work is performed via collaboration among many programs, the HSU publication serves an important role in keeping program staff up-to-date on important and relevant issues. Last year, the MCH Bureau collaborated with other UDOH programs and prepared eight brief HSU articles (baby-friendly hospitals; strategies to reduce infant mortality; postpartum visit; SSDI update; food insecurity during pregnancy; perceived racism; neighborhood safety; and domestic violence. One longer article discussing the MCH Block Grant Five-Year Needs Assessment Process and the selection of state priorities for the new five-year Block Grant cycle (FY16-FY20) was also included.

Operationalizing the Outcomes of the Needs Assessment Through the Establishment of Small Groups.
A meeting was held in November 2015 to bring together all UDOH staff who would be responsible for working and reporting on activities related to Utah's NPMs/SPMs. Leads were identified for each of the measures and discussions were held regarding cross-collaboration and teamwork on each performance measure. With each NPM/SPM "group" identified, work then began on developing ESMs for each measure. Staff participated in learning opportunities surrounding development of ESMs and met as a group to finalize plans and identify data sources for each ESM proposed. This group will be meeting on a regular basis to discuss the issues impacting the selected NPMs/SPMs. CSHCN created a Family Partnership Advisory Committee that will advise the Bureau on understanding the family/parent perspective on issues, needs and services and influence policies and program improvement. The Advisory Committee plans to meet as needed in the coming year to discuss ways to improve NPMs/SPMs and CSHCN needs.

II.B.2.Findings
II.B.2.a. MCH Population Needs

Women/Maternal Health
Utah mothers generally practice healthy behaviors which are reflected in pregnancy outcomes. Maternal depression has become a very pressing issue in Utah with the Utah Maternal Mental Health Collaborative and Intermountain Healthcare identifying women's mental health as a priority. We have challenges in identifying a good data source that will help us better understand the reasons why women are not receiving preventive health care. Discussions are underway on how we can collect qualitative data to help us understand barriers to this care. Also of concern are the increasing numbers of maternal deaths due to drug overdose and suicide. Non-pregnancy-related maternal deaths now outnumber those that are pregnancy-related; however, reported rates of maternal mortality will not reflect this as only pregnancy-related mortality is traditionally reported.

Perinatal/Infant Health
Utah's preterm birth (PTB) rate has met the Healthy People goal and there were declines in the PTB rate through 2011; however, rates remained steady from 2012 through 2014 and preliminary National Center for Health Statistics data show that Utah's PTB rate rose slightly in 2015. PTB remains the leading contributor to infant death and efforts to reduce this rate are imperative. Neonatal Abstinence Syndrome (NAS) continues to increase in Utah. Hospital admissions noting NAS increased 13% from 2013 to 2014.

Child Health
The National Survey of Children's Health has not been updated since the 2011/2012 report so it is difficult to assess changes in health status among the child health population. There are local data that provide a snapshot of child health in the state. Data from the UDOH Oral health survey (2015) has been collected and is currently being analyzed. UDOH also tracks overweight and obesity among public elementary school children and 2014 data show that more boys than girls were overweight/obese. These data also show that the percentage of boys who were overweight/obese increased significantly from 1st to 5th grade; overall, 20.9% of elementary school students were at an unhealthy weight.

CSHCN

As data for the CSHCN population have not been updated since the 2011/2012 National Survey, it is difficult to assess changes in health status and current needs among the CSHCN population. In the past year, to gather some data, we developed a survey that was sent to practitioners throughout the state inquiring about access to care. We look forward to the revised methodology and yearly data from the National Children's Health Survey that will soon be provided. The Integrated Services Program (ISP) has been working with program participants to assist them with applying for health insurance. The ISP also provides referrals and follow through for continuity of care for the child's overall well-being.

Adolescent Health

The teen pregnancy rate continues to decline in Utah, reaching an all time low in 2014. Utah's rate continues to be lower than that of the nation but rates of teen births continue to remain higher among women who are of American Indian race or Hispanic ethnicity. Data from Utah's Healthiest People Priorities Report (2013) show that suicide is a growing concern among Utah adolescents. Utah has one of the highest age-adjusted suicide rates in the U.S. and suicide was the leading cause of death for Utahns ages 10-17 (2013, YRBS). At 5.8%, the prevalence of current use of e-cigarettes is higher among Utah students than current cigarette smoking (3.9%).

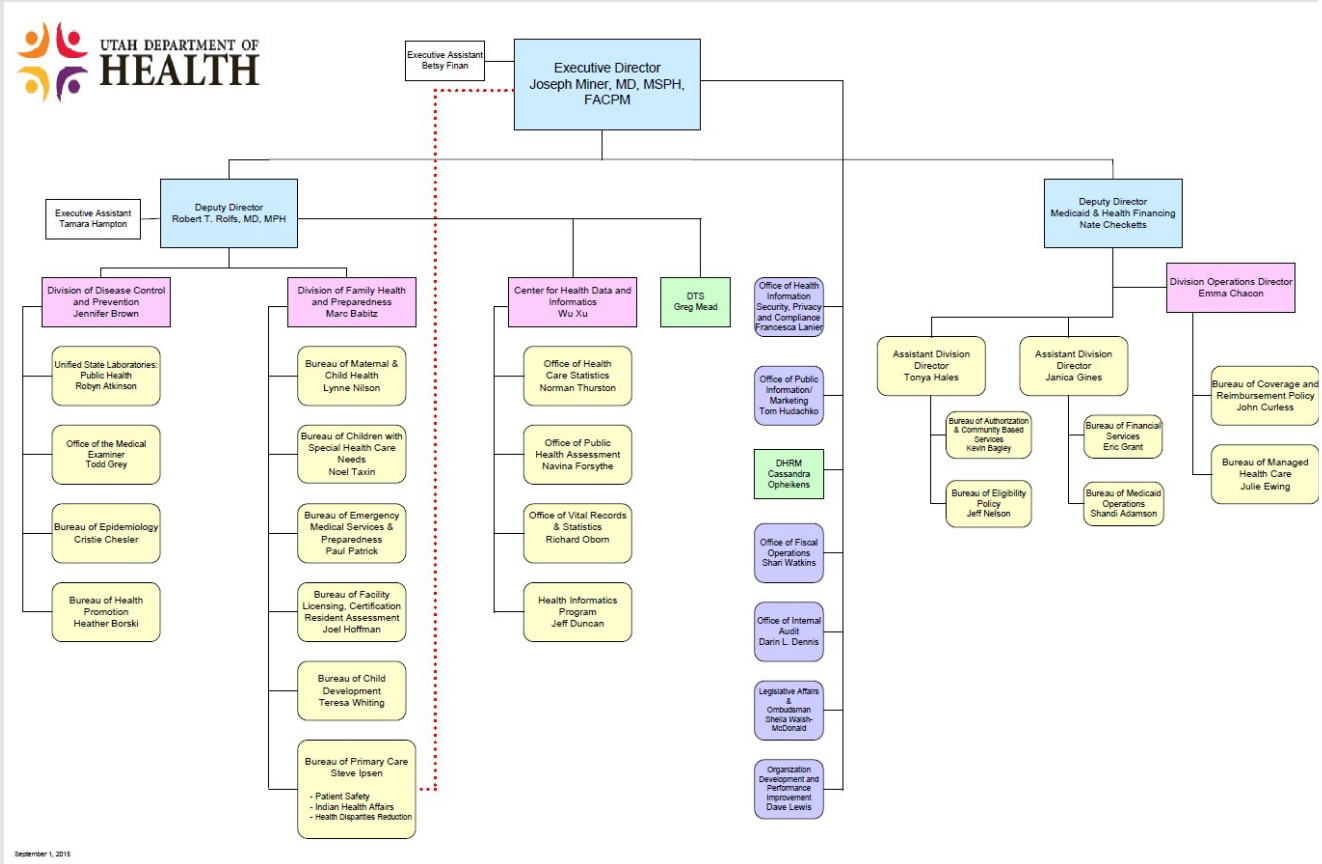
Cross Cutting/Lifecourse

Traditional measures of smoking during pregnancy are reported in 2.9% of pregnant women and there is growing concern about the use of e-cigarettes, of which we have little data for pregnant women. Access to dental care in Utah continues to be a major issue, particularly for Medicaid participants, undocumented/uninsured, and for individuals living in rural/frontier areas of the state. The 2016 Head Start Program Information Report indicated a low rate of pregnant women and children with dental homes in four Head Start/Early Head Start sites across the state. Staff from the Oral Health Program met with health directors in these programs to discuss potential access interventions.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

Changes in the State's organizational structure include a new Executive Director of the Department of Health. Joseph Miner, MD, MPH, who was appointed by the Governor in August 2015. Dr. Miner, an Internal Medicine physician, has years of experience in public health as the former Director of the Utah County Health Department.



II.B.2.b.ii. Agency Capacity

The Bureau of Maternal and Child Health is in collaboration with other state agencies, key partners/private organizations on a regular basis to do address ways to improve the health of women, infants and children in the state. The CSHCN Bureau was awarded a grant "Enhancing the System of Services for CSHCN through Systems Integration". This grant expands the

capacity of partnerships and shared resources to serve the CSHCN population in a more efficient and effective manner.The CSHCN Bureau applied for the Innovation and Care Integration for CSHCN with Autism Spectrum Disorder and Other Developmental Disabilities grant which, if awarded, will improve access to a comprehensive, coordinated state system of services that will lead to early diagnosis and entry into services for children with ASD/DD.

CSHCN staff work collaboratively with the Utah School for the Deaf and Blind (USDB) on a regular basis on early identification of newborns and children and referral to services. CSHCN is working to include USDB services in marketing efforts to reach children and youth in need.

II.B.2.b.iii. MCH Workforce Development and Capacity
State and Local MCH programs

The Utah Department of Health has applied for Public Health Accreditation and has involved all agency staff in conducting workforce knowledge and development needs assessments through the University of Utah School of Public Health. Findings from these assessments will assist the Department in workforce development plans for the future.

Staffing remains stable at approximately 46 full-time employees. While each program has experienced staff turnover, all positions were filled with competent applicants to meet the mission of the Division. Authorization was given to hire one new Health Program Specialist in the Oral Health Program to assist with the work associated with NPM 13. The vacant CSHCN Medical Director position was filled by Claudia Fruin, M.D., a 27-year veteran pediatrician. A new privacy/security officer was hired in June 2016.

Additional Workforce Capacity (not funded by Title V)

Staff from CSHCN and MCH maintain working relationships with non-Title V programs in the Department to create a statewide system of collaboration.

II.B.2.c. Partnerships, Collaboration, and Coordination

Hospital Facilities
The Newborn Screening Programs have expanded their marketing and education efforts with hospitals and practitioners to ensure screenings occur early and that follow-through and referrals are done in a timely manner to reduce potential poor outcomes.

Other Governmental Agencies
The CSHCN Bureau Director is the new chair of the state-mandated Coordinating Council for People with Disabilities. Early discussions are taking place with DCFS staff to implement teen pregnancy prevention education programs among foster care youth across the state. In collaboration with DCFS, the Fostering Healthy Children Program will be evaluating foster care files for appropriate prescribing of psychotropic medications and recommending adjustments if needed. MCH has a strong relationship with the Local Health Department Nursing Directors and in May 2016 agreed to work collaboratively and within their respective health departments on NPM #6 Developmental Screening.

Tribes, Tribal Organizations and Urban Indian Organizations
The CSHCN Bureau contracts with the UDAC for clinical services for residents living on reservations in rural Utah. The Indian Health Board liaison to the UDOH is part of the DFHP and educates staff regularly on how to coordinate services for and approvals with Utah tribes.

Public Health and Health Professional Educational Programs and Universities
CSHCN and the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) program renewed its partnership for an additional five years. The Family Voices Director participates, guides and provides consultation for improvements in the ISP and other CSHCN programs. In addition, the director and other family representatives have been working with the UDAC to provide Family to Family services.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Introduction

The Health Resources and Services Administration requires states to conduct a comprehensive needs assessment every five years. The purpose of the needs assessment is to review the health status of Utah's MCH/CSHCN populations and to identify emerging needs and gaps in services as we develop plans for the next five years. The goal guiding the assessment is to utilize the information gathered during the needs assessment process to formulate a plan of action to address the needs of women, mothers, infants, children, and youth in Utah, including those with special health care needs. The needs assessment helps us identify key needs of the three populations we serve, determine priorities that need attention, and establish the appropriate mechanisms that are required to address the priorities.

The Department of Health's and Utah's Title V vision is "A place where all people can enjoy the best health possible, where all can live, grow and thrive in healthy and safe communities. This vision guided the framework of the FY2016 MCH needs assessment process.

MCH Needs Assessment Leadership Team

A needs assessment leadership team was established in September 2013 to oversee the development and implementation of the needs assessment activities. The leadership team consists of the MCH and CSHCN Directors, Quality Improvement Director, CSHCN Family Director, MCH Epidemiologist, Maternal and Infant Health Program Manager, CSHCN Information Analyst, Data Resources Program Epidemiologist, and other key data staff. The MCH Bureau Director led the initiative and organized a series of planning meetings to discuss and set the direction and goals of needs assessment. The leadership team established processes, activities, and timelines and met on a regular basis to track progress and ensure assignments were completed on time. A separate data team was also established to conduct day-to-day data activities related to the needs assessment process.

Needs Assessment Methodology

The FY2016 - 2020 needs assessment was based on a multi-faceted approach to collecting, reviewing, and analyzing information. The overall process consisted of three major components: 1) collection and review of secondary sources of data for all previous as well as newly proposed performance measures; 2) collection of new primary data from various stakeholders using surveys and focus groups; and 3) application of a nine-step needs assessment model. Utah's needs assessment process included both quantitative and qualitative data.

1. Collection & Review of Secondary Data

The data team compiled and reviewed various secondary data sources and updated all previous 18 National and 10 State Performance Measures as well as Health Status Indicators, Health System Capacity Indicators, and Outcome Measures with five or more years of data with HP2020 goals. All measures were categorized for the three legislatively mandated Title V MCH population groups (pregnant women, mothers and infants; young children and adolescents; and children and youth with special health care needs). The data team worked very closely with key program staff to prepare narratives on assessment of health status for each of the three MCH populations. The leadership team reviewed the trend data and narratives on the three populations to determine progress and to identify strengths and challenges in meeting the needs of MCH populations. In addition data from the LHD Performance Measures Report (Appendix B) was also considered.

2. Collection of New Primary Data

The leadership team then developed a plan to collect new, primary data for this FY16 needs assessment cycle from a broad range of stakeholders. In our discussions, we ensured we had input from individuals representing a broader view of health needs and issues for mothers and children in the state. The plan included collection of data using a) a general stakeholder survey, b) a survey of parents of children and youth with special health care needs, c) a survey of local health departments to assess their service capacity, and d) a series of focus groups with community partners.

a. *Stakeholder Survey*

The stakeholder survey was developed by revising and modifying the previous 2010 MCH Needs Assessment Survey. We enhanced the stakeholder survey by adding more issues related to the health needs of mothers, children, and youth. We collaborated with the University of Utah Master of Public Policy (MPP) Program to conduct this survey. The survey was administered using Qualtrics, an online survey platform. The survey URL was emailed to parents and professionals in the fields of public health, health care, education, and government, and respondents were asked to prioritize what they thought were the most important health needs and health care access issues in the state and in

their communities. Of the 231 community members invited to participate, 172 completed the survey, which equates to a 74% response rate. (See Table 1 below for the top 10 health issues identified in the stakeholder survey.)

b. CSHCN Parent Survey

The CSHCN Bureau Director, managers, Data Analyst and CSHCN Family Director, and the MCH Bureau's Data Resources Program worked together to design the CSHCN Parent Survey. The survey was developed by modifying the previous 2010 CSHCN Parent Survey and by adding questions from the National CSHCN Survey. The survey consisted of 29 questions, and topics included type and level of disability, health insurance coverage, health care financial expenses, availability of care providers and services, quality of care, and challenges faced in obtaining care. Email and postcard invitations were sent to 4,937 individuals identified by CSHCN clinic databases as those who were caregivers for special needs children or youth up to age 21. The survey was administered primarily online using the SurveyMonkey.com platform, however, a toll-free telephone line with bilingual staff was also provided to assist Spanish-speaking respondents and those without access to a computer. A total of 804 surveys were completed, producing an estimated response rate of 16.3%. The open-ended comments were tabulated by data staff to incorporate in the analyses. Summary reports with survey findings were sent to needs assessment leadership team members to review prior to the leadership team meetings. (The CSHCN parent survey report, Appendix B).

Table 1. Top 10 Health Needs Identified in the 2014 Stakeholder Survey and 2014 CSHCN Parent Survey (by MCH Population)

Stakeholder Survey				CSHCN Parent Survey
Pregnant Women	Mother & Infant	Children	Adolescents	CSHCN
Depression	Depression	Abuse and neglect	Violence (bullying)	Deductible, copays, out-of-pocket expenses
Alcohol/drug	Parenting knowledge	Violence (bullying)	Lack of sexual health education	Non-covered expenses by health insurance
Lack of insurance	Infant abuse and neglect	Lack of insurance	Lack of physical activity	Financial stability
Unintended pregnancy	Lack of insurance	Lack of physical activity	Overweight/obesity	Eligibility for public programs due to income criteria
Domestic violence	Domestic violence/partner abuse	Lack of child care	Lack of after school supervision	Adequate insurance coverage
Lack of multivitamin	Poor nutrition during pregnancy	Lack of insurance	Injuries due to motor vehicle crashes	Cost of insurance (premiums)
Lack of family planning	Developmental delays in infants	Overweight/ obesity	Lack of access to contraceptives	Recreation and/or social activities
Diabetes prevention	Male/father involvement	Inadequate health and safety in child care	Lack of use of seatbelts	Waiting list for programs
Male/father involvement	Diabetes prevention	Lack of use of car seats & seatbelts	Unintended injuries	Relevant community services and resources
Excessive weight gain	Weight retention after pregnancy	Lack of after school supervision	Inadequate immunizations	Respite care

c. *Local Health Department Service Capacity Survey*

We conducted a service capacity survey among the 13 local health department (LHD) districts within the state to assess the extent of services they provide to local MCH populations. Seven of the 13 LHD districts are either large or multi-county districts covering large geographic areas. Several districts also include both rural and frontier areas within their service region. Many LHDs have been gradually moving away from providing direct services, recognizing they do not have the capacity to provide primary care in their communities. They instead have worked to enhance and strengthen core public health services. The 2015 survey was therefore administered to determine what MCH services are currently being provided by LHDs, what capacity and resources they have to provide these services, and what barriers exist in providing such services.

The survey included 14 questions and was organized into four sections: services related to women and infants,

services related to children and youth, barriers to providing service, and contact information. LHDs were requested to rate their ability to provide certain services as well as to rate the priority placed on those services. The survey was administered online using the SurveyMonkey.com platform. The survey link was emailed to all LHD Health Officers and Nursing Directors, and all 13 LHDs completed the survey.

The survey also gave LHD representatives the opportunity to discuss barriers they face in providing services. Lack of adequate funding was frequently mentioned as a barrier along with lack of public awareness about the availability and/or importance of MCH services as well as limited access to services due to geographical and transportation barriers. (LHD Service Capacity Survey report, Appendix B).

d. Focus Groups

An in-depth focus group process was designed to complement other data collected for Needs Assessment. In partnership with research scientists at Utah State University, focus groups were conducted with several community organizations and Utah Department of Health agencies in order to cultivate qualitative information about what they believe to be the most important issues currently faced by women, infants, children, and youth in the state. Examples of some of the groups that provided input include the Utah Indian Health Advisory Board, the Utah Women's Health Coalition, the Office of Health Disparities Birth Outcomes Committee, the Utah Department of Health's Office of Home Visiting and Local Health Departments, among others. In addition to identifying the most important needs of MCH populations in the state, focus group participants were asked how these problems should be addressed, what strategies they might be able to incorporate into their own work to address these issues, what needs to happen to improve the health of MCH populations in their communities and in the state overall, and what are the top three issues that need to be addressed within the next five years. Focus group notes were then analyzed and synthesized by the Utah State University researchers in such a way as to identify the top priorities and strategies for each MCH population domain. (A detailed Focus Group Report prepared by Utah State University can be found in the Appendix B and the top health issues identified for each population by the focus groups are shown in Table 2 below.)

Table 2. Top Priorities Identified in Focus Groups

Women/Prenatal	Infants	Children	Adolescents	CYSHCN
Lack of awareness and/or education regarding pregnancy spacing/family planning	Lack of effective non-intentional injury education (safe sleeping)	Lack of quality child care	Sexually transmitted infections (STIs)	Respite care
Delayed and/or inconsistent prenatal care	Immunizations	Immunizations	Teen pregnancy	Availability of specialized services
Lack of awareness regarding the importance of preventive care	Lack of quality child care	Obesity	Mental health and suicide	Lack of support to families in rural areas
Domestic violence	Low prevalence of breastfeeding	Poor oral health	Substance abuse	Poor coordination of services & need to tie to medical home
Mental health	Premature/low birth weight babies	Mental health and bullying	Immunizations	Transition to adulthood
			Obesity	Insurance

The health issues identified by the stakeholder survey, parent survey and focus groups were also rank ordered for pregnant

women, mothers and infants, and children and adolescents including those with special health care needs. The needs assessment leadership team spent many hours discussing and reviewing data and identified the top health needs for each of the three populations as identified by surveys and focus groups.

3. Nine-Step Needs Assessment Model

A nine-step conceptual model guided the leadership team's overall approach to the needs assessment process: (1) engagement of stakeholders; (2) assessment of MCH population needs and identification of desired outcomes and mandates; (3) examination of state strengths and capacity; (4) selection of state priorities; (5) selection of measures and setting of performance objectives; (6) development of an action plan; (7) allocation of resources; (8) monitoring of progress for impact on outcomes; and (9) reporting back to stakeholders. Though much work has already been accomplished using this model as a guide, we still have more work (Steps 6 - 9) to do in the upcoming months. Evidence-based Strategy Measures and planned program activities still need to be developed within the next year as required by the new transformed block grant measurement and reporting framework.

Prioritization Process and Selection of State Priorities

An MCH Needs Assessment Summit was held on April 2, 2015, to prioritize state needs collectively with various community partners. The leadership team identified more than 50 key MCH stakeholders representing various community organizations and Utah Department of Health agencies and invited them to the Summit. The leadership team also decided to share with stakeholders the new opportunity to select National Performance Measures by enabling them to vote at the MCH Summit for which measures they thought fit best with the state's priority needs. The stakeholders played a critical role by providing their diverse views of community needs and challenges and assisting us in the selection of appropriate state priorities and related performance measures. To inform the voting process, findings from surveys and focus group projects along with data related to previous as well as newly proposed block grant measures were presented at the Summit and provided to participants in paper format.

Summit participants were also reminded to take into account the following five criteria as they cast their votes: (1) data-driven—the need is supported by data; (2) feasibility/capacity—Title V UDOH programs and local health departments have the capacity to address the need; (3) effective evidence-based intervention—the intervention has an impact on the need; (4) overlap—the selected need overlaps with or is complementary to another priority issue; and (5) resources/sustainability —the state has adequate resources to sustain efforts to meet the need.

Using the "Poll Everywhere" text-to-vote platform, participants in attendance at the Summit voted via anonymous text messaging. Beginning with the 15 National Performance Measures, stakeholders first cast a single vote for the measure they thought should be selected within each of the six MCH population domains. After the top measure was determined within each population domain, participants then cast two additional votes to select the remaining two National Performance Measures among all population domains. After voting on the National Performance Measures, stakeholders were asked to submit open-ended texts into the polling program identifying what they believed were the most important state priorities that were not addressed by the selected National Performance Measures. The submitted issues were immediately analyzed and grouped into categories by the leadership team. Stakeholders then cast three votes to select additional Performance Measures from the following categories: mental health, access to services for vulnerable/disparate populations (including rural populations), injury/suicide, preconception/interconception, adequate insurance coverage, and comprehensive sexual education. As a result of the overall voting process, ten state priorities were identified as being most important.

State Priorities:

1. Preconception and interconception care
2. Breastfeeding
3. Developmental screening for infants and children
4. Preterm/ low birthweight babies / NICU
5. Prevention of overweight and obesity among child & adolescent
6. Specialty service availability/rural areas and improved care coordination, medical home and transition for children with special health care needs
7. Insurance coverage
8. Out of pocket cost/financial challenges faced by CSHCN parents
9. Injury and injury-related deaths
10. Suicide, mental health issues, and access to services

After the initial selection of priority needs at the Summit, the leadership team held a follow-up meeting on April 21, 2015, to use the list of state priorities established at the Summit to finalize the selection of the state's eight new National and four new State Performance Measures.

A series of meetings are planned for early fall 2015 to receive additional stakeholder input regarding the determination of Evidence-Based Strategy Measures and finalization of State Performance Measures as the new MCH Block Grant Guidance

has allowed states another year to develop these measures.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Utah is generally a very healthy state. For mothers, and children we have generally very good outcomes, often reflecting the national trends, but usually with better than average rates. Utah's population is growing and changing, with significant increases in the Hispanic and minority populations. Utah has a strong tertiary care system for perinatal and neonatal health care. These tertiary care centers are all situated in a relatively central geographic location around Salt Lake City. Utah also suffers from a shortage of certain types of health care Providers in different geographic areas, including nurses, neonatologists, perinatologists, dentists, mental health professionals, etc. Provider shortages exist throughout the state. Large, vast areas in Utah have high ratios of women of childbearing age and children to providers, resulting in limited access to health care providers in these areas. Collaborative relationships need to be fostered to continue to encourage consultation and referral of high-risk pregnant women as appropriate to tertiary centers.

Women/Maternal Health

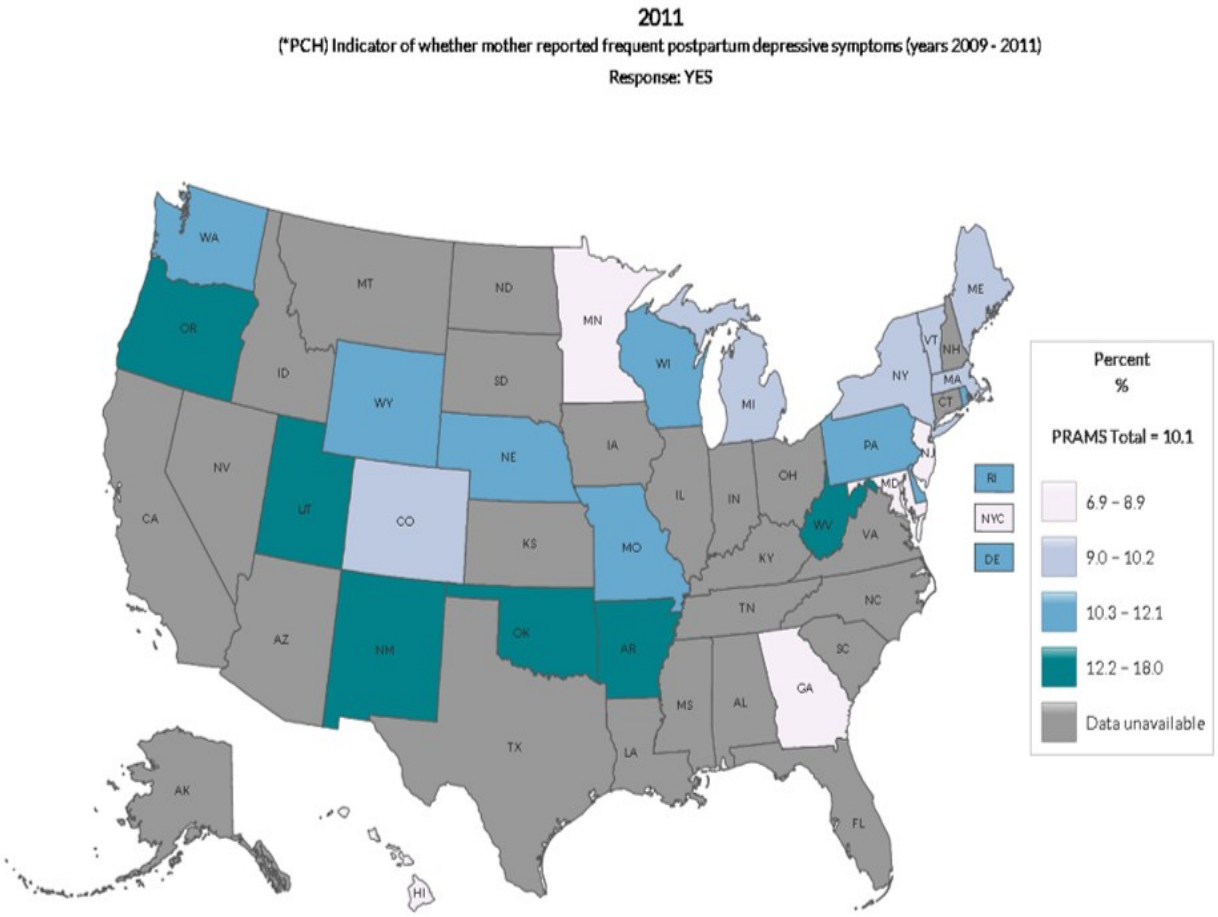
Health status:

Utah's mothers generally practice healthy behaviors which are reflected in pregnancy outcomes. Utah has already met the Healthy People 2020 goals related to weight before pregnancy, folic acid consumption, smoking and alcohol consumption prior to pregnancy, and cesarean sections. Two areas where Utah has not met Healthy People objectives are prenatal care and maternal mortality. While prenatal care rates are improving, maternal mortality is on the rise and is of concern to the state. Like other states, we are seeing an increase in obesity rates, diabetes and heart disease in the entire population. Utah's fertility rate soars above the national average of 62.9 per 1,000 at 80.8 per 1,000. Utah's 2013 birth rate was 17.6 per 1,000 compared to 12.5 per 1,000 in the U.S., the highest in the nation.

Gaps/challenges:

Access to prenatal health care varies depending on the geographic area of the state. According to Health Professional Shortage Area surveys, there are areas in Utah with high ratios of women of childbearing age to providers, resulting in limited access to a prenatal provider in their area**.** Women in rural communities may have to travel many miles to a provider and/or hospital. More than half of the counties (16 out of 29) are without any obstetrician-gynecologist with several counties reporting as few as 1 provider to 10,000 women of childbearing age. One rural county has no prenatal care or family planning provider of any kind. There is a need to promote collaboration to assure better access to consultation services for rural providers. A relatively small amount of Title V funding is contracted to two agencies in Salt Lake City to assist with the provision of prenatal care services for uninsured pregnant women.

Another health service gap for women of reproductive age in Utah is lack of coverage for mental health care services and accessible mental health services. Although data on availability of mental health care services for women of reproductive ages have not yet been compiled, anecdotal evidence indicates that this is a problem. In 2011, 14.5% of women responding to the PRAMS survey reported symptoms of postpartum depression.



Perinatal/Infant Health

Health status:

Utah's preterm birth rate has seen small declines in recent years and Utah has met the HP goal for this measure. However, preterm birth is one of the leading contributors to infant death and efforts to reduce this rate are imperative. Utah's rate of low birthweight infants is consistently lower than the national average. Utah's infant and fetal mortality rates are also lower than the national average and meet HP goals. Among the HP goals related to breastfeeding, Utah has met all but exclusive breastfeeding at six months. The Utah Birth Defect Network continues to monitor the occurrence of all structural major malformations for all pregnancies occurring in Utah residents. Tracking major birth defects including neural tube defects (NTDs) is crucial in planning, carrying out, and specifically related to NTDs , assessing folic acid programs aimed at increasing the number of babies born without these conditions. Since 1994, approximately 35 babies with a neural tube defect are born each year in Utah, with a cumulative total of 657 (7.6 per 10,000 births) between 1994 through 2012.

Gaps/challenges:

A challenge in the perinatal domain is the increase in Neonatal Abstinence Syndrome (NAS). In 2005, there were 65 hospital admission for NAS, with a 420% increase to 275 admissions in 2013. In 2012, it was estimated that the public substance abuse treatment system in Utah was serving only 17% of the current need.

And while Utah has high rates of breastfeeding, hospital practices can be improved. The latest Maternity Practices in Infant Nutrition and Care survey ranked Utah #36 for best practices, a decline from #24 in 2009.

Breastfeeding **is a public health priority.**

mPINC

Breastfeeding is associated with decreased risk for infant morbidity and mortality as well as maternal morbidity,[1] and provides optimal infant nutrition. *Healthy People 2020*[2] establishes breastfeeding initiation, continuation, and exclusivity as national priorities.

Changes in maternity care practices improve breastfeeding rates.

There are many opportunities to protect, promote, and support breastfeeding in Utah. Opportunities such as those listed below can help Utah bring ideal maternity care practices to *all* Utah hospitals.

Change opportunities:

- Examine Utah regulations for maternity facilities and evaluate their evidence base.
- Sponsor a Utah-wide summit of key decision-making staff at maternity facilities to highlight the importance of evidence-based practices for breastfeeding.
- Encourage and support hospital staff across Utah to be trained in providing care that supports mothers to breastfeed.
- Establish links among maternity facilities and community breastfeeding support networks in Utah.
- Implement evidence-based practices in medical care settings across Utah that support mothers' efforts to breastfeed.
- Integrate maternity care into related hospital-wide Quality Improvement efforts across Utah.
- Promote utilization of the Joint Commission's Perinatal Care Core Measure Set including exclusive breast milk feeding at hospital discharge in Utah hospital data collection systems.

Utah's 2013 Survey Results

72 Utah's State mPINC **Score** (out of 100)*

Utah's State mPINC **Rank** (out of 53)† **36**

mPINC Care Dimension	Care Dimension Subscore*	Ideal Response to mPINC Survey Question	Percent of UT Facilities with Ideal Response	Item Rank†
Labor and Delivery Care	84	Initial skin-to-skin contact is at least 30 min w/in 1 hour (vaginal births)	81	15
		Initial skin-to-skin contact is at least 30 min w/in 2 hours (cesarean births)	70	13
		Initial breastfeeding opportunity is w/in 1 hour (vaginal births)	81	7
		Initial breastfeeding opportunity is w/in 2 hours (cesarean births)	65	23
		Routine procedures are performed skin-to-skin	48	18
Feeding of Breastfed Infants	87	Initial feeding is breast milk (vaginal births)	83	19
		Initial feeding is breast milk (cesarean births)	73	25
		Supplemental feedings to breastfeeding infants are rare	36	11
		Water and glucose water are not used	92	---
Breast-feeding Assistance	82	Infant feeding decision is documented in the patient chart	95	---
		Staff provide breastfeeding advice & instructions to patients	83	49
		Staff teach breastfeeding cues to patients	80	42
		Staff teach patients not to limit suckling time	49	38
		Staff directly observe & assess breastfeeding	80	42
		Staff use a standard feeding assessment tool	78	17
		Staff rarely provide pacifiers to breastfeeding infants	37	38
Contact Between Mother and Infant	80	Mother-infant pairs are not separated for postpartum transition	58	43
		Mother-infant pairs room-in at night	92	---
		Mother-infant pairs are not separated during the hospital stay	48	21
		Infant procedures, assessment, and care are in the patient room	0	45
		Non-rooming-in infants are brought to mothers at night for feeding	89	31
Facility Discharge Care	47	Staff provide appropriate discharge planning (referrals & other multi-modal support)	20	41
		Discharge packs containing infant formula samples and marketing products are not given to breastfeeding patients	46	45
Staff Training	55	New staff receive appropriate breastfeeding education	11	41
		Current staff receive appropriate breastfeeding education	18	38
		Staff received breastfeeding education in the past year	60	26
		Assessment of staff competency in breastfeeding management & support is at least annual	41	49
Structural & Organizational Aspects of Care Delivery	68	Breastfeeding policy includes all 10 model policy elements	18	36
		Breastfeeding policy is effectively communicated	61	49
		Facility documents infant feeding rates in patient population	63	43
		Facility provides breastfeeding support to employees	60	43
		Facility does not receive infant formula free of charge	27	22
		Breastfeeding is included in prenatal patient education	85	42
		Facility has a designated staff member responsible for coordination of lactation care	68	34

* Quality Practice scores range from 0 to 100 for each question, dimension of care, facility, and state. The highest, best possible score for each is 100. Each facility and state's "Total Score" is made up of subscores for practices in each of 7 dimensions of care.

† Ranks range from 1 to 53, with 1 being the highest rank. In case of a tie, both are given the same rank. State ranks are not shown for survey questions with 90% or more facilities reporting ideal responses.

Questions about the mPINC survey?
Information about the mPINC survey, results, reports, scoring, and history is at: www.cdc.gov/mpinc

For more information:
Centers for Disease Control and Prevention
Division of Nutrition, Physical Activity, and Obesity
Atlanta, GA USA

November 2014

References

[1] Ip S, Chung M, Raman G, et al. Breastfeeding and maternal and infant health outcomes in developed countries. Rockville, MD: US Dept of Health and Human Services, Agency for Healthcare Research and Quality; 2007.

[2] US Dept of Health and Human Services. Healthy People 2020 Summary of Objectives: Maternal, Infant, and Child Health. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/MaternalChildHealth.pdf

[3] DiGirolamo AM, Grummer-Strawn LM, Fein S. Effect of maternity care practices on breastfeeding. Pediatrics 2008;122, Supp 2:S43-9.

[4] Fairbank L, O'Meara S, Renfrew MJ, Woolridge M, Sowden AJ, Lister-Sharp D. A systematic review to evaluate the effectiveness of interventions to promote the initiation of breastfeeding. Health Technology Assessment 2000;4:1-171.

Source: http://www.cdc.gov/breastfeeding/pdf/mpinc/states/2013/utahmpinc13_508tagged.pdf

Child Health

Health status:

Utah children are healthier than their national counterparts in general and exceed national averages in a number of health indicators. With the low rate of tobacco use along with alcohol, children in Utah live by and large in healthy family environments. Other strengths of the system are that the Utah Department of Health is collaborating with several organizations, under the leadership of the Utah Chapter of the American Academy of Pediatrics to improve health care services for children through primary care provider education and quality improvement projects. Utah's child population is relatively healthy when compared to national data as noted in the 2011/2012 National Survey of Children's Health. The Commonwealth Fund's State Scorecard report for 2014 ranked Utah 37th for uninsured children, 10th for children 19-35 months who are vaccinated, 9th for infant mortality, 7th for pediatric asthma hospital admissions, 5th for children with a medical home, and 1st for 10-17 year olds who were overweight or obese.

Gaps/challenges:

Utah is faced with a growing population of families without insurance, especially those of undocumented citizenship status, with limited resources which places a stress on the health care system. Local health districts and community health centers in the state have been forced to place limits on the number of individuals seen due to limited resources. This also prevents hiring additional public health nurses to provide services at needed levels or more in-depth services to the maternal and child populations of the state, such as care coordination, home visiting services, and grief support to families that experience SIDS. Financial barriers continue to exist for families and children whose condition and/or services are not covered by third party payers (e.g., pre-existing conditions, therapy, mental, orthodontia, dental and surgical exclusions). The new health reform law will increase access and extend health care coverage, but as of now Utah is not expanding Medicaid. Mental health services for children may be difficult to access, especially for very young children.

Health Status of Children

		Utah	U.S.
HEALTH STATUS			
Child Health Status	percent of children in excellent or very good health	86.9	84.2
Oral Health Status	percent of children with excellent or very good oral health	78.2	71.3
Premature Birth	percent of children who were born premature, that is three or more weeks early	9.9	11.6
Breastfeeding	percent of children age 0-5 who were ever breastfed	88.9	79.2
Risk of Developmental or Behavioral Problems	percent of children age 4 months to 5 years determined to be at moderate or high risk based on parents' specific concerns	20.1	26.2
Child Weight Status	percent of children age 10-17 years who are overweight or obese (BMI-for-age at or above 85th percentile)	22.1	31.3
HEALTH CARE			
Current Health Insurance	percent of children currently insured	91.3	94.5
Insurance Coverage Consistency	percent of children lacking consistent insurance coverage in the past year	14.7	11.3
Preventive Health Care	percent of children with a preventive medical visit in the past year	76.2	84.4
Preventive Dental Care	percent of children with a preventive dental visit in the past year	77.6	77.2
Developmental Screening	percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems	26.8	30.8
Mental Health Care	percent of children age 2-17 with problems requiring counseling who received mental health care	49.1	61.0
Medical Home	percent of children who receive care within a medical home	64.3	54.4
SCHOOL AND ACTIVITIES			
School Engagement	percent of children age 6-17 who are consistently engaged in school	81.6	80.4
Repeating a Grade	percent of children age 6-17 who have repeated at least one grade	2.9	9.1
Activities Outside of School	percent of children age 6-17 who participate in activities outside of school	83.8	80.1
Missed School Days	percent of children age 6-17 who missed 11 or more days of school in the past year	7.7	6.2

CHILD'S FAMILY			
Reading to Young Children	percent of children age 0-5 whose families read to them everyday	55.1	47.9
Singing and Telling Stories to Young Children	percent of children age 0-5 whose families sing or tell stories to them everyday	56.0	56.8
Family Meals	percent of children whose families eat meals together 4 or more days per week	83.2	78.4
Mother's Health	of children who live with their mothers, the percentage whose mothers are in excellent or very good physical and emotional health	67.6	56.7
Father's Health	of children who live with their fathers, the percentage whose fathers are in excellent or very good physical and emotional health	72.0	62.0
Smoking in the Household	percent of children who live in households where someone smokes	12.4	24.1
Adverse Childhood Experiences	percent of children who have had two or more adverse childhood experiences	18.5	22.6
CHILD AND FAMILY'S NEIGHBORHOOD			
Neighborhood Amenities	percent of children who live in neighborhoods with a park, sidewalks, a library, and a community center	69.3	54.1
Neighborhood Conditions	percent of children who live in neighborhoods with poorly kept or rundown housing	14.5	16.2
Supportive Neighborhoods	percent of children living in neighborhoods that are supportive	92.4	82.1
Safety of Child in Neighborhood	percent of children living in neighborhoods that are usually or always safe	94.4	86.6

Data Source
National Survey of Children's Health website 2011/2012

CSHCN

Health Status:

Data from the National Survey of Children with Special Health Care Needs show that Utah children with special health care needs CSHCN had more difficulties in maintaining health insurance throughout the year: 13.0% of children in Utah had no insurance at one point during the past year. Adequacy of insurance was slightly higher among Utah children compared to nation (37.7% vs. 34.3%), however Utah had more CSHCN families reporting no insurance compared to nation (6.3% vs. 3.5%). Utah families reported higher unmet needs for accessing health care and family support services and reported they spend more out of pocket than their national peers (34.3% vs. 22.1%), and that their child's condition causes more financial burden for the family (28.3% vs. 21.6%). Utah children had more conditions affecting their activities and missed more school days compared to children across the nation.

Gaps/challenges:

Families of CSHCN continue to express the need for adequate resources to meet the needs of their child and family. This includes affordable insurance that covers the services the child needs to maintain or improve their quality of life; family support services including respite care for the family and the child to function at their maximum potential; and easily accessible resources that are current and credible. There continues to be national and statewide shortages in developmental pediatricians, pediatric subspecialties, genetics and orthopedics, ancillary pediatric service providers, and child psychologists with specialty training in areas such as behavioral intervention, neurodevelopment and autism spectrum disorder. There continues to be service gaps for CSHCN as they transition to adult life. The newly created CSHCN

Integrated Services Program will work with youth and families and collaborate with other agencies and organizations to provide a smooth transition to adulthood. Resources available: websites containing transition information, such as the Medical Home Portal; brochures with lists of statewide resources; training events; agency conferences; and school-district fairs provide information.

2009/10 National Survey of Children with Special Health Care Needs

Utah Profile

Estimated Number of CSHCN: 112,278

Click on any row of data in the table below to view detailed results by age, race/ethnicity, household income and other subgroups.

Prevalence of CSHCN	State %	Nation %
CSHCN Prevalence		
Percent of children who have special health care needs	13.0	15.1
CSHCN Prevalence by Age		
Age 0-5 years	7.9	9.3
Age 6-11 years	14.5	17.7
Age 12-17 years	17.6	18.4
CSHCN Prevalence by Sex		
Male	14.2	17.4
Female	11.7	12.7
CSHCN Prevalence by Poverty Level		
0-99% FPL	13.7	16.0
100-199% FPL	12.8	15.4
200-399% FPL	12.2	14.5
400% FPL or more	14.1	14.7
CSHCN Prevalence by Hispanic Origin and Race		
Non-Hispanic	13.1	16.2
White	12.7	16.3
Black	24.8	17.5
Other	15.4	13.6
Hispanic	12.1	11.2
Spanish Language Household	5.7	8.2
English Language Household	18.0	14.4

National Indicators	State %	Nation %
Child Health		
CSHCN whose conditions affect their activities usually, always, or a great deal	28.8	27.1
CSHCN with 11 or more days of school absences due to illness	17.3	15.5
Health Insurance Coverage		
CSHCN without insurance at some point in past year	13.0	9.3
CSHCN without insurance at time of survey	6.3	3.5
Currently insured CSHCN whose insurance is inadequate	37.7	34.3
Access to Care		
CSHCN with any unmet need for specific health care services	24.7	23.6
CSHCN with any unmet need for family support services	10.0	7.2
CSHCN needing a referral who have difficulty getting it	28.6	23.4
CSHCN without a usual source of care when sick (or who rely on the emergency room)	10.5	9.5
CSHCN without any personal doctor or nurse	5.7	6.9
Family Centered Care		
CSHCN without family-centered care	31.3	35.4
Impact on Family		
CSHCN whose families pay $1,000 or more out of pocket in medical expenses per year for the child	34.3	22.1
CSHCN whose conditions cause financial problems for the family	28.3	21.6
CSHCN whose families spend 11 or more hours per week providing or coordinating child's health care	14.3	13.1
CSHCN whose conditions cause family members to cut back or stop working	25.5	25.0

MCHB Core Outcomes	State %	Nation %
CSHCN whose families are partners in shared decision-making for child's optimal health	71.5	70.3
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home	46.2	43.0
CSHCN whose families have adequate private and/or public insurance to pay for the services they need	55.9	60.6
CSHCN who are screened early and continuously for special health care needs	68.6	78.6
CSHCN who can easily access community based services	62.2	65.1
Youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence	49.3	40.0

Adolescent Health

Health status:

Utah adolescents are also generally healthy. A review of 2013 Youth Risk Behavior Survey data finds that Utah youth report higher rates of electronic bullying than their national peers. Utah youth also have higher rates of no physical activity all 7 days of the week and no physical activity in school each of the 5 days. Utah adolescents have the second highest rates of chlamydia in the state. The teen pregnancy rate in Utah has dropped dramatically in recent years. Between 2009 and 2013, the teen pregnancy rate for young women ages 15 - 19 dropped over 30%, from 30.8/1,000 to 20.6/1,000. At 5.8%, the prevalence of current use of e-cigarettes is higher among Utah students than current cigarette smoking (3.9%).Older adolescents (grades 8, 10, and 12) had a higher prevalence of asthma (11.1% to 12.9%) than children (ages 0-17) overall (6.7%). And lastly, data from the 2013 Prevention Needs Assessment survey, 14.1% of Utah students in grades 8, 10, and 12 report that they had seriously considered suicide in the previous year.

Gaps/challenges:

A challenge for MCH in this domain is that no one program or department has oversight on adolescent health issues. MCH oversees teen pregnancy, VIPP works on suicide and injury, and EPICC works on issues around physical activity and school activity. It is felt there is little oversight of bullying prevention in the Dept. of Health.

Cross Cutting/Lifecourse

Health status:

Utah's rate of smoking and alcohol consumption among women and youth are usually among the lowest in the nation. Smoking during pregnancy is reported in 3.2% of pregnant women. In 2013, 21.4% of women reported that they did not get needed care due to the cost. Close to 30% of women reported having no personal doctor or health care provider. Additionally, in 2012, 30.7% of women said they had not seen a dentist in the previous year. In 2008, seven percent of women with a live birth report they had never had their teeth cleaned.

Gaps/Challenges:

Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. The Oral Health Program at the UDOH has only 1 FTE hygienist and a half time State Dental Director, which limits their scope of services. Utah has not, to date, expanded Medicaid and there has not been a solution to covering the gap in uninsured.

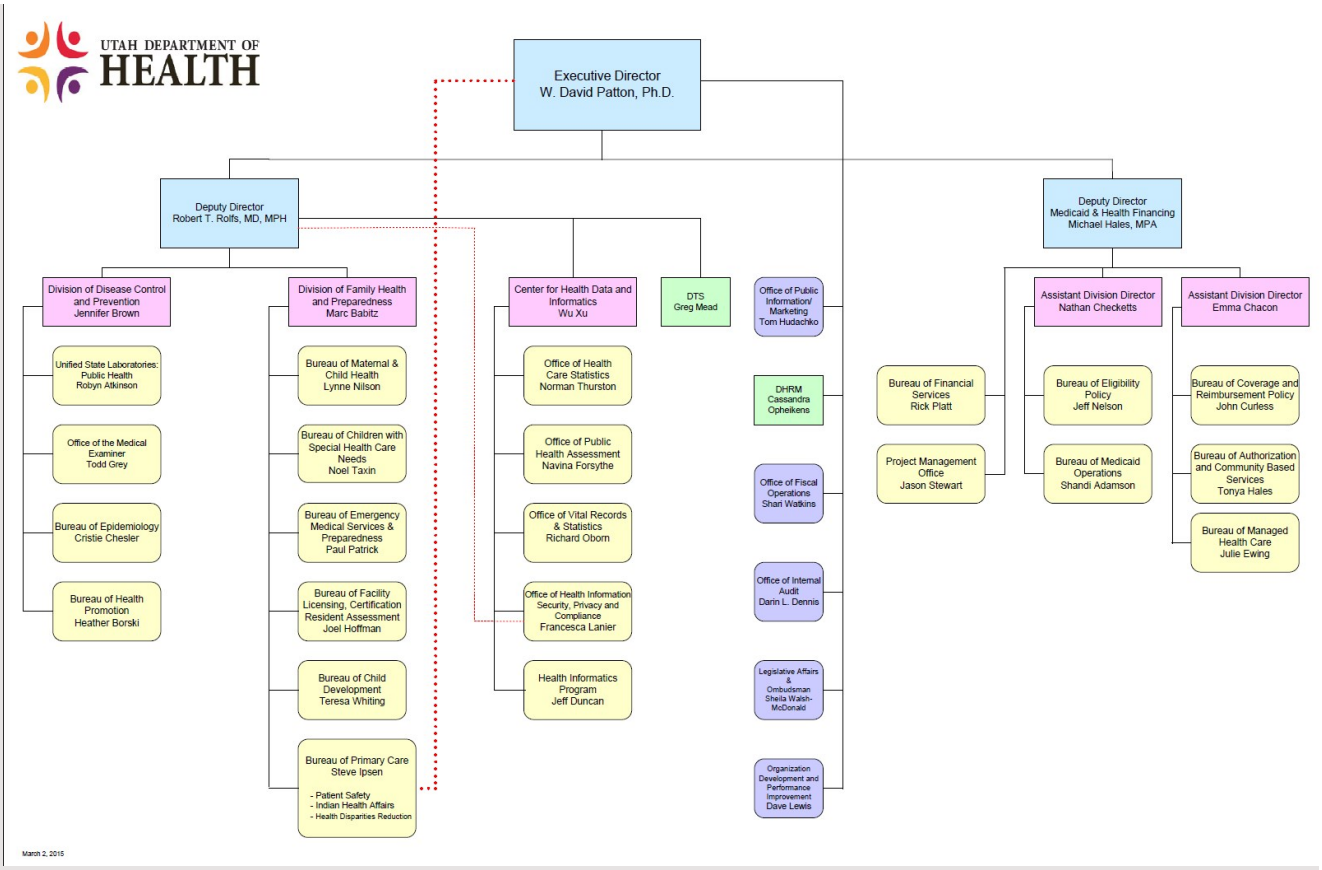
II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

In January 2011, Governor Gary Herbert appointed David Patton, PhD, as Executive Director of the Utah Department of Health (UDOH). Dr. Patton has years of experience in public administration and brings a wealth of experience and expertise in administration to the Department. The Deputy Director of the UDOH is Robert Rolfs, MD, MPH. The Executive Director of the Department is a cabinet level position reporting directly to the Governor.

The UDOH is Utah's Title V agency and is responsible for all aspects of Title V administration. The programs funded by Title V are mainly in two Bureaus in the Division of Family Health and Preparedness (DFHP): Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN). A small amount of Title V funding is allocated for oversight of our early childhood efforts in the Bureau of Child Development (CD), another bureau within the Division. The Division of Disease Control and Prevention's Bureau of Health Promotion uses Title V funds for violence and injury prevention and physical activity. Some Title V funds are contracted to health care providers for specialty services for consultation or direct services. In addition, local health departments receive Title V funds for maternal and child health services and violence and injury prevention activities.

Organizational chart:



The DFHP is headed by Marc Babitz, MD, a primary care physician with many years of experience in primary care practice, national and regional positions. The Division is organized into six Bureaus comprising approximately 30 programs. Each program reports to a Bureau Director. Since the Division also includes EMS, emergency preparedness, health facility licensure, and primary care clinics, Title V programs have opportunities to work closely with these programs.

The Division also includes other programs that address the health of Utah's mothers and children including the state Part C program, WIC program, and others. The senior level management staff of MCH, CSHCN, and CD bureaus brings a wealth of experience and depth of training to their respective program areas. They have the opportunity to lead an expert staff of about 200 individuals to improve the health of Utah's mothers, infants, children and youth, including those with special health care needs and their families. Appendix C, Senior Management CV's.

II.B.2.b.ii. Agency Capacity

Title V in Utah maintains a strong presence in the public health arena, at national, state and local levels and has been held in high regard for many years. The following Utah Department of Health Bureaus serve mothers, infants and children: MCH, CSHCN, Health Promotion and Child Development). The work of these bureaus crosses all six Title V domains.

- MCH – Domain 1 and 2 (Woman/Maternal Health, Perinatal/Infant Health)
- Child Development – Domain 3 (Child Health)
- MCH and Health Promotion – Domain 4 (Adolescent Health)
- CSHCN – Domain 5 (Children With Special Health Care Needs)
- MCH - Domain 6 (Cross cutting/Life Course)

This structure affords an opportunity for ongoing collaboration around Title V activities and programs to improve efficiency, move towards stronger leaders over programs and better understand what we all do to improve the health of mothers and children. This also allows a fresh look at clinical programs in terms of services we provide and how we provide them. Specific MCH/CSHCN Strategic Plans were developed for 2014-2016 and shown in Appendix C.

Title V staff continually identify needs of underserved mothers and children to prioritize allocation of resources. Staff weighs factors limiting access or availability of services across the state in partnership with community organizations and interested others. Staff develop plans and interventions to support health needs. Staff review and analyze MCH data and produce reports, fact sheets, abstracts and articles for publication. Several published peer review journal articles included Division staff as authors.

A detailed description of statewide system services and associated components are found in the sections that follow.

II.B.2.b.iii. MCH Workforce Development and Capacity

State and local MCH programs

Title V funds approximately 46 full-time employees (FTEs) at the state level to provide services to the public and infrastructure for addressing the needs of mothers and children, including those with special health care needs and their families. The state staff includes physicians, registered nurses, nutritionists, social workers, psychologists, audiologists, physical and occupational therapists, health educators, epidemiologists, and other disciplines. State staffing has been stable, which is helpful for continuity of operations. The MCH workforce continues at the Local Health Department level. We do not track staffing or FTEs at local health agencies since they are autonomous. However, it is important to note that one staff member in each area typically wears several different hats in his/her daily work. Each health district has a Health Officer, Nursing Director, WIC Director and other health professionals. It is up to the discretion of the LHD to determine staffing for Title V activities.

The MCH and CSHCN Bureaus conduct most of the activities required by the block grant and both directors report to the Title V Director Marc Babitz, MD, Division Director for Family Health & Preparedness (DFHP). The Bureau Director for Child Development also reports to Dr. Babitz. Staff in the Bureau of Health Promotion (BHP), housed in the Division of Disease Control and Prevention, conduct Title V activities and programs for MCH populations in the areas of violence and injury prevention and physical activity promotion. Staff in these programs report to their respective managers/Bureau Directors.

The Bureau of CSHCN is headed by Noël Taxin, M.S. Noël has extensive experience in management and in a number of areas related to health, such as Early Intervention and children with special health care needs. She also has experience in mental health and clinical work. The CSHCN Bureau includes fourteen programs. Noël is committed to integrating programs with each other and with other Bureaus' programs strengthen partnerships, establish new ones, and ensure available data are used to evaluate programs and services.

The Bureau of MCH is newly headed by Lynne Nilson, MPH, MCHES, who started in January 2015. The MCH Bureau includes 5 programs that focus specifically on mothers and children. Lynne also is committed to integrating programs with each other and with other Bureaus' programs, strengthen partnerships, establish new ones, and ensure that available data are used to evaluate programs and services. In addition, Lynne is a leader and has a demonstrated ability in fostering relationships with Local Health Department Health Officers, Nursing Directors, WIC Directors and a multitude of other partners. She is in regular communication with the BHP Bureau Director to coordinate and maintain the integrity of Title V activities for physical activity and violence/injury prevention.

The Bureau of Child Development is headed by Teresa Whiting. Teresa has background and experience in child development, child care, Head Start, the State Office of Child Care and child care licensing. As Director of the Bureau of Child Development, she oversees programs related to young children; including the state Part C program, Baby Watch/Early Intervention, the Office of Home Visiting, and Child Care licensing.

Monthly coordination meetings are conducted with key staff and the Title V Director to discuss coordination of programs and how to improve services to the MCH and CSHCN populations. Staff members are split among three Utah Department of Health buildings. The Bureau of Maternal and Child Health and Bureau of Child Development are housed at the Highland Drive Building. Staff in the Bureau of Children with Special Health Care Needs are housed in a building located near the University of Utah Hospitals and adjacent to Primary Children's Medical Center (PCMC) and the University of Utah Health Sciences Center (UUHSC). It is also within one mile of Utah's Shriners Hospital for Children. CSHCN offers clinical services in Salt Lake City as well as in Provo and Ogden. Additionally, staff provide services in rural areas throughout the state via itinerant clinics. Staff in the Bureau of Health Promotion are housed in the Cannon building.

Division planning and evaluation occur primarily at the program level with support from Division and Department data resources. The MCH Epidemiologist hosts regular meetings of the Data and Information Group (DIG) to share data issues related to mothers and children. The DIG is well attended by Title V staff and other Department staff. The DIG addresses critical issues related to MCH and CSHCN to share results or to problem-solve an issue. Feedback from Network members has been invaluable for presentations, policy setting and review of data analyses.

Local Health Departments (LHDs)

Staff of LHDs and the MCH/CSHCN programs have a strong and long history of working together, often in spite of tensions between the Department and local health officers. Fortunately, program staff generally do well in relating to their colleagues in the LHDs. In 2009, legislation was passed that mandates the UDOH to present any federal grant application to a Governance Committee consisting of UDOH representatives and local health officers. Through the efforts of both the UDOH and LHD leadership, we are making strides in building a more collaborative partnership. In addition, a conversation is underway with LHD health officers regarding streamlining contracts to focus more specifically on NPM/SPM objectives and evidence-based strategies.

The Department provides Title V funds to LHDs via contracts. State staff meet with local health officers and nursing directors as needed or requested. Representatives of the local health officers association and the local nursing directors association participate in various Division advisory committees or task forces to ensure their input and support.

Local Health Department Service Capacity Survey

In 2015, the UDOH conducted a service capacity survey among the 13 LHD districts within the state to assess the extent of services they provide to local MCH populations. The 2015 survey was administered to determine which MCH services are currently being provided by LHDs, what capacity and resources they have to provide these services, and what barriers exist in providing such services.

Analysis of this survey will be used by managers and stakeholders to develop strategic plans and activities in support of MCH goals at both the state and local health district level. By gaining insight into what MCH services are currently being offered by LHDs and by getting a better understanding of what the abilities of various LHDs are to offer these services, collaboration between the UDOH and LHDs will hopefully be more effective in achieving these goals. The data collected by this survey will also be very useful when renegotiating service contracts between the state and local health departments to achieve maximum alignment of priorities, goals, and activities between the two. (LHD Service Capacity Report, Appendix B).

Work Force Capacity

EPICC (Healthy Living through Environment, Policy, and Improved Clinical Care) 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. The program is organized around four domains: (1) Epidemiology and Surveillance (2) Policy and Environment (3) Health Systems, and (4) Community-Clinical Linkages. For the Block Grant, EPICC provides strategies to increase healthy nutrition and physical activity environments in early care and education (childcare/preschool) and in K-12 schools.

VIPP (Violence and Injury Prevention Program) works to reduce injury and violence in Utah, with specific focus on youth injury prevention. VIPP provides data, interventions, and prevention resources on child injury deaths, child abuse and maltreatment, child passenger safety, dating and domestic violence, infant sleep, motor vehicle crashes and occupant protection, falls, prescription drug overdoses, rape and sexual assault, school injuries, suicide, traumatic brain injuries, and violent deaths. VIPP is the lead agency for Safe Kids Utah and coordinates with local Safe Kids coalitions to reduce unintentional injuries among children and teens. VIPP reviews all child deaths as well as domestic violence-related deaths. VIPP contracts with all 13 local health departments in the state to address injury across the lifespan and works with hundreds of state, local, and community partners. VIPP receives funding from the CDC, Prevention Block Grant, HRSA, Administration on Aging, state TBI Fund, and Title V to carry out activities.

Additional Workforce Capacity (not funded by Title V)

Both the MCH and CSHCN Bureaus have a productive relationship with the Office of Vital Records and Statistics (OVRS). Staff from OVRS provide timely data to many staff within Title V programs. In addition to data, staff from Vital Records are asked to participate in many MCH/CSHCN advisory groups. Staff in OVRS have been very open to adapting the birth

certificate to provide Title V programs the data they need. In return, MCH/CSHCN staff participate in statewide training of birth and death certificate clerks and offer quality improvement suggestions to OVRS staff when data issues are identified.

Title V staff collaborate with the Office of Health Disparities Reduction (OHD) on an on-going basis. Title V staff serve on advisory committees for the OHD and their staff are members of many MCH/CSHCN advisory committees. In addition, staff from the OHD assist Title V staff with understanding issues in diverse communities, translation services, and developing culturally appropriate materials.

The CSHCN Medical Director, Audiologist/Speech Pathologist and Physical Therapist are members of Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee, which meets weekly to determine authorization for non-covered services for Medicaid recipients. The CSHCN staff serve on Medicaid committees and assist Medicaid with authorization of needed services for children with special needs.

The toll-free Baby Your Baby (BYB) Hotline provides information and referrals on providers and/or financial assistance for prenatal care, family planning, well child care, nutrition services, or other related services. Hotline staff collaborate well with the community to ensure that resource and referral information is current. The hotline is viewed as a valuable resource. BYB is also the face of the Medicaid Presumptive Eligibility program. Program oversight managed by the Division of Medicaid and Health Financing (DMHF). Quarterly coordination meetings for the presumptive eligibility program are held with staff from the BYB hotline, DMHF, and MCH.

Medicaid - The Utah Department of Health houses the state Medicaid agency and very fortunately Title V enjoys a strong relationship with Medicaid. Since Utah's CHIP Program, a stand-alone program, is administered by Medicaid, we are able to collaborate with the CHIP program as well. The Division works closely with Medicaid staff on pregnancy-related services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), oral health and other Medicaid-administered programs that serve mothers and children. Medicaid provides match for a number of programs that serve the Medicaid populations, such as Baby Your Baby outreach and PRAMS. Medicaid developed a targeted administrative case management model for CSHCN clients.

II.B.2.c. Partnerships, Collaboration, and Coordination

Federally Qualified Health Centers (FQHC) and state primary care association

The UDOH has a positive relationship with Community Health Centers (CHC), the Primary Care Association and the Association for Utah Community Health (AUCH). Title V programs are in the same Division as the Primary Care Office which enables us to work together more closely. Division staff has a strong collaborative relationship with the State Primary Care Association and the community health centers through invitations to sit on Division advisory committees, etc. The Department also has a very small contract with the Salt Lake Community Health Center for prenatal care for uninsured women. The Oral Health Program works with AUCH to provide technical assistance to their dental clinics and encourage the addition of dental clinics in other community health centers.

Tertiary care facilities

The Division has effective relationships with many of the tertiary facilities in the state, including eight perinatal centers and two children's centers. The Newborn Follow-up Program provides outcome data to the newborn intensive care units in the state. The University of Utah Health Sciences Center, a tertiary perinatal center, works closely with MCH Bureau staff on various grant projects. Staff regularly provides linked datasets to the University for studies and grant applications.

Other governmental agencies

Utah Title V programs coordinate efforts with numerous other Department programs, as well as outside agencies such as the Utah State Office of Education, Juvenile Justice, School for the Deaf and Blind, the Office of the Courts, and the Utah Highway Safety Office. Additional agencies are LHDs and private not-for-profit organizations and community-based agencies working to improve the health of mothers, children and children and youth with special needs. The CSHCN Bureau Director is a member of the state mandated Coordinating Council for People with Disabilities in which all state Divisions serving children and adults with disabilities are represented.

Mental Health and Social Services/Child Welfare

The Division works closely with the Department of Human Services, which serves the maternal and child population statewide in the areas of child welfare, mental health and substance abuse. For a number of years, Department staff has sought to strengthen the relationship with the Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) with varying success. DSAMH staff has been involved in UDOH committee work and vice versa. As an example, DSAMH advisory committees work with the Pregnancy Risk Line to promote messages about the impact of alcohol consumption during pregnancy. The Violence and Injury Prevention Program (VIPP) has developed a close working relationship with DSAMH as well. Program staff co-chair the Utah Suicide Prevention Coalition with DSAMH and work together on all suicide prevention efforts following the jointly developed activities of the Utah Suicide Prevention Plan. DSAMH staff serve on the Utah Child Fatality Review Committee and Domestic Violence Fatality Review Committee. VIPP also works with them on all prescription drug overdoses activities, such as coordinating the Use Only As Directed campaign. VIPP provides extensive data to DSAMH for use in their program planning and advises on legislative issues concerning suicide and prescription drugs, etc.

The Division has developed a strong collaborative working relationship with the Division of Child and Family Services (DCFS) and Child Protective Services (CPS) in a number of efforts, including providing services for children in foster care through a contract with the UDOH Fostering Healthy Children Program (FHC). FHC is an exceptional program that ensures these children and youth receive needed services. CSHCN staff participate on the Health Care Consortium Council for the Division of Child and Family Services (DCFS), which advises the DCFS Board on health issues for children in their system. UDOH Division representatives sit on the DCFS Child Abuse and Neglect Council, and an interagency group, Utah Prevention, to address substance use and other issues among youth. Division representatives are part of an interagency group to address youth transition issues.

The Baby Watch/Early Intervention (BWEI) Program works with DCFS to develop policy and procedures for CAPTA requirements for referral of children with substantiated abuse and neglect to BWEI. DCFS procedures require CPS personnel to conduct developmental screening of children ages birth to three at the initial home visit. Children who show potential problems are referred to BWEI. Local BWEI agencies partner with local DCFS personnel to train on the developmental screening tool and design referral procedures for children suspected of a developmental delay. The Interagency Coordinating Council (ICC), which advises BWEI, has 25 members representing the early childhood services community. The state brings together clinicians, political appointees, parents of special needs children, along with administrative representatives of various agencies including mental health, human services, education, Department of Insurance, Head Start, Workforce Services, Division of Services for People with Disabilities, physicians and representatives from Early Intervention providers to provide a broad vision of the service system based upon the participation and contributions of providers and consumers.

The CSHCN Bureau and the State Office of Education's Special Education Services, enjoy a strong working relationship and have collaborated on a number of projects, such as Medical Home and the development of several learning modules on the Medical Home Portal. A staff member sits on the Medical Home Advisory Committee. CSHCN and SES staff have worked together on the Utah Registry for Autism and Developmental Delays grant.

SSI, DDS and Vocation Rehabilitation

The SSI Specialist position in CSHCN continues to work with the Office of Disability Determination Services (DDS) by reviewing DDS claims and providing outreach and referral for potential Medicaid eligible children. The specialist provides information, referral and enabling services to families having difficulty accessing or utilizing services, such as Utah Legal Services, Disability Law Center or DDS. This specialist also speaks fluent Spanish. CSHCN staff is active in the Utah Center for Assistive Technology under Vocational Rehabilitation on advisory boards and coordinating direct care for individuals with disabilities.

Tribes, Tribal Organizations and Urban Indian Organizations

The CSHCN Bureau provides clinical services for residents living on reservations in rural Utah. The Indian Health Board liaison to the UDOH is part of the DFHP and educates staff regularly on how to coordinate services and approvals with Utah tribes. Staff from the MIHP have been working with the Indian Health Advisory Committee to improve services and follow up for women with gestational diabetes. In addition, Marc Babitz, MD, Title V Director serves as a consultant and adviser upon

request. The Indian Health Advisory Board also participated in focus groups on the five-year needs assessment, informing UDOH on health and cultural needs specific to the Indian American population.

Public Health and Health Professional Educational Programs and Universities

Two universities and a private college offer a Master of Public Health degree (University of Utah, Brigham Young University and Westminster College). The U of U also offers a PhD in Public Health. The Department is often asked to "mentor" students or to assist them with a project required for completion of a degree. MCH and CSHCN staff have been involved with several colleges and Universities in and out of state, providing multi-disciplinary internships for students in audiology, nursing, pharmacy, pediatric medicine, social work, dental hygiene, health education, and others.

U of U faculty from different departments are involved in a number of UDOH efforts to improve the health of mothers and children. Faculty participate in advisory committees such as the Perinatal Mortality Review program, Child Fatality Review Committee PRAMS Advisory Committee, and others. U of U Pediatric faculty serve on CSHCN advisory committees, including the Early Intervention Interagency Coordinating Council, the Medical Home Advisory Council, the Newborn Hearing Screening Advisory Committee and the Genetics Advisory Committee.

CSHCN has enjoyed an ongoing relationship with the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) program. CSHCN collaborates with the Utah State University Center for Persons with Disabilities and U of U Dept. of Pediatrics in an MCHB Leadership Grant. URLEND provides opportunities for students and professionals in health-related disciplines (pediatrics, physical and occupational therapy, speech-language pathology, psychology, nutrition, social work, audiology, pediatric dentistry, genetics, nursing, business/marketing, special education and families) to increase their knowledge and skills in providing services and supports to children with neurodevelopmental disabilities.

CSHCN Bureau has integrated the Utah Family Voices (UFV) as the Bureau family leadership component of service, who has parents on staff to provide family support to CSHCN families. The Family to Family (F2F) grant was awarded to UFV in 2008 and will continue through 2015. There are many efforts underway at the Federal level to request additional funding for long-term sustainability for the Centers across the country. CSHCN continues to dedicate MCH resources and funding to the Utah Parent Center to enhance family-to-family activities, the Autism Hotline and other resources.

The F2F maintains a database of family contacts, demographics feedback from families of identified service needs. In collaboration with the CSHCN Family Voices director, data are shared with CSHCN to understand the ongoing needs of families. The F2F staff is available as needed to the CSHCN clinics and programs to provide support and resource navigation to families. Services for families continue through the Utah Parent Center, UFV and the F2F Information grant.

A statewide Family Advisory Committee was established through the F2F grant. The committee includes families of CYSHCN, a young adult with special needs, key CSHCN staff, private providers and a Medicaid representative. The Utah Collaborative Medical Home Project works with this committee. The committee stakeholders ensure that the F2F Center project is effective in addressing the needs of Utah families of children and youth with special health care needs. Utah Family Voices received a Health Insurance and Financing Technical Assistance Initiative through the federal MCH Bureau. With this initiative, UFV has conducted parent focus groups to understand issues parents face with health insurance and financing and provide resources. The results will be used to develop a parent-focused toolkit for the Medical Home Portal website, the findings of which will be published for key stakeholders to use in outreach efforts and policy development. The Utah Family Voices Director is involved with the Family Advisory Committee at PCMC, Utah's tertiary pediatric facility. The committee will help develop best practice policies for family-centered care through PCMC. Issues of discharge planning and linking hospital care to community services for children and youth with special health care needs are being addressed. The advisory committee has been established as a forum for families of children and youth with special health care needs to resolve issues and problems with their hospital care.

Professional Organizations:

The CSHCN Medical Director sits on the Champion and Special Area Committee of the Utah Chapter of the American Academy of Pediatrics. Staff work with members of the Utah Chapters of the American College of Ob/Gyn, the American College of Family Practice and the American College of Certified Nurse Midwives on various projects. Individual staff are members of their respective professional associations, with memberships supported by the Department.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,178,000	$6,165,705	$7,186,786	$6,102,323
State Funds	$15,694,300	$15,244,589	$12,637,500	$16,992,700
Local Funds	$2,536,500	$1,794,900	$2,378,600	$2,429,500
Other Funds	$13,824,984	$36,814,378	$15,201,633	$11,586,460
Program Funds	$5,632,100	$5,804,140	$5,762,100	$5,008,690
SubTotal	$43,865,884	$67,061,212	$43,166,619	$42,119,673
Other Federal Funds	$56,266,334	$66,995,069	$58,339,300	$52,449,424
Total	$100,132,218	$134,056,281	$101,505,919	$94,569,097

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,349,076	$6,899,911	$7,374,954	
State Funds	$16,946,700	$16,235,243	$18,296,900	
Local Funds	$1,794,900	$1,188,395	$2,429,500	
Other Funds	$30,114,400	$11,081,603	$12,442,100	
Program Funds	$4,948,100	$4,798,663	$5,173,800	
SubTotal	$61,153,176	$40,203,815	$45,717,254	
Other Federal Funds	$59,382,100	$56,954,456	$57,415,800	
Total	$120,535,276	$97,158,271	$103,133,054	

	2020	
	Budgeted	Expended
Federal Allocation	$6,979,388	
State Funds	$10,851,188	
Local Funds	$1,050,094	
Other Funds	$10,833,700	
Program Funds	$5,233,600	
SubTotal	$34,947,970	
Other Federal Funds	$56,396,200	
Total	$91,344,170	

III.D.1. Expenditures

Utah 2018 EXPENDITURES - FINANCIAL NARRATIVE

Overview

The Title V federal funding, in conjunction with non-federal state monies and other federal funds, are obligated and expended to support Utah's Title V requirements, National and State Performance Measures, and priority needs. Approximately one-third of Title V funding supports Children with Special Health Care Needs (CSHCN) and an additional fifteen percent supports the MCH work of 13 local health departments across the state. The remaining Title V funding supports other critical MCH priorities such as: Safe Haven, Baby Your Baby, Maternal and Infant Health, Teratology Mother to Baby, Oral Health, School Health, Health Disparities, and Child Development. To assure alignment with Title V requirements, MCH Block Grant Leadership and Division of Family Health and Preparedness leadership meet throughout the year to review expenditures across all program and budget areas.

Expenditures (FY 2018 Annual Report Year)

Utah's Title V state match (as reflected on Form 2, line 3, "State MCH Funds" in Annual Report Expended) exceeds federal match and Maintenance of Effort requirements. State match is comprised of state general funds, including funds for Early Intervention, Child Development, Safe Haven, Reproductive Health, and Children with Special Health Care Needs. Fluctuations in actual State Funds expended can occur each year based on one-time funding as match and maintenance of effort requirements for other federal funds or transfers being received. Form 2, line 5, "Other Funds" in the Annual Report Expended represents Child Development, WIC rebates, Teratology, and funds from State of Utah Department of Workforce Services. Program Income (Form 2, line 6) includes transfer funds and revenue agreements supporting MCH activities.

Form 2, "Other Federal Funds," shows Utah's MCH work was also supported by a variety of other federal funds in FY 2018 including: Women, Infants and Children (WIC) ; State Systems Development Initiative; Pregnancy Risk Assessment Monitoring System, Early Intervention, Early Childhood Utah Developmental Screening, and Home Visitation Funds.

Utah tracks expenditures to comply with the Title V 30/30/10 legislative requirements. That is, a minimum of 30% of total funding must be expended for CSHCN; A minimum of 30% of total funding must be expended for preventive and primary care for children; And a maximum of 10% of total funding can be expended for Title V administration. In FY 2017, expenditures were tracked by CSHCN; Preventive and primary care for children ages 1-21; Pregnant women, mothers and infants; And other.

In FY 2018, 31% of Title V expenditures were CSHCN; 50.6% of expenditures were for preventive and primary care for and 8.2% of expenditures were for Title V administrative costs.

To assure the 30/30/10 requirement is properly documented and to record expenditures by the MCH Pyramid of Services, the Bureau of Maternal and Child allocates MCH Block Grant Funds throughout the Utah Department of Health (UDOH) to: the Bureau of Maternal and Child Health, the Bureau of Children with Special Health Care Needs, the Division of Disease Control and Prevention, the Bureau of Child Development and provides contracts to 13 Local Health Departments (LHD). Division Organizational charts reflecting this breakdown are shown (minus funds the 13 LHD's and funds contracted to the Division of Disease Control and Prevention)

2018 Expenditures for programs within each Bureau is detailed below:

Org	Program	2018 Actual Expenditures
BUREAU OF MATERNAL AND CHILD HEALTH		
4411	MCH Admin	$350,813
4413	Safe Haven	$58,423
4421	Maternal and Infant Health	$664,419
4431	Pregnancy Risk Line	$319,695
4461	Data Resources	$359,147
4491	Oral Health	$289,622
4664	CSHCN Integrated Services	$1,018,542
4664	CSHCN Clinical Services Contracts	$0
BUREAU OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS		
4612	CSHCN Admin.	$300,850
4626	Early Hearing Detection	$78,927
4693	Birth Defects	$469,365
4744	CHARM - Replace SSDI funds	$93,763
DISEASE CONTROL AND PREVENTION		
4414	Baby Your Baby	$191,734
4216	BHP Physical Activity	$99,210
4321	Violence & Injury (VIPP)	$333,351
4328	Community Injury (VIPP) - LHD Contracts	$388,824
FINANCIAL, LOCAL, OTHER		
4122	Financial Resources	$159,224
4123	LHD Contracts	$1,188,395
2306	Child Development	$61,395
4111	Utah Indian Health Advisory Board One Time	$0
4115	Health Disparities Federal MCH 2 Year Project	$28,060
	Indirect Cost	*$446,152*
	Total Budget for MCH Grant	$6,899,911

As mentioned, Title V funding is also allocated to each of the 13 LHD's in Utah using a funding formula as agreed upon by the UDOH Governance Committee. Each LHD receives a fixed amount of funds, with allocations ranging from $12,960 to $230,814. Funds are awarded to the LHD's to support programs/services for women, infants and children, National Performance Measure #6 Developmental Screening, State Performance Measure #3 Child Injury, State Performance Measure #4 Adolescent Suicide and other locally identified needs. Each LHD completes a work plan with SMART Objectives for the applicable performance measures selected. Contract deliverables are regularly monitored and annual reports are submitted. The reporting requirements for LHD's include: Annual Plan Report, and MCH Services Report (used for Form 5a reporting), and an Expenditure Report.

Expenditures reflect the priorities identified in the comprehensive needs assessment. Utah completed a comprehensive needs assessment process to identify priorities for the 2016-2020 MCH Block Grant Cycle. The

chosen National Performance Measures (NPM) and State Performance Measures (SPM) priorities were as follows:

- Women/Maternal Health - NPM #1 Well-Woman Visit
- Perinatal/Infant Health - NPM #3 Perinatal Regionalization, NPM #4 Breastfeeding and SPM #1 Preterm Birth
- Child Health - NPM #6 Developmental Screening and SPM #3 Child Injury
- Adolescent Health - NPM #8 Adolescent Physical Activity and SPM #4 Adolescent Suicide
- Children with Special Health Care Needs - NPM #10 Medical Home, NPM #11 Transition and SPM #2 CSHCN in Rural Areas
- Cross cutting - NPM #13A Oral Health for Pregnant Women and NPM #13b Oral Health - Children

III.D.2. Budget

Budget (FY 2020 Application Year)

Together with state general funds and other federal funds, the Title V MCH block grant is used to address Utah's MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. Utah's Title V Leadership Team meets on a regular basis to discuss all aspects of Title V, including the budget and how federal and non-federal funds are used to address the state's MCH needs. The table below illustrates projected Title V funding allocations for FY 2020.

Org	Program	Proposed Budget 10/01/2019 - 09/30/2020
BUREAU OF MATERNAL AND CHILD HEALTH		
4411	MCH Admin	$332,300.00
4411	Legislatively Mandated 5 Year Needs Assessment (TL EPI?)	$50,000.00
4421	Maternal and Infant Health (Maternal and Infant, Utah Women's Quality Collaborative, Prenitatal Review,	$475,100.00
4431,4413,4491	Family Youth Outreach (Pregnancy Risk Line, Oral Health, Safe Haven)	$666,895.00
4461	Data Resources	$272,600.00
4664	CSHCN Integrated Services	$382,100.00
4664	CSHCN Clinical Services Contracts	$851,000.00
BUREAU OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS		
4612,4626,4693,4744	Bureau of Children with Special Health Care Needs (Admin, Early Hearing Detection, Birth Defects, CHARM)	$907,500.00
DISEASE CONTROL AND PREVENTION		
4414	Baby Your Baby	$200,000.00
4216	BHP Physical Activity	$99,500.00
4321	Violence & Injury (VIPP)	$450,980.00
4328	Community Injury (VIPP) - LHD Contracts	$387,710.00
FINANCIAL, LOCAL, OTHER		
4122	Financial Resources	$150,000.00
4123	LHD Contracts	$1,188,400.00
2306	Child Development	$0.00
4111	Utah Indian Health Advisory Board One Time	$0.00
4115	Health Disparities Federal MCH 2 Year Project	$0.00
HISTORIC UNITS		
	Indirect Cost	$450,000.00
	Estimated Unspent Funds	
	Total Budget for MCH Grant	$6,864,085

Through state level programs and initiatives as well as local health department activities, these appropriations will be used to support work related to the following National Performance Measures (NPMs) and State Performance Measures:

Utah completed a comprehensive needs assessment process to identify priorities for the 2016-2020 MCH Block Grant Cycle. The chosen National Performance Measures (NPM) and State Performance Measures (SPM) priorities are as follows:

- Women/Maternal Health - NPM 1 Well-Woman Visit and NPM 13A Oral Health for Pregnant Women
- Perinatal/Infant Health - NPM 3 Perinatal Regionalization, NPM 4 Breastfeeding and SPM 1 Preterm Birth
- Child Health - NPM 6 Developmental Screening and SPM 3 Child Injury
- Adolescent Health - NPM 8 Adolescent Physical Activity, NPM 13b Oral Health - Children and SPM 4 Adolescent Suicide
- Children with Special Health Care Needs - NPM 10 Medical Home, NPM 11 Transition and SPM 2 CSHCN in Rural Areas

Utah's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2020, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted. For FY2020, 50.7% of the total Title V budget is designated for preventive and primary care for children; 31.1% is designated for Children with Special Health Care Needs; and 8.6% is designated for administrative costs. Title V leadership will hold budget discussions throughout the fiscal year to assure that the budget and spending are on track, and to address any new or unplanned MCH needs.

Utah meets the required Title V state match which is a $3 match in non-federal funds for every $4 of federal Title V funds. Utah exceeds the required match. Budgeting of match is found in Utah's "State MCH Funds" (Form 2, line 3) and is composed of state general funds including: Division Directors Office, Safe Haven, Informed Consent and Abortion Module, Home Visiting, Maternal Mental Health, Children with Special Health Care Needs, Birth Defects, Early Hearing Detection, and Child Development. Along with other federal funds, these state MCH dollars provide a critical component of Utah's MCH infrastructure. Form 2, line 5, "Other Funds" reflects funds including transfer funds for Child Development and WIC Formula Rebates, "Program Income" (Form 2, line 6) includes revenue transfers within the agency, Teratology revenue agreements and donations, CHSCN Clinic Collections, and other revenues. . Other federal funds anticipated in FY 2020 are indicated in Form 2, line 9, and are similar to funds noted in the Expenditures section.

Challenges

Utah continues to face challenges related to the Title V budget. For many years, Title V supported a variety of MCH projects and served as a gap-filling funding source. As reported in a previous application, a Funding Matrix was executed. Each program in the Utah Department of Health (and associated contractors) who receive Block Grant Dollars were required to complete the MCH Funding Matrix. The Title V MCH Block grant has provided funding and infrastructure dollars for many years to programs in the Bureau of MCH, the Bureau of Health Promotion, the Bureau of Children with Special Healthcare Needs and Local Health Departments. With the transformation of the Title V Block grant and possible reduction of federal funds, it was time to take a strategic look at when, where and why various programs are funded the way they are and to ensure that funds are being spent in the best manner possible, according to data-driven, identified needs and following grant guidance/requirements. "Historical" funding patterns needed to be revisited, justified and changed if necessary.

In addition, the current working MCH budget is over $7 million dollars, while the amount received from HRSA is just over $6.1 million per year. Funding allocations have begun to change to ensure we are spending within the level of our federal award. Some of the first changes to bridge the gap between ongoing obligations and the grant award include:

- Securing additional funding for CDC Projects
- Securing state general fund for Maternal Mental Health activities
- Securing additional revenue from the University of Utah
- Division of Family Health and Preparedness reorganization from (6) Bureaus to (4) Bureaus with MCH Block Grant funding no longer funding a Child Development Bureau Director
- Division of Family Health and Preparedness reorganization moving the Early Childhood Utah Program and Office of Home Visiting to the Bureau of Maternal and Child Health allowing maximization of funding and resources
- Attrition of (1) Children with Special Health Care Needs Bureau Health Program Specialist
- Attrition of (1) Data Resources Epidemiologist
- Attrition of .33 FTE from the Financial Administrative Resources Team
- Attrition of (1) Children with Special Health Care Needs Care Coordination Medical Assistant
- Attrition of (1) Children with Special Health Care Needs Office Specialist

Upon review of the current needs assessment, budget will continue to be aligned to the grant award, while meeting the areas of priority identified in the upcoming needs assessment, as well as performance measures.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Utah

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The Bureaus of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) are the lead agencies in Utah that provide leadership and direction for all Title V activities. The MCH/CSHCN Bureaus assess and assure the health of our populations, provide education, assess current and long-term needs, implement programs, and prioritize the issues for our populations. We navigate the public health and political climate of our state on a regular basis and strive to provide the best services with limited dollars. Stakeholder and family involvement is a key component in all of our efforts and provides us the direction and focus for our work.

Utah works to prioritize spending and services in the context of limited resources. We receive very little state general funding to support our programs yet we consistently identify priorities for vulnerable populations and shift resources when able.

There have been many changes Utah has navigated over the past 3-5 years that have been significant for service delivery and Bureau roles and responsibilities. The transformation of the Block Grant, internal UDOH changes, and moving programs between Bureaus has impacted our ability to do business as usual. This allows us the opportunity to “think outside the box” and create a “new normal” for prioritization and provision of services and programs.

Utah aligns its programs and activities with the “10 Essential Public Health Services to Promote Maternal and Child Health” framework. This model provides a well-rounded strategy which allows Utah to incorporate assessment, policy development, and assurance components within all of its programs. Utah ensures the State Action plan activities are linked to the 10 Essential MCH Public Health Services. Utah is stronger in some of the areas, but we are working to improve and become equally aligned across all services. A few examples are provided for each of the 10 Essential Services.

Examples of how Utah’s Title V programs promote Maternal and Child Health are presented below:

Ten Essential Public Health Services to Promote Maternal and Child Health in America
1. Assess and monitor maternal and child health status to identify and address problems.
• Utah's Title V programs develop and maintain a framework for data collection, analysis, and reporting. Programs track population demographics, health risks, health status, and health service utilization.
2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.
• Utah's Title V programs conduct population surveillance through the Pregnancy Risk Assessment Monitoring System, Utah Birth Defects Network, maternal mortality review, infant mortality review, and child death review.
3. Inform and educate the public and families about maternal and child health issues.
• The Baby Your Baby and Pregnancy Risk Line are two examples of how Utah informs and educates families and provides key information to improve health and birth outcomes.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
• MCH staff collaborates with Postpartum Support International Utah (PSIUt) where policy makers, health care providers, and families work on problems associated with maternal depression and anxiety. • CSHCN Bureau collaborates with community stakeholders and hospital providers to increase understanding of newborn screening and the importance to screen early and follow through.
5. Provide leadership for priority-setting, planning and policy development to support community efforts to assure the health of women, children, youth and their families.
• Title V Staff participate with a wide variety of partner and committees. In this role, staff are able to share health data, information on policies, and support shared work.
6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.
• Title V staff provide subject matter expertise and education regarding proposed legislation.
7. Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
• The CSHCN Programs provide care coordination, transition and follow up. They coordinate with the family and providers to ensure continuity of care.
8. Assure the capacity and competency of the public health and personal health workforce to effectively address maternal and child health needs.
• The MCH/CSHCN workforce is stable with very little turnover. Staff are committed and regularly keep up with changes and trends in the profession by attending conferences and trainings. Annual support and education is provided to staff to improve knowledge, capacity and work competency to better serve Utah's population. • A workforce evaluation is being implemented this year to determine additional training needs and opportunities for improvement.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health needs.
• Staff examine barriers in access to care for Title V populations. Programs gather and report on data collected from constituents on needs and problems with the service delivery system.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.
• The It Takes A Village (ITAV) project is a recent example of a solution to an MCH-related problem. The ITAV implemented a pilot project for a Pacific Islander population to raise awareness about birth outcome disparities and education about maternal and infant health. This project has been referred for inclusion in the AMCHP Innovation Station.

The mission of the MCH Bureau is to improve the health of Utah's mothers, children and families. The mission of the CSHCN Bureau is to improve the health and quality of life for CSHCN and their families through early screening and detection, data integration, care coordination, education, interventions, and life transitions. Together, with other UDOH programs, our goal is to improve the health outcomes of all Title V populations.

The state of Utah's vast geographic area and political conservatism makes it difficult to pass and enforce policies that ensure public health and to implement initiatives for all populations. Utah MCH and CSHCN Bureaus take an active role in creating and engaging committees to ensure a diversified perspective is understood in order to effectively implement programmatic activities.

Utah aligns its CSHCN services with the AMCHP's National Consensus Standard for Systems of Care for CYSHCN. Utah supports a coordinated care model which is inclusive of the family. Utah continues to struggle with agencies being in siloes and being open to reducing duplication of services and processes. Utah uses evidence-based approaches and values data in supporting initiatives to ensure a solid and robust foundation.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

UDOH senior level managers lead the work of planning, implementation, evaluation, data analysis capacity, including recruitment and retention of qualified program staff. MCH has approximately 52 full-time employees; 33 paid with Block Grant (BG) dollars for a total of 22.6 FTE. CSHCN has approximately 89 employees; 10 paid with BG dollars for a total of 4.4 FTE. The Bureau of Health Promotion has approximately 11 employees paid with BG dollars for a total of 4.3 FTE. UDOH staff are experienced and well-seasoned professionals. In addition, there are staff at the Local Health Department level who work to improve the health of MCH/CSHCN populations.

The MCH/CSHCN workforce in Utah is broad and diverse. When recruiting and hiring for vacancies most positions are relatively easy to fill, such as managers, health education specialists, epidemiologists, etc. Because salaries in the private sector are higher than state government, the more difficult positions to hire are RN's, APRN's and other clinical professionals. If a clinical professional comes to work for state government, it is because of the predictable work schedule and benefits, not for the compensation. Innovations in staffing structures/financing are limited.

Retention and recruitment of qualified staff is of utmost importance. All Bureaus working on Title V activities encourage or provide regular educational sessions and empower the Program Managers to understand systems change and ways to move forward to ensure the mission to serve women, infants, children and families continues. The Bureaus also provide continual education for self-improvement along with skill development in order to be more efficient and work collaboratively while maintaining a positive culture and climate.

All professional staff are required or encouraged to attend at least one professional conference or training each year. Out of state travel is allowed, but UDOH administration typically only allows 2-3 staff to travel to the same out of state conference. This becomes problematic when there are up to 6 staff who should attend the meeting.

The Integrated Services Program holds monthly training, problem solving, and program evaluation meetings with in-house program staff and the care coordinators contracted through four local health departments. ISP and LHD staff attend the Utah Children's Care Coordination Network (UCCCN) meeting. This multi-organizational group pairs care coordinators, nurses, practice managers, and clinical providers in a multi-disciplinary environment to learn about supports, services, and specialists around the state; share care coordination tips and best practices; and pursue group collective knowledge for solving concerns on challenging patient and family situations. UCCCN coordinates tele-learning technology which provides a virtual "face to face" environment in which all parties learn and share information. ISP clinical staff (APRN and psychologist) participate in weekly ongoing autism spectrum disorder training from specialists at the University of Utah through Project ECHO, a distance learning technology.

The CSHCN Bureau supports Utah Regional Leadership Education in Neurodevelopmental and Related Disabilities (URLEND) Training Programs to train future leaders in MCH and CSHCN. The Utah Early Hearing Detection and Intervention (EHDI) program is involved with URLEND. The Joint Commission on Infant Hearing 2007 Position Statement specifically addressed the critical need for "training professionals with pediatric specific and discipline-appropriate knowledge and skill to work with infants, children, and families" and the IPA supplemental grants to LEND programs were awarded in 2009 to fulfill this need.

The URLEND IPA program specifically addresses Utah training gaps through a combination of interdisciplinary didactic training, intensive clinical opportunities, and targeted leadership experiences. Responding to the aforementioned shortage of qualified infant and pediatric audiologists, the URLEND IPA program's goals are 1) Increase the number of pediatric audiologists with clinical and leadership skills, who will deliver interdisciplinary care to infants and young children with hearing loss, especially those children with comorbidities (autism spectrum disorders and other developmental disabilities (ASD/DD); and 2) Improved capacity for the URLEND region to screen, treat, and follow-up on infants and young children confirmed to have HL and those with HL and ASD/DD.

Between 2009 and 2019, the URLEND program has had 40 long-term trainees successfully complete the IPA strand. The URLEND-IPA program consists of more than 300 hours of LEND and IPA curriculum, split amongst didactic, leadership and clinical training. Trainees complete MCH Competency Self-Assessment Surveys both pre and post training and demonstrate improved knowledge, clinical, leadership and research skills regarding IPA and related MCH competencies (culturally sensitive, community based, family centered) care.

The EHDI program hosts a two-day conference each year for workforce development and to educate representatives

from birthing hospitals in Utah. Providing educational opportunities for Utah's infant and pediatric audiologists is crucial to a successful EHDI program. In 2018, the EHDI Program offered training to 42 attendees on Relational Audiology. Audiologists counsel families by providing information about a diagnosis, but do not have the training to better support the emotional experience of a new diagnosis.

In 2018, the FHP Division, in response to a legislative audit engaged in the process to develop a strategic plan. The Division provided the opportunity for all FHP employees to participate in the process. They held a daylong retreat to educate staff on strategic planning processes and assigned workgroups for ongoing development.

During the past year, the Division has invested in its staff workforce development by providing ongoing StrengthsFinder workshops which employees can voluntarily attend. The intent behind the workshops is for staff to identify their strengths and focus on them in their job duties to be more effective and satisfied with their contributions. Additionally, the classes allow employees to get to know each other, understand each other's strengths and integrate collaborations.

While there are seasoned MCH staff in Utah, there is much work to be done to raise self-reported skill proficiency levels. In 2018, a survey of state and local health department MCH staff was conducted to identify workforce development needs. A total of 63 responses were received with 33 (57%) from UDOH staff. Respondents were asked to identify primary work responsibilities. The top seven identified primary responsibilities reported by over 40% of respondents include data collection and analysis (52%), program management (50%), program evaluation (48%), assessment, planning, and policy (45%), link clients with health care (43%), surveillance (43%), and public education about MCH (41%). Only 21% report workforce development as a primary responsibility. Seventy percent of supervisors report that they use one or more workforce development assessment tools, with 61% reporting that they assess training needs every year.

Supervisory respondents ranked the MCH Leadership Competencies according their perception of greatest training need (1) and lowest training need (12). The table below shows average and ranking broken out by LHD and UDOH staff.

MCH Competency	LHD		UDOH	
	Avg	Rank	Avg	Rank
Public Health/ Title V Knowledge Base	6.42	9	6.50	4
Self-reflection	8.17	12	9.50	12
Ethics and Professionalism	6.08	8	7.13	8
Critical Thinking	4.82	4	5.63	3
Communication	4.36	1	5.00	2
Negotiation and Conflict Resolution	4.42	2	8.25	9
Cultural Competency	6.00	7	6.50	4
Family-Centered Care	6.42	9	9.00	11
Developing Others through Teaching and Mentoring	4.58	3	6.88	7
Interdisciplinary Team Building	4.92	5	8.50	10
Working with Communities and Systems	5.58	6	6.50	4
Policy and Advocacy	7.08	11	4.38	1

Top 3 greatest training needs identified for LHDs

1. Communication
2. Negotiation and Conflict Resolution
3. Developing Others through Teaching and Mentoring

Top 3 greatest training needs identified for UDOH

1. Policy and Advocacy
2. Communication
3. Critical Thinking

The majority (68%) of survey respondents agree or strongly agree they have the organizational capacity to provide

staff training that is accessible, topically applicable, and/or otherwise appropriate to their training needs.

Organizations use numerous methods to provide or facilitate staff development and training opportunities. Survey respondents indicated the top three preferred methods for providing trainings include: 1) National conferences/meetings, skills building sessions (CityMatCH, APHA, etc.), 2) One to three-day intensive training sessions with 25-50 trainees, and (tied) 3) Webcasts AND Blended learning (in person and distance methods). The top three barriers in accessing training were: 1) Cost of continuing education programs, 2) Difficult to take time away from work, and (tied) 3) Difficult to take time away from home/family/community AND Lack of adequate staffing to cover while training.

Respondents were also asked about plans to retire or leave the organization. Retirement: 90% of respondents are planning to retire in 2021 or later. Leaving organization in next year: 84% are not planning to leave their organization.

A very strong majority of respondents feel that they have leadership development opportunities, that they can grow professionally, that their organization supports leadership opportunities, they are prepared to take on current and future leadership challenges, they feel they are leaders, and they actively pursue learning and professional growth opportunities. The weakest areas identified in the leadership questions are that they have no professional development plan that supports their growth and they do not seek out leadership opportunities.

Responses from the survey will guide strategy development for strengthening the infrastructure of the state and local MCH/CSHCN. An MCH workforce development plan for Utah has been drafted with goals to increase communication, create a supportive work environment, identify and provide training opportunities, and track and evaluate provision of workforce development opportunities.

III.E.2.b.ii. Family Partnership

The CSHCN Bureau values family partnerships and the relationships are woven within the structure of the Bureau functions. The CSHCN Bureau partners with Utah Family Voices (UFV) and has both parents of CSHCN and individuals with special health care needs employed. The CSHCN Advisory Committee which is comprised of family members and individuals with special health care needs. This committee advises the Bureau on the family/parent perspective regarding issues, needs, and services, influences the direction of policies, contributes to program improvement, and ensures a voice for families and individuals with special health care needs to improve the system of care.

CSHCN Mission
To improve the health and quality of life for children with special health care needs, and their families, through early screening and detection, data integration, care coordination, education, intervention, and life transitions.

CSHCN has built capacity in family partnerships by including families and stakeholders in the CSHCN Mission and Strategic Plan. CSHCN conducts surveys with parents and engages in community discussions to identify needs within the community. CSHCN incorporates its family partners in providing support within clinic services and participating in advisory committees. The UFV Director participates in the Block Grant writing, review, and improvement processes. CSHCN collaborates with family partners on development of materials and resources provided to the public.

The CSHCN Bureau, in collaboration with Utah's Family to Family Health Information Center (F2F HIC) and Parent Training and Information Center, provides individual consultations, workshops, publications and web-based educational materials. The program partners with various disability, advocacy, and family organizations in the state in organizing events in various formats. Parent participation and perspective are considered and added into all the programs and services delivered to children and their families.

The Utah Birth Defect Network (UBDN) has established multiple community partnerships to support health promotion and education to communities and families in Utah. One example is the Utah Down Syndrome Foundation which brings families together to build a community and help individuals with Down syndrome reach their highest potential. UBDN regularly helps connect this parent group with the Integrated Services Program (ISP) to improve service access to those with Down syndrome and their families.

Strategic Goal	Goal Detail	How It Will Be Accomplished
Family, Professional and Stakeholder Partnerships	Families, professionals and stakeholders will partner in decision making at all levels	To accomplish this, CSHCN staff work to ensure family and customer satisfaction, collaborate with families, professionals and stakeholders to strengthen relationships and receive input on services and increase partnerships with families and key stakeholders
Access to Services	Provide Services and Supports.	Services will be accessible and organized in a manner which supports family-centered care. Staff work in this area to increase public awareness of CSHCN Bureau Programs, improve the CSHCN Bureau website to effectively guide and assist the public, inform the public on key CSHCN health issues, efforts and successes, screen children appropriately and follow up in a timely manner, educate and support CSHCN families on private and public insurance options, educate families and partners on systems of care for children to receive services in a well-functioning, timely and organized manner and utilize and link health data to improve health outcomes
Medical Home, Care Coordination and Life Transition	Align families with a medical home, coordination of care, and transition education	The CSHCN Bureau will promote family-centered, coordinated, ongoing comprehensive care within a medical home. Staff work on this area to increase communication, resources and awareness of service options within a medical home, coordinate care to assist families in navigating the healthcare system, focus on high risk populations, provide children and youth with special health care needs the opportunity to receive the services necessary to make transition to all aspects of life, and encourage awareness and education for health care, education, leisure, work, housing and independence
Cultural and Program Competence	Promote Environments of Cultural and Program Competence	Children with Special Health Care Needs and their families will receive culturally and linguistically appropriate services (CLAS). Work in this area includes providing CLAS services which consider race, ethnicity, religion, and language, developing and utilizing performance measures and objectives specific to each program mission, and ensuring programs align with the UDOH Strategic Plan and budget guidelines
Staff Development and Quality Assurance	Promote a positive working environment that supports individual and team development	Each employee will be valued and have the opportunity to develop and contribute to quality outcomes by providing CSHCN Bureau employee orientation with clear expectations, job description, and performance evaluations, offering frequent praise and feedback to employees, providing annual Bureau trainings, and monthly program improvement discussions, implementing quality control measures and training to increase accuracy and timeliness in data input into CSHCN Bureau databases and cultivating an environment of Continuous Quality Improvement (CQI)

The Early Hearing and Detection Intervention (EHDI) Program enhances family support and engagement by partnering with the Utah Parent Center/UFV to provide parent-to-parent support and leadership opportunities within the EHDI system. Parent consultants work to support the needs of families with infants/children who are deaf or hard-of-hearing (D/HH). They are integral members of the Utah EHDI team, providing insight on all aspects of Utah EHDI projects. Loss to follow-up is reduced when parent consultants call families to determine barriers of completing the screening/diagnostic process and facilitate its completion. Parent consultants can guide families through this potentially traumatic, painful process in a way professionals cannot. CSHCN programs are fortunate to have excellent family advocates who are known nationally as well as in the state for promoting the needs of children and families.

The Autism Systems Development Program has a long-standing collaborative committee, the Utah Autism Initiative,

which meets quarterly and is composed of 25 stakeholders, including families. The committee works to review and improve the system of care, integrate systems and participate and influence the direction of policies and legislation affecting individuals with autism.

The remaining CSHCN Bureau Programs are not funded by MCH although the philosophy, structure, and integration to include the family and individual with special health care needs voice is present.

The University of Utah's Department of Pediatrics hosts a website, the Medical Home Portal at www.medicalhomeportal.org, which was developed and funded through collaboration with the CSHCN Bureau and multiple partners. The Portal contains information on diagnosis, special education, transition, family issues, and coding, as well as a live chat capability with the ISP and resources for providers and families. The Medical Home Portal has expanded in capacity and content over the past year and allows for an interactive and personalized experience between the Portal and families of CSHCN. MCH funds continue to support the Medical Home Portal which assists and supports professionals and families in working together to care and advocate for CSHCN.

The MCH/CSHCN Bureaus are ensuring that systems integration dialogue and action continue with our community partners within existing funding streams.

The MCH Bureau has continued to financially support the Utah Children's Care Coordination Network (UCCCN). UCCCN is a source of information, resources, tools, expert advice, and peer learning and support for pediatric and family practice staff members who help coordinate the care of patients. UCCCN meetings are held monthly. Meetings engage Network members in:

- Education on coordinating care for children, with an emphasis on those with chronic conditions and special health care needs and the family- and patient-centered medical home approach
- Learning about local specialty and other service providers and other health-related resources for children and their families
- Sharing challenging cases, great ideas, unique resources, and lessons learned
- Using tools and techniques that will help the practices care for patients with special needs more efficiently and effectively, including new features that will soon be available on the Medical Home Portal

The UCCCN also offers its members an email listserv to seek answers to questions, share ideas, and find support between meetings. For practices, the UCCCN can assist with job descriptions, guidelines related to care coordination, and finding tools and other resources. There are no charges for participation.

The MCH Bureau gathers input from newly delivered mothers through the Pregnancy Risk Assessment Monitoring System surveys. Women often write free text at the end of their surveys, which provides valuable information on their experiences and needs. The Utah Women and Newborns Quality Collaborative is comprised of health professionals from Utah's hospitals and professional organizations and activities are accomplished through multiple workgroups.

Staff from MCH and CSHCN maintain working relationships with non-Title V programs in the Department to create a statewide system of collaboration.

A strong relationship exists with the MCH/CSHCN Bureaus and UFV. The UFV Director participates, guides and provides consultation for improvements in ISP and CSHCN programs.

The Integrated Services Program (ISP) partners with UFV staff to problem solve and work jointly with families who may be struggling to find and connect with supports and services in the community. ISP care coordination staff has made home visits to struggling families in concert with UFV staff to empower parents, caregivers, and patients to make informed decisions about the care and development of children and youth with special health care needs. Working in tandem, IPS and UFV staff have coordinated efforts with Juvenile Justice; Workforce Services (TANF, Supplemental Food, Medicaid, childcare eligibility determination); the foster care system; medical specialty and primary care; early and elementary education; local housing authorities; and US Citizenship and Immigration Services to ensure families apply for, comply with documentation requirements, and maintain services for which they may be eligible or receive services for which they may qualify.

ISP and four of the local health departments provide clinical services and care coordination in rural Utah, and, on a limited basis, along the Wasatch Front, working directly with families to assess and triage needs. Families referred into the system by providers or self-referral, undergo a rigorous intake process to determine family needs and priorities including education, self-sufficiency, transportation, housing, Medicaid/insurance coverage, and direct

medical services and are then referred to and scheduled with these services. Care Coordinators provide follow-up and encouragement and help families navigate personal and system barriers impeding them from obtaining support from within the community organizations and services around the state. A care plan is developed with the families taking into consideration their capacity for compliance, follow-through, organizational skills, and intellectual ability.

The MCH Bureau Director is co-chair of PSI Ut (formerly the Utah Maternal Mental Health Collaborative. The mission of PSI Ut is to increase and improve awareness, prevention, detection, and treatment of maternal mental health conditions in Utah. The goal is to ensure every woman in Utah receives information on risk, prevention, and treatment of pregnancy and postpartum mood and anxiety disorders.

The CSHCN Bureau Director is an active member of the state-mandated Coordinating Council for People with Disabilities. In collaboration with the Division of Child and Family Services, the Fostering Healthy Children Program has an APRN and three contracted psychiatrists to evaluate appropriate prescribing of psychotropic medications for children in the foster care system and recommend adjustments if needed. This program is receiving positive feedback for its services and continues to evaluate itself to be more effective.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The State Systems Development Initiative (SSDI) Grant is managed by the Data Resources Program (DRP). The mission of the DRP is to provide analytic resources and statistical expertise to MCH and CSHCN programs for assessing the health status of the MCH population, and for planning and evaluating services. SSDI funding allowed the DRP to hire a full time SSDI Grant Coordinator to manage project activities related to data collection and analysis, and provide additional analytic support to the MCH Bureau. Funding has also allowed the DRP to assist with the Five Year MCH Needs Assessment, the submission of Annual Block Grant (BG) Report and Application, and application of data analysis to program planning for Title V related projects. See the table below titled SSDI Goals, Objectives, and Activities (completed and planned), for a more complete description of SSDI activities.

Each year during the BG application process, the DRP conducts a mini needs assessment where the SSDI team reviews federally-available data to identify disparities in health outcomes within the MCH health domains, and provides these results to BG contributors to inform Title V program planning and emerging and unmet MCH population needs.

DRP SSDI Team has been assisting in the 2020 BG Needs Assessment by creating an extensive indicator report using data from the Minimum and Core Data Set (M/CDS), National Outcome and Performance Measures (NOM/NPM), vital records, hospital discharge data, and various publicly available datasets.

In additional, DRP has assisted both MCH Bureau and CSHCN Bureau to develop and implement two major surveys, the 2019 General Stakeholder Survey and the 2019 CSHCN Parent Survey. The SSDI team will continue to support the 2020 MCH Needs Assessment and assist in the identification of MCH priorities, and setting appropriate performance measures.

In order to help streamline the collection and submission of the yearly requirements of the BG Application and Annual Report, the DRP developed and implemented the Web-Enabled Systemic Tracking Tool, or WESTT. This system was developed to make the coordination and collection of required information from various public health programs more efficient. Trainings for contributors were held annually to ensure user learnability and familiarity with the system. The 2019 user manual with step-by step instructions was also developed to assist contributors at a more detailed level. DRP continues to implement new updates and improvements annually to WESTT and trains staff on use of these improvements. Improvements during FY18-19 included adding fields for BG Contributors to include information on challenges and emerging issues faced related to their National Performance Measures (NPM), and allowing the ability to transfer and change editing privileges for the Annual Reports and Plans for multiple users.

Throughout FY18, DRP provided analytic support to Utah Women and Newborn Quality Collaborative (UWNQC) subcommittees including assisting in analysis and manuscript preparation for a study on return on investment for Medicaid and use of progesterone to help prevent preterm births, and by creating letters for individual hospitals to inform them of the number of transfers they received from intended out of hospital births and feedback about these transfers from providers. In FY19, DRP will continue collaboration with UWNQC by performing analysis to assess neonatal and maternal outcomes related to hospitals' level of intensive care units for infants born with very low birth weight (VLBW) (NPM-03). This analysis will be performed using hospital discharge, birth, and death data, as well as data from a REDCap database of VLBW infants. This data will also be shared with the Centers for Disease Control and Prevention to perform a national study of outcomes for these VLBW infants and their mothers.

Additionally, a DRP epidemiologist also serves as the Alliance for Innovation on Maternal Health (AIM) Data Lead by collecting and managing data from participating hospitals, analyzing discharge data to identify aggregate cases of severe maternal morbidities, and providing outreach and technical assistance to participating hospitals. During FY18, Utah began working on implementation of a new safety bundle focused on maternal opioid use disorder. This safety bundle will not only focus on improving outcomes for mothers, but also their babies both long and short-term.

The DRP continues to build and enhance data linkage capacity and infrastructure for the MCH Bureau. During FY19, an overarching data sharing agreements was established with the Office of Vital Records (OVRS). This data sharing agreement allows for multiple programs within the MCH Bureau to access birth and death files without creating a new agreement for each new project. This will streamline many processes, allow for collaboration within the MCH Bureau, and support data quality improvement for various projects related to understanding and improving outcomes for MCH populations.

SSDI Goals, Objectives, and Activities (Completed and Planned)

Goal 1: Build and expand state MCH data capacity to support Title V program efforts and contribute to data-driven decisions

Objective 1.1: Convene Needs Assessment Leadership Team to review relevant data and develop a plan of action to guide the 2020 Needs Assessment

2018	2019
• Established 2020 MCH Needs Assessment Leadership Team • Reviewed Needs Assessment methodologies and methods used by others states • Trained staff on Needs Assessment methodologies	• Trained staff on Needs Assessment 9-Step model • Performed an assessment of secondary data and created an indicator report to share with domain leaders and stakeholders • Developed a timeline and assisted in writing a contract to work with the University of Utah to conduct key informant interviews, focus groups, and stakeholder meetings.

Objective 1.2: Assess health needs of MCH/Children with Special Health Care Needs (CSHCN) populations by collecting and analyzing data for the 2020 MCH Needs Assessment including a stakeholder survey, Local Health Departments (LHD) key informant interviews, CSHCN Parent survey, and focus groups

2019	2020
• Contracted with the University of Utah to conduct key informant interviews, focus groups, and stakeholder meetings • Developed 2019 Stakeholder Survey instrument • Built and implemented Stakeholder Survey (English and Spanish versions) • Analyzed data from survey and provided rankings of issues by domain to domain leaders • Assisted in development and implementation of online 2019 CSHCN Parent Survey • Analyzed CSHCN Parent survey data and provided results to domain leaders	• Provide assistance to University of Utah in analyzing qualitative data from the General Stakeholder and CSHCN Survey • Work with the University of Utah through their conducting of focus groups and key informant interviews

Objective 1.3: Identify state priorities for Utah MCH/CSHCN populations and develop associated National Performance Measures (NPMs) and State Performance Measures (SPMs) following the analysis of data related to the Title V 2020 MCH Needs Assessment process

2020
• Develop and share MCH Needs Assessment data fact sheets and reports with stakeholders • Invite critical partners among state, local, and community agencies to MCH Stakeholder meetings to rank state's prioritized needs • Select appropriate NPMs and SPMs for FY21-FY26 to be reported on the annual Block Grant • Select and develop appropriate Evidence-based Strategy Measures (ESMs) for the selected NPMs

Objective 1.4: Enhance the web-based application (WESTT) to better align with the updated MCH Block Grant guidance (FY19 - FY21) in order to coordinate the yearly submission of the Title V MCH Block Grant Application and Annual Report

2018 - 2019	2020 - 2022
• Annual User Feedback Survey was developed and analyzed • On-going enhancements were added to the system to increase user satisfaction and improve alignment to updated MCH Block Grant guidance • Offered assistance to Block Grant Contributors on use of the WESTT system • Completed yearly training and offered assistance to all Block Grant Contributors on use of the WESTT system	• Create and analyze Annual User Feedback Survey • Add on-going enhancements to the system to increase user satisfaction and improve alignment to updated MCH Block Grant guidance • Update the technical documentation and manual on the use of the WESTT system

Objective 1.5: Improve the current infrastructure in place for continuous health assessment of the MCH population needs

2018 - 2019	2020 - 2020
• Represented MCH/CSHCN Bureaus in the Department meeting for potential topics of Utah Health Status Update • Published twelve articles in Utah Health Status Update Publication	• Conduct an annual review of Federally Available Data • Publish article(s) in Utah Health Status Update Publication • Add BG NPMs and NOMs to IBIS-PH following Needs Assessment

Goal 2: Enhance and advance the utilization of linked MCH data information systems to support assessment of long-term health outcomes by conducting longitudinal research studies

Objective 2.2: Conduct a data validation study to assess the quality of the new synthetic progesterone variable in the birth certificate by linking Vital Records data and comparing to the Utah All-Payer Claims Database (APCD)

2018 – 2019*

- Created data sharing agreements with Intermountain hospitals to collect facility data on synthetic progesterone prescribing and treatment
- Created a database in REDCap for data collection to share data on a quarterly basis
- Trained hospital staff on using this REDCap database and provided ongoing technical assistance as necessary
- Assessed the quality of the synthetic progesterone treatment reporting variable
- Report on 17P use published in Utah Health Status Update
- Began also receiving data of 17P use from the University of Utah in addition to Intermountain facilities
- Began collaborating on return on investment publication for 17P use in Utah Medicaid births

*All activities related to this objective will be completed by 2020

Objective 2.3: Continue partnering with Medicaid to link Medicaid eligibility files with Birth Certificate Data and conduct a comprehensive assessment of health outcomes of women enrolled in Medicaid

2018	2019	2020
• Completed analyses to assess birth outcomes among women enrolled in Medicaid using Medicaid status from birth certificate data instead of Medicaid eligibility data	• Completed analysis and drafting of a manuscript concerning progesterone use and the potential return on investment in Medicaid enrolled women who reported having a previous preterm birth	• Submit and publish return on investment paper concerning Medicaid enrolled women with a history of previous preterm birth

Goal 3: Conduct and support program evaluative and quality improvement studies to assist Title V programs (Oral Health Program; Maternal and Infant Health Program; Women, Infants, and Children; and MotherToBaby Utah) in assessing their program interventions

Objective 3.1: Improve the data quality for National Performance Measure 13 by conducting pilot projects in assessing oral health knowledge as well as prevalence of dental visits amount Utah pregnant women and children

2018-2019

- Met with WIC Director and staff to assess the feasibility of expanding and implementing WIC Pilot Project in two clinic locations (Utah County and Weber County) to explore data collection on dental visits among WIC population (NPM-13A: *Percent of women who had a preventive dental visit during pregnancy*)
- Assisted OHP with 2017-2018 Adolescent Oral Health Campaign (NPM-13B: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)
- Published adolescent study findings in Utah Health Status Update publication
- Assist OHP in analyzing 2019 Adolescent Oral Health Pre/Post survey

Objective 3.3: Assist the Maternal and Infant Health Program by furthering analytic capacity within in Utah Women and Newborn Quality Collaborative (UWNQC) and Utah's Alliance for Innovation on Maternal Health (AIM)

2018	2019	2020 - 2022
• Provided analytic support to the UWNQC maternal subcommittee • Provided analytic support to the UWNQC out-of-hospital (OOH) birth subcommittee • Provided analytic support to the UWNQC board/steering committee • Supported Utah's Alliance for Innovation on Maternal Health (AIM) by providing data collection and analytical support	• Attended planning meetings for implementation of the new AIM opioid use disorder safety bundle • Developed letter for reporting to individual hospitals on their OOH transfers and related feedback from providers • Created pilot survey for the new maternal mental health UWNQC subcommittee	• Continue to provide analytic support • Assist with determination of data to be collected by hospitals with implementation of new safety bundle • Determine possibility of data quality improvement by using retrospective birth certificate records of documented preterm birth to supplement and determine accuracy of the self-report variable of having a previous preterm birth

Objective 3.4: *Improve the data quality and program evaluation for National Performance Measure (NPM)-03 by validating hospital reports of Very Low Birth Weight (VLBW) infants compared to state birth records*

2018	2019	2020
• Linked provisional birth data obtained from Office of Vital Records and Statistics (OVRS) and data entered directly to REDCap database by participating hospitals	• Met with and began collaboration with the CDC on the LOCATe analysis project • Wrote data sharing agreements to obtain hospital discharge data to provide to the CDC	• Compare data from hospital discharge to REDCap VLBW database to assess for data quality and determine a gold standard for future use • Provide CDC with data for their LOCATe analysis on maternal and neonatal outcomes in this VLBW population • Conduct analysis on outcomes of VLBW transfers in Utah hospitals

III.E.2.b.iv. Health Care Delivery System

The Bureaus of MCH/CSHCN (Title V) have a long-standing relationship with Medicaid (Title XIX) for the purpose of improving the health of women, infants and children and especially for CSHCN to ensure these vulnerable populations receive needed services and supports. Last year the two Divisions revised and updated the Interagency Agreement (IAA) to more adequately reflect the partnership and working relationship.

The IAA represents the overarching agreement between the two Divisions. Other specific program agreements are in place to ensure the MCH/CSHCN populations are receiving coordinated Title XIX and Title V care.

Program Outreach and Enrollment
CSHCN programs offer activities which include informing eligible/potentially eligible individuals about Medicaid, rural travel in support of Medicaid activities, referring, coordinating and monitoring the delivery of Medicaid services, and activities which improve coordination of care and delivery of services.

The list below provides some of the specific activities CSHCN performs for Medicaid enrollees.

Gathering and sending medical records	Scheduling medical appointments
Monitoring continued need for service	Following-up on referred medical services
Providing translation services	Coordinating or referring to waiver or Early Intervention programs
Evaluating the need for Medicaid	Identifying gaps or duplications in services
Collaborating with Medicaid, other agencies, and advisory groups	Participating in training on administrative requirements
Participating in or coordinating training which enhances identification, intervention, screening and referral	Educating the community
Establishing goals and objectives for health-related programs	Reviewing technical literature and research articles

The CSHCN Bureau collaboration includes regular meetings with Medicaid to discuss the variety of CSHCN issues, coverage, needs, and improvements to service and care.

Historically, CSHCN has primarily coordinated and collaborated with Medicaid to ensure services and funding for Title V populations. Medicaid and MCH/CSHCN have opened communications to improve collaboration among all Title V programs for their relative populations.

The Medicaid program provides matching funding to State dollars for several projects in the MCH/CSHCN Bureaus; the Pregnancy Risk Assessment Monitoring System (PRAMS), MotherToBaby, Fostering Healthy Children, Technology Dependent Waiver, Baby Watch Early Intervention, and WIC.

The MCH Integrated Services Program, Utah Birth Defect Network, Autism Systems, Hearing and Speech Programs, Baby Watch Early Intervention, Tech Dependent Waiver, and Fostering Healthy Children all provide administrative case management services, assistance, monitoring, coordination, referrals, and community education for Medicaid enrollees.

The programs provide extensive outreach throughout the state through many health fairs, agency and transition fairs, educational trainings, and one-on-one counseling sessions on obtaining services and how to be an advocate for your child.

The MCH/CSHCN Bureaus and Medicaid coordinate many committees that include stakeholders with diverse expertise who provide feedback and action to improve Utah's health outcomes.

The MCH/CSHCN database systems do not have the capacity to collect and report on the percent of services delivered by MCOs and PCCMs. MCH/CSHCN are providing Medicaid reported numbers in the following areas: pregnant women, infants < 1 year of age, children 1-22 and CSHCN.

The Medically Complex Children's Waiver (MCCW) serves children with medical complexities and complex medical conditions. The program is funded to serve approximately 530 children. Children enrolled in this program have access to unskilled routine and skilled nursing respite services, financial management services (to assist families self-directing respite care), as well as traditional Medicaid services.

The Technology Dependent Waiver, which was moved in early 2019 from DFHP to Medicaid for program administration, targets children who are dependent on certain types of technology and require skilled nursing or rehabilitation services. Individuals enrolled in the program have access to respite, family support, home health CNA, extended private duty nursing, in-home feeding therapy, and financial management services (to assist families self-directing respite care), as well as traditional Medicaid services.

Eligibility criteria for both programs:

Medically Complex Children's Waiver	Technology Dependent Waiver
0 through 18 years of age	Under 21 years of age at the time of admission
Have 3 or more specialty physicians, in addition to their primary care physician	Meet admission criteria for nursing facility care
Have involvement of 3 or more organ systems	Have at least one caregiver trained and available to provide care
Demonstrate a level of medical complexity based on a combination of need for device-based supports, high utilization of medical therapies, and treatments and frequent need for medical intervention	Require skilled nursing and/or skilled rehabilitation services at least 5 days per week and be dependent on one or more of the following: • Mechanical ventilator; • Tracheostomy based respiratory support; • Continuous or bi-level positive airway pressure (C-PAP or Bi-PAP); • Intravenous administrations of nutritional substances or medications through a central line
Have a level of disability determined by the State Medical Review Board	
Qualify for Medicaid based on his/her income and assets (parent's income and assets are not counted in determining the applicant's eligibility)	Qualify for Medicaid based on his/her income and assets (parent's income and assets are not counted in determining the applicant's eligibility)

Changes to the Utah Medicaid Program

Over the past several years, Utah has expanded Medicaid coverage to include more parents and childless adults. In recent years, Utah has increased Medicaid eligibility and benefits through state legislation, as well as a statewide ballot initiative.

Increased Coverage for Parents and "Targeted Adult Medicaid" (TAM)
At the direction of Governor Herbert and the legislature, Utah Medicaid expanded coverage in July 2017 to parents from 45% FPL to 60% FPL. Approximately 4,000 parents became eligible for coverage. In November 2017, CMS gave approval to expand coverage to adults without dependents living up to 5% FPL who are homeless, justice-involved, or have a substance use disorder and are receiving general assistance from the Department of Workforce Services. TAM enabled approximately 5,000 high-needs individuals to receive health care, including substance abuse and mental health treatment.

Medicaid and Family Planning Services
In 2018, the Legislature passed house bill 12 which directed Medicaid to unbundle immediate postpartum LARC insertion and pay for the devices separately from the inpatient hospital stay. The legislation also requires Medicaid to submit a waiver to CMS to expand family planning coverage to all women at or below 95% FPL.

Medicaid and Dental Coverage
Utah has also recently expanded dental coverage to more adults. Over the course of the 2018 and 2019 Legislative Sessions, the Governor and Legislature instituted Medicaid dental coverage for the TAM populations, older adults and disabled individuals. Medicaid does not provide dental benefits to parent/ caretakers or the majority of individuals without children. Children and pregnant women enrolled in Medicaid have dental benefits.

Medicaid Expansion
In November 2018, Proposition 3 passed in Utah. The ballot initiative directed the UDOH to expand Medicaid up to 138% FPL and receive the ACA federal enhanced matching rate. An estimated 150,000 individuals would become eligible for Medicaid coverage. Proposition 3 was slated to go into effect on 4/1/19.

On 2/11/19, Governor Herbert signed Senate Bill (S.B.) 96 (2019 Legislative Session) into law. This bill replaced Proposition 3 (2018 General Election). It anticipated 70- 90,000 individuals would become eligible for Medicaid by directing the UDOH to do the following:

1. Expand Medicaid up to 100% FPL on April 1st. Through this initial 'partial expansion', Utah would not receive the federal enhanced match rate, but more individuals would immediately be eligible for Medicaid coverage.
2. Apply for a waiver from CMS to receive the enhanced federal match to partially expand Medicaid up to 100% FPL. Utah would propose to finance its partial Medicaid expansion through a per capita cap financing mechanism, which would allow CMS to cap its federal contribution to Utah. This waiver is known as the "Per Capita Cap" waiver proposal.
3. Have a "fallback" waiver in place if Utah's partial expansion "Per Capita Cap" proposal is rejected. The "fallback" plan would allow Utah to expand Medicaid fully, up to 138% FPL, while also requesting additional provisions for the newly-eligible expansion population: a self-sufficiency or work requirement, the ability to cap or limit Medicaid enrollment, the ability to provide housing supports, an option to lockout individuals who deliberately violate program requirements, and allowing up to 12 months of continuous eligibility.

Under S.B. 96, adults with incomes between 101- 138% FPL would be eligible for the ACA health care exchange, when the 2019 Open Enrollment period begins. Utah requested a special enrollment period for individuals who missed the 2018 Open Enrollment because they anticipated full Medicaid expansion up to 138%. However, Utah's request was denied by CMS. In addition, S.B. 96 also superseded House Bill 12 from the 2018 Legislative Session, as enhanced family planning services are covered under the partial expansion.

In accordance with S.B. 96, on 4/1/19, Utah expanded Medicaid coverage to adults who earn up to 100% FPL. The expansion covered parents/caretakers and adults without children. Utah receives its regular federal match rate to pay for the expansion. The federal government covers approximately 70% of the costs associated with caring for these newly eligible adults, with the state covering the remaining 30%. To date, more than 33,000 Utah adults have been enrolled in the expanded Medicaid program.

In July of 2019, CMS gave notice to Utah that it would reject the request for a partial expansion with the enhanced federal matching rate, or the "Per Capita Cap" waiver proposal. Utah is now preparing the "fallback" waiver plan, which will expand Medicaid up to 138% FPL, and will request that CMS approve additional provisions for the expansion population including a work requirement and ability to limit enrollment. The "fallback" waiver is expected to be released in mid-October and earliest implementation date would be January 2020.

As Utah prepares the "fallback" waiver, Medicaid coverage for adults and parents up to 100% FPL remains open for enrollment. Fewer individuals have enrolled than projected. The UDOH is planning to invest in an outreach program

to help people learn about expansion.

III.E.2.c State Action Plan Narrative by Domain

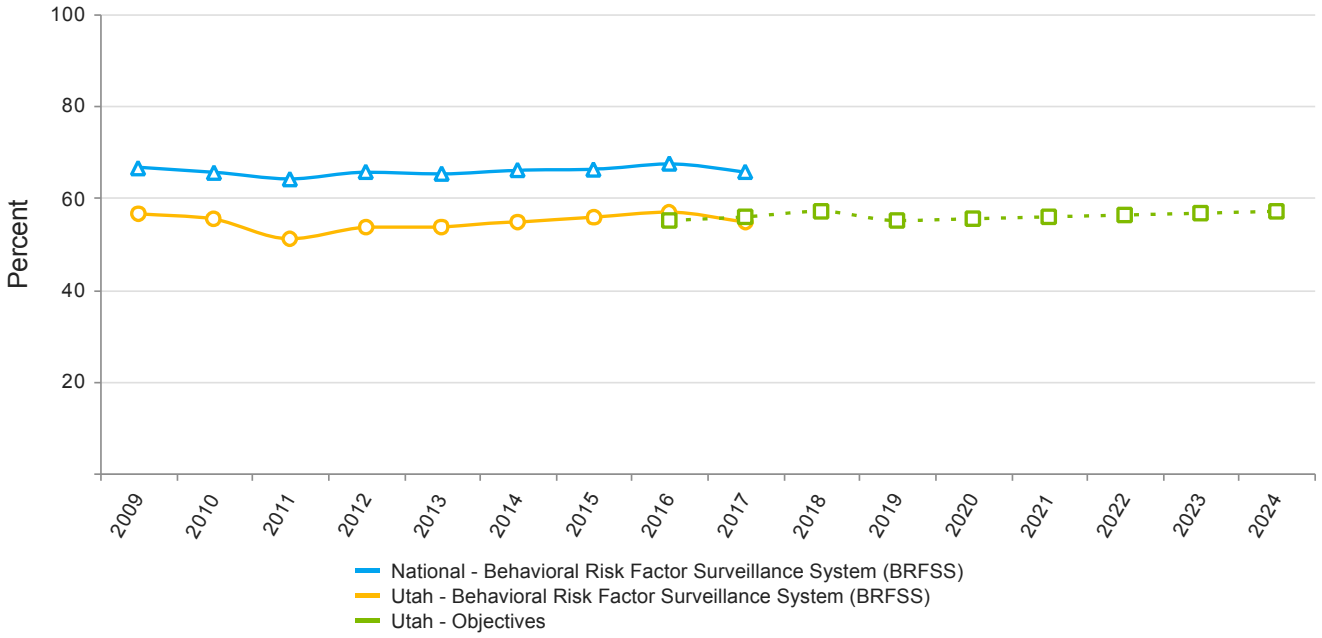
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	48.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	7.2 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	9.4 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	27.8 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	6.3	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.4	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	4.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.3	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	182.3	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	2.6 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	5.4	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	12.2 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.3 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	15.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	15.3 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	55	55.8	57
Annual Indicator	55.6	56.9	54.7
Numerator	313,251	328,066	321,738
Denominator	563,258	576,406	588,467
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	55.0	55.4	55.8	56.2	56.6	57.0

Evidence-Based or –Informed Strategy Measures

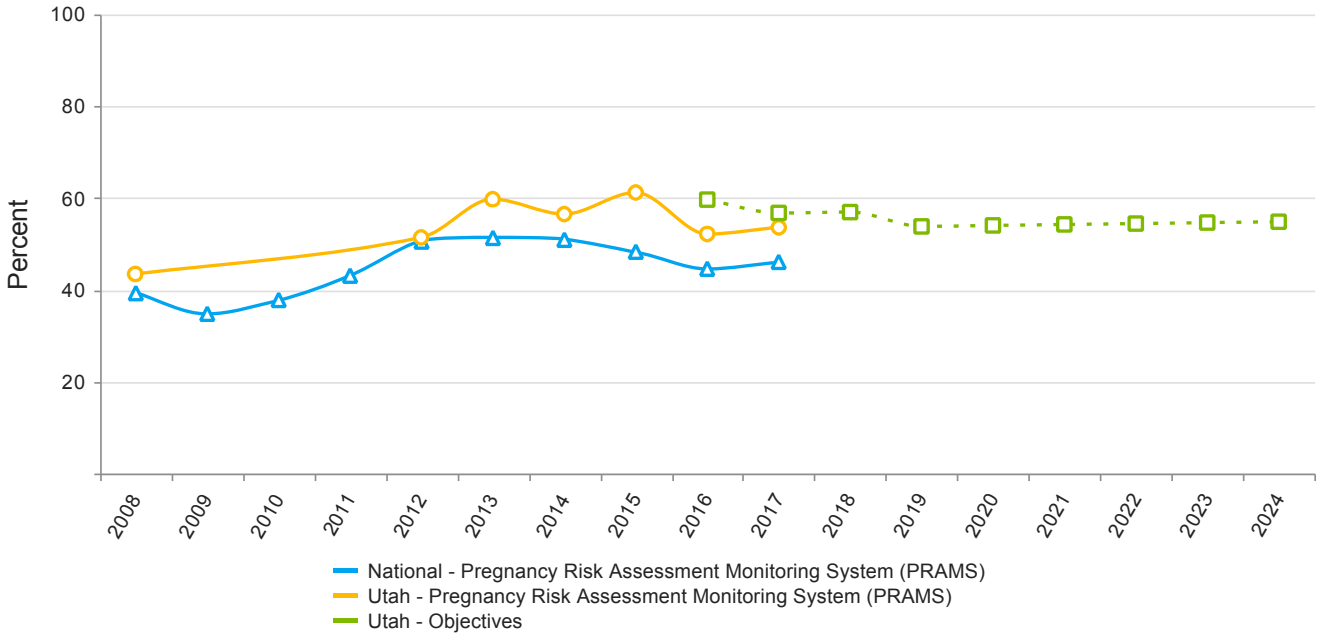
ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		1	1
Annual Indicator	1	1	1
Numerator			
Denominator			
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2015	2017	2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	59.6	56.7	56.9
Annual Indicator	56.5	61.2	53.6
Numerator	27,701	29,790	25,341
Denominator	49,001	48,710	47,301
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	53.8	54.0	54.2	54.4	54.6	54.8

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		45.3	37.1
Annual Indicator	45.1	36.9	25
Numerator	69	58	38
Denominator	153	157	152
Data Source	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report
Data Source Year	2015	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.2	25.4	25.6	25.8	26.0	26.2

State Action Plan Table

State Action Plan Table (Utah) - Women/Maternal Health - Entry 1

Priority Need

Inadequate health insurance coverage (NPM not reflective of this priority as State capacity and resources do not allow for impact on this priority).

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

a. By 2020, increase the percent of women who had a preventive dental visit during pregnancy from 56.5% (PRAMS, 2014) to 57.3%.

Strategies

1. Collaborate & target high risk populations with Head Start, Early Intervention, WIC, the Utah Office of Home Visiting and the Office of Health Disparities to share resources and provide education and training to agency staff on the importance of dental care during pregnancy with the goal to increase the percent of pregnant women who have a preventive dental visit during pregnancy.

2. The Oral Health Program Specialist and Oral Health Educator work closely with the professional advisory councils at many of the dental hygiene programs to encourage the professional development of dental hygiene students to create a public health minded workforce, including topics of social justice, health equity and cultural competence.

ESMs	Status
ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Utah) - Women/Maternal Health - Entry 2

Priority Need

Preconception and Interconception care

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By 2020, increase the percent of Utah women, ages 18-44, who had a preventive medical visit within the past 12 months from 54.8% (BRFSS, 2014) to 57.4%.

Strategies

1. Collaborate with institutions of higher learning to implement a peer preconception health program.

2. Partner with SUMA Social Marketing, a marketing firm based in Austin, TX, to create a knowledge survey on routine preventive care and distribute, through social media, to women of reproductive age.

ESMs	Status
ESM 1.1 - Formative Research: Number of focus groups conducted to understand why women are or are not receiving a yearly well-woman visit.	Inactive
ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

MCH Block Grant FY20 Application & FY18 Report

Women/Maternal Health

NPM-01: Well-Woman Visit: *Percent of women with a past-year preventive medical visit*

FY18 Annual Report

Program Activities:

This Performance Measure was not achieved. The Performance Objective was 57.0% and the Annual Indicator was 54.7%.

During FY18, the Maternal and Infant Health Program (MIHP) utilized the social media platforms Facebook and Pinterest to share information on preventive health care visits. These messages were shared under the Power Your Life logo and branding.

Educational outreach was done through numerous community events held at the University of Utah, Utah Valley University (UVU), local Bridal Fairs, a “Girls Night Out” health fair at a hospital, and a health fair through Centro Hispano, a community organization that provides health information and services to the Hispanic population in Utah County. At these events, MIHP staff handed out informational pamphlets and brochures about preventive care as well as answering the specific questions of individuals at these events.

MIHP staff partnered with March of Dimes of Utah to meet with and offer resources to community health centers. MIHP staff provided the clinics with copies of the Power Your Life booklet, and the Plan your Next Pregnancy brochure. MIHP staff also worked alongside the University of Utah’s Nursing program and the Utah Veterans Health Administration to see if the One Key Question® would be practical in the community health worker community and in the University Health Clinics and VA Women’s Center. An introduction and training in English and Spanish to One Key Question® was provided to community health workers, midwives, and clinicians. An additional educational opportunity was an STI presentation to a group home for women who were homeless or worked in sex industry. MIHP continued its partnership with Westminster College to implement a Preconception Peer Education program on their campus.

Finally, MIPH staff contracted with SUMA Social Marketing, Inc. to conduct focus groups on knowledge, perceptions, beliefs, and barriers associated with the well-woman exam. Four focus groups were conducted with a diverse group of women across Utah in two urban areas (Salt Lake City and Provo) and two in rural areas (Tooele and Price). Thirty-eight women ranging in ages from 18 to 44 discussed their perceptions of the well-woman visit, barriers/motivators to care, and suggestions about material creation and dissemination. Results of these groups found that women assign different meaning and different function to the terms associated with well-women visits (i.e. “routine check-up”, “well-woman exam”, and “preventive care”). These women also had varying opinions to which type of medical provider a women goes to for each check-up. Some of the women said they received preventive care with a family practitioner, others with primary care providers, and some with OB/GYNs.

SUMA offered recommendations including: determining and using only one term when encouraging and educating women to go to an annual preventive care appointment; to detail what happens at that appointment; create a dedicated website; use social media to promote activities; educate healthcare providers on the findings of the report and encourage them to use postcards or some other method to remind women about scheduling and going to their well-woman exam; and to create separate messages for younger women who most likely have not had children and may not yet be sexually active.

Accomplishments / Successes:

A strong, mutually beneficial partnership between the MIHP and two local universities, UVU and Westminster College, have assisted us reaching young college-aged women in Utah with messages about the importance of yearly preventive care, family planning, mental health awareness, and preconception health. Westminster continues to be willing and excited to create a sustainable preconception peer education program with MIHP. UVU continually invites staff from MIHP to staff a booth at a bi-annual student health fair. At each fair, we estimate that we talk to and give educational materials about preventive health to 150-200 students per visit.

A major success during FY18 was the contract with SUMA Social Marketing, Inc. and the completion of the focus groups. With the information provided by the participants and the recommendations made by SUMA, we will be able to discuss next steps.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-01:

- Ongoing, mutually beneficial relationships with two local universities, Westminster College and UVU, has allowed the MIHP to reach college-aged women with education and information about the importance of routine preventive care.
- Contracted with SUMA Social Marketing, Inc. to hold four focus groups with a diverse group of women to assess their knowledge, perceptions, and beliefs and barriers associated with the well-woman exam. A final report was delivered upon completion of the focus groups with recommendations for future activities.

Challenges / Gaps / Disparities:

The largest challenge faced during FY18 was determining how to use what we learned from the focus groups to create and implement evidence based programming that will result a measurable increase in women who seek out routine preventive care.

Agency Capacity / Collaboration:

Some of this work has been accomplished through the Healthy Utah Babies (HUB) partnership. HUB consists of participants representing the Birth Defects Network, WIC, MotherToBaby Utah (MTB UT), Baby Your Baby, and the Office of Vital Records.

The MTB UT program is one of our partners who has the opportunity to communicate directly with women on matters of preconception health. For example, MTB UT had a woman call their Pregnancy Risk Line concerned that she had to choose between "being sane," and being a mother because she was told that she would have to go off all her prescribed anti-anxiety medications. MTB UT reassured her that she could continue taking those medications during pregnancy and referred her to speak with her OB and psychiatrist to further talk about her concerns continuing her medications during pregnancy.

An ongoing partnership with both Westminster College and UVU will enable the MIHP to reach college-aged students with educational messages regarding routine preventive screenings and visits.

Summary Progress Report (2019) of ESMs related to NPM-01

ESM 1.1 - Formative Research: Number of focus groups conducted to understand why women are or are not receiving a yearly well-woman visit.*

*This ESM is currently inactive as the formative research has been completed during FY18.

ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.

Goal/Objective:

Increase the number of institutions of higher learning partnered with MIHP.

Significance of ESM 1.2:

The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows:

A well-woman or preconception visit provides a critical opportunity to optimize the health of women before, between, and beyond potential pregnancies by receiving recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease. For example, screening and management of chronic conditions such as diabetes and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit

has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost sharing.

ESM 1.2 Progress Report:

During FY18 MIHP staff worked with a Public Health Master's Student at Westminster College to create a preconception peer education training and student manual. This manual was adapted from the Office of Minority Health's, "A Heathy Baby Begins with You" campaign.

After MIHP staff and Westminster faculty approved the content of the training and student manual, a peer education training was held in March 2018. Eleven undergraduates in public health and nursing participated in a four-hour training on what it means to be a peer educator, expectations of being part of the program, preconception health, men's preconception health needs, contraception, and mental health. The trained peer educators were given teaching assignments for the next stage of implementation. Two weeks after the initial training, the peer educators held their first event, a class on preconception health. This class was advertised through posters placed on Westminster's campus as well as a booth that was set up in a central location. Twenty-two students attended the class put on by the peer educators. This surpassed the goal set of fifteen attendees.

MIHP staff continued the work started by the Westminster graduate student by ongoing contact and further training opportunities with the peer educators. MIHP staff has also been working with UVU to establish a peer education program on campus. During FY19/FY20 MIHP staff will have an intern from UVU to begin work on developing a peer education program on campus. This intern will conduct research to discover the needs of the students and recruit students to participate in the program.

A continuing challenge faced by the peer education program is keeping it sustainable. We have held or attempted to hold numerous training with different cohorts of potential peer educators that seemed interested in the training and becoming a peer educator, however competition for their time and energy pulled them away. We are encouraged by the commitment to the program shown by two students at Westminster College who were trained in March 2018. They have agreed to work with MIHP staff to continue working as peer educators, create a preconception peer educator club on campus, recruit new peer educators and hold a training in FY19.

MCH Block Grant FY19 Application & FY17 Report

NPM-13A: ***Percent of women who had a preventive dental visit during pregnancy***

FY18 Annual Report

Program Activities:

The Performance Measure was not achieved. The Performance Objective was 56.9% and the Annual Indicator was 53.6%.

With the continued collaboration of WIC, The Oral Health Program (OHP) worked on a pilot program in the Weber/Ogden area, as well as with Utah County WIC. The purpose of this collaboration was to collect data about whether pregnant moms were going to the dentist during their pregnancy. Two questions were posed in this pilot: 1) During the past 12 months, was there a time you needed dental care but could not get it at the time?; 2) Did you have your teeth cleaned during your most recent pregnancy? In Weber County, out of 568 individuals who participated in the pilot study, 119 respondents 'Yes' to the first question about needing dental care in the last year, but not being able to get it (21%). In Utah County, of the 409 respondents, 80 said that they needed dental care in the last year but were not able to get it (19%). To the second question of having a dental cleaning during their most recent pregnancy, of the 568 respondents in Weber County, 324 said that they did not have one (57%). In Utah County, 217 of the 409 respondents said they did not have a dental cleaning during their most recent pregnancy (53%). An additional activity planned for this project was OHP's Oral Health Specialist (OHS) applied fluoride varnish during an education class with WIC clients in March. In-service education is also scheduled with Provo WIC staff in the future.

Several times a year the OHS and Oral Health Educator (OHE) continue to share oral health education that is posted on Utah WIC SharePoint for WIC staff and participants. The OHS and OHE strategically connected Granite Peaks

Learning Center for ESL serving many refugees to Fortis Dental Hygiene School. Both were connected to the UDOH Office of Health Disparities and the OHP to provide partnerships that provide education and preventive care to ninety-five children and adults.

The OHS and OHE continuously worked with and managed public health interns to help augment and sustain the work that they did. They had two interns each semester.

In October of 2017, the OHE traveled to Southeastern Utah to meet with Family Spirit Home Visiting sites, WIC, Local Health Departments, and the Public Health Dental Hygienist and Head Start Staff in Cedar City, Kanab, Blanding, Monument Valley, Moab, and Price. The OHP provided educational materials for families in all of these locations, including the “12 Oral Health Messages” modules and magnets.

Since all of the home visitors in Monument Valley were licensed registered nurses, the OHE provided training on oral health risk assessment and proper fluoride varnish application. This increases access to preventive services, early detection, and appropriate referrals to dental teams.
The OHP continued to encourage, support, and partner in efforts with the Oral Health Coalition, the Utah Dental Association, and the Utah Dental Hygienists Association to increase the number of pregnant women who had preventive dental visits during pregnancy. Efforts were made to help encourage any general dentists who have concerns about treating pregnant women, to see these women, and provide appropriate care during pregnancy. An example would be sharing the National Maternal Child Oral Health Resource on Pregnancy and Dental Care with these associations.

In June 2018, at the Utah Dental Association annual leadership conference, the State Dental Director presented information on sealants and school-based sealant programs in general, as well as the Seal Your Smile program, which is operated by the UDOH’s Family Dental Plan Clinic program, to educate and encourage their support for these type programs. This program sees children from twelve elementary schools in the Salt Lake School District. The State Dental Director provided general supervision in accordance with Utah laws, for the OHP’s two public health dental hygienists, the OHS and the OHE. Periodically he provided on site supervision and visited some of the public health setting events during the year.

The OHP collaborated with the MotherToBaby (MTB) program in a survey regarding oral health for pregnant women. As MTB Utah was doing the dental survey, to see how many of the pregnant clients had received dental care during their pregnancy, those who said they had not, were asked why not. One woman said she "just knows" that she can't have any dental x-rays or anesthetic during pregnancy, so why bother going? MTB let her know she would not harm her baby by having regular dental care including x-rays and anesthetic, if needed, and that going without this routine care could increase the chance of miscarriage and prematurity.

Accomplishments / Successes:

Using the National Head Start Program Information Report (PIR), the OHS worked toward moving the needle on the National Performance Measures 13A & 13B with all the Head Starts’ statewide. These efforts include meeting with the State Head Start Collaborator, five individual Head Start/Early Head Start (HS/EHS) programs that had less than 50% of their participants visiting a dentist in the last year, and potential partner safety nets that can provide access to care.

The OHE presented to thirty-eight OB/GYN’s at the Utah Women and Newborns Quality Collaborative (UWNQC) meeting. Dental resources and Medicaid information was given.

The OHS provided maternal and infant oral health education, fluoride varnish, and referral resources to 150 refugees.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-13A:

- The OHP graduate intern worked with the MTB Program on their oral health questions data. She also worked with WIC comparing our pilot data from Ogden and Provo WIC clinics. Using these two data sets, along with PRAMS, she assessed where the biggest needs are and barriers to care for pregnant women and dental care.

- The OHP intern presented a poster at the Utah Public Health Association (UPHA) for the MTB Program. She

submitted a proposal on her research to speak at the 26th International Conference on Advanced Dental Care in Moscow. Her BYU Professor presented her report.

- The OHS provided an in-service presentation called Strategies for Promoting Oral Health for Pregnant Women, Infants, and Children to Cedar City EHS/HS staff. Also, a four minute long video segment on oral health for pregnant mothers and infants was made to share with staff.
- The OHS continued to coordinate KUTV Baby Your Baby segments with topics of oral health and pregnancy, baby bottle use, and other oral health topics.
- The OHP published and disseminated two Bi-Annual Oral Health Outreach Reports to stakeholders and other partners.
- The OHP continued using the "12 Oral Health Messages" created for pregnant mothers and children in collaborative efforts with WIC, HS, and the Home Visiting programs.

Challenges / Gaps / Disparities:

Limited funding resources and staff is a challenge as we try to reach all of the state to address social justice and health equities involving oral health. It is difficult to find programs to collaborate with that work with just pregnant women, so efforts continue with groups who have a significant number of pregnant women. It is also a challenge in some rural areas to find a dentist who accepts Medicaid to refer pregnant women for care. This is because all of the dentists in these areas who are Medicaid providers only see children. Language barriers are a problem for some pregnant women. Recent census data shows that about 120 languages are spoken in Utah, and about 14% do not speak English at home.

Many of the women we work with have so many other challenges they are facing including lack of employment, a child with other medical issues, being a single parent, language barriers, transportation barriers, etc. This makes dental care low on their list of priorities.

Agency Capacity / Collaboration:

The OHP's OHS served on the Early Childhood Caries National Committee under the direction of the Association of State and Territorial Dental Directors (ASTDD). She also served as the Dental Hygiene Liaison for the State of Utah for HS. Efforts have been made to increase the number of pregnant women, as well as children, that see the dentist. Concentrated efforts were made with five local HS/EHS programs that had less than 50% of their pregnant women see a dentist. The State Dental Director collaborated with Medicaid in efforts to increase the percent of pregnant women who have preventive dental visits.

Summary Progress Report (2019) of ESMs related to NPM-13A

ESM 13.1 - Collaborate with Early Head Start (EHS): Percent of pregnant women who had a dental exam and/or treatment during pregnancy

Goal/Objective:

Increase the percent of EHS pregnant women who have a dental exam and/or treatment during pregnancy.

Significance of ESM 13.1:

Measures the number of pregnant women in the EHS program who had a dental exam and/or treatment during pregnancy.

ESM 13.1 Progress Report:

This ESM is expected to increase the number of pregnant women who visit the dentist during pregnancy in the EHS program. The pregnant women in the HS Program are a group where many of them do not make it to the dentist. Especially in some of the rural areas of Utah where there are access-to-care challenges. The OHP will collaborate with EHS to help these women make it to the dentist.

This year, the ESM Performance Measure was not achieved. The Performance Objective was 36.9%, and the

Annual Indicator was 25.0%. The 5-Year Annual Projected Performance Objectives have been updated according to the data trend.

Other activities in the Women's Health domain that contribute to improvement in the National Outcome Measures

Utah works to adhere to the three-tier framework outlined in the MCH Block Grant guidance. While the focus of most activities is the ESM →NPM→ NOM framework, activities on improving NOMs outside of the NPMs transpires in parallel. The following programmatic activities also work to improve outcomes in this domain.

National Outcome Measures (NOM)

NOM 1: Percent of pregnant women who receive prenatal care beginning in the first trimester

The Baby Your Baby program works to get women into early prenatal care by offering temporary Medicaid coverage to women while they wait for Medicaid approval. Additionally the Baby Your Baby program runs a media campaign to encourage women to begin prenatal care in the first trimester.

During Fiscal Year 2018, MotherToBaby Utah provided 17,313 English and 1,526 Spanish Pregnancy Risk Line/MotherToBaby Utah brochures and 2,557 MotherToBaby English/Spanish Rack Cards to providers and women. MotherToBaby Utah provided education to 1,167 clients (including through their partners and relatives), 1,076 referred by their healthcare providers, pharmacists, genetic counselors, dermatologists, dentists, WIC, health insurance companies, Planned Parenthood, or other health-related providers, about receiving care during the first trimester. MotherToBaby Utah is Utah's regional teratogen information service designated and supported, in part, by the Maternal and Child Environmental Health Network Cooperative Agreement from the Maternal and Child Health Bureau, Health Resources and Services Administration.

NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Utah continues to participate in the Alliance for Innovation on Maternal Health. To date, participating hospitals have implemented components of the obstetric hemorrhage and hypertension safety bundles. We continue our partnership with Wyoming joined the collaborative work and participate in learning sessions through the Project ECHO (Extension for Community Health Outcomes) telehealth system. We are now working to increase the number of facilities submitting process measures to the data portal on a quarterly basis. Work will begin in the fall of 2018 on the Obstetric Care for Women with Opioid Use Disorder bundle. Utah was invited to the Maternal Mortality meeting at the national ACOG conference to present on the use of Project ECHO to reach rural hospitals and has been invited to do a joint presentation with New Mexico on Project ECHO at the AIM national meeting in July.

In Fiscal Year 2018, MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to the untreated chronic and acute conditions in an effort to help women remain healthy and avoid unnecessary acute episodes or hospitalizations due to questions about continuing medication treatments.

The Violence and Injury Prevention Program (VIPP) works with the Domestic Violence Action Council to implement strategies to prevent domestic violence fatalities.

NOM 3 - Maternal mortality rate per 100.000 live births

Utah has an established maternal mortality review (MMR) committee and all maternal deaths are brought to the committee for evaluation. Utah began entering all case information from 2015 forward into the national MMRIA data system (Maternal Mortality Review Information Application). Utah contributed maternal death data to the CDC and it was included in the 13 state MMWR report on maternal deaths. Utah was invited to present on our work related to mental health on the CDC Vital Signs Town Hall on maternal mortality.

Utah's MMR committee developed standard criteria to determine if maternal deaths due to suicide and accidental

overdose were pregnancy related. Dr. Metz and Dr. Smid, members of Utah's MMR who developed the criteria, made a presentation on the criteria at the MMRIA Users Meeting in June.

In 2019, Utah began collaboration with the CDC Foundation to contribute to enhanced surveillance and understanding around opioid related maternal deaths. Utah will be providing data on maternal opioid related deaths and working to improve data collection related to these deaths. In 2019, Dr. Marcela Smid published a study using Utah MMR data titled "Pregnancy-Associated Death in Utah, Contribution of Drug-Induced Deaths". The study generated a great deal of press coverage in Utah.

In May 2019, Utah submitted an application for the CDC Maternal Mortality grant opportunity. In our application, Utah proposed to become the MMR committee for the state of Wyoming. Regardless of funding, Utah and Wyoming will work towards implementing this process in 2019, building on our cross-state collaboration on maternal safety bundles.

The MMR data continues to inform the work of the Utah Women and Newborns Quality Collaborative (UWNQC) safety bundle workgroup (AIM). The goal of the AIM project is to reduce maternal deaths and severe maternal morbidity, so the actions described above contribute to mortality prevention as well.

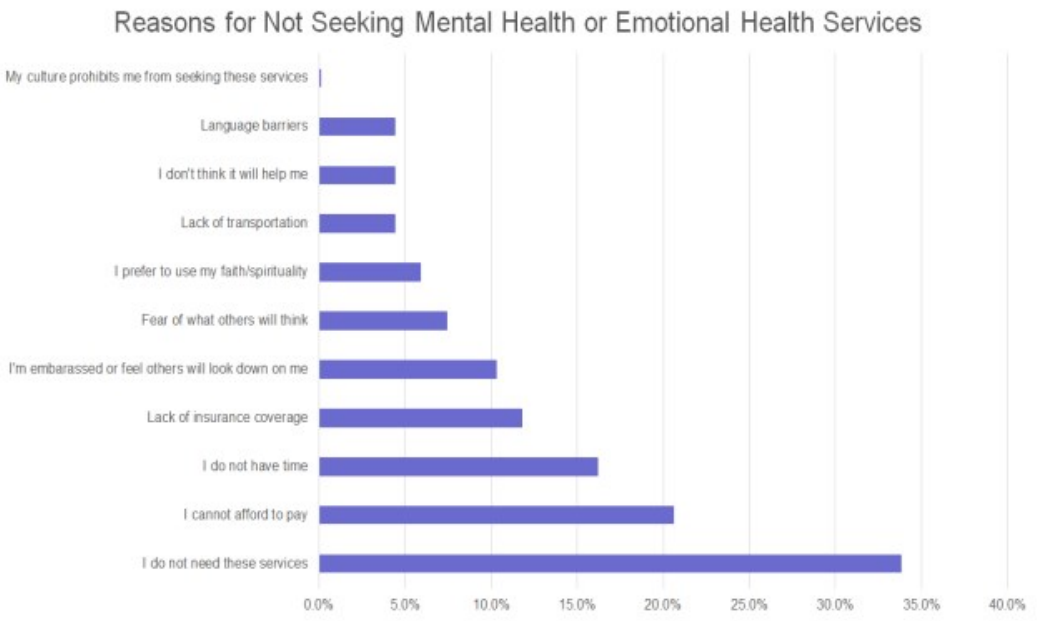
VIPP works with the Domestic Violence Action Council to implement strategies to prevent domestic violence fatalities. The program also works to prevent excessive alcohol and opioid use and runs a suicide prevention program.

NOM 29 - Percent of women who experience postpartum depressive symptoms following a recent live birth

There continues to be a focused effort in this area. The Policy group of Postpartum Support International Utah, a stakeholder group co-chaired by Utah's MCH Director, built on the momentum from last year's concurrent resolution on maternal mental health and successfully lobbied for three years of funding for maternal mental health efforts in Utah. The appropriations amount of $220,000 will allow the Maternal and Infant Health Program to keep the new Maternal Mental Health Specialist position as well as fund development of a resource and referral website for the public and providers and support other perinatal mental health projects. Events to support this effort this past year included: putting on a Perinatal Mood and Anxiety Disorders Conference Training 170 providers, getting February designated as Utah's Maternal Mental Health Awareness Month through the Governor's office, and including a Film Circuit in the State (over 100 members of the public attended), and coordinating a Climb Out of the Darkness Event in three Utah cities for survivor moms, families, and clinicians to attend.

The maternal mental health sub-committee of the UWNQC worked to develop screening and referral protocols for clinicians. The committee will begin pilot testing of the algorithms in 2019.

In 2018, the MIHP supported a public health student from the University of Arizona. The student, who was a practicing Ob/Gyn, implemented a series of focus groups and surveys among Utah's refugee populations to assess the mental health concerns among women of reproductive age. Findings of her study were that refugee women did not seek out mental health services for the following reasons:



When asked for recommendations to improve services/resources for mental health among refugee women, they noted better translators, better access, better cultural competency, a better network among organizations that serve the refugee community, and more education about mental health in the refugee community. The women also noted that while telehealth and the internet were good ideas, many in their community needed more education on how to use the technology. The study findings will be incorporated into the 2020 MCH Needs Assessment.

During FY18 4,805 English and 962 Spanish Postpartum Depression brochures were distributed to families and providers to help screen for depression and identify local resources. During FY18 MotherToBaby Utah provided education to clients and their providers about medications regarding the treatment of postpartum depression including the risk of untreated postpartum depression.

Other activities of note in the Maternal Health Domain:

The Utah Birth Defect Network (UBDN) provides health education to the community on birth defect prevention, preconception health, Zika Virus, and other health topics. For the period (7/1/2018 to 6/30/2019), the UBDN had 77 events, reached potentially 51,939 people, and distributed 5,021 bottles of prenatal vitamins and 2,745 Power Your Life bags. The UBDN also distributed 2,828 pens with 6 rotating messages, 5 of which are directly related to the MCH block grant. Those messages include ‘Take 400mcg of folic acid everyday’ ‘Birth Defects: Common, Costly, Critical’, ‘Mental Health Matters - Ask for Help!’, ‘Pregnant? Schedule a dental appt’, and ‘Schedule your yearly well-woman visit’. The health education efforts conducted through UBDN promote preconception and interconception health for women of reproductive age, which has been recommended to reduce risk of negative maternal and pregnancy outcomes.

MCH Block Grant FY20 Application & FY18 Report

Women/Maternal Health

NPM-01: Well-Woman Visit: ***Percent of women with a past-year preventive medical visit***

FY20 Annual Plan:

Annual Plan:

For FY20, the Maternal and Infant Health Program (MIHP) will use the recommendations made by SUMA Media Group to create and distribute educational materials through social media. The Healthy Utah Babies workgroup will also begin work on updating the Power Your Life website to include more information on the well-woman visit.

MIHP staff was able to create and secure an internship position with Utah Valley University (UVU). This intern position will work with the health promotion coordinator to establish a preconception peer education program in the campus. Beginning May 2019, a Community Health student from UVU will begin work on this project.

Westminster College peer educators will work towards making their peer education program a sustainable club on campus. A public health student, who was previously trained as a peer educator, will lead this club and work with the MIHP Health Promotion Program manager to recruit and train new students in the 2019-2020 school year.

We will be examining the impact of Utah's Medicaid expansion on the uptake of preventive health care and services.

Proposed Activities:

- Use recommendations proposed by SUMA Social Media, Inc. in their focus group report to update Power Your Life educational materials and website with the Healthy Utah Babies (HUB) workgroup.
- Continue working with Westminster College students to create a sustainable preconception health peer educator club on campus.
- Work with intern from UVU to establish a preconception health peer education program on campus.
- We will be examining the impact of Utah's Medicaid expansion on the uptake of preventive health care and services.

NPM-13A: ***Percent of women who had a preventive dental visit during pregnancy***

FY20 Annual Plan:

Annual Plan:

Starting October 2018, some changes were made in the Oral Health Program (OHP) structure. The OHP was a program directly under the MCH Bureau, but now it is a subprogram in the Family and Youth Outreach Program. The State Dental Director is not in this new program, but is directly under the MCH Bureau Director. He was also changed from 0.5 FTE to 0.25 FTE in this position. The Oral Health Specialist (OHS) and the Oral Health Educator (OHE) continue to be full time which makes the oral health staff 2.25 FTE.

The OHS and OHE will be sharing information to dentists and oral surgeons statewide on a resource published by the National Maternal and Child Oral Health Resource Center, “Prescribing Opioids for Women of Reproductive Age: Information for Dentist.”

With the goal to increase the percent of pregnant women who have a preventive dental visit during pregnancy, the OHP will collaborate with Head Start, Early Intervention, the Utah Office of Home Visiting, and the Women, Infants, and Children Program (WIC) to target high-risk populations, share resources, and provide education and training to agency staff on the importance of dental care during pregnancy.

The OHP will continue to use the “12 Oral Health Messages” modules and magnets to share with WIC offices, Head

Starts, Home visiting, etc. These messages include communication of 'It is safe to go to the dentist while pregnant'. The OHP will track oral health behavior among Utah mothers by analyzing new information in birth certificate data.

The OHP will also continue to encourage and support efforts in the Oral Health Coalition, the Utah Dental Association, and the Utah Dental Hygienists Association to increase the number of pregnant women who have preventive dental visits during pregnancy. Efforts will be made to help encourage any general dentists who have concerns about treating pregnant women, to see these women, and provided appropriate care during pregnancy.

In FY 20, the OHP plans to continue to collaborate with Medicaid to increase the number of children and pregnant women who have preventive dental visits and receive needed dental treatments. The State Dental Director will continue to work as a member of the Dental group with Utah Medicaid.

Proposed Activities:

- The OHP will continue to use the "12 Oral Health Messages" modules and magnets to share with WIC offices, Head Starts, Home visiting, etc.
- The OHP will also continue to encourage and support efforts in the Oral Health Coalition, the Utah Dental Association, and the Utah Dental Hygienists Association to increase the number of pregnant women who have preventive dental visits during pregnancy.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	6.3	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.4	NPM 3 NPM 4
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	4.1	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.3	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	182.3	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	51.5	NPM 4

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2016	2017	2018
Annual Objective	90	92.8	91.7
Annual Indicator	92.7	91.6	89.1
Numerator	480	522	521
Denominator	518	570	585
Data Source	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	90.0	90.4	90.8	91.2	91.6	92.0

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		100	100
Annual Indicator	100	100	100
Numerator	518	585	593
Denominator	518	585	593
Data Source	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

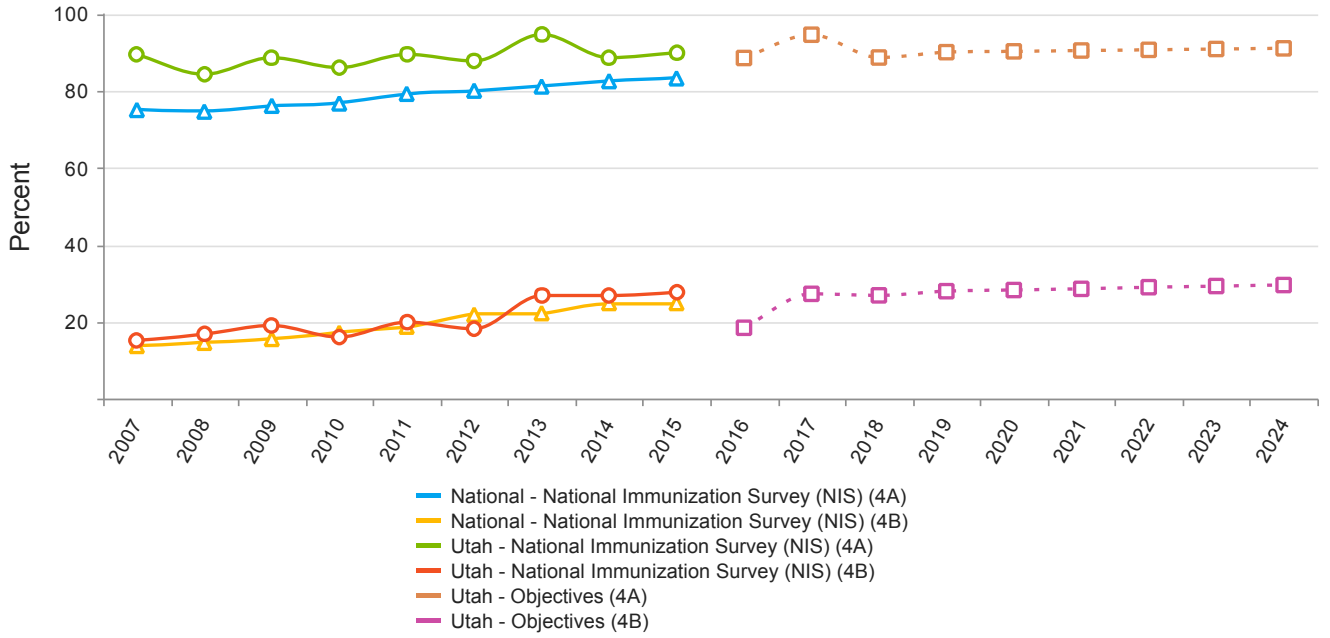
ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		100	100
Annual Indicator	0	0	0
Numerator	0	0	0
Denominator	10	10	10
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	88.5	94.5	88.6
Annual Indicator	94.4	88.4	89.7
Numerator	43,550	43,382	43,073
Denominator	46,122	49,063	48,030
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	90.0	90.2	90.4	90.6	90.8	91.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	18.5	27.3	26.9
Annual Indicator	27.0	26.8	27.8
Numerator	11,890	12,259	12,643
Denominator	44,056	45,790	45,490
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	28.0	28.3	28.6	29.0	29.3	29.6

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based 10 Steps to Breastfeeding Success

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		22	28
Annual Indicator	14	18	23
Numerator			
Denominator			
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	27.0	29.0	31.0	33.0	35.0

ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			178
Annual Indicator	26	89	114
Numerator			
Denominator			
Data Source	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	126.0	138.0	150.0	162.0	174.0	186.0

ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		9,400	10,800
Annual Indicator	9,335	10,771	9,700
Numerator			
Denominator			
Data Source	Utah WIC Program Computer Report	Utah WIC Program Computer Report	Utah WIC Program Computer Report
Data Source Year	SFY 2016	SFY 2017	SFY 2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9,700.0	9,800.0	9,900.0	10,000.0	10,100.0	10,200.0

State Performance Measures

SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		9	9.4
Annual Indicator	9.3	9.6	9.4
Numerator	4,712	4,852	4,582
Denominator	50,776	50,486	48,578
Data Source	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.4	9.4	9.3	9.3	9.2	9.1

State Action Plan Table

State Action Plan Table (Utah) - Perinatal/Infant Health - Entry 1

Priority Need

Preterm & low-birth-weight babies/NICU (continue with old SPM 3 & old NPM 17 due to ongoing need and focused efforts through the UWNQC)

NPM

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

By 2020, increase the percent of VLBW infants born at a hospital with a Level III+ Neonatal Intensive Care Unit from 90.0% to 91.8%.

Strategies

1.Collect data on VLBW infant morbidities through the VLBW REDCap database and assess outcomes by delivering facility

2. Share Levels of Care Assessment Tool (LOCATe) data with appropriate stakeholders

3. Develop standardized guidelines, based on consensus, for designation of level III NICUs

ESMs	Status
ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered	Active
ESM 3.2 - LOCATe: Percent of hospital facilities completing the LOCATe survey	Inactive
ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care	Active

NOMs

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (Utah) - Perinatal/Infant Health - Entry 2

Priority Need

Breastfeeding promotion

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

a. By 2020, Increase the percent of infants born in Utah who are ever breastfed from 87.9% (NIS, 2012) to 89.2%.

b. By 2020, Increase the percent of infants born in Utah who are exclusively breastfed through 6 months of age from 18.3% (NIS, 2012) to 27.2%.

Strategies

1. Implement the Stepping Up for Utah Babies program in delivering hospitals in Utah.

2. Work with workplaces to create a written breastfeeding policy that complies with the federal lactation accommodation law.

3. Increase access to, and use of, Utah WIC Breastfeeding Peer Counselor Program (BFPCP).

ESMs	Status
ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based 10 Steps to Breastfeeding Success	Active
ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards	Active
ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Utah) - Perinatal/Infant Health - Entry 3

Priority Need

Preterm & low-birth-weight babies/NICU (continue with old SPM 3 & old NPM 17 due to ongoing need and focused efforts through the UWNQC)

SPM

SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation

Objectives

By 2020, decrease the percent of preterm infants (infants born less than 37 weeks gestation) from 9.6% (UT Birth Data, 2016) to 9.3%.

Strategies

1. Collect preterm birth data from vital records to assess percentage of women who have had a previous preterm birth and received 17P.
2. Work with Health Systems statewide via UWNQC to collect information about the use of progesterone to prevent recurrent preterm birth.
3. Continue educating clinicians on the use of progesterone to prevent recurrent preterm birth via UWNQC.
4. Support LARC activities through the Division of Family Planning at the University of Utah.

MCH Block Grant FY20 Application & FY18 Report

Perinatal/Infant Health Domain

NPM-03: Perinatal Regionalization: *Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)*

FY18 Annual Report

Program Activities:

The Performance Measure was not achieved. The Performance objective was 91.7% and the Annual Indicator was 89.1%. Despite not meeting the Performance Objective, the Utah results are 6.5% higher than the Healthy People 2020 target of 83.7%. A 2010 review of very low birth weight (VLBW) infants delivered in risk-appropriate venues, the percentage across all states and jurisdictions between years 2000 and 2007 was 74.7%.[1] Historically, Utah's rate has been higher than the national rate and the Healthy People 2020. According to a review on National Performance Measure 3, only five states reported that more than 90% of VLBW births were delivered at Level III or higher hospital, and that this goal may not be achievable in all states.[2]

In comparing the 2016 and 2017 data to understand why the rates went down from 91.6% in 2016 to 89.1% in 2017, we found a statistically significant change in the percent of births that are less than 30 weeks in non-Level III facilities from 39% in 2016 to 60.7% in 2017. There did not appeared to be a significant variance between babies whose mothers lived in an urban vs. rural area and the levels of care where she delivered. However, we observed a slight increase for VLBW babies in urban areas not going to a Level III hospital from 2016 to 2017.

Utah implemented the CDC Levels of Care Assessment Tool (LOCATe) survey for understanding levels of care that serve pregnant women, mothers and infants. The results provided the levels of care by facility statewide for maternal and neonatal Intensive Care Units.

Accomplishments / Successes:

A key focus in FY18 was validating the data submitted by the hospitals in their surveys and addressing discrepancies between the hospital level assessment and the tool assessment. The CDC LOCATe is based on the most recent guidelines and policy statements issued by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine. As of February 2019, fifteen states were participating in CDC LOCATe. The response rate from hospitals in Utah accounted for over 99.9% of total Utah births. The tool helps to establish standardized assessments of maternal and neonatal care.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-03:

- The completion and reconciliation of LOCATe data was a key success toward standard statewide neonatal and maternal levels of care. The participating facilities represented 99% of Utah hospital births. For the neonatal levels, there was a 77% match of the hospital self-assessment and the CDC LOCATe assessment. For maternal, this was at 74%. Key discrepancies for neonatal was no neonatologist and for maternal it was missing subspecialist access.
- Discussions with hospitals on discrepancies was a major project. The strategy in talking about discrepancies with our largest health system, Intermountain Healthcare, was to work with the Executive Director of the Women and Newborns Clinical Program. This Healthcare System hosts over 50% of births statewide and our contact was key in having discussions with individual hospitals where the self-assessment did not match the CDC LOCATe level. With other Healthcare systems, we worked individually with each hospital to come to consensus on the levels.
- A multi-jurisdictional analysis with the CDC to compile LOCATe data by outcomes and levels of care will provide insights on perinatal regionalization. The Memorandum of Understanding (MOU) from the CDC to share data was received to initiate the analysis that will help link outcomes by levels of care.

Challenges / Gaps / Disparities:

One challenge is that the Quality Improvement Director left her role in March 2017. Now that a new resource is in place, the levels of care analysis can continue to progress. The data quality review was very time consuming and tedious to verify that the survey results accurately reflected what was currently happening at each facility. These discussions involved many back and forth conversations to achieve consensus and took longer amounts of time than was originally anticipated. The legal review of the MOU was also slower than anticipated, currently MIHP and CDC are moving forward on the multi-jurisdiction analysis.

Agency Capacity / Collaboration:

LOCATe has created various opportunities for informed conversations among stakeholders who work in the area of risk-appropriate care. This includes hospital administrators and clinicians such as Labor and Delivery Nurse Managers or Women and Newborn Directors. The Utah Women and Newborns Quality Collaborative (UWNQC) has Board and Committee members from each of the major health systems in Utah. This diversity of support has helped to build collaboration with the UDOH and increase the understanding on why we were working with the CDC on LOCATe. CDC has been a key partner in completing the LOCATe analysis.

Summary Progress Report (2018) of ESMs related to NPM-03

ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered

Goal/Objective:

Increase the percentage of reporting by hospital facilities where VLBW infants were delivered.

Significance of ESM 3.1:

Perinatal regionalization classifies hospitals at risk-appropriate levels in regards to care for both mothers and infants. This ensures that high-risk pregnancies and VLBW, preterm, or other at-risk infants have access to the most appropriate care. In Utah, hospitals self-designate their levels of care, and because of this, there is not uniformity with Utah's leveling. In an attempt to dig past the surface of a self-proclaimed level and see what is actually happening in our facilities, a database has been created for all Utah hospitals to report the outcomes of every VLBW infant either delivered or transferred to their facility. This data will allow Utah to have a more informed conversation about the importance of perinatal regionalization through the eyes of some of our most ill and vulnerable infants.

ESM 3.2 - LOCATe: Percent of hospital facilities completing the LOCATe survey

This ESM was accomplished and has been categorized as "inactive".

ESM 3.3 - Standardized guidelines: Percent of hospitals facilities providing support to build a consensus based model of Utah Standardized Level of Care

Goal/Objective:

Increase the number of hospitals facilities providing support to build a consensus-based model of Utah Standardized Level of Care to 100%.

Significance of ESM 3.3:

A survey carried out by the MCH Bureau several years ago provided objective criteria that indicates that Utah currently has ten hospitals that self-designate as Level III Neonatal Intensive Care Units (NICU). However, the survey data collected indicated that according to published guidelines for Perinatal Care, the number of Level III NICUs in Utah may actually be smaller than originally believed. Currently, Utah regulations that designate Levels of Care for Perinatal Services are imprecise, and there is no regular oversight of NICU services by the UDOH. Through collaboration, the MCH Bureau has worked on developing Utah specific guidelines for Neonatal Care based on the seventh edition of Guidelines for Perinatal Care.[3] However, these Utah specific guidelines have remained in draft form for the last few years. Following the collection of Utah specific data on VLBW infants, we will be able to again approach creation of these guidelines.

ESM 3.3 Progress Report:

This involves collaboration with the CDC LOCATe, which helps to create standardized levels of neonatal care. The Neonatal area of LOCATe is based on the most recent guidelines and policy statements issued by the American

Academy of Pediatrics. CDC will collaborate with us to provide technical assistance on interpretation of the data collected. Once the data validation of each delivering facility in Utah is complete, we will present the data to the UWNQC. If needed, UWNQC will provide guidance on the best way to move forward on standardized guidelines for designation of Level III NICUs. Development of consistent statewide neonatal level of care designations will provide helpful information for pregnant women when making delivery decisions. In addition, it may potentially reduce the risk for complications if more women at high risk for a VLBW baby choose to have their baby at a facility that can provide the level of care needed for a safe delivery.

NPM-04A & NPM-04B: Breastfeeding

NPM-04A: Breastfeeding: Percent of infants who are ever breastfed

NPM-04B: Breastfeeding: Percent of infants breastfed exclusively through 6 months

FY18 Annual Report

Program Activities:

The Performance Measures for both NPM-04A and NPM-04B have been achieved.
The Performance Objective for NPM-04A was 88.6% and the Annual Indicator was 89.7%.
The Performance Objective for NPM-04B was 26.9% and the Annual Indicator was 27.8%.

The Stepping Up for Utah Babies breastfeeding program continues working with and recruiting delivering hospitals for statewide implementation. During FY18, three hospitals (Central Valley Medical Center, Dixie Regional Medical Center, and Salt Lake Regional Medical Center) were trained in the Stepping Up program. These hospitals are found in urban and rural areas of Utah, and are reaching women of diverse backgrounds, socioeconomic status, race, ethnicity, and education levels. After the initial training, all hospitals began working towards implementing at least two evidence-based steps identified by the Ten Steps to Successful Breastfeeding.

The Utah WIC program developed a statewide goal in FY18 to increase referrals to the Utah WIC Peer Counseling Program. These referrals are documented in the WIC VISION computer system. In addition, a 45-hour lactation course was coordinated and Peer Counselors from various WIC local agencies attended.

During FY18, the Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) program continues to reach out to and collaborate with Utah worksites to create lactation policies that comply with federal and state laws. Seventy-nine worksites have completed the CDC Worksite Health Scorecard, Healthy Worksite Award, or EPICC Mini-Scorecard. Of the seventy-nine worksites, 86% currently have an existing breastfeeding policy in place that complies with federal standards. Twenty-five worksites have created a new policy or formal communication for breastfeeding/lactation support for employees. EPICC staff and Local Health Departments (LHDs) provided technical assistance and breastfeeding support materials.

Accomplishments / Successes:

Intermountain Healthcare continues to fully support and encourage all of member hospitals to implement the Ten Steps to Successful Breastfeeding through the Stepping Up program, and as of FY18, nineteen out of twenty-one Intermountain Hospitals have been trained and have created a breastfeeding policy that address implementation of all ten steps. During FY18, participating hospitals successfully implemented twelve evidence-based steps.

We also began to have some success in recruiting and training hospitals outside of the Intermountain Healthcare System. During FY18, two of the three new hospitals that began implementation were either in a rural area or outside the Intermountain Healthcare System.

The Utah WIC Program referred prenatal and postpartum WIC participants to the WIC Breastfeeding Peer Counseling Program using the Nutrition Interview, Referrals, and Participant Care Plan Screens in the Utah WIC VISION computer system. In addition, referrals were made to the WIC Breastfeeding Peer Counseling Program by the MotherToBaby Utah (MTB UT) program. The number of Peer Counseling Program referrals made in FY18 decreased from 10,771 to 9,606. In addition, the number of Peer Counselors employed by WIC decreased from forty-three to thirty-four. However, while the number of Peer Counselor referrals decreased, the ever breastfed prevalence increased from 87% to 88% in FY18 (data from Utah WIC VISION). Breastfeeding prevalence at six months and twelve months remained consistent at 37% and 33%, respectively. However, the exclusive breastfeeding prevalence at three and six months of age decreased to 31% and 19%, respectively.

Collaborating with the MTB UT program was beneficial in breastfeeding promotion, as these programs' referrals contributed to the ever breastfed and exclusive breastfeeding prevalence rates. Consumers will sometimes call MTB UT before they are breastfeeding with questions about the medications that they are taking and if these medications are safe to take while breastfeeding. MTB UT provides consumers with information about which medications can be used while breastfeeding and have found that most of the time, women are able to breastfeed while taking their

medications. MTB UT also clarifies incorrect information about which medications can be used while breastfeeding. For example, one breastfeeding mother was told that she had to pump and discard her milk for two weeks while she was taking metronidazole for a serious giardia infection. Her infant was four weeks old, and the mother found that after one week of pumping and discarding her milk that her milk supply was decreasing. MTB UT explained that metronidazole is compatible with breastfeeding and she did not need to pump and discard her milk. This mother was extremely happy to be able to keep her supply and continue breastfeeding her baby. Another example is a mother with a three-month-old infant who underwent an outpatient gallbladder removal. She was told to pump and discard her breast milk for “at least” one day after her surgery. MTB UT explained to this mother that the anesthetics are out of the milk before the procedure is finished, so she could feed her baby as soon as she felt like doing so after the surgery. The mother’s goal was to feed her baby until at least one year of age, so she was relieved that she did not have to resort to giving her baby formula.

Additional accomplishments of the WIC Breastfeeding Peer Counseling Program include that three local agencies were awarded national awards for their Breastfeeding Peer Counseling Programs. Davis County received the Loving Support Gold Award and the Loving Support Gold Premiere Award; Tri-County received the Loving Support Gold Award; and Utah County received the Loving Support Gold Premier Award. In addition, Local WIC agencies have expanded the reach of the Peer Counseling Program significantly through creating Breastfeeding Support Groups for the community, expanding communication channels to include at-home visits and texting, collaborating with local physician’s offices to improve community referrals to WIC Peer Counseling Services, and utilizing the Breastfeeding Attrition Prediction Tool (BAPT) to provide targeting breastfeeding education and counseling to participants.

The EPICC Program assisted worksites in develop a lactation policy that complies with national and state laws. From the seventy-nine responses collected, sixty-eight worksites currently had a breastfeeding policy or formal communication in place, and twenty-five worksites have created a policy within the past twelve months of the assessment. Additionally, seventy-seven worksites provide a private space for employees to express milk, seventy-nine worksites provide flexible break times to allow mothers to breastfeed and/or pump milk, and seventy-five worksites provide an on-site refrigerated space for breastmilk to be stored. Additionally, ten worksites were in the process of developing new policies or strengthen existing policies. EPICC reached out to the worksites that did not have an existing policy, but had the three components for breastfeeding support were provided example policies.

EPICC staff attended two worksite-networking events and the Utah Worksite Wellness Conference to increase contacts to worksites. Additionally, the EPICC program provided breastfeeding support material to conference attendees and offered “Your Guide to Breastfeeding” packets. Several local health departments continue to conduct their own assessments and have reached out to worksites within their jurisdictions and promote breastfeeding at the workplace. Currently, the EPICC Program is in the process of creating an on-demand breastfeeding webinar that explains the federal and state laws and describes the importance of breastfeeding support in the workplace. This will be shared with worksites in Utah

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-04:

- Intermountain Healthcare has endorsed the Stepping Up for Utah Babies program and has recommended that all hospitals in their system implement the program. As of this reporting, nineteen out of twenty-one Intermountain Healthcare Hospitals have been trained and have created a breastfeeding policy that address implementation of all ten steps.

- Three local WIC agencies were awarded national awards for their Breastfeeding Peer Counseling Programs.

- Local WIC agencies expanded the reach of the Peer Counseling Program significantly through creating Breastfeeding Support Groups for the community, expanding communication channels to include at-home visits and texting, collaborating with local physician's offices to improve community referrals to WIC Peer Counseling services, and utilizing the Breastfeeding Attrition Prediction Tool (BAPT) to provide targeted breastfeeding education and counseling to participants.

- The Utah Healthy Living through the EPICC program assisted worksites to develop a lactation policy that complies with national and state laws. With their assistance, twenty-five worksites created a policy, seventy-seven worksites provided a private space for employees to express milk, seventy-seven worksites provide flexible break times to allow mothers to breastfeed and/or pump and seventy-five worksites provided on-site refrigerated space for breast milk storage.

Challenges / Gaps / Disparities:

Challenges

An ongoing challenge to hospitals that have begun work on the Stepping Up for Utah Babies program is the amount of additional duties administrators and nurses must take on to accomplish the requirements set by the program. Due to this, some hospitals have pushed further implementation, beyond the initial training, down the list of "to dos" and slower progress is being made in the number of steps being completed. Furthermore, outreach to non-Intermountain facilities has proven challenging in identifying and talking to the correct person in the facility about the program.

Challenges that the WIC Breastfeeding Peer Counseling program faced during FY18 included a decrease in the number of employed Peer Counselors from forty-three to thirty-four. In addition, local agencies reported receiving a lack of support of Utah WIC's Breastfeeding Peer Counselor Program from local hospitals. Finally, decreased funding for WIC Breastfeeding Peer Counseling programs limits the amount of outreach that Peer Counseling programs can complete.

The challenges as outlined above may have contributed to a decrease in Exclusive Breastfeeding rates at three and six months of age.

The EPICC program continues to have difficulty with worksites not following up with health department staff after initial contact has been made with the worksites. Several worksites are not interested in working on breastfeeding policies and frequently state that they do not have employees who breastfeed or pump and there is no need for a policy. Many worksites would rather focus on other areas of worksite wellness (i.e. mental, social, and financial).

Emerging Issues

An emerging issue is the high turnover of Peer Counselors at this time. Common reasons for turnover include that the Peer Counselor's wage is not competitive, there are limited resources for continuing education for Peer Counselors, and that Peer Counselors are finding other jobs where continuing education is available and where the wages are competitive. To improve the continuing education available to Peer Counselors, the state WIC office applies for additional funds for a 45-hour lactation course for WIC staff, including Peer Counselors. A 45-hour lactation education course was offered in September 2018.

Agency Capacity / Collaboration:

Stepping Up program staff and staff from the EPICC program continue with a close partnership. Staff from the EPICC program advises Stepping Up staff on upcoming professional development opportunities, new breastfeeding research, and they use community engagement opportunities to discuss the Stepping Up program with their target audiences.

Even with changes in leadership, Intermountain Healthcare continues their support of the Stepping Up program.

The Utah WIC Program collaborates with all Utah Department of Health and MCH programs as well as community organizations such as hospitals, La Leche League, and Utah Breastfeeding Coalition to optimize breastfeeding support for moms and babies. The Utah WIC Program also collaborates with local county events, such as fairs to have a designated area for breastfeeding. Local counties have created breastfeeding events for the community to participate in, such as a community breastfeeding conference in Davis County. In addition, The Utah WIC Program also receives and addresses consumer calls on breastfeeding referred by the MotherToBaby Utah Program.

Summary Progress Report (2019) of ESMs related to NPM-04

ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based Ten Steps to Breastfeeding Success

Goal/Objective:

Increase the number of steps being implemented in Utah delivering hospitals.

Significance of ESM 4.1 & 4.3:

Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends that all infants,

including premature and sick newborns, to be exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates that breastfed children may be less likely to develop juvenile diabetes, may have a lower risk of developing childhood obesity and asthma, and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post-natal depression. Increased release of oxytocin while breastfeeding leads to a reduction in postpartum hemorrhage and quicker return to a normal sized uterus over time. Mothers who breastfeed may be less likely to develop breast, uterine, and ovarian cancer, and have a reduced risk of developing osteoporosis.

ESM 4.1 Progress Report:

The care that a new mother receives during her hospital stay for delivery, postpartum, and newborn care can greatly influence breastfeeding initiation, exclusivity, and duration outcomes. Institutional changes through adoption of evidence-based policies to support breastfeeding can significantly increase rates of breastfeeding.

The "Ten Steps" are evidence-based maternity care practices that demonstrate optimal support of breastfeeding, as well as improved care experiences and outcomes for non-breastfeeding families. These steps are endorsed by the American Academy of Pediatrics and the American Academy of Family Physicians and are promoted by the American Academy of College of Obstetricians and Gynecologists. Additionally, the "Ten Steps" are recommended breastfeeding interventions and, the 2010 White House Task force on Childhood Obesity's Report to the President: Solving the Problem of Childhood Obesity within a Generation, and the National Prevention Council's National Prevention Strategy.

During FY18, MIHP staff trained three new hospitals in the Stepping Up for Utah Babies program. Additionally, six previously trained hospitals successfully implemented twelve steps during FY18.

To date there are a total of twenty-three hospitals in Utah trained on the Stepping Up for Utah Babies program. These hospitals have successfully implemented sixty-eight steps. In FY19, Logan Regional completed all ten steps and became certified at the first Breastfeeding Friendly Facility through the Stepping Up for Utah Babies program.

ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards

Goal/Objective:

Increase the number of worksites that create or revise a lactation policy or formal communication.

Significance of ESM 4.2:

For infants not breastfeeding, there is an associated increased risk of infant morbidity and mortality, and significantly higher risk of many diseases including diabetes, obesity, leukemia, SIDS, NEC, etc.

Duration rates are greatly affected by mothers returning to work to businesses that are not meeting the federal workplace accommodation law. Policies must be in place and implemented to provide an environment that is conducive to supporting breastfeeding women.

ESM 4.2 Progress Report:

During FY18, the EPICC program continues to reach out to and collaborate with Utah worksites to create lactation policies that comply with federal and state laws. Among the worksites who have completed the CDC Worksite Health Scorecard, Healthy Worksite Award, or EPICC Mini-Scorecard, 86% currently have an existing breastfeeding policy in place that complies with federal standards. In FY18, twenty-five worksites created a new policy or formal communication for breastfeeding/lactation support for employees, bringing the total number of sites to 114. EPICC staff and Local Health Departments (LHDs) provided technical assistance and breastfeeding support materials.

ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program

Goal/Objective:

Increase the number of referrals to BFPCP by 1% in the next year.

ESM 4.3 Progress Report:

The Utah WIC Program referred prenatal and postpartum WIC participants to the WIC Breastfeeding Peer Counseling Program using the Nutrition Interview, Referrals, and Participant Care Plan Screens in the Utah WIC VISION computer system. The MotherToBaby Utah program also made referrals to the Utah WIC Breastfeeding Peer Counseling Program. The absolute number of referrals decreased to 9,606, which was below the goal of 10,900 referrals for FY18. In addition, the total number of Peer Counselors decreased from forty-three to thirty-four. The number of duplicated contacts to WIC participants made by WIC Breastfeeding Peer Counselors for pregnant women decreased to 15,384 and duplicated contacts for postpartum women decreased to 28,391. In addition, the ever breastfed prevalence increased to 88% and the breastfeeding prevalence at six and twelve months remained consistent at 37% and 33%, respectively. However, the exclusive breastfeeding prevalence at three and six months decreased to 31% and 19%, respectively. The Utah WIC Breastfeeding Peer Counseling Program was strengthened by offering a 45-hour Advanced Lactation Course in Sept 2018.

SPM-01: Preterm Birth: ***Percent of live births occurring before 37 completed weeks of gestation***

FY18 Annual Report

Program Activities:

The Preterm Birth (PTB) Rate decreased from 9.6% to 9.4%. This rate is below the U.S. preterm birth rate of 9.9% and the hits the Healthy People 2020 goal of 9.4%.

The Reduce PTB Committee of the Utah Women and Newborns Quality Collaborative (UWNQC) created a PTB Prevention Resources summary that highlights the resources developed including the PTB Prevention Series, the Utah Screening and Progesterone treatment process and care protocol, What to Do to Prevent a PTB: 17-P (Progesterone) Guide for Providers; 17-P for Preventing PTB Fact Sheet (English and Spanish), and What to Do After a PTB Guide for Families (English and Spanish). The resource also outlines how to implement changes and track improvement at hospitals. The committee disseminated these resources to hospitals and various clinicians at staff meetings.

Data Collection has been a key program activity. The Birth Certificate tracks progesterone use during pregnancy with the question: “During your most recent pregnancy did a doctor, nurse, or other health care worker try to keep your new baby from being born too early by giving you a series of weekly shots or daily vaginal suppositories of a medicine called Progesterone, Makena, or 17P (17-alplahydroxyprogesterone)?” From this data, we are able to track 17-P usage by hospital and show the run charts for UWNQC hospitals at monthly Reduce Preterm Birth Rate meetings. Via REDCap (Research Electronic Data Capture) database, our two largest health systems now provide data on women with a history of preterm birth who were offered and utilized progesterone in their current pregnancy.

Accomplishments / Successes:

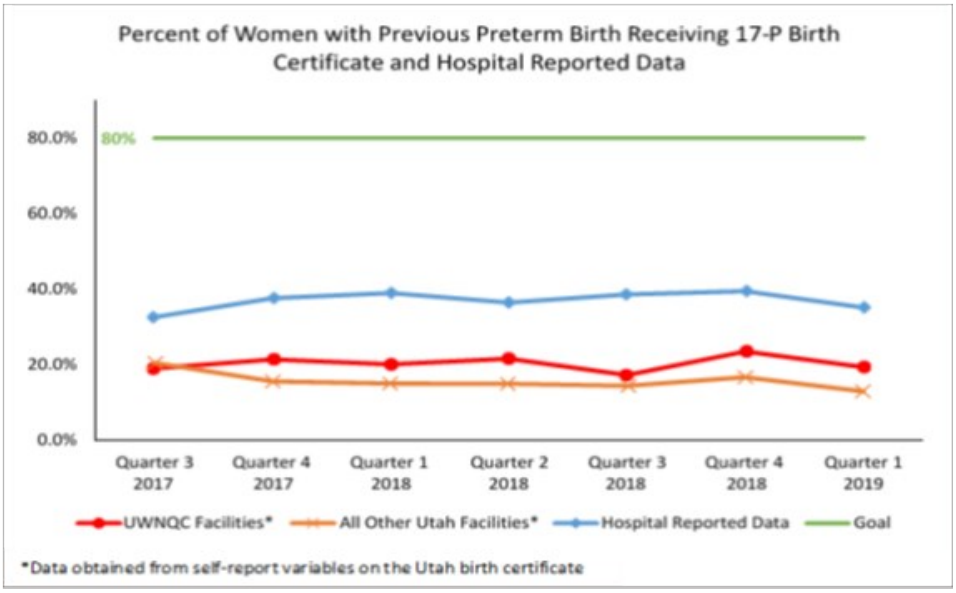
The UWNQC Prevent PTB Committee created a Preterm Birth Prevention Resources Summary which can be accessed on UWNQC updated website: https://mihp.utah.gov/uwnqc/reduce-preterm-birth.

Vital Records staff presented to providers on the importance of accurately reporting prior preterm births on the birth certificate. This included packets of information with UWNQC resources such as a 17-P for Preventing PTB for Providers.

Family Planning Services House Bill 12 passed during the 2018 legislative session that enacts provisions for family planning services within the state Medicaid program. It includes the Medicaid program reimbursing providers separately for the insertion of Long Acting Reversible Contraception (LARC) immediately after childbirth and provides family planning services to certain low-income individuals.

Summary of successes and accomplishments on “Moving the Needle” in relation to SPM1:

- Creating 17-P utilization run charts for individual hospitals and for statewide tracking has helped to visualize the baseline and have discussions with hospitals on how they can improve the number of eligible women who they are having a discussion about 17-P to reduce their risk. The charts are used at the Reduce PTB Committee meetings.



- The University of Utah, one of our major health systems, has executed a data sharing agreement with MIHP and UWNQC. They created a spontaneous PTB section in their Electronic Medical Record (EMR) EPIC which captures patient history of singleton spontaneous PTB, whether 17-P was offered, if the patient took 17-P injections and if so, when they were started. The data will help to establish a baseline and identify potential barriers to optimal treatment.
- There is a question on the birth certificate that asks during the most recent pregnancy did a doctor, nurse, or other healthcare worker try to keep your new baby from being born to early by giving a series of weekly shots or daily vaginal suppositories of a medicine progesterone, Makena, or 17-P. This has allowed us to establish a baseline from which we are creating the run charts and discussing with hospitals.

Challenges / Gaps / Disparities:

One challenge is that the Quality Improvement Director left her role in March 2017. Now that a new resource is in place, the PTB Reduction Committee can continue to be supported. The data received from hospitals and what is on the birth certificate does not always match. An audit or comparative analysis of this data would help provide insights on why the birth certificate rate is usually lower than the hospital reported rate.

Multiple births are a key factor in the PTB rate. In 2017, 3.6% of total births were multiples (twins, triplets, quadruplets, etc.), and this represented 23.6% of the total PTBs. When multiples are excluded from the PTB rate calculation, in 2016 the singleton PTB rate was 7.4%, and 7.5% in 2017. This is compared to the overall PTB rate including multiples of 9.6% and 9.4% in 2016 and 2017, respectively. The impact that multiple births have on the PTB rate is an important area to understand. The UWNQC committee has been focused on spontaneous singleton births, due to the potential impact the committee and its efforts can have on these births, rather than in cases of multiples.

In 2017, two of the three Local Health Districts where the PTB rate was over 10% were in rural areas. There are currently some telehealth programs in place that offer resources specific to rural residents.

Reviewing the rates of PTB by race and ethnicity, the highest rate for the past three years was among Native Hawaiian or Other Pacific Islanders (NHPI). Since 2012, The Utah Office of Health Disparities (OHD) in collaboration with public health and health care professionals and community partners has been working to address this issue, along with infant mortality. A final product of these efforts is the It Takes a Village (ITAV): Giving our babies the best chance project. ITAV raises awareness and educates NHPI families and community members about maternal and infant health in the context of Pacific Islander cultural beliefs and practices. ITAV is one of the outcomes of a birth outcomes disparities project that was originally rooted in the theoretical framework from the National Partnership for Action to End Health Disparities. The curriculum includes discussing topics such as birth spacing that can reduce the

risk for PTB.

The PTB Rate for Medicaid recipients reduced from 10.7% in 2016 to 10.3% in 2017. Since the five-year PTB rate trend for Medicaid recipients has been increasing, this is a population to continue to determine ways to provide recipients with PTB risk reduction resources.

Agency Capacity / Collaboration:

Stakeholders from the key major health systems in Utah: Intermountain Healthcare, MountainStar (HCA), Steward Health, and the University of Utah work with the UWNQC board and committees. This collaboration helps us to educate providers, collect PTB data, and implement statewide standard protocols and algorithms. Another partnership is with the University of Utah Family Planning Elevated team. They launched a Resource for Education on Pregnancy Planning in the fall of 2018 that included topics such as unintended pregnancy and birth implications and healthy birth spacing that are topics that impact the PTB rate.[4]

Government collaborations include working with Local Health Departments statewide and with hotlines such as the Utah Tobacco Quit Line, state resource center, Baby Your Baby, and MotherToBaby. Social Media efforts include public education about how to be heathy prior to pregnancy on the Power Your Life website, along with offering various resources on the UWNQC for providers and the public.

The collaboration with the Office of Vital Records is key in obtaining and analyzing 17-P data utilization. Stakeholder analysis indicated that UWNQC was lacking a parent representative on the UWNQC board and one parent representative was added in 2018 which helps keep the parent and patient experience at the forefront as evidence based interventions are implemented.

The collaboration between UWNQC and Family Planning Elevated at the University of Utah will continue as the House Bill 12 is implemented for a statewide, immediate Postpartum Long-Acting Reversible (LARC) Program. This includes offering a program that provides family planning services to low-income individuals, disseminating educational materials statewide, and training providers. Medicaid expansion in Utah has been uncertain, the goal is that this will be resolved to help shed light on how this impacts the implementation of this bill. The bill has provisions for family planning services within the state Medicaid program. It includes the Medicaid program reimbursing providers separately for the insertion of LARC immediately after childbirth, and providing family planning services to certain low-income individuals. Unintended pregnancy data will be tracked to determine if a reduction may help to move the needle in reducing preterm births.

Other activities in the Perinatal/Infant Health domain that contribute to improvement in the National Outcome Measures

Utah works to adhere to the three-tier framework outlined in the MCH Block Grant guidance. While the focus of most activities is the ESM →NPM→ NOM framework, activities on improving NOMs outside of the NPMs transpires in parallel. The following programmatic activities also work to improve outcomes in this domain.

National Outcome Measures (NOM)

NOM 4 - Percent of low birthweight deliveries (<2,500) grams)

As the majority of low birthweight deliveries are also preterm births (70.2%), much of the focus for reducing low birthweight is on prevention of preterm birth. Utah's preconception health campaign, "Power Your Life" encourages women to improve their health prior to pregnancy.

In Fiscal Year 2018, clients were educated about medications used during current pregnancies or while planning a pregnancy to treat conditions that could result in low birth weight deliveries such as mental health conditions, cardiovascular conditions, respiratory conditions, and the use of tobacco and other drugs. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated conditions during pregnancy in an effort to help women remain healthy and avoid complications that could result in babies with lower birth weight.

NOM 7 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Utah was awarded a pilot grant from the CDC to develop a stillbirth surveillance instrument and pilot for one year of data collection. The Utah SOARS (Study of the Associated Risks of Stillbirth) survey began data collection in August 2018. Once a full year of data is collected, it will be sent to the CDC for weighting and Utah can begin analysis of the data. We have been pleased with response rates to the survey, which is ~60% (unweighted) as of this submission. Nicole Stone, PRAMS Epidemiologist, presented on the project at the PRAMS National meeting, the MCH Epidemiology meeting, and the Council for State and Territorial Epidemiologists national meeting. Results of these analyses will be shared widely and implementation methods will be documented so this surveillance can be replicated in other states.

In Fiscal Year 2018, clients were educated about medications used during the perinatal period. Education was provided about the risks of the untreated conditions, such as hypertension, diabetes, tobacco and other substance use, and maternal infections, and the potentially teratogenic medications used to treat those conditions, such as angiotensin converting enzyme (ACE) inhibitors, non-steroidal anti-inflammatory drugs (NSAIDS), and valproate, that could result in perinatal complications and/or death. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated conditions during the perinatal period in an effort to help women remain healthy and avoid complications that could result perinatal deaths.

NOM 8 - a) Infant mortality rate per 1,000 live births

b) Neonatal mortality rate per 1,000 live births

c) Post-neonatal mortality rate per 1,000 live births

d) Preterm-related mortality rate per 100,000 live births

Utah has an active Perinatal Mortality Review (PMR) Program and a Child Fatality Review Committee (CFRC) Program. The PMR reviews deaths to all infants under the age of one due to perinatal conditions. The CFRC reviews all deaths to infants due to intentional/unintentional injury and sudden unexplained infant death. The PMR committee reviews cases for contributing causes and potential for prevention. Recommendations are made for implementation. We are working to publish case review information on a yearly basis and provide a summary to the Neonatal Committee of the UWNQC.

The PMR continues to work to decrease the backlog of infant cases needing to be reviewed. Having a PMR Abstractor this year has helped with catching up to more timely reviews. As noted, Utah’s infant mortality rate has seen an increase over the last three years. These trends have resulted in Utah’s infant mortality rate being equal to that of the U.S. in 2017. This rising rate is of concern and efforts are underway to examine contributing factors.

The PMR Coordinator participated on a committee with the Bureau of Epidemiology to examine deaths due to

Group B Streptococcus deaths among Utah's infants. Findings of this analysis will be published in the coming months.

In Fiscal Year 2018, clients were educated about medications used during the perinatal period. Education was provided about the risks of the untreated conditions, such as hypertension, diabetes, tobacco and other substance use, and maternal infections, and the potentially teratogenic medications used to treat those conditions, such as angiotensin converting enzyme (ACE) inhibitors, non-steroidal anti-inflammatory drugs (NSAIDS), valproate, and codeine that could result infant complications and/or death. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated conditions during pregnancy and breastfeeding in an effort to help women remain healthy and avoid complications that could result in infant deaths.

Over the 2018 fiscal year, the Utah Newborn Safe Haven hotline received 28 inquiries. The Utah Safe Haven project educates through community outreach about the Safe Haven law in the state. Utah mothers or a third-party acting on behalf of the mother, can relinquish a newborn at any 24-hour service hospital. The law is specific to unharmed newborns up to 3 days of age. Since the first Safe Haven law was passed in the United States in 1999, over 4,000 infants have been safely surrendered across the country, with an average of two relinquishments each year in Utah alone. Due to the popularity of similar laws in other states, the Safe Haven project is constantly providing education about the specifics of the Utah Safe Haven law--especially about Safe Haven locations. Some neighboring states allow police departments and fire stations to serve as Safe Haven locations-- this has created some confusion in our state, where only hospitals are recognized as Safe Haven locations due to rural police and fire stations not being staffed 24/7.

The Utah Newborn Safe Haven project met a few times with the advisory board members to address this ongoing challenge and to decide how to better use the current and additional funding that was procured at the last legislative session (February 2018). The Safe Haven Project and the advisory board decided the first priority was to create a new narrative that focused on hospitals being the only safe place to relinquish a newborn. Safe Haven staff along with some advisory board members formed a marketing subcommittee and worked on a new message. At this meeting it was decided that all outreach distribution efforts should be maximized by focusing on digital content, search engine marketing, social media targeted ads, and mobile technology accessibility. With the additional (ongoing) funding, the Safe Haven project and the advisory board subcommittee moved forward and contracted a new marketing vendor to develop the new digital campaign and to re-design all materials to create a uniform message with the new narrative. As part of the material redesign, the contracted advertising company developed a new mobile-friendly website landing page that matched the digital ad, to monitor user engagement, and visitor behavior and interaction with the new content.

During the run of this marketing strategy, the Utah Safe Haven ads had 816,480 visual impressions and 1,520 user interactions via search engine marketing, and 224,777 visual impressions and 6,798 user interactions via Social Media targeted ads. Overall the project website received 2, 320 visitors during the 2018 fiscal year, out of those users 2,280 were first time visitors and about half of them (1,237) accessed the website from a mobile device.

NOM 9 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

From 2013 to 2017, Utah saw 160 sudden unexpected infant deaths (SUID). This translates to a rate of 62.8 per 100,000 live births. In order to improve and standardize data collection of SUID cases, the Violence and Injury Prevention Program (VIPP) conducts statewide SUID surveillance, Sudden Death in Young (SDY) surveillance, and advanced fatality review. The Advanced Child Death Review Team is charged with reviewing and categorizing all SUID and SDY cases in Utah. Additionally, advanced autopsy guidance will be utilized by the Utah Office of the Medical Examiner (OME) and VIPP will work closely with the OME to ensure completion of the SUIDI form or SDY Field Investigation Guide. This will be provided to the VIPP will build on the current work to conduct violence and injury surveillance throughout Utah, disseminate the data to partners, and increase timeliness and quality of data, and greater utilization of data for prevention efforts. The overall goals of this project are to: 1) Increase data completeness, timeliness and case ascertainment resulting in a robust SUID and SDY surveillance system in Utah and 2) Increase policies and practices that are informed by SUID and SDY Case Registry data among partner agencies serving families and working to prevent sudden and unexpected infant and child deaths 3) Reduce the incidence of SUID and SDY in Utah.

In Fiscal Year 2018, MotherToBaby Utah educated clients about the risks of tobacco use during pregnancy and breastfeeding.

NOM 10 - Percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Through Utah's Power Your Life campaign, women are encouraged to stop using alcohol if they are considering a pregnancy.

Pregnancy Risk Line / MotherToBaby Utah provides information to providers and women about the risks of alcohol use during pregnancy. They work in collaboration with the Utah Fetal Alcohol Coalition to support projects and activities to educate women about alcohol use in pregnancy and breastfeeding and inform them of resources for families with children with Fetal Alcohol Spectrum Disorders including prevention, screening, diagnosis, treatment, and family support. During FY 2018, 3,096 English Alcohol brochures, 726 Spanish Alcohol brochures, 732 English Alcohol Tobacco and Other Drugs brochures, and 43 Spanish Alcohol Tobacco and Other Drugs brochures were distributed to families and providers. During FY2018, clients were educated about the risks of alcohol use during pregnancy.

Utah experiences a high frequency and intensity of binge drinking and a high rate of alcohol poisoning deaths. Through the Violence and Injury Prevention Program's (VIPP) Promoting Population Health through Increase Capacity in Alcohol Epidemiology, we aim to expand and maximize Utah's capacity in alcohol epidemiology, increase evidence-based strategies recommended by the Community Prevention Services Task Force and provide expertise and guidance to stakeholders and the public on excessive drinking and related harms. Alcohol has been one of the most widely used substances by youth in Utah. Similar to Utah adults, in 2017, adolescents report much lower rates of current alcohol use than the national average (8.8% of 8th, 10th and 12th grade students compared to 19.8% nationwide in 2016). The prevalence of binge drinking among youth who did drink (2017: 50.8%), however, was much closer to the national average (2015: 57.8%). The VIPP has published its first fact sheet looking at Excessive Alcohol Use in Utah.

VIPP staff attend the weekly Parents Empowered meetings which include representatives from all state agencies involved in preventing underage drinking and develops media campaign activities and local community mobilization projects around primary prevention. The VIPP has collected, analyzed and interpreted data of the following types to aid in prevention efforts:

- Youth and adult excessive alcohol use rates, including binge drinking among drinkers
- Adult intensity and frequency of binge drinking
- Alcohol attributable mortality
- Alcohol attributable hospitalizations and emergency department visits
- Number and location of alcohol outlets
- Alcohol related crash data and location

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

The Violence and Injury Prevention Program staff participate in Intermountain Healthcare's Opioid Community Collaborative. Funds are provided for two pilot programs in two separate counties targeting pregnant women with opioid dependence by providing medication-assisted treatment.

Utah added a variable to the birth certificate in 2016 to track maternal prescription drug use during pregnancy. The UWNQC Safety Bundle committee will be working with Utah and Wyoming facilities to implement the Obstetric Care for Women with Opioid Use Disorder bundle. There are bundle elements regarding neonatal abstinence affected infants.

The Utah Women and Newborns Quality Collaborative Neonatal Committee has done various projects to improve care for babies born with Neonatal Abstinence Syndrome. One key activity is developing a standard Neonatal Abstinence Syndrome protocol for hospitals statewide. The resource provides info on necessary systems changes, training, clinical care and tracking progress. This has been adopted by 9 out of 10 of the UWNQC participating hospitals. (http://health.utah.gov/uwnqc/pages/neonatal_resources.html). On the UWNQC website is a training class for all Utah providers: "The Opidemic: Our Role In Curbing This Devastation" which is a 2-1/2 hour core curriculum on prescriber education. In Fiscal Year 2018, clients were educated about medications used during current pregnancies or while planning a pregnancy to treat mental health conditions. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks, including neonatal abstinence syndrome, of medications for mental health and substance abuse conditions compared to the risks of untreated

conditions during pregnancy to promote healthy outcomes.

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner

The Child Health Advanced Records Management Program (CHARM) connects data from a variety of programs to present a consolidated record of newborn screening results such as newborn hearing and heelstick (ranges are included) and critical congenital heart defect (CCHD) results. Authorized private and public providers use the CHARM Web Interface (CWI) portal of the CHARM system to look up and view the child's health information/results from the above newborn screening tests to coordinate care and treatment. There is also a link to the Medical Home Portal (MHP) in the CWI. When a provider looks up a child's newborn screening results, they can click on the MHP link to find diagnostic and treatment information for newborn disorders. During the past grant year, the CHARM Program collaborated with the Utah Statewide Immunization Information System (USIIS) Program and added CCHD results in USIIS. This provides access to CCHD results to over 8000 users, including private and public health care providers. In addition, CHARM continued to collaborate on a data integration project with the Utah Early Hearing Detection and Intervention Program (EHDI) and Vital Records (VR) Programs called the “Birth Certificate Alert Project”. When parents apply for a birth certificate for their child at the state or local health department, a hearing screening alert is generated by CHARM if the child did not pass a hearing screening test, was not screened, or needs to complete the hearing screening process. When the birth certificate clerk sees the alert, he/she prints out a letter informing the parents or guardian that their child is in need of hearing screening follow-up and to contact the EHDI Program. From January 1, 2018 to June 18, 2019, there were 350 alerts generated to families. Out of these 350 alerts, 154 (44 %) families ended up completing the hearing screening process; 58 (16.6 %) are still in the process of completion. Out of the alerts generated, 73 of these babies resided in the NICU. For all 350 alerts, upon contact with family, six (2.6 %) families ultimately refused the screening. Out of those six, 6 (100%) were babies born out of hospital. This data linkage has improved follow-up efforts and care coordination for children that are deaf or hard of hearing.

A project that the CHARM Program collaborated and directed in 2017, continued in 2018. This project sends the clinical diagnostic audiology and Cytomegalovirus (CMV) test reports from Intermountain’s Electronic Health Record (EHR) system through the clinical Health Information Exchange’s (cHIE's) Direct Secure Messaging service to the Utah EHDI program. Through this integration, the EHDI Program can get the diagnostic audiology and CMV test result reports on 100% of the children in Intermountain’s EHR. However, during part of this past grant year, there was a gap in EHDI receiving these reports from Intermountain, due to an upgrade of their EHR system. The upgrade was recently completed and efforts to send the reports to the EHDI program has resumed. This project supports a mandate passed by the Utah State Legislature in 2013 to test all babies for CMV and provide appropriate follow-up and treatment within the appropriate time frame. Being able to obtain the diagnostic audiology and CMV reports from Intermountain electronically allows the EHDI Program to correctly complete Deaf and Hard of Hearing (D/HH) children's records in a more expeditious manner, so that these children can receive the timely treatment they need to maximize their developmental and communication potential.

Other activities of note:

Six years ago, the Utah Cytomegalovirus (CMV) Public Education and Testing Law (H.B. 81, 2013 General Session, UCA 26-10-10) went into effect. This two pronged mandate charges UDOH with the creation of a public education program to inform pregnant women and women who may become pregnant about the occurrence and transmission of CMV, the birth defects that CMV can cause, methods of diagnosis, and available preventive measures. Secondly, the law directs medical practitioners to test infants who fail the newborn hearing screen for congenital CMV (cCMV) and inform the parents about the possible birth defects that CMV can cause. Both the education and testing portions of this bill have made significant impacts for MCH/CSHCN priority populations including women, pregnant women, infants, children and teens. The law’s focus on educating women about CMV who are pregnant or might become pregnant is important in reducing the incidence of congenital CMV infection, an important contributor to low birthweight (LBW), preterm births, fetal and infant mortality, and children with special healthcare needs.

State educational efforts for CMV prevention awareness can directly affect the numbers of infants born with LBW/preterm/disability or stillborns by reducing the incidence of congenital CMV infections, which the EHDI CMV program is diligently working toward. Thus, the importance of educating women about CMV and ways to prevent its transmission during pregnancy is of paramount importance.

Since 2013, there have been many efforts to educate women and their primary care providers about ways to prevent transmission during pregnancy. Campaigns have included awareness signs in both English and Spanish billboards,

UTA buses and Trax, in targeted regions throughout the state. In addition, information has been included at many sporting venues including collegiate football games (the University of Utah, Utah State University, and Brigham Young University), basketball games, and gymnastics meets as well as professional sports including the Jazz, Stars and Bees, and performing arts playbills. Awareness campaigns have also been conducted in Megaplex and Cinemark theatres across the state in attempts to educate diverse populations. CMB awareness campaigns are also running in independent rural theaters in Vernal, Roosevelt and Heber, Utah.

Since social media is popular with younger adults and women of childbearing age, we have an active Facebook page, @CMVUtah, with some posts having more than 1,000 views. In addition, extensive information is available at the EHDI website health.utah.gov/cmv. Given the prevalence of social media use, paid boosted posts for surveys regarding women's knowledge of CMV and our educational campaigns has been used successfully, with 2700 survey responses obtained within 5 days during one campaign. Data on the number of babies with cCMV identified by hearing targeted screening began in July of 2013. Review of our data from the first years of our mandate shows a decreasing trend in the number of babies born with cCMV for this subset of infants, suggesting that public education efforts have been successful. Education efforts continue with a goal of impacting a decrease in other subsets of cCMV babies including symptomatic and NICU babies.

Since the mandate and its educational efforts, there has also been a marked increase in awareness of CMV among physicians, including neonatologists. In August of 2016, the University of Utah NICU (neonatal intensive care unit) providers began a symptom targeted screening for CMV. Two of the most common symptoms of cCMV in the NICU population are microcephaly and intrauterine growth retardation. Through our CMV Working Group we are coordinating efforts with the NICU and these targeted screenings are expanding to many hospitals across the state. This CMV Working Group developed a cCMV testing and follow-up flowchart which included the availability of a newly formed multi-disciplinary "Congenital CMV Clinic" at the University of Utah/Primary Children's Hospital.

We are also working together finalizing informational parent packets for the parents of cCMV babies identified by symptom and hearing targeted screenings. In 2018, 77% of NICU babies having just one of a list of possible CMV factors underwent CMV testing. Hearing targeted CMV testing has impacted the development and health of babies born with cCMV in Utah. Some of the babies who initially failed their hearing screening and were tested for CMV went on to have normal hearing. Since a hallmark of cCMV is progressive hearing loss, those children that tested positive for CMV but had normal hearing are closely monitored with frequent hearing testing. One such child began showing a mild hearing loss around 18 months which continue to progress. Had he not been identified as cCMV through our hearing-targeted testing, the identification of his hearing loss would most likely been delayed further impacting his speech and language development. In addition, all babies identified with cCMV are referred to Early Intervention. Early monitoring of their development is important since cCMV can also affect motor and cognitive development, cause seizures and affect vision. Starting July 1, 2013, any baby who failed the initial newborn hearing screen and subsequent outpatient screen or who failed the first screen after 14 days of life qualified for CMV testing. Our goal is that 100% of eligible babies be tested. During 2018, 96% of eligible infants received CMV testing.

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[1] Freeman VA. *Very low birth weight babies delivered at facilities for high-risk neonates: A review of Title V National Performance Measure 17*. Child Health Services Program, University of North Carolina at Chapel Hill; 2010.

[2] Payne, E., Garcia, S., Minkovitz, C., Grason, H., Karp, C., & Strobino, D. 2017: Women's and Children's Health Policy Center Johns Hopkins University: Strengthen the Evidence for Maternal and Child Health Programs. National Performance Measure 3 Risk-Appropriate Perinatal Care Evidence Review, 2017

[3] American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2012). *Guidelines for Perinatal Care (7th Edition)*. Elk Grove Village, IL.

[4] https://fpeutah.org/for-providers/

MCH Block Grant FY20 Application & FY18 Report

Perinatal/Infant Health

NPM-03: Perinatal Regionalization: *Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)*

FY20 Annual Plan:

Annual Plan:

Hospital Facilities in Utah self-designate their levels of perinatal care. Utah enacted a statewide mandate for collection of Very Low Birth Weight (VLWB) Infant Reporting data (Rule R433-1) in 2015. The VLBW data, along with the results from the CDC Levels of Care Assessment Tool (LOCATe) survey, will help to inform how to increase the percent of VLBW infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU). The report on VLBW data that includes morbidities associated with tertiary and non-tertiary birth locations will help to determine potential areas for quality improvement projects at hospitals. The recommendations on evidence-based interventions to address potential gaps will be reviewed to determine the capacity to implement.

Proposed Activities:

- Analyze two calendar years of hospital reported VLBW infant outcomes data and develop a VLBW report. This report will be shared with appropriate stakeholders, including the Utah Women and Newborns Quality Collaborative (UWNQC) Board and Neonatal Committee.
- Reviewing the way that VLBW data is collected in the REDCap database will help to ensure that it is an efficient process. This includes examining the process to ensure it works for both hospitals and the UDOH and provides the required data with minimal need to clean the data. Understanding how other states collect the data to determine potential best practices may be helpful.
- The UDOH is working on surveys going forward to be implemented in REDCap. REDCap is a secure web application for building and managing online surveys and databases which allows for robust data analysis and review. This will involve entering the most recent version of LOCATe into REDCap. There is also a new Intermountain Healthcare hospital scheduled to open by the end of 2020 that will be asked to complete the LOCATe survey.
- Analyze results from CDC LOCATe by linking outcomes by levels of care to determine if there are areas for potential quality improvement projects.
- MIHP will work to update Rule R432-100, General Hospital Standards, to reflect the most recent guidelines for levels of neonatal and maternal care. This was originally in our FY19 plan, yet our understanding is that updated maternal guidelines will be published within the next twelve months, so we plan to wait until these are published to update the rule.

NPM-04A & NPM-04B: Breastfeeding

NPM-04A: Breastfeeding: *Percent of infants who are ever breastfed*
NPM-04B: Breastfeeding: *Percent of infants breastfed exclusively through 6 months*

FY20 Annual Plan:

Maternal and Infant Health (MIHP) staff will continue to train hospitals and offer continuing support for the Stepping Up for Utah Babies breastfeeding program. The Stepping Up program manager, Nickee Palacios, will continue outreach to non-participating hospitals with a goal of training all remaining delivering hospitals during FY20.

Ms. Palacios will continue working with the EPICC program to create educational materials aimed at educating new moms and families about the Stepping Up program. These materials will be available through social media as well as printed materials that we will hand out at community events targeting breastfeeding mothers, such as Breastfeeding Cafes at local Farmer's Markets, and Big Latch events.

A major milestone was achieved in FY19 with Logan Regional Medical Center becoming the first hospital in Utah to successfully complete all ten steps and become a Breastfeeding Friendly Facility under the Stepping Up program. Their achievement has created a competition among the remaining Intermountain facilities so we anticipate more hospitals to achieve the Breastfeeding Friendly status in FY20.

The Utah WIC Program will continue the following activities in FY20: maintaining a statewide USDA goal to increase referrals to the Peer Counseling Program for all thirteen local agencies, documenting referrals to the Peer Counselor Program in the Utah WIC VISION computer system, each local agency will provide at least one training on breastfeeding, and additional lactation continuing education courses will be available to WIC staff as funds allow. The Utah WIC program will continue collaborating with the Utah Department of Health and community organizations.

The EPICC program will continue to assess new worksites on breastfeeding policy, accommodations, and leave time. In addition, the EPICC program will continue to partner with local health departments and worksites to provide information, resources, and technical assistance to help with the implementation of breastfeeding policy and accommodations. The EPICC program is currently working with the Utah Worksite Wellness Council to provide additional outreach to worksite within their network and list serve. EPICC plans to add additional breastfeeding questions in the worksite assessment surveys to ask if worksites are aware of the State and Federal Lactation laws. This will allow for a targeted-focused approach that can be made to those unaware of the law. EPICC plans to continue to present on breastfeeding support in the workplace at local conferences and chambers of commerce when possible.

Proposed Activities:

- The MIHP will continue to train hospitals and offer continuing support on the Stepping Up for Utah Babies program.
- All thirteen local agency WIC programs will increase referrals to their Peers Counseling Program, document referrals to the Utah WIC Peer Counseling Program in the WIC computer system, each local agency will offer at least one training on breastfeeding, and additional lactation continuing education courses will be available to WIC staff as funds allow.
- The EPICC program will continue to assess new worksites on breastfeeding policy, accommodations, and leave time.
- EPICC plans to add additional breastfeeding questions in the worksite assessment surveys to ask if worksites are aware of the State and Federal Lactation laws. This will allow for a targeted-focused approach to worksites who are unaware of the current laws.

SPM-01: Preterm Birth: ***Percent of live births occurring before 37 completed weeks of gestation***

FY20 Annual Plan:

The Reduce Preterm Birth (PTB) Committee of the Utah Women and Newborns Quality Collaborative (UQNQC) will continue to track data on the use of progesterone to prevent recurrent preterm birth. The participating hospitals submit data to the UDOH via a REDCap database on the number of women with a history of PTB who were offered and utilized progesterone (17-P) in their current pregnancy. This data will guide quality improvement efforts in ensuring eligible women are offered the treatment. The strategy includes working across health systems in engaging key stakeholders, collecting data, launching 17-P quality improvement projects, educating providers, and providing resources. Intermountain Healthcare, whose hospitals host over 50% of annual births in Utah, has been leading the way in piloting data collection and education outreach. Other health systems, such as the University of Utah, have implemented questions into the H & P (History and Physicals) of their EMR (EPIC) to track 17-P utilization at their hospital.

Proposed Activities:

- UWNQC is a state-wide network of professionals, hospitals, and clinics dedicated to improving the health outcomes for Utah women and babies using evidence based practice guidelines and quality improvement processes. The Reduce PTB Committee of UWNQC will continue to collect PTB data from the birth certificate to assess the percentage of women who have had a previous PTB and received 17-P, a type of synthetic progesterone used to treat women at high risk for PTB.

- The Reduce PTB Committee of UWNQC will reengage 17-P Quality Improvement (QI) Teams at hospitals to identify team members at each site to include: a champion, Obstetrician provider, nursing staff, and an administrative resource. The committee will work with these teams to verify they have the resources needed to improve their rates of increasing 17-P utilization. They will determine the potential of piloting a project at a clinic.

- The UWNQC Reduce PTB Committee will work with a major health system to conduct an audit comparing the data received from this health system to the data on the birth certificate to understand the discrepancy and recommend how to get the numbers more in sync.

- MIHP will work with a CDC fellow to quantify the return on investment for reducing PTB. This data will be helpful in working with caregivers in high risk areas to show them the benefits of implementing strategies to reduce PTB.

- The Reduce PTB Committee will examine the potential of collaborating with a high risk population such as Medicaid, WIC, or Home Visiting. The ability to reduce the PTB rate in a high risk population will help address health equity. It Takes a Village program for Native Hawaiians and Pacific Islanders was the only program in Utah to be named a “Promising Practice” by the Association of Maternal and Child Health Programs. The goal of this program is to find a champion in the community to take the lead for the program and the Utah Office of Health Disparities has also reached out to the refugee community as a potential to replicate the program.

- UWNQC’s Reduce PTB Committee will continue to support the work of the Family Planning Elevated at the University of Utah. In an effort to improve the intended pregnancy rate across the state of Utah, Family Planning Utah expands access to contraceptive education, training, and services for Utah providers and patients. They offer various provider trainings which are publicized and attended by UWNQC participants. The committee will also assist with the implementation of the Family Planning-House Bill 12, which enacts provisions for family planning services for Utah Medicaid recipients.

- On March 20, 2019, the executive director of the UDOH signed a statewide standing order allowing pharmacists to dispense contraceptives in the form of pills, patch, or rings to women ages 18 or older. Through this standing order, any woman can walk into a participating pharmacy and purchase hormonal contraception without needing a prescription. Women will be able to receive birth control pills, contraceptive patches, or vaginal rings from participating pharmacists after they complete a health history form, have their blood pressure taken, and talk with the pharmacist about which contraceptive method will work best for them.

Patients will still be responsible for covering the cost of their medications and the consultation with the pharmacist, either by utilizing insurance coverage or paying out of their pocket. Women will be required to provide proof of a visit with their health care provider every two years. The impact on this standing order will be reviewed on unintended pregnancies along with the effect on PTB.

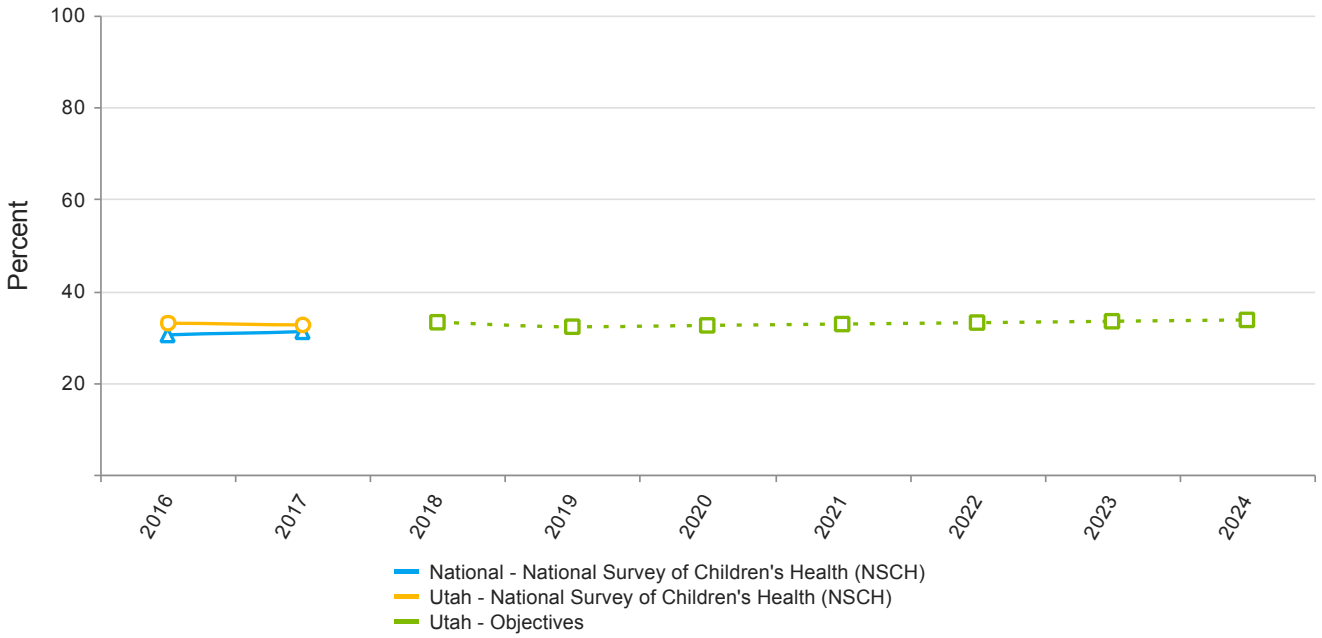
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.3 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			33.2
Annual Indicator		33.1	32.6
Numerator		38,611	32,987
Denominator		116,514	101,171
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	32.2	32.5	32.8	33.1	33.4	33.7

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		1,475	1,689
Annual Indicator	1,414	1,601	1,601
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

ESM 6.2 - Home visitors training on the use of the ASQ developmental screening tool: Number of ASQ screenings conducted by home visitors

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		3,000	2,028
Annual Indicator	2,693	1,930	1,930
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

ESM 6.3 - Help Me Grow Utah (HMGU) ASQ screenings: Number of ASQ screenings conducted by Help Me Grow Utah (HMGU) staff

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		4,000	3,500
Annual Indicator	3,733	3,178	3,178
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

ESM 6.4 - Healthcare provider well-child checks: Number of ASQ online screenings done during well-child checks

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		300	350
Annual Indicator	267	299	299
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

ESM 6.5 - Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	45.0	55.0	65.0	75.0	85.0

ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	198.0	218.0	240.0	264.0	291.0

State Performance Measures

SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		14.7	15.1
Annual Indicator	15.1	15.8	15.7
Numerator	144	152	152
Denominator	950,511	960,913	967,283
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	14.9	14.5	13.9	13.5	13.0	12.5

State Action Plan Table

State Action Plan Table (Utah) - Child Health - Entry 1

Priority Need

Developmental screening (continuation of old SPM5)

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By 2020, increase the Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year from 33.1% (NSCH, 2016) to 33.4%.

Strategies

1. Continue to offer on-site follow-up and technical assistance to early care and education providers in the implementation of developmental screening in their programs.

2. Continue to train home visitors (Targeted Case Managers, Family Spirit, and Parents As Teachers Providers) on use of the ASQ screening tool and provide follow-up support and ASQ materials to assist them in implementing developmental screening.

3. Continue to provide financial support to Help Me Grow Utah (HMGU) to conduct community outreach and enroll families in developmental screening using the ASQ tools.

ESMs	Status
ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers	Inactive
ESM 6.2 - Home visitors training on the use of the ASQ developmental screening tool: Number of ASQ screenings conducted by home visitors	Inactive
ESM 6.3 - Help Me Grow Utah (HMGU) ASQ screenings: Number of ASQ screenings conducted by Help Me Grow Utah (HMGU) staff	Inactive
ESM 6.4 - Healthcare provider well-child checks: Number of ASQ online screenings done during well-child checks	Inactive
ESM 6.5 - Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.	Active
ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Utah) - Child Health - Entry 2

Priority Need

Injury and injury-related deaths

SPM

SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)

Objectives

By 2020, decrease the rate of injury deaths among children and adolescents ages 1-19 from 15.8 per 100,000 (Utah 2016 Death Certificate data) to 14.5 per 100,000. (Due to overlap of ages across both the child and adolescent domains, Utah has chosen to assign this indicator to the Child Health Domain.)

Strategies

1. Provide funding to 13 local health departments to conduct local prevention activities.
2. Provide surveillance data and information on childhood injuries and deaths to partners, policy makers, and media.
3. Continue to co-chair and provide technical assistance to the Utah Teen Driving Task Force.
4. Evaluate the effectiveness of the motor vehicle parent night program being offered at various schools in Utah.
5. Publish the annual Teen Memoriam book.
6. Provide education, awareness, and prevention activities to children 1-19 and their parents.
7. Conduct media campaigns targeting parents of 15-17-year-olds to encourage parents to be more involved in driver education training and to better understand Utah's graduated drivers licensing law.
8. Use social and traditional media platforms to educate Utahns about child injury prevention laws and strategies to prevent injury death.
9. Continue to review 100% of all child injury deaths to improve response and develop recommendations for prevention and system change.
10. Provide evidence-based suicide prevention programs to youth ages 12-19.

MCH Block Grant FY20 Application & FY18 Report

Child Health Domain Annual Report

NPM-06: Developmental Screening: *Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool*

FY20 Annual Report

Program Activities:

The Performance Measure for NPM-06 was not quite achieved. The Performance Objective was 33.3% and the Annual Indicator was 32.6% of Utah's infants and children (ages nine months through 35 months) received an age-specific developmental screening annually, according to Federally Available Data. The new Performance Objective for NPM-06 is to increase the percent of infants and children (ages 9 months through 35 months) receiving age-specific developmental screening to 33.1%.

The lead agency's programmatic efforts to address this priority need are routinely performed by the UDOH, Bureau of Maternal and Child Health's (MCH) program named, Early Childhood Utah (ECU). ECU is comprised of two distinct teams. One team consists of three UDOH staff members, known as the ECU State Team. The ECU State Team coordinates various activities aimed at improving Utah's early childhood system. The ECU State Team also engages in activities designed to promote early childhood developmental health.

The other team, named the Early Childhood Utah Advisory Council, is the Governor's Early Childhood Advisory Council which has been formed according to the rules and regulations found within the Head Start Act pertaining to each state’s Early Childhood Advisory Council. Utah participates in the Federal ECCS grant. ECCS grant activities also focus upon improving the developmental health of children, ages 0-3, which reside in communities that are wrestling with significant social and health disparities. The composition and activities of this team are also guided by the requirements of the HRSA/MCH Early Childhood Comprehensive Systems Grant (H25MC00268-"ECCS"). The ECU State Team is comprised of a Program Manager, a Promoting Developmental Health Program Coordinator, and an Early Childhood Integrated Data System Program Coordinator. The activities assigned to all three of these roles contribute toward Utah’s efforts at meeting the objective of NPM-06.

During this reporting timeframe, the ECU Program Manager (ECU PM) actively engaged in efforts to improve the overall coordination of the early childhood service delivery system in Utah. The logic is, if early childhood systems are effectively coordinated, universal best practices will dictate regardless of where a family with young children may live, they will have the opportunity to learn how important it is for infants, toddlers, and preschoolers to achieve age-specific developmental milestones. The family, child, and caregivers will also have consistent access to developmental screening opportunities to guide and monitor their child's progress.

One strategy for improving the early childhood service delivery system in Utah is the effective orchestration of the ECU Advisory Council. The PM assures that the ECU Advisory Council is consistently staffed with representation from over thirty different early childhood agencies and/or programs. The ECU PM provides oversight for the work of six ECU Advisory Council Subcommittees. The ECU PM also assists with developing strategic work plans and timelines for the advisory and subcommittees and for tracking and reporting upon ECU’s progress toward achieving our co-created objectives, thereby creating a continuous quality improvement (CQI) feedback loop.

The ECU Advisory Council’s articulated mission is “to promote broad statewide coordination and collaboration

among a wide range of early childhood programs and services in the state to ensure that Utah children enter school healthy and ready to learn." Representatives from the agencies and programs that participate in the ECU Advisory Committee concur that one of the most effective strategies to ensure Utah children enter school healthy and ready to learn is to support frequent developmental screening for infants, toddlers, and preschoolers and to ensure that any family with children that may be in need of supportive social and/or health services, receives it.

One of the tangible steps the ECU Advisory Council agencies takes to support frequent developmental screening and referral to any needed services is to support, market, and fund the mission and activities of Utah's Help Me Grow program. The Department of Workforce Services/Office of Child Care, the Department of Human Services/Division of Child and Family Services, and the UDOH's MCH Bureau all fund and support Help Me Grow Utah (HMG) activities.

HMG's informed practices help identify families with young children that may need assistance with accessing a developmental screening opportunity and if challenges are discovered, and if the family is willing, HMG assigns a care coordinator to help families navigate the complex landscape of applicable programs and services. HMG provides resources and referrals to families that have the potential of improving a child's developmental health and trajectory.

HMG collects comprehensive data regarding the families they assist. The data includes the number of families who contacted HMG for assistance related to a developmental concern and the disposition of the intake (i.e., the parent/caregiver received helpful information and/or was connected to related services). HMG also provides valuable demographic data such as 1) the age of the child/children the concern was regarding, 2) who called, 3) how the caller discovered HMG resources, 4) the reason/issue for the parent's request for services, 5) how many referrals HMG provided for residents of the PBC, 6) data disaggregated for the number of referrals per issue, 7) barriers related to receiving information and/or services, and 8) race/ethnicity data.

The ability for HMG and an additional forty (actively screening) early care/education and health providers to offer development screening opportunities for children across the state is made possible through the Child Care Development Block Grant through the Department of Workforce Services/Office of Child Care and through the HRSA/MCH ECCS funds granted to the UDOH.

The opportunity for early care and education providers to facilitate age appropriate development screening opportunities is powered through the lead agency's Ages and Stages Questionnaire (ASQ) database/online enterprise account (via Brookes Publishing). Since 2011, UDOH has enrolled over 160 early care and education providers, at no cost to their agency/program, in our Promoting Developmental Health Program. Enrolled early care and education providers include pediatricians, federally qualified pediatric community health centers, hospitals, MIECHV home visitors, Medicaid-targeted case management, county health departments, child care and head start providers, school districts, and beyond.

While the lead agency may not have fully met the performance objective for NPM-06, developmental screenings (ASQ-3), captured by the UDOH ASQ account, for 0-3 year olds, has steadily increased. According to the UDOH ASQ database, in 2016, 5,992 0-3 year olds, across the state, received an ASQ-3 screen. In 2017, 7,777 0-3 year olds received an ASQ-3 screen. In 2018, 8,892 received an ASQ-3 screen. This statewide ASQ-3 data represents a 48% increase in 0-3 year olds receiving an age appropriate developmental screen between 2016 and 2018.

As stated earlier in this section, the UDOH also participates in the HRSA/MCH-ECCS grant. Through the ECCS grant, UDOH and our designated early childhood partners target developmental screening efforts in three marginalized communities. From 2015 to 2018, ASQ-3 screens for 0-3 year olds residing in these communities

grew by 402% (from 49 to 246). One community, also a recipient of the Federal Rural Impact Grant (San Juan County), went from one ASQ-3 screen captured by the UDOH ASQ account in 2016, to 100 ASQ-3 screens entered into the UDOH ASQ account in 2018.

The activities and improvements presented above can be attributed to the investments the UDOH (and our partner agencies) are making to promote developmental health for Utah's infants, toddlers, and preschoolers. These investments are not only financial, the UDOH and our early childhood stakeholders spend a considerable amount of time analyzing developmental screening data and engaging in the CQI process. Promoting the developmental health of children in Utah goes well beyond NPM-06. Yes, the lead agency intends to increase the number of children receiving age appropriate developmental health screens, but equally as important, UDOH aims to improve the percentage of children scoring above the cutoff mark. The path to accomplish this aim will be described in the UDOH annual plan for July 2019-June 2020.

Accomplishments / Successes:

From July 2017 - June 2018 The Early Childhood Utah (ECU) program at the Utah Department of Health (UDOH) continued to offer financial support and technical assistance to Help Me Grow Utah and to MIECHV Home Visiting caregivers. ECU engaged in ASQ online onboarding activities and provided additional training and to a variety of early care and education providers such as Federally Qualified Community Health Centers, school districts, childcare providers, Head Start, hospitals, pediatricians, etc.

One can attribute the positive trending data listed in the previous section and just below to the developmental health promoting activities of ECU and our many early childhood partners and stakeholders.

Between July 1, 2017 and June 30, 2018; 6,649 nine-month through thirty-five month olds received a developmental screen (ASQ-3 and/or ASQ-Social Emotional) as per the statewide UDOH-ASQ online account. Just as important to focus upon, 66.3% (4,414) of those children had scores in the developing age appropriately range, 19.2% (1,283) of those children were in the monitoring range and, corresponding with national data, there were significant developmental concerns for 14.3% (952) of the children that received an age aligned development screening through UDOH-ASQ early care and education providers.

As described in the previous section, ECU works directly with Help Me Grow (HMG) to increase the number of families and children that have an opportunity to receive age aligned development screening opportunities, growing and learning resources and if needed, care coordination such as helping families connect to early intervention providers. Preliminary data analysis reveals that ECU's ongoing working relationship with HMG may lead to an increase in the number of young children receiving age aligned developmental screens and connections to the most applicable resources.

Between July 1, 2017 and June 30, 2018, HMG facilitated 2,964 age aligned developmental screens. Over the course of FY 2015-2018 HMG facilitated 10,509 age aligned developmental screens in Utah and all of those families/children received access to developmental health resources and care coordination.

The synergistic, positive effects of funding and co-training a part time WIC intake employee with a part time HMG care coordinator is becoming evident in one of Utah's ECCS collective impact communities, San Juan County. In this frontier, poverty stricken, low resourced yet beautiful, and grand community, in 2016, 0 children were referred to HMG. However, after our collective 'intervention' throughout 2017, 43 (0-3) children were referred to HMG, and in 2018, 48 (0-3) children were referred to HMG (923, 0-3 year olds reside in San Juan County). All of these families/children were connected to no-cost, development health promoting activities, screening services, and care

coordination.

Working effectively with our MIECHV and other early childhood partners throughout the state is also paying dividends. In another ECCS targeted-impact urban community (Ogden, UT - 84401; with 1,722 0-3 year olds) age aligned development screens increased from a total of 83 in 2015 and 2016 combined to 228 in 2017 and 2018 combined, a 175% growth rate (for 0-3 year olds, ASQ-3). Our MIECHV partners in this community, Prevent Child Abuse Utah (PCAU), contributed 0 screens to the UDOH ASQ online account in 2015, 8 in 2016, 37 in 2017, and 59 in 2018, displaying much improved participation and investment in the UDOH ASQ online database and Utah's early childhood system of care (the PCAU data is for 0-3 year olds, ASQ-3).

One additional example of a blooming early childhood developmental screening relationship is portrayed by ASQ data received from our county health department partners in Davis County, Utah. From 2015 to 2018, Davis County Health Department completed 4,680 age aligned screens, 84% (3,929) of those screens were completed in 2018 alone. UDOH and ECU believe this data demonstrates the forward momentum that Utah is achieving with regards to increasing the number and percentage of screens 9 month through 35 month year olds receive.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-06:

- Throughout FY18, 6,649 nine-month through thirty-five months old received an age aligned developmental health screen through the UDOH ASQ online account (ASQ-3 and ASQ SE).
- 85.5% of the 6,649 screens were above cutoff or in the monitoring zone.
- From 2015 to 2018, Help Me Grow Utah facilitated 10,509 age aligned developmental screens (ASQ-3 and ASQ-SE; all intervals/all ages).

Challenges / Gaps / Disparities:

Challenges

Challenges that temporarily impeded developmental screening progress in Utah are related to the lead agency's ambition to "clean up" the UDOH ASQ online account's privacy policy and parental disclosure/consent documentation. Prior to this process, issues of data ownership and data use may have been unclear to caregivers and parents. In order to mitigate this circumstance, UDOH's legal counsel and our privacy and security team spent a considerable amount of time reviewing three Brooke's Publishing documents: 1) the Family Access End User License Agreement, 2) Terms of Use, and 3) Privacy Policy.

After this thorough legal review, UDOH decided the best path forward would be to create our own ASQ Privacy Policy and Consent to Use of Data documentation and to create multiple and very apparent links on each enrolled program's ASQ online landing page that families access to complete age aligned developmental screening. The link to the UDOH ASQ disclosure, consent, and terms of use document will be available alongside the link to the "hard-coded" Brooke's disclosure and data use document.

UDOH is currently in the process of assessing each enrolled programs intention of remaining enrolled and active in the UDOH Developmental Health Promotion Program (ASQ program) and updating each program's landing page with the new UDOH disclosure, consent, and terms of use document.

The document review and development process described above took 4 months (April-July) to accomplish and enrollment of new programs into the UDOH ASQ online account was paused during this time.

Another advantage to engaging in this "clean up" process revolves around the lead agencies desire to produce

enhanced ASQ reports and to engage in outcome research related to our developmental health promotion program.

With the permissions that were already in place via the Brooke's publishing documents, the lead agency is currently in the process of integrating ASQ data with our Early Childhood Integrated Data System. These integrated data reports will give the lead agency increased insights into the distinct number of children that receive ASQ screens, what type of early care, education and referral services these same children receive, and in which order or sequence the services are received in. Phase I participating agencies include Head Start, WIC, Home Visiting, Help Me Grow, and Child Care.

In addition to the integrated data reports described above, the lead agency is investing in the development of enhanced ASQ reporting functionality. These enhanced ASQ data reports will give the lead agency a much easier way to assess which programs are actively screening children, determine where these programs are located, as well as much improved methods for discovering the results of screening activities i.e., above cutoff, monitoring zone, below cutoff.

Finally, in the near future, meeting the challenge of "cleaning up" our ASQ disclosure, consent and terms of use documents will better position the lead agency to engage in outcome research related to the efficacy of promoting developmental health and screening services. For example, were children that received developmental screening and any applicable follow up services able to avoid remedial and/or special education services in the K-3 environment.

Emerging issues

Utah's population base is rapidly shifting from a predominantly white to a more racially diverse population. Utah is also welcoming and accommodating to refugee resettlement efforts. As such, the lead agency and our partners often encounter language barriers when it comes to facilitating a parent involved screening tool such as the ASQ. ASQ materials are readily available in Spanish, but our refugee population represents dozens of languages ranging from Somali and Sundanese to Arabic. At times, our ASQ providers have access to interpreters that can assist with translation, but much of the language and tasks involved in completing a developmental screening are not easy to translate across languages nor cultures. This emerging issue has been quite apparent in one of our ECCS collective impact communities, South Salt Lake, a new home for many refugees.

Additional emerging issues relate to concerns about data security. Our ASQ providers share families' concerns with us. Families are worried about data breaches and the potential exploitation of their personal data. Families are also fearful of the "government" using their data to identify and deport them.

The lead agency has created a method for parents to opt out of completing developmental screens for their children online, instead parents can complete age aligned screens via paper forms. The downside to this approach is that UDOH is unable to capture this informative screening data. The upside is additional children receive the opportunity to participate in developmental screening and referral to any services that may be applicable.

Agency Capacity / Collaboration:

Early Childhood Utah (ECU) is the program at UDOH that orchestrates the lead agency's developmental health promotion program. ECU is also the program designated by the Governor's office to function as the State Advisory Council on Early Childhood, otherwise known as the Early Childhood Utah Advisory Council. Due to our unique position as the body responsible for improving early childhood systems, we work closely with dozens of agencies and programs that provide myriad services to families with young children. Promoting healthy development and ensuring all children have consistent access to age aligned developmental screening is a high priority for this

collaboration.

ECU works strategically with the agencies and programs listed below, most of these agencies/programs also report back to their own advisory and subcommittees which include teams of parents, families, and/or service consumers:

The Utah Office of Child Care, Weber State University, Maternal Infant Early Childhood Home Visiting, Medicaid Targeted Case Managers, the Utah Chapter of the American Academy of Pediatrics, the Governor's Office and Legislators, United Way, Help Me Grow Utah, Child Care Resource & Referral Agencies, the City of South Salt Lake, the Ogden United Promise Neighborhood Prenatal to Three Committee, the San Juan County Early Childhood Commission, the Head Start Association and Collaboration Office, Intermountain Health Care, Midtown Community Health Clinics, Voices for Utah Children, Utah Navajo Health System, School Districts, Division of Human Services, and Early Intervention Part C IDEA, Utah State Board of Education, and County Public Health Departments.

Summary Progress Report (2019) of ESMs related to NPM6

The following four ESMs have been deactivated.

ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers

ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers

ESM 6.3 - Help Me Grow Utah (HMGU) ASQ screenings: Number of ASQ screenings conducted by Help Me Grow Utah (HMGU) staff

ESM 6.4 - Healthcare provider well-child checks: Number of ASQ online screenings done during well-child checks

**These measures were deactivated and replaced as the data was too difficult to extract from the database. New measures have been developed that more accurately reflect current activities.*

Two new ESMs have been created this year:

ESM 6.5 – Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.

Goal/Objective:

Increase the participation of enrolled programs in the UDOH ASQ online account by 10%.

Significance of ESM 6.5:

By increasing the percentage of enrolled programs that actively participate in the UDOH ASQ online account, UDOH will gain an improved ability to track and increase the number of age aligned developmental screens that 9 month-35 month olds receive. The percent of enrolled programs that contributed any screening data to the UDOH ASQ online account in calendar year 2018 was 25%, which is 41 out of 163 enrolled programs.

ESM 6.5 Progress Report:

This ESM has been revised to include the objective of increasing the percentage of enrolled programs that are actively contributing screening data to the UDOH ASQ account.

Help Me Grow is already the second highest active contributor to the UDOH ASQ online account, they contributed 2,879 screens in 2018.

UDOH can more effectively increase the number and percentage of screening data received by the UDOH ASQ account by targeting efforts toward increasing the screening activity of inactive, yet enrolled programs. In calendar year 2018, 163 programs were enrolled, but only 41 (25%) programs contributed any screening data to the UDOH ASQ online account. Active will be defined as a program contributing any ASQ-3 and/or ASQ-SE data to the UDOH ASQ online account within a 12-month period.

ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.

Goal/Objective:

Increase the number of new programs enrolled in the UDOH ASQ online account by 10%.

Significance of ESM:

If additional programs are enrolled and actively participate in the UDOH ASQ online account, UDOH may increase the number of 9 month through 35 month olds receiving an age aligned developmental screening. The effectiveness of this strategy will be measured by the increase in the number of new programs enrolled in the UDOH ASQ online over a 12-month time frame. At the end of calendar year 2018, 163 programs were enrolled in the UDOH ASQ online account.

ESM 6.6 Progress Report:

Connecting with childcare providers, after they have participated in a developmental screening class, to offer ASQ materials, training, and technical assistance is a good strategy. However, it is difficult to measure and may not help us achieve the end objective. At this time, developmental screening classes are not widely nor frequently available.

UDOH will continue to outreach to childcare providers that participate in developmental screening classes. UDOH will also outreach to early care and education providers such as targeted case management providers, pediatricians, community health clinics, school districts, etc. in order to increase the number of programs that are participating in the UDOH ASQ online account.

Progress toward meeting this goal will be measured by the number of new programs that enroll in the UDOH ASQ online account. If additional programs are enrolled and actively participate in the UDOH ASQ online account, UDOH may increase the number of 9 month through 35 month olds receiving an age aligned developmental screening.

SPM-03: Child Injury Deaths: ***The rate (per 100,000) of injury deaths among children aged 1-19***

FY18 Annual Report

Program Activities:

Strategy 1. Provide education, awareness, and prevention activities to children 1-19 and their parents.

In addition to strategies that the Violence and Injury Prevention Program (VIPP) directly implements, VIPP also contracts with 13 local health departments (LHD) and several community based organizations (CBO) to provide education, awareness, and prevention activities to children ages 1 to 19 years and their parents.

During the reporting period, LHD's provided several suicide prevention training sessions as part of their suicide prevention activities targeting children and their parents. These included 110 Question, Persuade, and Refer sessions with 3,039 reached, two SafeTALK sessions with 55 reached, and three Mental Health First Aide trainings with 56 reached. Furthermore, LHDs collaborated with school districts to support and coordinate activities with local hope squads reaching 3,695 children. Finally, LHDS distributed 810 gun locks to residents in their communities. Several CBOs implement primary prevention programs that include bystander intervention and healthy relationship education. More than 943 unique cycles of healthy relationships education were implemented during the reporting period.

Safe Kids Utah (SKU) is a non-profit organization that strives to reduce unintentional injuries in children and teens. SKU has been serving the kids of Utah for over twenty years and has been dedicated to finding innovative ways to educate Utahns on how to keep kids safe from unintentional injuries. SKU is the leading non-profit organization in the state when it comes to car seat and active transportation safety. SKU works to educate parents about child passenger safety and in order to do this successfully, they work with 13 local Safe Kids coalitions throughout Utah. These coalitions work hard to provide accurate information to their communities. During the reporting period, SKU and the VIPP engaged in the following media and public awareness efforts: 1) Avoid a Deadly Summer – Tips to prevent injuries during the summer months, 2) Fireworks are Exciting but Injure More than 3,500 Children Each Summer –
Safe Kids Utah reminds parents to be prepared and follow top safety tips, and 3) Safe Infant Sleep – Tips for parents on the safest ways to put their baby to sleep.

To promote Child Passenger Safety Week, several activities were conducted throughout the state to support car seat checkpoints and help local health department staff with training and certification. These included community free events such as, "Ask the Car Seat Expert", Car Seat Checkpoints, Car Seat Education, and Car Seat Classes, sponsored by SKU. A total of 333 car seats were disseminated to low-income families. In addition, three Child Passenger Safety Course trainings were held to certify advocates to train caregivers on how to properly install car seats (65 individuals trained). Child Passenger Safety Technicians trained came from hospitals, health departments, local fire and police, retail, health plans, head starts, and unaffiliated advocates.

In addition to child passenger safety activities, parent night programs are conducted as part of the driver's education curriculum to bring awareness and educate parents and students on deadly driving behaviors and Utah Graduate Driver's Licensing laws. To complement efforts related to motor vehicle crashes, LHDs conducted seatbelt observation studies that helps leverage funds from the Highway Safety Office to conduct additional seatbelt studies throughout Utah.

Other efforts to provide awareness and education in Utah include pre-conference and conference planning for Zero Fatalities and Four Corners without Borders. Pre-conferences provide an opportunity to help keep Child Passenger Safety Technicians, particularly in rural areas, keep up-to-date on their skills, and obtain CEUs for recertification.

Strategy 2. Provide funding to thirteen local health departments to conduct local prevention activities.

VIPP partners with thirteen LHDs to establish injury prevention priorities, strengthen local injury prevention program capacity, develop community-based injury prevention projects, and implement evidence-based programs. The current VIPP Strategic Plan addresses priority areas across the MCH service areas and include: child maltreatment, infant sleep, school-related injuries, motor vehicle crashes, suicides, teen dating violence, prescription drug overdoses, sexual assault and family violence, traumatic brain injuries, and youth sports concussion.

MCH funding enables local health departments to maintain a basic level of violence and injury prevention programmatic efforts by supporting a portion of an FTE for an injury prevention coordinator across all thirteen local health departments. MCH funding supports eight local health departments to serve as the lead agency and coordinator of local Safe Kids coalitions. Funding was allocated based on the approved funding formula for local health departments. All thirteen local health departments were required to conduct activities and implement evidence-based programs in the areas of child passenger safety, teen driver safety, suicide prevention, and distribute child injury messages through traditional and social media platforms.

The majority of these funds are used to implement evidence-based programs or promising practices for teen driving, child passenger safety, Safe Kids focus areas for unintentional injuries (water safety, sports safety, school related-injuries, etc.), teen suicide prevention, traumatic brain injury and youth sports concussions, firearm safety, suffocation, etc. Much of the partnerships and implementation of these activities are done by Safe Kids Utah and the local Safe Kids coalitions throughout the state.

Strategy 3. Conduct media campaigns targeting parents of 15-17 year olds to encourage parents to be more involved in driver education training and to better understand Utah's graduated drivers licensing law.

For the past 11 years, VIPP, the Utah Department of Transportation Zero Fatalities Program, and Utah Teen Driving Task Force have worked closely with parents and families who have lost a teenager in a motor vehicle crash to tell their stories in a memoriam book, in addition to prevention messages. This culminates in a Teen Memoriam lunch with current and previous families who are provided information about grief support and available services. Grief counselors present on the stages of grief and families are provided an opportunity to share their story. This event creates an informal space for the families to connect and receive support. The families become a support network for each other and have expressed their appreciation and comfort in being able to share their story with others.

The goal of the effort is to personally meet with the participating families, provide grief resources, and help support their prevention messages to other families and young drivers. We held the event in November 2018 to share stories of families who lost a child in a motor vehicle crash in 2017. Additionally, we work closely with the media contractor to evaluate the parent seminars in Utah high schools and the parent night programs as part of the driver’s education curriculum to bring awareness and educate parents and students on deadly driving behaviors and Utah Graduate Driver’s Licensing laws.

Strategy 4. Provide surveillance data and information on childhood injuries and deaths to partners, policy makers and media.

VIPP identifies school injuries through the Student Injury Reporting System (SIRS). The SIRS is an online database

that helps to identify where, when, how, and why students get hurt at school. The SIRS database identifies reportable school injuries as an injury that caused the loss of at least one-half day of school and/or warranted medical attention and treatment from a school nurse, physician, or other health care provider. VIPP has provided this database as a free resource for schools to house their injury data. An online system (https://sir.health.utah.gov) contains data starting on September 1, 2011. Users of the SIRS include Risk Managers at each of Utah's 41 school districts, school staff (such as principals, secretaries, coaches) at more than 800 Utah public schools. Data collected includes school district and number, date and time of injury, sex, aid that was given to the student, contributing factors of the injury, and activity during which the injury occurred.

While the SIRS holds a large amount of data regarding student injuries at school, data users and school districts had no way to easily explore, analyze, or display their data to better understand what it means. To increase availability of the data, the VIPP and the Office of Public Health Assessment launched a queryable system on the Indicator Based Information System for Public Health (IBIS) for school districts to use to look at their own student injury data since 2012. School district data is queryable at the school level, and users can look at variables such as grade, student sex, injury type, contributing factors, period, surface type, activity, number of days absent and actions taken. Additionally, the system allows school districts to populate graphs for better data use.

The VIPP is developing a user-friendly guidance on how to run various data queries using IBIS. The VIPP hopes this new data query system allows school districts to better use and understand their student injury data, ultimately making better, data-informed decisions on how to keep Utah students safe.

In addition to student injuries, VIPP took the lead in developing the 2017 Utah Adolescent Health Report using data from the Prevention Needs Assessment (PNA), a survey administered in Utah public schools in grades 6, 8, 10, and 12 on substance abuse, violence, injury, and chronic conditions. The data included in the report shows adolescent rates for important health indicators by local health district, grade, and sex. Results on selected indicators from violence and injury-related categories included: mental health (feeling sad or hopeless, psychological distress, suicide ideation, suicide plan, and suicide attempt), substance abuse (binge drinking, marijuana use, and prescription drug abuse), and violence and injuries (driver talking on cell phone, driver texting, seat belt use, bullied at school electronic bullying, and dating violence). The data presented in this report are expected the help school administrators, teachers, and public health practitioners identify health and safety needs of Utah students and take steps towards protecting and improving student health.

VIPP staff participated in developing the 2017 Youth Risk Behavior Survey (YRBS) report which includes key finding and recommendations for creating healthy, safe, and supportive environments where students can focus on learning. Similar to the PNA, the YRBS is administered in Utah public schools in grades 9-12. The data included in the report show high school rates for suicide ideation and attempts, motor vehicle crashes, technology, sports concussions, alcohol, school safety, dating violence, and sexual violence.

Strategy 5. Use social and traditional media platforms to educate Utahns about child injury prevention laws and strategies to prevent injury death.

VIPP's media specialist created social media content, scheduled the content on a regular basis and disseminated content to local health departments for use in promoting the prevention of child injury, teen driving safety, teen dating violence prevention, teen suicide prevention, Safe Kids coalition activities, bullying prevention, summer safety, injury prevention laws (e.g., GDL and concussion), and drowning prevention. VIPP social media posts are reaching over 80,000 each month with more than 1,000 monthly engagements and an estimated reach through LHD efforts to promote child injury prevention messages continues to exceed 150,000 people.

News releases and advisories were distributed to local media promoting the prevention of youth injury and violence prevention (e.g., news releases and advisories for the Utah Safe Kids Summer Safety Tips, Firearm Safety, Teen Memoriam, Utah Adolescent Health Report, YRBS Report, and Infant Safe Sleep).

VIPP manages a teen dating violence prevention Facebook page, the Use Only As Directed website and Facebook page, and contributes to the Suicide Prevention website and Facebook page.

Strategy 6. Continue to co-chair and provide technical assistance to the Utah Teen Driving Task Force.

VIPP staff participate on the monthly Utah Teen Driver Task Force to discuss efforts to address traffic safety among teen drivers. Members of the Task Force represent a variety of local, state, and private agencies concerned about coordinating activities to improve the safety of teen drivers, passengers, and pedestrians. The Task Force goals are to: 1) reduce the rate of motor vehicle crashes and deaths in Utah among teens ages 13-19, 2) bring together stakeholders with an interest in teen driving to ensure activities are coordinated throughout the state, 3) create an effective marketing campaign designed to reduce risky behaviors among teen drivers and passengers, 4) use storytelling to encourage safe driving behaviors, 5) develop, support, and advocate for effective teen driving policies, and 6) support continued innovation in driver education materials.

Strategy 7. Continue to review 100% of all child injury deaths to improve response and develop recommendations for prevention and system change.

Since 1992, the Child Fatality Review Committee (CFRC) has been charged with the review of the circumstances and causes of all childhood deaths in Utah. The purpose of the CFRC is to develop a better understanding of child deaths in order to reduce the number of these tragedies. The goals of the CFRC are to: 1) identify and describe risk factors by studying and reporting trends and patterns of child deaths in Utah, 2) maximize resources through interagency collaboration to identify and describe the delivery of services by the involved systems (medical, human services, and law enforcement) to high-risk children, and make policy recommendations to improve the service systems to better meet the needs of families involved with these systems, 3) promote effective prevention strategies to reduce the number of child deaths, and 4) refer issues and propose strategies to appropriate organizations and agencies to promote education and prevention.

The CFRC meets once a month to review deaths of all Utah children (ages 0-18) who died within the three months prior, as well as any more recent suspicious cases. The cases reviewed by the CFRC include any death that falls under OME jurisdiction. These include homicides, suicides, suspicious, or undetermined deaths, as well as any sudden and unexpected deaths. This death review process provides a detailed understanding of how and why child deaths occur in Utah. CFRC data is entered into a national database. Recommendations are compiled after each review and shared with key stakeholders to implement for systems change.

Strategy 8. Evaluate the effectiveness of the motor vehicle parent night program being offered at various schools in Utah.

VIPP is working with the media contractor who conducts the parent night programs throughout Utah to develop an evaluation plan of the parent night program in addition to the curriculum being used in driver’s education programs. Evaluation technical assistance has been provided by the CDC, who is also interested in this strategy. An average of fifteen parent night programs are conducted per month during the school year.

Strategy 9. Provide evidence-based suicide prevention programs to youth ages 12-19.

During the reporting period, LHDs provided several suicide prevention training sessions as part of their suicide prevention activities targeting children and their parents. These included 110 Question, Persuade, and Refer sessions with 3,039 reached, two SafeTALK sessions with 55 reached, and three Mental Health First Aide trainings with 56 reached. Furthermore, LHDs collaborated with school districts to support and coordinate activities with local hope squads reaching 3,695 children. Finally, LHDs distributed 810 gun locks to residents in their communities.

Strategy 10. Publish the 2017 Teen Memoriam book.

For the past 11 years, the VIPP, Utah Department of Transportation Zero Fatalities Program, and Utah Teen Driving Task Force have worked closely with parents and families who have lost a teenager in a motor vehicle crash to tell their stories in a memoriam book.

We meet personally with the participating families, provide grief resources, and help spread their prevention messages to other families and young drivers. The families become a support network for each other and have expressed their appreciation and comfort in being able to share their story with others. We held the family event in November to share stories of families who lost a child in a motor vehicle crash in 2017. The memoriam books were provided to each high school in Utah.

Accomplishments / Successes:

The rate of child injury deaths among children ages 1-19 years of age has remained stable with an overall downward trend indicating a 17.4% decrease in child injury deaths since 1999. Males have had a consistently higher child injury death rate compared to females, and children ages 15 to 19 years have had consistently higher child injury death rates compared to ages 1 to 14 years of age.

With the increase in suicide prevention efforts at the local health district (LHD) level, VIPP feels confident that the rate of suicide deaths will start to decrease over time. In addition, VIPP just hired a full time suicide prevention coordinator that has provided technical assistance to the LHDs and is assisting with resource coordination with school districts. An emphasis on suicide prevention efforts have been placed on VIPPs priorities, and VIPP has become involved in participating more broadly in state and local efforts for suicide prevention.

VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens and have engaged LHDs in this effort. Identified overarching themes for VIPP's state strategic plan include: 1) Laws and Policies – Promote laws and policies that support safe communities, 2) Cultural – Encourage social norms that promote safety and health, 3) Health Access – Improve access and utilization to physical and behavioral health care, 4) Physical Environment – Enhance the physical environment to improve safe and healthy living, 5) Economic Development – Improve the socioeconomic conditions for Utahns, and 6) Connectedness – Promote individual, family, and community connectedness.

As a result of this work, VIPP has been able to engage non-traditional partners, has been instrumental in informing state level work on shared risk and protective factors, has implemented primary prevention trainings to local communities in Utah, has presented on national webinars, and has had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-03:

- Suicide prevention activities were emphasized in local health department contracts. As a result, there was an

increase in individuals reached through suicide prevention activities in local communities. These included 110 Question, Persuade, and Refer sessions with 3,039 reached, two SafeTALK sessions with 55 reached, and three Mental Health First Aide trainings with 56 reached. Furthermore, LHDs collaborated with school districts to support and coordinate activities with local hope squads reaching 3,695 children. Finally, LHDs distributed 810 gun locks to residents in their communities. (July 3rd, 2017 - June 29th, 2018)

- VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens and have engaged LHDs in this effort. Identified overarching themes for VIPP's state strategic plan include: 1) Laws and Policies – Promote laws and policies that support safe communities, 2) Cultural – Encourage social norms that promote safety and health, 3) Health Access – Improve access and utilization to physical and behavioral health care, 4) Physical Environment – Enhance the physical environment to improve safe and healthy living, 5) Economic Development – Improve the socioeconomic conditions for Utahns, and 6) Connectedness – Promote individual, family, and community connectedness.

  As a result of this work, VIPP has been able to engage non-traditional partners, has been instrumental in informing state level work on shared risk and protective factors, has implemented primary prevention trainings to local communities in Utah, has presented on national webinars, and has had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state. (January 1st, 2018 - June 29th, 2018)

- To increase awareness of violence and injury impacting youth, VIPP took the lead in developing the 2017 Utah Adolescent Health Report using data from the Prevention Needs Assessment (PNA). The data included in the report showed that 27.3% of students reported feeling sad or hopeless, 20.6% of students reported psychological distress, 18.1% of students seriously considered suicide, 14.3% of students made a suicide plan, and 7.7% of students made one or more suicide attempts. Percentages for all of these indicators are highest among females, and 10th and 12th grade students were significantly more likely to have reported feeling sad or hopeless, to have reported psychological distress, and seriously considered suicide. In addition, 8.1% of students reported recently using marijuana and 5.5% of students reported binge drinking. Marijuana use and binge drinking increased with increasing grade. Further, 2.7% of students reported recently using prescription medications without a prescription.

  Additional data showed that 48.8% of students reported talking on a cell phone while driving, and 37.6% reported texting while driving, both of which are forms of distracted driving. Students in 12th grade reported significantly more distracted driving than students in 8th and 10th grade. Majority of students reported frequently wearing a seatbelt (95.5%). Females and students in lower grades were significantly more likely to be bullied than males and students in higher grades. Overall, 27.9% of students reported being bullied at school and 27.2% of students reported being bullied over the Internet, by email, or by someone with a cell phone. Students in 8th grade were significantly more likely to be electronically bullied than 12th grade students. Females reported more than 50% more electronic bullying than males. Overall, 10.7% of students reported experiencing dating violence in the past year. Females had significantly higher percentages of dating violence than males.

  VIPP staff participated in developing the 2017 Youth Risk Behavior Survey (YRBS) report which includes key finding and recommendations for creating healthy, safe, and supportive environments where students can focus on learning. Recommendations for violence and injury included efforts to: utilize evidence-based materials to educate students about dating violence and how to build healthy relationships; increase

protective factors and decrease risk factors for various forms of violence; adopt a concussion policy in accordance with Utah law; require coaches, trainers, student athletes, parents, and school nurses to take their respective CDC Heads Up online training; replace damaged equipment promptly, especially helmets and other protective head gear; participate in the Student Injury Reporting System (SIRS); implement an evidence-based or best practices suicide prevention program; train staff to recognize the signs and symptoms of depression and suicide; inform parents and student about the consequences of underage drinking; and implement evidence-based programs aimed at preventing underage drinking.

Challenges / Gaps / Disparities:

Challenges

VIPP has been conducting strategic planning to focus on shared risk and protective factors, and meetings and primary prevention trainings have been held with the Injury Community Implementation Board, local health departments, and staff to gear up for this approach. It has been challenging to finalize the strategic plan due to competing priorities and less familiarity to this new approach and way of addressing violence and injury in the state. In addition, many funding sources are very siloed, making it difficult to focus on a comprehensive, primary prevention efforts, where impact can be leveraged by having shared prevention vision to reduce risk factors and promote protective factors.

Emerging Issues

Over the last few years, suicide by firearm in youth have been increasing. Efforts to promote means restriction and firearm safety among adults who own firearms is of paramount importance, in addition to promoting protective factors such as connectedness among youth.

Agency Capacity / Collaboration:

VIPP partnered with multiple agencies and entities to address the child injury performance measure. VIPP continues to contract with all thirteen local health departments to implement evidence-based injury and violence prevention programs to reduce risk factors and promote protective factors associated with injury and violence. Local health departments were also contracted to collaborate with local entities to enhance injury and violence efforts in their health district. Collaborations included Safe Kids coalitions, law enforcement agencies, hospital systems, parent-teacher associations, school districts, firearm retailers, fire departments, EMS, and others. Staff at the local and state level is supported to maintain certifications in various disciplines that may impact moving the needle for child injury mortality. These disciplines include maintaining certifications as child passenger safety technicians, QPR instructors, SafeTALK instructors, Mental Health First Aid instructors, and other injury-related trainings.

National experts conducted a technical assessment of VIPP's injury infrastructure, policy, and programs in the summer of 2018 through the Safe States Alliance State Technical Assessment Team (STAT) program. The STAT assesses injury and violence prevention within the state health agency, focusing on specific roles, relationships, and performance of the designated injury and violence prevention program. The goal is to support the development, implementation, and evaluation of injury and violence prevention efforts at the state health department level by conducting an on-site, point-in-time assessment of the injury and violence prevention program, and providing recommendations for improvement.

The assessment focuses on core components of a successful state health department injury and violence prevention program, including infrastructure, data, policy, and program strategies. For each core component, Safe States Alliance has developed standards and indicators that describe the conditions that should exist within an ideal,

comprehensive, state health department injury and violence prevention program. The assessment often serves to refocus a participating state by requiring it to reflect on its strengths, weaknesses, opportunities, and barriers to success. The STAT process also serves to bring together different members of the injury and violence prevention community, and allows individuals to share ideas for program development.

VIPP STAT recommendations encouraged VIPP to finalize the strategic plan focusing on shared risk and protective factors, prioritize staff activities to meet grant deliverables, prioritize hiring a Suicide Prevention Coordinator, develop a publications protocol, publish timelier reports, and modify LHD contracts to focus on high-impact actions.

Other activities in the Child Health domain that contribute to improvement in the National Outcome Measures

Utah works to adhere to the three-tier framework outlined in the MCH Block Grant guidance. While the focus of most activities is the ESM →NPM→ NOM framework, activities on improving NOMs outside of the NPMs transpires in parallel. The following programmatic activities also work to improve outcomes in this domain.
National Outcome Measures (NOM)

NOM 13 - Percent of children meeting the criteria developed for school readiness

Violence during childhood can have lasting impacts throughout the lifespan affecting school readiness for children. There are several risk and protective factors that contribute to and protect from child abuse and neglect in Utah. As a result, the Violence and Injury Prevention Program is strategicly planning around shared risk and protective factors to increase child health and school readiness. This will incorporate strategies to build and improve upon a sustainable, multi-sectoral program to promote safe, stable, nurturing relationships and environments for children and families by implementing best practice strategies.

The mission of Safe Kids Utah is to prevent childhood injuries in kids and teens ages 0-19 in the state of Utah by working with schools to increase awareness around bicycle and pedestrian safety to and from school, sports injury awareness and teen driving safety. The Student Injury Reporting System (SIRS) is an invaluable data collection tool that tracks injuries that occur while traveling to and from school and during school time or school-related activities. The SIRS helps to identify where, when, how, and why students get hurt at school. By using this information, education officials can pinpoint risk factors at individual schools and develop safety guidelines and prevention programs which can minimize the physical and financial impact of injury on the individual, family, school, and community. Since 1983, the Utah Department of Health, Utah State Office of Education, and local school districts have collected data on student injuries in Utah public schools. All 41 Utah school districts and over 800 public schools have participated and data collection has remained fairly consistent over the past 30 years. Injuries that meet the following criteria are entered into the SIRS database:

1. Injury caused the loss of at least one-half day of school and/or
2. Injury required medical attention and treatment from a school nurse, physician, or other health care provider.

NOM 15 - Child mortality rate, ages 1 through 9, per 100,000

In 1992, the Utah Child Fatality Review Committee (CFRC) was established. The CFRC was charged with the review of the circumstances and cause of all childhood deaths in the state. The purpose of the CFRC is to develop a better understanding of child deaths in order to reduce the number of intentional and unintentional deaths of Utah children. Often, this involves improving the response of various agencies involved in the investigation of child deaths to prevent future deaths. In order to improve and standardize data collection of SUID cases, the Violence and Injury Prevention Program (VIPP) conducts statewide SUID surveillance, Sudden Death in Young (SDY) surveillance, and advanced fatality review. The Advanced Child Death Review Team is charged with reviewing and categorizing all SUID and SDY cases in Utah. Additionally, advanced autopsy guidance will be utilized by the Utah Office of the Medical Examiner (OME) and VIPP will work closely with the OME to ensure completion of the SUIDI form or SDY Field Investigation Guide. This will be provided to the VIPP will build on the current work to conduct violence and injury surveillance throughout Utah, disseminate the data to partners, and increase timeliness and quality of data, and greater utilization of data for prevention efforts. The overall goals of this project are to:

1. Increase data completeness, timeliness and case ascertainment resulting in a robust SUID and SDY surveillance system in Utah

2. Increase policies and practices that are informed by SUID and SDY Case Registry data among partner agencies serving families and working to prevent sudden and unexpected infant and child deaths
3. Reduce the incidence of SUID and SDY in Utah.

The mission of Safe Kids Utah is to prevent childhood injuries in kids and teens ages 0-19 in the state of Utah by working with schools to increase awareness around bicycle and pedestrian safety to and from school, sports injury awareness and teen driving safety. Knowing which car seat or booster seat is right for your child - based on their age, height, and weight - and type of vehicle is critical in decreasing the child mortality rate. Trained child passenger safety technicians are available throughout Utah to help install child safety seats the right way.

NOM 23 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

The leading causes of traumatic brain injuries among youth ages 5 to 19 are from motor vehicle traffic crashes, bicycle crashes, recreational activities, falls, and pedestrian crashes. The Violence and Injury Prevention program has developed the infrastructure within the local public health system to facilitate success of concussion education and implementation of concussion management programs, including linking individuals to resource facilitation services. Efforts to strengthen the capacity of local public health systems to implement suicide and opioid overdose prevention strategies have increased over the last few years. Local staff are trained to implement the evidence based Question, Persuade, and Refer (QPR) trainings in their communities and local health departments are gearing up for a community crisis response training and development and community guides for suicide and opioid post-vention responses. This includes linking individuals to mental health and substance abuse treatment.

NOM 27- a) Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series
b) Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
c) Percent of adolescents, ages 13 through 17 years, who have received at least one dose of the HPV vaccine
d) Percent of adolescents, ages 13 through 17 years, who have received at least one dose of the Tdap vaccine
e) Percent of adolescents, ages 13 through 17 years, who have received at least one dose of the meningococcal conjugate vaccine

The CHARM system continues to integrate immunization histories of children from the Utah Statewide Immunization Information System (USIIS) and provides them electronically to the Baby Watch/Early Intervention Program, the Early Hearing Detection and Intervention Program, the Fostering Health Children Program, the WIC Program, Newborn Screening Heel-stick Program, and private provider clinics. These programs that have obtained immunization information through the CHARM system have been able to identify children in need of immunizations, and follow-up with parents to get their children vaccinated and up-to-date.

Other activities of note:

The Healthy Living Through Environment, Policy and Improved Clinical Care Program (EPICC) works with the State Board of Education (USBE) Child Nutrition Program to provide professional development opportunities to School Food Authorities on the following areas: Smarter Lunchroom, Smart Snacks, Local Wellness Policies, School Lunch and Breakfast Programs,, Farm to Fork, Non-Food Rewards, Recess Before Lunch, and other nutrition related opportunities. EPICC and USBE also provide professional development opportunities to school health and PE

teachers, specialists and paraprofessionals K-12. Topics include physical activity, quality PE, mental health, and health standards. There were 550 attendees across the state who attended this conference.

EPICC also works closely with Utah Department of Transportation in promoting Safe Routes to School. Activities would include in working with Local Education Agencies and schools to strengthen Safe Routes to School plans and maps, promoting walking and biking to school, promoting walking school buses and bicycle trains, Bike Utah's BEST program, Safe Routes Assembly, and other activities that promote healthy, active lifestyles.

MCH Block Grant FY20 Application & FY18 Report

Child Health Domain

NPM-06: Developmental Screening: ***Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool***

FY20 Annual Plan:

Annual Plan:

There are three objectives that will inform developmental health promotion activities that UDOH will engage in throughout FY20.

Objective #1: Improve the developmental screening rates of programs that are currently enrolled in the UDOH Ages and Stages Questionnaire (ASQ) online account. If the lead agency is able to activate enrolled programs that are not currently participating in the ASQ program, then it is possible UDOH may increase the number of 9 month-35 month olds that receive age aligned developmental health screens.

In January 2019, the lead agency conducted a survey with all ASQ enrolled programs. The survey inquired about each programs' intention to continue to facilitate ASQ developmental screening opportunities to their young clientele and asked if any technical assistance (TA) is needed in order to continue in the ASQ program. The outreach email also explained and included the new UDOH ASQ online disclosure, consent, and terms of use documentation.

Staff from our Early Childhood Utah Program (ECU) are in the process of analyzing the survey results and conducting outreach to programs as indicated. Throughout FY20, ECU will act upon information ascertained from survey data. In other words, ECU will re-enroll early care and education programs (ECE) that indicated via the survey they understood the new ASQ disclosure/consent information and were ready to re-enroll. ECU will also communicate with and offer TA to ECE programs that request it. Additionally, ECU will contact each program that has expressed that they were no longer inclined to participate in our developmental health promotion program and see what we can do to bridge gaps, address concerns, and ideally change minds.

Re-enrolling ECE ASQ programs consists of: 1) distributing and receiving a signed copy of our new enrollment form; 2) updating each programs' online account permissions and; 3) revising each programs' ASQ online landing page to include links to the lead agency's new ASQ data disclosure, consent, and terms of use one page document.

Objective #2: ECU will continue to work closely with our many early childhood stakeholders, partners, and with the larger ECE community to promote the importance of infant/toddler and preschooler developmental health along with emphasizing how important it is for ECE providers to integrate the use of reliable and valid screening tools, such as the ASQ, into their curriculum and/or practice.

Through this constant communication about our program and through targeted outreach to ECE providers such as licensed and regulated Child Care and Head Start programs, MIECHV Home Visitors, community health and mental health practitioners, and to state and/or federally funded preschool programs, we hope to increase the number of agencies that actively participate in our, 'no-cost' to them, ASQ online program.

The lead agency's ASQ online program provides an easy method for caregivers to involve parents in the developmental screening process either through the distribution of 'paper copies' of age aligned screening forms, or

through linking parents to the program's ASQ online landing page. Each program is given the opportunity to utilize an ASQ landing page with a url that is unique to each participating program. The ASQ software also provides programs with easy to use parent notification, screening management, and data reporting tools.

Each agency enrolled in the UDOH Developmental Health Promotion Program receives access to the online products and physical ASQ kits. Each kit comes with a learning activity resource manual and an instructional manual. The lead agency offers ASQ-3 and ASQ-SE2 in English and Spanish, and there is no cost for programs to enroll and participate.

Once a program in enrolled, ECU will offer TA and track the program's level of activity. ECU will engage in outreach communication to reinforce programs for actively participating and seek to mitigate any problems that may impede a program's ability to facilitate developmental screening opportunities and to enter the screening data into the UDOH ASQ online account.

Objective #3: ECU will utilize ASQ data to track children whose screening scores fall within the monitoring zone and/or below cutoff. Not only is it essential for as many 9 month-35 month olds to receive age aligned developmental screening as possible, but it is equally important for families to receive access to the resources and/or services they may need to best improve the developmental trajectory of their child/children.

When programs are enrolled into our ASQ program, they acknowledge being responsible to link families to resources and/or services that may be needed to improve that child's environment and/or health. The ECE caregivers that participate in the ASQ program are known for being efficient at linking families to any available resources the family and child may need. Caregivers that participate in the ASQ program are pediatricians, home visitors, child care/preschool, and Head Start teachers, targeted case managers, etc. Most, if not all of the programs, we enroll in the ASQ program are required by the state and/or federal funders to provide triage and case management services. One of our most integral partners for facilitating developmental screening and then providing care coordination as applicable is Help Me Grow Utah.

The lead agency will monitor screening data 'across the board' and per program type. If we observe screening result rates that are misaligned with national norms we will work closely with the program(s) to confirm the data and design are the most appropriate community, familial, and/or programmatic interventions.

UDOH is currently in the midst of developing the ability to easily generate informative ASQ screening and screening result summary reports that automatically display data visualization graphics. These enhanced ASQ reports will be ready for use during FY20. ECU staff will utilize this data to identify regions of the state and/or categories of programs that see a statistically significant number of children whose screening scores fall within the monitoring zone and/or below cutoff. Ideally, through systems work and collective impact we will witness ever-increasing numbers of children move from the monitoring zone to above cutoff.

Proposed Activities:

- ECU will contact each enrolled program, assess any needs or barriers to participation, problem solve, mitigate issues, provide technical assistance and support, and engage in the CQI process.
- Utilize our network of ECE stakeholders and partners to identify and conduct outreach to new ECE programs that provide infant/toddler services.
- Track the data on aggregate numbers of children scoring in the monitoring zone or below cutoff.
- Discover and work with the community to address developmental screening trends not aligned with national

norms.

SPM-03: Child Injury Deaths: ***The rate (per 100,000) of injury deaths among children aged 1 -19***

FY20 Annual Plan:

The Violence and Injury Prevention Program (VIPP) at the Utah Department of Health was established in 1983. Utah was one of the first five health departments in the United States to have an injury prevention program. The VIPP is currently housed in the Bureau of Health Promotion in the Division of Disease Control and Prevention. Across the Bureau of Health Promotion, there is support for violence and injury prevention to address shared risk and protective factors. The VIPP has thirty staff dedicated to violence and injury surveillance and prevention activities. The staff has varying backgrounds, expertise, and experience in a variety of public health-related issues, including surveillance, conducting quality assurance activities, and generating data reports. The VIPP staff members participate on several national organizations and have longstanding, established relationships with key state-level agencies.

The VIPP has extensive internal and external partnerships and collaborates with these partners to conduct surveillance and prevent violence and injury. The VIPP partners with all thirteen local health districts (LHD) in Utah and providers funding and support to them to address violence and injury prevention topics. In addition, the VIPP provides funding and support to other local partners and community-based organizations such as Rape Prevention and Education grantees. The VIPP primarily sets its priorities based on injury data, while also considering legislative and Department of Health priorities. Utah was one of the early participants in the National Violent Death Reporting System (NVDRS) and the first state to include overdose deaths in NVDRS. Utah was the first state to gather and report data on school injuries, a project that continues to this day.

VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens and have engaged LHDs in this effort. We have also identified overarching themes for VIPP's state strategic plan include which include: 1) Laws and Policies – Promote laws and policies that support safe communities, 2) Cultural – Encourage social norms that promote safety and health, 3) Health Access – Improve access and utilization to physical and behavioral health care, 4) Physical Environment – Enhance the physical environment to improve safe and healthy living, 5) Economic Development – Improve the socioeconomic conditions for Utahns, and 6) Connectedness – Promote individual, family, and community connectedness.

As a result of this work, VIPP has been able to engage non-traditional partners which has been instrumental in informing state level work on shared risk and protective factors, implemented primary prevention trainings to local communities in Utah, presented on national webinars, and have had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state.

Proposed Activities:

- VIPP will identify risk and protective factors shared by at least two of the following top causes of child (ages 1-19) injury deaths: suicide, motor vehicle crashes, drug poisoning, falls, drowning, and/or homicides. Prevention activities will be built around these shared factors.
- Finalize and implement a strategic plan around shared risk and protective factors.
- Review 100% of all child deaths in Utah. Enter data gleaned from these reviews in the national child death review database.
- Continue funding all thirteen LHDs to implement evidence-based injury prevention programs within their communities.
- Provide surveillance data and information on childhood injuries and deaths to partners, policy makers, and

media through fact sheets, reports, quarterly newsletter, and social media posts.

- Use social and traditional media platforms to educate Utahns about child injury prevention laws and strategies to prevent injury death.
- Continue to support and provide technical assistance to the Utah Teen Driving Task Force.
- Provide at least five evidence-based suicide prevention programs to youth ages 12-19.
- Publish the 2018 Teen Memoriam book.

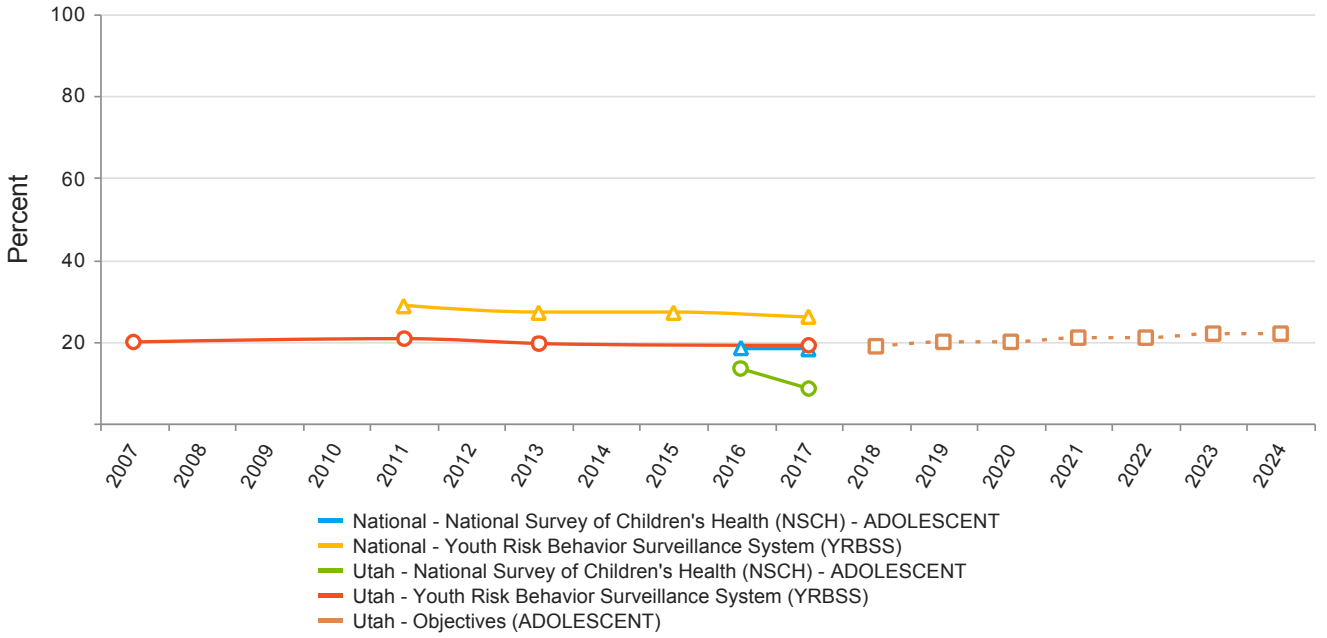
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	12.2 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.3 %	NPM 8.2 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016_2017	8.7 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	8.2 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	9.6 %	NPM 8.2

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2016	**2017**	**2018**
Annual Objective	19.9	19.9	18.9
Annual Indicator	19.7	19.7	19.1
Numerator	29,466	29,466	30,959
Denominator	149,852	149,852	162,207
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2013	2013	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2016	**2017**	**2018**
Annual Objective			18.9
Annual Indicator		13.6	8.7
Numerator		37,056	25,092
Denominator		272,391	287,812
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	20.0	20.0	21.0	21.0	22.0	22.0

Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		10	25
Annual Indicator	7.1	25	25
Numerator		1	1
Denominator		4	4
Data Source	School Health Profiles	UDOH Policy Database	UDOH Policy Database
Data Source Year	2016	2017	2017
Provisional or Final ?	Provisional	Final	Final

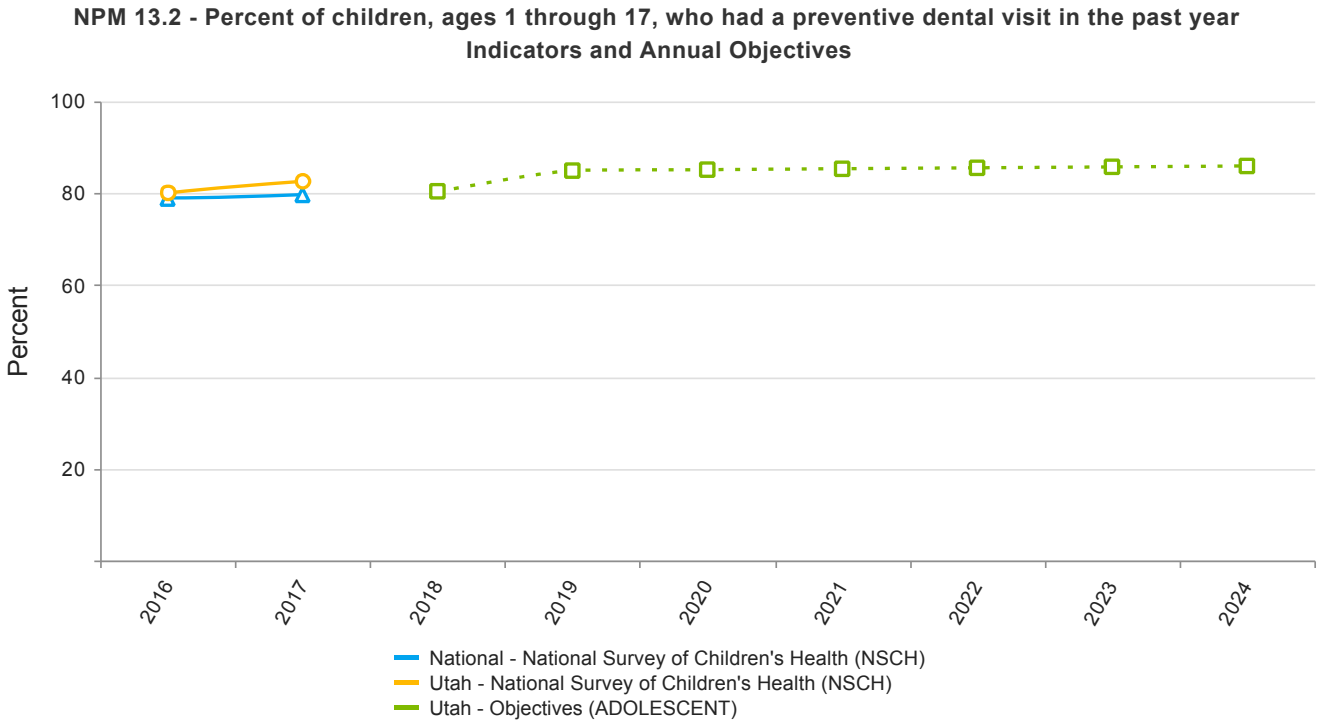
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	50.0	50.0	75.0	75.0	75.0

ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		4	35
Annual Indicator	6	34	31
Numerator			
Denominator			
Data Source	EPICC Training Database	EPICC Training Database	EPICC Training Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	36.0	37.0	38.0	39.0	40.0	41.0



NPM 13.2 - Adolescent Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			80.3
Annual Indicator		80.1	82.4
Numerator		684,515	701,280
Denominator		854,160	851,339
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	84.8	85.0	85.2	85.4	85.6	85.8

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		53.6	51.5
Annual Indicator	53.4	51.3	54.2
Numerator	116,623	109,115	109,777
Denominator	218,295	212,848	202,518
Data Source	CMS 416	CMS 416	CMS 416
Data Source Year	FFY16	FFY17	FFY18
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	54.4	54.6	54.8	55.0	55.2	55.4

State Performance Measures

SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		14.7	15.1
Annual Indicator	15.1	15.8	15.7
Numerator	144	152	152
Denominator	950,511	960,913	967,283
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	14.9	14.5	13.9	13.5	13.0	12.5

SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		21	16.7
Annual Indicator	21	17.2	21.5
Numerator	49	41	52
Denominator	233,809	238,378	242,153
Data Source	Utah Death Certificate Database, OVRS	tah Death Certificate Database, OVRS	tah Death Certificate Database, OVRS
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	21.5	20.5	20.0	19.5	19.0	18.5

State Action Plan Table

State Action Plan Table (Utah) - Adolescent Health - Entry 1

Priority Need

Overweight & obesity prevention (continuation of old SPM 8)

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

By 2020, increase the percent of adolescents who are physically active at least 60 minutes per day from 19.7% (YRBSS, 2013) to 20.0%.

Strategies

1. Work with Local Health Departments to educate schools and Local Education Agencies (LEA) to adopt the frame work of Comprehensive School Physical Activity Program (CSPAP) to increase daily physical activity.

2. Provide trainings and professional development opportunities to Physical Education (PE) teachers, classroom teachers, and school administration on strategies to incorporate 60 minutes of physical activity a day.

ESMs	Status
ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP	Active
ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)	Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Utah) - Adolescent Health - Entry 2

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

b. BY 2020, increase the percent of children (ages 1 through 17) who had a preventive dental visit in the past year from 80.1 (NSCH, 2016) to 80.7%.

Strategies

1. Collaborate & target high risk populations with Head Start, Early Intervention, WIC, the Utah Office of Home Visiting and the Office of Health Disparities to share resources and provide education and training to agency staff on the importance of dental care for children with the goal to increase the percent of children who have a preventive dental visit in the past year.

2. The Oral Health Program (OHP) will Collaborate with Utah Medicaid with the goal to increase the percent of children who have preventive dental visits as well as dental treatment needed. The OHP will also collaborate with the Utah Oral Health Coalition, the Utah Dental Association, Head Start, the Office of Health Disparities, WIC, and the Utah Office of Home Visiting to reach these goals.

3. The Oral Health Program Specialist (OHS) and Oral Health Educator (OHE) work closely with the professional advisory councils at many of the dental hygiene programs to encourage the professional development of dental hygiene students to create a public health minded workforce, including topics of social justice, health equity and cultural competence.

ESMs	Status
ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Utah) - Adolescent Health - Entry 3

Priority Need

Suicide, mental health issues, and access to mental health services (continuation of old NPM16)

SPM

SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)

Objectives

By 2020, decrease the rate of suicide death among Utah youth ages 15-19 years old from 17.2 per 100,000 (Utah 2016 Death Certificate data) to 15.9 per 100,000.

Strategies

1. Identify and target surveillance data for policymakers, schools, local health departments, etc.
2.. Produce and disseminate timely data on youth suicides.
3. Continue distribution of firearm locks and firearm safety brochures to families of teens.
4. Provide at least five evidence-based suicide prevention training sessions to teens and/or their families.
5. Continue to review all youth suicides in Child Fatality Review and develop recommendation and prevention strategies.

MCH Block Grant FY20 Application & FY18 Report

Adolescent Health Domain

NPM-08: Physical Activity: *Percent of adolescents in grades 9-12 who report being physically active at least 60 minutes per day in the past week*

FY18 Annual Report

Program Activities:

The Performance Measure was met. The Performance Objective was 18.9 and the Annual Indicator was 19.1%.

This year, EPICC staff continued to build partnerships and work with the Utah State Board of Education (USBE) and SHAPE Utah to provide professional development opportunities that included components of Comprehensive School Physical Activity Program (CSPAP). These three organizations worked together to provide two state conferences. One conference was for Secondary Health and PE teachers. Over 300 people attended this conference. The other conference was for elementary classroom teachers. There were 225 people who attended this conference.

The EPICC program also continued to work with local health departments (LHD) to promote and provide technical assistance for schools to implement components of CSPAP. EPICC staff and LHDs provided support to strengthen Local Education Agencies (LEA) wellness policies. Wellness policies have a section that focuses on physical activity and physical education. EPICC staff encouraged LEAs to adopt components CSPAP into the wellness policy.

Accomplishments / Successes:

The EPICC program partnered with the Utah State Board of Education (USBE) and SHAPE Utah to offer a statewide professional development opportunity to elementary classroom teachers. The focus of the conference is Healthy Bodies, Healthy Minds which incorporated components of the Comprehensive School Physical Activity Program. There were 250 attendees which included classroom teachers, local health department representatives, and partners. Participants were encouraged to complete the CSPAP Training Tools for Healthy Schools e-Learning Series https://www.cdc.gov/healthyschools/professional_development/e-learning/cspap.html.

The three organizations also provided a statewide professional development to the 300 secondary PE specialists who attended the conference. This conference had a health and PE breakout sessions for participants to attend. The PE breakout sessions focuses on the components of CSPAP.

The Training Tools for Healthy Schools: Promoting Health and Academic Success, eLearning series is also available on the EPICC website to promote professional development. The training consists of four core training tools. Continuing education credits are offered to participants, along with a certificate of completion at the end of each module.

There is an important difference between physical activity and physical education. Because of these two conferences we are able to demonstrate the need that children should be engaged in both physical activity and physical education every day.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-08:

- EPICC staff partnered with the State Board of Education and SHAPE Utah to provide PE/PA professional development opportunities to elementary classroom teachers, paraprofessionals, secondary PE specialists, coaches, teachers, local health department representatives, and other organizations.
- SHAPE America's mission is to advance professional practice and promote research related to health and physical education, physical activity, dance, and sport. SHAPE Utah is the local chapter of this organization. Because of the ongoing work between USBE, UDOH, and SHAPE Utah the statewide conferences have been successful.

Challenges / Gaps / Disparities:

With the four targeted school districts (Cache, Canyons, Granite, and Salt Lake) that the EPICC program has provided additional technical assistance each district has implemented components of CSPAP differently. Since districts are implementing CSPAP components, additional training is not needed.

LEAs are open to the idea of incorporating components of CSPAP. However, because CSPAP can look very different in every school, it can be difficult to collect data. The data that we collect to measure if students are receiving 60 minutes of physical activity a day is only captured in the secondary schools. Unfortunately, our work is not being captured with the data source that CDC has identified for states to use.

There is also a very high turnover with those who teach PE. In our state, elementary PE is taught by paraprofessional educators and classroom teachers. There are only a few districts that have a PE specialist. When implementing CSPAP, we are consistently educating and training new staff.

USBE saw the value in participants so they were able to allow more people to attend both conferences.

Agency Capacity / Collaboration:

The EPICC program has a MOU with the Utah State Board of Education (USBE). This has helped leverage the continuity of messaging to PE specialists, teachers, and other organizations. Our relationship with the USBE has continued to build support around PE/PA activities. The planning committee of these two conferences consists of many partnerships within the state which include, Primary Children's, Select Health, Utah Department of Transportation, Highway Safety, Universities, Utah PTA, and many more.

The EPICC program also partners with all of the Bureau of Health Promotion programs. This collaboration is done through a monthly meeting with individuals who focus in the school setting. Once a year during this meeting we invite all of our partners from USBE to attend and we educate each other on current projects. This is also a good time to understand how the two departments can strengthen programs, funding, and infrastructure. The relationship between UDOH and USBE is stable, and encouraging that, it will continue to grow.

Over the years, the relationship between UDOH and SHAPE Utah has also strengthened. EPICC staff was nominated to be the president of the SHAPE Utah during the 2019-2020 school year. During this time the National SHAPE America convention will be in Salt Lake City, April 2020. This is a great opportunity for the EPICC program to work with many national, state, and local partners.

The CSPAP framework has a component that encourages schools to involve family and community engagement. Schools have been able to engage the family and community by offering family fun nights and PTA sponsored events. Engaged parents help advocate for schools to provide a healthy school environment for their kids. CDC developed a set of resources called Parents for Healthy Schools to help support these efforts. The resources will educate parents and the community about school nutrition environment and services, school-based physical education and physical

activity (CSPAP), and ways to support schools in managing chronic health conditions in the school settings.

Summary Progress Report (2019) of ESMs related to NPM-08

ESM 8.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP

Goal/Objective:

Increase percent of schools within the four targeted LEAs: Cache, Canyons, Granite, and Salt Lake, which have implemented CSPAP.

Significance of ESM 8.1:

A CSPAP is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime.

ESM 8.1 Progress Report:

School Health Profiles (Profiles) collects this information, but assessment is at a school level, not LEA. Also, since the district policy was put into place after Profiles was completed, there may be gaps in awareness of written plans by individual school principals. Therefore, we are using the UDOH Policy database for our data source.

If schools adopt the framework of CSPAP, students will have the opportunity to receive 60 minutes of physical activity a day. Physical education is an academic subject and serves as the foundation of the CSPAP by providing the opportunity for students to learn knowledge and skills. This knowledge and skills are needed to establish and maintain physically active lifestyles throughout childhood and adolescence, and into adulthood.

In the four targeted LEAs, district PE specialists identified role models in the schools, other than the PE teacher, to lead the CSPAP framework. Most elementary PE teachers are paraprofessionals with low paying positions. We found that someone other than the PE teacher provided a more sustainable anchor to CSPAP. It is also easier to work with elementary schools then the secondary schools because the teachers are more open to change and new ideas.

A training was provided to all four LEAs during a professional development day. This was a huge success. Maximizing physical activity opportunities in schools is coordinated, well planned, and thoughtfully executed and evaluated by the CSPAP champion. This creates a culture of physical activity that is integrated throughout the school environment, and reaches beyond the school, and into the community.

A school that establishes student health as a priority will form a CSPAP team and develop a comprehensive physical activity plan that includes all of the components described in the preceding sections. This divides the workload among multiple individuals. A CSPAP reflects the social, emotional, and cultural needs of students, their families, and the broader community. This thereby establishes a strong social and culturally supportive environment for students, families, and communities to engage in physical activity.

ESM 8.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP).

Goal/Objective:

Increase the number of LEAs receiving professional development and technical assistance to establish, implement,

and evaluate the CSPAP.

Significance of ESM 8.2:

Professional development is designed to actively engage learners. Teachers who attend professional development about physical activity, and who incorporate movement during the school day, will increase student opportunity to be active for 60 minutes a day.

ESM Progress Report:

If more LEAs are receiving professional development on CSPAP, there will be more schools that are implementing 60 minutes of physical activity before, during, and after school.

We found that providing CSPAP training during a professional development day was successful. Teachers are already committed or mandated to attend, so we did not have to worry about coordinating a substitute. Having district buy-in to CSPAP also helped provide leverage as to the topic during the professional development learning session. Each of the targeted school districts have allowed a CSPAP training for the past two school years. In Salt Lake School District we provided CSPAP trainings at the beginning and middle of the year. By providing the two trainings, the CSPAP leader was able to gather ideas from other schools on how to implement CSPAP. We will continue to promote components of CSPAP during the statewide Secondary Health and PE Conference, elementary Healthy Bodies, Healthy Minds Conference, and by promoting the CDC e-learning opportunities.

NPM-13B: ***Percent of children, ages 1 through 17, who had a preventive dental visit in the past year***

FY18 Annual Report

Program Activities:

The Performance Measure was achieved. The Performance Objective was 80.3% and the Annual Indicator was 82.4%

The Oral Health Specialist (OHS) connected the Ogden HS with a local dentist to provide screenings, fluoride varnish, and education to over 262 individuals and families. They based the health fair on the OHP's twelve Oral Health Messaging with twelve educational stations. Later that year, the National Center on Early Childhood Health & Wellness duplicated this idea at a national conference and used five educational stations based on the twelve OH messaging.
The OHS connected and met with Community Health Connect in Utah County, and with the Director of Utah Valley University's Dental Hygiene School to provide basic preventive care at 25 Title I schools.

The OHP's OHS strategically connected rural Central Utah, Richfield LHD, and Utah Valley University dental hygiene students, where they provided preventative care to WIC clients and Head Start families. They provided complete preventive care for eighteen individuals, eleven were children.

The OHS partnered with the Utah Academy of Family Physicians to speak at a conference on Oral Systemic Health covering a variety of topics. Preparation was made fall of 2018. She spoke at the conference February 2019.

The OHP's Oral Health Educator (OHE) managed interns who implemented an educational intervention in middle schools and high schools along the Wasatch Front. This built sustainability into this adolescent intervention. Anonymous pre- and post-tests were administered to all students before and after the educational segment which was used as an evaluation measure. In addition, educational presentation brochures that included a list of local safety net dental clinics were made available to all students. The OHE and OHP interns provided 95 presentations to 2,812 students.

The OHE and OHP Interns gave modified educational presentations to pre-K, elementary, middle, and high school age students at the Utah School for the Deaf and the Blind at the Ogden, Salt Lake, and Orem campuses. Sixteen presentations were given to 150 pre-K and elementary age students, twenty-six middle school, and twenty high school age students. Modifications to these educational presentations include several hands-on activities such as practicing brushing and flossing time, instructional brushing music, nutritional activities, visual aids, and one- on-one time with each student.

The OHP partnered with The Office of Health Disparities (OHD) who has had a five-year grant "State Partnership Initiative to Address Health Disparities" to fund events to increase access to medical and dental care. The OHD created strong partnerships in the community. This pilot project targeted two geographic areas, Glendale and South Salt Lake, based on a poverty map formula. The OHS and OHE provided dental screenings which were conducted through partnerships with local community organizations. After screenings were performed, prevention and restorative care was provided at Family Dental Plan (FDP), one of the partners in the project. Approximately over 300 children and adults received either screening, preventive, and/or restorative care. A dental school and three hygiene schools were involved with this project.
The OHP continued to work with Medicaid, using the CMS 416 report that shows annual EPSDT participation for dental visits. Also, as Medicaid was constantly changing in the state, we worked together with them to help providers,

families, and partnerships to understand these changes.

The OHP OES organized volunteers for dental screenings at the Special Olympics Healthy Athletes Dental Clinic in the fall and spring, and helped coordinate charity care for the athletes at the Salt Lake Donated Dental Services dental clinic, as well as other locations. The OHS and OHE along with dental students provided screenings and fluoride varnish. Some of the athletes received general anesthesia for treatment. Some of these athletes are children with special health care needs.

OHP Interns presented at elementary school assemblies in Utah and Salt Lake counties during the month of February for National Children's Health Month. In February of 2018, twenty-two presentations were given to 355 students. As part of the Oral Health Program's collaboration with Family Dental Plan, OHP interns provided twelve presentations to approximately 6,000 students at school based sealant assemblies. There educational presentations were given in the weeks before the preventive sealant clinic came to the school. This program was run in the twelve Title I schools in Salt Lake School District.

The OHE modified an educational presentation for Health Access Project (HAP) clients. These uninsured clients must participate in this educational class before receiving dental services through HAP. The OHE facilitated a collaboration between HAP and Fortis Dental Hygiene School in which students came about once a month to provide the educational class and answer clients' oral health related questions. The students gave nine presentations to forty HAP families.
The OHE collaborated with Salt Lake Community College (SLCC) dental hygiene students, volunteer dental hygienist, and Historic Scott School (an after school program in South Salt Lake). The OHE presented to thirty-four elementary and middle school age students. After the presentation, the children were split into four groups that rotated between stations on brushing, flossing, nutrition, screenings, and fluoride varnish. This allowed all of the children to participate in hands-on activities and have one-on- one instruction.

During these rotations, the OHE and volunteer dental hygienist provided screenings and fluoride varnish to twenty-one students with signed parental consents. All children who were screened were sent home with the results of their screening and local dental resources to share with their parents. One urgent case was found and reported to the child's parent with a referral to see a dentist. The OHE followed up with the parent and school coordinator the next day, a dentist had seen the child in less than 24 hours, and the urgent dental issue was resolved.

The State Dental Director with the OHP collaborated with Medicaid in efforts to increase the percent of children who have preventive dental visits. The OHP Secretary and State Dental Director provided support to the Utah Oral Health Coalition (UOHC). The other OHP staff also assisted. All of the OHP staff were non-voting members of the coalition. The UOHC worked to increase network of programs and to increase access to care for the underserved.

Accomplishments / Successes:

Using the National Head Start Program Information Report (PIR), the Oral Health Specialist (OHS) tried to move the needle on the National Performance Measures 13A and 13B with all the Head Starts statewide. These efforts included meeting with the State Head Start Collaborator, five individual Head Start/Early Head Start programs that had less than 50% of their participants visiting a dentist in the last year, and potential partner safety nets that can provide access to care.
Specifically, she has strategically connected Bountiful Smiles and Davis Applied Technical School (dental assisting students) to the Davis Head Early Head Start to apply fluoride varnish to all the Head Start kids in Davis County.

OHS and Oral Health Educator (OHE) provided dental screenings and fluoride varnish to Rural Head Starts in

Wendover, Tooele, and Grantsville Utah.

Additional oral health education and training has been provided statewide by the OHS and OHE to Head Starts, Home Visiting, and WIC clinics staff and clients.

The OHS and OHE are now writing bi-annually oral health articles for the Utah Chapter of the American Academy of Pediatrics.

The OHP published and disseminated two Bi-Annual Oral Health Outreach Reports to stakeholders and other partners.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-13B:

- Annually, the OHS collaborates with the PA Program from the University of Utah, with the Migrant Head Start (MHS). In June, OHS and OHE attended each of the MHS locations (Honeyville, Genola, and Providence), and did physical assessments, oral health risk assessments, and applied fluoride varnish. Over 400 children were seen at MHS. In the fall, they also visited the Ute Tribe Head Start (UTHS) with this interprofessional collaboration to provide the same care, along with referrals. Approximately 120 children were seen at (UTHS).
- The OHS worked with a National Oral Health Initiative to help eradicate dental disease in children. She partnered with local and national partners strategically to address this.
- The OHP published and disseminated two oral health outreach reports with stakeholders and other partners.

Challenges / Gaps / Disparities:

It is challenging to collect data on charity events in Utah. In observing these types of events, it is certain that not all groups record all the charity work that is done. Because no billing is done for these events, data tracking was not often done as well. The larger more organized groups were better at keeping good data, but because some volunteers did not record everything they did accurately, there were still challenges in tracking data.

Agency Capacity / Collaboration:

The OHP continued good partnerships and collaborations with Head Start, WIC, the Office of Home Visiting, the Utah Oral Health Coalition, the OHD, Utah Medicaid, the Utah Dental Hygienist Association, the Utah Dental Association, and others in efforts to improve dental care for children in Utah.

The OHS continued the great collaboration with the University of Utah PA Program, Migrant Head Start, and Ute Tribe Head Starts. Providing well child visits, oral health risk assessments, fluoride varnish, and referrals.

The OHS presented at two conferences about her interprofessional collaboration with the PA Program and other work with Head Start in Utah. First, was Strategies for Promoting Oral Health in Head Start, Child Care, and Home Visiting Programs at the National Oral Health Conference Round table on April 16, 2018 in Louisville, KY. Second was at the American Dental Hygiene Association on Promoting the Oral Health of Young Children by Working in Dental Public Health. Associate State & Territorial Dental Directors (ASTDD) paid for the OHS to present at both of these.

Summary Progress Report (2019) of ESMs related to NPM-13B

ESM 13.2 - Collaborate with Medicaid: Percent of Medicaid children who had a preventive dental visit

Goal/Objective:

Increase the percent of Medicaid children ages 1 - 18 who had a preventive dental visit.

Significance of ESM 13.2:

Measures the number of Medicaid children who have a preventive dental visit.

ESM 13.2 Progress Report:

This ESM is expected to increase the number of Medicaid children ages 1 through 18 years who have preventive dental visit in the past year. This includes an additional year of age 18 years, but it is close to the age range for NPM 13B. The Medicaid population is a group that has higher dental needs that those of higher economic status. They are part of the population in Utah that is important to concentrate on in improving this measure. The ESM Performance Measure was achieved. The Performance Objective was 51.5% and the Annual Indicator was 54.2%. The Five-Year Annual Projected Performance Objectives have been updated.

SPM-04: Suicide: ***The rate (per 100,000) of suicide deaths among youths aged 15-19***

FY18 Annual Report

Program Activities:

The Performance Measure was not met. The Performance Objective was 16.7 and the Annual Indicator based on 2017 Death Certificate data was 21.5.

Strategy 1: Evaluate the Utah Violent Death Reporting System, National Child Death Review Database, Prevention Needs Assessment, and the Youth Risk Behavior Survey for their usefulness in monitoring suicide.

An evaluation plan has been developed for the Utah Violent Death Reporting System and the National Child Death Review Database and will be implemented in the upcoming months. In addition, both systems will be evaluated using the "Updated Guidelines for Evaluating Public Health Surveillance Systems" to help inform evaluation efforts related to suicide surveillance.

To understand the usefulness of the Prevention Needs Assessment (PNA) in monitoring suicide indicators, VIPP took the lead in developing the 2017 Utah Adolescent Health Report using data from the PNA, a survey administered in Utah public schools in grades 6, 8, 10, and 12 on substance abuse, violence, injury, and chronic conditions. The data included in the report shows adolescent rates for important health indicators by local health district, grade, and sex. Results on selected indicators from violence and injury-related categories included mental health (feeling sad or hopeless, psychological distress, suicide ideation, suicide plan, and suicide attempt), substance abuse (binge drinking, marijuana use, and prescription drug abuse), and violence and injuries (driver talking on cell phone, driver texting, seat belt use, bullied at school electronic bullying, and dating violence). The data presented in this report are expected the help school administrators, teachers, and public health practitioners identify health and safety needs of Utah students and take steps towards protecting and improving student health.

The data included in the report to help monitor suicide showed that 27.3% of students reported feeling sad or hopeless, 20.6% of students reported psychological distress, 18.1% of students seriously considered suicide, 14.3% of students made a suicide plan, and 7.7% of students made one or more suicide attempts. Percentages for all of these indicators are highest among females, and 10th and 12th grade students were significantly more likely to have reported feeling sad or hopeless, have reported psychological distress, and seriously considered suicide.

Additional data showed that females and students in lower grades were significantly more likely to be bullied than males and students in higher grades. Overall, 27.9% of students reported being bullied at school and 27.2% of students reported being bullied over the Internet, by email, or by someone with a cell phone. Students in 8th grade were significantly more likely to be electronically bullied than 12th grade students. Females reported more than 50% more electronic bullying than males. Overall, 10.7% of students reported experiencing dating violence in the past year. Females had significantly higher percentages of dating violence than males.

In addition, VIPP staff participated in developing the 2017 Youth Risk Behavior Survey (YRBS) report which includes key finding and recommendations for creating healthy, safe, and supportive environments where students can focus on learning. Similar to the PNA, the YRBS is administered in Utah public schools in grades 9-12. The data included in the report show high school rates for suicide ideation and attempts, motor vehicle crashes, technology, sports concussions, alcohol, school safety, dating violence, and sexual violence. Recommendations for violence and injury related to suicide included efforts to utilize evidence-based materials to educate students about dating violence and

how to build healthy relationships, increase protective factors and decrease risk factors for various forms of violence, implement an evidence-based or best practices suicide prevention program, and train staff to recognize the signs and symptoms of depression and suicide.

Strategy 2. Continue to review all youth suicides in Child Fatality Review and develop recommendations and prevention strategies.

The Utah Multidisciplinary Child Fatality Review Committee (CFRC) reviewed 100% (n = 68) of all suicide related child fatalities statewide during the reporting period. This was an increase from the prior year (n = 41). Data from these reviews included recommendations and are submitted to a national child death review database. Over the last few years, youth suicides have been increasing in Utah, leading the VIPP to request epidemiological assistance from the Centers for Disease Control and Prevention (CDC) 2017. Their findings were reported to the Utah Department of Health in November 2017. The full report can be accessed here: http://health.utah.gov/vipp/pdf/Suicide/CDCEpi-AidReport.pdf

As a result of this study, Governor Gary S. Herbert created a Youth Suicide Task Force in January 2018. This task force, chaired by Lt. Governor Spencer J. Cox and Rep. Steve Eliason (Sandy) was charged with identifying priorities, and then to report back on effective programs, tools, and methods in youth suicide prevention in Utah. The report from this task force was submitted to the Governor in February 2018. You can access the report here: https://drive.google.com/file/d/1nKp7kpGF7PpKF962fIDIUyQM6uiilih9/view

Strategy 3. Identify and target surveillance data for policymakers, schools, local health departments, etc.

The 2017 Utah Adolescent Health Report using data from the PNA, a survey administered in Utah public schools in grades 6, 8, 10, and 12 on substance abuse, violence, injury, and chronic conditions, was shared with policymakers, schools, and local health departments. The data included in the report shows adolescent rates for important health indicators by local health district, grade, and sex. Results on selected indicators from violence and injury-related categories included: mental health (feeling sad or hopeless, psychological distress, suicide ideation, suicide plan, and suicide attempt), substance abuse (binge drinking, marijuana use, and prescription drug abuse), and violence and injuries (driver talking on cell phone, driver texting, seat belt use, bullied at school electronic bullying, and dating violence). The data presented in this report are expected the help school administrators, teachers, and public health practitioners identify health and safety needs of Utah students and take steps towards protecting and improving student health.

The 2017 Youth Risk Behavior Survey (YRBS) report was also shared with key stakeholders, particularly to encourage the implementation of key recommendations. Recommendations for violence and injury related to suicide included efforts to utilize evidence-based materials to educate students about dating violence and how to build healthy relationships, increase protective factors and decrease risk factors for various forms of violence, implement an evidence-based or best practices suicide prevention program, and train staff to recognize the signs and symptoms of depression and suicide.

Strategy 4. Develop, staff and conduct a youth suicide fatality review with partners.

All suicides are reviewed monthly in Child Fatality Review. Additionally, youth suicides have been the focus of several suicide fatality reviews. Goals of the review are to, 1) ascertain unique or emerging risk factors; 2) identify diagnoses more in patients who die by suicide; 3) identify risk to others associated with the decedent (contagion, clusters, first responders, informants, etc.); 4) Identify system issues that may have contributed to lack of recovery or treatment; and 5) identify foreseeability/preventability of the death.

Over the last few years, suicide by firearm in youth have been increasing. Efforts to promote means restriction and firearm safety among adults who own firearms is of paramount importance, in addition to promoting protective factors such as connectedness among youth.

Strategy 5. Produce and disseminate a yearly, Youth Suicide Fact Sheet.

Updated youth suicide fact sheets are produced every year. You can access the CDC Investigation Health Status Update here: http://www.health.utah.gov/vipp/pdf/Suicide/HealthStatusUpdateCDCEpi-AidYouthSuicide.pdf

In addition, the most recent suicide fact sheet can be accessed here:
http://www.health.utah.gov/vipp/pdf/Suicide/SuicideInUtah2018.pdf

Strategy 6. Continue distribution of firearm locks and firearm safety brochures to families of teens.

Local health departments distributed 810 gun locks to community members throughout Utah. Gun locks can be obtained free of charge from any health department, mental health authority or local police station or by contacting the VIPP. The most recent brochure that is disseminated to communities can be found here:
http://www.health.utah.gov/vipp/pdf/UTVDRS/gun-safety.pdf

Strategy 7. Provide at least five evidence-based suicide prevention training sessions to teens and/or their families.

During the reporting period, LHDs provided several suicide prevention training sessions as part of their suicide prevention activities targeting children and their parents. These included 110 Question, Persuade, and Refer sessions with 3,039 reached, two SafeTALK sessions with fifty-five reached, and three Mental Health First Aide trainings with fifty-six reached. Furthermore, LHDs collaborated with school districts to support and coordinate activities with local hope squads reaching 3,695 children.

Strategy 8. Increase the number of public health partners that are active in suicide prevention activities.

We were fortunate enough to be able to fund all thirteen of Utah's local public health departments to provide some level of suicide prevention coordination in their communities. We continue to partner with traditional and non-traditional partners to advance suicide prevention throughout the state. For example, we have a strong partnership with the Utah Shooting Sports Council to provide prevention and messaging around safe storage of firearms.

Accomplishments / Successes:

The Violence and Injury Prevention Program recorded several accomplishments and successes towards addressing adolescent suicides during the reporting period. The VIPP Suicide Prevention Coordinator is staffed and is now fully engaged in suicide prevention efforts at the state and local level. The VIPP requested epidemiological assistance from the Centers for Disease Control and Prevention (CDC) in 2017. Youth suicide data was analyzed to better determine trends, common precipitating factors for suicide, and risk and protective factors for suicidal behaviors unique to Utah youth. Their findings were reported to the Utah Department of Health in November 2017. The full report can be accessed here: http://health.utah.gov/vipp/pdf/Suicide/CDCEpi-AidReport.pdf

As a result of the report, Governor Herbert created a Youth Suicide Task Force in January 2018. This task force, chaired by Lt. Governor Spencer J. Cox and Rep. Steve Eliason (Sandy), was charged with identifying priorities, and then to report back on effective programs, tools, and methods in youth suicide prevention in Utah. The report from

this task force was submitted to the Governor in February 2018. You can access the report here: https://drive.google.com/file/d/1nKp7kpGF7PpKF962fIDIUyQM6uiilih9/view

That report led to several suicide prevention bills and funding allocation from the Utah State Legislature. Unfortunately, the legislature has not allocated any funding to primary prevention of suicide.

VIPP staff continue to participate on the SafeUT Commission. The SafeUT App, which is a new statewide resource that youth can download on their phones to chat with a crisis counselor 24/7 or put in an anonymous tip if they are worried about a friend. This app has received thousands of tips/chats from Utah youth and is available throughout Utah.

Finally, as a result of collaborating with partners, and educating and providing information to policy makers, the Utah legislature passed HB 346 in the 2017 legislative session, which created a Psychological Autopsy Position at the Office of the Medical Examiner within UDOH. Dr. Michael Staley was hired in July, and has been conducting interviews with families and friends after a suicide to determine risk factors, gather data for the UVDRS, inform suicide fatality review, and to refer the families to support and resources for their loss.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-04:

- Suicide prevention activities were emphasized in local health department contracts. As a result, there was an increase in individuals reached through suicide prevention activities in local communities. These included 110 Question, Persuade, and Refer sessions with 3,039 reached, two SafeTALK sessions with fifty-five reached, and three Mental Health First Aide trainings with fifty-six reached. Furthermore, LHDs collaborated with school districts to support and coordinate activities with local hope squads reaching 3,695 children. Finally, LHD distributed 810 gun locks to residents in their communities.
- VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens and have engaged LHDs in this effort. Identified overarching themes for VIPP's state strategic plan include: 1) Laws and Policies – Promote laws and policies that support safe communities, 2) Cultural – Encourage social norms that promote safety and health, 3) Health Access – Improve access and utilization to physical and behavioral health care, 4) Physical Environment – Enhance the physical environment to improve safe and healthy living, 5) Economic Development – Improve the socioeconomic conditions for Utahns, and 6) Connectedness – Promote individual, family, and community connectedness.

  As a result of this work, VIPP has been able to engage non-traditional partners, been instrumental in informing state level work on shared risk and protective factors, implemented primary prevention trainings to local communities in Utah, presented on national webinars, had several abstracts accepted to present on this topic, and provided technical assistance and guidance on this approach to reducing child injury deaths in the state.
- The VIPP requested epidemiological assistance from the Centers for Disease Control and Prevention (CDC) in 2017. Youth suicide data was analyzed to better determine trends, common precipitating factors for suicide, and risk and protective factors for suicidal behaviors unique to Utah youth. Their findings were reported to the Utah Department of Health in November 2017. The full report can be accessed here: http://healt h.utah.gov/vipp/pdf/Suicide/CDCEpi-AidReport.pdf

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That report led to several suicide prevention bills and funding allocation from the Utah State Legislature. Unfortunately, the legislature has not allocated any funding to primary prevention of suicide.

Challenges / Gaps / Disparities:

Challenges

The adolescent disparity in suicide continues to be investigated to help understand contributing factors associated with the suicide mortality rate among youths. This year, VIPP has again proposed to add questions the SHARP survey to measure sexual orientation and its association with suicide and other violence-related outcomes, which have been accepted by the school districts.

VIPP has been conducting strategic planning to focus on shared risk and protective factors, and meetings and primary prevention trainings have been held with the Injury Community Implementation Board, local health departments, and staff to gear up for this approach. It has been challenging to finalize the strategic plan due to competing priorities and less familiarity to this new approach and way of addressing violence and injury in the state. In addition, many funding sources are very siloed, making it difficult to focus on a comprehensive, primary prevention efforts where impact can be leveraged by having shared prevention vision to reduce risk factors and promote protective factors.

Emerging Issues

Over the last few years, suicide by firearm in youth have been increasing. Efforts to promote means restriction and firearm safety among adults who own firearms is of paramount importance, in addition to promoting protective factors such as connectedness among youth. In addition, technology as a risk factor for suicide needs to be explored.

Agency Capacity / Collaboration:

Suicide prevention is a cross-program effort involving injury prevention, substance abuse, mental health, and other health professionals. VIPP partnered with multiple agencies and entities to address the suicide prevention among adolescents performance measure. VIPP contracted with all thirteen local health departments to implement evidence-based suicide prevention programs and activities to reduce risk factors and promote protective factors associated with suicide. Local health departments participate on their local suicide prevention coalitions as well as the Utah Suicide Prevention Coalition to coordinate efforts, share successes, and implement best practices. VIPP co-chairs this statewide coalition with the suicide prevention coordinator with the Department of Substance Abuse and Mental Health.

The four state suicide prevention coordinators from the Division of Substance Abuse and Mental Health, the Utah State Board of Education, the Utah Chapter of the National Alliance on Mental Illness, and VIPP work together very closely to plan and implement state efforts to prevent suicide and suicidal behaviors as well as leverage resources.

Utah is changing its prevention approach to center around increasing protective factors and reducing the risk factors that most impact violence and injury related outcomes, at all levels of the socio-economic model.

National experts conducted a technical assessment of VIPP's injury infrastructure, policy, and programs in the

summer of 2018 through the Safe States Alliance State Technical Assessment Team (STAT) program. The STAT assesses injury and violence prevention within the state health agency, focusing on specific roles, relationships, and performance of the designated injury and violence prevention program. The goal is to support the development, implementation, and evaluation of injury and violence prevention efforts at the state health department level. This is done by conducting an on-site, point-in-time, assessment of the injury and violence prevention program, and providing recommendations for improvement.

The assessment focuses on core components of a successful state health department injury and violence prevention program including infrastructure, data, and policy and program strategies. For each core component, Safe States Alliance has developed standards and indicators that describe the conditions that should exist within an ideal, comprehensive, state health department injury and violence prevention program. The assessment often serves to refocus a participating state by requiring it to reflect on its strengths, weaknesses, opportunities, and barriers to success. The STAT process also serves to bring together different members of the injury and violence prevention community and allows individuals to share ideas for program development.

VIPP STAT recommendations encouraged VIPP to finalize the strategic plan focusing on shared risk and protective factors, prioritize staff activities to meet grant deliverables, prioritize hiring a Suicide Prevention Coordinator, develop a publications protocol, publish timelier reports, and modify LHD contracts to focus on high-impact actions.

Other activities in the Adolescent Health domain that contribute to improvement in the National Outcome Measures

Utah works to adhere to the three-tier framework outlined in the MCH Block Grant guidance. While the focus of most activities is the ESM →NPM→ NOM framework, activities on improving NOMs outside of the NPMs transpires in parallel. The following programmatic activities also work to improve outcomes in this domain.

National Outcome Measures (NOM)

NOM 16 - Adolescent mortality rate, ages 10 through 19, per 100,000

The leading causes of traumatic brain injuries among youth ages 5 to 19 are from motor vehicle traffic crashes, bicycle crashes, recreational activities, falls, and pedestrian crashes. The Violence and Injury Prevention program has developed the infrastructure within the local public health system to facilitate success of concussion education and implementation of concussion management programs, including linking individuals to resource facilitation services. Further, the capacity of local public health systems to implement suicide and opioid overdose prevention strategies have increased over the last few years. Local staff are trained to implement the evidence-based Question, Persuade, and Refer (QPR) trainings in their communities and LHDs are gearing up for a community crisis response training and development and community guides for suicide and opioid post-vention responses. This includes linking individuals to mental health and substance abuse treatment.

A bystander is someone who witnesses another person or group being harmed or hurt verbally, physically, emotionally, or culturally. Bystander intervention is about being more than a witness to harm and violence. It is when someone takes action, or does something, to help someone else who they witness experiencing harm, violence, or need; someone can take action before, during, or after the harm or violence has happened. The Violence and Injury Prevention Program conducts bystander trainings throughout the community and implemented a bystander intervention media contest focused on dating violence.

NOM 17 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Parent Night program reaches driver's education programs in 90% of public schools to help educate parents and teens about the top five dangerous driving behaviors and on Graduated Drivers Licensing laws. For the past ten years, the Violence and Injury Prevention Program, Utah Department of Transportation Zero Fatalities Program, and Utah Teen Driving Task Force have worked closely with parents and families who have lost a teenager in a motor vehicle crash to tell their stories in a memoriam book. The purpose of the teen memorial booklets is to prevent teen injury and death due to motor vehicle crashes. Stories are a very powerful way to reach teens and young drivers about the impact their decisions have on the ones they love.

NOM 28 - Teen birth rate, ages 15 through 19, per 1,000 females

A bystander is someone who witnesses another person or group being harmed or hurt verbally, physically, emotionally, or culturally. Bystander intervention is about being more than a witness to harm and violence. It is when someone takes action, or does something, to help someone else who they witness experiencing harm, violence, or need; someone can take action before, during, or after the harm or violence has happened. The Violence and Injury Prevention Program conducts bystander trainings throughout the community and implemented a bystander intervention media contest focused on dating violence.

Utah receives both the Abstinence Only and Personal Responsibility Education Program funding streams from the Family and Youth Services Bureau. Funds for these programs are distributed to community organizations and local health departments via sub-awardee contracts and monitored by the Adolescent Pregnancy Prevention Specialist.

The Utah Women and Newborns Quality Collaborative partners with the University of Utah Family Planning Research Group on various projects. This team worked on HER Salt Lake which provided free birth control to more than 7,400 people in Salt Lake County and 4,400 of those individuals enrolled in a longitudinal study to help understand the social, health and economic impact that free contraception has on their lives.

Other activities of note:

Alcohol has been one of the most widely used substances by youth in Utah. Similar to Utah adults, in 2017, adolescents report much lower rates of current alcohol use than the national average (8.8% of 8th, 10th and 12th grade students compared to 19.8% nationwide in 2016). The prevalence of binge drinking among youth who did drink (2017: 50.8%), however, was much closer to the national average (2015: 57.8%). Youth who drink alcohol are more likely to experience:

- School problems, such as higher absence and poor or failing grades.
- Social problems, such as fighting and lack of participation in youth activities.
- Legal problems, such as arrest for driving or physically hurting someone while drunk.
- Physical problems, such as hangovers or illnesses.
- Unwanted, unplanned, and unprotected sexual activity.
- Disruption of normal growth and sexual development.
- Physical and sexual assault.
- Higher risk for suicide and homicide.
- Alcohol-related car crashes and other unintentional injuries, such as burns, falls, and drowning.
- Memory problems.
- Abuse of other drugs.
- Changes in brain development that may have lifelong effects.
- Death from alcohol poisoning.

In general, the risk of youth experiencing these problems is greater for those who binge drink than for those who do not binge drink. Youth who start drinking before age 15 years are six times more likely to develop alcohol dependence or abuse later in life than those who begin drinking at or after age 21 years. The Violence and Injury Prevention Program has increased its capacity in Alcohol Epidemiology and works with key stakeholders to identify target populations to reach and implement strategies based on the Community Guide.

MCH Block Grant FY20 Application & FY18 Report

Adolescent Health Domain

NPM-08: Physical Activity: *Percent of adolescents in grades 9-12 who report being physically active at least 60 minutes per day in the past week*

FY20 Annual Plan:

The EPICC program will continue working with the State Board of Education and SHAPE Utah to provide professional development opportunities to local education agencies. The National SHAPE America Conference will be in Salt Lake City in April 2020. EPICC staff is currently the SHAPE Utah president and will work with Local Education Agencies (LEA) to provide support for Health and PE teachers to attend.

EPICC staff will also continue to work with LEAs to use a multi-component approach by which school districts and schools use all available opportunities for students to be physically active, meet the nationally recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime.

EPICC staff will work with the Utah State Board of Education provide technical assistance to LEA to strengthen the language around the physical activity and physical education components of the local wellness polices.

Continue to work with partners to educate the Utah State School Board about the importance of recess. EPICC staff will work with Action for Healthy Kids to create and propose USBE recess guidelines.

Proposed Activities:

- By June 30, 2020, EPICC staff will continue to provide LEAs with technical assistance and support by offering services to strengthen the local wellness policy. Local Health Departments will ensure that comprehensive language around physical activity and physical education are integrated into the policy.
- By June 30, 2020 EPICC staff will work with Action for Healthy Kids to establish State Board of Education recess guidelines.
- By June 30, 2020, EPICC staff will work with Utah Department of Transportation's Safe Routes to School team to ensure that schools have current the Safe Routes maps and plans. We will also work on revising the Safe Routes to School funding application that local agencies can apply for both infrastructure and non-infrastructure projects that gets kids walking and biking to school.
- By April 2020, EPICC staff will fulfill the duties and responsibilities as the president of SHAPE Utah. During this time, EPICC staff will provide guidance, support, and information to the SHAPE America to ensure that a successful convention is represented in Salt Lake City.

NPM-13B: ***Percent of children, ages 1 through 17, who had a preventive dental visit in the past year***

FY20 Annual Plan:

In FY20, the Oral Health Program (OHP) plans to continue to collaborate with Medicaid to increase the number of children and pregnant women who have preventive dental visits and receive needed dental treatments. The State Dental Director will continue to work as a member of the Dental group with Utah Medicaid.

The OHP OHS will continue to collaborate with Head Start and WIC, and the OHP Oral Health Educator with the Utah Office of Home Visiting, in efforts to increase the number of children visiting the dentist. Developed by the OHP, the "12 Oral Health Messages" and the magnet will continue to be used with these programs.

The OHP will also continue to work with Utah's refugee population by helping with the Church of Jesus Christ of Latter-Day Saints Humanitarian Center Program.

The OHS and OHE will continue to strategically partner with Granite Peaks Adult Learning Center, OHD, and Fortis Dental Hygiene School to provide refugees with oral health education including topics of pregnancy and nutritional habits for young children. Fortis dental hygiene school then provides preventive services for refugees.

The OHP Oral Health Educator with OHP interns will continue to provide oral health education and dental referrals to middle and high school students in select schools within Canyons, Granite, Weber, and Tooele School Districts.

The OHP will collaborate with the UDOH Family Dental Plan Clinic Program's Seal Your Smile program in efforts to increase the number of children in underserved schools who receive dental sealants. With funding from the Salt Lake School Foundation, the Seal Your Smile program started in the fall of 2017 with twelve Salt Lake schools.

The State Dental Director will continue to work with the Utah Dental Association to encourage participation in programs for underserved children in Utah. The State Dental Director will also continue to encourage dentists to see children with Utah Medicaid dental benefits. Efforts will also be made to encourage first dental visits by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

In FY19, the OHP will start planning for the 2020 statewide school survey of the children's oral health status. The survey will follow the Basic Screening Survey recommendations of the Association of State and Territorial Dental Directors.

Proposed Activities:

- The Oral Health Specialist (OHS) also serves as the State Dental Hygiene Liaison for Head Start (HS). She uses the Program Information Report (PIR) from HS to strategically target what programs she can help increase dental home access and education. She will continue these efforts with partnerships from the University of Utah PA program and now Dixie Dental Hygiene School to see children in more rural areas, where access is more of a challenge.
- The OHS, OHE, and State Dental Director will continue to work with and promote tele-dentistry to increase access to care for school-based programs.
- The OHS and OHE will continue to provide oral health articles bi-annually for the American Academy of Pediatrics Utah Chapter newsletter.

- The OHP will continue to use the “12 Oral Health Messages” modules and magnets to share with WIC offices, Head Start, Home Visiting, etc. Maternal and infant oral health messages are included in this.
- The State Dental Director will continue to work with the Utah Dental Association to encourage participation in programs for underserved children in Utah.

SPM-04: Suicide: ***The rate (per 100,000) of suicide deaths among youths aged 15-19***

FY20 Annual Plan:

The Violence and Injury Prevention Program (VIPP) at the Utah Department of Health was established in 1983. Utah was one of the first five health departments in the United States to have an injury prevention program. The VIPP is currently housed in the Bureau of Health Promotion in the Division of Disease Control and Prevention. Across the Bureau of Health Promotion, there is support for violence and injury prevention to address shared risk and protective factors. The VIPP has thirty staff dedicated to violence and injury surveillance and prevention activities. The staff has varying backgrounds, expertise, and experience in a variety of public health-related issues, including surveillance, conducting quality assurance activities, and generating data reports. The VIPP staff members participate on several national organizations and have longstanding, established relationships with key state-level agencies.

The VIPP has extensive internal and external partnerships and collaborates with these partners to conduct surveillance and prevent violence and injury. The VIPP partners with all thirteen local health districts in Utah, provides funding and supporting for them to address violence and injury prevention topics. In addition, the VIPP provides funding and support to other local partners and community-based organizations such as Rape Prevention and Education grantees. The VIPP primarily sets its priorities based on injury data, while also considering legislative and Department of Health priorities. Utah was one of the early participants in the National Violent Death Reporting System (NVDRS), and the first state to include overdose deaths in NVDRS. Utah was the first state to gather and report data on school injuries, a project that continues to this day.

VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. We have begun developing a strategic plan focusing on this shared lens and have engaged LHDs in this effort. Identified overarching themes for VIPP's state strategic plan include: 1) Laws and Policies – Promote laws and policies that support safe communities, 2) Cultural – Encourage social norms that promote safety and health, 3) Health Access – Improve access and utilization to physical and behavioral health care, 4) Physical Environment – Enhance the physical environment to improve safe and healthy living, 5) Economic Development – Improve the socioeconomic conditions for Utahns, and 6) Connectedness – Promote individual, family, and community connectedness.

As a result of this work, VIPP has been able to engage non-traditional partners, has been instrumental in informing state level work on shared risk and protective factors, has implemented primary prevention trainings to local communities in Utah, has presented on national webinars, and has had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state.

Proposed Activities:

- Continue to review all youth suicides in Child Fatality Review and develop recommendation and prevention strategies.
- Identify and target surveillance data for policymakers, schools, local health departments, etc.
- Produce and disseminate timely data on youth suicides.
- Continue distribution of firearm locks and firearm safety brochures to families of teens.
- Provide at least five evidence-based suicide prevention training sessions to teens and/or their families

Children with Special Health Care Needs

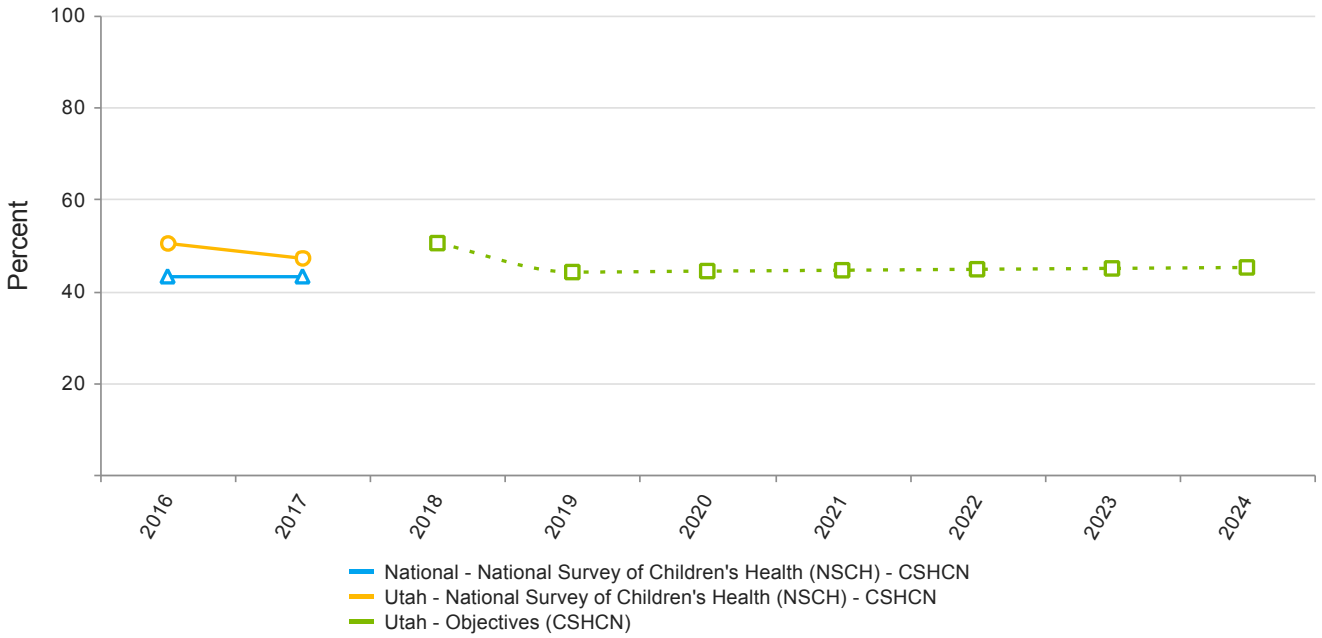
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016_2017	11.6 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	39.6 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	92.3 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016_2017	3.1 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			50.4
Annual Indicator		50.4	47.2
Numerator		75,090	68,219
Denominator		148,990	144,415
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.1	44.3	44.5	44.7	44.9	45.1

Evidence-Based or –Informed Strategy Measures

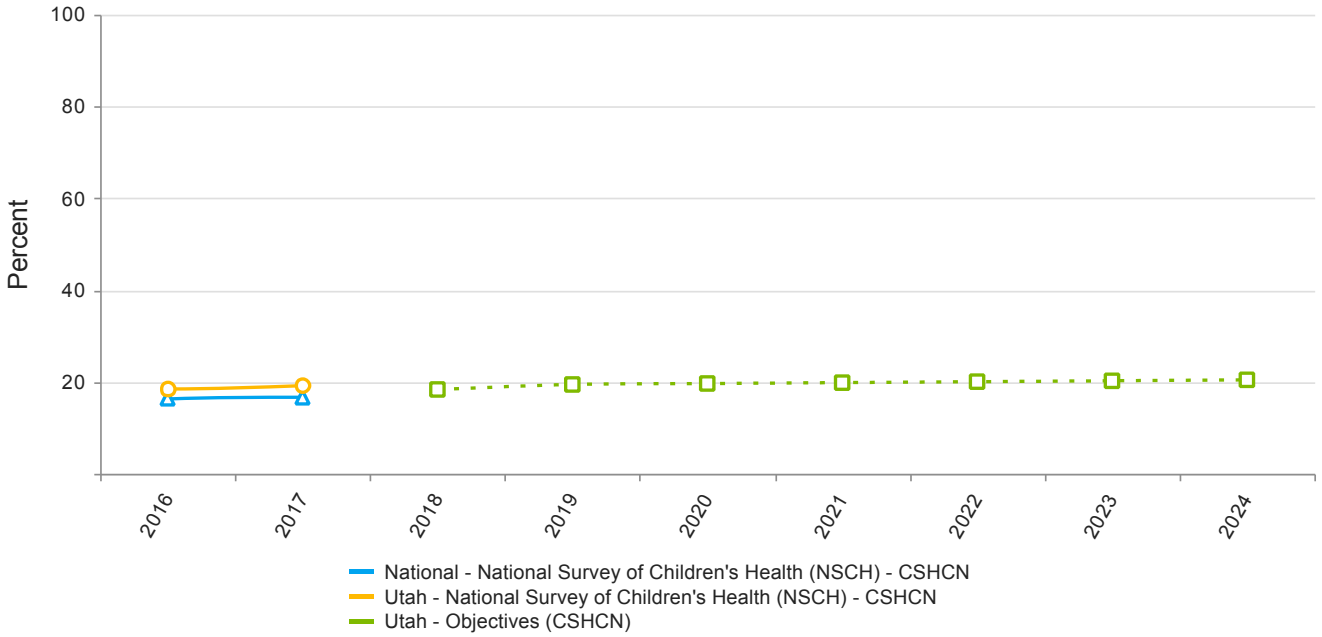
ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		69	67
Annual Indicator	68.8	67.3	68.1
Numerator	99	115	286
Denominator	144	171	420
Data Source	Program Level Data	Program Data, Integrated Services Program	Program Data, Integrated Services Program
Data Source Year	FFY17	FY2017	FY2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	68.0	69.0	69.0	70.0	70.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			18.4
Annual Indicator		18.4	19.3
Numerator		11,791	12,760
Denominator		64,109	66,028
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	19.5	19.7	19.9	20.1	20.3	20.5

Evidence-Based or –Informed Strategy Measures

ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		23.5	20
Annual Indicator	23.5	23.5	76.2
Numerator	16	16	16
Denominator	68	68	21
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2016	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	76.5	77.0	77.5	78.0	78.5	79.0

ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		69	67
Annual Indicator	68.8	67.3	68.1
Numerator	99	115	286
Denominator	144	171	420
Data Source	Program Level Data, UESC Family Survey	Integrated Services Program Data	Integrated Services Program Data
Data Source Year	FFY17	FY2017	2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	68.0	69.0	69.0	70.0	70.0

State Performance Measures

SPM 2 - CSHCN Rural Clinical Services: The percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		3.3	1
Annual Indicator	1.9	0.8	1.6
Numerator	550	272	533
Denominator	28,704	35,870	34,275
Data Source	CSHCN/UDAC Billing Data	CSHCN/UDAC Billing Data (2017) and Pop Est (2016)	ISP Utilization Data
Data Source Year	2015	2016-17	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	3.0	3.0	3.0	3.0	3.0

State Action Plan Table

State Action Plan Table (Utah) - Children with Special Health Care Needs - Entry 1

Priority Need

Out-of-pocket costs/financial challenges faced by CSHCN parents

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

By 2020, increase the percent of children with special health care needs who receive care within a medical home from 50.4% (NSCH, 2016) to 52.4%.

Strategies

1. Educate primary care providers (medical homes) on the components of a medical home through the Utah Chapter of the American Academy of Pediatrics "Growing Times" quarterly newsletter.

2. Provide education to families and practitioners on benefits of the Medical Home Portal, Utah's shared resource to ensure access to the components of a medical home and requested services.

3. Support newly-developed agreements to enhance feedback among professional organizations to improve care coordination for children with special health care needs.

4. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah.

ESMs	Status
ESM 11.1 - UESC Family Survey: Number of responses to the Utah Enhanced Services for CYSHCN (UESC) Family Survey	Inactive
ESM 11.2 - UESC Practitioner Survey: Number of responses to the Utah Enhanced Services for CYSHCN (UESC) Practitioner Survey	Inactive
ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (Utah) - Children with Special Health Care Needs - Entry 2

Priority Need

Out-of-pocket costs/financial challenges faced by CSHCN parents

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By 2020, increase the percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care from 18.4% (NSCH, 2016) to 18.5%.

Strategies

1. Partner with and provide funding to the Utah Parent Center in support of education to families, youth and CSHCN on transition to adulthood.

2. Provide informational training and resources to increase awareness and knowledge to support adolescents transitioning to adulthood.

3. Educate families and primary care providers (medical homes), through various methods, on the definition, purpose, tools, and processes of transition to adulthood as identified in the Six Core Elements of Health Care Transition 2.0 in consideration of the needs identified by the results of the Family Survey.

4. Establish a sub-committee from the CSHCN Bureau Advisory Committee for adolescents transitioning to adulthood utilizing the Utah Valley University, Passages Program along with Scenic View Academy.

ESMs	Status
ESM 12.1 - UESC Family Survey: Number of responses to the Utah Enhanced Services for CYSHCN (UESC) Family Survey	Inactive
ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood	Active
ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Utah) - Children with Special Health Care Needs - Entry 3

Priority Need

Specialty service availability (rural areas) and improved care coordination for children with special health care needs (continuation of old SPM 9)

SPM

SPM 2 - CSHCN Rural Clinical Services: The percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)

Objectives

By June 30, 2019, establish a new baseline of children with special health care needs in the rural areas of the state who receive direct clinical services or care coordination.

Strategies

1. Train and support care coordinators at four local health districts (San Juan, Southeast, Central, and Tri-County).
2. Hire full-time and part-time clinical staff to provide direct care services for CSHCN residing in the rural target areas.
3. Consult with the local health departments to provide comprehensive care coordination services to children with special health care needs.
4. Monitor contractual obligations of the local health departments in the target population areas to ensure compliance.
5. Assist the local health departments working with children with special health care needs to market the program and recruit children who may benefit from care coordination and direct clinical services.

MCH Block Grant FY20 Application & FY18 Report

CSHCN Domain

NPM-11: Medical Home: ***Percent of children with special health care needs having a medical home***

FY18 Annual Report

Program Activities:

The Performance Measure was not achieved. The Performance Objective was 50.4% and the Annual Indicator from the 2017 National Survey of Children's Health was 43.9%.

In FY18, the Utah Enhanced Services for CSHCN grant ended, but its administrators and partners continued to work together to improve the system of services for CSHCN. The Integrated Services Program and its partners, including Utah Family Voices, educated professionals about the components of a medical home through quarterly Utah Chapter of American Academy of Pediatrics' Growing Times newsletter articles. The Integrated Services Program educated providers on the availability of care coordination services and worked to improve a shared plan of care for families and their providers. The Medical Home Portal (shared resource) updated content for families and providers and updated community resources. The Utah Children's Care Coordination Network provided training and networking opportunities for care coordinators.

Accomplishments / Successes:

Organizations worked together to improve the system of services. Shared plans of care (SPoC) and a sample template were developed to improve care coordination organization for CSHCN, providers, and families. The Utah Children's Care Coordination Network, with leadership provide by the Medical Home Portal, Utah Family Voices, and other partners, provided training for families and providers to ease use and provide continuity as well as provided an avenue for developing and testing documents such as the SPoC. Slightly more than 20% of the target population had a documented SPoC in the Integrated Services Program electronic medical record. The Bureau of Maternal and Child Health provided financial support for the Medical Home Portal. Improvements were made to the Medical Home Portal including adding content, adding customizable lists for users, expanding local services listings, adding a live-help telephone support process, and adding partners. Three agreements were developed to improve feedback processes among providers. The organizations referred families, assisted each other with care coordination, assisted in the development of a SPoC, and shared follow-up information to assist communication with each other and the families.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-11:

- The Integrated Services Program worked with partners to implement shared plans of care for families and professionals regarding needs for CSHCN.
- The Integrated Services Program and its partners educated professionals about the components of a medical home through four quarterly Utah Chapter of the American Academy of Pediatrics' Growing Times newsletter articles.
- MCH Bureau funded enhancements to the medical home portal including adding content, adding customizable lists for users, expanding local services listings, adding a live-help telephone support process, and adding partners.

Challenges / Gaps / Disparities:

Challenges

The measure of medical homeness is as abstract as the concept of medical home and includes multiple data points from multiple questions asked of parents. Parents who do not understand the range of services that their primary care providers offer may fail to respond positively to survey questions, and therefore, unknowingly underrepresent the medical homeness of their primary care provider's office. Primary care providers are not trained to advertise the range of medical home services that they offer. Additionally, limited funding, staff time, and technological limitations have posed challenges for educating families and professionals, and promoting the Medical Home Portal, Utah's shared resource for the Utah Enhanced Services for CSHCN grant. Those challenges have also limited the ability to provide a shared plan of care in an electronic format that could be accessed by families and multiple partner organizations.

Agency Capacity / Collaboration:

Multiple partnerships existed through a variety of projects. For example, the Utah Regional Leadership Education in Neurodevelopmental and related Disabilities project, partnered with Utah State University, the University of Utah, and several other organizations. The Medical Home Portal engaged families and providers in developing content and identifying resources for families of CSHCN and their providers. The Utah Enhanced Services for CSCN grant utilized a State Interagency Team to guide improvements in the system of services. Other projects similarly worked with families and providers to improve the system of services.

Summary Progress Report (2019) of ESMs related to NPM-11

***ESM 11.1 - UESC Family Survey: Number of responses to the Utah Enhanced Services for CSHCN (UESC) Family Survey**

***ESM 11.2 - UESC Practitioner Survey: Number of responses to the Utah Enhanced Services for CSHCN (UESC) Practitioner Survey**

**The above two ESMs have been deactivated as we have completed the activities related to the measures.*

ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Goal/Objective:

Increase the percentage of families connected to community resources.

Significance of ESM 11.3:

The goal is that CSHCN receive coordinated care, and can easily access community-based services. Services are available, but families may be unaware of the services, or unaware of how to access the services.

ESM 11.3 Progress Report:

The MCH Integrated Services Program (ISP) and Utah Family Voices (UFV) use Utah's Shared Resource, the Medical Home Portal at www.medicalhomeportal.org, to help families find and connect to needed resources for their children with special health care needs (CSHCN). Families that are served, are eligible for a follow-up contact to determine if they connected with the resources suggested by the ISP and UFV. Challenges with follow-up include contacting families in crisis for follow-up, asking follow-up questions during care coordination for families in crisis, and families in crisis remembering what resources were offered, contacted, and useful. Increase use by families of the Utah shared resource and assure linkage to the needed / requested services.

Notes & Comments:

The 2016 survey resulted in seven practitioner responses. The 2017 survey was cancelled due to lack of response from practitioners. During the final meeting of the State Interagency Team meeting of the Utah Enhanced System for CSHCN (UESC) grant in 2017, partner organizations noted increases in the amount of content added to Utah's shared resource (Medical Home portal), efforts to increase youth with transition plans, increases in participants in the Utah Children's Care Coordination Network (UCCCN), and expanded exploration of platforms for a Shared Plan of Care (SPoC). With the end of the UESC grant and moving the Integrated Services Program to the MCH Bureau, in light of the challenges of encouraging practitioners to respond to the survey, discussions will need to explore the availability of staff and resources to administer the survey again.

NPM-12: Transition: ***Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care***

FY18 Annual Report

Program Activities:

The Performance Measure was achieved. The Performance Objective was 18.4% and the Annual Indicator from the 2017 National Survey of Children's Health was 20.2% (2016-2017 average was 19.3%). Due to changes in the sampling methodology and significant changes in the questions, this measure was not comparable to previous surveys. National Performance Measure 12 is a composite score of several questions.

Utah's education and service agencies that have key roles and responsibilities in transition have each added new programs and initiatives in this area over the past three years, and families are more aware of new possibilities and options for post-secondary education and employment. Articles in the Utah Chapter of the American Academy of Pediatrics newsletter, Growing Times, were used to educate providers on the components of a medical home including transition. ISP continued to fund the Medical Home Portal and the Utah Children's Care Coordination Network, both of which serve to help families of youth with special health care needs of transition age. ISP partnered with the Interagency Outreach Training Initiative to administer funding for people with disabilities including those of transition age.

Accomplishments / Successes:

Participating primary care practices who provide care coordination are communicating with schools around care and accommodations for their patients. The Medical Home Portal / Shared Resource is well utilized both in Utah and in other states, and is providing information that is needed by families and providers including resources for families and providers regarding transition to adulthood. Due to limited resources, the Utah Bureau of Maternal and Child Health could not solely accomplish the transition activities and relied on partner organizations to support activities. However, the Bureau of Maternal and Child Health provided financial support for the Medical Home Portal which includes information for providers and families about transition to adulthood.

One positive example of state collaboration occurred with transition activities when staff leveraged their participation on other stakeholder committees. The Utah Transition Action Team (UTAT), Employment Partnership, and Utah Regional Leadership Education in Neurodevelopmental and related Disabilities (URLEND) were groups that conducted activities to improve the system of services for transition-age individuals. The Employment Partnership also supported transition to adulthood. The Coordinating Council for Persons with Disabilities (CCPD), a state mandated group of disability service agency representatives, which included agency executive directors, conducted discussions regarding a communication platform that could jointly serve their service users. The CSHCN Bureau Director served as the chair.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-12:

- Participating primary care practices who provide care coordination are communicating with schools around care and accommodations for their patients.
- The Medical Home Portal / Shared Resource is well utilized both in Utah and in other states and is providing information that is needed by families and providers including resources for families and providers regarding transition to adulthood.
- Coordinating Council for Persons with Disabilities (CCPD) conducted discussions regarding a

communication platform that could jointly serve their service users.

Challenges / Gaps / Disparities:

The Annual Indicator from the 2017 National Survey of Children's Health was not comparable to the 2009/10 data due to changes in the sampling methodology and significant changes in the questions.

Limited funding, staff time, and technological limitations have posed challenges for educating families and professionals regarding transition to adulthood and promoting the Medical Home Portal, Utah's shared resource, which contains information and resources to assist families and providers in transition to adulthood.

Families continue to face challenges accessing care coordination and often do not have a transition plan for older children. Partner organizations in education, workforce services, and other fields collaborate to support transition to adulthood.

Agency Capacity / Collaboration:

Collaborative partners, not limited to the Employment Partnership, Interagency Outreach Training Initiative, and Coordinating Council for Persons with Disabilities, provided outreach, tools, and training to health care providers and families, and supported transition services such as supports for employment. The partners included the Utah Parent Center, Utah Family Voices, Medicaid, Social Security Administration, Utah State University Center for Persons with Disabilities, Division of Services for People with Disabilities, Utah State Office of Education, Vocational Rehabilitation, Work Ability Utah, and the Utah Developmental Disability Council. The Utah Children's Care Coordination Network and Medical Home Portal provided training and support for care coordinators and family partners from a variety of private provider offices and healthcare organizations in the state. The Utah Parent Center provided several workshops for parents and youth in transition including topics of guardianship, medical transition, employment, and education. ISP works with several of the local school districts to provide information to families in transition at transition and agency fairs sponsored by the districts.

Summary Progress Report (2019) of ESMs related to NPM-12

***ESM 12.1 - UESC Family Survey: Number of responses to the Utah Enhanced Services for CSHCN (UESC) Family Survey**

****This ESM measure has been inactivated as the project has been completed.***

ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood

Goal/Objective:

Increase percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood.

Significance of ESM 12.2:

A written transition plan may help families of children with special health care needs to consider the health and other needs, and determine actions to help the youth transition to adulthood. The Utah Enhanced Services for CSHCN (UESC) Family Survey attempts to determine if families have access to a written transition plan, one of the components of the Six Core Elements of Health Care Transition 2.0.

ESM 12.2 Progress Report:

Significance of ESM:

A written transition plan may help families of children and youth with special health care needs consider the health and other needs and determine actions to help the youth transition to adulthood. The UESC Family Survey attempts to determine if families have access to a written transition plan, one of the components of the Six Core Elements of Health Care Transition 2.0.

ESM Progress Summary 12.2

National Performance Measure 12 is a composite score of several questions. Understanding the general percentage of CSHCN without a written transition plan will help determine needs that will guide outreach, training, and collaboration with partner organizations. The Performance Objective of 28% was not met. The 2016 survey noted that 24% of respondents with a child 15 years old or older had a written transition plan, compared to 20% for the 2017 survey. Continued education of families and healthcare providers will be provided through social media, newsletter articles, and participation in collaborative interagency workgroups that serve transition-age individuals and their families. Education will focus on the importance of transition, the importance of a written transition plan, and needs identified by the Family Survey. Additional funding from the MCH Bureau will be sought to support the coordination and promotion of resources necessary to make transitions to adult health care.

ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Goal/Objective:

Increase the percentage of families connected to community resources by 67%.

Significance of ESM 12.3:

The goal is that CSHCN receive coordinated care, and can easily access community based services. Services are available, but families may be unaware of the services, or unaware of how to access the services.

ESM 12.3 Progress Report:

The MCH Integrated Services Program (ISP) and Utah Family Voices (UFV) use Utah's Shared Resource, the Medical Home Portal at www.medicalhomeportal.org, to help families find and connect to needed resources for their children with special health care needs (CSHCN). Families that are served are eligible for a follow-up contact to determine if they connected with the resources suggested by the ISP and UFV. Challenges with follow-up include contacting families in crisis for follow-up, asking follow-up questions during care coordination for families in crisis, and families in crisis remembering what resources were offered, contacted, and useful. From July 2016 to June 2017, the MCH Integrated Services Program reported, of the 171 families that were referred to specific sections of the Medical Home Portal (shared resource), and on telephone follow-up, 115 (67%) reported receiving a needed service, support, or specialist. In March 2017, the ISP moved from the CSHCN Bureau to the MCH Bureau. The Integrated Services Program was charged with re-implementing a clinical services program for rural CSHCN in 2017 through 2018. As that work progressed, follow-up on parent survey indicated that 75% of families connected with a needed support, specialist, or service.

SPM-02: Rural Clinics: ***Percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program***

FY18 Annual Report

Program Activities:

The Performance Measure was not achieved. The performance Measure was 2.0 and the Annual Indicator was 1.56. The Annual Performance Measure had previously been 3.0 for several subsequent years. SPM-02 was discontinued in the FY18 grant application. However, SPM-02 has been re-worked and is included in the 2019 grant application. The updated performance measure is 2.0, and includes both care coordination and direct clinical services provided to CSHCN in rural Utah.

By the start of FY18 (October 1, 2017), contracts were being negotiated between UDOH and four local health districts/departments (LHD) for the provision of care coordination at the local and regional level. Given the lack of pediatric and specialty care in these areas, and a great need to connect families with supports, services, and specialists, the Integrated Services Program and the MCH Bureau contracted with San Juan County Health Department, TriCounty Health Department, Central Utah Health District, and Southeast Utah Health District. Five year contracts were executed on November 1, 2017. Care coordination staff were hired at the local health departments over the next several months, with the last position being filled in July. Training on electronic medical records, community outreach, care coordination principles and practices, and our direct multidisciplinary clinical service model began for this new staff. Ongoing live training (face to face) for the LHDs ensued throughout the calendar year from our seasoned ISP staff, and remotely via the Utah Children's Care Coordination Network the third Wednesday of every month.

In October, 2017, ISP and MCH began the process to create a Request for Proposal to contract with clinical providers to deliver evaluative and diagnostic services (psychology, pediatrics, occupational therapy, physical therapy, speech pathology, and audiology) for the four local health departments with whom we had contracted for care coordination. The process, including State Procurement requirements, took over five months. We received inadequate response from the pediatric specialty community on two subsequent solicitations. As such, we moved to obtain approval from the UDOH Executive Director's Office to close the RFP solicitation, and move to direct hire for these positions. The opening, advertising, and interviewing for two full-time positions (psychology and pediatric APRN) began in April 2018. These two positions were hired by mid-summer. Four additional limited part-time positions were advertised for occupational therapy, physical therapy, speech pathology, and audiology. Given that these positions are limited to twenty-two rural traveling clinics per year, normal advertising yielded almost no applicants. The ISP manager reached out to past UDOH employees, and other community partners to connect with various candidates on an individual basis. By September 2018, we had hired the last of these four remaining part-time positions.

The Integrated Services for Children with Special Health Care Needs team implemented direct clinical services on August 24, 2018, with our first traveling clinic in Vernal. By the end of CY18, two additional clinics were held in Vernal (TriCounty Health Department), two in Richfield (Central Utah Health District), two in Blanding (San Juan County Health Department), and one each in Price and Moab (Central Health District), with services from our Pediatric APRN, psychologist, OT, PT, SLP, and audiologist. For CY18, 337 unique children in rural Utah received either care coordination, direct clinical services, both from the in-house ISP team, the care coordinators at the local health districts, and the multidisciplinary evaluation and diagnostic team.

ISP established a Memorandum of Agreement April 1, 2018 with the University of Utah's Pediatric Orthopedic group to continue to fund air travel via State Aeronautics, ground transportation to and from rural clinic sites, and the cost of rental for clinical space at Dixie Regional Medical Center in St. George. Pediatric Orthopedics evaluates and diagnoses children twelve times per year in Vernal, Moab, Blanding, and St. George. For CY18, the University of Utah's Pediatric Orthopedic group saw 196 unique patients, and 308 patient encounters in rural Utah. Direct services to rural patients, including ISP clinical visit, care coordination, and pediatric orthopedics totaled 533 unique patients. Statewide (rural and urban) we provided services for 833 unique patients, and 1688 patient encounters.

Accomplishments / Successes:

Partnerships were formally established between ISP/MCH and four local health departments. Care coordination staff was hired at those same health departments with formal training taking place both face to face, with ISP staff, and remotely through monthly Utah Children's Care Coordination Network seminars and sharing sessions. Full-time staff was hired to cover both traveling clinics and a small Wasatch Front clinical presence, an APRN and APRN dually certified in family practice and pediatrics. Four part time specialists were hired to cover rural clinics, an occupational therapist, physical therapist, speech pathologist, and audiologist. We began to formally offer clinical services in rural Utah the end of August 2018, with clinics scheduled every other month through the end of the calendar year, and throughout 2019 in Vernal, Richfield, and Moab/Price, and quarterly in Blanding. We were able to establish a formal relationship with the University's Pediatric Orthopedic group through MOU to allow for Title V funding of in-state air travel, ground transportation, and limited clinical space rental for twelve pediatric orthopedic clinics in St. George, Vernal, Moab, and Blanding. The ISP Program Manager attended weekly staffing meetings with the University Developmental Center (UDAC) to facilitate a care coordination consultative role, receive referrals for care coordination of UDAC patients, provide direct care coordination for those patients, and close the communication feedback loop between ISP and the University.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-02:

- ISP established a MOU with University of Utah's Pediatric Orthopedic group to continue to fund air travel, clinical space rental, and ground transportation for twelve rural clinics per year.
- Care Coordinators were hired at four LHDs, and in depth training was provided by ISP and the Utah Children's Care Coordination Network.
- Full-time clinical staff, am APRN and a Pediatric Nurse Practitioner, were hired for rural and Wasatch Front clinics, part-time staff, and OT, PT, SLP, and Audiologist, were hired to cover rural traveling clinics.
- Direct clinical and care coordination services provided to 533 unique patients in rural Utah.
- Statewide, 833 unique patients served through clinical services (including pediatric orthopedics) and care coordination, with 1688 patient encounters.

Challenges / Gaps / Disparities:

In CY2018, one of our seasoned care coordinators retired. That position was not refilled. Instead, that salary/benefit money was used to bolster the costs associated with hiring two full-time practitioners. As such, the statewide care coordination case load and ensuing referrals, were redistributed among the four remaining care coordinators. The percentage of children residing in rural areas of the state who received care coordination or direct clinical services was 1.56 which falls below the new goal of 2.0, as re-established in the FY19 grant application. The advertising, interviewing, hiring, and on-boarding of staff was time consuming, especially when it came to hiring the very part-time specialists to cover our twenty-two traveling clinics per year. Traditional job posting yielded no tangible results, and we moved to a direct contact methodology, through which we reached out to providers known by our current and former staff. This ultimately netted four qualified specialists (OT, PT, SLP, Audiology), albeit not until August and

September 2018. Due to staffing challenges, clinics did not begin until August 2018.

A large quantity of equipment and supplies needed to be procured to allow for testing and evaluation of CSHCN in our clinics. We ran into some purchasing road blocks through current State procurement procedures requiring a sole source authorization for the psychological testing equipment and protocols. Sole source authorization takes many weeks to complete. Once orders were authorized and submitted to the vendors, an internal accounting error through one of the vendors delayed delivery of the testing equipment for several months. While the accounting issue was being resolved, which occurred in October, we used testing equipment borrowed by some of our community partners as a stop-gap measure.

Utah's rural and frontier nature continue to be a great challenge to our families living in those parts of the state. Families struggle to find services appropriate to their child's special need whether it is behavioral, physical health including pediatrics, specialty health care, or other enabling services. Often the closest of these services is hours away. Telehealth and teleconsultation are making in-roads, but may not always be appropriate or applicable to the family's needs. Families of children with autism spectrum disorder frequently receive a diagnosis, but are then unable to receive applied behavior analysis (ABA) therapy in their community. Some ABA agencies provide teleconsultation, but do not reach all rural communities. Lack of health insurance, both commercial and public, or being underinsured, continues to be a problem for many families of children with special health care needs residing in rural counties.

Historically, CSHCN offered multi-disciplinary clinics that catered to a wide-variety of gross and fine motor, speech, hearing, and developmental delays. The current need in the community appears to be that of seeking an autism diagnosis. Given the relatively small group of ISP service providers traveling to rural clinics, the wait list to see our psychologist is growing. In some of our rural sites, the wait can be six months or more.

Agency Capacity / Collaboration:

ISP works with programs within the CSHCN Bureau to facilitate referrals between programs. ISP has provided care coordination to many families who have children who are deaf or hard of hearing, who participate in the Early Hearing Detection and Intervention program. ISP collaborates with Utah Family Voices to partner in the care coordination of families of children with special health care needs around the state. ISP works with community partners, such as Help Me Grow, to help families whose children are screened for developmental delay. ISP actively participates in the Utah Children's Care Coordination Network and funds University of Utah staff to coordinate those meetings and distribute communication and resources to the care coordinators at pediatric offices, family practices, and local health departments around the state. ISP has continued its ongoing relationship with the University Developmental Assessment Center to connect their patients and families with supports, services, and specialists from which they may benefit. The ISP program manager participates on the Utah Autism Initiative, a consortium of autism service, medical, and behavioral health providers; the Employment Partnership, a work group of state and community agencies charged with helping those with special needs connect with work and training; the Health Disparities Advisory Council which aligns state and community partners with the special needs and considerations of our migrant, ethnic, and those who speak languages other than English populations; and the Early Hearing Detection and Intervention Advisory Board which works to create and implement policy affecting children who are diagnosed as deaf or hard of hearing. ISP continues to attend agency and transition fairs sponsored by school districts around the state which target families of students with special needs. We promote care coordination and transition planning with these families. ISP and MCH have worked closely with the behavioral health authority in the state's, Department of Human Services, to ensure CSHCN have access to behavioral and mental health diagnosis and treatment that is coordinated with the care received through primary and specialty care.

Other activities in the CSHCN domain that contribute to improvement in the National Outcome Measures

Utah works to adhere to the three-tier framework outlined in the MCH Block Grant guidance. While the focus of most activities is the ESM →NPM→ NOM framework, activities on improving NOMs outside of the NPMs transpires in parallel. The following programmatic activities also work to improve outcomes in this domain.

National Outcome Measures (NOM)

NOM 19 - Percent of children with special health care needs (CSHCN), ages 0 through 17

The CSHCN Bureau provides regular outreach throughout the state to educate the public on children and youth with special needs issues. Below are two examples of our outreach efforts.

The Utah Birth Defect Network (UBDN) has been expanding its health education and outreach efforts. Compared to MCH grant period (7/1/2016-6/30/2017), the UBDN has increased the number of community events attended, number of potential people reached, number of bottles of multivitamins and educational materials distributed, and number of preconception health topics discussed for the past grant period (7/1/2017-6/30/2018).

Health education and outreach is an important function of the UBDN. The UBDN works with other state programs and community organizations to provide education and resources to Utah women ages 18 – 44. Through education and outreach, community members and their families become more aware of birth defects, learn about how to reduce the chances of having a pregnancy affected by birth defects, and learn how to increase the chances of having a healthy pregnancy.

Between 7/1/2017 and 6/30/2018, the UBDN has served up to 18,862 people through 72 community events. The UBDN distributed 9,757 bottles of multivitamins containing 400 micrograms of folic acid and 7,362 educational materials covering topics such as birth defect prevention, critical congenital heart disease screenings, oral health during pregnancy, and maternal mental health.

	7/1/2016 – 6/30/2017	7/1/2017 – 6/30/2018
Number of events	35	72
Number of potential people reached	15,794	18,862
Number of bottles of multivitamins distributed	7,423	9,757
Number of educational materials distributed	2,093	7,362

UBDN in an effort to meet requirements for rapidly identifying and reporting ZIKA cases to CDC. Established collaboration with the Early Hearing Detection and Intervention (EHDI) program to have cases with hearing loss electronically submitted to UBDN for review. Through this established collaboration it was determined that the addition of pulse oximetry results for CCHD screening can also be submitted through EHDI's HiTrack system. Allowing smaller hospitals and midwives a mechanism to report their CCHD screening results.

The Child Health Advanced Records Management Program's (CHARM) primary population in its core database consists of children age 0-18 years of age that are born in Utah and also migrate into the state. CHARM is then able to match children between other programs' system databases and find health information on the primary MCH population each program serves. Since CHARM's data contains both birth data of children born in Utah and in-migration, population estimates have been used as the denominator for CHARM's reach. The percentage of the population 0-18 that CHARM reaches per year based on population estimates is 99.7%. CHARM also reaches 8000+ health care providers in programs and clinics that have access to, or use CHARM, to find health information

on children to coordinate care, treatment, and follow-up.

In FY 2018, MotherToBaby Utah distributed 1,137 English CMV brochures, 137 Spanish CMV brochures, and 17 CMV posters to help prevent cytomegalovirus exposures and reduce the number of potential, future CSHCN.

NOM 20 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

The Child-Health Advanced Records Management (CHARM) program began in 2000, and is a coordinated, Department-wide effort within the Utah Department of Health (UDOH) that creates an electronic health record for children in Utah. The child health record can be printed and given to parents/guardians to assist MCH/CSHCN populations (infants, children, teens, mothers, families) and programs with continuity of care and follow-up. CHARM allows real-time access and data sharing among appropriate health care programs and partners. It supports the coordination of services the child has received by sharing accurate and real time data (newborn screening test results, immunizations, and services received) with programs and medical home providers that serve MCH and CSHCN populations statewide and in the rural areas of the state. The CHARM system in the CSHCN Bureau has demonstrated (though studies with clinics) that it reduces duplicate tests and expedites appropriate referrals, services, and follow-up. Because a child's health information is readily available through CHARM, the medical home knows what tests have or have not been done and, subsequently, saves the family money and reduces health care costs. It also eliminates referring families for services they do not need which saves parents time. During the past grant year, the CHARM program increased the percentage of health care providers utilizing the CHARM Web Interface (CWI) for treatment and care coordination purposes by 10% (from 80-88 health care providers/users).

The CHARM Program currently integrates with the Early Hearing Detection and Intervention (EHDI) and Baby Watch/Early Intervention (BW/EI) Programs to provide hearing screening results to health care providers to ensure that a child with special health care needs receives appropriate follow-up services with EI and the child’s medical home. CHARM continues to assist these efforts to support special health care needs children, parents, and providers. When a child transitions from part C to part B, the health information provided through CHARM is documented in the child’s record when the child moves from infant/toddler services to preschool, which provides continuity of care. In addition, CHARM provides immunization information and hearing screening results to the Baby Watch/Early Intervention (BW/EI) Program via a CHARM tab in their Baby & Toddler Online Tracking System (BTOTS). EI providers in urban and rural areas of the state can click on the tab to get this information on a child they are already looking up in their BTOTS system. The BW/EI program also shares limited Individualized Family Service Plan information (enrollment and referral date, and EI advisor name) with the EHDI Program through CHARM. EI providers get consent from parents to share this information with the EHDI program during intake. The sharing of the BW/EI information helps the EHDI program follow-up on children they have referred to BW/EI to make sure these kids are receiving services, and timely treatment that they need, to maximize their developmental and communication potential. CHARM will continue to collaborate with the BW/EI program to determine their data needs and also integrate with other MCH programs to provide them with additional information on children to meet the needs of children/families they serve.

Lastly, during 2018, CHARM and EHDI also collaborated with the state WIC Program to send a list of children with hearing screening alerts to WIC, so that WIC can match them with children in their system and help EHDI conduct follow-up efforts. EHDI sent WIC a list of 32 children’s names that were lost to follow-up, and WIC had information on 18 (56%) of them! An MOU was established among all programs for this project. This process will be automated in the next grant year with the implementation of a WIC updater in the CHARM system.

NOM 21 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

The Autism Systems Development Program (ASDP) in the Bureau of CSHCN seeks to advance, educate and empower the lives of individuals affected by Autism Spectrum Disorder (ASD) in Utah by monitoring occurrence, reducing the age at first diagnosis, referring to services, facilitating research, and providing education and outreach. The effectiveness of the program is determined using the following measures: ASD prevalence and its dissemination to the public and the median age of children diagnosed with an ASD, with performance goal of decreasing the median age of diagnosis for children with ASD from 50 months to 45 months by 2020.

ASD prevalence and its dissemination to the public.
Accurate ASD prevalence estimates are critical for driving policy decisions and informing other MCH and CSHCN Programs on NPMs on care coordination and transition.

In Utah, ASD prevalence is measured by The Utah Registry of Autism and Developmental Disabilities (URADD). URADD, a joint effort between the Utah Department of Health and the University of Utah Department of Psychiatry, is a statewide, population-based surveillance system for autism spectrum disorder (ASD) and developmental disabilities (DD) and was established in 2005. Nearly all efforts to identify children with ASD in the U.S., such as the CDC's Autism and Developmental Disabilities Monitoring Network are limited to particular age groups (e.g. 4 year olds and 8 year olds). However, in Utah, we are able to ascertain ASD prevalence throughout the lifespan.

Percent of children diagnosed with an autism spectrum disorder in Utah (2014)			
Age	Overall	Boy	Girl
4-year-olds	0.5% (1 in 198)	0.8% (1 in 124)	0.2% (1 in 546)
6-year-olds	1.1% (1 in 90)	1.8% (1 in 57)	0.4% (1 in 235)
8-year-olds	**1.7% (1 in 60)**	**2.5% (1 in 40)**	0.7% (1 in 141)
16-year-olds	1.5% (1 in 65)	2.4% (1 in 42)	0.6% (1 in 162)
Data Source: The Utah Registry of Autism and Developmental Disabilities			

In addition to age, ASD prevalence is also broken down by county. This allows the ASDP and partnering agencies to develop resources based on the need of specific counties according to their age group, such as provider need, both evaluation and therapy services, and needs relating to transition to adulthood.

Number of children diagnosed with an autism spectrum disorder by County								
	COUNTY							
Age 16-years-olds	Cache	Davis	Salt Lake	Tooele	Utah	Washington	Weber	Utah Total
Overall	22	87	318	18	122	22	51	718
Male	14	74	252	16	101	17	42	583
Female	8	13	66	2	21	5	9	135
Data Source: The Utah Registry of Autism and Developmental Disabilities								

Reducing the Age of First Diagnosis.
Performance Goal: Decrease the median age of diagnosis for children with ASD from 50 months to 45 months by 2020.

In Utah, the ASDP seeks to improve early identification of ASD and to reduce the age of first diagnosis, with the goal of decreasing the median age of diagnosis for children with ASD from 50 months to 45 months by 2020. During 2016, a needs assessment was carried out to determine factors that most impacted the median age of diagnosis for children with ASD. Two areas were identified and focused on; the percentage of children screened for ASD at 18 and 24 months using the M-CHAT R/F and the wait time for an Autism evaluation.

Objective 1: Increase the percentage of children screened for autism at 18 and 24 months using the M-CHAT R/F from 44 percent to 50 percent by 2020.

The ASDP has developed several strategies to increase the percentage of children screened for autism at 18 and 24 months using the M-CHAT R/F from 44 percent to 50 percent by 2020. In 2018, the ASDP and the parents' group the Autism Council of Utah worked with Local Health Departments (LHD), Early Intervention (EI) Programs, and primary care providers to increase awareness of appropriate screening protocols for autism. In 2019, in collaboration with the University of Utah Department of Psychiatry, the ASDP developed an electronic version of the M-CHAT R/F that provides immediate scoring results and available resources for parents/guardians. This allows parents/guardians to screen their child for autism, locate an evaluation provider, and locate their local EI Program and/or Applied Behavior Analysis providers.

Objective 2: Reduce the wait time for an Autism Evaluation from 8 months to 4 months by 2020.

In 2018, the ASDP developed a strategy to help reduce the wait time for an Autism Evaluation from 8 months to 4 months by 2020 by maintaining an Autism Evaluation Referral List. The Autism Evaluation Referral List allows primary care physicians, care coordinators, EI Programs and parents to select from a list of autism evaluation providers in the State of Utah. This list allows parents to research evaluation providers and determine which provider is best for their needs. As of 2019, the Autism Evaluation Referral List is downloaded an average of 784 times per month, and the average wait time for an evaluation is just 3 months.

Summary of Activities:

- Measured ASD prevalence rates.
- Determined the median age of diagnosis.
- Developed and continually update an ASD Resource Flyer for children aged birth to 9 years, in English and Spanish.
- Trained community teams in medically underserved areas that include LHD, EI Programs, and primary care providers on autism screening (M-CHAT R/F) protocols.
- Provided an online screening tool for autism (M-CHAT R/F) to LHD, EI Programs, and primary care providers.
- Presented on autism screening (M-CHAT R/F) procedures at Intermountain Medical Center Grand Rounds in April of 2018.
- Updated and promoted the Autism Evaluation resources list on CSHCN Website, averaging over 866 downloads per month in 2018.
- Surveyed providers to determine wait times for evaluations.
- Worked with primary care providers to give parents multiple resource options for ASD services.
- Worked with care coordinators to give parents multiple resource options.
- Worked with Autism Council of Utah to distribute Autism Evaluation list to parents.

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NPM-11: Medical Home: *Percent of children with special health care needs having a medical home*

FY20 Annual Plan:

In partnership with the Utah Chapter of the American Academy of Pediatrics (AAP), articles will be placed in the Growing Times newsletter on a quarterly basis that will highlight medical home components, community resources, practice improvements, partnership opportunities, and other medical-home related topics to educate families and providers on the components of a medical home. The Utah Bureau of Maternal and Child Health (MCH) will collaborate with the Medical Home Portal to review content and resources for families and providers and provide funding for the Medical Home Portal. The Bureau of MCH will continue to collaborate with Early Childhood Utah, the Office of Home Visiting, The Early Childhood Comprehensive Systems (ECCS) grant, the Family to Family Health Information Center, the Interagency Outreach Training Initiative Steering Committee, the Employment Partnership workgroup, and the Utah Oral Health Coalition.

Proposed Activities:

- The Bureau of Maternal and Child Health (MCH) will revise and support newly-developed agreements to enhance feedback among professional organizations to improve care coordination for children with special health care needs by June 2020.
- The Bureau of Maternal and Child Health (MCH) will provide four quarterly newsletter articles for the Utah Chapter of the American Academy of Pediatrics' Growing Times newsletter by June 30, 2020.
- The Bureau of Maternal and Child Health (MCH) will help ensure that families use the Utah shared resource, the Medical Home Portal, and are linked to the needed/requested services.

NPM-12: Transitions: ***Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care***

FY20 Annual Plan:

Education about the elements of transition for families and providers will be provided mainly through the Medical Home Portal. The Integrated Services Program (ISP) will continue to fund a portion of the Medical Home Portal and the Utah Children's Care Coordination Network. ISP will partner with local school districts to provide information and planning on transition for parents and youth with special health care needs at district-sponsored transition/agency fairs. ISP will continue to work with families to ease the transition between pediatric health and adult health. ISP will promote transition activities with the care coordinators based at the four local health departments.

Proposed Activities:

- The Maternal and Child Health (MCH) Bureau and Integrated Services Program will educate families and primary care providers (medical homes), through various methods, on the definition, purpose, tools, and processes of transition to adulthood as identified in the Six Core Elements of Health Care Transition 2.0 in consideration of the needs identified by the results of the Family Survey.
- The Maternal and Child Health (MCH) Bureau and Integrated Services Program will help ensure that families use the Utah shared resource (Medical Home Portal) and are linked to the needed / requested transition services.
- The Maternal and Child Health (MCH) Bureau will provide four quarterly newsletter articles for the Utah Chapter of the American Academy of Pediatrics' Growing Times newsletter by June 30, 2019.

SPM-02: Rural Clinics: ***Percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program***

FY20 Annual Plan

In FY20, the Integrated Services for Children with Special Health Care Needs (IS4CSHCN) team will continue to support twenty-two traveling clinics in rural Utah including Moab, Price, Vernal, Richfield, and Blanding. As the community needs and reason referral have evolved over the past several years, we are re-evaluating the utility of a full multidisciplinary team (OT, PT, SLP, and audiology) providing support services in our rural communities. Given the long waiting list for autism evaluation and diagnosis, and having only one psychologist on the IS4CSHCN team, we are currently working with community partners to evaluate the feasibility of contracting with them for additional psychology support. If this proves to be a viable option within current fiscal constraints, we would consider eliminating PT and SLP, and instead channeling those monies to psychology for additional evaluation and diagnosis particularly for families seeking an ASD diagnosis. ISP will continue to support air travel, ground transportation, and rental of clinical space in St. George for the University of Utah Pediatric Orthopedics group as they provide orthopedic consultation in Moab, Blanding, Vernal, and St. George.

IS4CSHCN will continue to work with the care coordinators at the local health departments to market care coordination services in their corresponding communities. While the number of children able to benefit from direct evaluative and diagnostic clinical services is extremely limited, the impact of care coordination for CSHCN within the community reaches an exponentially larger number. Marketing and ongoing education with community partners of the benefits of care coordination ensures a robust referral base and subsequently a higher care coordination case load for the local health departments.

IS4CSHCN values the face to face interaction with families seeking services for their CSHCN, and will continue to partner with local school districts to promote care coordination at agency and transition fairs. IS4CSHCN and the Program Manager will continue to serve on committees and councils that target children and youth with special health care needs such as the Early Hearing Detection and Intervention Advisory Board, Employment Partnership, Health Disparities Advisory Council, and the Utah Autism Initiative.

IS4CSHCN seeks to partner with sister programs within the Utah Department of Health such as the Office of Primary Care and Rural Health, Early Hearing Detection and Intervention Program (EHDI), Family and Youth Outreach Program, Fostering Health Children Program, and Medicaid and CHIP. Recently IS4CSHCN aided the Family and Youth Outreach Program with its grant application seeking HRSA funding for pediatric mental health care access, and would offer care coordination to children and youth with behavioral health needs in target areas. The IS4CSHCN staff and LHDs will provide care coordination services to families referred from the EHDI program for children who are deaf or hard of hearing. Our care coordinators will aid families in understanding, applying for, and maintaining ongoing Medicaid and CHIP eligibility.
IS4CSHCN will continue to provide funding for the Utah Children's Care Coordination Network and will encourage active participation by staff, LHD care coordinators, and care coordinators in pediatric and family practice offices. We will also continue to provide partial funding for the Medical Home Portal, through the University of Utah's Department of General Pediatrics, which serves as a resource and information database in an interactive web-based platform seeking to educate families of children with special health care needs and their primary care providers.

Proposed Activities:

- Provide clinical evaluation and diagnosis for CSHCN through twenty-two traveling clinics for children residing

in Southeast Health District, San Juan County, Central Utah Health District, and the TriCounty Health Department.

- Promote expedited diagnosis of autism spectrum disorder in rural Utah through increased presence of psychologists with expertise in the field.
- Expand the reach of care coordination services within the four target health districts in rural Utah.
- Seek opportunities to leverage both expertise and funding from sister programs and agencies targeted with providing services to CSHCN.
- Provide ongoing training opportunities for care coordinators working with CSHCN across the state through interaction with IS4CSHCN staff, the Utah Children's Care Coordination Network, and the Medical Home Portal.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Public input has always been a valued part of the annual MCH Block Grant application process. Each year, the Utah Department of Health (UDOH), the Bureau of Maternal and Child Health (MCH), uses multiple strategies to collect input from both general public and key stakeholders. However, due to 2020 MCH Needs Assessment activities, during CY2019 we forwent the usual strategies, and solicited public input through alternative methods.

First, the Utah MCH Bureau's Data Resources Program (DRP) worked with MCH/ Children with Special Health Care Needs (CSHCN) Bureau staff to conduct a comprehensive General Stakeholder Needs Assessment survey with key stakeholders. The survey instrument allowed participants to respond only to which of the five health domains, in addition to the option of access to care, in which they wanted to provide input. In addition to general demographics questions, each domain had a list of possible domain specific issues, in which respondents were able to select and rank their top seven issues that they perceived to be significant a problem for their communities. There were also open-ended questions addressing needed services and an opportunity for respondents to list one issue they may have identified that was not included in the supplied list. Surveys were implemented and distributed online in both English and Spanish. We received 1,892 surveys where respondents completed ranking in at least one health domain.

Second, the MCH Bureau's DRP worked in conjunction with members of the CSHCN Bureau and Utah Family Voices to administer a statewide survey to parents and caregivers of children with special health care needs. The survey instrument had thirty-eight questions and topics that included health insurance coverage, care coordination, transition, availability of care providers and services, and challenges faced in obtaining care. CSHCN Bureau and Utah Family Voices sent out survey invitations to individuals identified as caregivers for special needs children, or youth up to age 21. The survey was administered online, and 1,161 were surveys completed. The data was analyzed by DRP and presented to domain leaders.

Third, the MCH Bureau has collaborated with the University of Utah (UofU) and secured them as a contractor to conduct various components of Needs Assessment. The UofU will assist in the 2020 Needs Assessment process by conducting key informant interviews and focus groups, and holding stakeholder meetings to select health priorities. Additionally, the UofU will assist in analysis of the qualitative data obtained from the surveys.

UofU has conducted key informant interviews with several UDOH agencies and community organizations in order to cultivate qualitative information about what they believe to be the most important issues currently confronting women, infants, children, and youth in the state, including those with special health care needs.

In addition to identifying the most important needs of MCH populations in the state as a whole, focus groups will be conducted by the UofU in various communities. To obtain a more complete understanding of the perceived health needs and top issues within the five MCH domains, these focus groups will target individuals and special groups, including those underrepresented in the two online Needs Assessment surveys. Focus group notes will then be analyzed and synthesized by the UofU. To assist in identification and selection of the top priorities and strategies for each MCH population domain, results from these focus groups will be presented to stakeholders in regional meetings.

Fourth, stakeholder meetings are planned for early fall 2019 to receive stakeholder input regarding the determination of state priorities and selection of Performance Measures (NPM/SPM). Selection of priorities will occur following multiple meetings where health issues are presented with data from surveys, key informant interviews, and focus groups. Top issues will be selected following discussions on MCH Bureau capacity to impact, and whether the health

issue is currently being addressed by another Bureau or agency. Utah's Needs Assessment process and subsequent results will be submitted at length in the upcoming BG application.

As discussed above, the MCH Bureau uses multiple strategies to collect input from both general public and key stakeholders. Although not used during the current reporting period, during the FY21 reporting period, the following methods to obtain public input will be resumed:

1. Email Invitation to Key Stakeholders
2. Website Posting/Web Application
3. Newsletters
4. Use of Social Media
5. Announcement Flyers
6. Other Outreach Methods (Advisory Meetings)

Since NPMs and SPMs measures will not be finalized by Utah until FY 20, we plan to post public notices during April 2020 in major newspapers throughout the state about the planned activities related to NPMs, SPMs, and ESMs. This will allow us to provide the public with a more complete understanding of how all state priorities will be addressed within the entire BG measure framework. We also plan to collect public comments using our web application and sending a web link to an extensive list of stakeholders, including parents, consumers, health care providers, members of academia, community-based advocacy organizations, community health clinics, local health departments, and various government agencies. As we have done in the past, we will utilize the web analytics service, Google Analytics, to gain insight into our website traffic and trends. Additionally, UDOH staff and other agency partners will be informed and briefed about the FY21 Block Grant Application and public comment process during regular bureau, data, and taskforce meetings.

III.G. Technical Assistance

Utah's Title V agency currently has not identified any technical assistance (TA) needs for the FY2020 MCH Block Grant Application. As we identify any needs, we will seek TA.

The Utah MCH and CSHCN Bureaus have contacted the National Center for Education in Maternal and Child Health at Georgetown University to seek technical assistance with developing and enhancing evidence-based strategy measures. Work will begin in the fall of 2019 on ESMs related to NPM 6.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V_Medicaid_IAA_MOA_FINAL.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Appendix_A_Programs_HPSA_2019_FINAL.pdf

Supporting Document #02 - Appendix B_2015 Needs Assessment Reports.pdf

Supporting Document #03 - Appendix_C_CurriculumVitae_2019_FINAL.pdf

Supporting Document #04 - Appendix_D_LHD_2019_FINAL.pdf

Supporting Document #05 - Appndix_E_Partnerships_Publications.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MCH_CSHCN_BHP_org_charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Utah

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,979,388	
A. Preventive and Primary Care for Children	$ 3,542,502	(50.7%)
B. Children with Special Health Care Needs	$ 2,176,855	(31.1%)
C. Title V Administrative Costs	$ 600,000	(8.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,319,357	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,851,188	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,050,094	
5. OTHER FUNDS (Item 18e of SF-424)	$ 10,833,700	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 5,233,600	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 27,968,582	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,897,700		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 34,947,970	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 56,396,200	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 91,344,170	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 463,200
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 751,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 192,300
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 237,400
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 420,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 142,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,034,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 42,951,500
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 6,641,100
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 239,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 223,000

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,349,076		$ 6,899,911	
A. Preventive and Primary Care for Children	$ 2,871,324	(39.1%)	$ 3,493,004	(50.6%)
B. Children with Special Health Care Needs	$ 2,506,022	(34.1%)	$ 2,143,907	(31%)
C. Title V Administrative Costs	$ 682,000	(9.3%)	$ 628,152	(9.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,059,346		$ 6,265,063	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 16,946,700		$ 16,235,243	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,794,900		$ 1,188,395	
5. OTHER FUNDS (Item 18e of SF-424)	$ 30,114,400		$ 11,081,603	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 4,948,100		$ 4,798,663	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 53,804,100		$ 33,303,904	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,897,700				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 61,153,176		$ 40,203,815	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 59,382,100		$ 56,954,456	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 120,535,276		$ 97,158,271	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 583,700	$ 597,936
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 588,200	$ 817,843
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 205,000	$ 164,288
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 4,122,500	$ 2,225,901
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 420,200	$ 410,506
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 223,000	$ 141,780
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 47,166,800	$ 46,761,710
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 194,000	$ 203,363
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 5,509,500	$ 5,368,878
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Community-Based Integrated Service Systems (CISS)	$ 88,200	$ 74,106
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 50,000	$ 45,000
Department of Health and Human Services (DHHS) > Other > Other	$ 231,000	$ 143,145

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: This budgeted amount is for time period 10/01/2019 - 09/30/2020. It includes base budget funding of FY 2020 grant award of $6,164,172 as well as estimated funds remaining in year two of the FY 2019 grant award.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: This budget amount reflects current MCH activities, current reporting from Local Health Department subrecipients.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budget amount reflects Bureau of Children with Special Health Care Needs Activities, Children with Special Health Care Needs Oral Health Services, Children with Special Health Care Needs ISP Clinical Services and reporting from Local Health Departments. Contracts with Local Health Departments have been fully implemented.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: A reduction of costs in the administrative line item was taken from last years budget submission amount of $654,000. This includes attrition of (1) FTE from the Financial Administrative Services Team and reassignment of workload while still ensuring the proper oversight of Maternal and Child Health Bureau, Children with Special Health Care Needs Bureau, and MCH Block Grant.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**

	Field Note: An increase in state funds for Office of Home Visiting was received for State Fiscal Year 2020. Budget amount includes all state funds appropriated for Maternal Child Health activities and excludes funds being used for match or maintenance of effort for other federal grants. MOE required for transfer being received from Department of Workforce Services for Child Care Licensing transfer of Federal Dollars.	
6.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Reported by Local Health Department subrecipients. The Department is continuing to revise the reporting required by the Local Health Department to more accurately capture the type of funds being used at the local level to support MCH Block Grant Activities.	
7.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: TANF funds previously available for Office of Home Visiting are no longer available.	
8.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Major programs receiving program income include Teratology (Family Youth Outreach) Fostering Health Children, Newborn Screening, Early Intervention, and Fostering Health Children. Collections anticipated for Children with Special Health Care Needs Fee for Service.	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Budgets and expenditure amounts have been reduced and redirected beginning in fiscal year 2018 and aligned with historical expenditures, matrix, and anticipated needs assessment and program goals and measures	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**

	Field Note: CSHCN Expenditures include activities recorded in the Children with Special Health Care Needs Bureau , the Children with Special Health Care Needs Clinics, Maternal and Child Health Bureau (including Oral Health Special Olympics screenings and activities) Budget amount lower than expected based on start up costs for Local Health Department clinics for Children with Special Health Care Needs. Funds were reallocated to next yearly contract period with a one time no cost extension amendment	
11.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: State Fiscal Year 2018 Expenditures for partial directors office and financial Resources, safe haven, informed consent, prams state, CSHCN state, pregnancy risk line, baby watch early intervention state	
12.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Reported by Local Health Department Financial Reports and Monthly Expenditure Reports	
13.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Budget included WIC food funds that should have been accounted for as Federal Revenue. Actual expenditures include only WIC food rebates.	
14.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Program Income includes Workforce Agreements, Newborn Screening Agreements, Birth Defects Agreements, Baby Watch Collections, and Fostering Healthy Children Agreements.	
15.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**

	Field Note: WIC amount funded continues to decline as WIC participation in the State continues to decline	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Additional SRAE funds received	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: No continuation of MIECHV expansion funds	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Utah

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 318,969	$ 294,772
2. Infants < 1 year	$ 708,500	$ 683,703
3. Children 1 through 21 Years	$ 2,834,000	$ 2,858,799
4. CSHCN	$ 2,176,855	$ 2,143,907
5. All Others	$ 341,064	$ 290,578
Federal Total of Individuals Served	$ 6,379,388	$ 6,271,759

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 3,472,045	$ 3,794,226
2. Infants < 1 year	$ 3,184,307	$ 3,479,878
3. Children 1 through 21 Years	$ 6,524,790	$ 7,130,243
4. CSHCN	$ 13,193,940	$ 14,418,242
5. All Others	$ 4,100,870	$ 4,481,402
Non-Federal Total of Individuals Served	$ 30,475,952	$ 33,303,991
Federal State MCH Block Grant Partnership Total	$ 36,855,340	$ 39,575,750

Form Notes for Form 3a:

Due to Division and Department reorganization, some programs are no longer in the Division including Tech Dependent Waiver, Health Clinics of Utah, Family Dental Plan, and Office of Health Disparity. This has had an effect on Non Federal Funds.
In addition, transfer funds have decreased as we were being awarded one time funds from other agencies. Transfer funds being received require MOE which reduces amount available to report for MCH Block Grant.

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Amount includes infants and children in Form 2	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Amount includes infant and children in form 2	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Includes infants and children in form 2	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: includes infants and children in form 2	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Utah

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 697,939	$ 551,993
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 139,588	$ 88,319
C. Services for CSHCN	$ 558,351	$ 463,674
2. Enabling Services	$ 2,791,755	$ 2,932,633
3. Public Health Services and Systems	$ 3,489,694	$ 3,415,285
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 551,993
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 551,993
Federal Total	$ 6,979,388	$ 6,899,911

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 1,204,573	$ 1,304,780
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 614,332	$ 665,440
B. Preventive and Primary Care Services for Children	$ 289,098	$ 313,140
C. Services for CSHCN	$ 301,143	$ 326,200
2. Enabling Services	$ 28,488,590	$ 30,858,685
3. Public Health Services and Systems	$ 1,052,839	$ 1,140,500
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,304,780
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,304,780
Non-Federal Total	$ 30,746,002	$ 33,303,965

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Direct service budget included funding contracted to Local Health Departments to provide sepcialty care visits to Children with Special Health Care Needs and direct services provided to children by the Oral Health Program, including dental screenings and other oral health services.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: The enabling services budget includes funding for care coordination and referrals, provided by the Integrated Services Program and Local Health Departments; health education for individuals or families, environmental health risk reduction, health literacy, and outreach provided by the Pregnancy Risk Line/MotherToBaby Program, the Birth Defects Network and the Integrated Services Program.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Public health services and systems budget includes needs needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, and population-based programs provided by the Maternal Infant Health Program (including maternal mental health, Maternal Mortality Review, and breastfeeding and prenatal education), Data Resources Program, and Family and Youth Outreach Program, and the Bureau of Health Promotion. It also includes health promotion campaigns for injury prevention including car seat checks and suicide prevention provided by the Violence and Injury Prevention Program and training and policy implementation to improve physical activity for adolescents in school systems by the Physical Activity Program in the Bureau of Health Promotion.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Utah

Total Births by Occurrence: 49,664 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	49,601 (99.9%)	879	52	52 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	47,671 (96.0%)	567	93	87 (93.5%)

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Diet Monitoring (0-18 years)	856	74	74	74
Diet Monitoring (Pregnant Women)	143	7	7	7

4. Long-Term Follow-Up

Long term follow-up is not part of the Utah Newborn Screening Program. Once a confirmed diagnosis is made, the infant is referred to the appropriate specialist for long-term care and treatment.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Newborn Hearing - Receiving At Least One Screen**
	Fiscal Year:	**2018**
	Column Name:	**Other Newborn**
	Field Note: 2018 data	
2.	**Field Name:**	**Newborn Hearing - Referred For Treatment**
	Fiscal Year:	**2018**
	Column Name:	**Other Newborn**
	Field Note: There were six children who had a hearing loss that were not referred for treatment (in our case, Early Intervention). Two children moved out of state, four had undetermined loss and still need audiological follow-up.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Utah

Annual Report Year 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	13,537	32.8	0.0	53.4	4.5	9.3
2. Infants < 1 Year of Age	11,409	76.9	0.0	12.8	1.8	8.5
3. Children 1 through 21 Years of Age	21,658	49.5	0.4	30.8	7.2	12.1
3a. Children with Special Health Care Needs	4,922	22.4	0.0	74.6	3.0	0.0
4. Others	3,370	14.4	0.0	64.1	18.6	2.9
Total	49,974					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	48,585	Yes	48,585	77	37,410	13,537
2. Infants < 1 Year of Age	49,651	Yes	49,651	100	49,651	11,409
3. Children 1 through 21 Years of Age	1,060,715	Yes	1,060,715	24	254,572	21,658
3a. Children with Special Health Care Needs	180,003	Yes	180,003	92	165,603	4,922
4. Others	1,989,717	Yes	1,989,717	3	59,692	3,370

Form Notes for Form 5:

Used FAD data for form 5a when insurance status was unknown.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**
	Field Note: Pregnant Women number derived from the following sources: • PRL Health education (Pregnant Women through 60 days postpartum / breastfeeding), Infants less than 1 are not counted (not duplicated) since the health education is provided to the women/mothers and not the infant, phone, email, in-person, etc. individual contacts / education episodes (n=1681). • HRC 1-800 Call Non-Eligibility Calls (PW, Others), FY 18 phone calls to Imm, CHIP (n=6591). • OHP Direct oral health screenings (n=6). • MCH Service Report (n=4184).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**
	Field Note: Infants number derived from the following sources: • MCH Service Report (n=9513). • Hearing Screening by the EHDI Team (n=87) • PRL calls regarding breastfeeding infants under age 1 (n=1809)	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**
	Field Note: Children 1 through 21 years number derived from the following sources: • PRL Health education (Children 1-21, women not pregnant yet, or breastfeeding more than 60 days postpartum), phone, email, in-person, etc. individual contacts / education episodes (n=21). • OHP Direct oral health screenings (n=1204). • MCH Service Report (n=15371). • OHP CSHCN Direct oral health screenings (n=281). • ISP Rural Pediatric Orthopedics (U of U/PCMC), unique children seen through rural U of U peds ortho clinics (n=308). • CSHCN Case Management (Utah Family Voices), Un-duplicated counts of intakes (n=1213). • CSHCN Case Management/care coordination (ISP), (n=842). • CSHCN Translation, F/U notes, CMV Records, Family Support (n=2220). • CSHCN Autism Referral, Scheduling, monitoring, referral, coordination (n=3). • CSHCN Autism Explanation of benefits, referral and assistance (n=55).	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
• OHP CSHCN Direct oral health screenings (n=281).
• ISP Rural Pediatric Orthopedics (U of U/PCMC), unique children seen through rural U of U peds ortho clinics (n=308).
• CSHCN Case Management (Utah Family Voices), Un-duplicated counts of intakes (n=1213).
• CSHCN Case Management/care coordination (ISP), (n=842).
• CSHCN Translation, F/U notes, CMV Records, Family Support (n=2220).
• CSHCN Autism Referral, Scheduling, monitoring, referral, coordination (n=3).
• CSHCN Autism Explanation of benefits, referral and assistance (n=55).

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
"Others" number derived from the following sources:
• PRL Health education (men/partners/relatives, women 22+ not pregnant yet or more than 60 days postpartum, professionals), phone, email, in-person, etc. individual contacts / education episodes (n=1681).
• PRL Safe haven Calls, Calls to safe Haven (n=28).
• OHP Direct oral health screenings (n=872).
• MCH Service Report (n=789).

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**

Field Note:
Pregnant Women
• MIHP PMR (# of Cases Viewed) (PW) (n=43).
• MIHP PRAMS # of Women who get a Survey) (PW) (n=2137).
• MIHP Safety Bundle Hospital (PW) (n=35040).
• OHP outreach education (n=342).

37562/48585=77.3% served

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**

Field Note:
Infants under 1 year of age
• MIHP Number of infant cases reviewed in PMR, Number of infant deaths reviewed in committee (n=35).
• MIHP Births in participating Baby Friendly Hospitals, Number of infants born in hospitals participating in Stepping Up (n=31012).
• CSHCN Hearing Screening, Number of infants screened (n=48661).
• CSHCN CCHD Screening Numbers, Children screened in hospitals (n=48217).
• ASQ-3, ASQ:DE, ASQ:SE-2 screening on infants <1 (n=3756)
• MIHP UWNQC, Number of infants with NAS born in UWNQC participating facilities (n=150).

100% served

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2018**

Field Note:
Children 1 - 21
• VIPP Injury Prevention, # of injury deaths ages 1 to 21 (n=152).
• VIPP LHD Counts, # of people reached via LHD implementation of evidence-based programs (n=32566).
• EPICC Physical Activity (C 1-21), # of adolescents who were physically active 60 minutes, 7 days per week (n=30959).
• OHP Group Education Adolescents (C 1-21), Education presentations at middle schools (n=86032).
• MIHP PREP/Ab ED, # of kids enrolled in PREP/AbEd programs (n=11423).
• # of Developmental Screenings (n=9220)
• ISP Medical Home Portal (C 1-21), users Medical Home Portal (n=123373).
• CHSCN EHDI Committee, Individuals participated in EHDI Committee (n=164).
• CSHCN Hearing/Speech Training, Coordinated training for screening and referral (n=977).
• CSHCN Community Education, Autism Council, grand rounds, health fairs (n=2630).
• CSHCN Autism Downloads, ABA resource and EvalProvider downloads (n=15739). • CSHCN UBDN Surveillance cases (n=860).
• OHP Ed (n=587)

258165/1060715=24.3%

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
• ISP Medical Home Portal (C 1-21), users Medical Home Portal (n=123373).
• CHSCN EHDI Committee, Individuals participated in EHDI Committee (n=164).
• CSHCN Hearing/Speech Training, Coordinated training for screening and referral (n=977).
• CSHCN Community Education, Autism Council, grand rounds, health fairs (n=2630).
• CSHCN Autism Downloads, ABA resource and EvalProvider downloads (n=15739). • CSHCN UBDN Surveillance cases (n=860).
• OHP Ed (n=587)

165242/180003=91.8%

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
Others
• EPICC Professional Development for Teachers, Number of local education agencies where staff received professional development and technical assistance on the development, implementation or evaluation of recess and multi-component physical education policies (n=31).
• EPICC Breast Feeding Policy (PW, Others), Number of employers that provide space and time for nursing mothers to express breast milk (n=114).
• MIHP PREP/Ab Ed, Number of parents enrolled in PREP/AbEd programs (n=9).
• CSHCN UBDN Community Education, Events, # reached, # of vitamins distributed (n=21499).
• HRC BYB, impressions for one segment. (n=25884).
• OHP Outreach education (n=342)

49787/1989717 = 2.5%

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Utah

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	48,737	36,816	756	7,874	461	1,345	522	0	963
Title V Served	47,507	35,923	706	7,674	441	1,310	519	0	934
Eligible for Title XIX	13,144	7,715	429	3,792	299	333	256	0	320
2. Total Infants in State	49,664	37,559	773	7,980	467	1,370	537	0	978
Title V Served	48,578	36,633	723	7,774	446	1,335	533	0	1,134
Eligible for Title XIX	13,339	7,842	437	3,832	302	302	219	0	405

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data, Total deliveries 2017	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data, Resident Deliveries, 2017	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data, Medicaid Status based on Self-Reported Enrollment to Medicaid Program, among resident deliveries 2017	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data, Occurrent births, 2017	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data, Resident Births, 2017	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data, Medicaid Status based on Self-Reported Enrollment to Medicaid Program, total resident births 2017	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Utah

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 826-9662	(801) 826-9662
2. State MCH Toll-Free "Hotline" Name	Baby Your Baby	Baby Your Baby
3. Name of Contact Person for State MCH "Hotline"	Marie Nagata	Marie Nagata
4. Contact Person's Telephone Number	(801) 538-6519	(801) 538-6519
5. Number of Calls Received on the State MCH "Hotline"		5,055

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	1. Chilren's Health Insurance Program (CHIP); 2. Mother To Baby; 3. Utah Newborn Safe Haven	1. Children's Health Insurance Program (CHIP); 2. Mother To Baby; 3. Utah Newborn Safe Haven
2. Number of Calls on Other Toll-Free "Hotlines"		13,026
3. State Title V Program Website Address	www.health.utah.gov/mch, www.health.utah.gov/cshcn	www.health.utah.gov/mch, www.health.utah.gov/cshcn
4. Number of Hits to the State Title V Program Website		134,842
5. State Title V Social Media Websites	www.poweryourlife.org	www.poweryourlife.org
6. Number of Hits to the State Title V Program Social Media Websites		746,097

Form Notes for Form 7:

Number of Calls on Other Toll-Free "Hotlines":
Calls to CHIP Hotline=3,430
Calls to Immunization Hotline=3,161
Calls to Mother To Baby Hotline=6,407
Calls to Newborn Safe Haven=28

Number of Hits to the State Title V Program Website:
MCH Website=6,605
CSHCN Website=128,237

Form 8
State MCH and CSHCN Directors Contact Information

State: Utah

1. Title V Maternal and Child Health (MCH) Director	
Name	Lynne Nilson
Title	Title V/Bureau of Maternal and Child Health Director
Address 1	3760 South Highland Drive
Address 2	PO Box 142002
City/State/Zip	Salt Lake City / UT / 84114
Telephone	(801) 273-2858
Extension	
Email	lpnilson@utah.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Noel Taxin
Title	Bureau Director, Children with Special Health Care Needs
Address 1	44 Mario Capecchi Drive
Address 2	
City/State/Zip	Salt Lake City / UT / 84113
Telephone	(801) 584-8529
Extension	
Email	ntaxin@utah.gov

3. State Family or Youth Leader (Optional)	
Name	Gina Pola-Money
Title	Family Representative
Address 1	230 West 200 South #1101
Address 2	
City/State/Zip	Salt Lake City / UT / 84101
Telephone	(801) 272-1068
Extension	
Email	gina.ufv@gmail.com

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Utah

Application Year 2020

No.	Priority Need
1.	Preconception and Interconception care
2.	Breastfeeding promotion
3.	Developmental screening (continuation of old SPM5)
4.	Preterm & low-birth-weight babies/NICU (continue with old SPM 3 & old NPM 17 due to ongoing need and focused efforts through the UWNQC)
5.	Overweight & obesity prevention (continuation of old SPM 8)
6.	Specialty service availability (rural areas) and improved care coordination for children with special health care needs (continuation of old SPM 9)
7.	Inadequate health insurance coverage (NPM not reflective of this priority as State capacity and resources do not allow for impact on this priority).
8.	Injury and injury-related deaths
9.	Out-of-pocket costs/financial challenges faced by CSHCN parents
10.	Suicide, mental health issues, and access to mental health services (continuation of old NPM16)

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Preconception and Interconception care	New	
2.	Breastfeeding promotion	New	
3.	Developmental screening (continuation of old SPM5)	Continued	
4.	Preterm & low-birth-weight babies/NICU (continue with old SPM 3 & old NPM 17 due to ongoing need and focused efforts through the UWNQC)	Continued	
5.	Overweight & obesity prevention (continuation of old SPM 8)	Continued	
6.	Specialty service availability (rural areas) and improved care coordination for children with special health care needs (continuation of old SPM 9)	Continued	
7.	Inadequate health insurance coverage	Continued	While lack of insurance was identified in the both 2010 & 2015 needs assessment as a priority measure, however, current State capacity and resources do not allow us to make an impact in this area. As such, oral health was the measure selected by the stakeholder group as the cross cutting NPM of choice.
8.	Injury and injury-related deaths	New	
9.	Out-of-pocket costs/financial challenges faced by CSHCN parents	New	While this financial challenge has been identified as a priority, the State has decided to focus on medical home and transition where a greater impact will be achieved.
10.	Suicide, mental health issues, and access to mental health services (continuation of old NPM16)	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 2

Field Note:
This is identified as a new priority in 2015. However, this was identified as a potential priority in 2010 but was not included in the final top 10 priorities as this issue was addressed through the national performance measure (NPM 11).

Field Name:

Priority Need 4

Field Note:
State has selected preterm births as a state performance measure based on 2015 Needs Assessment (new SPM1)

Field Name:

Priority Need 6

Field Note:
State has selected specialty service availability in rural areas as a state performance measure (new SPM2)

Field Name:

Priority Need 7

Field Note:
While lack of insurance was identified in both 2010 & 2015 needs assessment as a priority measure, however, current State capacity and resources do not allow us to make an impact in this area. As such, oral health was the measure selected by the stakeholder group as the cross-cutting NPM choice.

Field Name:

Priority Need 8

Field Note:
This priority was selected for State performance measure based on 2015 Needs Assessment (new SPM3)

Field Name:

Priority Need 10

Field Note:
State has selected adolescent suicide as a state performance measure to report on FY16-FY20 (new SPM4). This used to be NPM16 and State has decided to continue with the measure.

Form 10
National Outcome Measures (NOMs)

State: Utah

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

2019 note related to ESM 6.1-6.4:
These measures were replaced as the data was too difficult to extract from the database. New measures have been developed that more accurately reflect current activities.

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	83.4 %	0.2 %	39,991	47,942
2016	82.1 %	0.2 %	41,057	49,986
2015	84.3 %	0.2 %	42,102	49,916
2014	83.2 %	0.2 %	41,858	50,292
2013	79.3 %	0.2 %	40,079	50,551
2012	78.0 %	0.2 %	39,813	51,035
2011	77.8 %	0.2 %	39,513	50,791
2010	76.9 %	0.2 %	39,560	51,428
2009	75.5 %	0.2 %	40,090	53,098

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	48.6	3.7	178	36,666
2014	45.0	3.1	218	48,501
2013	43.4	3.0	208	47,944
2012	42.5	3.0	206	48,516
2011	51.2	3.2	251	49,018
2010	46.5	3.1	233	50,134
2009	55.4	3.3	285	51,494
2008	51.9	3.1	279	53,720

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	12.7
Numerator	19
Denominator	149,840
Data Source	Maternal Mortality Review Information Application
Data Source Year	2015-2017

NOM 3 - Notes:

Rate is for 2015-2017. These years were used as this is when Utah started using the CDC's Maternal Mortality Review Information Application. Pregnancy relatedness determined by the Perinatal Mortality Review Committee.

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	7.2 %	0.1 %	3,507	48,571
2016	7.2 %	0.1 %	3,622	50,451
2015	7.0 %	0.1 %	3,561	50,768
2014	7.0 %	0.1 %	3,572	51,143
2013	7.0 %	0.1 %	3,567	50,938
2012	6.8 %	0.1 %	3,522	51,447
2011	6.9 %	0.1 %	3,544	51,211
2010	7.0 %	0.1 %	3,655	52,249
2009	7.0 %	0.1 %	3,766	53,870

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	9.4 %	0.1 %	4,588	48,583
2016	9.6 %	0.1 %	4,851	50,464
2015	9.3 %	0.1 %	4,722	50,777
2014	9.1 %	0.1 %	4,678	51,154
2013	9.2 %	0.1 %	4,667	50,953
2012	9.1 %	0.1 %	4,701	51,463
2011	9.4 %	0.1 %	4,838	51,222
2010	9.5 %	0.1 %	4,971	52,256
2009	9.8 %	0.1 %	5,278	53,884

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	27.8 %	0.2 %	13,530	48,583
2016	28.1 %	0.2 %	14,201	50,464
2015	27.6 %	0.2 %	14,023	50,777
2014	28.0 %	0.2 %	14,309	51,154
2013	27.5 %	0.2 %	14,004	50,953
2012	28.5 %	0.2 %	14,678	51,463
2011	29.3 %	0.2 %	15,001	51,222
2010	30.4 %	0.2 %	15,873	52,256
2009	29.4 %	0.2 %	15,828	53,884

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.3	0.4	318	50,616
2015	5.3	0.3	269	50,908
2014	5.8	0.3	295	51,304
2013	5.8	0.3	295	51,099
2012	5.2	0.3	269	51,584
2011	5.4	0.3	278	51,351
2010	5.5	0.3	289	52,408
2009	6.0	0.3	325	54,042

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.4	0.3	274	50,464
2015	5.0	0.3	255	50,778
2014	4.9	0.3	251	51,154
2013	5.2	0.3	264	50,957
2012	4.8	0.3	248	51,465
2011	5.5	0.3	281	51,223
2010	4.9	0.3	254	52,258
2009	5.3	0.3	284	53,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	4.1	0.3	206	50,464
2015	3.3	0.3	169	50,778
2014	3.6	0.3	184	51,154
2013	3.6	0.3	183	50,957
2012	3.5	0.3	178	51,465
2011	3.7	0.3	191	51,223
2010	3.4	0.3	176	52,258
2009	3.9	0.3	212	53,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.3	0.2	68	50,464
2015	1.7	0.2	86	50,778
2014	1.3	0.2	67	51,154
2013	1.6	0.2	81	50,957
2012	1.4	0.2	70	51,465
2011	1.8	0.2	90	51,223
2010	1.5	0.2	78	52,258
2009	1.3	0.2	72	53,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	182.3	19.0	92	50,464
2015	141.8	16.7	72	50,778
2014	160.3	17.7	82	51,154
2013	164.8	18.0	84	50,957
2012	145.7	16.8	75	51,465
2011	179.6	18.7	92	51,223
2010	139.7	16.4	73	52,258
2009	196.7	19.1	106	53,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	51.5	10.1	26	50,464
2015	78.8	12.5	40	50,778
2014	45.0	9.4	23	51,154
2013	74.6	12.1	38	50,957
2012	70.0	11.7	36	51,465
2011	74.2	12.0	38	51,223
2010	45.9	9.4	24	52,258
2009	55.7	10.2	30	53,887

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.6 %	0.5 %	1,293	49,026
2014	2.0 %	0.4 %	1,002	49,617
2013	3.4 %	0.6 %	1,655	49,397
2012	2.5 %	0.4 %	1,251	49,569
2011	3.2 %	0.5 %	1,583	49,479
2010	2.9 %	0.5 %	1,439	50,570
2009	3.5 %	0.5 %	1,825	52,323
2008	4.5 %	0.6 %	2,429	53,622
2007	3.4 %	0.5 %	1,825	53,085

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.4	0.3	265	48,781
2015	5.4	0.4	200	37,050
2014	5.5	0.3	271	49,033
2013	5.0	0.3	242	48,479
2012	4.6	0.3	225	49,091
2011	4.1	0.3	203	49,747
2010	3.4	0.3	173	50,851
2009	2.4	0.2	125	52,113
2008	2.5	0.2	136	54,301

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	12.2 %	1.3 %	103,585	850,236
2016	12.3 %	1.3 %	104,276	847,619

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	14.5	1.8	67	462,979
2016	16.5	1.9	77	465,422
2015	16.4	1.9	76	463,495
2014	16.4	1.9	76	463,698
2013	15.3	1.8	71	464,813
2012	14.8	1.8	69	465,523
2011	16.2	1.9	75	464,349
2010	17.4	1.9	80	460,821
2009	17.4	2.0	79	453,465

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	33.7	2.6	170	504,304
2016	34.7	2.7	172	495,491
2015	32.6	2.6	159	487,016
2014	38.9	2.9	185	475,579
2013	28.0	2.4	131	468,312
2012	29.7	2.6	136	457,540
2011	33.1	2.7	151	456,011
2010	30.7	2.6	138	449,041
2009	33.2	2.7	147	442,958

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	10.4	1.2	74	714,340
2014_2016	11.2	1.3	78	698,607
2013_2015	9.9	1.2	68	683,941
2012_2014	10.2	1.2	68	669,115
2011_2013	9.9	1.2	66	664,407
2010_2012	10.7	1.3	71	661,785
2009_2011	12.1	1.4	80	662,845
2008_2010	11.8	1.3	78	659,486
2007_2009	14.5	1.5	95	653,558

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2017	20.3	1.7	145	714,340
2014_2016	21.2	1.7	148	698,607
2013_2015	20.9	1.8	143	683,941
2012_2014	19.1	1.7	128	669,115
2011_2013	14.6	1.5	97	664,407
2010_2012	13.1	1.4	87	661,785
2009_2011	11.5	1.3	76	662,845
2008_2010	11.7	1.3	77	659,486
2007_2009	11.3	1.3	74	653,558

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	16.0 %	1.1 %	146,008	913,753
2016	16.4 %	1.3 %	148,990	908,918

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	11.6 %	2.2 %	16,864	146,008
2016	16.7 %	3.2 %	24,809	148,990

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	2.6 %	0.5 %	19,884	755,224
2016	3.4 %	0.8 %	25,777	751,536

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	10.4 %	1.4 %	78,263	755,135
2016	9.8 %	1.2 %	73,016	746,215

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	39.6 %	4.6 %	46,616	117,735
2016	50.0 %	5.1 %	55,128	110,264

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	92.3 %	1.0 %	841,932	912,027
2016	92.7 %	1.0 %	839,113	905,467

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.2 %	0.2 %	1,870	22,919
2012	8.7 %	0.2 %	2,234	25,640
2010	12.5 %	0.2 %	3,264	26,045
2008	13.2 %	0.2 %	2,710	20,592

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	9.6 %	0.8 %	15,119	157,588
2013	6.4 %	0.9 %	9,582	148,705
2011	8.5 %	0.9 %	12,565	147,470
2009	6.5 %	0.9 %	9,599	148,617
2007	8.5 %	1.8 %	11,853	138,672
2005	5.4 %	0.9 %	7,528	140,227

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	8.7 %	1.6 %	32,848	377,409
2016	9.5 %	1.9 %	31,613	334,315

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	6.7 %	0.5 %	61,508	924,827
2016	5.3 %	0.5 %	48,721	921,098
2015	7.6 %	0.4 %	69,298	911,752
2014	9.2 %	0.6 %	82,818	905,149
2013	9.0 %	0.6 %	80,465	897,411
2012	9.3 %	0.5 %	82,538	885,518
2011	11.1 %	0.7 %	97,541	881,364
2010	11.0 %	0.7 %	96,001	871,851
2009	10.2 %	0.6 %	88,555	867,275

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	67.9 %	3.6 %	50,466	74,289
2016	72.2 %	3.5 %	52,669	72,909
2015	68.1 %	3.7 %	49,887	73,266
2014	70.8 %	4.0 %	51,143	72,245
2013	75.2 %	3.1 %	54,856	72,942
2012	73.0 %	3.7 %	54,501	74,692
2011	66.7 %	3.5 %	51,551	77,311
2010	49.9 %	3.6 %	39,804	79,839
2009	41.2 %	3.7 %	30,764	74,688

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	47.5 %	1.9 %	414,038	872,604
2016_2017	48.9 %	2.3 %	419,571	858,546
2015_2016	53.0 %	2.0 %	447,297	844,753
2014_2015	56.7 %	2.7 %	474,068	835,656
2013_2014	49.8 %	2.0 %	410,487	823,784
2012_2013	49.7 %	2.3 %	414,308	833,893
2011_2012	49.9 %	3.0 %	405,162	811,568
2010_2011	50.7 %	3.1 %	415,172	818,880
2009_2010	41.6 %	1.7 %	356,428	856,798

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	58.8 %	3.1 %	148,169	251,933
2016	49.7 %	3.4 %	122,400	246,483
2015	44.2 %	3.3 %	106,783	241,401

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	91.6 %	1.7 %	230,739	251,933
2016	84.0 %	2.5 %	206,917	246,483
2015	82.0 %	2.6 %	197,845	241,401
2014	84.8 %	2.3 %	201,179	237,210
2013	86.2 %	2.5 %	199,689	231,605
2012	81.5 %	3.2 %	184,425	226,329
2011	81.4 %	3.0 %	180,183	221,294
2010	68.8 %	3.1 %	144,662	210,187
2009	64.1 %	3.1 %	133,903	208,756

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	85.1 %	2.2 %	214,435	251,933
2016	76.6 %	2.9 %	188,764	246,483
2015	71.5 %	2.9 %	172,598	241,401
2014	66.9 %	3.0 %	158,734	237,210
2013	61.0 %	3.4 %	141,239	231,605
2012	56.5 %	3.6 %	127,839	226,329
2011	58.5 %	3.6 %	129,348	221,294
2010	48.9 %	3.2 %	102,672	210,187
2009	42.1 %	3.2 %	87,791	208,756

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.2	0.4	1,801	118,837
2016	15.6	0.4	1,829	117,114
2015	17.8	0.4	2,021	113,774
2014	19.5	0.4	2,163	110,859
2013	20.6	0.4	2,254	109,472
2012	23.2	0.5	2,494	107,507
2011	23.6	0.5	2,542	107,499
2010	28.0	0.5	3,049	108,858
2009	30.7	0.5	3,349	108,952

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.3 %	1.2 %	7,092	46,498
2016	14.9 %	1.2 %	7,229	48,455
2015	12.1 %	1.0 %	5,903	48,727
2014	12.4 %	1.0 %	6,112	49,129
2013	12.5 %	1.1 %	6,173	49,266
2012	11.4 %	0.9 %	5,645	49,349

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	3.1 %	0.6 %	28,591	908,178
2016	2.8 %	0.6 %	25,483	906,201

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Utah

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	55	55.8	57
Annual Indicator	55.6	56.9	54.7
Numerator	313,251	328,066	321,738
Denominator	563,258	576,406	588,467
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	55.0	55.4	55.8	56.2	56.6	57.0

Field Level Notes for Form 10 NPMs:

None

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data			
	2016	2017	2018
Annual Objective	90	92.8	91.7
Annual Indicator	92.7	91.6	89.1
Numerator	480	522	521
Denominator	518	570	585
Data Source	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	90.0	90.4	90.8	91.2	91.6	92.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	88.5	94.5	88.6
Annual Indicator	94.4	88.4	89.7
Numerator	43,550	43,382	43,073
Denominator	46,122	49,063	48,030
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	90.0	90.2	90.4	90.6	90.8	91.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	18.5	27.3	26.9
Annual Indicator	27.0	26.8	27.8
Numerator	11,890	12,259	12,643
Denominator	44,056	45,790	45,490
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	28.0	28.3	28.6	29.0	29.3	29.6

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			33.2
Annual Indicator		33.1	32.6
Numerator		38,611	32,987
Denominator		116,514	101,171
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	32.2	32.5	32.8	33.1	33.4	33.7

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
This objective is based on the 2017 NCHS rate of 31.9%.

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2016	**2017**	**2018**
Annual Objective	19.9	19.9	18.9
Annual Indicator	19.7	19.7	19.1
Numerator	29,466	29,466	30,959
Denominator	149,852	149,852	162,207
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2013	2013	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT			
	2016	**2017**	**2018**
Annual Objective			18.9
Annual Indicator		13.6	8.7
Numerator		37,056	25,092
Denominator		272,391	287,812
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	20.0	20.0	21.0	21.0	22.0	22.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			50.4
Annual Indicator		50.4	47.2
Numerator		75,090	68,219
Denominator		148,990	144,415
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	44.1	44.3	44.5	44.7	44.9	45.1

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note:	This projection is based on the 2017 NCHS rate of 43.9%.

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			18.4
Annual Indicator		18.4	19.3
Numerator		11,791	12,760
Denominator		64,109	66,028
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	19.5	19.7	19.9	20.1	20.3	20.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: Projection based on 2016-2017 NCHS rate of 19.3%	

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	59.6	56.7	56.9
Annual Indicator	56.5	61.2	53.6
Numerator	27,701	29,790	25,341
Denominator	49,001	48,710	47,301
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	53.8	54.0	54.2	54.4	54.6	54.8

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			80.3
Annual Indicator		80.1	82.4
Numerator		684,515	701,280
Denominator		854,160	851,339
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	84.8	85.0	85.2	85.4	85.6	85.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: Projection based on 2017 NCHS rate of 84.6%	

Form 10
State Performance Measures (SPMs)

State: Utah

SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		9	9.4
Annual Indicator	9.3	9.6	9.4
Numerator	4,712	4,852	4,582
Denominator	50,776	50,486	48,578
Data Source	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9.4	9.4	9.3	9.3	9.2	9.1

Field Level Notes for Form 10 SPMs:

None

SPM 2 - CSHCN Rural Clinical Services: The percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		3.3	1
Annual Indicator	1.9	0.8	1.6
Numerator	550	272	533
Denominator	28,704	35,870	34,275
Data Source	CSHCN/UDAC Billing Data	CSHCN/UDAC Billing Data (2017) and Pop Est (2016)	ISP Utilization Data
Data Source Year	2015	2016-17	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: A decision has been made to discontinue this measure. State will make an effort to select an appropriate replacement.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Denominator data is based on population estimates. Source: IBIS 2017.	

SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		14.7	15.1
Annual Indicator	15.1	15.8	15.7
Numerator	144	152	152
Denominator	950,511	960,913	967,283
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	14.9	14.5	13.9	13.5	13.0	12.5

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		21	16.7
Annual Indicator	21	17.2	21.5
Numerator	49	41	52
Denominator	233,809	238,378	242,153
Data Source	Utah Death Certificate Database, OVRS	tah Death Certificate Database, OVRS	tah Death Certificate Database, OVRS
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	21.5	20.5	20.0	19.5	19.0	18.5

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Utah

ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		1	1
Annual Indicator	1	1	1
Numerator			
Denominator			
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2015	2017	2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		100	100
Annual Indicator	100	100	100
Numerator	518	585	593
Denominator	518	585	593
Data Source	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		100	100
Annual Indicator	0	0	0
Numerator	0	0	0
Denominator	10	10	10
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Awaiting VLBW morbidity data analysis to convene consensus group.

ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based 10 Steps to Breastfeeding Success

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		22	28
Annual Indicator	14	18	23
Numerator			
Denominator			
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	27.0	29.0	31.0	33.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			178
Annual Indicator	26	89	114
Numerator			
Denominator			
Data Source	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	126.0	138.0	150.0	162.0	174.0	186.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		9,400	10,800
Annual Indicator	9,335	10,771	9,700
Numerator			
Denominator			
Data Source	Utah WIC Program Computer Report	Utah WIC Program Computer Report	Utah WIC Program Computer Report
Data Source Year	SFY 2016	SFY 2017	SFY 2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	9,700.0	9,800.0	9,900.0	10,000.0	10,100.0	10,200.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
BFPC
State FY 2016 Data; 7/1/2015 – 6/30/2016
Participation: Grand Total—56,538
9,335/56,538==16.51%
Referral Summary to Breastfeeding Program:
9,335 Total Number of Referrals

ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		1,475	1,689
Annual Indicator	1,414	1,601	1,601
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 6.2 - Home visitors training on the use of the ASQ developmental screening tool: Number of ASQ screenings conducted by home visitors

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		3,000	2,028
Annual Indicator	2,693	1,930	1,930
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 6.3 - Help Me Grow Utah (HMGU) ASQ screenings: Number of ASQ screenings conducted by Help Me Grow Utah (HMGU) staff

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		4,000	3,500
Annual Indicator	3,733	3,178	3,178
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 6.4 - Healthcare provider well-child checks: Number of ASQ online screenings done during well-child checks

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		300	350
Annual Indicator	267	299	299
Numerator			
Denominator			
Data Source	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System	ASQ Enterprise Online Data System
Data Source Year	2016	2017	2017
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 6.5 - Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.

Measure Status:	Active

Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	45.0	55.0	65.0	75.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Projections based on baseline measure of 25% in calendar year 2018 (41 of 163 enrolled providers contributing screening data). 2019 Projection = 35%.

ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	198.0	218.0	240.0	264.0	291.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**

Field Note:
Projections based on baseline measure of 163 in calendar year 2018. 2019 Projection = 180.

ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		10	25
Annual Indicator	7.1	25	25
Numerator		1	1
Denominator		4	4
Data Source	School Health Profiles	UDOH Policy Database	UDOH Policy Database
Data Source Year	2016	2017	2017
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	50.0	50.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		4	35
Annual Indicator	6	34	31
Numerator			
Denominator			
Data Source	EPICC Training Database	EPICC Training Database	EPICC Training Database
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	36.0	37.0	38.0	39.0	40.0	41.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		69	67
Annual Indicator	68.8	67.3	68.1
Numerator	99	115	286
Denominator	144	171	420
Data Source	Program Level Data	Program Data, Integrated Services Program	Program Data, Integrated Services Program
Data Source Year	FFY17	FY2017	FY2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	68.0	69.0	69.0	70.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		23.5	20
Annual Indicator	23.5	23.5	76.2
Numerator	16	16	16
Denominator	68	68	21
Data Source	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2016	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	76.5	77.0	77.5	78.0	78.5	79.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		69	67
Annual Indicator	68.8	67.3	68.1
Numerator	99	115	286
Denominator	144	171	420
Data Source	Program Level Data, UESC Family Survey	Integrated Services Program Data	Integrated Services Program Data
Data Source Year	FFY17	FY2017	2018
Provisional or Final ?	Provisional	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	68.0	69.0	69.0	70.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		45.3	37.1
Annual Indicator	45.1	36.9	25
Numerator	69	58	38
Denominator	153	157	152
Data Source	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report
Data Source Year	2015	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.2	25.4	25.6	25.8	26.0	26.2

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		53.6	51.5
Annual Indicator	53.4	51.3	54.2
Numerator	116,623	109,115	109,777
Denominator	218,295	212,848	202,518
Data Source	CMS 416	CMS 416	CMS 416
Data Source Year	FFY16	FFY17	FFY18
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	54.4	54.6	54.8	55.0	55.2	55.4

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
CMS-416 Report for Utah, Numerator = line 12b 'Total' Medicaid children ages 1 - 18 years who had a preventive dental visit; Denominator = line 1b 'Total' Medicaid children ages 1 - 18 years eligible for 90 days or more

Form 10
State Performance Measure (SPM) Detail Sheets

State: Utah

SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To reduce the percent of live births occurring before 37 completed weeks of gestation
Definition:	**Numerator:** Number of preterm births (less than 37 completed weeks of gestation) **Denominator:** Total number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH Objective 9.1: Reduce total preterm births to 11.4%
Data Sources and Data Issues:	Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health
Significance:	Preterm birth is a leading cause of infant mortality. Babies born preterm have increased risks for long-term morbidities and often require intensive care after birth. Health care costs and length of hospital stay are also higher for premature infants.

SPM 2 - CSHCN Rural Clinical Services: The percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	To increase the percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)
Definition:	**Numerator:** Number of CSHCN children in the rural areas of the state who received direct clinical services contractually from the University Developmental Assessment Center **Denominator:** Total number of CSHCN children in the rural areas of the state **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CSHCN billing data and NSCH data for total percent of CSHCN
Significance:	CSHCN in rural areas may be more likely to have unmet health care needs due to transportation difficulties or because care is not available in the area. Additionally, there may be greater time and financial burdens associated with the necessity of obtaining care at provider sites located further from home.

SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	To reduce the rate of injury-related deaths among children and adolescents ages 1 to 19
Definition:	**Numerator:** Number of injury-related deaths among children and adolescents ages 1 to 19 **Denominator:** Total number of children and adolescents ages 1 to 19 **Unit Type:** Rate **Unit Number:** 100,000
Data Sources and Data Issues:	Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; National Center for Health Statistics (NCHS) / U.S. Census Bureau
Significance:	Each year, an average of 450 Utah children dies in Utah. Approximately one-third of these deaths are due to injury. Injuries are mostly preventable, yet they continue to be a leading cause of death for children and adolescents in Utah.

SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the rate of suicide death among youth ages 15 to 19
Definition:	**Numerator:** Number of suicide deaths among youth ages 15 to 19 **Denominator:** Total number of youths ages 15 to 19 **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	MHMD-1 Reduce the suicide rate -- MHMD-2 Reduce suicide attempts by adolescents -- IVP-30 Decrease firearm related death -- IVP-43 -- Surveillance of violent death -- ECBP-2 Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity
Data Sources and Data Issues:	Office of Vital Records and Statistics, Center for Health Data and Informatics, Utah Department of Health - IBIS Injury Mortality Module
Significance:	Utah has witnessed a steady increase in the rate of suicide fatalities among this age group over the past 10 years. In 2013, suicide surpassed unintentional injuries to become the leading cause of death among youth ages 10-19 in Utah. On average, 37 youths in Utah die from suicide and 942 are injured in a suicide attempt each year.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Utah

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Utah

ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of institutions of higher learning partnered with MIHP.
Definition:	**Numerator:** Number of institutions of higher learning **Denominator:** N/A (number of institutions of higher learning partnered with MIHP.) **Unit Type:** Count **Unit Number:** 99
Data Sources and Data Issues:	MIHP Program Level data
Significance:	The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows: A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	100% of VLBW infants reported to Utah Department of Health database.
Definition:	**Numerator:** Total number of VLBW infants entered into VLBW Database **Denominator:** Total number of VLBW infants born in Utah **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Program Specific Data from VLBW Infant Morbidity REDCap Database
Significance:	Perinatal regionalization classifies hospitals at risk-appropriate levels in regards to care for both mothers and infants. This ensures that high-risk pregnancies and LBW, preterm or other at-risk infants have access to the most appropriate care. In Utah, hospitals self-designate their levels of care and because of this, there is not uniformity with Utah's leveling. In an attempt to dig past the surface of a self-proclaimed level and see what is actually happening in our facilities, a database has been created that all Utah hospitals report the outcomes of every VLBW infant either delivered or transferred to their facility. This data will allow Utah to have a more informed conversation about the importance of Perinatal Regionalization through the eyes of some of our most ill and vulnerable infants.

ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Increase the percent of hospitals facilities providing support to build a consensus-based model of Utah Standardized Level of Care to 100%
Definition:	**Numerator:** The number of level III NICU facilities providing support/consensus **Denominator:** The total number of level III hospital facilities in the State (UT) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Program-specific data of agreement collected at meetings and/or email
Significance:	A survey carried out by the Maternal and Child Health (MCH) Bureau several years ago provided objective criteria that indicates Utah currently has ten hospitals that self-designate as level III neonatal intensive care units (NICU) while the survey data collected indicate that number is much smaller based on the published Guidelines. Currently, Utah regulations that designate Levels of Care for Perinatal Services are imprecise and there is no regular oversight of NICU services by the Department. Through collaboration, the MCH Bureau has worked on developing Utah specific Guidelines for Neonatal Care based on the 7th edition of Guidelines for Perinatal Care; however, these guidelines have remained in draft form for the last few years. With the collection of Utah specific data on VLBW infants, creation of these guidelines will be able to be reapproached.

ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based 10 Steps to Breastfeeding Success
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number steps being implemented in Utah delivering hospitals.
Definition:	**Numerator:** Number of steps implemented **Denominator:** N/A (Number of steps implemented) **Unit Type:** Count **Unit Number:** 999
Data Sources and Data Issues:	Program level data
Significance:	Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of worksites that create a lactation policy that complies with federal standards.
Definition:	**Numerator:** Number of worksites with a policy **Denominator:** N/A/ (Number of worksites with a policy) **Unit Type:** Count **Unit Number:** 999
Data Sources and Data Issues:	Healthy Utah Worksite Assessment Survey
Significance:	For infants not breastfeeding, there is an associated increased risk of infant morbidity and mortality and significantly higher risk of many diseases including diabetes, obesity, leukemia, SIDS, NEC, etc. Duration rates are greatly affected by mothers returning to work to businesses that are not meeting the federal workplace accommodation law. Policies must be in place and implemented to provide an environment that is conducive to supporting breastfeeding women. Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of referrals to BFPCP by 1% in the next year.
Definition:	**Numerator:** Number of referrals **Denominator:** N/A/ (Number of referrals) **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Utah WIC Program Computer Reports *It was suggested that BF PC Contacts Summary Report could be modified to separate duplicated and unduplicated contacts. Clinic Services Referral Summary Report will provide number referred to Peer Counselor Program.
Significance:	Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the number of ASQ screenings conducted by early care and education providers.
Definition:	**Numerator:** Number of ASQ screenings conducted by early care and education providers **Denominator:** N/A (Number of ASQ screenings conducted by early care and education providers) **Unit Type:** Count **Unit Number:** 9,999
Data Sources and Data Issues:	ASQ Enterprise Online Database
Significance:	Follow-up after initial training will help ensure that developmental screenings become a part of the culture of the early care and education program, thus increasing the number of screenings done annually.

ESM 6.2 - Home visitors training on the use of the ASQ developmental screening tool: Number of ASQ screenings conducted by home visitors
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the number of ASQ screenings conducted by home visitors
Definition:	**Numerator:** Number of ASQ screenings conducted by home visitors **Denominator:** N/A (Number of ASQ screenings conducted by home visitors) **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	ASQ Enterprise Online Database
Significance:	Training and technical assistance will help ensure that developmental screenings become a part of the culture of the Home Visiting Program, thus increasing the number of screenings done annually.

ESM 6.3 - Help Me Grow Utah (HMGU) ASQ screenings: Number of ASQ screenings conducted by Help Me Grow Utah (HMGU) staff
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the number of ASQ screenings conducted by HMGU staff
Definition:	**Numerator:** Number of ASQ screenings conducted by HMGU staff **Denominator:** N/A (Number of ASQ screenings conducted by HMGU staff) **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	ASQ Enterprise Online Database
Significance:	Increased parent education through Help Me Grow Utah will inform parents of the importance of staying current on developmental screenings.

ESM 6.4 - Healthcare provider well-child checks: Number of ASQ online screenings done during well-child checks
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the number of ASQ online screenings done during well-child checks
Definition:	**Numerator:** Number of ASQ online screenings done during well-child checks **Denominator:** N/A (Number of ASQ online screenings done during well-child checks) **Unit Type:** Count **Unit Number:** 9,999
Data Sources and Data Issues:	ASQ Enterprise Online Data System
Significance:	Increased health provider education through Help Me Grow Utah will inform doctors of the importance of helping their patients stay current on developmental screenings.

ESM 6.5 - Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.
Definition:	**Numerator:** The number of enrolled programs that contribute any screening data to the UDOH ASQ online account throughout the calendar year. **Denominator:** The number of programs that are enrolled in the UDOH ASQ online program. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	UDOH ASQ online account.
Significance:	By increasing the percentage of enrolled programs that actively participate in the UDOH ASQ online account, the UDOH will gain an improved ability to track and increase the number of age aligned developmental screens that children ages 9-35 months receive.

ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of programs enrolled in the UDOH ASQ online account by 10%.
Definition:	**Numerator:** Number of programs enrolled in the UDOH ASQ online account. **Denominator:** n/a **Unit Type:** Count **Unit Number:** 999
Data Sources and Data Issues:	UDOH ASQ online account.
Significance:	If additional programs are enrolled and actively participate in the UDOH ASQ online account; UDOH may increase the number of children ages 9-35 months receiving an age aligned developmental screening.

ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the percent of schools within four targeted local eduation agencies (LEAs)--Cache, Canyons, Granite, and Salt Lake--that have implemented CSPAP
Definition:	**Numerator:** Number of schools within the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake--that have implemented CSPAP **Denominator:** Total number of schools within the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	School Health Profiles
Significance:	A Comprehensive School Physical Activity Program (CSPAP) is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally-recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime.

ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)
NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the CSPAP
Definition:	**Numerator:** Number of local education agencies (LEAs) in the state that received professional development on CSPAP **Denominator:** N/A (Number of local education agencies (LEAs) in the state that received professional development on CSPAP) **Unit Type:** Count **Unit Number:** 99
Data Sources and Data Issues:	EPICC training database
Significance:	Professional development is designed to actively engage learners. Teachers who attend professional development about physical activity and who incorporate movement during the school day will increase student opportunity to be active for 60 minutes a day.

ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of families connected to community resources by June 2017.
Definition:	**Numerator:** Families who were connected with a community resource **Denominator:** Families that allowed a follow-up contact (call, email, etc.) to determine if they were connected with a community resource **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Program data, Integrated Services Program, CSHCN. The CSHCN Integrated Services Program will collect data in FY2017 based on families referred by the shared resource (Medical Home Portal). The Integrated Services Program will attempt to follow up with families to determine if they were connected with a community service.
Significance:	The goal is that CSHCN receive coordinated care and can easily access community based services. Services are available but families may be unaware of the services or unaware of how to access the services.

ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood.
Definition:	**Numerator:** Number of respondents with a child over 15 years old who report having a written transition plan. **Denominator:** Number of respondents with a child over 15 years old who responded to the question about a written transition plan. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Program level data, UESC Family Survey
Significance:	A written transition plan may help families of children and youth with special health care needs consider health and other needs and determine actions to help the youth transition to adulthood. The UESC Family Survey attempts to determine if families have access to a written transition plan, one of the components of the Six Core Elements of Health Care Transition 2.0.

ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
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<tr><td>Unit Number:</td><td>100</td></tr>
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</td></tr>
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ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the percent of EHS pregnant women who had a dental exam and/or treatment during pregancy.
Definition:	**Numerator:** Number of EHS pregnant women who had a dental exam and/or treatment during the reporting year **Denominator:** EHS total enrollment of pregnant women **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Utah Office of Head Start - Program Information Report (PIR) Summary Report - 2015 - State Level, Numerator - line C.21, p. 17; Denominator = line A.14, p. 3
Significance:	Measures the number of pregnant women in the EHS program who had a dental exam and/or treatment during pregancy.

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the percent of Medicaid children ages 1 - 18 who had a preventive dental visit
Definition:	**Numerator:** Number of Medicaid children aged 1-18 who had a preventive dental visit **Denominator:** Number of Medicaid children aged 1-18 eligible for Medicaid for 90 days or more **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	CMS-416 Report for Utah, Numerator = line 12b 'Total' Medicaid children ages 1 - 18 years who had a preventive dental visit; Denominator = line 1b 'Total' Medicaid children ages 1 - 18 years eligible for 90 days or more.
Significance:	The Medicaid population is a group that has higher dental needs that those of higher economic status. They are part of the population in Utah that is important to concentrate on in improving this measure.

Form 11
Other State Data

State: Utah

The Form 11 data are available for review via the link below.

Form 11 Data