# Maternal and Child Health Services Title V Block Grant

## Utah

## FY 2021 Application/ FY 2019 Annual Report

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## I. General Requirements

## I.A. Letter of Transmittal


State of Utah
GARY R. HERBERT
*Governor*
Spencer J. Cox
*Lieutenant Governor*

**Utah Department of Health**
Joseph K. Miner, MD, M.S.H.P.
*Executive Director*

**Division of Family Health and Preparedness**
Paul Patrick
*Division Director*

**Bureau of Maternal and Child Health**
Lynne Nilson, MPH, MCHES
*Bureau Director*


August 12, 2020

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 2021 and the Annual Report for Fiscal Year 2019.

The 2021 application includes the 5-year needs assessment, an outline of new state priorities for 2020-2025, and the annual plan for the National and the State Performance Measures which includes the evidence based strategy measures. The Annual Report for the FFY 2019 provides the results of our planned efforts completed during this time period.

We are excited to continue our work in addressing the National and State Performance Measures to improve the health of MCH/CSHCN populations.

Sincerely,

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

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


UTAH DEPARTMENT OF HEALTH

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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

Utah's Title V Maternal & Child Health Block Grant is administered by the Bureaus of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) in the Division of Family Health Preparedness (DFHP) of the Utah Department of Health (UDOH) and are the lead agencies responsible for the work of this grant. Utah's MCH/CSHCN programs collaborate with other state and local agencies, partners and stakeholders to implement strategies to move the needle for women, infants, children and children with special health care needs. In Utah, the MCH Block Grant program focuses its activities in five domain areas including 1) Women/Maternal Health, 2) Perinatal/Infant Health, 3) Child Health, 4) Adolescent Health and 5) CSHCN.

### 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 2019 population count is estimated at 3,205,958. Utah is known for its signature demographics, which include the youngest population, largest household sizes, and one of the most rapidly growing populations. The headquarters of the Church of Jesus Christ of Latter Days Saints is also housed in Utah.

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.

| Race | Non-Hispanic | | Hispanic | | Total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| American Indian/ Alaskan Native | 45,168 | 1.39% | 26,894 | 0.83% | 72,062 | 2.22% |
| Asian | 110,839 | 3.41% | 7,938 | 0.24% | 118,777 | 3.65% |
| Black | 53,093 | 1.63% | 13,896 | 0.43% | 66,989 | 2.06% |
| Native Hawaiian/ Pacific Islander | 45,766 | 1.41% | 4,333 | 0.13% | 50,099 | 1.54% |
| White | 2,528,000 | 77.78% | 414,423 | 12.75% | 2,942,423 | 90.53% |
| Total | 2,782,866 | 85.62% | 467,484 | 14.38% | **3,250,350** | |

Until 2017 historically, Utah had claimed the highest general fertility rate in the nation. Utah's 2018 general fertility rate now ranks 4th highest in the nation. Utah's fertility rate was 68.4 live births per 1,000 women in 2018 compared to 59.1 nationally. Utah continues to have the highest birth rate in the U.S. (14.9 Utah vs.11.6 U.S.). Utah's birth numbers declined for the fourth consecutive year with 47,211 live births to Utah residents in 2018.

### Title V Funding

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. The MCH/CSHCN Bureaus continue to evaluate the effectiveness of funded programs and work with the Division Finance Office to redirect budgets accordingly. Block Grant funds are distributed as follows: Bureau of Maternal and Child Health: Programs - Maternal Infant Health, Family Youth & Outreach (Adolescent/Child, Early Childhood Utah, Oral Health, Pregnancy Risk Line/MotherToBaby and Safe Haven), 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, and Integrated Services Program; Bureau of Health Promotion: Programs - Violence and Injury Prevention, Physical Activity, Baby Your Baby; and 13 Local Health Departments. It is anticipated a reallocation of funds will be put into effect in 2021.

**Five-Year MCH Needs Assessment**

Over the past 18 months, Utah conducted a statewide MCH/CSHCN Needs Assessment (NA) as required by HRSA. The MCH/CSHCN leadership team contracted with the University of Utah, Division of Public Health to conduct a comprehensive needs assessment. The 2020 MCH Needs Assessment used a community-engagement approach to gather information from stakeholders in Utah. Components of the comprehensive Needs Assessment included data collection via surveys, key informant interviews, tribal consultation, and focus groups. Regional and statewide stakeholder meetings were held both in person and virtually with activities culminating in a MCH/CSHCN Stakeholder Summit. Over 3,000 people participated in the assessment process and included stakeholders and partners who are parents, caregivers, health service professionals, community organizations, public health professionals, and mental health professionals. Data gathered from this process was used to select state health priorities which will become the focus in the MCH and CSHCN bureaus for the next five years.

Data collection began with a Stakeholder Survey and CSHCN Parent Survey. The Stakeholder Survey asked respondents to rank a list of issues for the maternal, infant, child, and adolescent domains and answer open-ended questions to provide further insight. The CSHCN Parent Survey asked questions on topics including strengths, weaknesses and needs of services for the population. Qualitative data were gathered from key informant interviews and focus groups with health departments, health care facilities, communities, social services, and members of priority populations (e.g., mothers of young children, adolescents, and parents of CSHCN) in both urban and rural settings. Topics discussed during these interviews focused on successes, recommendations, and needs specific to the community or population. Five stakeholder meetings were organized throughout Utah to present quantitative/qualitative preliminary findings. These meetings gave stakeholders a chance to help interpret findings and offer input in the prioritization of MCH and CSHCN issues.

The input provided by stakeholders and members of the MCH/CSHCN populations allowed many different perspectives on community health issues and needs. This input played a critical role in figuring out the most effective state priorities and performance measures. The Needs Assessment Summit resulted in selecting ten state MCH/CSHCN priorities as the focus for Title V activities, seven National Performance Measures (NPM), and three State Performance Measures (SPM) (see Table 1).

Collaboration with a variety of partners for this needs assessment process was instrumental in shaping future efforts to achieve the best health outcomes for mothers, children, and families in Utah.

**Utah's Maternal and Child Health Needs, Priorities, and Performance Measures**

*Table 1.* State Health Needs, Priorities, and Performance Measures, Utah, 2020

| | Identified Top 10 Health Needs via Surveys | Themes from Focus Groups & Key Informant Interviews | Final Priorities & Performance Measures |
|---|---|---|---|
| Maternal | ▪ Depression, anxiety, or other mental health issues<br>▪ Family planning services<br>▪ Domestic violence/partner abuse<br>▪ Parenting knowledge<br>▪ Drug use during pregnancy or postpartum<br>▪ Immunizations<br>▪ Environmental exposures<br>▪ Prenatal care | ▪ Access<br>– Affordable health insurance; Mental health services; Family planning and pregnancy care; Specialty care; Culturally and linguistically appropriate care<br>▪ Mental health and substance abuse<br>▪ Women's health across the lifespan | ▪ Perinatal Mood and Anxiety Disorders<br>▪ Access to Care<br><br>**NPM 1 – Well-Woman Visit:**<br>Percent of women, ages 18-44, with a preventive medical visit in the past year<br>**SPM 1 – Perinatal Mood and Anxiety Disorders:**<br>Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care. |
| Infant | ▪ Immunizations<br>▪ Abuse and neglect<br>▪ Developmental delays<br>▪ Environmental exposures<br>▪ Poor nutrition during infancy<br>▪ Breastfeeding<br>▪ Neonatal abstinence/withdrawal | ▪ Services<br>– WIC; Immunizations; Prenatal to five or "P-5"; Be Wise; Baby your Baby; Early Intervention<br>▪ Breastfeeding<br>▪ Care coordination<br>▪ Neonatal Abstinence Syndrome<br>▪ Abuse/ACEs<br>▪ Childcare | ▪ Breastfeeding<br><br>**NPM 4 – Breastfeeding:**<br>A: Percent of infants who are ever breastfed.<br>B: Percent of infants breastfed exclusively through 6 months. |
| Child | ▪ Depression or other mental health problems<br>▪ Abuse and neglect<br>▪ Parental involvement<br>▪ Immunizations<br>▪ Access to safe preschool or childcare<br>▪ Bullying<br>▪ Dental care | ▪ Schools as resources and partners<br>▪ Abuse/ACEs<br>▪ Childcare<br>▪ Poverty | ▪ Developmental delays<br>▪ Economic stability<br>▪ Family connectedness<br>▪ Dental care<br><br>**NPM 6 - Developmental Delays:**<br>Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year.<br>**NPM 13 - Oral Health*:**<br>Percent of children, ages 1-17, who had a preventive dental visit in the past year.<br>**SPM 2 - Family Connectedness*:**<br>Percent of days that all family members in the household eat together in one week. |
| Adolescent | ▪ Depression or other mental health problems<br>▪ Suicide (includes suicidal ideation and social isolation)<br>▪ Bullying<br>▪ Sexual health education<br>▪ Drug use<br>▪ Abuse and neglect<br>▪ Overweight/Obesity | ▪ Mental health and suicide<br>▪ Sex and life skills education<br>▪ School nurses<br>▪ Substance and tobacco/vaping use<br>▪ Physical education | ▪ Mental health<br>▪ Economic Stability<br><br>**NPM 9 - Bullying:**<br>Percent of adolescents, ages 12-17, who are bullied or who bully others.<br>**SPM 3 – School Lunch*:**<br>Number of students enrolled in the free or reduced-price lunch program. |
| CSHCN | ▪ Community resources and services<br>▪ Autism spectrum disorder<br>▪ Care coordination<br>▪ Early intervention services<br>▪ Mental health<br>▪ Developmental screening<br>▪ Violence, abuse, or neglect | ▪ Parent support<br>▪ Care coordination<br>▪ Access<br>– More providers; reduce waiting lists timeframes; expand rural/distance outreach (increase telehealth); affordability of insurance | ▪ Family and provider connectedness/care coordination<br>▪ Transition<br><br>**NPM 11 - Medical Home:**<br>Percent of children with and without special health care needs, ages 0-17, who have a medical home.<br>**NPM 12 - Transition to Adulthood:**<br>Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care. |

*SPMs applies to both Child and Adolescent health domains

### Family Centered Services

Utah places a high value on family centered partnerships and collaboration. An example includes the CSHCN Bureaus partnership with Utah Family Voices. Utah Family Voices supports statewide family centered care for all children and youth with special health care needs and/or disabilities.

Additionally, the CSHCN Bureau has a CSHCN Advisory Committee composed 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.

### Title V Partnerships

MCH/CSHCN have established partnerships that help expand the work of reaching women, infants, children, and families. Federal and non-federal funds are leveraged to deliver programs, services and create a statewide system of collaboration. 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 Policy Group), 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**

Accomplishments Related to the Performance Measures (NPMs and SPMs) During FY19 are reflected below and show Utah's progress during the past year on achieving the National and State Performance Measures.

| FY19 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) Unable to determine if objective was met due to question change in 2018 BRFSS survey |
| Reached college-aged women with education and information about the importance of routine preventive care. Partnered with Cherish Families to reach polygamous families living in rural Utah. Topics included preconception health, birth control, and general women's health. |
| **NPM 13A –** Oral Health-Pregnant Women: (Percent of women who had a dental visit during pregnancy) Objective Not Met |
| Supported Utah 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. Published and disseminated two Bi-Annual Oral Health Outreach Reports to stakeholders and other partners. Continued using the "12 Oral Health Messages" in collaboration with WIC, Head Start, Fostering Healthy Children, and Home Visiting programs. |
| **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) Objective Met |
| Worked with hospitals to resolve discrepancies between hospitals' self-assessed level and the Level of Care Assessment Tool (LOCATe) assessment and communicated results to hospitals. Provided data to the CDC for a multi-jurisdictional analysis on outcomes and levels of care. |
| **NPM 4 –** Breastfeeding: 4A (Percent of infants who are ever breastfed) & 4B (Percent of infants breastfed exclusively through 6 months) Objective Not Met |
| The Utah WIC Breastfeeding Peer Counseling Program outreached with local hospitals, medical offices, community programs, etc. Intermountain Healthcare endorsed the Stepping Up for Utah Babies program. All hospitals are trained and breastfeeding policies implemented. EPICC staff provided ten worksites with policies, resources and education materials. |
| **SPM 1 –** Preterm Birth: (Percent of live births occurring before 37 completed weeks of gestation) Objective Met |
| UWNQC and Family Planning Elevated at the University of Utah collaborated on implementation of a statewide, immediate Postpartum Long-Acting Reversible (LARC) Program. This program offers family planning services to low-income individuals, disseminates educational materials statewide, and trains providers. |

| Child Health |
| --- |
| **NPM 6 –** Developmental Screening: (Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool) Objective Not Met |
| Through the UDOH ASQ online account, 8,157 children ages 9-36 months received an age aligned developmental health screen. ASQ data was integrated with the UDOH Early Childhood Integration Data System and an ASQ training curriculum and training schedule was established. |
| **SPM 3 –** Child Injury: (Rate of injury deaths among children 1-19) Objective Not Met |
| The Utah Coalition for Protecting Childhood focused its efforts on upstream approaches. Events included: Youth Mental Health Screening nights, suicide prevention-training sessions creation of a Youth Services Directory which contains nearly 150 local services such as medical treatment, counseling, self-care, support groups, classes and crisis lines. |
| **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) Objective Not Met |
| EPICC staff partnered with the State Board of Education and SHAPE Utah to provide PE/PA professional development opportunities and also partnered with Utah Department of Transportation to develop "Safe Routes to School" programs. |
| **NPM 13B –** Oral Health-Children: (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year) Objective Not Met |
| The Oral Health Program worked to implement educational interventions in classrooms including school based sealant assemblies, reaching thousands of students. In partnership with local community organizations, dental screenings were conducted where children and some adults received either screening, preventive and/or restorative care. |
| **SPM 4** - Adolescent Suicide: (The rate of suicide deaths among youths aged 15-19) Objective Met |
| Governor Herbert created a Youth Suicide Task Force which led to several suicide prevention bills and funding allocations. VIPP, using a shared risk and protective factor approach: developed a strategic plan, and engaged LHDs. LHDs provided several suicide prevention-training sessions as part of their suicide prevention activities. |
| **Children with Special Health Care Needs** |
| **NPM 11 –** Medical Home: (Percent of children with special health care needs having a medical home) Objective Not Met |
| The Integrated Services Program (ISP), including LHDs, served over 800 unique CSHCN families with over 2800 care coordination encounters. Contracts continued with University of Utah Children's Care Coordination Network (UCCCN) and Medical Home Portal. |
| **NPM 12 –** Transition: (Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care) Objective Not Met |
| Collaborated with multiple medical, vocational, educational, and behavioral health organizations to address transition-related issues. Partner organizations provided direct transition training and referral for families of youth and young adults with CSHCN. |

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 up stream" for the health of women, infants and children. The Title V Block Grant application for Utah represents a comprehensive effort to improve 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. This application reflects the commitment and efforts of MCH/CSHCN and other UDOH staff and community partners working together to achieve the goals, strategies and areas requiring attention are outlined hereafter.

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

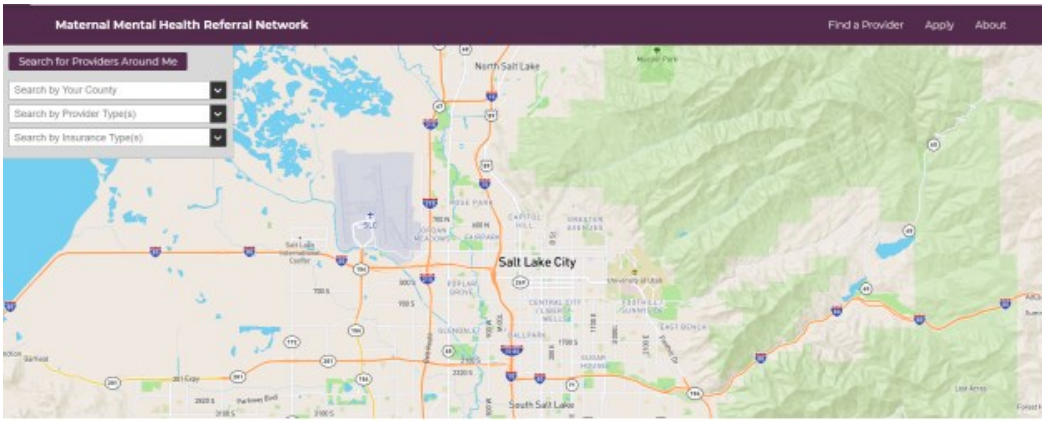
Title V funds support many MCH/CSHCN efforts across the state. One of the challenges is distributing limited state and federal dollars among populations with the greatest need. Needs assessments, surveys, data collection and reports are the best way to identify Title V population needs. The budget outlines where Block Grant dollars are distributed. A comprehensive five year needs assessment was conducted this past year. MCH/CSHCN used this information to reassess and select NPMs, SPMs, ESMs for the 2021-2025. The MCH/CSHCN Bureaus continue to evaluate the effectiveness of funded programs and work with the Division Finance Office to redirect budgets accordingly.  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, Family Youth & Outreach (Adolescent/Child, Early Childhood Utah, Oral Health, Pregnancy Risk Line/MotherToBaby and Safe Haven), Office of 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) and Integrated Services Program; 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

Data and stakeholder feedback indicated that resources for Perinatal Mood and Anxiety Disorders (PMADs) were lacking and it was difficult to find a provider to refer women. In response, Utah developed the Maternal Mental Health Referral Network, which included compiling a list of trained maternal mental health providers, and working with the local Postpartum Support International chapter to train 170 additional providers to be included on the site. Visitors can search for providers with PMAD training, and results can be narrowed down by insurance type. The website is accessible at: https://maternalmentalhealth.utah.gov/.

Since the February launch, there have been 4,799 visits to the site. While a large portion of those visitors occurred during the launch of the website, over half of those visits were made after the start of COVID. Specific information on the new referral network was provided on Utah's Coronavirus website: https://coronavirus.utah.gov/mental-health/. Visits increased by 21% in May. During this month, we actively promoted use of the website via social media platforms.

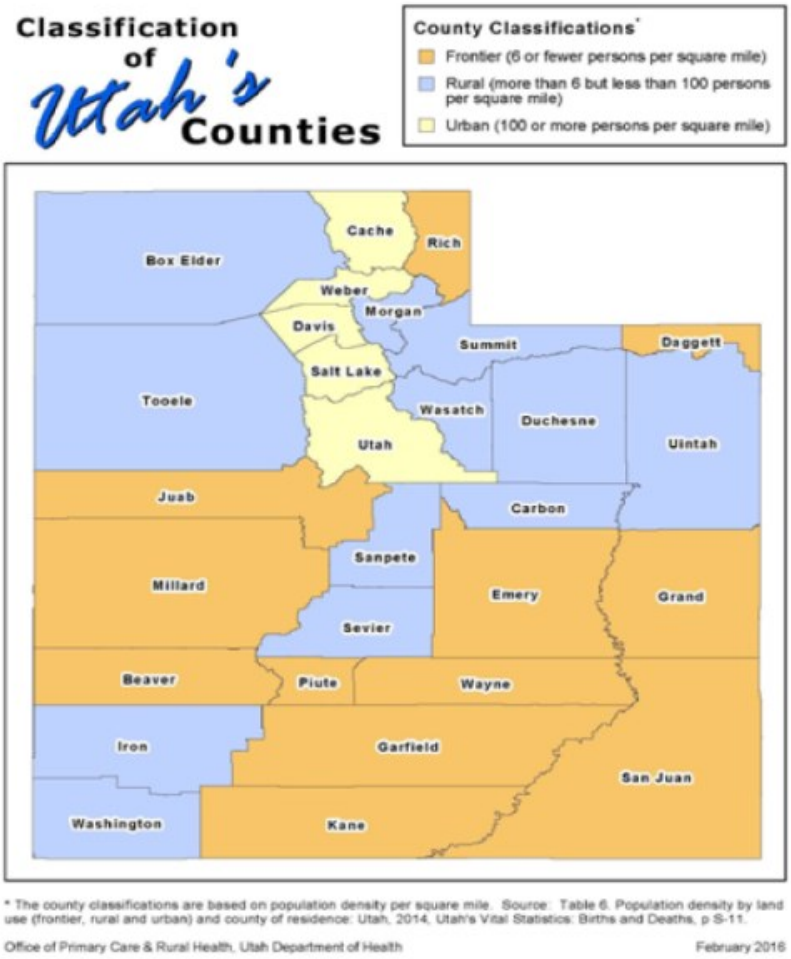



Efforts are also being made to offer telemental health services to women in four rural health districts. Women are screened for PMADs at their local health department and receive immediate results. Women are then asked if they would like further information and referral. Those who opt in are referred to the University Of Utah School Of Nursing and are offered counseling via telehealth.

### III.B. Overview of the State

### Population Demographics

Utah is geographically the thirteenth largest state and is a largely rural and frontier state. Thirty-six 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 2018 average population density is 37.2 persons per square mile, compared to 93.8 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.




Utah's 2019 population was estimated at 3,205,958. From 7/1/18 to 6/30/19, Utah's population grew by 1.7 percent, an increase of 44,853 people. According to the Census Bureau, Utah's 2019 growth was the fourth highest in the nation, behind other intermountain-west states Idaho, Nevada, and Arizona.

Population estimates for 2018 detail Utah's racial/ethnic populations:

| Race | Non-Hispanic | | Hispanic | | Total | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| American Indian/ Alaskan Native | 45,168 | 1.39% | 26,894 | 0.83% | 72,062 | 2.22% |
| Asian | 110,839 | 3.41% | 7,938 | 0.24% | 118,777 | 3.65% |
| Black | 53,093 | 1.63% | 13,896 | 0.43% | 66,989 | 2.06% |
| Native Hawaiian/ Pacific Islander | 45,766 | 1.41% | 4,333 | 0.13% | 50,099 | 1.54% |
| White | 2,528,000 | 77.78% | 414,423 | 12.75% | 2,942,423 | 90.53% |
| Total | 2,782,866 | 85.62% | 467,484 | 14.38% | **3,250,350** | |

According to a 2014 survey by the Pew Foundation, the predominant religion in Utah is the Church of Jesus Christ of Latter Day Saints (LDS), and Utah is the world headquarters of the church. The Pew Foundation 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.

Utah has resettled over 15,000 refugees since 1995 and ranks 24th in refugee arrivals. Recent data shows that the number of refugee arrivals in Utah declined from a high in 2016 of 1,555 to 539 in 2018. Of those arrivals in 2018, 51.4% were female. Most refugees in Utah arrive from the Democratic Republic of the Congo, Somalia, Iraq, and Burma.

In 2018, life expectancy at birth was 77.5 years for males and 81.2 years for females in Utah. The median age of Utah's population is 31 years, versus 37.9 in the U.S., making Utah the state youngest in the nation. The 2014-2018 American Community Survey (ACS) estimates note that 40.7% of Utah's population is under the age of 25, compared with 32.3% nationwide.

**Utah's Births**

Until 2017, Utah had claimed the highest general fertility rate in the nation. Utah's 2018 general fertility rate now ranks 4th highest in the nation. Utah's fertility rate was 68.4 live births per 1,000 women in 2018 compared to 59.1 nationally. Utah continues to have the highest birth rate in the U.S. (14.9 Utah vs.11.6 U.S.). Utah's birth numbers declined for the fourth consecutive year with 47,211 live births to Utah residents in 2018.

| Maternal Race/Ethnicity | Number of Births | Percent of Births |
|---|---|---|
| American Indian/Alaskan Native | 478 | 1.0 |
| Asian | 1,121 | 2.4 |
| Black/African American | 662 | 1.4 |
| Hispanic/Latina | 8,101 | 17.2 |
| Native Hawaiian/Pacific Islander | 430 | 0.9 |
| Two or more races | 259 | 0.5 |
| White, Non-Hispanic | 34,636 | 73.4 |
| Unknown | 1,524 | 3.2 |

Overall, Utah's birth outcomes are generally favorable. However, disparities emerge when examined by race and ethnicity:

| Maternal Race/Ethnicity | Preterm Birth* | Low Birthweight* | Cesarean Section* | Infant Mortality** | Teen Births* |
|---|---|---|---|---|---|
| American Indian/ Alaskan Native | 8.2% | 7.3% | 25.9% | 2.6/1,000 | 32.8/1,000 |
| Asian | 9.2% | 9.5% | 26.4% | 7.6/1,000 | 5.2/1,000 |
| Black/African American | 11.6% | 10.4% | 29.4% | 9.4/1,000 | 27.8/1,000 |
| Hispanic/Latina | 11.2% | 8.6% | 24.6% | 5.6/1,000 | 32.9/1,000 |
| Native Hawaiian/ Pacific Islander | 13.3% | 7.9% | 33.7% | 10.0/1,000 | 15.0/1,000 |
| Two or more races | 10.4% | 6.2% | 23.6% | *** | 2.6/1,000 |
| White, Non-Hispanic | 8.8% | 6.6% | 21.4% | 4.6/1,000 | 9.7/1,000 |
| Unknown | 11.4% | 9.8% | 27.1% | 16.8/1,000 | |
| Statewide | 9.4% | 7.2% | 22.6% | 5.3/1,000 | 14.1/1,000 |
| *2018 Vital Records data, ** 2015-2018 linked birth-death data, ***Data suppressed due to small numbers | | | | | |

### Utah's Economy

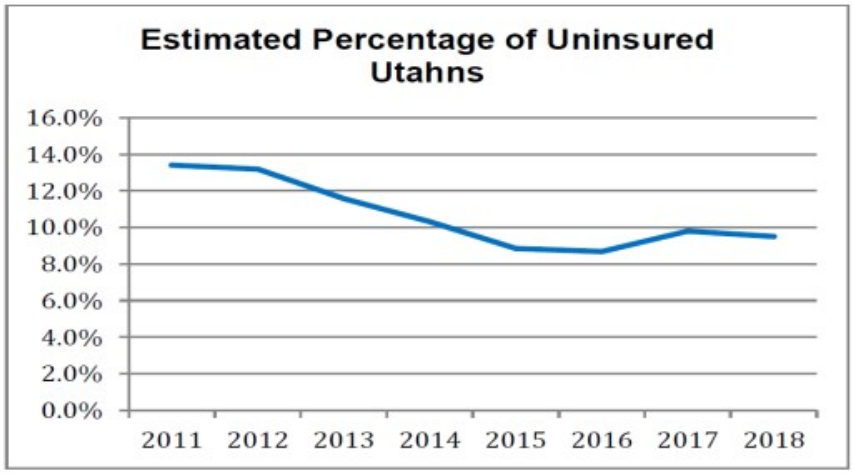
The Bureau of Labor Statistics notes that the 2018 unemployment rate in Utah was 3.0 compared to 3.9 for the nation. The 2014-2018 ACS estimates for median household income put Utah's $68,374 above the U.S. at $60,293. However, Utah's households are also large, resulting in a significantly lower per capita income ($28,239 vs. $32,621). There is also large variation in median income when broken out by race and ethnicity:

| Race/Ethnicity | Median Income (2014-2018 American Community Survey) |
|---|---|
| American Indian/Alaskan Native | $41,942 |
| Asian | $70,759 |
| Black/African American | $42,739 |
| Hispanic | $49,787 |
| Pacific Islander/Native Hawaiian | $64,594 |
| White Non-Hispanic | $71,859 |

According to the 2014-2018 ACS 5-Year estimates, the percentage of individuals with incomes below the federal poverty level is 9.0% in Utah vs. 11.8% in the U.S. Poverty rates also range widely, depending on county of residence. Poverty rates in 2018 were lowest in Morgan County (4.0%) and highest in San Juan County (22.6%), with a statewide mean of 9.1%. The National Survey of Children's Health finds that 12.6% of families had a household income at or below 100% FPL, compared to 19.7% nationally.

**Health Insurance**

In 2018, data from the Behavioral Risk Factor Surveillance System (BRFSS) estimated that 9.5% of Utahns were uninsured.




Rates of uninsured fell for all age groups except 19-26 and 35-49. Rates of uninsured decreased significantly for those living between 0-138% of the Federal Poverty Level (FPL). Rates of uninsured vary by race/ethnicity:

| Race/Ethnicity | No Insurance |
|---|---|
| American Indian/Alaskan Native | 22.0% |
| Asian | 14.2% |
| Black/African American | 22.2% |
| Hispanic | 42.5% |
| Pacific Islander/Native Hawaiian | 24.6% |
| White Non-Hispanic | 10.9% |

Insurance rates also decreased for children ages 0-17 living at or below 138% FPL. Utah BRFSS estimated that 5.7% of children below 18 years were without health insurance. The 2018 National Survey of Children's Health has higher estimates of no insurance among this group, at 8.3%.

**Education**

Based on the 2014-2018 ACS, Utah had a higher percentage of residents with a high school diploma, at 92.0% vs. 87.7% 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. (22.0% vs 19.4%) and similar to the U.S. for those with graduate degrees (11.3% vs 12.1%). According to the 2019 Kids Count report, Utah has a higher percentage of children ages 3-4 who are not in school compared to the nation (57% 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. Utah's average family size is also larger than the U.S. (3.6 vs 3.2). The percent of Utah family households with one or more persons under the age of 18 is higher at 40.3% vs. 30.3% nationally.

**Children and Adolescents**

National Survey of Children's Health data from 2018 illustrate many areas where Utah's children differ:

| | Utah % | U.S. % |
|---|---|---|
| **Race/Ethnicity** | | |
| Hispanic | 17.6 | 25.2 |
| White Non-Hispanic | 73.2 | 50.5 |
| Black Non-Hispanic | 0.3 | 13.4 |
| Asian Non-Hispanic | 2.7 | 4.8 |
| Other Non-Hispanic | 6.2 | 6.1 |
| **Primary language spoken in home** | | |
| English | 89.8 | 84.9 |
| Non-English | 10.2 | 15.1 |
| **Highest Education in Household** | | |
| Less than High School | 8.6 | 10.0 |
| High School | 11.8 | 19.1 |
| Some College | 21.4 | 22.0 |
| College Graduate | 58.2 | 48.9 |
| **Family Structure** | | |
| Two parent, currently married | 78.3 | 62.7 |
| Two parent, not currently married | 2.5 | 8.5 |
| Single parent | 16.9 | 22.8 |
| Other family type | 2.2 | 6.0 |
| **Not insured at time of NCHS survey** | 8.3 | 6.6 |
| **Current insurance not adequate** | 30.2 | 26.0 |
| **2 or more adverse childhood events** | 17.3 | 17.8 |

The 2017 Youth Risk Behavior Survey illustrates differences between Utah youth and those in the nation: Utah youth were significantly more likely to report that they carried a weapon in the past 30 days (24.0% vs. 15.7) and were more likely to report having carried a weapon onto school property (7.1% vs. 3.8%). Utah youth were significantly more likely to report having experienced sexual violence (17.6% vs. 9.7%). Utah youth report higher rates of seriously considering suicide attempt (21.6% vs. 17.2%) Utah youth were less likely than their U.S. peers to report any form of tobacco or alcohol use, but were just as likely to report illicit drug use.

The County Health Ranking and Roadmaps report reveals that the percentage of children who are eligible for free or reduced price lunch vary from 13% in Morgan County (north) to 100% in San Juan County (south). For children residing in Utah, there are noted disparities by county of residence.

**Children with Special Health Care Needs (CSHCN)**

Data from the 2018 National Survey of Children's Health (NSCH) found 17.4% of Utah children have one or more functional difficulties and 16.8% of Utah children have special health care needs. Utah's percentage of children with special health care needs ranks sixth lowest in the nation.

2017-2018 NSCH data shows that Utah's rate of children ages 3-17 diagnosed with autism is 2.1% and is lower than the U.S. rate of 2.9%. The 2018 National Survey of Children's Health data provides important information on Utah's CSHCN population and their parents:

| | Utah % | U.S. % |
|---|---|---|
| **Race/Ethnicity** | | |
| Hispanic | 19.4 | 20.0 |
| White Non-Hispanic | 73.4 | 53.7 |
| Black Non-Hispanic | 0.0 | 16.6 |
| Asian Non-Hispanic | 3.2 | 3.1 |
| Other Non-Hispanic | 3.9 | 6.6 |
| **Household Income** | | |
| 0-99% FPL | 23.5 | 23.1 |
| 100-199% FPL | 22.4 | 23.5 |
| 200-399% FPL | 28.6 | 23.8 |
| 400% or greater FPL | 25.4 | 29.7 |
| **One or More Current or Lifelong Health Conditions** | 21.4 | 23.0 |
| **Not insured at time of NCHS survey** | 9.9 | 4.0 |
| **Current insurance not adequate** | 37.8 | 32.5 |
| **Currently uninsured or had periods without coverage in past 12 months** | 10.4 | 9.2 |
| **Child has coordinated, ongoing, comprehensive care in a medical home** | 36.9 | 42.1 |
| **Problems paying for child's medical or health care bills in past 12 months** | 23.9 | 16.4 |
| **Family member cut back hours, stopped working, or both** | 17.8 | 19.8 |

**Attention Deficit Hyperactivity Disorder (ADHD) Prevalence Estimates**

Nationally, the prevalence of ADHD relies on the National Survey of Children's Health (NSCH).
In 2016, an estimated 6.1 million U.S. children 2–17 years of age (9.4%) had ever received an ADHD diagnosis.

For the first time, Utah has been able to develop a prevalence estimate of ADHD through the Utah Registry of Autism and Developmental Disabilities (URADD). Identification of ADHD was based on a community medical ADHD diagnosis (ICD-9: 314.00, 314.01 and ICD-10: F90.0, F90.1, F90.2, F90.8, and F90.9).

| Percent of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in Utah (2018) | | |
|---|---|---|
| **Birth Year** | **Count** | **Percentage** |
| 2012 (6-year-olds) | 768 of 50,305 | 1.5% |
| 2011 (7-year-olds) | 1,131 of 51,662 | 2.2% |
| 2010 (8-year-olds) | 1,499 of 52,672 | 2.8% |
| 2007 (11-year-olds) | 1,086 of 54,129 | 2.0% |
| 2006 (12-year-olds) | 1,687 of 53,185 | 3.2% |
| 2005 (13-year-olds) | 1,932 of 52,831 | 3.7% |
| Data Source: The Utah Registry of Autism and Developmental Disabilities and the UDOH Public Health Indicator Based Information System (IBIS) | | |

**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 in the Division of Disease Control and Prevention, 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.

Over the past two years, MCH/CSHCN staff in partnership with the University Of Utah Division Of Public Health conducted a comprehensive statewide needs assessment to determine the priority focus for the upcoming five years. The detailed Needs Assessment Report is found later in this document. Using results from a detailed review of Utah data and the statewide Needs Assessment, Domain Leaders met and identified priority areas, associated National and State Performance measures (NPM/SPM) and Evidence Based Strategy Measures (ESM). Designated MCH/CSHCN program staff are assigned responsibility for one or more National/State Performance measures. Additional goals and objectives are developed by each program as issues arise. Regular meetings are held to evaluate, re-assess and change strategies and/or 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. For a more comprehensive description of Title V programs, please see Appendix A.

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 the 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 OPHA also conducts the Behavioral Risk Factor Surveillance System (BRFSS). 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 MCH/CSHCN Bureau's collaborate across the UDOH to ensure integrated use of data and population assessment.

The Utah Department of Health (UDOH) conducts a Utah Healthcare Safety Net bi-annual meeting. The meeting involves 50+ stakeholders vested in MCH/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 2019 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. The Health Rankings Report notes that Utah's rate of children in poverty is the lowest in the nation. 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. The State was well prepared when the COVID-19 pandemic hit, as it had already been pilot testing telework and telehealth services. This past year, the Governor's initiative was to get 30% of the State workforce teleworking. As such, we were rapidly able to move employees to a work from home environment. Utah has also been working on expanding telehealth capacity to address teleservice needs, protections and requirements for MCH/CSHCN populations.

**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, mental health and telehealth, because of concern for confidentiality and anonymity, as well as cultural beliefs in seeking these services. Telehealth technology also poses barriers with lack of technology lines, services and equipment in both rural and frontier areas.

The America's Health Ranking Reports lists Utah's health challenges as having a low rate of primary care physicians, low immunization coverage among children, and large differences in health status by high school education.

Reorganization of the UDOH and DFHP continued this year. Some of the major transitions which occurred in this grar period: the CSHCN Bureau moved from the 44 North Mario Capecchi location after 40 plus years of occupation at thi location to join the DFHP at the Highland Drive location (including ISP moving back to the CSHCN Bureau); both the Security and Privacy Officer and the Division Deputy Director, left employment in the Division. Due to the COVID-19 outbreak, on April 1, 2020, Governor Herbert appointed both temporary Executive Director, General Jefferson Burton and temporary Chief Deputy, Richard Saunders to support the current leadership of Joseph Miner, M.D., Marc Babitz, M.D., and Nathan Checketts. The variety of reorganizational changes has increased the turnover of employees that has created challenges with workloads, timeliness of rehiring, orienting and stabilizing new employees. On August 3, 2020, the UDOH announced another administrative change. General Burton left employment to pursue a Senate seat opening and Richard Saunders moved into Interim Executive Director to support current leadership. Dr. Miner will now serve as the Chief Medical Advisory to the UDOH and to the Executive Office of the Governor through the end of the year.

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

need has grown and posed a leadership challenge while maintaining competency, relevancy and quality.

**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/CSHCN 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 comprises the UDOH and 13 Local Health Departments (LHD). The Utah Department of Health and three LHDs are accredited by the Public Health Accreditation Board. 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 who operate 56 clinics throughout the state. 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.

For many years, the UDOH provided 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 FY2018, 47% had Medicaid/Medicare, and 13% were uninsured. In addition to regular clinical services, the HCU provides immunizations and health screenings for newly resettled refugees in Salt Lake and Weber counties and provides

medical screenings for children in protective service care in multiple counties. Due to COVID-19 and resulting legislative budget reductions, all three clinics will be closing in the next couple of months.

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/CSHCN 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. Of Utah's hospital systems, the largest is 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 expanded 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. In June 2020, the EHDI Program purchased 32 Otoacoustic Emission (OAE) equipment for local health departments and midwives who needed equipment. They are setting up education sessions for use of the new equipment. This will ensure providers can offer this service statewide and EHDI data remains updated and timely follow up can occur.

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.

The UDOH funds 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.

Starting in July 2019, the DFHP was requested by the Governor to support his initiative to implement and pilot teleworking. The Division over the past year transitioned many programs to telework. Some direct care service programs had not transitioned due to privacy and security concerns with patient care. Then in March 2020, when

Utah started to experience the COVID-19 pandemic, telehealth became a quick methodology to implement. Due to previous experience with teleworking, both the MCH/CSHCN Bureaus were able to convert to a telehealth platform to provide continuity of care throughout Utah. National standards and changes allowed Utah to implement face-to-face services by telehealth. Proudly we made the transition within two weeks while ensuring guidelines were written to direct our services to occur in a safe, private and confidential manner. Virtual services cannot replace a face-to-face connection and services but we have found keeping communications open, providing online support and services have been invaluable during this time of crisis. We project this immediate transition has provided an opportunity for the future in offering virtual services when the individuals we serve do not have access or the ability to have a visit in person.

**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. The County Health Rankings and Roadmaps Report notes that the ratio of population to primary care physicians is 1,730:1 statewide, but ranges from 740:1 in Grand County to 10,080:1 in Emery County. The report also notes that seven of Utah's counties had negative trends in this measure. High population to provider ratios can also be seen among dentists and mental health care providers. Among dentists, the statewide ratio is 1,470:1 and among mental health care providers, the ratio is 300:1.

A 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.

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 for support, 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's Public Behavioral Health System**

Utah's public behavioral health systems have a similar structure as public health. Utah's Department of Human Services contracts with local county governments who are designated as local mental health authorities and local substance abuse authorities to provide prevention, treatment, and recovery services. There are 13 local authorities that deliver services throughout the state, several are co-located with the local health department.

**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 is 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.

On December 23, 2019, the Centers for Medicare and Medicaid Services (CMS) authorized the Utah Department of Health to implement a full Medicaid expansion in the state. It is estimated that up to 120,000 Utah adults are eligible for the expansion program. The state requires newly eligible adults to enroll in their employer-sponsored health plan if one is available. Medicaid will then cover the individual's monthly premium and other out-of-pocket expenses like copays and deductibles.

Full Medicaid expansion took effect in Utah as of January 2020. Adults ages 19-64 are now eligible with household incomes up to 138% of the FPL. Enrollment in Medicaid continues year round and is not limited to an annual enrollment period. A self-sufficiency/work requirement was established, but has been currently suspended due to the COVID pandemic.

**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. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

### III.C.2.a. Process Description

**Introduction -** The Statewide Maternal and Child Health Needs Assessment for Utah, conducted for the HRSA Title V Block Grant, was a joint effort of the Utah Department of Health and the University of Utah. In Utah, the MCH Block Grant program focuses its activities in five domain areas including 1) Women/Maternal Health, 2) Perinatal/Infant Health, 3) Child Health, 4) CSHCN, and 5) Adolescent Health. The process was led by the UDOH Bureaus of Maternal and Child Health and Children with Special Healthcare Needs.

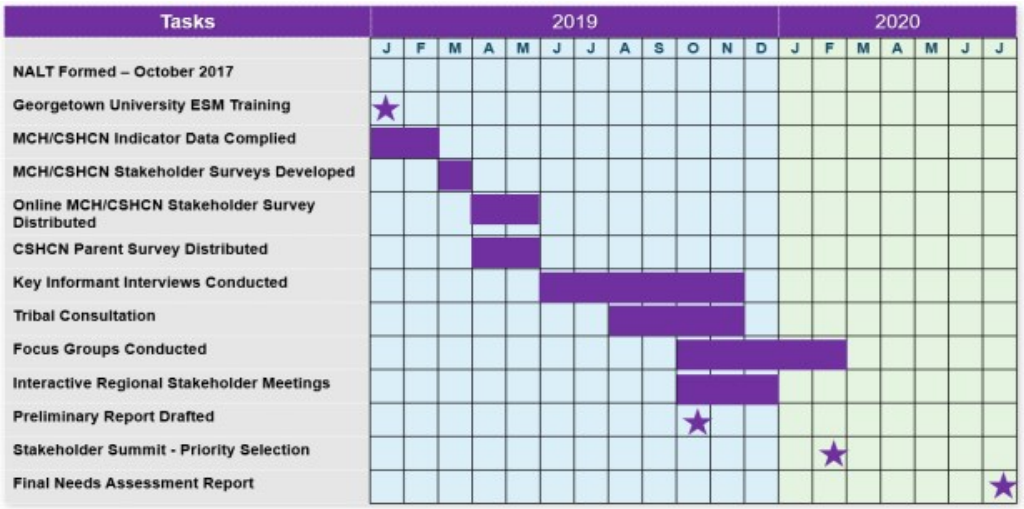
**Needs Assessment Planning Process -** As part of the Title V 2020 Maternal and Child Health (MCH) Needs Assessment, a Needs Assessment Leadership Team (NALT) was established to oversee the development and implementation of the 2020 MCH Need Assessment (NA) activities. The NALT consisted of the Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Bureau Directors, a Needs Assessment Project Lead, CSHCN Family Representative, MCH/CSHCN Epidemiologists, select MCH/CSHCN Program Managers, and Domain Leaders.

In order to inform Utah's 2020 MCH/CSHCN NA, a literature review of NA methodologies and processes used by other states was conducted. Review included documentation of the processes used in selection of national and state priorities. This review provided insight into potential methods for Utah to use. Noteworthy processes were presented to NALT and followed with a discussion on what Utah's process would be. Additionally, through this review, where available, survey instruments were reviewed to look for opportunities to enhance and compliment Utah's surveys.

An indicator report of over 270 variables outlining measures related to Utah's MCH and CSHCN populations was created to inform the needs assessment process. Data sources included the American Community Survey (ACS), Pregnancy Risk Assessment Monitoring System (PRAMS), National Vital Statistics System (NVSS), National Immunization Survey (NIS), National Survey of Children's Health (NSCH), and Youth Risk Behavior Surveillance System (YRBSS). Where available, rates were also stratified by race and ethnicity, and compared to Healthy People 2020 goals and the nation overall.

The 2019 MCH Indicator Report for Utah was shared with the NALT to provide an overview of the current strengths and weaknesses in the health status of Utahans. The report was used in selection of populations and topics to address in key informant interviews and focus groups. Additionally, the report was used by domain leaders to help identify questions for two surveys, MCH/CSHCN Stakeholder Survey and the CSHCN Parent Survey.

**Methods -** A community engaged approach was used to gather input from over 3,000 people through a variety of modalities including online surveys, key informant interviews, focus group discussions, face to face interviews, review of secondary data, interactive regional stakeholder meetings, and a statewide MCH/CSHCN summit. The following timeline outlines the activities of the Needs Assessment process:



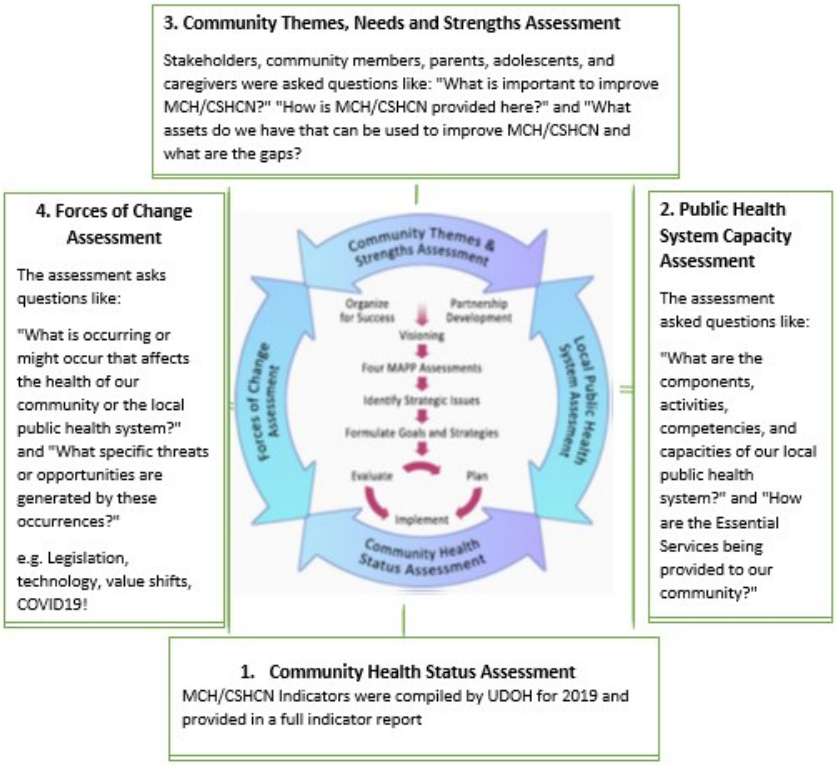

Participation by method, is presented in Table 1.

**Table 1. Participation in Utah MCH Needs Assessment Activities, 2019-2020**

| | | Activity | # Participants |
|---|---|---|---|
| 1 | MCH/CSHCN Stakeholder Survey | Online survey | 1,892 |
| 2 | CSHCN Parent Survey | Online survey | 1,161 |
| 3 | Tribal Consultation | 3 meetings | 15* |
| 4 | Focus Group Discussions | 6 FGDs | 48 |
| 5 | Key Informant Interviews | 52 interviews | 59 |
| 6 | Regional Stakeholder Meetings | 5 meetings | 86 |
| 7 | Statewide Summit | 1 Summit | 87 |
| | | | **3,348** |
| | **estimated attendance* | | |

The Utah Needs Assessment process served to inform the UDOH about MCH and CSHCN needs and was framed using the National Association of County and City Health Officials (NACCHO), Mobilizing for Action through Planning and Partnerships (MAPP) model. The four MAPP assessments as described below:

**MAPP (Mobilizing for Action through Planning and Partnerships) Model with Annotated Modifications for the Utah Statewide Public Health Needs Assessment, 2020**




### III.C.2.b. Findings

### III.C.2.b.i. MCH Population Health Status

## Results

1. **Community Health Status Assessment**

Selected indicators from the 2019 Indicator Report were selected for their relevance to findings from other parts of the assessment as well as their absolute relevance in terms of real gaps or deficiencies in health status. It is important to note that health status indicators showed health disparities in many cases for other racial and ethnic groups. These disparities will be reviewed and addressed in strategic planning.

**Health Insurance**

Percent of women of reproductive age who reported being uninsured = **14.7%**

Percent of children and adolescents who are continuously and adequately insured, ages 0 – 17 = **61.1%**

**Access to Care**

Percent of Children with Special Health Care Needs, ages 0 -17 = **16.4%**

Percent of children with special health care needs who have a medical home, ages 0 -17 = **18.4%**

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care, ages 12 – 17 = **44.9%**

Percent of Utah children who have received dental sealants ages 6-9 = **44.9%**

**Mental Health**

Percent of women who reported postpartum depression = **14.7%**

Percent of children and adolescents with a mental/behavioral condition who receive treatment or counseling = **50.0%**

Percent of adolescents who reported feeling sad or hopeless = **33.0%**

Percent of adolescents who reported making a plan about how they would attempt suicide = **17.1%**

Percent of adolescents who reported attempting suicide = **9.6%**

Percent of adolescents who reported being bullied on school property = **19.4%**

Percent of adolescents who reported being electronically bullied = **18.0%**

**Substance Use**

Percent of adolescents who reported that they currently use an electronic vapor product = **7.6%**

Percent of adolescents who reported being offered, sold, or given an illegal drug on school property = 25.9%

Percent of adolescents who reported that they have never drank alcohol = **69.6%**

Percent of adolescents who reported that they have ever used marijuana = **16.6%**

**Immunizations**

Percent of children who have completed the combined 7-vaccine series = **67.9%**

Percent of female adolescents who have received at least one dose of the HPV vaccine = **63.1%**

**Nutrition and Physical Activity**

Percent of infants who were exclusively breastfed through 3 months = **55.5%**

Percent of children who are physically active at least 60 minutes per day, ages 6 – 11 = **21.9%**

**Reproductive/Sexual health**

Adolescent female Chlamydia rate, ages 15 - 19, per 100,000 = **1651**

Teen birth rate, ages 18 - 19, per 1,000 female population = **30.0**

**2. Public Health System Capacity Assessment**

Systems issues were often described by stakeholders during interviews and focus groups, using terms such as ‘social determinants of health’, ‘health inequities or disparities’, and lack of ‘universal healthcare’. Systems issues included problems such as poverty, geography/rurality, and the lack of affordable and accessible healthcare for everyone. Groups described as vulnerable included people with low income, but with low-wage jobs so they do not qualify for Medicaid, immigrants who may be afraid to seek any governmentally funded service, and underrepresented minorities and their children.

Socio-political norms were described as prevailing values of self-reliance and small government and used as a rationale to limit funding to health and social programs. Utah ranks among the lowest states in funding per capita for education, public health, school nursing, and has not been favorable to Medicaid expansion. Participants lamented that Utah describes itself as a family state, yet it does not pay for important services to help families thrive. Participants felt strongly that Utah needs to invest more funding into MCH/CSHCN programs. The Utah Indian Health Advisory Board made a specific recommendation to invest more into MCH/CSHCN programs. Despite limited funding, public health and other care workers were described as hard working and doing more with less.

Specifically:

- o More investments are needed in school health, CSHCN, WIC, and Home Visiting.
- o More “situational awareness” among public health departments is needed to better support and fund equitable sexual health services statewide and foster better access to CSHCN services.
- o Public Health funding distributions should consider tribal entities for MCH/CSHCN funding, along with local jurisdictions.

System Strengthening and Quality Improvement **-** There are specific recommendations for process improvements for programs and services. A cross-cutting process improvement would be to improve capacity to market health information to the public.

Health departments are expert networkers and collaborators, however, there are additional opportunities to collaborate with healthcare and social service providers and other leaders to improve the design of MCH/CSHCN services and health outcomes.

Workforce Development – Public health professionals need continued support to perform well. They are dedicated and hardworking and compassionate, many wear multiple hats, and “do more with less”. Resources such as the CDC Workforce Development can help provide a framework for a strong and sustainable public health workforce. For example, during the COVID pandemic many of the MCH/CSHCN employees jumped in and took additional roles such as working on a COVID hotline, providing administrative supports to the State Epidemiologist, performing COVID contact tracing, and providing COVID resources and information regarding the MCH/CSHCN populations, among many other duties. Although, this pandemic and its health consequences are humbling, this pandemic is a public health issue and staff were open to learning new skills in order to help the Utah citizens. Utah is working on actively promoting health equity and addressing social determinants of health through strategic partnerships and investing in evidence-based programs. We are assessing our recruitment strategies to increase diversity of staff who serve the community.

**3. Community Themes, Needs and Strengths Assessment**

Stakeholders, community members, parents, adolescents, and caregivers were asked questions like: "What is important to improve MCH/CSHCN?" "How is MCH/CSHCN provided here?" and "What assets do we have that can be used to improve MCH/CSHCN and what are the gaps? Main themes included: Strengths/Assets, Mental Health, Affordable Care/Health Insurance, and Access to Care.

**Key Needs -** Participants identified top priority issues, such as specific MCH/CSHCN topics or services, but they also described issues that are systemic and overarching. Top concerns are listed next, but in no particular order as they are clearly interrelated issues.

**Top Concerns -**

**Mental Health** – Mental health, including perinatal depression, depression, anxiety, and suicide were top concerns in all domain areas with the exception of the infant domain. Specific recommendations for mental health include:

- Expanding mental health and substance use services for women, children, adolescents, and men/fathers.
- Increase awareness of ACEs and need for parent and provider education.
- Address high rates of perinatal depression and the barrier of stigma when talking to providers.
- Address substance use and pregnant women (Opioids/Methamphetamine) is a significant problem, especially in some rural areas counties.
- Expand the effort to increase the number of school counselors.
- Youth Suicide, especially among LGBTQ youth needs to be addressed, stigma and bullying reduced.

**Violence/Abuse/Neglect** – Violence, primarily family violence, was a priority concern in all five domains. Types of violence include intimate partner violence, child abuse and neglect, lack of parental involvement, and bullying of children and adolescents.

Specific recommendations for addressing abuse and neglect include:

- Expanding parenting education.
- Increasing access to affordable and quality childcare.
- Increasing awareness of ACEs among parents and providers.
- Addressing school and cyber bullying.

**Access to Care/Health Insurance** – Access to care related to affordability, including affordable health insurance, was a key issue for women, infants, and CSHCN domains. It was not noted as a priority for children and adolescents but was a particular concern of parents with CSHCN. There is strong support

among stakeholders for 'universal' type of insurance coverage. However, they think they are the only ones. "This is Utah" is a sentiment used implying that this [universal/equitable] health coverage will never happen. There is hesitancy to voice their true feelings on this matter.

Specific recommendations for addressing access to care include:

- Recognize and leverage broad support for universal healthcare or Medicaid expansion among stakeholders (professionals and parents).
- Leverage partnerships to expand access to CHIP, Medicaid, and other health insurance options.
- Policy changes paired with outreach to vulnerable populations to alleviate fears of immigration problems.
- Streamline and speed up eligibility processes for CSHCN health insurance and disability services. Parents of CSHCN describe very long wait times to get into specialty providers, which delays critical services during their child's developmental milestones. For example, they have been on waiting lists for 8-10 years.
- Increase funding and support services for children with special healthcare needs.

**Access to Care/Due to limited care** – A variety of types of care were described as very limited and sometimes non-existent. This was the top concern for the CSHCN domain, where specialty medical care is extremely limited, especially in rural areas, and developmental screening is not comprehensive. Mental health and behavioral health services were described as very limited and as a system that is not nearly robust enough to meet the needs. Other programs and services that are wanted and needed, but limited in scope include family planning, sexual health education for youth, quality and affordable childcare and afterschool care, school nursing, dental care, and training for parents/parenting skills. Specific recommendations for public health funding include:

- Conducting more assessments to build case for funding and demonstrate return on investment.
- Increase visibility of important services, such as Medicaid, CHIP, CSHCN, Home Visiting, and many other MCH services need to be much more visible statewide.
- Leverage partnerships to find innovative ways to fund programs.
- Increase advocacy efforts for public health funding, specifically for MCH/CSHCN programs.
- Investments into more care coordination statewide can help link people to needed CSHCN and MCH care.
- Services need to be culturally and linguistically appropriate to be accessible to all, especially underrepresented minorities and families who may have mixed immigration status.
- Need more OB/GYNs, Pediatricians, Psychologists, and counselors in rural areas.
- More telehealth services needed in rural areas, especially for CSHCN, ABS treatment, and others.
- Need more rotations of specialists to rural areas for CSHCN
- Need more school nurses so school nurses can be the first line of defense for youth. Nurse to student ratio is extremely low.

Programs valued/wanted by participants - Based on the types of priorities described by survey participants, the following table shows specific health programs or services valued by participants from the MCH/CSHCN online survey (N=1,892) and lists specific health issues or topics, not systems issues, such as health insurance and broader social issues.

**Priority Issues and Service Needs of MCH/CSHCN Participants**

| Domain | Priority Issues – Specific to health services or topics |
|---|---|
| Women/ Perinatal | Mental Health (perinatal depression), access to family planning, domestic violence, parenting skills, substance use, immunizations |
| Infant | Immunizations, abuse/neglect, developmental delays, environmental exposures (e.g. air quality), nutrition, breastfeeding |
| Child | Depression, abuse/neglect, parental involvement, immunizations, childcare, after school care, school nursing, nutrition/overweight, dental care, air quality |
| Adolescent | Depression and anxiety, suicide, sex education, drug use, vape/tobacco, social isolation, abuse/neglect, overweight, alcohol, school nursing, physical activity |
| CSHCN | Access to CSHCN services/specialty care and screening, autism services, care coordination, early intervention, parent support, mental health, developmental screening, abuse/neglect, suicide, bullying, community and recreation opportunities |

**Results of Online Surveys: Top 10 Ranked Issues by Domain**

**Women/Maternal Health -** A total of 1,025 people answered questions about maternal health in the online survey. The majority were women (88.5%), 87.0% were white, 9.2% Hispanic/Latino, and 2.0% Asian American/Asian. Less than one percent of participants were Black or African American, or American Indian, Native American, or Alaskan Native respectively. Participants were likely to be older than 25. Ranking by age group did not differ among ages 25+, but those younger than 25 were more likely to be concerned about alcohol use during pregnancy, 25 – 34 also ranked male/father involvement, and folic acid use to prevent birth defects. The majority of participants reported their primary role as a clinician or public health professional 64.4%, while 35.6% identified as a parent or community member. The majority of respondents, 82.8% were urban dwellers, compared to 17.2% rural. The top 10 issues for this domain are:

**Maternal Health Domain – Top 10 Ranked Issues (n = 1025)[a]**

| Rank[b] | |
|---|---|
| 1 | Depression, anxiety, or other mental health issues |
| 2 | Access to health care |
| 3 | Not having health insurance |
| 4 | Access to family planning services |
| 5 | Domestic violence/partner abuse |
| 6 | Parenting knowledge |
| 7 | Drug use: illicit use during pregnancy or postpartum |
| 8 | Not getting immunizations |
| 9 | Environmental exposures (such as air pollution, pesticides, other metals/chemicals)[c] |
| 10 | Prenatal care[c] |

*Note.*
[a]Number of domain respondents who ranked issues from 1 to 7
[b]Ranked following weighting of frequency items were selected at each ranking level from 1 to 7 then added together. i.e. (n ranked 1st x 7) + (n ranked 2nd x 6) + . . . (n ranked 7th x 1) = weighted n.
[c]Tied for rank at 9[th]

**Infant/Perinatal Health -** A total of 638 people answered questions about infant health in the online survey. The majority were women (85.9%), 87.1% were white, 9.7% Hispanic/Latino, and 1.6% Asian American/Asian, American Indian, Native American, or Alaskan Native, and 0.6% were Black or African American. The sample suggests that non-white participants were underrepresented when compared to the overall population. Rankings did not vary much by age group. The majority of participants reported their primary role as a clinician or public health professional,

66%, while 34% identified as a parent or community member. Priority rankings were similar in these groups with the exception of neonatal abstinence/withdrawal made the list for health professionals, but not community member/parents. The majority of respondents, 84.6%, were urban dwellers compared to 15.4% rural. The top 10 issues for this domain are:

| Infant Health Domain – Top 10 Ranked Issues (n = 638)[a] | |
|---|---|
| Rank[b] | |
| 1 | Access to health care |
| 2 | Infants not receiving immunizations |
| 3 | Infant abuse and neglect |
| 4 | Not having health insurance |
| 5 | Developmental delays |
| 6 | Environmental exposures (such as air pollution, pesticides, other metals/chemicals) |
| 7 | Poor nutrition during infancy |
| 8 | Breastfeeding: lack of initiation |
| 9 | Breastfeeding: exclusively at six months of age |
| 10 | Neonatal abstinence/withdrawal (exposure to drugs while in the womb) |

*Note.*
[a]Number of domain respondents who ranked issues from 1 to 7
[b]Ranked following weighting of frequency items were selected at each ranking level from 1 to 7 then added together. i.e. (n ranked 1st x 7) + (n ranked 2nd x 6) + . . . (n ranked 7th x 1) = weighted n.

**Child Health -** A total of 812 people answered questions about child health in the online survey. The majority were women (85.1%), 85.0% were white, 13.1% Hispanic/Latino, and 1.6% Asian American/Asian, 0.6% American Indian, Native American, or Alaskan Native, and 0.4% were Black or African American. The sample suggests that when compared to the overall population, non-white participants were underrepresented. Rankings did not vary much by age group. The majority of participants reported their primary role as a clinician or public health professional, 62.6%, while 37.4% identified as a parent or community member. The majority of respondents, 83.0%, were urban dwellers, compared to 17.0% rural. The top 10 issues for this domain are:

| Child Health Domain – Top 10 Ranked Issues (n = 812)[a] | |
|---|---|
| Rank[b] | |
| 1 | Depression or other mental health problems |
| 2 | Abuse and neglect |
| 3 | Parental involvement |
| 4 | Immunizations |
| 5 | Access to safe preschool or child care |
| 6 | Bullying |
| 7 | Dental care |
| 8 | Overweight/Obesity |
| 9 | Air quality |
| 10 | After school supervision[c] |
| | Optimal nutrition[c] |

*Note.*
[a]Number of domain respondents who ranked issues from 1 to 7
[b]Ranked following weighting of frequency items were selected at each ranking level from 1 to 7 then added together. i.e. (n ranked 1st x 7) + (n ranked 2nd x 6) + . . . (n ranked 7th x 1) = weighted n.
[c]Tied for rank at 10th

**Children with Special Health Care Needs -** A total of 423 people answered questions about the health of children with special health needs in the online survey. The vast majority were women (81.9%), 89.9% were white, 7.2% were Hispanic or Latino, 1.3% were Asian American/Asian, only 0.3% American Indian, Native American, or Alaskan Native, and 3.6% were Black or African American. The sample suggests that non-white participants were underrepresented, with the exception of African Americans or Blacks, who were slightly overrepresented. Rankings did not vary much by age group with the exception of those under 25. In this group, oral/dental health ranked #1 and violence, abuse and neglect #2. The majority of participants reported their primary role as a clinician or public health professional 71.5%, while 28.5% identified as a parent or community member. The majority of respondents, 82.7%, were urban dwellers, compared to 17.3% rural. The top 10 issues for this domain are:

| Children with Special Health Care Needs Domain – Top 10 Ranked Issues (n = 423)[a] | |
|---|---|
| Rank[b] | |
| 1 | Community resources and services |
| 2 | Autism spectrum disorder |
| 3 | Care coordination |
| 4 | Early intervention services |
| 5 | Health insurance |
| 6 | Mental health |
| 7 | Developmental screening |
| 8 | Violence, abuse, or neglect |
| 9 | Suicide |
| 10 | Bullying |

*Note.*
[a]Number of domain respondents who ranked issues from 1 to 7
[b]Ranked following weighting of frequency items were selected at each ranking level from 1 to 7 then added together. i.e. (n ranked 1st x 7) + (n ranked 2nd x 6) + . . . (n ranked 7th x 1) = weighted n.

**Adolescent Health -** A total of 609 people answered questions about adolescent health in the online survey. The vast majority were female (79.7%), 87.8% were White, 8.2% were Hispanic or Latino, 1.6% were Asian American/Asian, only 0.4% were American Indian, Native American, or Alaskan Native, and there were no Black or African American respondents. The sample suggests that non-white participants were underrepresented and African Americans or Blacks were not represented at all. Rankings did not vary much by age group with the exception of those under 25. In this group, oral/dental health ranked #2 and teen pregnancy ranked 8th. The majority of participants reported their primary role as a clinician or public health professional, 72.3%, while 27.7% identified as a parent or community member. The majority of respondents, 82.0%, were urban dwellers, compared to 18.0% rural. The top 10 issues for this domain are:

| Adolescent Health Domain – Top 10 Ranked Issues (n = 609)[a] | |
|---|---|
| Rank[b] | |
| 1 | Depression or other mental health problems |
| 2 | Suicide |
| 3 | Bullying |
| 4 | Sexual health education |
| 5 | Suicidal ideation |
| 6 | Drug use |
| 7 | Social isolation |
| 8 | Abuse and neglect |
| 9 | Overweight/Obesity |
| 10 | Alcohol use |

*Note.*
[a]Number of domain respondents who ranked issues from 1 to 7
[b]Ranked following weighting of frequency items were selected at each ranking level from 1 to 7 then added together. i.e. (n ranked 1st x 7) + (n ranked 2nd x 6) + . . . (n ranked 7th x 1) = weighted n.

**Strengths and Assets -** Strengths and assets were discussed commonly and over 100 community resources were named specifically by stakeholders, some small, some large. Quality and caring providers were lauded, there was recognition that many services are provided well despite limited resources. Rural and urban participants described a sense of community and demonstrated significant collaboration and coordination among agencies and organizations that support the public's health and maternal and child health. Communities have found innovative ways to overcome challenges, such as transportation in rural areas, coordination for CSHCN, and addressing intergenerational poverty through coalitions.

**Forces of Change -** Forces of change are identified by asking questions such as "What is occurring or might occur that affects the health of our community or the local public health system?" or "What specific threats or opportunities are generated by these occurrences?" Some forces of change are noted below.

**COVID-19 Pandemic -** The most notable force of change is the COVID-19 pandemic, which emerged in the latter part of this assessment in Spring of 2020. While consequences of this disruptive force are not fully understood, there

are some emerging concerns and opportunities to consider:
• With people isolating at home, fewer women and children may be accessing well-child, prenatal visits, dental, and other preventive healthcare.
• With children isolated at home, not attending school, child abuse and ACEs may go undetected.
The economic downturn caused by the pandemic will put pressure on public health programs, we anticipate a larger proportion of the population will become eligible for programs like Medicaid, Baby your Baby, Early Intervention, WIC, and others.
• Multiple programs in MCH and CSHCN have experienced budget reductions and more are likely in coming months in reaction COVID-19 related economic crisis. These cuts are driven by a desire of Utah lawmakers to prioritize balancing the budget, which negatively impacts health and social services.
• With people at home including providers, CSHCN clinics services and home visits have been put on hold, only allowing for telehealth. Not providing in person visits limits the ability for screening, assessments, diagnosing and comprehensive care.
• Telehealth is becoming more accessible and reimbursable, meaning more specialty care and mental health care may be available. This is a timely opportunity, especially for rural areas.

**Attitudes toward Medicaid and the Affordable Care Act -** Efforts to repeal or dismantle the affordable care act continue at the national level and in Utah, efforts to expand Medicaid have had limited success. However, there may be growing support for access to health insurance through Medicaid and the Affordable Care Act as more jobs are lost due to the pandemic.

**Immigration Policy -** Immigration policies at the national level continue to tighten and may prevent immigrants from accessing services for which they are eligible.

**Racial Justice Movement -** Given the findings in this report about addressing social determinants of health and need to address health disparities, especially among underrepresented minorities, it is important to acknowledge the recent protests in Utah and around the country that bring attention to systemic racism. This indicates a new level of consciousness among the populace about racism and by extension provides an opportunity to broaden the discussion and momentum to better address social determinants of health.

**Recommendations -** Recommendations from the University of Utah Division of Public Health from the *Utah Maternal and Child Health Statewide Needs Assessment, 2020* report, to the Utah Department of Health were used to guide the selection of State and National Performance Measures that will address some of the top MCH/CSHCN priorities. Other recommendations included: UDOH should continue organizing for success with its partners and formulate goals and specific objectives with key metrics. While UDOH should focus on specific MCH/CSHCN priorities to make concerted progress, they should consider addressing broader issues that are barriers to improvement, such as the funding issue. This may require more effort in the areas of public health advocacy and policy. Partnerships could strengthen this effort.

In addition to MCH/CSHCN focused SPM and NPMs, UDOH should work with partners to:
1. Address social determinants of health and intergenerational poverty.
2. Improve access to healthcare and affordable health insurance.
3. Better fund Children with Special Healthcare Needs and leverage new telehealth efforts.
4. Address family violence, abuse, neglect and increase affordable childcare, and
5. Work across sectors to expand needed mental health services.

**III.C.2.b.ii. Title V Program Capacity**

**III.C.2.b.ii.a. Organizational Structure**

The Utah Department of Health (UDOH) is one of many state agencies in the structure of Utah's Government. The Bureaus of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) are housed in the Division of Family Health and Preparedness (DFHP), one of four Divisions in the UDOH. MCH/CSHCN are the lead agencies responsible for the administration of Title V activities.

During most of the past year, leadership at the Utah Department of Health remained stable. In March 2020, Governor Herbert made a variety of adjustments to UDOH as a result of COVID. The Governor appointed an Acting Executive Director, General Jefferson Burton and Acting Deputy Director, Richard Saunders to support the existing Executive Director, Dr. Joseph Miner, with day to day COVID related matters. In August 2020, the Governor appointed Richard Saunders as Interim Executive Director of the UDOH with Dr. Miner as the Chief Medical Advisor to the UDOH and to the Executive Office of the Governor through the end of the year. Both Deputy Directors Marc Babitz, MD and Nate Checketts (Medicaid Director) remain in their positions.

The Division of Family Health and Preparedness (DFHP) is headed by Director Paul R. Patrick. 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.

The attached organizational chart outlines the Senior Level Directors and Managers of the Utah Department of Health (UDOH) and DFHP. Additionally, Deputy Director, Curtis Burk, supporting DFHP Director Paul Patrick, left employment. Lastly, the CSHCN Bureau moved from the 40-year location of 44 North Mario Capecchi Drive to join the DFHP at the Highland building location.

**III.C.2.b.ii.b. Agency Capacity**

The MCH and CSHCN Bureaus 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 Bureau of Maternal and Child Health oversees five programs that focus on improving the health of MCH populations: the Maternal and Infant Health Program (Utah Women Newborn Quality Collaborative, Maternal/Infant Mortality Review, PRAMS, SOARS, Stepping up for Utah Babies, Power Your Life and Maternal Mental Health); the Family and Youth Outreach Program (Adolescent/Child, Oral Health, Pregnancy Risk Line/Mother to Baby, Utah Early Childhood Utah); the Data Resources Program (including SSDI); the Office of Home Visiting (MIECHV); and Women Infants and Children (WIC) Program. The MCH Bureau also contracts with and oversees 13 local health department contracts for services to mothers, children and adolescents.

The CSHCN Bureau oversees fifteen 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; Integrated Services Program (ISP); Kurt Oscarson Children's Organ Transplant Fund; Organ Donations; Utah Birth Defects Network (including Zika Surveillance Intervention and Referral Program); Utah Family Voices and Weber Early Intervention Program. 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.

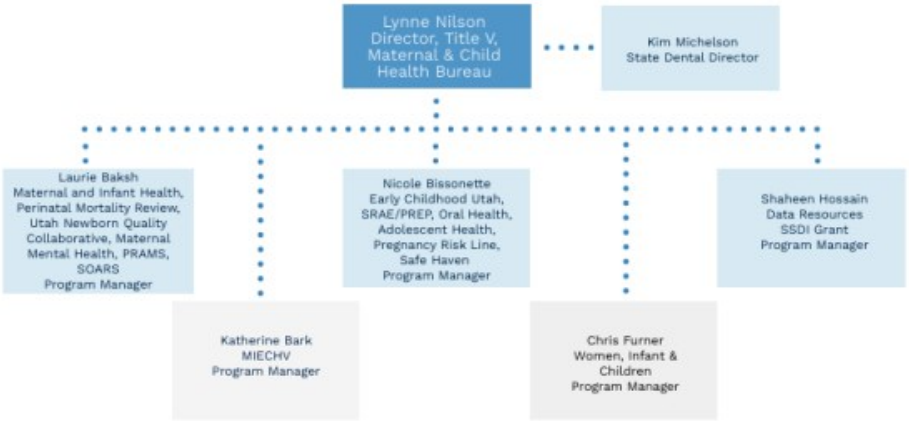
The CSHCN Bureau programs strive to coordinate care for the children and families served throughout the State. The ISP contracts with four LHD's to provide Care Coordination in those communities throughout the State. The Bureau has internal communication methods to encourage care coordination and transition for the populations served using 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. Additionally, other platforms such as: Hi-Track, monthly meetings, data sharing agreements, CHARM and shared resources to create a system which flows smoothly for Bureau employees are utilized. 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.

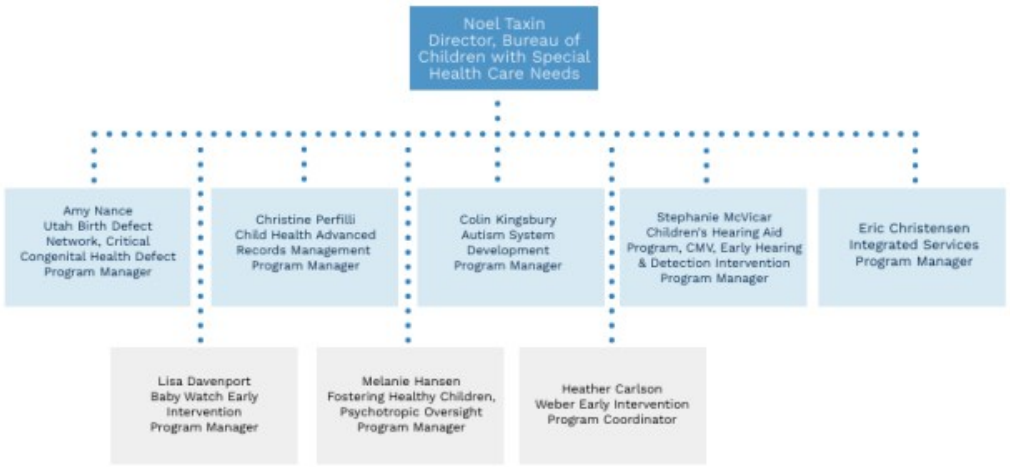
#### III.C.2.b.ii.c. MCH Workforce Capacity

MCH/CSHCN managers lead the work of planning, implementation, evaluation, and data analysis capacity. The graphics below show the names and titles of the Bureau's/Programs in MCH/CSHCN and the Bureau of Health Promotion who address MCH/CSHCN issues. A blue box indicates if a program is funded (full or part) by Title V Block grant dollars.

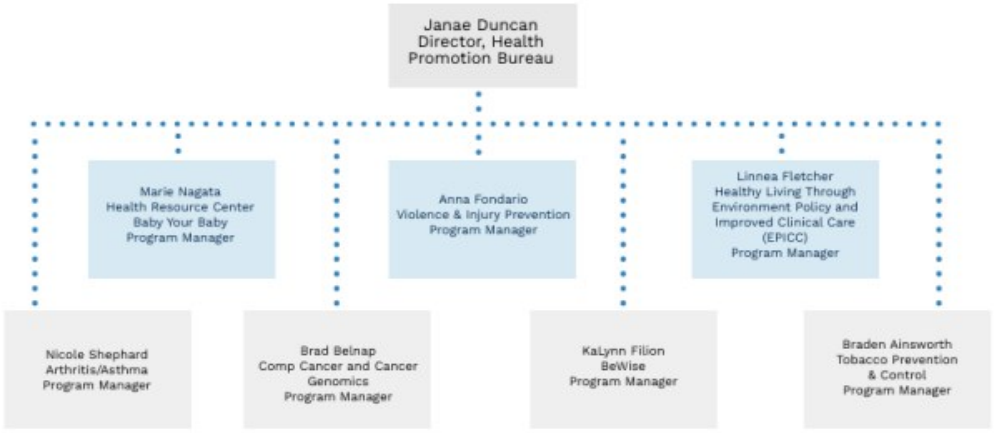
**Bureau of MCH -** The Bureau of Maternal and Child Health oversees five programs that focus on improving the health of MCH populations: the Maternal and Infant Health Program (Utah Women Newborn Quality Collaborative, Maternal Mortality Review, PRAMS, SOARS, Stepping up for Utah Babies, Power Your Life and Maternal Mental Health; the Family and Youth Outreach Program (Adolescent/Child, Oral Health, Pregnancy Risk Line/Mother to Baby, Utah Early Childhood Utah (ECU); the Data Resources Program (including SSDI); the Office of Home Visiting (MIECHV); and Women Infants and Children (WIC) Program. The MCH Bureau also contracts with and oversees 13 local health department contracts for services to mothers, children and adolescents.




**Bureau of CSHCN -** The CSHCN Bureau oversees fifteen 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; Integrated Services Program (ISP); Kurt Oscarson Children's Organ Transplant Fund; Organ Donations; Utah Birth Defects Network (including Zika Surveillance Intervention and Referral Program); Utah Family Voices and Weber Early Intervention Program. 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.




**Bureau of Health Promotion -** The Bureau of Health Promotion oversees programs that work to reduce the leading causes of illness and death for Utahns through prevention, early detection, and management of injuries, chronic diseases and conditions and promotion of early prenatal care in community, school, worksite and health care settings. They are: Alzheimers, Arthritis, Asthma, Baby Your Baby, BeWise, Cancer Control (Breast/Cervical, Comprehensive and Genomics), Check Your Health/Health Resource Center, EPICC (Healthy Living through Environment, Policy, and Improved Clinical Care), Tobacco Prevention and Control, Violence and Injury Prevention (VIPP).




**Local Health Departments -** The UDOH provides Title V funds to LHD's via contract. All 13 Local Health Departments work on identified MCH and Child/Adolescent identified priorities. Four of the 13 receive funds to provide CSHSN Care Coordination for families.

We do not track staffing or FTEs at local agencies since they are autonomous from the UDOH. It is important to note that one staff member in each area typically wears several "hats" in his/her daily work. Each health district has a Health Officer, Nursing Director, Environmental Health Director, WIC Director and other health professionals. It is up to the discretion of the LHD to determine staffing for Title V 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.

One of the CSHCN Audiologists is a member of Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee, which meets to determine authorization for non-covered services for Medicaid recipients. The CSHCN staff serve on Medicaid committees and assist Medicaid with services and sharing of knowledge in serving 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).

**Medicaid -** The Utah Department of Health houses the state Medicaid agency and 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 matching dollars for a number of programs that serve the Medicaid populations, such as Baby Your Baby outreach, Mother To Baby, and PRAMS. Medicaid developed a targeted administrative case management model for CSHCN clients.

#### III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

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 can include networking, information sharing, collaboration, integration, formal contractual agreements, joint trainings or co-sponsorship of events. Most all of the programs/agencies participated in the 5-year needs assessment.

The following programs are housed within the MCH/CSHCN Bureaus and staff in these programs collaborate regularly to assess needs and implement programs to improve the health of MCH/CSHCN populations:

Programs funded by HRSA Maternal and Child Health Bureau:

- State System Development Initiative (SSDI)
- Maternal, Infant and Early Childhood Home Visiting (MIECHV)
- Early Childhood Systems of Care (ECCS)
- Mother to Baby (MotherToBaby, a service of the non-profit Organization of Teratology Information Specialists
- Utah Birth Defects Network
- Autism Systems Development Program

- CHARM
- Utah Parent Center, Family to Family, Health Information Center
- University of Utah Medical Home Portal and Utah Children's Care Coordination Network
- Integrated Services Program
- Early Hearing Detection & Intervention Program
- Central, San Juan, Southeast and Tri County Local Health Departments

Other programs funded by Health and Human Services/CDC/USDA/Department of Education:

- Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)
- Maternal, Infant and Early Childhood Home Visiting (MIECHV)
- Sexual Risk Avoidance Education (SRAE)
- Personal Responsibility Education Program (PREP)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- WIC
- Universal Newborn Screening Hearing Grant
- Early Hearing Detection & Intervention Surveillance Grant
- Birth Defects Surveillance Grant
- Baby Watch Early Intervention

Collaboration and partnership with Local Health Departments (LHD) enables the State to become more aware of needs and issues affecting MCH/CSHCN populations and creates a unified focus at the local level. Staff from LHDs and the MCH/CSHCN programs have a strong and long history of working together and have a strong collaborative partnership with each other. LHD Health Officers, Nursing Directors, WIC directors, and Care Coordinators were very involved in the MCH/CSHCN Needs Assessment. LHD Contracts are in place and focus on NPM/SPM objectives and evidence-based strategies. MCH/CSHCN staff meet with nursing directors, health officers and care coordinators on a regular basis to support their efforts to improve outcomes for MCH/CSHCN populations.

Title V collaborates with other UDOH programs to address the needs of the MCH/CSHCN populations. Title V dollars are allocated to VIPP to address child and adolescent health as it relates to injury, suicide, and healthy relationships. Dollars are also allocated to the EPICC program to address healthy eating and physical activity in children and adolescents. The Baby Your Baby program provides education about pregnancy and assists women with presumptive eligibility for Medicaid. Staff in VIPP and EPICC are involved with the implementation of NPM/SPM activities. The Division of Medicaid and Health Financing, also housed in the UDOH, works with both Bureaus to ensure the health needs of Title V populations are met. The Office of Vital Records works closely with Title V staff to provide timely birth and death data for assessment and reporting. Title V programs are in the same Division as the Office of Primary Care and Rural Health which enables us to work together more closely.

The Indian Health Board liaison, who is housed in the Executive Director’s office of the UDOH educates staff regularly on how to coordinate services and approvals with Utah tribes. The Indian Health Advisory Board (IHAB) also participated in focus groups on the five-year needs assessment, informing UDOH on health and cultural needs specific to the Indian American population. 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. This past year multiple meetings were held with the IHAB as part of the Needs Assessment process to ensure that the needs of the Native Indian population were addressed.

The UDOH has a positive relationship with Community Health Centers (CHC), the Primary Care Association and the Association for Utah Community Health (AUCH). 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.

Effective partnerships with Utah's hospital systems have been formed through the Utah Women and Newborns Quality Collaborative (UWNQC). Through UWNQC, participating hospitals regularly work on improving the care for Title V populations, an example of which is implementing the Opioid Use Disorder, hemorrhage, and hypertension safety bundles. Additionally, the Critical Congenital Heart Defects and Early Hearing Detection & Intervention Programs work with hospitals and mid- wives to improve screening rates for all newborns in the state by providing education and follow up.

MCH/CSHCN staff work closely with the Utah Division of Substance Abuse and Mental Health (DSAMH), Department of Human Services, which serves the maternal and child population statewide in the areas of child welfare, mental health and substance abuse. Recently, DSAMH staff participated on the Maternal Mental Health Policy Committee along with MCH staff working on this important issue. DSAMH staff sit on Utah's Perinatal Mortality Review Committee to provide expertise in case reviews.

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 CSHCN Fostering Healthy Children Program (FHC). FHC is an exceptional program that ensures these children and youth receive needed medical, dental and mental health services.

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.
Additionally, legislation passed in 2020 allows for better coordination of services with women identified as using substances during pregnancy. Staff in the MIECHV and MIHP programs have been working with DCFS on this project.

The Baby Watch/Early Intervention (BWEI) Program has a number of collaborative relationships. They worked with DCFS to develop policy and procedures for CAPTA requirements for referral of children with substantiated abuse and neglect to BWEI. 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 Baby Watch Early Intervention program has an Interagency Coordinating Council (ICC) which is an independent advisory board appointed by the governor and required by federal regulation to include parents, EI providers, agencies, and representatives from the community. The purpose of the ICC is to provide meaningful direction, assistance, and support to the lead agency.

The CSHCN Bureau, Integrated Services Program (ISP) has a number of community collaborations, including the: Medical Home Portal, Medical Home Advisory Committee and the Office of Disability Determination Services (DDS) A bilingual ISP staff works with DDS to review claims and provide outreach and referral for potential Medicaid eligible children. This ISP care coordinator/specialist provides information, referral and enabling services to families having difficulty accessing or utilizing community resources or specialty care.

Lastly, the Autism Systems Development Program within CSHCN and Utah State Board of Education staff have collaborated on data collection to improve outcomes for individuals with autism and developmental delays, through th Utah Registry for Autism and Developmental Delays Program and the Autism Developmental Disabilities Monitoring grant.

#### III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

As a conclusion to the Needs Assessment process, a statewide in-person (with virtual capacity) summit was held on February 28, 2020. At this meeting, findings from the needs assessment, including previous stakeholder meetings, were presented. The NALT domain leaders presented their recommendations about the selection of state and national performance measures for the next five-year cycle of the Title V grant. The audience was polled using PollEverywhere to share their input about the recommendations. Participants then broke into interest areas and further developed and presented recommendations.

After the stakeholder summit, the NALT met to make final decisions on state priorities and performance measures. The final state priorities are as follows: Perinatal Mood and Anxiety Disorders, Access to Care, Breastfeeding, Developmental Delays, Economic Stability, Family Connectedness, Dental Care, Mental Health (adolescents), Family and Provider Connectedness/Care Coordination, and Transition.


Maternal and Child Health
PERFORMANCE MEASURES
Five-Year Cycle Comparison of Selected Performance Measures
2016–2020 Performance Measures
Continuation Status
2021–2025 Performance Measures
National Performance Measures
Maternal
NPM 1: WELL-WOMAN VISIT
Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
Continued
NPM 1: WELL-WOMAN VISIT
Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
Infant
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).
Discontinued
NPM 4: BREASTFEEDING
A: Percent of infants who are ever breastfed.
B: Percent of infants breastfed exclusively through 6 months.
Continued
NPM 4: BREASTFEEDING
A: Percent of infants who are ever breastfed.
B: Percent of infants breastfed exclusively through 6 months.
Child
NPM 6: DEVELOPMENTAL DELAY
Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the last year.
Continued
NPM 6: DEVELOPMENTAL DELAY
Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the last year.
Adolescent
NPM 8: PHYSICAL ACTIVITY
Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day.
Discontinued
New
NPM 9: BULLYING
Percent of adolescents, ages 12-17, who are bullied or who bully others.
CSHCN
NPM 11: MEDICAL HOME
Percent of children with or without special health care needs, ages 0 through 17, who have a medical home.
Continued
NPM 11: MEDICAL HOME
Percent of children with or without special health care needs, ages 0 through 17, who have a medical home.
NPM 12: TRANSITION
Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transition to adult health care.
Continued
NPM 12: TRANSITION
Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transition to adult health care.
NPM 13A: ORAL HEALTH
Percent of women who have had a preventive dental visit during pregnancy.
Discontinued
NPM 13B: ORAL HEALTH
Percent of children, ages 1 through 17, who had preventive dental visit in the past year.
Continued
NPM 13B: ORAL HEALTH
Percent of children, ages 1 through 17, who had preventive dental visit in the past year.
State Performance Measures
Maternal
New
SPM 1: PERINATAL MOOD & ANXIETY DISORDER
Percent of mothers that a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care.
Infant
SPM 1: PRETERM BIRTH
The percent of live births occurring before 37 completed weeks of gestation.
Discontinued
Child
SPM 3: CHILD INJURY DEATHS
The rate of injury related deaths among children and adolescents ages 1 to 19 (per 100,000).
Discontinued
New
SPM 2: FAMILY CONNECTEDNESS
Percent of family members in the household eat together weekly.
Adolescent
SPM 4: ADOLESCENT SUICIDE
Rate of suicide deaths among adolescents ages 15 to 19 (per 100,000).
Discontinued
New
SPM 3: ECONOMIC STABILITY
Number of students enrolled in the free or reduced price lunch program.
CSHCN
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 continually from University Development Assessment Center (UDAC).
Discontinued

### III.D. Financial Narrative

| | 2017 | | 2018 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $7,186,786 | $6,102,323 | $7,349,076 | $6,899,911 |
| State Funds | $12,637,500 | $16,992,700 | $16,946,700 | $16,235,243 |
| Local Funds | $2,378,600 | $2,429,500 | $1,794,900 | $1,188,395 |
| Other Funds | $15,201,633 | $11,586,460 | $30,114,400 | $11,081,603 |
| Program Funds | $5,762,100 | $5,008,690 | $4,948,100 | $4,798,663 |
| SubTotal | $43,166,619 | $42,119,673 | $61,153,176 | $40,203,815 |
| Other Federal Funds | $58,339,300 | $52,449,424 | $59,382,100 | $56,954,456 |
| Total | $101,505,919 | $94,569,097 | $120,535,276 | $97,158,271 |

| | 2019 | | 2020 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $7,374,954 | $6,160,252 | $6,979,388 | |
| State Funds | $18,296,900 | $15,490,482 | $10,851,188 | |
| Local Funds | $2,429,500 | $0 | $1,050,094 | |
| Other Funds | $12,442,100 | $15,200,399 | $10,833,700 | |
| Program Funds | $5,173,800 | $947,208 | $5,233,600 | |
| SubTotal | $45,717,254 | $37,798,341 | $34,947,970 | |
| Other Federal Funds | $57,415,800 | $44,894,510 | $56,396,200 | |
| Total | $103,133,054 | $82,692,851 | $91,344,170 | |

| | 2021 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $6,561,290 | |
| **State Funds** | $14,630,450 | |
| **Local Funds** | $0 | |
| **Other Funds** | $16,023,900 | |
| **Program Funds** | $1,103,500 | |
| **SubTotal** | $38,319,140 | |
| **Other Federal Funds** | $50,430,575 | |
| **Total** | $88,749,715 | |

**III.D.1. Expenditures**

## UTAH 2019 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 programs such as: Safe Haven, Baby Your Baby, Maternal and Infant Health, Teratology Mother to Baby, Oral Health, School Health, and Early Childhood Utah. 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 2019 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 composed of state general funds, including funds for Early Intervention, Home Visiting, Safe Haven, Maternal Mental 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 WIC rebates, and other revenue from other State Agencies (Department of Workforce Services, Department of Human Services), as well as revenue agreements with private nonprofits. Program Income (Form 2, line 6) includes fee revenue such as Pregnancy Risk Line collections, Baby Watch parent fees, CSHCN insurance billings, and Kit Fee.

Form 2, "Other Federal Funds," shows Utah's MCH work was also supported by a variety of other federal funds in FY 2019 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 2019, 37.15% of Title V expenditures were CSHCN; 44.8% of expenditures were for preventive and primary care and 9.8% 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, 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)

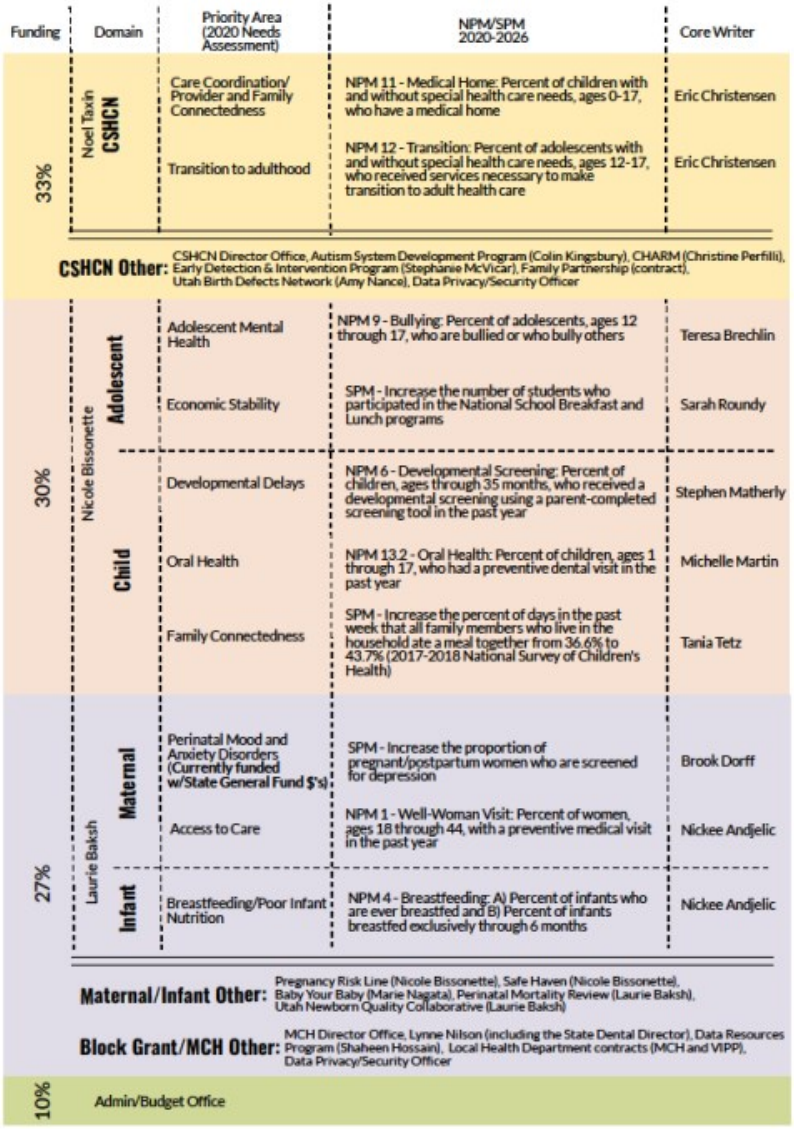
**III.D.2. Budget**

## UTAH BUDGET (FY 2021 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 2021:

| Program | Proposed Budget 10/01/2020 - 09/30/2021 |
|---|---|
| **BUREAU OF MATERNAL AND CHILD HEALTH** | |
| MCH Admin | $388,000.00 |
| Maternal and Infant Health (Maternal and Infant, Utah Women's Quality Collaborative, Prenitatal Review, | $375,500.00 |
| Family Youth Outreach (Pregnancy Risk Line, Oral Health, Safe Haven) | $556,900.00 |
| Data Resources | $272,600.00 |
| **BUREAU OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS** | |
| Bureau of Children with Special Health Care Needs (Admin, Early Hearing Detection, Birth Defects, CHARM) | $757,500.00 |
| CSHCN Integrated Services | $1,234,200.00 |
| **DISEASE CONTROL AND PREVENTION** | |
| Baby Your Baby | $200,000.00 |
| BHP Physical Activity | $99,500.00 |
| Violence & Injury (VIPP) | $450,980.00 |
| Community Injury (VIPP) - LHD Contracts | $387,710.00 |
| **FINANCIAL, LOCAL HEALTH DEPARTMENT, OTHER** | |
| Financial Resources | $150,000.00 |
| LHD Contracts | $1,188,400.00 |
| Child Development | $50,000.00 |
| Utah Indian Health Advisory Board One Time | $0.00 |
| Health Disparities Federal MCH 2 Year Project | $0.00 |
| | |
| Indirect Cost | $450,000.00 |
| | |
| | $6,561,290.00 |

Through state level programs and initiatives as well as local health department activities, these appropriations, as well as future budget appropriations, will be used to support work related to the following Needs Assessment conducted during FY 2021:




Utah's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2021, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted. For FY 2021, 51.9% of the total Title V budget is designated for preventive and primary care for children; 32.8% is designated for Children with Special Health Care Needs; and 9.5% 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 Early Childhood Utah. 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 from other state agencies, and WIC Formula Rebates, "Program Income" (Form 2, line 6) include Teratology collections and donations, and other CSCHN fee revenue. Other federal funds anticipated in FY 2021 are indicated in Form 2, line 9, and are similar to funds noted in the Expenditures section.

Challenges

As has been the case for a few years now, Utah continues to face challenges related to the Title V budget. The current

working MCH budget has been reduced from over $7 million dollars annually to approximately $6.56 million, while the amount received from HRSA is just over $6.1 million per year. Funding allocations continue to change to ensure we are spending within the level of our federal award as well as prioritizing the outcomes from the Needs Assessment. The most recent changes to bridge the gap between ongoing obligations and the grant award include:

- Securing outside grant funding for MCH/CSHCN Projects
- Lease savings from closure of the Children with Special Health Care Needs Building. CSHCN Bureau is now at the Division of Family Health and Preparedness Highland Drive Building.
- Reduction of Pregnancy Risk Line Contract with the University of Utah.

Further challenges include significant budget reductions to the state appropriations Department and Division wide due to loss of revenue stemming from the COVID-19 pandemic. Due to these reductions, the Bureau of Maternal and Child Health experienced reduction of funding for the State Dental Director position, Safe Haven, and Abortion Informed Consent effort.

## 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.<br>• 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.<br>• 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 43 full-time employees; 20 paid with Block Grant (BG) dollars for a total of 15.5 FTE. CSHCN has approximately 95 employees; 25 paid with BG dollars for a total of 12 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, both MCH/CSHCN collaborate with 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 licensed professionals. The difficulty in finding candidates is the inequities of salaries in the private sector are so much higher than in state government. The incentive for a medical professional to work for the state is the 8-5 Monday to Friday work schedule, paid holidays, and benefits, not because of 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 with special health care needs, 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 the UDOH administration typically only allows 2-3 staff to travel to the same out of state conference. Attendance and traveling becomes problematic when there are up to six staff who should attend the meeting. Starting March 2020, during the COVID-19 outbreak, all travel has been discontinued but all MCH/CSHCN staff are using virtual technology to participate in meetings and learning opportunities. With all national conferences going virtual this year there are staff who are "attending" that normally would not. An example is the WIC Director who is planning on attending the AMCHP conference this fall.

Workforce development and coordination with the Integrated Services Program. This program holds weekly 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. Starting March 2020, the ISP program has solely utilized technology to serve the children with special health care needs and their families to protect the community from the COVID-19 outbreak.

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 EHDI Program Manager, Dr. Stephanie McVicar, has been one of the Audiology Core Faculty since 2011 and Infant-Pediatric Audiology (IPA) program coordinator from 2011-2019. 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 2020, the URLEND program has had 43 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. These trainees also participate in monthly hearing screenings conducted with the Utah EHDI program at the South Main Clinic, one of Salt Lake City's Community Health Centers serving mainly low-income Hispanic families.

The EHDI program hosts an annual statewide training conference with representatives from all birthing hospitals in Utah, including infant and pediatric audiologists. In September 2019, the State EHDI Conference was held with 50 attendees. The theme for the 2019 training conference was "Just-In Time for Families". This all-day conference featured Justin Osmond as the keynote speaker with a talk entitled, "I may have a hearing loss but my hearing loss doesn't have me". Additional seminar topics included Family Experiences; Screening Equipment, Protocols and Techniques; Ask the EHDI Team; HiTrack for Audiologists; CMV Documentation; Where is the Gap? An Analysis of those who declined Early Intervention; and Medical & Audiological Management of Microtia/Atresia/Middle Ear Fluid. This conference was unique in that instead of hosting the event at the Utah Department of Health CSCHN building, it was held in partnership with the Utah State Office of Rehabilitation, Division of Services for the Deaf and Hard-of-Hearing, at their Sanderson Community Center of the Deaf and Hard-of-Hearing. It was a great way for attendees to experience all that the Sanderson Center has to offer and vice-versa. Providing educational opportunities for Utah's infant and pediatric audiologists is crucial to a successful EHDI program.

During 2019-2020 URLEND project year. The CSHCN Bureau also participated in a Foster Care initiative in evaluating transition planning for youth to adulthood. This project was structured through the University of Utah, South Main Clinic in Salt Lake City who is a main provider for services to children and youth in Utah's Foster Care System and primary care services to women, men and children during all stages of life. South Main also has an obstetrics/gynecology clinic and a Teen Mother and Child Program to help promote health during pregnancy. The URLEND project research will assist in supporting the new five-year goals for CSHCN under the NPM of Transition.

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 to 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.

This past year, MCH Workforce Development "training pages" were created that provide an "at a glance" menu of training opportunities for staff and LHD's to use during the year for the AMCHP Workforce and Leadership Development website, the MCH Navigator website and Advancing Health Transformation (also from the MCH Navigator site). The pages outline the Training Purpose, a What/How to use, Topics, Format of Training and Examples of Specific Training Available (See Appendix C). These will be included into LHD contracts for the upcoming year, with an expectation that staff will participate in at least one training opportunity from these resources, or another MCH/CSHCN training opportunity of their choice. In addition, these resources will be provided to the MCH/CSHCN staff for use throughout the year.

In 2019, the UDOH conducted an employee satisfaction survey. The survey asked questions about Bureau specific positions and then UDOH organization satisfaction. Results were distributed to Bureau Directors to examine employee responses. The UDOH encouraged Bureau Directors to use the data to identify areas where satisfaction could be improved upon. The responses to the survey were mostly positive. Questions were scaled (1-5) with (5 being most satisfied). The MCH/CSHCN Bureau Director's found question responses regarding direct Bureau work scored in the 3.5-5 range and UDOH Executive Leadership question responses scored in the 3-4 range. Both MCH/CSHCN Bureau Directors reviewed the UDOH satisfaction survey feedback. Highlights of the report (not all-inclusive) for the MCH/CSHCN Bureaus are as follows:

| | MCH Bureau | CSHCN Bureau |
|---|---|---|
| Completed responses | 45 | 53 |
| Mean Overall Score (out of 5) | 4.07 | 3.98 |
| The people I work with cooperate to get the job done | 4.38 | 4.28 |
| The work I do gives me a sense of meaning | 4.31 | 4.08 |
| Overall, I enjoy my job | 4.02 | 4.08 |
| I feel that my organization is providing sufficient support/training for my professional development | 4.00 | 3.58 |
| It is clear what is expected of me to be successful in my position | 3.96 | 4.15 |
| I feel that my input is valued | 3.80 | 3.75 |
| UDOH policies are enforced consistently among employees | 3.67 | 3.68 |
| I feel like I have enough information from executive leadership to know what is important in our organization | 3.82 | 3.57 |

Overall, staff comments suggested improvements could be made regarding Executive Leadership's UDOH communication, process improvements, recognition and pay. Employees voiced to Bureau leadership a desire for improvement of transparency and clearer communication from UDOH leadership.

Starting March 2020, when the world experienced the COVID pandemic the UDOH and Bureaus adapted to the workforce needs, work environment and efficiencies immediately by all employees moving to teleworking. Teleworking was implemented to ensure safety of our employees and MCH/CSHCN customers served throughout the State. Transitioning to telework and telehealth services has been challenging due to the new service delivery system but we have found through surveying customers the platform has mostly worked to keep them connected to services.

The UDOH and Bureaus need to continue to research methodologies to address the need for direct clinical care assessments, treatments, and other duties which cannot be performed with telehealth. Since March, MCH/CSHCN have implemented informal surveys asking employees satisfaction with the telework and telehealth platform and feedback suggests workforce satisfaction and productivity has improved.

Each Bureau Director meets weekly with Program Managers as a team and then individually to ensure Programs are functioning as efficiently as possible and with leadership support. Additionally, the State Human Resource Department is offering monthly “Off the Shelf Series Virtual Classes” on telework challenges and ways to improve work efforts. This series educates employees and creates a forum for discussion with other State employees. Additionally, the State of Utah has a statewide wellness council who encourages each Department and Division to participate. Every month employees receive an invitation to participate in health and wellness activities to improve their wellbeing. For example:

Week 1: Modify your routine for the “new normal” whether it’s back to school or work.
Week 2: Create healthy habits to help get you through the pandemic – bolster your immune system with proper nutrition, exercise and rest.
Week 3: Adjust your schedule: time management tips for our current condition.
Week 4: Self-care for you and caring for others: manage fears and anxiety and find ways to lend a hand to those in need.

#### 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 following information is to outline some activities and collaborations both the CSHCN and MCH Bureaus participate in and encourage support of family partnerships and collaborations with stakeholders.

The CSHCN mission is 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.

The CSHCN Bureau partners with Utah Family Voices (UFV) and has both parents of CSHCN and individuals with special health care needs employed. 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.

CSHCN has built capacity in family partnerships by including families and stakeholders in the CSHCN Mission and Strategic Plan. The Bureau has a CSHCN Advisory Committee which is composed 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 CSHCN Bureau conducts surveys with parents and engages in community discussions to identify needs within the community. The CSHCN Bureau incorporates its family partners in providing support within clinic and Bureau services and participating in advisory committees.
The CSHCN Bureau Director is an active member of both the state-mandated Coordinating Council for People with Disabilities and Utah Developmental Disabilities Council. Both these committees' purposes include alignment and coordination of professionals, agencies and families to better serve the disability populations.

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) and Baby Watch Early Intervention Program to improve service access to those with Down syndrome and their families.

**CSHCN Strategic Plan**

| 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 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 provide clinic and home visits to struggling families in collaboration 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, ISP 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.

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.  CSHCN 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 CSHCN 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 CSHCN Bureau Director is an active member of both the state-mandated Coordinating Council for People with Disabilities and Utah Developmental Disabilities Council. Both these committees' purposes include alignment and coordination of professionals, agencies and families to better serve the disability populations.

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 composed of health professionals from Utah's hospitals and professional organizations and activities are accomplished through multiple workgroups.

In MCH, the Early Childhood Utah Program staffs the Early Childhood Council, this council serves as the advisory entity to the Governor’s Early Childhood Commission. The goal of the group is to make recommendations that improve the lives of children in the State of Utah. The group has five standing committees, Health and Access to Care, Data and Policy, Parent Engagement, Social, Emotional and Mental Health, and Early Care and Education. The membership on this Council is made of experts in multiple disciplines related to children and families, including the MCH Title V Director. Additional MCH representation includes CSHCN, Integrated Services, Oral Health, and WIC. Additionally parents of children are represented on the Council and participate on the Family Engagement workgroup.

The MCH/CSHCN Bureaus are ensuring that systems integration dialogue and action continue with our community partners within existing funding streams and maintain working relationships with non-Title V programs in the Department to create a statewide system of collaboration.

**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.

The SSDI Project Team (Project Director, Grant Coordinator, and Epidemiologist), housed in the DRP, has been actively involved in leading the MCH Bureau's efforts in conducting the comprehensive 2020 MCH/CSHCN five-year needs assessment (NA). DRP has worked closely with the Needs Assessment Leadership Team (NALT) and the University of Utah, who was chosen as a contractor to assist in this process. DRP has assisted in development and implementation plans for the NA and identification of stakeholders. In order to help inform Utah's 2020 NA, DRP conducted a literature review of NA methodologies and processes used by other states. Review included documentation of the processes used in selection of national and state priorities. This review provided insight into potential methods for Utah to use. Noteworthy processes were presented to NALT and followed with a discussion on what Utah would want to adopt. Additionally, through this review, where available, survey instruments were reviewed to look for opportunities to enhance and compliment Utah's surveys. DRP also created an extensive indicator report of over 270 indictors using data from the Minimum and Core Data Set (M/CDS), birth and death certificates, and various publicly available datasets outlining measures related to Utah's MCH and CSHCN populations. This indicator report was shared with the NALT to provide an overview of the current strengths and weaknesses in the health status of Utahns. The report was used in selection of populations and topics to address in key informant interviews and focus groups. Following review of the indicator report, DRP worked with domain leaders to help identify questions for two surveys, MCH/CSHCN Stakeholder Survey and the CSHCN Parent Survey. The MCH/CSHCN Stakeholder Survey and the CSHCN Parent Survey were analyzed by DRP, who then provided stakeholder rankings and tables of various issues in the MCH and CSHCN domains. Additionally, prior to the Needs Assessment Stakeholder Summit where priorities were selected, DRP created multiple infographics to summarize survey findings to stakeholders. Following the Stakeholder Summit, DRP compiled an overview of ESMs created by other states to assist in Utah's selections of ESMs for newly selected National Performance Measures (NPM).

In order to help streamline the collection and submission of the yearly requirements of the BG Application and Annual Report, DRP developed and implemented the Web-Enabled Systemic Tracking Tool, or WESTT. DRP continues to implement new updates and improvements annually to WESTT and trains staff on use of these improvements. Improvements during FY19 included adding fields for BG Contributors to include information on challenges and emerging issues faced related to their NPMs and State Performance Measures (SPM) and allowing the ability to transfer and change editing permissions for the Annual Reports and Plans. Additionally, in anticipation of new priorities and performance measures following the 2020 NA, WESTT was modified to include extra fields and measures as placeholders. These placeholders allowed contributors to include information related to any performance measure, including those that were newly selected. The MCH epidemiologist and web coordinator conducted multiple trainings with staff, both new staff, and staff who had used WESTT in the past, to ensure the ability of all contributors to use WESTT for reporting.

During FY19, a new data sharing process was created to streamline our ability to access and use data throughout the MCH Bureau. Through creation of an overarching data sharing agreement (DSA) between the MCH Bureau and the Utah Office of Vital Records and Statistics (OVRS), all projects and programs within MCH are able to access and use identifiable Birth and Death certificate data, including fetal and infant deaths, without navigating through the approval process for each additional project. This agreement also allows MCH programs to share identifiable data with each other and allows DRP to assist in analyses without additional agreements. Prior to this DSA, the old process required every program to draft and submit their own request to OVRS. Following review by OVRS and revisions by each program, it would take many weeks before these requests would be approved and the program could obtain the requested data.

Throughout FY19, DRP provided analytic support to Utah Women and Newborn Quality Collaborative (UWNQC) subcommittees including conducting analysis on factors associated with intrapartum transfers to hospital for delivery from planned out-of-hospital birth settings and linking birth certificate records by the mother, dating back to the year 1999, enabling identification of mothers who had actually had a preterm birth, rather to solely relying on self-reporting

by the mother to assess utilization of progesterone in women with a previous preterm birth. During FY19, DRP wrote data sharing agreements and obtained IRB approval to provide the CDC data for analysis looking at neonatal and maternal outcomes based on CDC LOCATe level of care (NPM-03). The UWNQC Data Coordinator successfully merged data from birth and death certificates, as well as hospital discharge data, with a 98.8% matching rate. This data set was de-identified and then provided to the CDC for analysis.

DRP will continue collaboration with UWNQC for the remainder of the SSDI grant cycle by assisting the neonatal subcommittee in development of data collection plans for their newly proposed projects, updating the out-of-hospital birth report, and drafting a manuscript on factors related to intrapartum transfer from out-of-hospital birth settings. As part of Utah Administrative Rule R433-1., Very Low Birth Weight (VLBW) Infant Reporting, hospitals are required to enter all admissions of VLBW infants (deliveries and transfers) into a REDCap database. A report on this data will be compiled and provided to hospitals.

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 FY19, Utah launched 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. A new data sharing agreement was drafted and approved for this project so that hospital discharge data for the infant would also be available to track outcomes for infants with neonatal abstinence syndrome.

## SSDI Goals, Objectives, and Activities

**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<br>• Reviewed needs assessment methodologies and methods used by others states<br>• Trained staff on Needs Assessment methodologies | • Performed as assessment of secondary data and created an indicator report to share with domain leaders and stakeholders<br>• Developed a timeline and wrote 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<br>• Developed 2019 Stakeholder Survey Questions<br>• Built and implemented a stakeholder survey<br>• Analyzed data from survey and provided rankings of issues by domain to domain leaders<br>• Developed and implement online 2019 CSHCN Parent Survey<br>• Analyzed stakeholder and CSHCN survey data | • Worked with the University of Utah through their conducting of focus groups and key informant interviews<br>• Helped University of Utah to draft needs assessment report including editing methods sections<br>• Complied an overview of ESMs created by other states to assist in Utah's selections of ESMs for newly selected NPMs |

**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 |
|---|
| • Developed and shared MCH Needs Assessment data fact sheets and reports with stakeholders<br>• Invited critical partners among state, local, and community agencies to MCH Summit to rank state's prioritized needs<br>• Selected appropriate NPMs and SPMs for FY20-FY25 to be reported on the annual Block Grant<br>• Selected and developed appropriate Evidence-based Strategy Measures (ESMs) for the selected NPMs and SPMs |

**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 |
|---|---|---|
| • Annual User Feedback Survey was developed and analyzed<br>• On-going enhancements were added to the system to increase user satisfaction and improve alignment to updated MCH Block Grant guidance<br>• Offered assistance to Block Grant Contributors on use of the WESTT system | • Added on-going enhancements to the system including adding the ability to transfer and change editing permissions and report on challenges and emerging issues<br>• Updated the technical documentation and manual on the use of the WESTT system<br>• Offered assistance to all Block Grant Contributors on use of the WESTT system | • WESTT was modified to include extra fields which allowed contributors to include information related to any newly selected performance measures<br>• Updated the technical documentation and manual on the use of the WESTT system<br>• Offered assistance to all Block Grant Contributors on 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 |
|---|---|---|
| • Represented MCH/CSHCN Bureaus in meeting for potential topics of Utah Health Status Update<br>• Published articles in Utah Health Status Update Publication | • Conducted an annual review of Federally Available Data<br>• Publish article(s) in Utah Health Status Update Publication | • Published articles in Utah Health Status Update Publication<br>• Created a data sharing agreement with the Office of Vital Records and Statistics to ensure data accessibility for all programs within the MCH Bureau |

| 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 hospitals to collect facility data on synthetic progesterone prescribing and treatment<br>• Created a database in REDCap for data collection to share data on a quarterly basis<br>• Trained hospital staff on using this REDCap database and provided ongoing technical assistance as necessary<br>• Assessed the quality of the synthetic progesterone treatment reporting variable<br>• Prepared a report on findings | • Began also receiving data of 17P use from the University of Utah in addition to Intermountain facilities<br>• Report on 17P use published in Utah Health Status Update<br>• Continue to share data of 17P on a quarterly basis with UWNQC<br>• Collaborated on a return on investment publication for 17P use in Utah Medicaid births<br>• Linked birth certificate records by the mother, dating back to the year 1999, enabling identification of mothers who had actually had a preterm birth, rather to solely relying on self-reporting by the mother. |
| **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** |
| • Completed analyses to assess birth outcomes among women enrolled in Medicaid using Medicaid status from birth certificate data | • Completed analysis and drafting of a manuscript concerning progesterone use and the potential return on investment in Medicaid enrolled women who reporting having a 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**

- Met with WIC Director and staff to assess the feasibility of expanding and implementing WIC Pilot Project in several clinic locations 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

**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 |
|---|---|---|
| • Provided analytic support to the UWNQC maternal subcommittee<br>• Provided analytic support to the UWNQC out-of-hospital (OOH) birth subcommittee<br>• Provided analytic support to the UWNQC board/steering committee<br>• 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<br>• Developed letter for reporting to individual hospitals on their OOH transfers and related feedback from providers<br>• Created pilot survey for the new maternal mental health UWNQC subcommittee | • Assisted with determination of data to be collected by hospitals with implementation of new safety bundle<br>• Conduct a risk assessment analysis of intrapartum transfers to hospitals in women having an out-of-hospital birth and submitted an abstract<br>• Update and distribute letter for reporting to individual hospitals on their OOH transfers and related feedback from providers |

**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 project<br>• Wrote data sharing agreements to obtain hospital discharge data to provide to the CDC<br>• Compare data from hospital discharge to REDCAp VLBW database to assess for data quality and determine a gold standard for future use | • Linked birth certificate data to hospital discharge data for the CDC's LOCATe project<br>• Provided CDC with data for their LOCATe analysis on maternal and neonatal outcomes<br>• Drafted a report on data collected in REDCap on VLBW births to distribute to participating 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 support. In 2019, 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 Integrated Services Program, Baby Watch Early Intervention, 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.

Eligibility criteria for both programs:

<table>
<tr><th>Medically Complex Children's Waiver</th><th>Technology Dependent Waiver</th></tr>
<tr><td>0 through 18 years of age</td><td>Under 21 years of age at the time of admission</td></tr>
<tr><td>Have 3 or more specialty physicians, in addition to their primary care physician</td><td>Meet admission criteria for nursing facility care</td></tr>
<tr><td>Have involvement of 3 or more organ systems</td><td>Have at least one caregiver trained and available to provide care</td></tr>
<tr><td>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</td><td rowspan="2">Require skilled nursing and/or skilled rehabilitation services at least 5 days per week and be dependent on one or more of the following:<ul><li>Mechanical ventilator;</li><li>Tracheostomy based respiratory support;</li><li>Continuous or bi-level positive airway pressure (C-PAP or Bi-PAP);</li><li>Intravenous administrations of nutritional substances or medications through a central line</li></ul></td></tr>
<tr><td>Have a level of disability determined by the State Medical Review Board</td></tr>
<tr><td>Qualify for Medicaid based on his/her income and assets (parent's income and assets are not counted in determining the applicant's eligibility)</td><td>Qualify for Medicaid based on his/her income and assets (parent's income and assets are not counted in determining the applicant's eligibility)</td></tr>
</table>

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%. 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.

Based on this communication from CMS, Utah immediately prepared and submitted an 1115 waiver amendment based on phase 3 of S.B.96 on November 1, 2019. This waiver request includes the following proposals for Utah's Medicaid Expansion:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including Adult Expansion and Targeted Adult Populations
- Lock-out from the Medicaid Expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports for groups within Medicaid Expansion
- Not allowing hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a $25 copayment for non-emergent use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of

individuals that may receive Targeted Adult Medicaid.

- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah's Premium Partnership for Health Insurance (UPP).

On December 23, 2019, the Centers for Medicare and Medicaid Services (CMS) authorized the Utah Department of Health (UDOH) to implement a full Medicaid expansion in the state. The expansion extends Medicaid eligibility to Utah adults whose annual income is up to 138% of the federal poverty level ($17,608 for an individual or $36,156 for a family of four). The federal government covers 90% of the costs for these services, with the state covering the remaining 10%. CMS has not yet approved the other items in this waiver request. The state continues discussions with CMS on these remaining items.

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

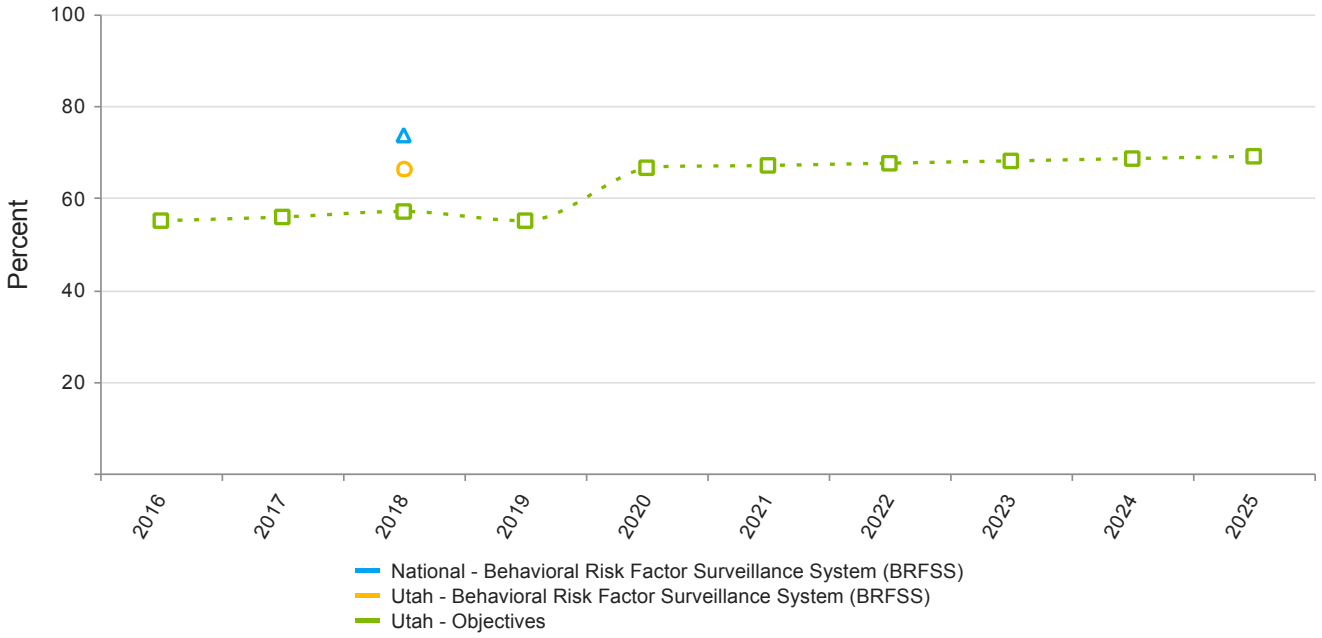
**Women/Maternal Health**

**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-2017 | 58.1 | NPM 1 |
| NOM 3 - Maternal mortality rate per 100,000 live births | NVSS-2014_2018 | 10.9 | NPM 1 |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) | NVSS-2018 | 7.2 % | NPM 1 |
| NOM 5 - Percent of preterm births (<37 weeks) | NVSS-2018 | 9.4 % | NPM 1 |
| NOM 6 - Percent of early term births (37, 38 weeks) | NVSS-2018 | 28.9 % | NPM 1 |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2017 | 6.0 | NPM 1 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 5.9 | NPM 1 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2017 | 4.5 | NPM 1 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 1.4 | NPM 1 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2017 | 183.2 | 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-2017 | 6.1 | NPM 1 |
| NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2017_2018 | 12.2 % | NPM 13.1 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.7 % | NPM 13.1 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2018 | 13.1 | NPM 1 |
| NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth | PRAMS-2018 | 14.7 % | 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** | **2019** |
| Annual Objective | 55 | 55.8 | 57 | 55 |
| Annual Indicator | 55.6 | 56.9 | 54.7 | 66.1 |
| Numerator | 313,251 | 328,066 | 321,738 | 394,166 |
| Denominator | 563,258 | 576,406 | 588,467 | 595,993 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 66.5 | 67.0 | 67.5 | 68.0 | 68.5 | 69.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 1.1 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 100 |
| Numerator | |
| Denominator | |
| Data Source | Salt Lake County Home Visiting Program Data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 150.0 | 225.0 | 300.0 | 400.0 | 450.0 |

**ESM 1.2 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Maternal and Infant Health Program data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 5.0 | 7.0 | 11.0 | 13.0 | 15.0 |

**ESM 1.3 - Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Behavioral Risk Factor Surveillance System |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 2.0 | 3.0 | 3.0 | 3.0 | 3.0 |

**State Performance Measures**

**SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 56 |
| Numerator | 25,866 |
| Denominator | 46,186 |
| Data Source | Pregnancy Risk Assessment Monitoring System |
| Data Source Year | 2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 57.0 | 58.0 | 59.0 | 62.0 | 65.0 |

**State Action Plan Table**

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

| Priority Need |
| --- |
| Women's access to care |

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

| Objectives |
| --- |
| By 2025, increase the percent of Utah women, ages 18-44, who had a preventive medical visit within the past 12 months from 66.1% (BRFSS, 2018) to 69.0%. |

| Strategies |
| --- |
| 1. Collaborate with Salt Lake County home visiting program to educate women on well-woman visits. |
| 2. Engage community partners to develop a well-woman visit strategic plan. |
| 3. Improve understanding of barriers to receipt of routine preventive care. |

| ESMs | Status |
| --- | --- |
| ESM 1.1 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff. | Active |
| ESM 1.2 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah. | Active |
| ESM 1.3 - Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care. | 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

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

## Priority Need

Perinatal mood and anxiety disorders

## SPM

SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care

## Objectives

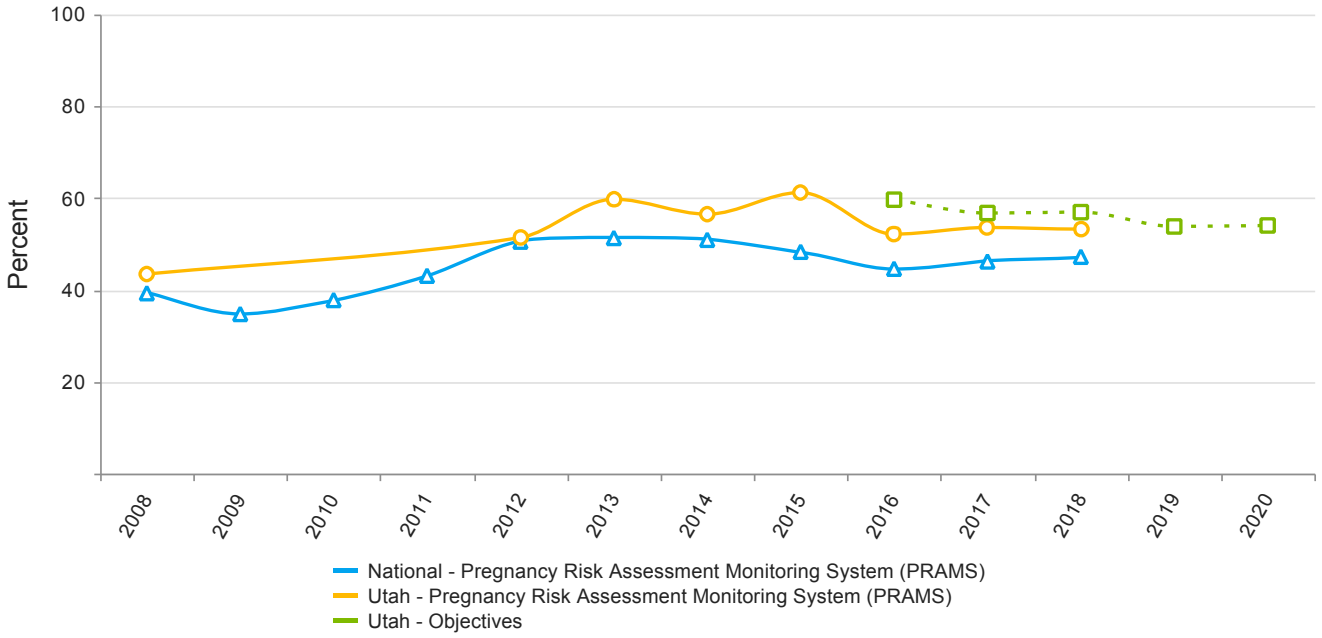
By 2025, increase the number of women who self-report if a healthcare provider asked them if they were feeling down or depressed both during prenatal and postpartum care from 56% (2019 PRAMS) to 59%.

## Strategies

1. Increase the number and types of information and training materials for providers statewide.
2. Increase the number and types of providers trained statewide.

**2016-2020: National Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | 59.6 | 56.7 | 56.9 | 53.8 |
| Annual Indicator | 56.5 | 61.2 | 53.6 | 53.2 |
| Numerator | 27,701 | 29,790 | 25,341 | 24,250 |
| Denominator | 49,001 | 48,710 | 47,301 | 45,610 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2018 |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 45.3 | 37.1 | 25.2 |
| Annual Indicator | 45.1 | 36.9 | 25 | 25.9 |
| Numerator | 69 | 58 | 38 | 43 |
| Denominator | 153 | 157 | 152 | 166 |
| Data Source | Utah Office of Head Start, Program Report | 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 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**MCH Block Grant FY21 Application & FY19 Report**

**Women/Maternal Health**

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

**FY19 Annual Report**

**Program Activities:**

This Performance Measure appears to have been achieved (the Performance Objective was 55.0% and the Annual Indicator was 66.1%). However, due to the changes in the wording of the survey instrument we are uncertain of the comparability to previous data.

During FY19, the Maternal and Infant Health Program (MIHP) utilized the social media platforms Facebook, Pinterest, and Instagram, to share information on preventive health care visits. These messages were shared under the Power Your Life logo and branding. Nickee Palacios, the MIHP health educator also did an on air television spot on preconception/women's health.

Educational outreach was done through numerous community events including, the annual Junior League "Care Fair," University of Utah, West Jordan Chamber of Commerce Health Fair, an event for single mothers, a health fair targeting Spanish families sponsored by Centro Hispano, a preconception/women's health class for women in the Hildale community, a Pacific Islander Family Wellness Fair, two health fairs at Utah Valley University, and the annual March for Babies event. At these events, MIHP and staff from Utah Birth Defects Prevention Network handed out informational pamphlets and brochures about preventive care as well as answering the specific questions of the diverse groups of people that attend these events.

MIHP was able to secure an intern from Utah Valley University (UVU) to help run and manage a peer education program on campus. This intern successfully recruited five peer educators and held two on-campus health fairs that educated on the importance of obtaining a family health history and preconception/women's health. This intern also assisted with creating a community class targeting couples that are planning a pregnancy in the next year. The plan was to pilot this class at a local health department during FY19, however due to the public health recommendations for the COVID-19 pandemic, these classes were canceled.

**Accomplishments / Successes:**

A strong, mutually beneficial partnership between the MIHP and UVU has assisted us in reaching young college-aged women in Utah with messages about the importance of yearly preventive care, family planning, mental health awareness, and preconception health. UVU continually invites staff from MIHP and the Utah Birth Defects Network, to have a booth at a bi-annual student health fair. At each fair, we estimate educational materials about preventive health were given to about to 150-200 students.

The MIHP health educator presented the findings of the focus groups we conducted during FY19 at a national health education conference. This allowed staff to make connections with other health educators working on women's health issues across the country.

A major success is the ongoing relationships the MIHP program has developed with community organizations. For example, ongoing relationships with UVU and the University of Utah provided us an opportunity to reach thousands of women with health messaging. A new partnership with Cherish Families allowed us to reach women in a former polygamous community with preconception health, birth control, general woman's health, and birth defects prevention education. This population has been isolated and hard to reach in the past.

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

- Ongoing, mutually beneficial relationships with a local university, Utah Valley University, has allowed the MIHP to reach thousands of college-aged women with education and information about the importance of routine preventive care.
- A new partnership formed with Cherish Families has enabled the MIHP to reach a historically difficult population to reach, the polygamous families that live in rural Utah. Through this partnership, MIHP staff were able to teach a class and have a booth at a local health fair in the polygamous town of Hildale. Topics

educated on included preconception health, birth control, general woman's health, and birth defects prevention.

- MIHP health promotion coordinator was accepted to present on the well-woman focus group findings at the 2019 National Society of Public Health Educators (SOPHE) Conference.

**Challenges / Gaps / Disparities:**

The largest challenge faced during FY19 was retaining trained peer educators engaged in a preconception peer education program. The program competed with their other responsibilities, both academically and personal and it was challenging setting up ongoing planning meetings with them.

**Agency Capacity / Collaboration:**

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

The Utah Birth Defects Network (UBDN) is a major partner for this performance measure. Staff from UBDN attend all health fairs with the MIHP staff. Program staff work together and often share resources and educational material. Both programs also use their respective social media accounts to share messages about preconception/women's health.

Another important partner, MotherToBaby Utah (MTB UT), provides information to women about exposures in the preconception period, during pregnancy, and during breastfeeding. In FY19, MTB UT answered questions from 395 women and their providers about exposures as they were planning for future pregnancies. MTB UT provides information about immunizations, controlling chronic conditions, taking prenatal vitamins, and other exposures to help women plan for their pregnancies.

**Summary Progress Report (2020) 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.

During FY18 the MIHP contracted with the SUMA media group to conduct four focus groups with a diverse group of women of reproductive age. SUMA recruited the women from two urban (Salt Lake and Utah) and two rural (Tooele and Carbon) counties. Each focus group had 7-11 participants and were in various stage of life, some were single and others were married, some were mothers, and some self-disclosed that they were not yet sexually active. At the conclusion of the focus groups, SUMA submitted a written report with the finding and recommendations.

Recommendations the MIHP programs plans to further study included choosing one term, "preventive care," "routine checkup," or "well-woman exam" when educating and encouraging our target population to seek this type of care and creating a website and more educational materials that detail what should happen during a routine preventive care visit.

Finally, the contract with SUMA required they work with MIHP staff to create a survey on routine preventive care that would be conducted through social media.

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

**This ESM is currently inactive as the Peer preconception health has been completed during FY20.

**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 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, 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 FY19, MIHP staff worked with UVU to offer an internship for a student to oversee, with assistance from MIHP staff, a preconception peer education program on campus. In August 2019, Taylor Gregory, an undergrad student majoring in health education, began this internship. She committed to a full school year, August 2019-April 2020.

Ms. Gregory had several goals for this internship:

1. Recruit fellow students to be UVU Peer Educators.
2. Create a peer education training for the UVU peer educators
3. Hold a preconception peer education program training
4. Hold at least two campus-wide events educating students on preconception health
5. Create and hold a community preconception class
6. Create social media messages for the Power Your Life Instagram account

August through September, Ms. Gregory successfully recruited five additional students to be trained as peer educators. All of these students were majoring in the health field, and in September 2019, were trained in preconception health and becoming a peer educator. Together the peer educators created a flyer on the importance of knowing your family health history. They distributed this flyer at a two health and wellness fairs put on by the Student Wellness Programs. Ms. Gregory had a booth on general preconception health. She created a “Jeopardy” type game where participants were asked a question about preconception health. When participants stopped and played the game, they were entered into a drawing for a bigger prize. She was able to reach 100+ students with this booth.

Working with MIHP staff, Ms. Gregory created a presentation targeting couples who were considering a pregnancy in the next year. The next steps were to offer the class through local health departments. However, this was not accomplished during FY19 due to COVID-19 limiting community gatherings. MIHP staff plan to use Ms. Gregory’s presentation and offer the classes during FY21.

A continuing challenge faced by the peer education program is keeping it sustainable. We have held or attempted to numerous training and ongoing planning with trained peer educators, however, competition for their time and energy pulled them away.

The new ESMs for NPM-01 are listed in the Annual Plan section.

**MCH Block Grant FY21 Application & FY19 Report**

**Women/Maternal Health**

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

**FY19 Annual Report**

**Program Activities:**

The Performance Measure was not achieved. The Performance Objective was 53.8% and the Annual Indicator was 53.2%.

In 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 program in the Family and Youth Outreach Program, which is under the MCH Bureau. The State Dental Director (SDD) is not in this new program but is directly under the MCH Bureau Director. His time was also changed from 0.5 FTE to 0.25 FTE in this position. The OHS and the OHE continued to be full time.

In June 2019, at the Utah Dental Association annual leadership conference, the SDD presented information on Utah Medicaid updates. There were two Utah managed care dental care plans operating statewide for pregnant women which provides basic dental benefits, such as diagnostic, preventive, restorative (fillings), endodontists (root canals), oral surgery, and dentures (with prior approval). Most other adults have only emergency dental benefits. On July 1, 2019, fee reimbursements to dentists went up 21%.

The SDD provided general supervision in accordance with Utah laws, for the Oral Health Program's two public health dental hygienists who operate in various public health settings. His time permitted him to visit a few events during the year. The SDD collaborated with Medicaid in efforts to increase the percentage of pregnant women who receive preventive dental visits.

The OHP continued to encourage, support, and partner in efforts with the Utah 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. The OHP maintains strong relationships with all state dental and dental hygiene schools and connects staff from Home Visiting, WIC, Head Start, and other programs to the schools and other low-cost options. 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.

Efforts were made to increase the number of pregnant women, as well as children, that see the dentist. Concentrated efforts were made with five local Head Start/Early Head Start programs that had less than 50% of their pregnant women see a dentist.

The OHE provided in person staff training to Parents as Teachers Home Visiting sites on the 12 oral health messages. The OHE provided quarterly emails with updated educational resources for home visitors and families including, Brush Book Bed, National Maternal and Child Oral Health Resource Center, and Early Childhood Learning & Knowledge Center materials. The OHP also provided a low cost dental resource guide, by county, and worked to connect families to care. These emails and follow up calls included all of the home visiting sites. The OHS and OHE also trained family advocates at the Community Building Community (CBC) dental clinic in Midvale on the 12 oral health messages and motivational interviewing techniques. This health center had advocates going into patients' homes and providing home visits to vulnerable families.

In December 2019, the OHS, OHE, two OHP interns, and dental hygiene students from Fortis Dental Hygiene School (FDHS), provided education to 50+ refugee students. Several topics of oral health were discussed, including nutrition, pregnancy, and babies not going to bed with a bottle. The OHP collaborated with the Office of Health Disparities and Granite Peaks to provide access to care for these refugee students. At the end of the week, a free day of preventive care was provided for the refugees at FDHS. Over thirty-five children and adults received preventive care.

In February 2019, the OHS, OHE, interns, and dental hygiene students provided maternal and infant oral health education, fluoride varnish, and referral resources to 150 refugees at the LDS Humanitarian Center. The OHS met with a case manager afterward to help coordinate care for those with dental needs.

In June 2019, the OHS and OHE, along with a volunteer dental hygienist, went to Ibapah, UT (Goshute Tribe) for a health fair. They provided screenings and fluoride varnish to over twenty-eight children and thirty-eight adults. Local

dental resources in adjacent cities were provided. They also had educational materials, which included the 12 oral health messages, dry mouth, pregnancy, diabetes, and opioid awareness material from Violence Injury Protection Program.

The OHE presented to teen parents in Utah County about oral health during pregnancy and early intervention strategies for their infant and toddler children. Ten teen moms were reached through this effort and all teens and their children received dental supplies. The OHP presented at the Annual Utah Early Childhood Conference to early childhood caregivers and administrators. Topics covered included; “it's safe and important to go to the dentist during pregnancy,” regular snacks and meal times for children, and not putting babies to bed with a bottle.

The OHS and OHE work closely with State WIC staff providing information to WIC clients and staff statewide. The OHS and the OHE presented to statewide WIC directors and other WIC staff multiple times in the state, using the Smiles for Life! Preventive Strategies for Promoting Oral Health for Pregnant Women, Infants, and Children curriculum. This curriculum was created by the National Center of Early Childhood Health & Wellness. Both provided two minutes segments, three times a year, on a Utah Broadcast ‘Baby Your Baby’ on Pregnancy and Oral Health. In addition, the OHP attended the Junior League Care Fair and provided educational materials on oral health and pregnancy, infant care, and children's oral health. Over seventy-five materials were given out.

In August 2018, the OHS reached out to all community water fluoridation (CWF) engineers in the state by personal visits, emails, or phone calls. She shared evidence based research education promoting CWF by the American Academy of Pediatrics. The OHS also asked what barriers, concerns, and calls are they receiving from the public. Approximately 52% of the state of Utah receives the benefits of CWF. Future plans of CWF to be initiated in Moab, Utah.

**Accomplishments / Successes:**

October 2018, the OHS presented to family advocates from Cherish Families on oral health and motivational interviewing. Cherish Families provides help for former Fundamentalist Church of Jesus Christ of Latter-Day Saints members and others practicing polygamy https://cherishfamilies.org/about/). Basic oral health education was shared and messages of pregnancy and infant oral health care were stressed. Health Promotion Coordinator from the MIHP also came and spoke on preconception health to about fifteen local mothers. This population has not trusted public health workers in the past to come into their community, so this was a wonderful first step of bringing education and resources into this community.

The OHS researched three years (2015-2017) of visits to rural Utah emergency departments for non-traumatic dental visits. This data was presented at the Rural Hospital Administrators Summit in May 2019. Thirty-nine participants were in attendance, including all state rural hospital executive administrators. An MCH Epidemiologist from the Data Resource program helped with all the data information and graphs. Further retrospective research study of eleven full years, from 2007-2017, is ongoing and a report including all hospitals in Utah was released to the public December of 2019. Over 6200 visits of children ages 0-19 were documented.

In February 2019, the OHP held its first annual Oral Health Conference for Community Health Workers (CHW) at Roseman School of Dentistry. All CHWs in the state were invited to attend. The OHS coordinated this event with the Association of Utah’s Community Health Centers (AUCH), Roseman School of Dentistry, and the Community Health Workers Coalition of Utah. An introduction to Oral Health was given along with topics on systemic connections to oral health, pregnancy and oral health, and children’s oral health issues. Great discussions on overcoming barriers to care were discussed. Statewide dental resources were shared and Zoom/ Skype was used so all CHW in the state would join in.

The OHP partnered with Violence and Injury Protection Program to educate dentists and oral surgeons on Opioids for all populations, especially pregnant women and children. The OHP developed an opioid toolkit for dentists and oral surgeons in Utah. They also collaborated with the Utah Dental Association and the Association of Utah Community Health Programs. The OHS and OHE will be sharing information to dentists and oral surgeons statewide based on information published by the National Maternal and Child Oral Health Resource Center, “Prescribing Opioids for Women of Reproductive Age: Information for Dentists.” The Oral Health Program (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, with the goal to increase the percentage of pregnant women who have a preventive dental visit during pregnancy.

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

- The Oral Health Specialist and Oral Health Educator continue to present and coordinate four KUTV Baby Your Baby segments a year. Topics for these segments included Oral Health and Pregnancy, baby bottle use, “primary teeth are important,” and other oral health topics. These reached the public throughout the state of Utah.
- The Oral Health Program continued using the “12 Oral Health Messages” created for pregnant mothers and children in collaborative efforts with WIC, Head Start, Fostering Healthy Children, and Home Visiting programs.
- The Oral Health Program published and disseminated two Bi-Annual Oral Health Outreach Reports to stakeholders and other partners.
- The Oral Health Program continued to encourage and support efforts in the Utah 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.

**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 priority.

Emerging in Utah and nationwide is teledentistry. This is a proactive way to address access to care. The OHP and SDD are working together with the Utah Oral Health Coalition, Smart Smiles program (school based/long-term facility/public health setting), and others dedicated to expanding teledentistry. The OHS and OHE met with a major regional hospital that just opened a dental clinic at their location. The OHS is facilitating conversations between a manager of one Utah hospital and dental hygienist about implementing teledentistry options in their emergency room as a pilot. We are hoping to take this best practice model to other hospitals statewide. Future conversations with WIC and Head Start staff to implement pilot teledentistry days are being discussed.

**Agency Capacity / Collaboration:**

The OHP will also collaborate with the Utah Oral Health Coalition, the Utah Dental Association, Utah Dental Hygiene Association, Head Start, the Office of Health Disparities, WIC, Utah Office of Home Visiting, Smart Smiles, six dental hygiene schools, and two dental schools to reach the goal of increasing the percentage of pregnant women who receive a preventive dental visit.

The OHS and OHE shared information with dentists and oral surgeons statewide at the Utah Dental Association regional meetings on a report published by the National Maternal and Child Oral Health Resource Center, “Prescribing Opioids for Women of Reproductive Age: Information for Dentists.” was published by the National Maternal and Child Oral Health Resource Center. This was done in collaboration with the Violence and Injury Protection Program on this Opioid project and funding.

The Oral Health Program (OHP) will collaborate with Head Start, Early Intervention, the Utah Office of Home Visiting, and WIC to target high-risk populations, 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. OHP also collaborated with MotherToBaby to be a resource for dentists and the public on questions regarding pregnancy and opioid prescriptions.

The OHP Oral Health Specialist 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 Head Start.

**Summary Progress Report (2020) 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:**

The ESM 13.1 Performance Measure was achieved. The Performance Measure was 25.2% and the Annual Indicator was 25.9%. This ESM was designed to increase the number of pregnant women who visit the dentist during pregnancy in the Early Head Start program. Pregnant women in the Head Start 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 Oral Health Program will collaborate with EHS to help these women make it to the dentist.

*NPM-13A and related ESMs were discontinued following the 2020 MCH Needs Assessment.

**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 2019, MotherToBaby Utah (MTB UT) had 1795 contacts, who responded to demographic questions, with insurance coverage and 134 with no insurance. During Fiscal Year 2019 MTB UT provided education to 35 clients regarding folic acid use. During Fiscal Year 2019 12,316 MotherToBaby Utah English brochures and 2903 MotherToBaby Utah Spanish brochures, 9556 English/Spanish Rack Cards, 827 English Preconception brochures, and 2 Spanish Preconception brochures were distributed to families and providers to provide information about prenatal care and services.

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

In Fiscal Year 2019, MotherToBaby Utah provided education to women and providers about medications used to treat chronic conditions before and during pregnancy and while breastfeeding including cardiovascular, autoimmune, psychiatric, endocrine, respiratory, substance dependence, genetic, neurological, and other conditions. 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 conditions in an effort to help women remain healthy and avoid unnecessary acute episodes or hospitalizations due to questions about continuing medication treatments. Research showed that untreated maternal mood conditions result in additional costs to society of approximately $31,800 for each mother-infant pair. MotherToBaby Utah provided health information about mood medication in pregnancy and breastfeeding to 615 clients in FY 2019. Assuming that those 615 client contacts had the desired effect of helping pregnant and breastfeeding women and their providers decide to start, continue, or resume mood medications, then it could be inferred that MotherToBaby Utah saved over $19,000,000 for families, early intervention services, health insurance plans, special education services, taxpayers, and others.

Utah is a member state of the Alliance for Innovation on Maternal Health and partners with Wyoming to implement maternal safety bundles. Hospitals have been working in past years to implement the hemorrhage and hypertension safety bundles. In 2019, hospitals voted to begin work on implementation of the Obstetric Care for Women with Opioid Use Disorder safety bundle. Utah began a collaborative project with the University of Utah Maternal-Fetal Medicine Department to create an enhanced data set on severe maternal morbidity. This data set will include information gathered from severe maternal case review using the Council on Patient Safety's SMM review form. This enhanced data set will be used for analysis of SMM events in Utah.

**NOM 3: Maternal mortality rate per 100,000 live births**

In Fiscal Year 2019, MotherToBaby Utah provided education to women and providers about medications used to treat chronic conditions (some women had multiple co-occurring chronic conditions) before and during pregnancy and while breastfeeding including cardiovascular, autoimmune, psychiatric, endocrine, respiratory, substance dependence, genetic, neurological, and other conditions. 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 conditions in an effort to help women remain healthy and avoid complications and death due to questions about continuing medication treatments.

Utah has an established maternal mortality review (MMR) committee and all maternal deaths are brought to the committee for review and prevention recommendations. Utah began using the MMRIA data system (Maternal Mortality Review Information Application) in 2015. Utah continued its collaboration with the CDC Foundation to contribute to enhanced surveillance and understanding of maternal overdose deaths. Utah was awarded a grant from

the CDC via the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality. With this funding, Utah and Wyoming are partnering to conduct a single maternal mortality review committee for both states. The grant also allowed Utah to hire a new epidemiologist dedicated to case identification and data analysis of maternal deaths. The program disseminated its findings that substance use and mental health are major contributors to maternal mortality in Utah. This brought attention to the need for more substance use disorder and mental health services in the perinatal period.

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

During FY 2019 9,045 English Postpartum Depression brochures and 3,228 Spanish Postpartum Depression brochures were distributed to families and providers to help screen for depression and find local resources. During FY 2019 MotherToBaby Utah provided education to women and their providers about medications regarding the treatment of postpartum depression including the risk of untreated postpartum depression. Research showed that untreated maternal mood conditions result in additional costs to society of approximately $31,800 for each mother-infant pair. MotherToBaby Utah provided health information about mood medication in pregnancy and breastfeeding to 615 clients in FY 2019. Assuming that those 615 client contacts had the desired effect of helping pregnant and breastfeeding women and their providers decide to start, continue, or resume mood medications, then it could be inferred that MotherToBaby Utah saved over $19,000,000 for families, early intervention services, health insurance plans, special education services, taxpayers, and others.

A majority of Local Health Departments (9 to 13) provide resources and support for women in their community who have postpartum depression. They educate and screen prenatal clients for postpartum depression through WIC, breast feeding education, during clinical visits. etc. Many also provide referral services for telemental health sessions with trained mental health professionals across the state and also refer to the UDOH Maternal Mental Health Resource and Referral website to help clients find providers.

**MCH Block Grant FY21 Application & FY19 Report**

**Women/Maternal Health**

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

**FY21 Annual Plan**

**Annual Plan:**

During FY21, the Maternal and Infant Health Program (MIHP) will continue to work to understand the knowledge, attitudes, and behaviors of women of reproductive age regarding the well-woman visit.

In their health education outreach to women of reproductive age, 18-44 years in Utah, MIHP will use social media platforms, Facebook, Instagram, and Pinterest. Additionally, the MIHP health educator will participate in local health fairs to share information on the well-woman visit. The MIHP health educator will use online graphic design programs to create eye-catching and educational images, flyers, or brochures that will be available at the health fairs and shared via these social media platforms.

In FY21, MIHP is planning to use two strategies to increase our understanding of the reasons behind why or why not women of reproductive age schedule and attend a well-woman visit. The first strategy is to find and use already developed questions or develop our own questions for the Utah Behavioral Risk Factor Surveillance Survey (BRFSS). Currently, the BRFSS asks, “About how long has it been since you last visited a doctor for a routine checkup?” While this question answers how many women visited a doctor for a routine checkup, it does not offer guidance on the reasons behind respondents' answers. We plan to include questions asking BRFSS respondents the barriers and facilitators of vising a doctor for a routine checkup.

Our second strategy is to form a coalition of community partners and organizations that work with women of reproductive age to create a strategic plan that will guide future activities. Working with other experts in our community, we plan to create consistent messaging that all members of the coalition can use to educate the women in their communities. We plan to invite partners that represent different sectors of our target population to ensure that we reach all women across the state.

Through these two strategies, we hope to build on the information we received a couple of years ago from the focus groups to create a plan that caters to the specific needs of the women in Utah.

Finally, we plan to partner with the Salt Lake County Health Department’s Home Visiting program to educate their clients on women’s health, including preconception health and the well-woman visit. Salt Lake County Home Visitors will use materials from the Power Your Life program to guide the education and discussion

**Proposed Activities:**

- Use social media platforms to educate women on the well-woman visit.
- Create a coalition for community partners and organizations that work with women of reproductive age to create a strategic plan that will guide future activities.
- Add questions to the Utah Behavioral Risk Factor Surveillance Survey (BRFSS), asking respondents on the barriers and facilitators of visiting a doctor for a routine checkup.
- Partner with the Salt Lake County Health Department’s Home Visiting program to educate their clients on women’s health, including preconception health and the well-woman visit

**New ESMs related to NPM-01***

*The following three ESMs (1.1 – 1.3) are new for FY21. These ESMs were developed following the 2020 MCH Needs Assessment.

**ESM 1.1 – Home Visiting: The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.**

**Goal/Objective**:

Increase the number of home visiting clients that receive education on the well-woman visit from Salt Lake County

Home Visiting Program staff.

**Significance of ESM 1.1:**

A trusted professional, like a home visitor is an effective messenger on the importance of a well-woman visit. Educating and encouraging home visiting clients to schedule and attend a well-woman exam can help them maintain a healthy lifestyle and minimize health risks.

**ESM 1.2 – Community Partners: The number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.**

**Goal/Objective**:

Increase the number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.

**Significance of ESM 1.2:**

Public health issues are best addressed by developing and sustaining partnerships between community organizations, medical experts, and government. Programs that develop and sustain these partnerships provide opportunities to improve the health of women during her lifespan.

**ESM 1.3 – Survey Questions: Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.**

**Goal/Objective**:

Increase the number of question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.

**Significance of ESM 1.3:**

Success of public health messaging must include input from the population it is trying to reach. Using the Utah Behavioral Risk Factor Surveillance Survey (BRFSS), program staff will be able to ask a diverse group of women on the facilitator and barriers to receiving a well-woman visit. With this information it is possible to create programming that will resonant with our target population, thus increasing the percentage of women who receive care.

**Women/Maternal Health**

**SPM-01:** ***Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care.***

**FY21 Annual Plan**

**Annual Plan:**

This SPM is a new measure following the 2020 MCH Needs Assessment.*

The maternal mental health specialist has created a Toolkit for maternal mental health, with the help of the Utah Women and Newborns Quality Collaborative's Maternal Mental Health Subcommittee (UWNQC MMH), and it is currently in a pilot phase. During July 2020-June 2021, the Toolkit will have implemented feedback and changes from the current pilot projects, and will take on a second round of pilot projects to further improve the Toolkit. This new version of the Toolkit will also be offered on the UWNQC MMH website for downloads, after information is offered from the downloading organization, in order to provide feedback and understand what types of organizations are utilizing the Toolkit, and what sections they find helpful, and not helpful.

Other than the Toolkit, there currently exists one download for maternal mental health, SUNSHINE (BAILANDO in Spanish). We will increase the implementation of this material to more types of providers. We will also offer this resource in a new format, other than a flyer/poster format, with more information where someone can find resources.

Trainings will continue throughout the state, and we will be expanding to other agencies within the Utah Department of Health for partnership. Potential partnerships include the Office of Rural Health, Office of Home Visiting, working more with the Latinx population, and reaching out to individuals we haven't been able to reach thus far.

We will also be offering peer support trainings for LHDs to implement, along with offering training for Local Mental Health Authorities, to have a specialized Maternal Mental Health specialist within their clinical settings to reach underserved, under-insured, and uninsured women.

A comprehensive review of the Perinatal Mortality Review Committee's recommendations from death data will occur within the UWNQC MMH group, and possible projects will be coming from that to implement in hospital and clinical settings throughout the state to help with care coordination of women, medication management, and emergency services.

Lastly, the maternal mental health specialist will find ways to promote the newly established Maternal Mental Health Referral Network, so more people know about this as a resource for both families and providers offices. Along with this, further improvements on the website will be made for better utilization.

**Proposed Activities:**

- The Utah Maternal Mental Health Specialist will better the Maternal Mental Health Toolkit for providers in hospitals and clinical settings, and will promote for providers to be trained in Maternal Mental Health.
- Training and promotion opportunities will be sought to teach both the public and providers how to access and use the Maternal Mental Health Referral Network.
- Further maternal mental health information and training materials will be developed and available to be accessed by families and providers across the state. These materials will be accessible via downloaded and to be shipped if needed.
- Peer support trainings will be promoted and taught to LHDs and Local Mental Health Authorities.
- Maternal Mental Health trainings will occur statewide for a variety of professionals (psychotherapists, midwives, OB/GYN's, nurses, LHDs, physical therapists, home visitors, community health workers, etc.) in order to increase the number and types of providers who can offer support to families.

**Perinatal/Infant Health**

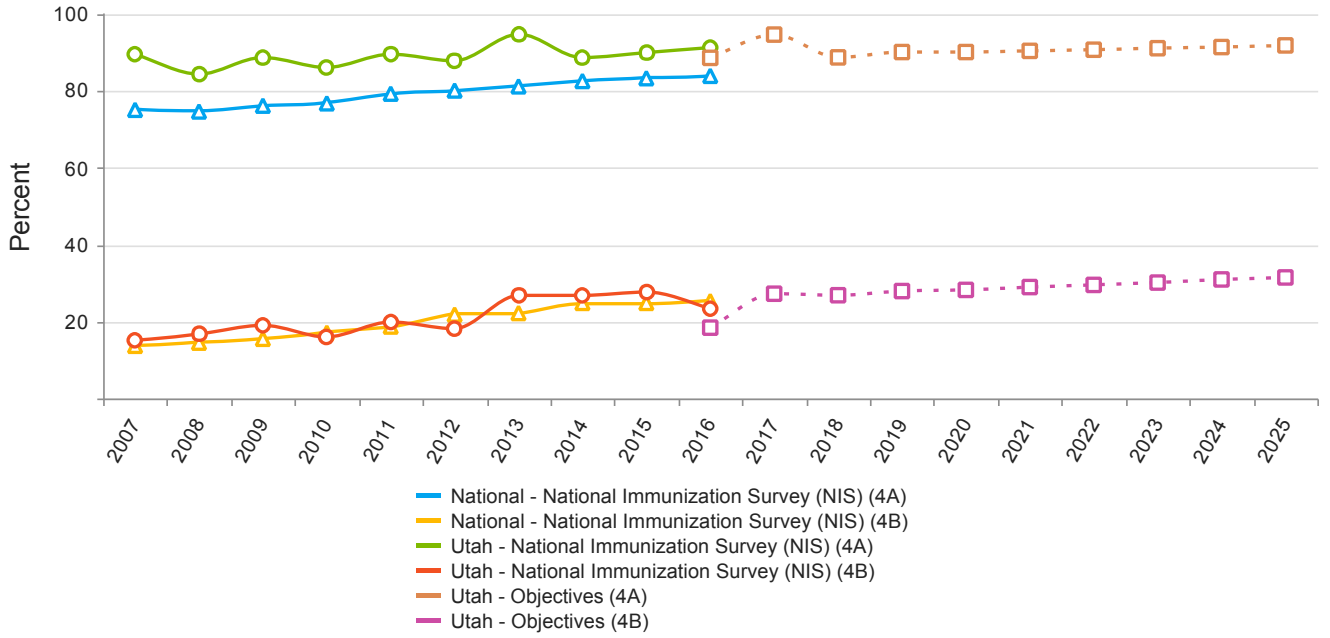
**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2017 | 6.0 | NPM 3 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2017 | 5.9 | NPM 3<br>NPM 4 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2017 | 4.5 | NPM 3 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2017 | 1.4 | NPM 4 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2017 | 183.2 | NPM 3 |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2017 | 67.9 | NPM 4 |

## National Performance Measures

### 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** | **2019** |
| Annual Objective | 88.5 | 94.5 | 88.6 | 90 |
| Annual Indicator | 94.4 | 88.4 | 89.7 | 91.2 |
| Numerator | 43,550 | 43,382 | 43,073 | 45,052 |
| Denominator | 46,122 | 49,063 | 48,030 | 49,404 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 90.0 | 90.3 | 90.6 | 91.0 | 91.3 | 91.7 |

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

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | 18.5 | 27.3 | 26.9 | 28 |
| Annual Indicator | 27.0 | 26.8 | 27.8 | 23.5 |
| Numerator | 11,890 | 12,259 | 12,643 | 11,415 |
| Denominator | 44,056 | 45,790 | 45,490 | 48,506 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 28.3 | 29.0 | 29.6 | 30.2 | 31.0 | 31.5 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 4.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a "Breastfeeding Friendly Facility."**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 13.2 |
| Numerator | 6,225 |
| Denominator | 47,211 |
| Data Source | Vital Records Birth Certificate Data |
| Data Source Year | 2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 20.0 | 23.0 | 26.0 | 29.0 | 32.0 |

**ESM 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 13.9 |
| Numerator | 983 |
| Denominator | 7,093 |
| Data Source | WIC Program Data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 14.0 | 15.0 | 16.0 | 17.0 | 18.0 |

**ESM 4.3 - Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | EPICC Program Data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 20.0 | 40.0 | 60.0 | 80.0 | 100.0 |

**State Action Plan Table**

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

| Priority Need |
| --- |
| Breastfeeding/poor infant nutrition |

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

| Objectives |
| --- |
| A) By 2025, increase the percent of infants born in Utah who are ever breastfed from 89.7% (NIS, 2015) to 91.7%. B) By 2025, increase the percent of infants born in Utah who are exclusively breastfed through 6 months of age from 27.8% (NIS, 2015) to 31.5%. |

| 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 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a “Breastfeeding Friendly Facility.” | Active |
| ESM 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor. | Active |
| ESM 4.3 - Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance | 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

**2016-2020: National Performance Measures**

**2016-2020: 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 | 2019 |
| Annual Objective | 90 | 92.8 | 91.7 | 90 |
| Annual Indicator | 92.7 | 91.6 | 89.1 | 90 |
| Numerator | 480 | 522 | 521 | 448 |
| Denominator | 518 | 570 | 585 | 498 |
| Data Source | IBIS, Utah Birth Certificate Data | IBIS, Utah Birth Certificate Data | IBIS, Utah Birth Certificate Data | IBIS, Utah Birth Certificate Data |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 100 | 100 | 100 |
| Annual Indicator | 100 | 100 | 100 | 100 |
| Numerator | 518 | 585 | 593 | 498 |
| Denominator | 518 | 585 | 593 | 498 |
| Data Source | REDCap VLBW Infant Morbidity Database | REDCap VLBW Infant Morbidity Database | REDCap VLBW Infant Morbidity Database | REDCap VLBW Infant Morbidity Database |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 100 | 100 | 100 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | 0 | 0 | 0 | 0 |
| Denominator | 10 | 10 | 10 | 10 |
| Data Source | Program Level Data | Program Level Data | Program Level Data | Program Level Data |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 9 | 9.4 | 9.4 |
| Annual Indicator | 9.3 | 9.6 | 9.4 | 9.4 |
| Numerator | 4,712 | 4,852 | 4,582 | 4,434 |
| Denominator | 50,776 | 50,486 | 48,578 | 47,211 |
| Data Source | Utah Birth Certificate Data, OVRS | Utah Birth Certificate Data, OVRS | Utah Birth Certificate Data, OVRS | Utah Birth Certificate Data, OVRS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**MCH Block Grant FY21 Application & FY19 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)*

**FY19 Annual Report**

### Program Activities:

The Performance Measure was achieved. The Performance Objective was 90.0% and the Annual Indicator was 90.0%. Additionally, the Utah results are 7.5% higher than the Healthy People 2020 target of 83.7%.

According to a 2010 review of very low birth weight (VLBW) infants delivered in risk-appropriate settings, the percentage of VLBW infants born in hospital with a level III or higher neonatal intensive care unit (NICU), changed only slightly across all states and jurisdictions between 2000 and 2007 (74.2% to 74.7%, respectively).[1] Historically, Utah's rate had been higher than the national rate and the Healthy People 2020 baseline of 75% and goal of 83.7%. According to the National Performance Measure 3 Risk Appropriate Perinatal Care Evidence Review, "Five states reported greater than 90% of VLBW births were delivered at level III or higher hospitals, a goal that may not be achievable in all states."[2]

### Accomplishments / Successes:

In comparing the rate of VLBW infants for Utah to the national rate, Utah had a rate of 1.09%, with a nationwide rate of 1.38%. The Utah VLBW rate was 26.6% lower than the national rate in 2018.[3] Utah implemented the CDC Levels of Care Assessment Tool (LOCATe) survey for understanding levels of care that serve pregnant women, mothers, and infants. The CDC LOCATe tool is based on the most recent guidelines and policy statement issued by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine. The results provided the levels of care by facility statewide. Having a standardized assessment of the delivering hospitals levels of care has been helpful in various forums including our Perinatal Mortality Review.

A key focus in FY19 was working with the hospitals on any discrepancies between the hospital level assessment and the LOCATe tool assessment, along with communicating the results to each hospital. Discussions with hospitals involved various emails and phone conversations, and involved more time that was originally anticipated. Each delivering hospital received an electronic summary of their results based on their survey answers and the CDC assessment, with details on their LOCATe assessed Neonatal and Maternal levels. This has been a helpful conversation starter, as well as a tool they can utilize when looking at expanding their services and/or hospitals. A new hospital opened in Utah October 2018, they completed the survey as well. Therefore, all delivering hospital in Utah, who delivered a baby during FY19, havea LOCATe assessed Neonatal Level.

Utah has also worked to provide the CDC with data to conduct a multi-jurisdictional analysis. The CDC will use this data to assess outcomes by LOCATe level of care and provide additional insights on perinatal regionalization. The Memorandum of Understanding (MOU) with the CDC to share data was executed, and Utah provided this data to the CDC during FY19.

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

- Worked with hospitals to resolve discrepancies between the hospital level assessment and the LOCATe tool assessment.
- Communicated the LOCATe assessment results to each hospital via electronic letter and summary.
- Executed a MOU to initiate a multi-jurisdictional analysis with the CDC to compile LOCATe data by outcomes and levels of care.

### Challenges / Gaps / Disparities:

In 2015, a rule on VLBW Reporting was implemented in Utah. This rule requires hospitals to enter their VLBW data into a REDCap database. REDCap is a secure web application for building and managing online surveys and databases, which allows for robust data analysis and review. There has been decreased compliance with hospitals

entering this information since 2017. Additionally, feedback from hospitals indicates that the requirement is burdensome due to the time it takes to pull or enter the data, and that they do not have the resources to compile the information. Therefore, this rule will be reviewed in order to determine if this rule should be renewed. or sunsetted going forward.

**Agency Capacity / Collaboration:**

LOCATe has created various opportunities for informed conversations among stakeholders who work in the area of risk-appropriate care. Stakeholders include hospital administrators and clinicians, such as labor and delivery nurse managers and 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 diverse support has helped to build collaboration with the Utah Department of Health, and increase understanding on benefits of the work with the CDC on LOCATe. CDC has been a key partner in completing the LOCATe analysis. The plan is to continue to use the results from CDC LOCATe for discussions on how we can continue to improve health outcomes for women and infants.

**Summary Progress Report (2020) of ESMs related to NPM-03**

*The following ESMs were accomplished and have been categorized as "inactive".*

**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 3.1 Progress Report:**

Maternal and Infant Program staff worked with Utah's delivering facilities to ensure that morbidity data on 100% of very low birthweight babies (VLBW) were entered into the REDCap system in compliance with rule 433-1. The implementation of the rule has made it possible to collect the data from all facilities and birth certificate data were used to verify reporting by delivering facility. With three years of data collected to date, this will provide information to analyze outcomes by level of care and birth volume and create a report of the findings. This report will help to determine if there are gaps in getting VLBW babies to be delivered in a hospital with a Level III Neonatal Intensive Care Unit (NICU).

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

**Goal/Objective:**

Increase the percentage of hospital facilities completing the LOCATe survey to 95%.

**Significance of ESM 3.2:**

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 selfdesignate their levels of care, and because of this, there is not uniformity with Utah's leveling. In 2009, a survey was administered collecting the levels of care from all Utah hospital facilities. Since 2009, four additional hospital facilities have opened their doors. In addition to collecting level of care information from these four additional facilities, it will also be valuable to be able to compare our data with hospital facilities nationwide.

**ESM 3.2 Progress Report:**

All but one hospital completed the survey. The hospital that did not complete the survey is a small rural facility with a minimal number of low risk deliveries.

**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.[4] 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-3 and related ESMs were discontinued following the 2020 MCH Needs Assessment.

**Perinatal/Infant Health Domain**

**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**

**FY19 Annual Report**

**Program Activities:**

NPM-4A: The Performance Measure was not achieved. The Performance Objective was 90.0% and the Annual Indicator was 89.7%.

NPM4B: The Performance Measure was not achieved. The Performance Objective was 28.0% and the Annual Indicator was 27.8%.

The Stepping Up for Utah Babies program continues to work with and recruit delivering hospitals for statewide implementation. During FY19, two hospitals, Castleview Hospital and Layton Hospital, were trained in the Stepping Up program. Castleview Hospital is located in Carbon County, a rural area of Utah. Layton Hospital is located along the populous Wasatch Front. However, it is a brand new hospital, which allows the policies and procedures outlined by the Stepping Up program to be considered the norm, when patients deliver in that facility. After the initial training, the 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 FY19 to increase referrals to the Utah WIC Peer Counseling Program. These referrals are documented in the WIC VISION Computer System. Additional goals included that each local agency will offer at least one training on breastfeeding; lactation education courses for WIC Staff, including peer counselors, will be offered as WIC funds allow; and the Utah WIC Breastfeeding Peer Counseling Program continues to collaborate with Utah Department of Health and community organizations.

In FY19, 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. Additional referrals were made to the Utah WIC Breastfeeding Peer Counseling program by the MotherToBaby Utah (MTB UT) program. Furthermore, each local agency offered at least one training on breastfeeding, and many local agencies asked their peer counselors to participate in the trainings through sharing new breastfeeding research with other staff members. Finally, a 45-hour Lactation Education course was offered to all WIC staff members, including peer counselors.

During FY19, the Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) program continued to reach out to, and collaborate with Utah worksites to create lactation policies that comply with federal and state laws. EPICC utilizes various worksite assessments to collect lactation data. During FY19, eight-nine worksites completed either the CDC Worksite Health Scorecard, Healthy Worksite Award, or EPICC Mini-Scorecard. Of those, thirty-two worksites currently have an existing breastfeeding policy in place that complies with federal standards. Forty-five worksites have created a new policy, formal communication, or revised and updated a policy for breastfeeding/lactation support for employees. EPICC staff and Local Health Departments (LHDs) reach out to worksites to provide technical assistance and breastfeeding support materials to ensure federal lactation law compliance and policy development.

**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. As of FY19, all Intermountain Hospitals have been trained and created a breastfeeding policy that addresses the implementation of all ten steps. During FY19, participating hospitals successfully implemented a total of eighty-eight steps. Additionally, one hospital completed all ten steps and became the first hospital in Utah to complete the Stepping Up for Utah Babies program and certify as a “Breastfeeding Friendly Facility.”

We had some success in recruiting hospitals outside the Intermountain Healthcare system with the training of a rural, independent hospital.

The number of WIC Breastfeeding Peer Counseling Program referrals made in FY19 decreased from 9,606 to 9,026. However, the number of breastfeeding peer counselors employed by WIC increased from thirty-four to thirty-six. Utah rates for WIC's ever breastfed prevalence, and the breastfeeding at six months, stayed consistent at 88% and 37%, respectively. Additionally, exclusive breastfeeding rates at three and six months stayed consistent at 31% and 19%, respectively. The breastfeeding at twelve months rate, decreased from 33% to 32%. The number of duplicated contacts to WIC participants for FY19 decreased to 14,514 prenatal contacts and 25,749 postpartum contacts.

Collaborating with the MTB UT Program was beneficial as its referrals contributed to the consistent breastfeeding prevalence rates. MTB UT provides information to help women initiate and continue breastfeeding when they have questions about medications or other exposures. One woman stated, "I thought I'd have to stop breastfeeding my baby for the two weeks I have to take this medicine. My milk supply isn't good, so I was worried I'd lose it. Thanks so much for letting me know I can keep feeding her while I take it. You guys are real life savers!" It is common for women to ask questions about medications and exposures while breastfeeding, including pain relievers, cold medications, antidepressants, antibiotics, and herbal supplements. Women often hear conflicting information and need a trusted source for explaining why one provider says one thing and another provider says something that seems very different.

Additional accomplishments of the Utah WIC Breastfeeding Peer Counseling Program included extending outreach to local hospitals, medical offices, community programs, and community events. Several local agencies developed trailers that provide nursing mothers with a place to breastfeed at community events, such as local fairs. Three agencies created and hosted events to promote breastfeeding for World Breastfeeding Month. The Davis County WIC program hosted an annual Breastfeeding Conference, the Salt Lake County WIC Program hosted a Women's Health & Breastfeeding Fair, and the Utah County WIC program held a Breastfeeding Conference. All of these events were available for WIC staff, community partners, and community members to attend. Furthermore, more local agencies are expanding the communication methods that peer counselors can use to contact WIC participants, such as through email, texting, social media, and after-hours breastfeeding hotlines. All of these communications methods improve the ease of providing breastfeeding assistance to WIC participants.

To address the common challenge of inadequate pay to retain WIC Peer Counselors, the Salt Lake County WIC program began working with their human resources department to increase the pay rate for WIC Peer Counselors in their agency.

EPICC staff attended three worksite-networking events to increase exposure and collect worksite contacts. During these events, EPICC staff was able to connect with ten worksites to talk about lactation accommodations and provide resources and breastfeeding material. The EPICC program was able to provide breastfeeding support material, including and offered "Your Guide to Breastfeeding" packets to attendees at the Utah Worksite Wellness Conference. Fifteen worksites reached out for additional support and help in developing policies. EPICC was able to present in front of one Chamber of Commerce meeting and distribute breastfeeding resource. Local health department staff continue to conduct their own assessments, have reached out to twenty-three worksites within their jurisdictions, and promoted breastfeeding accommodation at the workplace. 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. Additional materials on legislation and lactation in the workplace have been compiled and shared with LHDs and worksites as well as the EPICC website.

**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, all Intermountain Healthcare Hospitals have been trained and have created a breastfeeding policy that addresses the implementation of all 10 steps.
- The Utah WIC Breastfeeding Peer Counseling Program extended outreach to local hospitals, medical offices, community programs, and community events.
- EPICC staff was able to connect with ten worksites to talk about lactation accommodations and provide resources and breastfeeding material. The EPICC program was able to provide breastfeeding support material, including and offered "Your Guide to Breastfeeding" packets to attendees at the Utah Worksite Wellness Conference. Fifteen worksites reached out for additional support and help in developing policies.

- During FY18 and FY19 five hospitals have completed all ten steps and have become certified as a Breastfeeding Friendly Facility under the Stepping Up for Utah Babies program.

**Challenges / Gaps / Disparities:**

An ongoing challenge to hospitals that have begun work on the Stepping Up for Utah Babies program, is the amount of additional duties administrators, nurses, and educators must take on to accomplish the requirements set by the program. However, this year, the first Intermountain Healthcare facility completed all ten steps. As a result, many of the other facilities were motivated to step up their timeline and complete steps. Furthermore, outreach to non-Intermountain facilities have proven challenging in identifying and talking to the correct person in the facility about the program.

One challenge that the Utah WIC Breastfeeding Peer Counseling Program faced during FY19 included inadequate funding to Peer Counseling program to provide current Peer Counselors with adequate pay or to provide them with benefits. The inadequate pay may contribute to the high turnover of Peer Counselors. Despite this challenge, there was an increase in the number of employed peer counselors from thirty-four to thirty-six between FY18 and FY19. An additional challenge reported by some local agencies was a lack of support of Utah WIC's Breastfeeding Peer Counseling program at local hospitals.

The challenges outlined above may have contributed to the decreased number of WIC Breastfeeding Peer Counseling Program referrals and the decreased breastfeeding prevalence at twelve months rate.

The EPICC program and LHDs continue to have difficulty with worksites not following up after initial contact has been made. Worksites often mention that they are not interested in working on breastfeeding policies, as other topics are a higher priority. Another common challenge worksite frequently state that they do not have employees who breastfeed or pump and there is no need for a policy. There is also confusion over the actual lactation accommodation law, what is required, what is considered "private space" and "reasonable break time."

One emerging issue that the Utah WIC Breastfeeding Peer Counseling Program experienced in FY19 is the decreasing WIC caseload. Because the Utah WIC Program's overall caseload is decreasing, there is a smaller caseload for the breastfeeding peer counselors, which limits the amount of hours that are available for them to work. Additionally, several local agencies reported that there is a lack of training resources for new peer counselors. To improve the resources available to peer counselors, the state WIC office applies for additional funds for 45-hour lactation courses for WIC staff, including peer counselors, to attend. A 45-hour lactation education course was offered in September 2018.

**Agency Capacity / Collaboration:**

Stepping Up for Utah Babies 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 their community engagement opportunities and social media platforms to discuss and market 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, medical offices, La Leche League, and the Utah Breastfeeding Coalition to optimize breastfeeding support for moms and babies. The Utah WIC Program also collaborates with local county events such as fairs, in order to provide a designated spot for breastfeeding moms to nurse. In addition, the Utah WIC Program receives and addresses consumer calls on breastfeeding referred by the MTB UT program.

The EPICC program will continue to partner with local health departments to assess new worksites on breastfeeding policy, accommodations, and leave time and provide information, resources, and technical assistance to assist with the implementation of breastfeeding policy and accommodations. The EPICC program is currently working with the Utah Worksite Wellness Council to create a separate "breastfeeding accommodation award," as well as to provide additional outreach to worksite within their network and contacts. Additionally, EPICC will review the current resources on our website and the webinars offered to identify gaps and provide updated material to share with Public Employees Health Plan and insurance brokers.

**Summary Progress Report (2020) of ESMs related to NPM-04**

**ESMs 4.1- 4.3 have been deactivated following the 2020 MCH Needs Assessment.*

Following is a progress summary of the old ESMs. The new ESMs are provided in the Annual Plan section.

**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:**

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, 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 4.1 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 FY20, MIHP staff trained one new hospital in the Stepping Up for Utah Babies program. Additionally, nine previously trained hospitals successfully implemented 27 steps during this time period.

A major success is that four hospitals were certified in all ten steps and are now considered a “Breastfeeding Friendly Facility” in Utah. These achievements garnered local media attention with newspapers and television news covering the story. MIHP staff also provided an on-air live interview with the local CBS station, KUTV, on the Stepping Up for Utah Babies program.

Since the inception of this program in 2015, 20 hospitals have implemented a total of 112 steps.

**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 FY20, EPICC program continued to reach out to, and collaborate with Utah worksites to create lactation policies that comply with federal and state laws. During FY20, eighty-three worksites completed either the CDC Worksite Health Scorecard, Healthy Worksite Award, or EPICC Mini-Scorecard. Of those, 61% of worksites currently have an existing breastfeeding policy in place that complies with federal standards. Sixteen worksites have created a new policy, formal communication, or revised and updated a policy for breastfeeding/lactation support for employees and 84% of the worksites provide private space and provided paid or unpaid break time for expressing breast milk. EPICC staff and LHDs provided technical assistance and breastfeeding support materials to worksites that do not have policies or are not compliant with lactation accommodation law.

**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 percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.

**Significance of ESM 4.3:**

Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Mothers who receive help and support when they need it are more likely to reach their breastfeeding goals and meet their infant's complete nutritional needs. A mother's ability to begin and continue breastfeeding can be influenced by a host of community factors, and programs like WICs breastfeeding peer counselors can provide important coaching to enable and sustain breastfeeding efforts in WIC clients. Peer counseling interventions greatly improve breastfeeding initiation, duration, and exclusivity.

**ESM 4.3 Progress Report:**

The Utah WIC Program refers 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 Program computer system entitled VISION. The MTB UT Program also makes referrals to the Utah WIC Breastfeeding Peer Counseling Program. For FY19, the absolute number or referrals were 9,026, which was below the target objective of 10,900 referrals. The number of employed peer counselors increased from 34 to 36. The number of duplicated contacts to WIC participants for FY19 decreased to 14,514 prenatal contacts and 25,749 postpartum contacts. Utah WIC's breastfeeding prevalence rates primarily remained consistent between FY18 and FY19, with the only decrease in prevalence seen for the Breastfeeding Prevalence at 12 months, which decreased from 33% to 32%.

The performance objective set for FY20 is a total 9,700 referrals. To date, there have been 7,293 referrals to the WIC Breastfeeding Peer Counseling Program in FY20. The number of duplicated contacts to date are 12,670 prenatal contacts and 18,551 postpartum contacts. Current Breastfeeding Prevalence rates for FY20 include the Ever Breastfed Prevalence rate staying consistent at 88%; the Breastfeeding Prevalence at 6 & 12 months at 35% and 31%; and the Exclusive Breastfeeding Prevalence at 3 & 6 months at 31% and 18%.

**Perinatal/Infant Health Domain**

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

**FY19 Annual Report**

**Activities:**

The Performance Measure was achieved. The Performance Objective was 9.4% and the Annual Indicator was 9.4%. This rate is below the 2018 U.S. preterm birth rate of 10.0% and the hits the Healthy People 2020 goal of 9.4%.

The Reduce Preterm Birth Committee of the Utah Women and Newborns Quality Collaborative (UWNQC) created a Preterm Birth Prevention Resources summary that is available online at our updated website (https://mihp.utah.gov/uwnqc/reduce-preterm-birth). This website highlights the resources developed to address preterm birth including the Preterm Birth Prevention Video Series, the Utah Screening and Progesterone treatment process and care protocol, What to Do to Prevent a Preterm Birth: 17P (Progesterone) Guide for Providers, 17P for Preventing Preterm Birth Fact Sheet (English and Spanish), and What to Do After a Preterm Birth 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 Utah 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)?”. Via a 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. From this data, we are able to track 17P usage by hospital and show the run charts for UWNWC hospitals at UWNQC Reduce Preterm Birth Rate Committee meetings. Using 17-P utilization run charts for individual hospitals and for statewide tracking, has helped to visualize baseline utilization, and have discussions with hospitals on how they can improve the number of eligible women who they are having a discussion about 17P to reduce their risk.

**Accomplishments / Successes:**

Vital Records staff presented to providers statewide on the importance of accurately reporting prior preterm births on the birth certificate. This included packets of information with UWNQC resources such as a 17P for Preventing Preterm Birth for Providers. Having the collaboration of Vital Records for our data collection and training providers has been a helpful resource. One of our contacts at Vital Records serves on one of our UWNQC committees, this allows her to see our activities and understand why capturing the data is important.

The University of Utah, one of our major health systems, has a data sharing agreement with MIHP and UWNQC. They created a spontaneous PTB section in their Electronic Medical Record (EMR) EPIC. This helps captures patient history of spontaneous preterm birth, whether 17P was offered, if the patient took 17P injections, and if so, when they were started. The data will help to establish a baseline and identify potential barriers to optimal treatment.

Multiple births are a factor in the preterm birth rate. In 2018, 2.2% of total births were multiples (twins, triplets, quadruplets, or higher), and this represented 23.7% of the total preterm births. The UWNQC committee has been focused on spontaneous singleton births, as the committee cannot affect preterm birth that occurs in multiple gestations. When excluding multiple births, the preterm birth rate in Utah during 2018 was 7.4% of all singleton births vs. 9.4% when multiples are included.

There were three LHDs in 2018 that had preterm birth rates over 10%. Two of these three were in rural areas. There are currently some telehealth programs in place that offer resources specific to rural residents.

Reviewing the rates of preterm birth by race and ethnicity, the rates for women who reported being white, Alaskan or American Indian, and Asian, went down in 2018 in comparison with 2017. The highest rate for the past five years is 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: Giving our babies the best chance (ITAV)” 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, which can reduce the risk for preterm births.

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 preterm birth data, and implement statewide standard protocols and algorithms. There is also collaboration with the March of Dimes and the local leader is a member of the UWNQC board. 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 17P data utilization.

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, both of which affect the preterm birth rate (https://fpeutah.org/for-providers/). The collaboration between UWNQC and Family Planning Elevated at the University of Utah will continue as the House Bill 12 from the 2018 Legislative session 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. 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.

In Fiscal Year 2019, MotherToBaby Utah provided education to women and their providers about medications used during current pregnancies or while planning a pregnancy to treat conditions that could result in preterm births such as mental health conditions, cardiovascular conditions, respiratory conditions, the use of tobacco and other drugs, autoimmune conditions, and influenza. 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 preterm births.

**Summary of successes and accomplishments on “Moving the Needle” in relation to SPM-01:**

- Created Preterm Birth Prevention Resources summary and posted on UWNQC website https://mihp.utah.gov/wp-content/uploads/Preterm-Birth-Prevention-Resources-Summary.pdf
- Tracked 17P usage by hospital and showed the run charts for UWNWC hospitals at UWNQC Reduce Preterm Birth Rate Committee meetings. This includes the University of Utah, one of our major Health Systems, creating a spontaneous PTB section in their Electronic Medical Record (EMR) for reporting.
- UWNQC and Family Planning Elevated at the University of Utah collaborating on implementation of House Bill 12 from the 2018 Legislative session for a statewide, immediate Postpartum Long-Acting Reversible (LARC) Program. This offers a program that provides family planning services to low-income individuals, disseminating educational materials statewide, and training providers.

**Challenges / Gaps / Disparities:**

The preterm birth rate for Medicaid recipients increased from 10.26% in 2017 to 10.67% in 2018. This is a population to continue to determine ways to provide recipients with preterm birth risk reduction resources. Another challenge is limited evidence informed interventions to reduce preterm birth.

**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 preterm birth data. and implement statewide standard protocols and algorithms. There is also collaboration with the March of Dimes and the local leader is a member of the UWNQC board. 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 17P data utilization.

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, which both affect the preterm birth rate (https://fpeutah.org/for-providers/). The collaboration between UWNQC and Family Planning Elevated at the University of Utah will continue as the House Bill 12 from the 2018 Legislative session 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. 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.

*SPM-01 was discontinued following the 2020 MCH Needs Assessment.

**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)**

In Fiscal Year 2019, MotherToBaby Utah provided education to women and their providers 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 8: Perinatal mortality rate per 1,000 live births plus fetal deaths**

In Fiscal Year 2019, MotherToBaby Utah provided education to women and their providers 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 including aspirin and ibuprofen), and valproate, that could result 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 in perinatal deaths

Utah's Perinatal Mortality Review Program reviews deaths to infants due to perinatal conditions. Infant death cases are reviewed by a multidisciplinary committee which assesses preventability and makes recommendations for prevention.

The Study of the Associated Risks of Stillbirth (SOARS) is an ongoing, state-specific, population-based survey designed to collect information on maternal experiences and behaviors prior to, during, and immediately following pregnancy among mothers who have recently experienced a stillbirth. SOARS was initiated in 2018 in an effort to find out why stillbirths occur and how to prevent future fetal deaths. Using methodology similar to the Pregnancy Risk Assessment Monitoring System (PRAMS), Utah women who recently experienced a fetal death are mailed a survey. We are awaiting a weighted data set from the CDC to begin analysis and publish findings.

**NOM 9: Infant Mortality Rate per 1,000 live births**

The safe haven project worked with the Utah state legislature to extend the safe newborn drop off from 3 days to 30 days. With the new changes in the law, the legislature awarded extra funding for education in addition to the current efforts that include a multi-digital campaign using social media and digital radio ads. The safe haven project also worked together with Utah EMS department to develop a training module that will provide education credit for licensing all emergency medical workers that includes medics, paramedics, firefighters and other first responders in law enforcement agencies.

**NOM 10: Percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

In Fiscal Year 2019, MotherToBaby Utah provided education to women and their providers about the risks of alcohol use during pregnancy. They provided information through in-person, telephone, email, chat and text contacts. They provided information through printed brochures, newsletters, social media posts, and television news segments. They worked 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 2019, 314 English Alcohol brochures, 1,170 Spanish Alcohol brochures, 1,858 English Alcohol Tobacco and Other Drugs brochures, and 257 Spanish Alcohol Tobacco and Other Drugs brochures were distributed to families and providers.

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

The Violence and Injury Prevention Program (VIPP) developed the Utah Public Opioid Dashboard and included NAS as an indicator to increase awareness of NAS in Utah. In addition, Through the Overdose Data to Action cooperative agreement with the CDC, the Utah Birth Defect Network works to link mothers and newbors with NAS to services and support systems.

In Fiscal Year 2019, MotherToBaby Utah provided education to women and their providers about medications used during current pregnancies or while planning a pregnancy to treat mental health conditions and pain. 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, substance abuse conditions, and pain 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 (CHARM) Program connects data in real time from a variety of programs to present a consolidated record of newborn screening results such as newborn hearing, heel-stick (ranges are included) and critical congenital heart defect (CCHD) results. One way the CHARM system shares the connected data in real time is through its CHARM Web Portal (CWP). Authorized private and public health providers continued to use the CHARM Web Portal (CWP) to look up and view a child's health information/results from the above newborn screening tests to coordinate care, treatment, and follow-up in a timely manner. Providers also had access to a Medical Home Portal (MHP) link in the CWP. Therefore, when a provider was looking up a child's newborn screening results, they could also click on the MHP link to find diagnostic and treatment information for newborn disorders. In addition, CHARM continued to collaborate on a project with the Early Hearing Detection and Intervention (EHDI) and Vital Records (VR) Programs called the “Birth Certificate Alert Project”. Through CHARM's data integration with EHDI and Vital Records VR, 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 process. When the birth certificate clerk sees the alert, he/she prints out a letter informing the parents or guardian that their child needs a hearing screening follow-up and instructs them to contact the EHDI Program. From January 1, 2018 - June 18, 2019, 350 hearing alerts were generated for children by the CHARM system; 44% (154) completed a hearing screening test after the alert. This linkage has improved follow-up efforts and care coordination for children that are deaf or hard of hearing.

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[4] American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2012). Guidelines for Perinatal Care (7th Edition). Elk Grove Village, IL.

**MCH Block Grant FY21 Application & FY19 Report**

**Perinatal/Infant Health**

**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***

**FY21 Annual Plan**

**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. Stepping Up program manager, Nickee Palacios, will continue outreach to non-participating hospitals with a goal of training all remaining delivering hospitals during FY21.

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.

The Utah WIC Program will continue the following activities in FY21: 1) maintaining a statewide goal to increase referrals to the Peer Counseling Program for all thirteen local agencies, so that more eligible WIC participants receive at least one contact from a WIC Breastfeeding Peer Counselor; 2) each local agency will provide at least one training on breastfeeding; and 3) 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. EPICC will develop and distribute a survey for women to complete who utilize breastfeeding/lactation accommodations at the workplace. Completing the brief questionnaire will give women the opportunity to share their thoughts about what is working well, and what could be improved. EPICC will be providing breastfeeding packets and material to worksites. MotherToBaby UT will continue working with EPICC to analyze the emails received through their survey to find other information to supplement these initial plans. They will also find ways to collaborate to create breastfeeding supportive environments in State agencies that need it.

**Proposed Activities:**

- The Maternal and Infant Health Program (MIHP) will continue training hospitals and offering support for the Stepping Up for Utah Babies breastfeeding program.
- Utah WIC will continue working towards increasing referrals to the Peer Counseling Program for all 13 local agencies.
- The Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) program will continue to work with new worksites on breastfeeding policy, accommodations, and leave times.
- The Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) program will develop and distribute a survey to women who utilize breastfeeding/lactation accommodations at the workplace to learn about their personal experience with the policy.

**ESMs related to NPM-04***

*The following three ESMs (4.1 – 4.3) are new for FY21. These were developed following the 2020 MCH Needs Assessment.

**ESM 4.1 - Stepping Up for Utah Babies**: **The proportion of live births that occur in facilities that have met the requirements set by the Stepping up for Utah Babies program to become a "Breastfeeding Friendly**

**Facility."**

**Goal/Objective:**
Increase the proportion of live births that occur in facilities that have met the requirements set by the Stepping up for Utah Babies program to become a "Breastfeeding Friendly Facility."

**Significance of ESM 4.1:**

Hospital policy and practice significantly affect whether a woman feels confident enough to reach her breastfeeding goals. The Stepping Up for Utah Babies program encourages and recognizes hospitals that offer an optimal level of care for lactation based on the World Health Organization (WHO)/United Nations Children's Fund (UNICEF) Ten Steps to Successful Breastfeeding. To be designated as a "Breastfeeding Friendly Facility," facilities must meet the requirements set by Stepping Up program staff for each of the Ten Steps. By fully implementing all Ten Steps, the participating hospitals can help new mothers successfully start and continue breastfeeding.

**ESM 4.2 - Breastfeeding Peer Counselor: The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.**

**Goal/Objective:**

Increase the percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.

**Significance of ESM 4.2:**

Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Mothers who receive help and support when they need it are more likely to reach their breastfeeding goals and meet their infant's complete nutritional needs. A mother's ability to begin and continue breastfeeding can be influenced by a host of community factors, and programs like WICs breastfeeding peer counselors can provide important coaching to enable and sustain breastfeeding efforts in WIC clients. Peer counseling interventions greatly improve breastfeeding initiation, duration, and exclusivity.

**ESM 4.3 – Workplace Lactation Policies: Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance.**

**Goal/Objective:**

Increase the number of surveys received from women who utilize lactation policies and/or lactation rooms at the workplace.

**Significance of ESM 4.3:**

The U.S. Surgeon General calls for employers to have high-quality employee lactation support programs and policies that work towards reducing breastfeeding barriers for working mothers. The effectiveness of these polices in supporting the needs of breastfeeding mothers is currently unknown in Utah. By getting their input, we can encourage workplaces to update current policies that meet the needs of lactating workers so they can reach their personal breastfeeding goals.

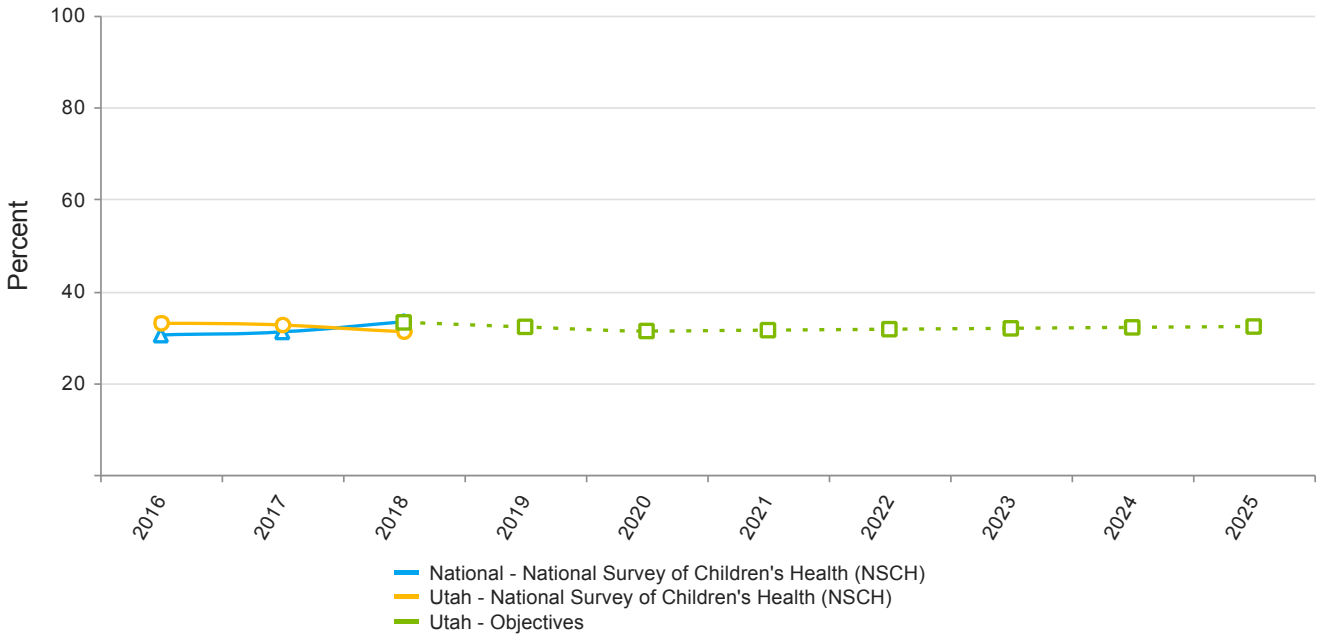
**Child Health**

**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 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2017_2018 | 12.2 % | NPM 13.2 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.7 % | NPM 6<br>NPM 13.2 |

## 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** | **2019** |
| Annual Objective | | | 33.2 | 32.2 |
| Annual Indicator | | 33.1 | 32.6 | 31.1 |
| Numerator | | 38,611 | 32,987 | 29,418 |
| Denominator | | 116,514 | 101,171 | 94,514 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 31.3 | 31.5 | 31.7 | 31.9 | 32.1 | 32.3 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program**

| Measure Status: | Active |
|---|---|

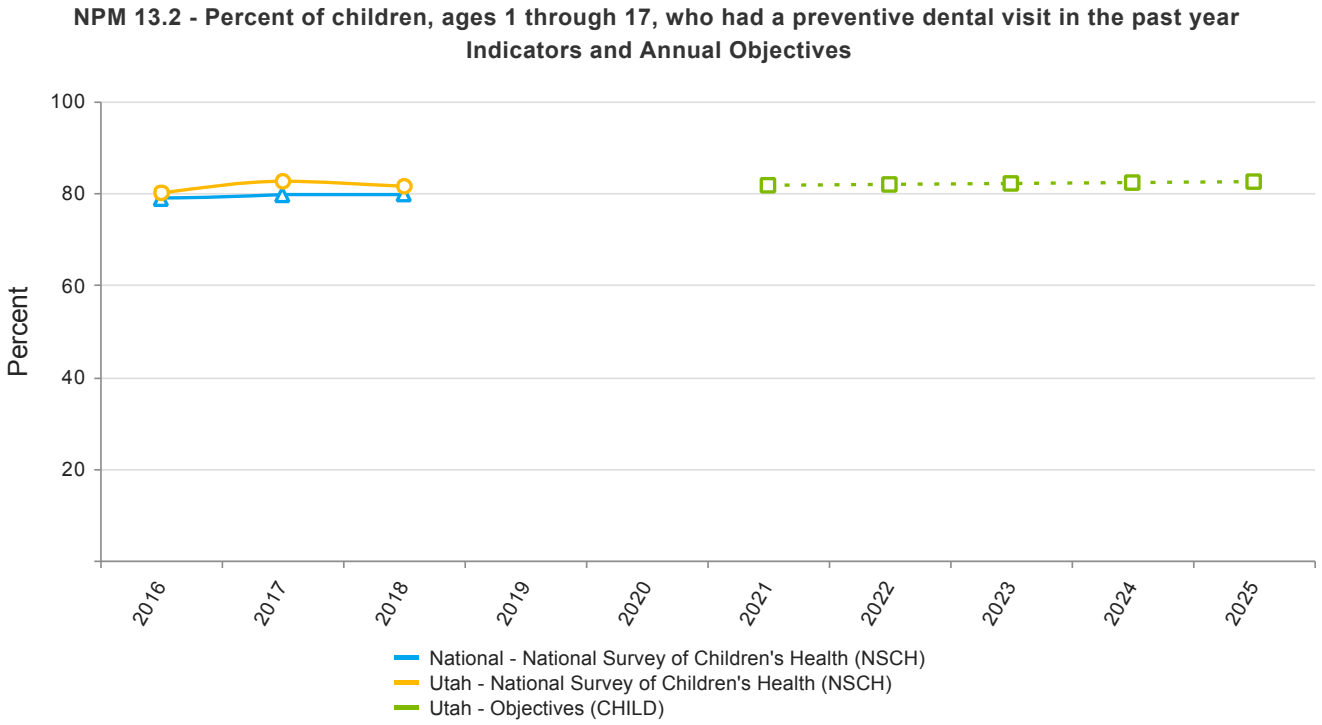
| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Early Childhood Utah program data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 12.0 | 12.0 | 12.0 | 12.0 | 12.0 |

**ESM 6.2 - The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 8,157 |
| Numerator | |
| Denominator | |
| Data Source | The Brookes Publishing UDOH ASQ Online Enterprise |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 8,565.0 | 8,993.0 | 9,443.0 | 9,915.0 | 10,411.0 |




**NPM 13.2 - Child Health**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 80.3 | |
| Annual Indicator | | 80.1 | 82.4 | 81.4 |
| Numerator | | 684,515 | 701,280 | 698,309 |
| Denominator | | 854,160 | 851,339 | 857,676 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 81.6 | 81.8 | 82.0 | 82.2 | 82.4 |

**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 | 2019 |
| Annual Objective | | 53.6 | 51.5 | 54.4 |
| Annual Indicator | 53.4 | 51.3 | 54.2 | 55.5 |
| Numerator | 116,623 | 109,115 | 109,777 | 105,122 |
| Denominator | 218,295 | 212,848 | 202,518 | 189,242 |
| Data Source | CMS 416 | CMS 416 | CMS 416 | CMS-416 |
| Data Source Year | FFY16 | FFY17 | FFY18 | FFY19 |
| Provisional or Final ? | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 55.7 | 55.9 | 56.1 | 56.3 | 56.5 | 56.7 |

**State Performance Measures**

**SPM 2 - Percent of family members who live in the household that ate a meal together 4 or more days per week.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 76.7 |
| Numerator | 692,413 |
| Denominator | 903,273 |
| Data Source | National Survey of Childrens Health |
| Data Source Year | 2017-2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 77.7 | 78.7 | 79.7 | 80.7 | 81.7 |

**SPM 3 - Percent of students enrolled in the free or reduced price lunch program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 32.2 |
| Numerator | |
| Denominator | |
| Data Source | USBE, Child Nutrition Program Database |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 32.2 | 32.7 | 33.2 | 33.7 | 34.0 |

**State Action Plan Table**

State Action Plan Table (Utah) - Child Health - Entry 1

| Priority Need |
| --- |
| Developmental delays |

| 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 2025, increase the percentage of children, ages 9 months through 35 months, who receive a parent-completed developmental health screen in the previous year from 31.1% (NSCH, 2017-18) to 32.3%. |

| Strategies |
| --- |
| 1. Increase the number of parent-completed developmental health screens received by children ages 9 months - 35 months by training additional Early Care & Education and Health programs in ASQ Online. |
| 2. Increase the number of parent-completed developmental health screens received by children ages 9 months - 35 months contributed to the UDOH ASQ Online Enterprise Account. |

| ESMs | Status |
| --- | --- |
| ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program | Active |
| ESM 6.2 - The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs. | 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

Oral health

### NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

### Objectives

By 2025, increase the percent of children (ages 1 through 17) who had a preventive dental visit in the past year from 81.4% (NSCH, 2017-2018) to 82.6%.

### Strategies

1. 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, Fostering Healthy Children and the Utah Office of Home Visiting to reach these goals.

2. Collaborate & target high risk populations with Head Start, Early Intervention, Fostering Healthy Children, and WIC. The Utah Office of Home Visiting and the Office of Health Disparities, Smart Smiles (school based dental preventive program) 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.

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.

4. The OHS collaborates with the University of Utah's Physician Assistants Program for interprofessional development.

| 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) - Child Health - Entry 3

### Priority Need

Family connectedness

### SPM

SPM 2 - Percent of family members who live in the household that ate a meal together 4 or more days per week.

### Objectives

By 2025, increase the percent of family members who live in the household that ate a meal together 4 or more days per week from 76.7% to 81.7% (2017-2018 National Survey of Children's Health)

### Strategies

1. Promote family meal time to Utah residents through schools, childcare centers, social media and proclamations.
2. Promote Interventions to families and local health departments

**2016-2020: National Performance Measures**

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 14.7 | 15.1 | 14.9 |
| Annual Indicator | 15.1 | 15.8 | 15.7 | 15 |
| Numerator | 144 | 152 | 152 | 147 |
| Denominator | 950,511 | 960,913 | 967,283 | 977,706 |
| Data Source | Utah Death Certificate Database, OVRS | Utah Death Certificate Database and Pop estimates | Utah Death Certificate Database and Pop estimates | Utah Death Certificate Database and Pop estimates |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

## MCH Block Grant FY21 Application & FY19 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 in the past year*

**FY19 Annual Report**

### Program Activities:

The Performance Measure was not achieved. The Performance Objective was 32.2% and the Annual Indicator was 31.1%. This data was obtained from the National Survey of Children's Health (NSCH), combined 2017-2018 data. However, due to a high percentage of missing values, NSCH specified that data for NPM-06 might not be reliable.

***Activity #1:*** Improve the developmental screening rates of programs that are currently enrolled in the UDOH Ages and Stages Questionnaire (ASQ) online account.

In order to discover an accurate screening rate baseline for programs enrolled in our Brookes Publishing/UDOH ASQ Online Enterprise Account our program, Early Childhood Utah (ECU), inventoried all of our ASQ online accounts. We discovered 175 accounts had been created since UDOH began our Developmental Health Promotion Program in 2010.

Within Utah's 2019/2020 ESMs for NPM-06, ECU defined active accounts as programs that completed an online screen within the previous twelve months. According to this definition, there were eighty-six inactive Early Care and Education (ECE) provider accounts/programs. Inactive ECE providers included Early Head Start/Head Start programs and licensed childcare programs. Seventeen of these inactive accounts were subaccounts originally created for Local Health Departments (LHD). Six inactive accounts were for child care resource and referral agencies who establish accounts in order to facilitate family child care providers' access to ASQ training and materials. Three inactive accounts were UDOH test/mock accounts created for training purposes. There were also nine miscellaneous inactive accounts created for home visiting, early intervention, tribal, and other early childhood health programs. After an appropriate level of outreach and continued tracking of screening activity, all ASQ online accounts deemed inactive have been disabled. Disabled accounts are easy to activate should an early childhood program decide to participate in the UDOH Developmental Health Promotion Program again.

In an effort to continuously improve screening rates, between 12/7/18 and 3/3/20, ECU enrolled fifteen new programs and re-enrolled thirty-one programs in our ASQ online Enterprise account.

Care types that currently participate in the UDOH ASQ online account include licensed child care programs, Early Head Start/Head Start grantees, Early Intervention IDEA Part C programs, LHDs, MIECHV local implementation sites, State Education Agency funded programs, community health centers, universities, and one of our most active screening programs, Help Me Grow Utah.

With regards to increasing developmental health screening rates, forty-nine active programs completed 15,339 screens in 2019. In 2018, forty-one programs completed 13,120 screens.
Below is a list of currently enrolled screening programs, by care type and by service delivery area. Two of the programs, Help Me Grow Utah and Davis County Health Department, completed 6,972 or 45% of our screens. Over time, we hope to duplicate Davis County's screening accomplishments with several of the State's LHDs.

| Program Name | STATUS | PBC | SDA | 2019 total # of screens completed |
|---|---|---|---|---|
| Bear River Health Department - LHD | re-enrolled | | Logan | 754 |
| Central Utah Health Department - LHD/OHV | re-enrolled | | Central Utah | 101 |
| Davis County Health Department - LHD | re-enrolled | Ogden | Davis | 3476 |
| Salt Lake County Health Department - LHD/OHV | re-enrolled | SSL | SLC | 504 |
| San Juan County Health Department - LHD/OHV | re-enrolled | San Juan | San Juan | 48 |
| Southeast Utah Health Department - LHD/OHV | NEW | | Southeast | 1 |
| Southwest Utah Health Department - LHD | NEW | | Southwest | 1 |
| Weber Morgan Health Dept. - LHD | re-enrolled | Ogden | Weber-Morgan | 104 |
| Wasatch County Health Dept - LHD/OHV | NEW | | Wasatch County | 0 |
| Utah County Health Dept. - LHD/OHV | NEW | | Utah County | 0 |
| Prevent Child Abuse Utah - OHV | re-enrolled | Ogden | Ogden | 384 |
| Central Utah Health Department - EI | NEW | | Central Utah | 0 |
| Davis Early Intervention - EI | re-enrolled | | Davis | 40 |
| *DDI Vantage Duchesne - EI* | NEW | | Duchesne | 0 |
| *DDI Vantage East - EI* | NEW | SSL | SLC | 16 |
| *DDI Vantage Tooele - EI* | NEW | | Tooele | 0 |
| *DDI Vantage West - EI* | NEW | | SLC | 0 |
| Root For Kids - EI/HS | re-enrolled | | St. George | 521 |
| San Juan School District-Early Intervention Program - EI | NEW | San Juan | San Juan | 5 |
| Duchesne County Preschool - USBE Pre-K | re-enrolled | | Duchesne | 224 |
| Emery County Preschool - USBE Pre-K | re-enrolled | | Emery | 213 |
| Granite School District Community Centers - USBE LEA | NEW | SSL | SLC | 11 |
| Granite School District Connection High School Early Learning - USBE LEA | NEW | SSL | SLC | 38 |
| Wasatch County School District Preschools - USBE Pre-K | re-enrolled | | Wasatch County | 55 |
| Brigham Pediatrics - MD | re-enrolled | Ogden | Brigham & Ogden | 342 |
| Intermountain McKay-Dee Developmental Resource Team (Ogden) IHC - MD | re-enrolled | Ogden | Ogden | 48 |
| Midtown Community Health Center - MD | re-enrolled | Ogden | Ogden | 617 |
| Utah Navajo Health System - MD/OHV | re-enrolled | San Juan | San Juan | 27 |
| Bear River Head Start - HS | NEW | | Logan | 136 |
| Mountainland Head Start, Inc.- HS | re-enrolled | | Utah County | 664 |
| RUCD Head Start - HS | re-enrolled | San Juan | Price and San Juan | 1118 |
| A To Z Building Blocks - CC | re-enrolled | | Utah County | 397 |
| Child Care Connection - CC | NEW | | Hyrum | 0 |
| Depot Daycare - CC | re-enrolled | Ogden | Ogden | 34 |
| Dorothy Miller - CC | NEW | | SLC | 0 |
| Intermountain Best Friends Child Development Center (Logan) IHC - CC | re-enrolled | | Logan | 166 |

| | | | | |
|---|---|---|---|---|
| Intermountain Child Development Center (SLC) IHC - CC | re-enrolled | | SLC | 426 |
| Intermountain Dixie Child Development Center (St. George) IHC - CC | re-enrolled | | St. George | 336 |
| Intermountain McKay-Dee Child Development Center (Ogden) IHC - CC | re-enrolled | Ogden | Ogden | 99 |
| Intermountain R-Kids (Provo) IHC - CC | re-enrolled | | Utah County | 179 |
| Little Seed Evolution Child Care Center LLC - CC | re-enrolled | Ogden | Ogden | 141 |
| Progressive Preschool - CC | re-enrolled | Ogden | Ogden | 193 |
| Sweethearts At Play - CC | NEW | Ogden | Ogden | 0 |
| The Neighborhood House - CC | re-enrolled | SSL | SLC | 121 |
| The Preschool Playhouse - CC | NEW | SSL | Magna | 0 |
| UKids - Guardsman Way - CC | re-enrolled | | SLC | 2 |
| Help Me Grow Utah - R&R | re-enrolled | Statewide | Statewide | 3496 |
| USU TeleVisits - University | NEW | | Logan | 6 |
| Weber State University MSL Children's School - University | re-enrolled | Ogden | Ogden | 295 |
| | | | | **15339** |
| *(DDI Vantage counted as one program)* | | | | |
| | | | | |
| LHD=Local Health Dept. | | | | |
| OHV=Utah Office of Home Visiting (MIECHV) | | | | |
| EI=IDEA Part C, Early Intervention | | | | |
| USBE=State Education Agency | | | | |
| MD=Private MD or Comm. Health Center | | | | |
| HS=Early Head Start/Head Start | | | | |
| CC=Licensed Child Care | | | | |
| R&R=Resource and Referral | | | | |
| PBC = Place Based Community | | | | |
| SDA = Service Delivery Area | | | | |

***Activity #2:*** In order to promote the importance of infant/toddler and preschooler developmental health, ECU will continue to work closely with our many early childhood stakeholders, partners, and with the larger ECE community. Emphasis will be placed on the importance for ECE providers to integrate the use of reliable and valid screening tools, such as the ASQ, into their curriculum and/or practice.

ECU is currently collaborating with many partners including licensed and regulated childcare and Head Start programs, MIECHV home visitors, Office of Home Visiting (OHV), community health and mental health practitioners, and with state and/or federally funded preschool programs to provide critical recommendations and information to the newly formed Utah Governor's Commission on Early Childhood. We strive to strengthen these partnerships in order to promote the importance of infant/toddler developmental health and integrating reliable screening tools, like the ASQ, into their ongoing practice and curriculum.

ECU is implementing ASQ Developmental Screening training for the Early Childhood Comprehensive Systems' (ECCS) three place-based communities (PBC), OHV, Office of Child Care, Statewide LHDs, and anyone in the community who is interested. This is a training program created to increase overall knowledge and use of the ASQ developmental screener and access the UDOH ASQ Database, expanding the current number of screens statewide. All LHDs are directly involved with outreach to and services with pregnant women and parents/caregivers of young children. Our collaboration with the Office of Home Visiting, to improve healthy development of children, through contracts with three home visitors, one in each PBC area, increases caregiver well-being and understanding of the importance of early childhood development. We have established community resources and coordinated strategies that are currently strengthening our PBC areas but are also establishing community partners whose systems' work is invested in the use of the ASQ developmental screening as a vital tool in their individual practices strengthening the families and children they work with.

***Activity #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 9-35 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.

ECU utilized a variety of methodologies, metrics, and data to measure and monitor ASQ online screening results. Our team has a laser focus on the developmental health of the state's infants and toddlers, otherwise known as Zero-Three.

Activities included (all data shared/reviewed is aggregated data):

- Track the number of ASQ screens children receive across the state with additional focus upon our PBCs and 0-3 year olds.
- Track the number and proportion of screens that are above cutoff, in the monitoring zone, and/or below cutoff.
- Track the number of ECE and health programs that are actively participating in the UDOH ASQ Online Enterprise Account.
- Track the number of family/child "intake calls" that are made to Help Me Grow from residents of our PBCs.
- Track the number of Help Me Grow intakes and screens that result in referrals for additional assessment/intervention (for residents of our PBCs).

Recently we added below cutoff by program and below cutoff by domain reports to our mix of data to review, analyze, and present to our Early Childhood Stakeholders as applicable.

We monitor the progress of our screening program by, 1) generating the aforementioned data out of the ASQ Online account; 2) analyzing the screening data for trends; 3) transforming the data into visuals that are easy for targeted teams to understand and discuss; and 4) meeting together monthly with targeted community leads to review monthly dashboard data, and biannual Help Me Grow intake/referral reports, along with comprehensive annual reports.

Another method employed for tracking our program's progress is the reporting out of grant objectives, ASQ and Help Me Grow metrics, and narrative reports with Utah's State Advisory Council, otherwise known as the Early Childhood Utah Advisory Council. ECU members offer critique on the data and on the interventions underway, and suggest ways to improve service delivery and avenues to involve additional partners. The ECU Advisory Council is also poised to make broad and specific recommendations to the newly legislated and formed Early Childhood Governor's Commission.

**Accomplishments / Successes:**

In 2019, forty-nine programs completed 15,339 developmental health using the UDOH ASQ Online Enterprise Account. In 2018, forty-one programs completed 13,120 screens. This represents a one-year increase of 17%. This data is for all ages, both ASQ-3 and ASQ-SE, during the 2019 calendar year.

In 2019, Early Childhood Utah staff conducted an inventory and "cleansing" of the programs enrolled in our ASQ Online Enterprise Account. This inventory resulted in the disabling of eighty-six inactive accounts, re-enrolling thirty-one active programs, and enrolling fifteen new providers. Conducting this inventory and the enrollment/re-enrollment process provides ECU with enough detailed information to establish a clear line of communication with every active program. Future communication highlights may include information on 1) ASQ training opportunities, 2) ASQ tips/tricks for generating useful screening reports, and 3) an emphasis on the importance of referrals to additional services and/or activities to improve developmental health outcomes.

Our ASQ Online provider inventory and "clean-up" also affords ECU the improved ability to track ASQ screening data on a more granular and detailed level, such as by the program's service delivery area and/or by care types. Additionally, ASQ data can now be more easily monitored for below cutoff percentages in conjunction with program outreach as needed and as applicable.

Another accomplishment in 2019 was the realignment and rejuvenation of the ECU Advisory Council. Through quarterly ECU Advisory meetings and through bi-monthly ECU subcommittee meetings, we promote the importance of integrating developmental health screenings into practices across the state. A big win for Utah in 2019 was the onboarding of an Early Childhood Governor's Commission. This recently legislated body is another avenue ECU can utilize to promote age aligned and parent completed developmental screening opportunities across the state.

In 2019, through one-time Preschool Developmental Block grant funds, Utah developed and published an Early Childhood (ages 0-5) Statewide Needs Assessment, along with a 0-5 Early Childhood Systems Strategic Plan. The importance of promoting developmental health screening for young children was included in both of these comprehensive reports. Utah's legislators, the Early Childhood Governor's Commission, and Early Childhood Utah will utilize both of these reports to inform our path forward.

Finally, another significant accomplishment for Utah in 2019 was the integration of the UDOH ASQ Online database with our Early Childhood Integrated Data System (ECIDS). Through this data integration, UDOH is poised to

examine how many distinct children receive ASQ screens and services by one or more programs. ECIDS>ASQ reports are able to display screening results alone or in combination by time frame, zip code, interval, and program. Programs that participate in the UDOH ASQ Online Enterprise Account will be given access rights to ECIDS>ASQ reports so they can easily generate ASQ data and visualizations specific to their program.

**Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-06:**

- There were 15,339 ASQ screens contributed to the UDOH ASQ online account (all ages, both tools, all programs).
- Using the UDOH ASQ online account, 6,730 children ages 9 - 36 months old, received an ASQ-3 screen.
- Using the UDOH ASQ online account, 1,427 children ages 12 - 36 months old, received an ASQ-SE2 screen.
- Fifteen new screening programs were enrolled/on boarded in the UDOH ASQ online account.
- Thirty-one UDOH ASQ online programs were re-enrolled.
- An ASQ training curriculum and training schedule, sponsored by UDOH, was established for 2020.
- Utah's State Advisory Council for Early Childhood was rejuvenated and realigned as the Early Childhood Utah Advisory Council.
- An Early Childhood Governor's Commission was sworn in and orientated.
- ECU Rules and Regulations were submitted to the state rules division.
- ASQ data integration with the UDOH Early Childhood Integrated Data System.

**Challenges / Gaps / Disparities:**

In FY19, challenges included, maintaining sustained efforts to inventory and "clean-up" our ASQ Online account through various modalities of outreach to both active and inactive screening programs. At times, it was challenging to achieve contact with programs and then ascertain their commitment to continuing in our ASQ online initiative.

Developing a training schedule and curriculum that worked for screening programs that provide services across the state like LHDS, licensed childcare programs, MIECHV, and state funded home visitors was challenging.

Related challenges included working with the vendor, Help Me Grow Utah (HMG), to ensure they had a qualified/certified ASQ trainer in place so that both our program, Early Childhood Utah, and HMG could provide training across the state.

Another significant challenge for our team has been the need to adjust to the steady turnover of key contacts and leads within our PBCs. Our program expends a considerable amount of effort focused upon increasing developmental screening opportunities and appropriate referrals/follow ups within our PBCs. When we lose key contacts or leads to agency turnover, we take the time to build new relationships and assist with bringing new contacts/leads up to speed with this important program.

Since 2010, UDOH has distributed over 400 ASQ-3 and ASQ SE/SE2 kits in English and Spanish. Each kit costs $300, resulting in a $119,700 expenditure in just over 10 years, or
approximately $12,000 per year.

Further ASQ expenditures include our ASQ Online Enterprise Account with the Family Access feature, along with additional charges per screen completed; these costs average well over $10,000 annually.

The HRSA/ECCS CoIIN grant has helped to fund the ASQ online program costs listed above, as well as supporting developmental health promotion program staff and our data integration efforts. The HRSA/ECCS grant expires in July 2021; as such, an emerging issue is how will this invaluable program be funded in the future?

Another emerging issue is the overarching need for a widely accessible, "real-time" ASQ and follow up database. Our many early childhood stakeholders consistently express a desire for early care and education, and health providers to have access to real time ASQ data that would reveal whether a child has had a previous screen or not. Stakeholders also express the need for dynamic database information that pertains to the disposition of the child/family, concerning any follow-up referrals and/or additional assessments that may be indicated.

Obviously, a significant emerging circumstance revolves around myriad issues the Coronavirus 19 Pandemic will leave in its wake. Specially for NPM-06, will infants/toddlers and families continue to receive direct, face/face services that promote early developmental health, services such as high quality child care, Early Head Start/Head Start, Home Visiting, Early Intervention Parts B and C, state funded Pre-K, etc.? One also has to wonder if the need for developmental health screening will increase exponentially after this crisis subsides, and if so, will there be an increase in funding to support wide-scale efforts?

**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 direct 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 legislated collaboration.

ECU works strategically with the agencies and programs listed below, most of these agencies/programs also report back to their own advisory councils and subcommittees, which includes teams of parents, families, and/or service consumers:

> The Utah Office of Child Care, Weber State University-Early Learning Program, UDOH 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 (2020) of ESMs related to NPM-06**

The following four ESMs (6.1 – 6.4) 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 6.2 - 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 were too difficult to extract from the database. New measures have been developed that more accurately reflect current activities.

**ESM 6.5 – Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account.***

**Goal/Objective:**

Increase the participation of enrolled programs in the UDOH ASQ online account by 10%. It is hoped that by tracking this measure and by increasing the number of ASQ online training sessions Early Care & Education and Health programs have access to, ASQ online enrollment and participation will increase. Ideally, this will lead to an increase

**Significance of ESM 6.5**:

Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected or if there is cause of concern and further evaluation is necessary. This ESM is significant to increasing the number of developmental screens received by children ages 9 - 35 months. In order to increase the number of screens received by infants/toddlers we need to increase the number of Early Care & Education and Health programs that offer developmental screening services to families with young children. ECE and Health programs cannot provide ASQ online services without first being trained in ASQ online. If UDOH can sponsor an increased number of ASQ online training opportunities, additional ECE and Health providers will enroll in the UDOH ASQ online account, and hopefully, actively participate. Ideally, increased ASQ online training opportunities will lead to an increase in the number of developmental health screening opportunities for 9 - 35 month

year old children.

**ESM 6.5 Progress Report:**

The only way to increase the percent of children, ages 9 months through 35 months, who receive a parent-completed developmental screening, is to increase the actual number of screening opportunities that are given to families with newborns, infants, and toddlers. Correspondingly, one of the methods for discovering if Utah is increasing the number of screens received by the target age group is to increase the level of participation in our ASQ Online Enterprise Account. Finally, training, enrolling, "activating," and then facilitating ongoing/sustained screening practices is the critical foundation for increasing the percent of screens received by 0-3 year olds.

It is interesting to note that the NPM-06 Federally Available Data on the prevalence of 9 months to 35 months receiving developmental screening in Utah is derived by polling 100 parents of the targeted age group, and asking them if they completed a screen with language or social development questions. For this particular NPM measure, the Child and Adolescent Health Survey website cites that the Confidence Interval Width exceeds 20 percentage points and the data is missing values more than 2% and as such, this FAD may be deemed unreliable; 2017-2018 combined data sets.

According to actual screening data from the UDOH ASQ Online Enterprise Account, Utah has steadily increased the number of screens, received by all ages and received by 0-3 year olds. Over the last five years, Developmental Health Screens for all ages increased by 122%, and screens for 0-3 year olds increased by 58% as evidenced by the screening data displayed below:

Statewide usage reports for all participating programs, by calendar year

| | 2015 | 2016 | 2017 | 2018 | 2019 | Total | Increase rate |
|---|---|---|---|---|---|---|---|
| ASQ-3 and ASQ SE, all ages | 6,901 | 7,673 | 10,436 | 13,120 | 15,339 | 53,469 | 122% |
| ASQ-3 only, ages 0-3 | 6,208 | 5,992 | 7,777 | 8,892 | 9,785 | 38,654 | 58% |

**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 programs enrolled in the UDOH ASQ online account by 10%. One aspect of an essential method for increasing the number of parent-completed developmental screens received by 9 month - 35 month year old children is to track/monitor the number of screens that are contributed to our ASQ online Enterprise account.

**Significance of ESM 6.6:**

Early identification of developmental disorders is critical to the well-being of children and their families. Nationally, the percent of children with a developmental disorder has been increasing, yet overall, screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit. This measure is significant because only by monitoring and increasing the number of programs participating and the number of screens contributed to our ASQ online Enterprise account will we be able to increase the percentage of 9 month - 35 month year old children that receive parent-completed developmental health screening opportunities.

**ESM 6.6 Progress Report:**

The only way to increase the percent of children, ages 9 months through 35 months that receive a parent-completed developmental screening is to increase the actual number of screening opportunities that are given to families with newborns, infants, and toddlers. Correspondingly, one of the methods for discovering if Utah is increasing the number of screens received by the target age group is to increase the level of participation in our ASQ Online Enterprise Account. Lastly - training, enrolling, "activating," and then facilitating ongoing/sustained screening practices is the critical foundation for increasing the percent of screens received by 0-3 year olds.

It is interesting to note that the NPM-06 Federally Available Data on the prevalence of 9 months to 35 months receiving developmental screening in Utah is derived by polling 100 parents of the targeted age group and asking them if they completed a screen with language or social development questions. For this particular NPM measure, the Child and Adolescent Health Survey website cites that the Confidence Interval Width exceeds 20 percentage

points and the data is missing values more than 2% and as such, this FAD may be deemed unreliable (2017-18 combined data sets).

According to actual screening data from the UDOH ASQ Online Enterprise Account, Utah has steadily increased the number of screens, received by all ages and received by 0-3 year olds. Over the last five years, Developmental Health Screens for all ages increased by 122%, and screens for 0-3 year olds increased by 58% as evidenced by the screening data displayed below:

Statewide usage reports for all participating programs, by calendar year

| | 2015 | 2016 | 2017 | 2018 | 2019 | Total | Increase rate |
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| ASQ-3 and ASQ SE, all ages | 6,901 | 7,673 | 10,436 | 13,120 | 15,339 | 53,469 | 122% |
| ASQ-3 only, ages 0-3 | 6,208 | 5,992 | 7,777 | 8,892 | 9,785 | 38,654 | 58% |

For 9 mo - 36 mo ASQ-3 = 6730 (out of 11,389 - all ages)

For 12 mo - 36 mo ASQ SE-2 = 1427 (out of 2641 - all ages)

*Following the 2020 MCH Needs Assessment, ESM 6.5 and 6.6 have been deactivated.

**Child Health Domain**

**NPM-13B:** ***Percent of children, ages 1 through 17, who had a preventive dental visit in the past year***

**FY19 Annual Report**

**Program Activities:**

The Performance Measure was not achieved. The Performance Objective was 84.8% and the Annual Indicator was 81.4%

In 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 program in the Family and Youth Outreach Program. The State Dental Director (SDD) is not in this new program, but is directly under the MCH Bureau Director. His time was also changed from 0.5 FTE to 0.25 FTE in this position. The OHS and the OHE continued to be full-time.

The SDD started working 0.75 FTE for the Family Dental Plan Clinics operated by the Utah Department of Health instead of 0.5 FTE. He continued to serve as the Assistant Clinical Director and the State Occupation Health Officer for the program. He also provided treatment twice a month, for a half day each, at three juvenile justice system youth centers in their onsite dental clinics for incarcerated children.

In June 2019, at the Utah Dental Association annual leadership conference, the SDD presented information on Utah Medicaid updates. There were two Utah managed care dental care plans operating statewide for children. These plans provided basic dental benefits such as diagnostic, preventive, restorative (fillings), endodontists (root canals), and oral surgery. There was also one managed care CHIP plan. On July 1, 2019, fee reimbursements to dentists went up 21%.

The SDD provided general supervision in accordance with Utah laws, for the Oral Health Program's two public health dental hygienists. These hygienists operate in various public health settings. His time permitted him to visit a few events during the year.

The SDD collaborated with Medicaid in efforts to increase the percentage of children who receive preventive dental visits.

The OHP OHS, 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 (SLDD) dental clinic, as well as other locations statewide. The OHS and Oral Health Educator (OHE), along with dental and dental hygiene students, provided screenings and fluoride varnish. These athletes are children and adults with intellectual disabilities.

The OHS spoke to eighty dental students at Roseman Dental School in the fall of 2018 regarding Motivational Interviewing, as they see children and families. This information was originally created and presented at the National Oral Health Conference in 2017.

The OHP's adolescent oral health campaign educational intervention is in its third year and continuing. The OHE managed interns who implemented this intervention in middle schools along the Wasatch Front, building sustainability. Anonymous pre- and post-tests continued to be administered to all students before and after the educational intervention, and used as an evaluation measure. In addition to the educational presentation brochures with local safety net, dental clinics were made available to all students. The OHE and OHP interns provided 126 presentations to 2,938 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. Nineteen presentations were given to 159 pre-K and elementary age students, and 67 middle school and 27 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 OHE went to Duchesne High School in Roosevelt, UT and Uintah River High School, a public charter school on the Ute Tribe Uintah Ouray reservation, and met with the health specialist and school administrators to provide

toothbrushes, toothpaste, and educational materials for their students.

The OHE collaborated with Salt Lake Community College (SLCC) dental hygiene students and Oquirrh Mountain fitness center, for a lunch in the park program. This program provides free and reduced lunch program at school, and student can get a free lunch during the summer. The OHE and OHS presented to thirty-six elementary age children and seven adults through this program. After the presentation, the children were split into four groups that rotated between stations on brushing, flossing, nutrition, and going to the dentist. This allowed all of the children to participate in hands-on activities and have one-on- one instruction. The OHE also coordinated with SLCC dental hygiene students and Midvale Middle School to provide an oral health education booth, and local dental resources to sixty-five families. An education and resource booth was also provided at Granite Park Junior High reaching an additional 100 families. Granite Park serves a diverse population of students from over forty countries.

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 provide dental screenings that 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 377 children and adults received either screening, preventive, and/or restorative care in FY19. 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. Additionally, as Medicaid was constantly changing in the state, we worked together with Medicaid to help providers, families, and other partners we worked with, to understand these Medicaid changes.

As part of the Oral Health Programs collaboration with Family Dental Plan, OHP interns provided thirteen presentations, to approximately 5,000 students, at school based sealant assemblies. These educational presentations were given in the weeks before the preventive sealant clinic came to the school. This program was run in the 12 title one schools in Salt Lake School District.

In February 2019, the OHS oversaw working with an OHP intern to send out over 1028+ emails to all elementary and middle schools in Utah for National Children's Dental Health Month. Information included the prevention of cavities, nutrition, reducing soda consumption, and other oral health information. We continued to work with other school-based programs and tried to strategically collaborate and create access with sustainability. We shared information regarding HRSA and primary care grants to these organizations.

The OHS collects information from all school programs involved in SWISH (school based fluoride swish program), and is available for questions regarding topics such as benefits.

As the State Dental Hygiene Liaison, the OHS spoke in November of 2018 at a Regional Head Start conference in Salt Lake City to 25+ staff and parent advocates. She presented Smiles for Life! Preventive Strategies for Promoting Oral Health for Pregnant Women, Infants, and Children. She also spoke at several other parent events and staff trainings. She works closely with the State Head Start Collaborator to review the Periodic Information Report (PIR) and discuss barriers, challenges, and resources to help expand access to care and create sustainability with connections to creating dental homes for each child and family.

The OHS sits on the statewide Early Childhood Utah Board and works with the medical/dental home committee.

In January 2019, the OHS wrote an article for UAEYC (Utah Association for the Education of Young Children), on the American Academy of Pediatricians (AAP) oral health program: Brush, Book, Bed. This publication reaches about 400 educators, clinicians, and other staff that work with early childhood education. This article was also included in the WIC Wire for February.

The OHP continues their collaboration with the Physician Assistant (PA) Program's interprofessional training of providing oral health risk assessments (OHRA) on children and applying fluoride varnish. The OHP, along with the PA program, provided OHRA, fluoride varnish and well child visits to 127 Ute tribe Head Start children in September of 2018. Two children were found with abscesses and appointments were made that day for the children to be seen by a dentist in the local area.

In addition, in September 2018, the OHP's OHS and OHE provided education and oversight to twenty PA students, providing screenings and fluoride varnish to upwards of seventy migrant farm workers in Santaquin, UT. Many of these migrant farm workers are the parents of the migrant Head Start children we provide services to every June.

OHS and OHE provided dental screenings and fluoride varnish to Rural Head Starts in three cities in Utah, Wendover, Tooele, and Grantsville. Additional oral health education and training has been provided statewide by the OHS and OHE to Head Starts, Home Visiting, Fostering Healthy Utah Children, 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.

The OHS and OHE presented to statewide WIC directors and other WIC staff multiple times in the state, using the Smiles for Life! Preventive Strategies for Promoting Oral Health for Pregnant Women, Infants, and Children curriculum. This curriculum was created by the National Center of Early Childhood Health & Wellness.

**Accomplishments / Successes:**

In efforts to increase interprofessional workforce training and created sustained access to care, in March 2019, the OHS strategically connected the Dixie Dental Hygiene School Director, University of Utah PA Program faculty, and Head Start and Parent as Teachers Root for Kids in St. George, Utah. We are piloting the best practice model of Migrant Head Start interprofessional collaboration. Both schools provided oral health care to children and pregnant women for Root for Kids. The dental hygiene students during this outreach clinic taught the PA students how to do oral cancer screenings, and they saw seventeen children and their families.

**Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-13B:**

- The 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. She will also try to extend this collaboration to the Hildale community where they are expanding Head Start and Home Visiting.
- The OHE managed interns who implemented an educational intervention in schools along the Wasatch Front, building sustainability. Brochures with local safety net dental clinics were made available to all students. The OHE and OHP interns provided 126 presentations to 2,938 students.
- In collaboration with Family Dental Plan, thirteen presentations, to approximately 5,000 students, were given at school based sealant assemblies. This program was run in the twelve title one schools in Salt Lake School District.
- In collaboration with the Office of Health Disparities (OHD), the OHS and OHE provided dental screenings, which were conducted in partnerships with local community organizations. After screenings were performed, prevention and restorative care was provided at Family Dental Plan (FDP). Approximately 377 children and adults received either screening, preventive, and or restorative care in FY19. There were many partners involved in this project, including one dental school and three dental hygiene schools.

**Challenges / Gaps / Disparities:**

Teledentistry - is a new emerging issue for our state. We have a few partners expanding and using teledentistry in school based programs. Senate bill 135 was passed, which promotes and supports teledentistry in Utah by defining key terms, establishing standards of care, enhancing the informed consent, strengthening the patient's ability to file a complaint, and directing the Department of Professional Licensing (DOPL) to establish rules.

**Agency Capacity / Collaboration:**

Annually, the OHS collaborates with the PA Program from the University of Utah and the Migrant Head Start (MHS). In June, the OHS and OHE attended each of the MHS locations (Honeyville, Genola, and Providence), and provided physical assessments, oral health risk assessments applied fluoride varnish. Over 400 children are seen at the (MHS). With this interprofessional collaboration, in the fall, they visit the Ute Tribe Head Start (UTHS) to provide the same care, along with referrals. Approximately 120 children are seen at (UTHS). The OHS will follow-up on urgent needs found. We try to establish dental homes in the prospective areas. Additionally, in the fall of 2019, we then went and saw the parents of the Migrant Farm HS children and provided screenings and fluoride varnish to approximately

eighty migrant farm workers.

The OHS collaborates with the Fostering Healthy Children Program. This program consists of nurses that help foster children with their medical and dental homes and care. The OHS provided education to over fifty-four staff statewide on oral health and dental resources.

The OHS also wrote an article for the Utah Association for Education of Young Children (UAEYC), on the AAP oral health program: Brush, Book, Bed. This is distributed to 400+ educators, clinicians, and other staff that work with early childhood education. This article was also shared with WIC staff statewide. The Brush, Book, Bed has been shared with all early intervention programs that the OHP partners with.

The OHE will continue to collaborate with local dental hygiene programs to provide education resource booths at back to school nights and at summer lunch programs in high need areas.

In efforts to improve dental care for children in Utah, the OHP will continue good partnerships and collaborations with Head Start, WIC, Fostering Healthy Children, 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.

**Summary Progress Report (2020) 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.

*Utah will continue with ESM 13.2.

**Child Health Domain**

**SPM-03: Child Injury Deaths:** ***The rate (per 100,000) of injury deaths among children aged 1-19***

**FY19 Annual Report**

**Program Activities:**

The Performance Measure was not achieved. The Performance Objective was 14.9 and the Annual Indicator was 15.0.

***Strategy 1:*** 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.

VIPP has begun focusing on shared risk and protective factors to address many violence and injury prevention topics in the state. By focusing on shared risk and protective factors for topic causes of child injury deaths, VIPP has developed prevention activities, strengthened non-traditional partners, and worked to streamline resources.

Risk and protective factors were identified for suicide and were included in the suicide fact sheet (https://health.utah.gov/vipp/pdf/Suicide/overall-suicide-factsheet-12-14.pdf). Some risk factors were alcohol or drug abuse, diagnosable mental health disorder, easy access to lethal methods, such as firearms or pills, family history of suicide or violence, lack of social support, loss of a family member or friend, especially if by suicide, physical health problems, relationship or school problems, family conflict, and stressful life event or loss. Some protective factors were receiving effective mental health care or substance abuse treatment, positive connections to family, peers, community, and social institutions that foster resilience, restricted access to highly lethal means of suicide, such as firearms or pills, skills in problem solving, conflict resolution, and nonviolent handling of disputes, and cultural and religious beliefs that discourage suicide and support self-preservation.

***Strategy 2:*** Finalize and implement a strategic plan around shared risk and protective factors.

We have been working through the lens of Shared Risk and Protective Factors (SRPF) in order to maximize the effects of our prevention efforts. This type of approach requires both an understanding of the theoretical framework behind these efforts, as well as a practical understanding of how to align current and future efforts in this regard. To better understand our readiness to transition into using this type of approach across efforts, we partnered with Safe States to conduct an evaluation of both internal and external partners. We plan to use these result to help inform our strategic planning process. In addition, to develop tools, related to our approach to SRPFs, that states can use to help develop the capacity in working towards a similar approach, we participated in an expert convening with ASTHO, Safe States, CDC, and the Colorado Department of Public Health and Environment.

As mentioned above, in an effort to work on shared risk and protection across injury and violence topics, we have developed a strategic plan focusing on this shared lens and have engaged LHDs and VIPP staff in this effort. Identified overarching themes for VIPP's state strategic plan include encouraging social norms that promote safety and health, improving access and utilization to physical and behavioral health care, enhancing the physical environment to improve safe and healthy living, improving the socioeconomic conditions for Utahns, and promoting individual, family, and community connectedness.

This strategic plan helps to break down silos in VIPP, working to reduce multiple forms of injury and violence among Utah children. The VIPP is working with traditional and non-traditional partners to develop common language, align prevention strategies, and optimize resource utilization across these areas of risk and protection.

***Strategy 3:*** 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 the thirteen 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, LHDs provided several suicide prevention training sessions as part of their suicide prevention activities targeting children and their parents. These evidence based suicide prevention programs included ninety-eight community sessions, with 2,527 reached. Local health departments distributed 2,413 gunlocks to community members throughout Utah. Gunlocks can be obtained free of charge from any health department,

mental health authority, 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.

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 thirteen 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. In total, 540 car seats were disseminated to low-income families. In addition, forty-one car seat checkpoints and 889 car seat checks were conducted. Child Passenger Safety Course trainings were held to certify advocates to train caregivers on how to properly install car seats. 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.

The bystander intervention programming has steadily grown over the reporting period. Utah has six community organizations and four higher education organizations who have incorporated bystander intervention training and education into their existing curriculums, or as a part of their ongoing healthy relationships programming. These organizations serve over 2/3 of our state’s population. We have also updated the training curriculum to meet broader community needs and have begun to train and support teachers in five school district on bystander intervention approach and programming to move this approach into schools in Utah. This training has reached thousands of community members and students around the state

***Strategy 4:*** Continue funding all 13 local health departments to implement evidence-based injury prevention programs within their communities.

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 includings 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, and 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 5:*** 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.

Since the year 2007, 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, to bring awareness and educate parents and students on deadly driving behaviors and Utah Graduate Driver's Licensing laws, 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.

***Strategy 6:*** 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.

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 or during school sponsored activities. 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 forty-one school districts and 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 dating back to 2012 (https://ibis.health.utah.gov/ibisph-view/query/selection/studentinj/StudentInjSelection.html). 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 at which injury occurred (e.g., before school, athletic event, lunch, and fieldtrip), 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 developed 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. A student concussion fact sheet was released in 2019 student data came from the SIRS (https://health.utah.gov/vipp/pdf/TBI/ConcussionsInSchoolsFactsheet.pdf).

Additionally, the School Health Profiles survey provides a snapshot of health-related education policies, and programs in Utah schools. The Centers for Disease Control and Prevention in collaboration with the Utah Department of Health developed a questionnaire and conducts a survey of secondary schools every other year. The profiles help state and local education and health agencies monitor and assess characteristics of school health programs. They include information on policies related to physical education, tobacco-use prevention, nutrition, asthma management, health services, and violence and injury prevention. Recommendations for violence and injury related efforts include efforts to align school policies with the best available evidence.

***Strategy 7:*** 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 staff published 114 social media posts reaching 54,674 people. The average post reach was 480 per post, and 4,556 per month. Total engagement was 2,757 with the average of 24 engagements per post and 230 per month. There were 715 reactions to the posts, with an average of 6 reactions per post and 60 per month. There was a total of 311 shares, with the average share per post being 3 and per month 26.

VIPP ran a Positive Teen Behavior campaign during October 2019. Creative ads included messaging for opioids misuse, safe driving, TBI prevention, healthy relationships, and suicide prevention. Snapchat received 1,621,258 impressions with 18,947 Swipe Ups (clicks). Instagram received 3,900,567 impressions and 3,339 link clicks. Overall the campaign reached 566,521 people aged 13-18.

Six news releases and advisories were distributed to local media promoting the prevention of youth injury and violence prevention (e.g. “Drowning Danger Still High”, “Health Officials Urge Water Safety”, “New Report Highlights Trends in Utah Adolescent Health: Mental health identified as a key concern”, “Top Tips to Keep Teens Safe Behind the Wheel”, “Families Honor the Lives of Teen Crash Victims”, “Utah Teens Continue to Grapple with Unhealthy Dating Relationships”, and “Officials Warn of Deadly Temperatures: 11 children have died this summer after being left alone in a vehicle”).

Seven pieces of educational material were produced and published by VIPP staff. Material included, “Suicide Report”, “Sports Concussion”, “School Concussion Factsheet”, “Essentials for Childhood” brochure, “Drowning Factsheet”, “Swimming Safety” promotional video, and “Student Head injuries” promotional video.

***Strategy 8:*** Continue to support 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 9:*** Review 100% of all child deaths in Utah. Enter data gleaned from these reviews in the national child death review database.

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 10:*** Evaluate the effectiveness of the motor vehicle, parent night program being offered at various schools in Utah.

VIPP is works with the media contractor who conducts the parent night programs throughout Utah to evaluate 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 11:*** Provide at least five evidence-based suicide prevention programs to youth ages 12-19.

Local health departments distributed 2,413 gunlocks to community members throughout Utah. Gunlocks can be obtained free of charge from any health department, mental health authority, 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

LHDs provided several suicide prevention training sessions as part of their suicide prevention activities targeting children and their parents. These evidence based suicide prevention programs included ninety-eight community sessions with 2,527 reached.

As a result of data and evaluation efforts, the following implications for prevention have been determined: with parents/guardians having legal authority over nearly 9 out of 10 of the firearms used in suicides of youth under 18, parents are key to prevention; urging parents to lock their guns may not entirely address the youth firearm suicide issue if their teenagers know where the keys are or indeed own a gun and control the keys; a more useful message may be to lock all guns and ensure children and teens don't have access to the keys or combination; when a youth is struggling with a mental health or substance abuse problem or life crisis, storing guns away from home may be prudent; parents may be unaware that youth can use long guns to take their lives; some parents who do lock their guns may be unaware their child can defeat the lock; and clinicians, gun owners, and others could work together to develop messaging and storage
options that are sensitive to local values and realities.

***Strategy 12:*** Publish the 2018 Teen Memoriam book.

Since the year 2007, 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 2018.

**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 LHD level, VIPP feels confident that the rate of suicide deaths will start to decrease over time. In addition, VIPP has 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 VIPP's priorities and VIPP has become involved in participating more broadly in state and local efforts for suicide prevention. As part of this effort, the VIPP is collaborating with multiple state partners to develop a community "postvention" toolkit to provide guidance to LHDs and their local communities on writing a "postvention" response plan.

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: encourage social norms that promote safety and health; improve access and utilization to physical and behavioral health care; enhance the physical environment to improve safe and healthy living; improve the socioeconomic conditions for Utahns; and 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, has 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.

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

- The Utah Coalition for Protecting Childhood (UCPC) focused its efforts on upstream approaches to child maltreatment prevention. Research has shown that economic instability and intergenerational poverty are risk factors for child maltreatment. Economic instability underlies all social determinants of health, which negatively

impact long term health outcomes and opportunity equity.

- We collaborated with community partners in the planning, implementation, and evaluation of two youth mental health screening nights in a local health district, one for junior high and high school students and the other for pre-kindergarten and elementary students. These events were attended by 145 youth and their families. The events were held to provide access to mental health screening for youth, to link them with appropriate service providers and treatment, and to serve as an early intervention for those in need. Screenings were provided at no cost. Following the event, twenty-one follow-up appointments were made and forty-three referrals were given. Every family was given a Youth Services Directory, which contained nearly 150 local services such as medical treatment, counseling, self-care, support groups, classes, and crisis lines.
- Suicide prevention activities were emphasized in local health department contracts. During the reporting period, LHDs provided several suicide prevention-training sessions as part of their suicide prevention activities targeting children and their parents. These evidence based suicide prevention programs included ninety-eight community sessions, with 2,527 reached. Finally, LHDs distributed 2,413 gunlocks to residents in their communities.
- VIPP has focused on shared risk and protective factors to address many violence and injury prevention topics in the state. We have developed 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 encourage social norms that promote safety and health, improving access and utilization to physical and behavioral health care, enhance the physical environment to improve safe and healthy living, improving the socioeconomic conditions for Utahns, and promoting individual, family, and community connectedness.
- As a result of this work, VIPP has continued to be able to engage non-traditional partners, 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.

**Challenges / Gaps / Disparities:**

Funding sources are often very siloed, making it difficult to focus on comprehensive, primary prevention efforts where impact can be leveraged by having shared prevention vision to reduce risk factors and promote protective factors.

Over the last few years, the rate in youth of suicide by firearm has been increasing. In 2018, Utah saw the highest rate recorded for firearm suicide deaths (13.25 deaths per 100,000 youth ages 15-19). 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:**

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 are supported in maintaining 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, 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.

*SPM-03 has been dropped following the 2020 MCH Needs Assessment.

**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**

The CHARM system integrates data between the Early Hearing Detection and Intervention (EHDI) and Baby Watch Early Intervention (BWEI) Programs. This linkage enables the EHDI program to know that a child with hearing loss has been referred to early intervention by six months of age for follow-up care. Receiving timely treatment and intervention for children that are Deaf and Hard of Hearing maximizes their developmental and communication potential so they can be ready for school entry. Likewise, the BWEI program receives hearing screening results in its BTOTS system through CHARM from the EHDI program. This has enabled the BWEI staff to know if a child has received a hearing screening, or still needs one, thereby providing timelier follow-up care and comprehensive service/treatment plans for a child. In addition, 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.

UDOH-MCH is developing an Early Childhood Integrated Data System (ECIDS) with participants like WIC, IDEA Part C, MIECHV, Head Start, Child Care, UDOH-ASQ screening programs and Help Me Grow. UDOH-MCH will be able to match data with Utah's State Education Agency (SEA) to better assess if children that received early childhood services enter school better prepared to learn. The SEA has developed a Kindergarten Entry/Exit Readiness Profile (KEEP). Data matching, analysis and research will be facilitated by the Utah Data Research Center created by state legislation in 2017.

**NOM : 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 links immunization histories of children, ages 0-18, from the Utah Statewide Immunization Information System (USIIS) and provides it 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 continued to identify children in need of immunizations, and follow-up with parents to get their child vaccinated and up-to-date. As stated in NOM 19, CHARM collaborated with the Utah Birth Defects and USIIS Programs during the past grant year and linked the Critical Congenital Heart Defect (CCHD) results to USIIS through the CHARM system. Public and private providers can now obtain the CCHD results, in addition to the hearing screening results, in USIIS.

**MCH Block Grant FY21 Application & FY19 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 in the past year*

### FY21 Annual Plan

### Annual Plan:

Five broad activities closely related to improving and tracking developmental health screens for 9 month through 35 month olds are planned for 2020/21.

1. Early Childhood Utah (ECU) is developing an ASQ3 (Ages and Stages Developmental Questionnaire Screening tool) training program that will be offered through the Office of Child Care to their licensed childcare providers and programs. This program will train participants in the ASQ3 and ASQSE-2 (Ages and Stages Developmental Questionnaire and the Social Emotional screening tool) developmental screening tools as well as the importance of parent participation and proper referral to resources and information for families. The training also introduces the UDOH ASQ online database. Once a participant successfully completes the course, they can enroll in the online UDOH ASQ system. This will allow the provider to use the online tool to screen the children enrolled in their program.

2. ECU is contracting with HMGU (Help Me Grow Utah) to have three of their employees trained in the Master Trainer for the ASQ3 and ASQSE-2 and then offer an ASQ3 and ASQSE-2 training held once a month at different Local Health Departments (LHD) throughout the state. This training will be offered to the community as a whole, with emphasis on training the LHDs and Office of Home Visiting (OHV) staff, which includes but is not limited to Parents as Teachers (PAT), OHV staff, WIC Nurses, and LHD RNs, and providers.

3. ECU will continue to work closely with the three Place Based Communities (PBC) to continue increasing the use of the ASQ Developmental Screening Tool by engaging and educating partners on the tool, sharing resources, and referring to appropriate services through helping families access the different partners within the PBC. Partners include, but are not limited to, LHDs, Home Visiting, Early Intervention, Early Head Start, Head Start, and medical providers. The overall goal being to increase the knowledge that providing direct access to the ASQ with their enrolled children, more children with developmental delays will be identified earlier and receive appropriate interventions.

4. ECU will continue to staff the Early Childhood Utah Advisory Council to coordinate statewide early childhood activities with a multisector membership. The Council provides recommendations from the five subcommittees (i.e., Health, Early Care and Education, Data and Research, Social, Emotional and Mental Health, Parent Engagement) to the Governor's Commission on Early Childhood.

5. Early Childhood Utah will continue to develop and enhance data relationships and data tools that are imperative to our work.

Early Childhood Integrated Data System (ECIDS): Utah's ECIDS delivers both essential quantitative data and qualitative opportunities. In the quantitative department, our ECIDS produces a distinct count of all children born in Utah, that are still under 6 along, with a distinct count of any child under six that has, or is being served by ECIDS data sources. ECIDS data sources include Vital Records Birth and Death registries, WIC, MIECHV, IDEA Early Intervention Part C, Child Care Subsidy, Early Head Start and Head Start, Help Me Grow Utah, and our ASQ online database. Utilizing this distinct count capability, ECIDS displays program crossover data that shows how many distinct children have been enrolled in one program, or more than one program, as well as child enrollment/exit sequence reports. ECIDS data is available at the zip code level and has dynamic timeframes.

With regards to qualitative implications, ECIDS data will be matched with the state's longitudinal data system, the Utah Data Research Center (UDCRC). UDRC is designed to evaluate the impact of and the return on investing in early childhood services. The first data sources targeted to engage in impact research with UDRC are WIC, Home Visiting (MIECHV), and Early Intervention Part C. A data sharing agreement is in place between UDOH and UDRC. UDRC was legislated and developed to conduct longitudinal research in 2017.

The Early Childhood Utah - Community Assessment Tool (CAT) is a Tableau data product designed to provide easy access and navigability to early childhood demographic data for a wide array of early childhood stakeholders and policy makers. The CAT has under six years of age population data, four different poverty levels, mother and child risk factors such as mother's education level/age, and receipt of prenatal care, as well as counts and percents of low birth weight and preterm births. Additionally, the CAT has race/ethnicity data, household demographic data such as, single/two parent households, one/both parents working, and a display/categorization of the early childhood services available to families across the state. CAT data is publicly available at the county, the local health district (13), or statewide levels in annual timeframes.

ECIDS>ASQ Reports: Through our API with the Brookes ASQ Online Enterprise system and ECIDS technology, we are able to produce ASQ data and reports that display a distinct count of children that have received an ASQ screen from one or more participating screening programs. This ECIDS and ASQ interface allows UDOH to produce screening result reports by various provider types, by various intervals, and by above cutoff, monitoring level, and below cutoff. UDOH screening programs will be given access to their own program's ASQ account and reports, in order to assist their program with ASQ monitoring and improvement efforts.

**Proposed Activities:**

- Sponsor and facilitate ASQ-3, ASQ SE-2, and ASQ online training to licensed and regulated Child Care providers.
- Sponsor and facilitate ASQ-3, ASQ SE2, and ASQ online training to Local Health Departments, Home Visiting providers, Health Care providers and to any Early Care and Education and Health program that would like to participate.
- Continue to work closely with our three Place Based Communities to increase developmental health screens along with the appropriate referrals and follow up as indicated.
- Early Childhood Utah staff will continue to facilitate the functioning of the ECU Advisory Council and the five ECU subcommittees.
- ECU will continue to develop the process to make early childhood system recommendations to the Early Childhood Governor's Commission.
- Develop and enhance integrated data products and cross-agency, longitudinal research that will assist Early Childhood Utah stakeholders and policy-makers with making data driven policy decisions.

**New ESMs related to NPM-06***

*The following two ESMs (6.1 – 6.2) are new for FY21. These ESMs were developed following the 2020 MCH Needs Assessment.

**ESM 6.1 – Number of annual ASQ trainings offered by the Early Childhood Utah program.**

**Goal/Objective**:

Conduct at least 12 ASQ trainings per year.

**Significance of ESM 6.1:**

Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected, or if there is cause of concern, and further evaluation is necessary. This ESM is significant to increasing the number of developmental screens received by children ages 9 months - 35 months. In order to increase the number of screens received by infants/toddlers, we need to increase the number of Early Care & Education (ECE) and Health programs that offer developmental screening services to families with young children. ECE and Health programs cannot provide ASQ online services without first being trained in ASQ online. If UDOH can sponsor an increased number of ASQ online training opportunities, additional ECE and Health providers will enroll in the UDOH ASQ online account and hopefully, actively participate. Ideally, increased ASQ online training opportunities will lead to an increase in the number of developmental health screening opportunities for 9 month - 35 month year old children.

**ESM 6.2 – The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.**

**Goal/Objective**:

Increase the number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.

**Significance of ESM 6.2:**

Early identification of developmental disorders is critical to the well-being of children and their families. Nationally, the percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit. This measure is significant because only by monitoring and increasing the number of programs participating, and the number of screens contributed to our ASQ online Enterprise account, will we be able to increase the percentage of 9 month - 35 month year old children that receive parent completed developmental health screening opportunities.

## Child Health Domain

**NPM-13B:** ***Percent of children, ages 1 through 17, who had a preventive dental visit in the past year***

**FY21 Annual Plan**

**Annual Plan:**

In FY21, the Oral Health Program (OHP) plans to continue to collaborate with Medicaid to increase the number of children who receive preventive dental visits and receive needed dental treatments. The State Dental Director (SDD) will continue to work as a member of the dental group with Utah Medicaid.

The SDD will continue to work with the Utah Dental Association to encourage participation in programs for underserved children in Utah. The SDD 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.

Currently, FY20, the OHP is planning for the 2020 statewide school survey of the children's oral health status, which is planned to be carried out starting August 2021. The survey will follow the Basic Screening Survey recommendations of the Association of State and Territorial Dental Directors.

The OHS will release a report in December 2019 regarding Emergency Department non-traumatic dental visits. This report covers a full 11 year period in Utah from 2007-2017. The data showed that in Utah, for children ages 0-19, more than 4.7 million dollars were spent on non-traumatic oral health visits to the ED. Medicaid/CHIP covered 45.7% of charges, private health insurance covered 38%, and 13.8% were self-pay/no charge. Hospital Discharge data was used for this report. The results of this report were shared with the Utah Oral Health Coalition and other key stakeholders. Strategic collaborations and solutions is an ongoing discussion.

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, Tooele School Districts, and at the Utah School for the Deaf and the Blind. The OHE will continue to collaborate with local dental hygiene programs to provide education resource booths at back to school nights in middle schools. The OHE is also working with the MCH web developer to put this educational presentation with pre and post assessment online, so that all middle schools in the state can access this intervention.

The OHP will continue to collaborate with the UDOHs 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. Continued education will be provided by OHP interns.

**Proposed Activities:**

- The OHS, OHE, and SDD will continue to work with and promote teledentistry to increase access to care for school-based programs and to facilitate discussion regarding the possibilities of a pilot teledentistry with a WIC site.
- 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 collaborate with the Early Detection Intervention Program (EDIP) to create educational materials regarding prevention spreading CMV and dental decay.
- The OHP will collaborate with the CSHCN Autism Program and create materials regarding oral health prevention and autism.
- The OHP will continue to use the "12 Oral Health Messages" modules and magnets to share with WIC's, Head Start, Fostering Healthy Children, Home Visiting, etc. Maternal and infant oral health messages are included in this.
- The SDD will continue to work with the Utah Dental Association to encourage participation in programs for underserved children in Utah.
- The OHS will write a report on non-traumatic dental visits to Utah emergency rooms. The data regarding children 0-19 will be shared with Voices for Utah Children, Utah Oral Health Coalition, and other stakeholders.

- The OHE in collaboration with OHP Interns will continue to provide middle school students with the adolescent oral health campaign educational intervention and local dental resources.
- The OHP will continue interprofessional collaborations and outreach to vulnerable populations with the University of Utah's PA Program.
- The OHS is working with the State Community Health Workers (CHW) Coalition to make Oral Health Telehealth educational segments available online for all CHW's.
- The OHS is working with school RNs and the State School Nurse Collaborator to try to convert all schools that are participating in SWISH, to fluoride varnish. Consequently, they are not making SWISH products anymore.

**Child Health Domain**

**SPM-02: Family Connectedness:** ***Percent of days that all the family members in the household eat together in one week***

**FY21 Annual Plan**

**Annual Plan:**

This SPM is new following the 2020 MCH Needs Assessment.*

The CDC states that upstream interventions "involve policy approaches that have the potential to affect large populations through regulation, increasing access, or economic incentives." One area that has been found to impact population health is connectedness. In an article in the Child Youth Services Review, published in 2018, stated "youth who feel connected to people and institutions in their communities may be buffered from other risk factors in their lives. As a result, increasing connectedness has been recommended as a prevention strategy."

Looking at the different options to measure connectedness, Utah chose to look at an upstream intervention to increase the percent of days in the past week that all family members who live in the household ate a meal together from 36.6% to 43.7% (2017-2018 National Survey of Children's Health). Family meals will be used as a proxy measure for connectedness. Research shows that family meals are important not only because they introduce healthier food choices, but also increase connectedness. These efforts support development, mental health, physical health, as well as emotional health. The Healthy Living Through Environment, Policy, and Improved Clinical Care (EPICC) Program with the Violence and Injury Prevention (VIPP) Program at the Utah Department of Health, will work together on these activities.

The activities planned for July 2020-June 2021, not only include promotion of family meal time, but also include communication tools such as conversation cards, classes, and partner training to increase the percent of families having meal times together. The Family and Youth Outreach Program (FYOP) at the Utah Department of Health will carry out these activities.

**Proposed Activities:**

- Promote the Utah Family Meals Facebook page through social media channels. Utah Family Meals is an established resource for healthy family meals recipes and ideas.
- Record and distribute podcasts regarding family meals to a variety of audiences to promote the benefits of family mealtime.
- Increase the number of families that participate in the Child Nutrition Program (CNP) seamless summer meal program. The Seamless Summer Option (SSO) is a Federal meal program that encourages more School Food Authorities (SFAs) already participating in the National School Lunch Program (NSLP) and School Breakfast Program (SBP) to provide meals in low income areas during the traditional summer vacation periods and during school vacation periods longer than ten school days for year-round schools. The SSO combines features of the NSLP, SBP, and Summer Food Service Program (SFSP), and reduces paperwork and administrative burdens to make it easier for SFAs to feed children during summer and other school vacation periods. The goal is to ensure that children who rely on the NSLP and SBP continue to have access to nutritious meals when the school year ends or is not in session.
- Promote healthy family meals through Teaching Obesity Prevention in Child Care Settings (TOP Star program). TOP Star is a proven effective program for increasing nutrition and physical activity in childcare centers. Working with parents to promote healthy family meals provides additional options.
- Develop, promote the use of, and distribute conversation cards to Utah families. Conversation cards are a deck of cards that have pre-printed questions or ideas to discuss over dinner. These cards can be used as jump-starts to have conversations during meals and opening communication lines between parents and youth. Similar card decks have been used by other states in their youth interventions.
- Promote and implement Families Talking Together (FFT) to parents. Parents are still very influential on the decisions their children make, so open communication between them is very importation. The FTT program increases the ability of parents to communicate and engage positively with their teen(s). This creates a safe environment where the youth 10-14 years old can connect and communicate with their parents. This

connection decreases the initiation of risky behaviors.

- Train local health departments and community based organizations in primary prevention and the shared risk and protective factor model. A shared risk and protective factor approach refers to prioritizing risk and protective factors linked to multiple forms of injury or violence in prevention planning, partnership, and programmatic efforts (vs focusing on different violence outcomes separately). This approach gives us the opportunity to streamline and scale up prevention approaches and services. Breaking down some of the traditional “silos” across different forms of injury and violence, and moving toward a shared risk and protective factor approach, can help us better coordinate with partners and agencies that have traditionally focused on a single form of injury or violence, as well as leverage and coordinate resources to bring efficiencies to programs and strategies as they are scaled up for population-level impact.

The progress of these activities will be measured in a variety of ways. These include surveys, website statistics, class rosters, reports, and program records. These data sources will provide a 5-year picture of this measure.

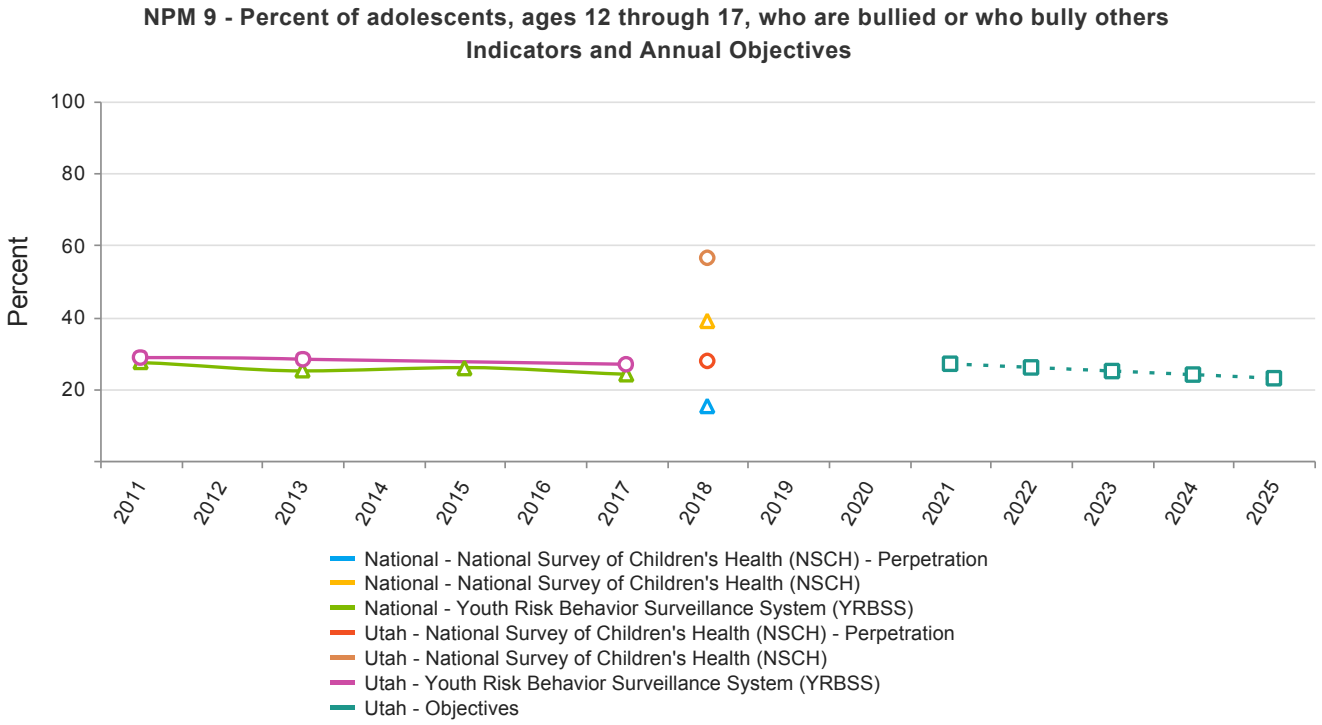
*SPM-02 was developed following the 2020 MCH Needs Assessment.

**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-2017_2018 | 12.2 % | NPM 13.2 |
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 | NVSS-2018 | 33.5 | NPM 9 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 | NVSS-2016_2018 | 20.0 | NPM 9 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.7 % | NPM 8.2<br>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-2017_2018 | 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-2016 | 7.9 % | 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**




| Federally Available Data | |
|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 26.9 |
| Numerator | 44,345 |
| Denominator | 164,763 |
| Data Source | YRBSS |
| Data Source Year | 2017 |

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Perpetration** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 27.7 |
| Numerator | 86,153 |
| Denominator | 311,307 |
| Data Source | NSCHP |
| Data Source Year | 2018 |

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 56.4 |
| Numerator | 176,896 |
| Denominator | 313,579 |
| Data Source | NSCHV |
| Data Source Year | 2018 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 27.0 | 26.0 | 25.0 | 24.0 | 23.0 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 9.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Program records, attendance records. |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**ESM 9.2 - The number of adolescents who receive bystander training (Upstanding)**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 300 |
| Numerator | |
| Denominator | |
| Data Source | Program Data |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 350.0 | 400.0 | 450.0 | 500.0 | 550.0 |

**ESM 9.3 - Percent of adolescents who are physically active at least 60 minutes per day.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 21 |
| Numerator | 41,142 |
| Denominator | 195,912 |
| Data Source | Estimates for percent of students physically activ |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 23.0 | 23.0 | 25.0 | 25.0 | 27.0 |

**ESM 9.4 - The number of youth participating in the Wyman Teen Outreach Program (TOP)**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 400 |
| Numerator | |
| Denominator | |
| Data Source | PREP and SRAE Reports Wyman Connect |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 400.0 | 400.0 | 400.0 | 400.0 | 400.0 |

**ESM 9.5 - The proportion of Utah students participating in an evidence-based school based prevention program (PAX Good Behavior Game).**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0.7 |
| Numerator | 5,000 |
| Denominator | 666,858 |
| Data Source | Utah State Board of Education, Student Violence |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 1.5 | 2.0 | 3.0 | 4.0 | 5.0 |

**ESM 9.6 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 75 |
| Numerator | 171,000 |
| Denominator | 228,000 |
| Data Source | Internal Revenue Service |
| Data Source Year | 2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 76.0 | 78.0 | 79.0 | 81.0 | 83.0 |

**ESM 9.7 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 100 |
| Numerator | |
| Denominator | |
| Data Source | Program Data |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 200.0 | 300.0 | 400.0 | 500.0 | 600.0 |

**State Performance Measures**

**SPM 2 - Percent of family members who live in the household that ate a meal together 4 or more days per week.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 76.7 |
| Numerator | 692,413 |
| Denominator | 903,273 |
| Data Source | National Survey of Childrens Health |
| Data Source Year | 2017-2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 77.7 | 78.7 | 79.7 | 80.7 | 81.7 |

**SPM 3 - Percent of students enrolled in the free or reduced price lunch program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 32.2 |
| Numerator | |
| Denominator | |
| Data Source | USBE, Child Nutrition Program Database |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 32.2 | 32.7 | 33.2 | 33.7 | 34.0 |

**State Action Plan Table**

State Action Plan Table (Utah) - Adolescent Health - Entry 1

### Priority Need

Adolescent mental health

### NPM

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

### Objectives

By 2025, decrease the percentage of adolescents (10-18 years of age) who report being bullied at school in the past 12 months from 27.9% (YRBSS 2017) to 23%.

### Strategies

1. Work with schools and parents to increase training for students, parents and staff on protective factors such as physical activity and communication.

| ESMs | Status |
|---|---|
| ESM 9.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak). | Active |
| ESM 9.2 - The number of adolescents who receive bystander training (Upstanding) | Active |
| ESM 9.3 - Percent of adolescents who are physically active at least 60 minutes per day. | Active |
| ESM 9.4 - The number of youth participating in the Wyman Teen Outreach Program (TOP) | Active |
| ESM 9.5 - The proportion of Utah students participating in an evidence-based school based prevention program (PAX Good Behavior Game). | Active |
| ESM 9.6 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit | Active |
| ESM 9.7 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR) | Active |

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Utah) - Adolescent Health - Entry 2

## Priority Need

Economic stability

## SPM

SPM 3 - Percent of students enrolled in the free or reduced price lunch program

## Objectives

By 2025, increase the number of students who participate in the National School Breakfast and Lunch Programs from 47.0% (Utah State Board of Education Child Nutrition Program Database) to 62.0%.

## Strategies

1. Increase the number of school food authorities that use innovative service models to make breakfast and lunch more convenient and appealing to students.

2. Work with Local Education Agencies (LEA) to strengthen Local Wellness Polices that promote student wellness, prevent and reduce childhood obesity, and provide assurance that school meal nutrition guidelines meet the minimum federal school meal standards.

3. Work with Local Health Departments to educate and reach out to the families who have not automatically qualified or filled out an application to receive free or reduced price benefits for breakfast and/or lunch.

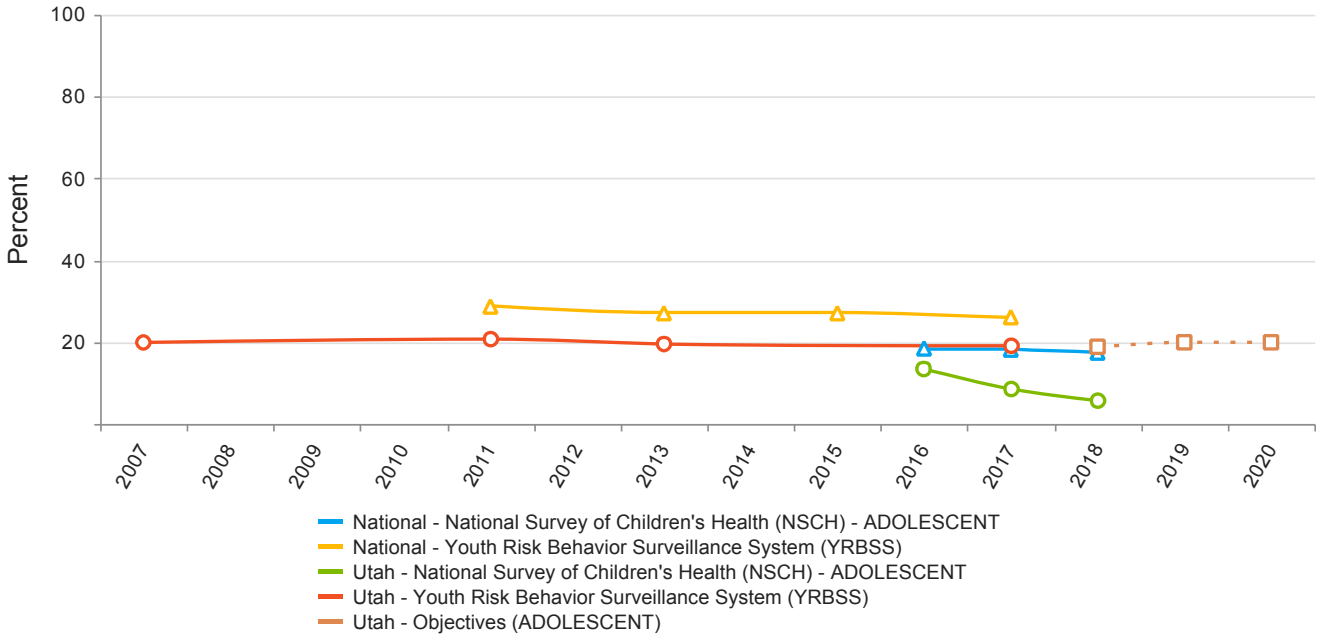
4. Support the Utah State Board of Education Child Nutrition Program by advancing the quality of school meal programs.

5. Educate LEAs about professional development opportunities to ensure that school nutrition program personnel have the knowledge and skills to manage and operate the National School Breakfast and Lunch Programs correctly and successfully.

**2016-2020: National Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | 19.9 | 19.9 | 18.9 | 20 |
| Annual Indicator | 19.7 | 19.7 | 19.1 | 19.1 |
| Numerator | 29,466 | 29,466 | 30,959 | 30,959 |
| Denominator | 149,852 | 149,852 | 162,207 | 162,207 |
| Data Source | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT |
| Data Source Year | 2013 | 2013 | 2017 | 2017 |

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 18.9 | 20 |
| Annual Indicator | | 13.6 | 8.7 | 5.7 |
| Numerator | | 37,056 | 25,092 | 17,632 |
| Denominator | | 272,391 | 287,812 | 311,115 |
| Data Source | | NSCH-ADOLESCENT | NSCH-ADOLESCENT | NSCH-ADOLESCENT |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

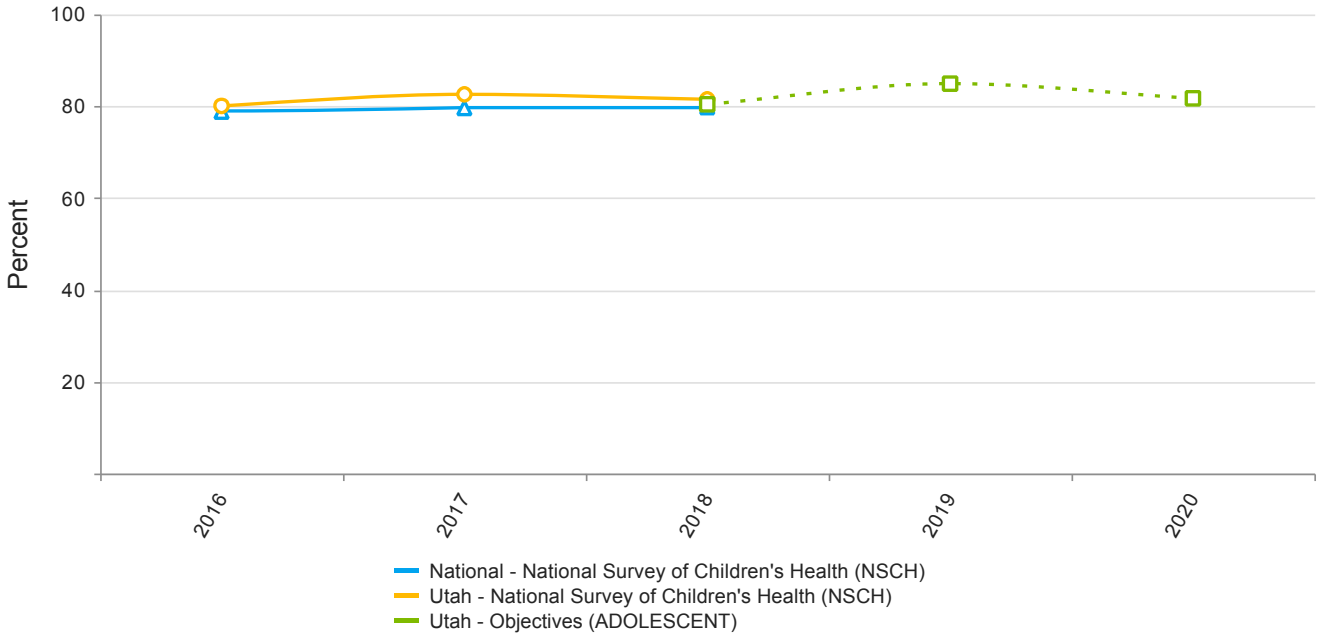
**2016-2020: ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP**

| Measure Status: | | | Active | |
|---|---|---|---|---|
| **State Provided Data** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | 10 | 25 | 25 |
| Annual Indicator | 7.1 | 25 | 25 | 25 |
| Numerator | | 1 | 1 | 1 |
| Denominator | | 4 | 4 | 4 |
| Data Source | School Health Profiles | UDOH Policy Database | UDOH Policy Database | UDOH Policy Database |
| Data Source Year | 2016 | 2017 | 2017 | 2017 |
| Provisional or Final ? | Provisional | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 4 | 35 | 36 |
| Annual Indicator | 6 | 34 | 31 | 34 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | EPICC Training Database | EPICC Training Database | EPICC Training Database | EPICC Training Database |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**
**Indicators and Annual Objectives**




**2016-2020: NPM 13.2 - Adolescent Health**

| **Federally Available Data** | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 80.3 | 84.8 |
| Annual Indicator | | 80.1 | 82.4 | 81.4 |
| Numerator | | 684,515 | 701,280 | 698,309 |
| Denominator | | 854,160 | 851,339 | 857,676 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**2016-2020: Evidence-Based or –Informed Strategy Measures**

None

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 14.7 | 15.1 | 14.9 |
| Annual Indicator | 15.1 | 15.8 | 15.7 | 15 |
| Numerator | 144 | 152 | 152 | 147 |
| Denominator | 950,511 | 960,913 | 967,283 | 977,706 |
| Data Source | Utah Death Certificate Database, OVRS | Utah Death Certificate Database and Pop estimates | Utah Death Certificate Database and Pop estimates | Utah Death Certificate Database and Pop estimates |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**2016-2020: 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** | **2019** |
| Annual Objective | | 21 | 16.7 | 21.5 |
| Annual Indicator | 21 | 17.2 | 21.5 | 21.3 |
| Numerator | 49 | 41 | 52 | 53 |
| Denominator | 233,809 | 238,378 | 242,153 | 248,985 |
| Data Source | Utah Death Certificate Database, OVRS | Utah Death Certificate Database, OVRS | Utah Death Certificate Database, OVRS | Utah Death Certificate Database, OVRS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**MCH Block Grant FY21 Application & FY19 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*

### FY19 Annual Report

### Program Activities:

The Performance Measure was achieved. The Performance Objective was 20.0% and the Annual Indicator was 19.1% (YRBS 2017).

The Utah Department of Health, Utah State Board of Education (USBE), and SHAPE Utah partnered to offer two statewide Health and PE Conferences. The Choices conference was held February 5-6, 2019 for secondary health and PE teachers. There were 283 individuals who attended this conference. During this conference attendees were able choose from 50 breakout sessions that focused on a wide variety of health and PE topics.

The Healthy Bodies, Healthy Minds conference was held on June 11, 2019 for elementary classroom teachers. There were 180 individuals who attended this conference. Twenty breakout sessions were offered that provided a wide variety of games-based activities that demonstrated the long-term benefits of play and set the foundation for creating a safe, inclusive, and respectful environment for students. Participants left the conference with ready-to-use group management tools, as well as an understanding of how to select and leverage games that support the physical, social, and emotional development of students.

### Accomplishments / Successes:

During FY19, with SHAPE America, SHAPE Utah also started planning the national conference, which would have been held in Salt Lake City in 2020. Due to the COVID-19 pandemic, this conference was canceled.

Action for Health Kids also worked with USBE Jennie Earl on a Utah State Board of Education Best Practice Recess Guidance for Local Education Agencies (https://www.schools.utah.gov/file/6c5c979f-803f-4f10-ad4a-7925a3d1348a). The intent of this document is to provide elementary schools with best practice guidelines for recess. The recommendations support the USBE's Safe and Healthy Schools goal in their strategic plan.

The USBE developed a model health and wellness policy for Local Education Agencies to follow when creating new policies. The model policy outlines the best approach to ensuring environments and opportunities for all students to practice lifelong healthy habits that promote physical, mental, and social health. There were 3 1/2 internal employees, and 1 1/2 Utah Department of Health employees who created language for the model policy. This policy will go before the State School Board in 2020.

### Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-08:

- Strengthened the relationship between the Utah Department of Health, Utah State Board of Education, and SHAPE Utah.
- Provided professional development opportunities for all PE teachers, PE specialists, Administrators, and elementary classroom teachers to attend.
- Partnered with Utah Department of Transportation to develop Safe Routes to School programs that increase students’ ability to walk and bike to school.
- Created a State Board of Education Health and Wellness Policy for Local Education Agencies to follow.
- 87% of physical education teachers or specialists received professional development on physical education or physical activity in the past year.
- 77.9% of schools provide the opportunity for students to be physically active at least 60 minutes during, before, and after school.

### Challenges / Gaps / Disparities:

PE teachers consistently have insufficient instructional resources and not enough opportunities to participate professional development.

Additionally, the State Board of Education does not require a certified PE specialist at the elementary level. If the

scope and sequence is not taught at the elementary level, it can be a challenge for secondary PE teachers. Also, students are only required to take 1.5 USBE credits of PE in grades 9-12.

**Agency Capacity / Collaboration:**

Action For Healthy Kids Utah creates healthier schools by bringing all the members of a school community together, and equipping them with the tools and resources they need to make change happen. This coalition includes members representing the State Board of Education, Utah Department of Health, Utah Parent Teacher Association, and other community partners. This past fiscal year we all supported the new Utah Health Standards and Recess Guidance.

**Summary Progress Report (2020) 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:**

We found that providing a CSPAP training during a professional development day was successful. Teachers are already committed or mandate 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. We will continue to promote components of CSPAP during the statewide Secondary Health and PE Conference, elementary Healthy Bodies, Healthy Minds Conference, and promoting the CDC e-learning opportunities.

**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:**

The focus of the Comprehensive School Health Program (CSPAP) will still continue as we move forward. The EPICC Program, USBE, and SHAPE Utah will continue to provide professional development opportunities to Local Education Agencies, schools, administrators, and teachers to implement components of CSPAP.

*NPM-08 has been dropped following the 2020 MCH Needs Assessment. As we move forward, we will not be reporting on this National Performance Measure. However, we will continue the work on increasing the percent of school aged students who are physically active for 60 minutes a day, as we move our focus to reducing the percentage of adolescents who are bullied on school property. We will create the school environment to that support proactive approaches to prevent bullying on playgrounds such as teaching empathy, creating an inclusive community, developing youth leaders, and encouraging positive attitudes.

**Adolescent Health Domain**

**SPM-04: Suicide:** ***The rate (per 100,000) of suicide deaths among youths aged 15–19***

**FY19 Annual Report**

**Program Activities:**

The Performance Measure was achieved. The Performance Objective was 21.5 and the Annual Indicator was 21.3.

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.

Applicable surveillance systems have been evaluated every year using the Updated Guidelines for Evaluating Public Health Surveillance Systems. The results of the yearly system evaluation are kept on file. Utah has seen an increase in the sensitivity of ICD-10 codes in suicides, homicides, and deaths of undetermined intent. This adds to the value of the Utah Violence Death Reporting System (UTVDRS) in providing counts that are more accurate for the manner of death. The VIPP epidemiologists meet monthly to review timeliness measures to ensure continuous program improvement. The sensitivity and predictive value positive of ICD-10 codes in determining the suicide manner of death was 98% and 100% in 2018 and 99% and 100% in 2019, respectively. In 2018, there were 813 UTVDRS cases. Of these, 98.65% had death certificate completion, 98.15% had ME completion, and 79.34% had LE completion. In 2019, there were 774 UTVDRS cases. Of these, 28.42% had death certificate completion, 28.17% had ME completion, and 10.85% had LE completion.

Suicides and the circumstances around suicide have been highly utilized by the Utah Suicide Prevention Coalition. Fact sheets are regularly updated and distributed to partners, the State Office of Education submitted legislative reports using UTVDRS data, the Suicide Fatality Review used data from UTVDRS to identify cases for review, and the state suicide plan is currently being updated using the most recent UTVDRS data. We partnered with several local mental health authorities to provide data for local suicide fatality reviews.

The Office of the Medical Examiner has a Suicide Prevention Research Coordinator. This person works closely with the doctors, and has been reviewing suicide cases, as well as conducting psychological autopsies on questionable cases, to help determine the manner of death. We have been able to work with this person as well to be able to gain access to suicide notes for abstraction of medical examiner cases. We will also be able to have access to any psychological autopsy reports or notes he generates for specific cases.

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 = 66) of all suicide related child fatalities statewide during the reporting period. Data from these reviews include recommendations, which 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) in 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/1nKp7kpGF7PpKF962fIDIUyQM6uiiIih9/view

This task force report was used to implement or continue some recommendations on youth suicide prevention. One of the recommendations was SafeUT, a statewide crisis and safety tip-line/app for youth that provides real-time crisis intervention through texting and a confidential tip program. This free mobile app provides students anonymous and confidential two-way communication with SafeUT crisis counselors or school staff. Licensed clinicians are available 24/7 in the CrisisLine call center to respond to all incoming chats, texts, and calls. These professionals provide supportive and crisis counseling, suicide prevention, and referral services. Gatekeeper training was

provided through QPR (Question, Persuade, Refer) and Mental Health First Aid which are courses intended to train “lay gatekeepers” or “lay mental health first responders” (e.g., parents, teachers, ministers, coaches, advisors, caseworkers) who are strategically positioned to recognize and refer someone at risk of suicide. QPR is the mental health analog of CPR, a rapid, effective approach to a crisis that could lead to potentially fatal self-harm. Mental Health First Aid is both more expansive and intensive, teaching how to identify, understand, and respond to signs of mental illnesses and substance use disorders.

Strategy 3: Identify and target surveillance data for policymakers, schools, local health departments, etc.

School Health Profiles provides a snapshot of health-related education, policies, and programs in Utah schools. The Centers for Disease Control and Prevention, in collaboration with the Utah Department of Health, developed a questionnaire and conducts a survey of secondary schools every other year. The profiles help state and local education and health agencies monitor and assess characteristics of school health programs. They include information on policies related to physical education, tobacco-use prevention, nutrition, asthma management, health services, and violence and injury prevention. Recommendations for violence and injury related efforts to suicide include efforts to align school policies with the best available evidence.

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 1) to 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.

Researchers at the Harvard T.H. Chan School of Public Health carried out a Utah Suicide Prevention and Gun Study. The study linked data from Utah’s Violent Death Reporting System to criminal background checks, concealed carry permit status, and hospital data to learn, in greater depth, about opportunities to prevent suicide overall and firearm suicide in particular. The study can be found here:
https://dsamh.utah.gov/pdf/suicide/Suicide%20and%20Firearm%20Injury%20in%20Utah%20-%20Final%20Report.pdf

Strategy 5: Produce and disseminate a yearly Youth Suicide Fact Sheet.

This fact sheet includes information showing the rates of suicide deaths for ages 10-17 and 18-24, by age and sex. The fact sheet also contained circumstance data to better understand circumstances around suicide, and provided information on warning signs, risk factors, protective factors, prevention tips, and resources. Further data on youth firearm suicides show that 91% of firearm suicides among youth under 18 occurred at home, most of the guns used in youth suicides belonged to the family (68%) or the youth (19%), rifles and shotguns accounted for 62% of rural youths’ firearm suicides, and Utah’s youth suicide rate is similar to its neighbors, but significantly higher than the nation’s. The 2018 Suicide Fact Sheet can be found 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 2,413 gunlocks to community members throughout Utah. Gunlocks can be obtained free of charge from any health department, mental health authority, 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 evidence based suicide prevention programs

included 98 community sessions with 2,527 reached.

As a result of data and evaluation efforts, the following implications for prevention have been determined, with parents/guardians having legal authority over nearly 9 out of 10 of the firearms used in suicides of youth under 18, parents are key to prevention; urging parents to lock their guns may not entirely address the youth firearm suicide issue if their teenagers know where the keys are, or indeed own a gun and control the keys, a more useful message may be to lock all guns and ensure children and teens don't have access to the keys or combination; when a youth is struggling with a mental health or substance abuse problem or life crisis, storing guns away from home may be prudent, parents may be unaware that youth can use long guns to take their lives; some parents who do lock their guns may be unaware their child can defeat the lock; and clinicians, gun owners, and others could work together to develop messaging and storage
options that are sensitive to local values and realities.

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 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. As a result of VIPP's request for epidemiological assistance from the Centers for Disease Control and Prevention in 2017, 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/1nKp7kpGF7PpKF962fIDIUyQM6uiiIih9/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.

The Youth Suicide Prevention Coordinator serves as the Utah Department of Health's Executive Director's designee on the SafeUT Commission. The SafeUT App, is a statewide resource that anyone, though particularly targeted to 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 receives thousands of tips/chats from Utah youth and is available throughout Utah.

**Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-04:**

- We collaborated with community partners in the planning, implementation, and evaluation of two Youth Mental Health Screening nights in a local health district for junior high and high school students and pre-kindergarten and elementary students, 145 youth and their families attended the events. The events were held to provide access to mental health screening for youth, to link them with appropriate service providers and treatment, and to serve as an early intervention for those in need. Screenings were provided at no cost. As a result of the event, twenty-one follow-up appointments were made and forty-three referrals were given. Every family was given a Youth Services Directory, which contains nearly 150 local services such as medical treatment, counseling, self-care, support groups, classes, crisis lines, etc.
- Suicide prevention activities were emphasized in local health department contracts. During the reporting period, LHDs provided several suicide prevention training sessions as part of their suicide prevention activities targeting children and their parents. These evidence based suicide prevention programs included 98 community sessions with 2,527 reached. Finally, LHDs distributed 2,413 gunlocks to residents in their communities.
- VIPP has focused on shared risk and protective factors to address many violence and injury prevention topics in the state. We have developed 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, encourage social norms that promote safety and health, improving access and utilization to physical and behavioral health care, enhance the physical environment to improve safe and healthy living, improve the socioeconomic conditions for Utahns, and promoting individual, family, and community connectedness.

As a result of this work, VIPP has continued to be 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, 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

  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/1nKp7kpGF7PpKF962fIDIUyQM6uiiIih9/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.

**Challenges / Gaps / Disparities:**

The adolescent disparity in suicide continues to be investigated to help understand contributing factors associated with the suicide mortality rate among youths. In 2018, VIPP again proposed to add questions the 2019 SHARP survey to measure sexual orientation and its association with suicide and other violence-related outcomes, which have been accepted by the school districts.

Over the last few years, suicide by firearm in youth have been increasing. The year 2018 saw the highest rate recorded for firearm suicide deaths (13.25 deaths per 100,000 youth ages 15-19). 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 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.

*SPM-04 has been dropped following the 2020 MCH Needs Assessment.

**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: a) Adolescent mortality rate, ages 10 through 19, per 100,000
b) Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
c) Adolescent suicide rate, ages 15 through 19, per 100,000

In Fiscal Year 2019, MotherToBaby Utah provided education to adolescents about medications used during pregnancy or breastfeeding to treat mental health conditions. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated mental health conditions in an effort to help women remain healthy and avoid complications that could result in adverse outcomes for women of childbearing age including adolescents.

Adolescent suicide rate, ages 15 through 19, per 100,00: The Social Emotional Learning and Askabale Adult toolkit is a new project out of the Family and Youth Outreach Program. Its goal is to increase the ability of parents and paraprofessionals to effectively support youth with disabilities by providing professional development and parent education training. This will introduce paraprofessionals and parents to skills that build social emotional learning skills, increase positive adult-teen communication, and strengthen relationships with young people. During FY 2020 the progress included receiving internal approvals for contracting with training developers and buying the training materials, coordinating an on-line training for paraprofessionals with the SEL toolkit developers, going to the Safe and Healthy schools conference to promote the project, coordinated and hosted the in-person TEEN Speak Training of Educators workshop with developer. Between February 2020 and March 2020, FYOP worked with the SEL Toolkit developer to create four videos that explain each toolkit section. These videos are now the self-paced SEL Training for school paraprofessionals (and other school personnel). After the COVID-19 restrictions started, the in-person trainings stopped (UDOH employees are not allowed to do in-state or out of State travel so far until September 2020). FYOP reached out to the TEEN Speak developer to find out about the possibility of doing the workshops virtually. By May 2020, the TEEN Speak guide to implement the workshops via ZOOM became available. Park City School District was the first one to implement TEEN Speak workshops virtually towards the end of May. FYOP encountered internal hurdles regarding the use of ZOOM, but is going through the process to receive approval to use it. FYOP worked with the Utah Department of Technology Services to create a website where the self-paced SEL Toolkit training is housed as well as TEEN Speak training calendar and material order form. The page fyo.utah.gov will go live in mid-June. After implementing the tools that the participants learned through training, they reported that they saw improvement in the youth with whom they work.

**MCH Block Grant FY21 Application & FY19 Report**

## Adolescent Health Domain

### NPM-09: Bullying: *Percent of adolescents, ages 12 through 17, who are bullied or who bully others*

**FY21 Annual Plan**

**Annual Plan:**

Our objective to decrease the percentage of Utah students in grades 8, 10, and 12 who report that they were bullied in the previous 12 months. This objective will be achieved through the utilization of several different approaches:

1. TEEN Speak is a communications program (total eight hours: including self-study and in-person presentation) that provides parents a menu of strategies they can use to improve communication with their youth;
2. The Upstanding Program, a bystander intervention program with the potential to make a positive difference in a bullying situation, particularly for the youth who is being bullied. The Upstanding Program teaches children simple strategies for standing up to bullying that effectively removes, rather than provides, more peer attention;
3. Physical activity options to increase the number of students who are active through a variety of options throughout the day;
4. The Wyman Teen Outreach Program (TOP) increases teens' ability to build positive connections with others through weekly peer group meetings and community service learning.

**Proposed Activities:**

- Provide a communications program to the parents of Utah adolescents
- Provide bystander training to school-aged children
- Provide physical activity opportunities to adolescents
- Provide the Wyman Teen Outreach Program to Utah adolescents

**New ESMs related to NPM-09***

*The following seven ESMs (9.1 – 9.7) are new for FY21. These ESMs were developed following the 2020 MCH Needs Assessment.

**ESM 9.1 – Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).**

**Goal/Objective**:

Implement the Teen Speak training with 500 Utah parents in 5 years.

**Significance of ESM 9.1:**

Teen Speak is a communications program that provides parents a menu of strategies they can use to improve communication with their youth. The program is 8 hours and includes self-study and an in-person presentation.

**ESM 9.2 – The number of adolescents who receive bystander training (Upstanding).**

**Goal/Objective**:

Increase the number of adolescents who have received the Upstanding curriculum.

**Significance of ESM 9.2:**

Bullying is the unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. Passive bystanders provide the audience a bully craves and the silent acceptance that allows bullies to continue their hurtful behavior. A bystander to bullying is anyone who witnesses bullying either in person or in digital forms like social media, websites, text messages, gaming, and apps. When bullying occurs, bystanders are present 80 percent of the time. A bystander has the potential to make a positive difference in a bullying situation, particularly for the youth who is being bullied. Studies show, when youth who are bullied are defended and supported by their

peers, they are less anxious and depressed. The Upstanding Program teaches children simple strategies for standing up to bullying that effectively removes, rather than provides, more peer attention.

**ESM 9.3 – Percent of adolescents who are physically active at least 60 minutes per day.**

**Goal/Objective**:

Increase the number of students who are active for at least 60 minutes a day, through a variety options, throughout the school day.

**Significance of ESM 9.3:**

Physical activity has brain health benefits for school-aged children, including improved cognition (e.g., academic performance, memory) and reduced symptoms of depression. Regular physical activity in childhood and adolescence can also be important for promoting lifelong health and well-being and preventing risk factors for various health conditions like heart disease, obesity, and type 2 diabetes.

**ESM 9.4 – The number of youth participating in the Wyman Teen Outreach Program (TOP).**

**Goal/Objective**:

Increase the opportunities for 400 youth to build positive connections with others through the Wyman Teen Outreach Program.

**Significance of ESM 9.4:**

The Wyman Teen Outreach Program (TOP) increases teens' ability to build positive connections with others through weekly peer group meetings and community service learning.

**ESM 9.5 – The proportion of Utah students participating in an evidence-based school based prevention program (PAX Good Behavior Game).**

**Goal/Objective**:

Increase the proportion of Utah students participating in an evidence-based school based prevention program to reduce referrals for fighting, bullying, and other forms of aggression.

**Significance of ESM 9.5:**

Multiple systematic reviews of various universal school-based programs demonstrate beneficial impacts on youths' skills and behaviors, including delinquency, aggression, bullying perpetration, victimization, and bystander skills that lower the likelihood of violence and support victims. For example, among students in pre-kindergarten through high school, the Task Force for Community Preventive Services found a 15% relative reduction in violent behavior. Using different outcome measures, the median relative reduction in aggression and violent behavior associated with universal school-based programs, varied by grade level, with a 32% reduction for pre-kindergarten and kindergarten students, 18% reduction for elementary students, 7% reduction for middle school students, and 29% reduction for high school students.

Researchers suggest the benefits of these school-based approaches could be strengthened if programs implemented at early grade levels are continued into the critical high school years. These programs were effective in reducing youth violence in different types of school environments, including ones with varying socioeconomic status, crime rates, or predominant race/ethnicity of students. Examples of effective classroom-based programs are Good Behavior Game (GBG), Promoting Alternative Thinking Strategies® (PATHS), Life Skills®, Training (LST), and Steps to Respect (STR). The GBG has demonstrated that participants had significantly lower levels of classroom aggression in elementary school, and some studies of the long-term effects of GBG showed significantly lower levels of aggression in middle school and lower prevalence of antisocial personality disorder and violent crime by age 19 to 21.These effects were for male youth with relatively higher levels of early aggression when compared to youth in alternative intervention conditions. These participants also had lower prevalence of alcohol abuse, smoking, and suicidal ideation by the time they reached young adulthood.

PAX improves classroom performance. Compared to their peers, students in PAX classrooms demonstrated higher test scores on Statewide Standardized Math and Reading, higher reading levels, reduced need for Special Education Services, and higher graduation and college entrance rates.

PAX has also been show to Improve mental health outcomes. Students in PAX classrooms demonstrated remarkably fewer problematic behaviors, reduced risk for mental, emotional, and behavioral disorders, fewer symptoms of depression, fewer school-related injuries and symptoms of aggression, reduced rates of bullying, and decreased suicide ideation and fewer attempts.

PAX is also associated with substance use prevention. Students in PAX classrooms demonstrated decreased tobacco use, reduced alcohol use, decreased illicit drug including opioid abuse, and less overall service use for drug abuse or psychiatric disorder.

The PAX Good Behavior Game adheres to SAMHSA's six key principles of a trauma-informed approach and model for a trauma-informed classroom. PAX creates a nurturing environment in every school and classroom, allowing young people to develop pro-social behaviors in a safe setting far from the predatory environments that encourage anti-social behavior. PAX provides teachers with proven and tested strategies shown to support development, preventing the re-traumatization of children who have been exposed to adversity and violence. PAX strategies allow students to co-create consistent expectations, and summon peer support in creating a nurturing classroom/school environment. The GBG has shown a $64.18 benefit for every $1 investment.

**ESM 9.6 – Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit.**

**Goal/Objective:**

Increase the percent of Utahns who qualify and file for the Earned Income Tax Credit from 75% to 83%.

**Significance of ESM 9.6:**

Bullying is associated with a number of community-level risks, such as concentrated poverty, residential instability, and density of alcohol outlets. Reducing exposure to these community-level risks can potentially yield population-level impacts on youth violence outcomes. Prevention approaches to reduce these risks include changing, enacting, or enforcing laws, city ordinances, and local regulations, and creating policies to improve household financial security, safe and affordable housing, and the social and economic sustainability of neighborhoods. Public-private partnerships and community-driven needs and services are important elements of these approaches. Strengthening household financial security through tax credits, such as the Earned Income Tax Credit (EITC), can help families increase their income while incentivizing work or offsetting the costs of child-rearing and help create home environments that promote healthy development. The evidence suggests that the EITC can lift families out of poverty. Simulations show that a Child Tax Credit of a $1000 allowance per child, paid to each household regardless of income or tax status, would reduce child poverty in the United States from 26.3% to 23.2%; a $2000 allowance per child would reduce child poverty to 20.4%; a $3000 allowance per child would reduce child poverty to 17.6%; and a $4000 allowance per child would reduce child poverty to 14.8%.

**ESM 9.7 – Number of Utahns who have been trained in Question, Persuade, Refer (QPR).**

**Goal/Objective:**

Increase the number of Utahns who have been trained in Question, Persuade, Refer (QPR).

**Significance of ESM 9.7:**

While the QPR intervention was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely applied as a universal intervention for anyone who may be experiencing emotional distress. It has been suggested by independent researchers and federal leadership that originally funded and conducted QPR studies, that the QPR intervention could be useful in a much broader application, and not just for the detection of persons at risk for suicide. When QPR is applied to distressed youth with informed compassion and understanding, the intervention becomes useful for the detection of a wide range of "troubled" behavior, e.g., non-suicidal self-injury (NSSI), perfectionism, eating disturbances, sleep problems, bullying, and other behavioral indices of youth who may be at risk, identified, and treated "upstream" of the onset of suicidal ideation.

**Adolescent Health Domain**

**SPM-03: Economic Stability:** ***Number of students enrolled in the free or reduced price lunch program***

**FY21 Annual Plan**

**Annual Plan:**

We will work with the State Board of Education Child Nutrition Program to help increase participation to ensure that the children in Utah have adequate access to safe and nutritious foods. Meeting this basic need is essential to establishing healthy eating patterns and development of a strong foundation for academic achievement. Child Nutrition Programs administer ten federal food programs and sub programs for school nutrition. These programs are appropriated under United States Department of Agriculture (USDA) and administered by Food and Nutrition Service (FNS). The federal food programs are primarily designed to ensure that Local Education Agencies (LEAs) to have the necessary knowledge and resources to enable them to provide children access to safe and healthy foods. The EPICC Program will work with the State Board of Education Child Nutrition Program to continue to support LEAs to strengthen the Local Wellness Policies by using the WellSAT 2.0 assessment tool.

**Proposed Activities:**

- Support and assistant Local Education Agencies to strengthen Local Wellness Policies by using the WellSAT 2.0. This will be aligned with the Child Nutrition Program Administration Review that is conducted on a five year cycle.
- Work with the Utah State Board of Education to provide professional development opportunities to LEAs, schools, food service, and teachers.
- Work with the State Board of Education, Local Health Departments, and community partners to promote and increase the number of school sites that participate in food programs and sub programs for school nutrition.

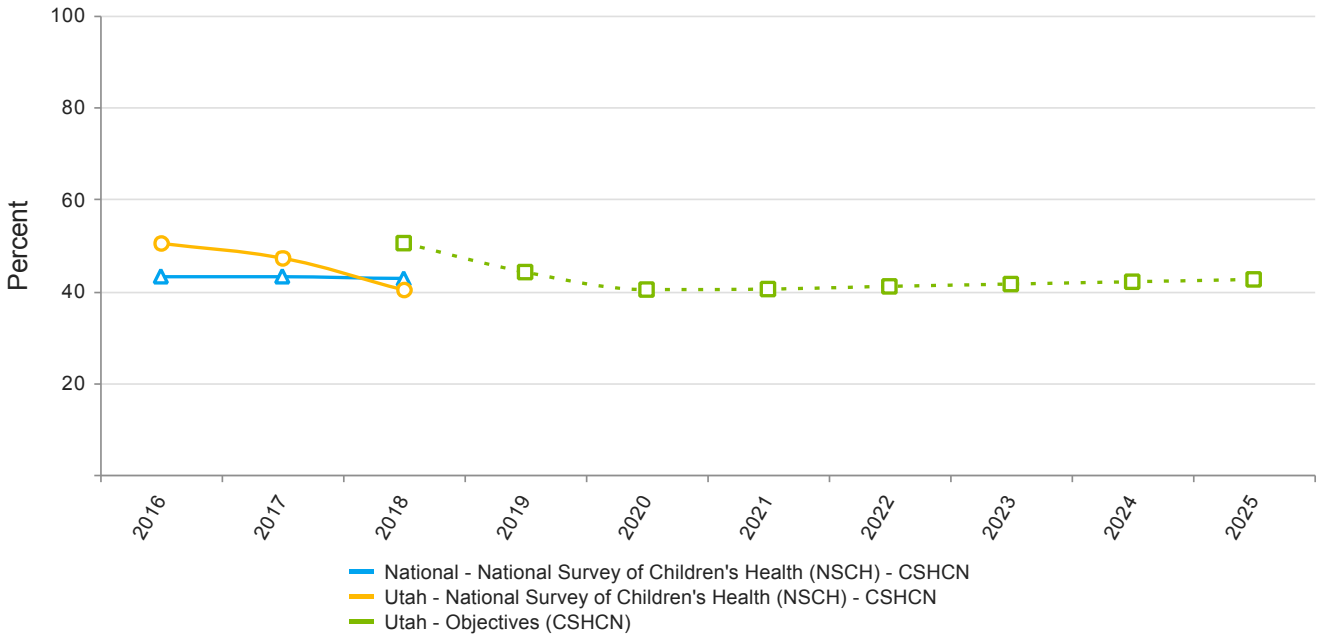
**Children with Special Health Care Needs**

**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-2017_2018 | 8.4 % | NPM 11<br>NPM 12 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2017_2018 | 40.1 % | NPM 11 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2017_2018 | 91.7 % | 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-2017_2018 | 3.7 % | 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** | **2019** |
| Annual Objective | | | 50.4 | 44.1 |
| Annual Indicator | | 50.4 | 47.2 | 40.2 |
| Numerator | | 75,090 | 68,219 | 59,263 |
| Denominator | | 148,990 | 144,415 | 147,327 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 40.3 | 40.4 | 41.0 | 41.5 | 42.0 | 42.5 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 11.1 - Percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN stakeholder workgroup survey |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Pre- and Post-training survey |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**ESM 11.3 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN EMR or comprehensive database |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**ESM 11.4 - Percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Survey/Scan of pediatric and family practice provi |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

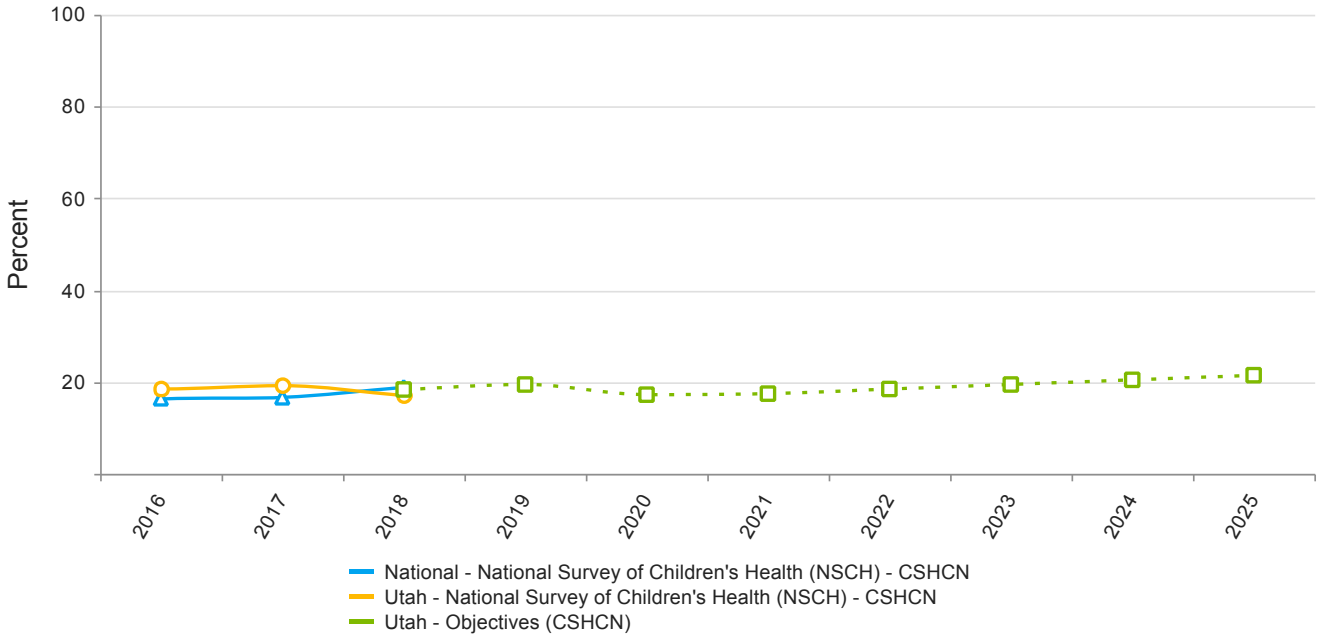
**ESM 11.5 - Percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Follow-up survey of providers who participated in |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**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** | **2019** |
| Annual Objective | | | 18.4 | 19.5 |
| Annual Indicator | | 18.4 | 19.3 | 17.1 |
| Numerator | | 11,791 | 12,760 | 13,378 |
| Denominator | | 64,109 | 66,028 | 78,194 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 17.3 | 17.5 | 18.5 | 19.5 | 20.5 | 21.5 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Stakeholder work group survey. |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Stake holder work group survey of transition-age y |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**ESM 12.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Stakeholder work group survey for transition train |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**State Action Plan Table**

State Action Plan Table (Utah) - Children with Special Health Care Needs - Entry 1

### Priority Need

Family and provider connectedness/Care coordination

### NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

### Objectives

By 2025, increase the percent of children with special health care needs who receive care within a medical home from 40.4% (NSCH, 2017-18) to 42.5%.

### Strategies

1. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah.
2. CSHCN Bureau create a stakeholder work group to organize and unify existing education materials to market importance of medical home (primary care, dental, behavioral/mental health).
3. Work group determine best practices and educate the public on importance of medical home.
4. Work group evaluate and select a database to track care coordination efforts.
5. Work group collaborate and determine collection methods to scan State on providers who utilize or desire to utilize telehealth, and assess best practices, barriers, and capacity.
6. Work group review and utilize Baby Watch Early Intervention Program tele-intervention cost study data to assess the benefits and challenges with utilizing virtual platforms for services.
7. Work group encourage providers to incorporate the seven components of a medical home after being trained through online learning modules or other educational media.

| ESMs | Status |
| --- | --- |
| ESM 11.1 - Percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home. | Active |
| ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home. | Active |
| ESM 11.3 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care. | Active |
| ESM 11.4 - Percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs. | Active |
| ESM 11.5 - Percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home. | 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

Transition to adulthood

### 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 2025, increase the percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care from 17.5% (NSCH, 2017-18) to 21.5%.

### Strategies

1. CSHCN Bureau to create a stakeholder work group to organize and unify existing educational materials and market on importance of transition to adulthood.

2. Determine best practices for educating the public, including medical and behavioral health providers, on the importance of transition to adulthood through a variety of traditional and on-line marketing, informational, and educational modules.

3. Work group to evaluate and select database to collect statewide data on transition efforts.

4. Survey families of transition-age youth who have been trained on the unified transition curriculum to assess skill development and progress toward reaching transition goals.

| ESMs | Status |
|---|---|
| ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood. | Active |
| ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan. | Active |
| ESM 12.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice. | 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

**2016-2020: National Performance Measures**

**2016-2020: State Performance Measures**

**2016-2020: 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** | **2019** |
| Annual Objective | | 3.3 | 1 | 2 |
| Annual Indicator | 1.9 | 0.8 | 1.6 | 0 |
| Numerator | 550 | 272 | 533 | 0 |
| Denominator | 28,704 | 35,870 | 34,275 | 35,988 |
| Data Source | CSHCN/UDAC Billing Data | CSHCN/UDAC Billing Data (2017) and Pop Est (2016) | ISP Utilization Data | ISP Utilization Data |
| Data Source Year | 2015 | 2016-17 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

## MCH Block Grant FY21 Application & FY19 Report

### CSHCN Domain

### NPM-11: Medical Home: *Percent of children with special health care needs having a medical home*

**FY19 Annual Report**

**Program Activities:**

The Performance Measure was not achieved. The Performance Objective was 44.1% and the Annual Indicator from the 2017-18 National Survey of Children's Health (combined data sets) was 40.2%.

In FY19, the Integrated Services Program (ISP) sponsored articles written by MCH Bureau staff in the Growing Times newsletter, a publication of the Utah Chapter of the American Academy of pediatrics to educate providers and families on topics related to the medical home. Article topics included components of a medical home, community resources, practice improvements, and partnership opportunities. The Utah MCH Bureau utilized social media such as Facebook and Twitter to send educational messages to families and providers about the importance of participating in a medical home. The ISP partially provided funding for the Medical Home Portal (Utah's shared resource) and collaborated with their staff and family representatives to review content and resources contained on that website. ISP also provided funding for the Utah Children's Care Coordination Network (UCCCN), which serves as a training, education, communication, and problem-solving forum for pediatric care coordinators around the state. The entire ISP team, including care coordinators from four local health districts, actively participated in the UCCCN monthly meetings and the ISP manager meets monthly to plan the educational agenda for upcoming meetings. The MCH Bureau collaborated with the University of Utah's Department of Pediatrics including the University Developmental Assessment Center (UDAC), and Utah Family Voices to encourage and promote care coordination within the medical home model. The MCH Bureau continued to collaborate with Early Childhood Utah, the Office of Home Visiting, The Early Childhood Comprehensive Systems grant, the Family to Family Health Information Center; The Employment Partnership work group, the Utah Oral Health Coalition, and the Utah Parent Center.

**Accomplishments / Successes:**

The MCH Bureau continued to collaborate with community partners to promote components of the Medical Home including care coordination. A major accomplishment in FY19 was establishing contracts with four local health departments for care coordinators in rural health districts where support and services for children with special health care needs may be sparse or non-existent. The care coordinators reside and work locally; hence, they know their community resources, local contacts, decision makers, social influencers, and the children and families they are charged to serve. Additional contracts were established to ensure that the Utah Children's Care Coordination Network was funded (ten monthly meetings and two educational learning sessions were held) to promote networking, peer connections, and resource sharing among pediatric care coordinators across the state. The Utah Medical Home Portal (Utah's shared resource) was partially funded to ensure resources, services, medical conditions, and best practices are vetted and published for families of children with special health care needs and providers who serve them. Ongoing funding continued for Utah Family Voices to partially cover their efforts to provide family-to-family support and specific help for families of children diagnosed with Autism Spectrum Disorder. The ISP team participated in multiple benefits fairs across the state through which they promoted the medical home concept and provided resource and referral, including the Medical Home Portal, for families desiring care coordination. The ISP team, including the local health department care coordinators, served over 800 CSHCN families and patients, with 2800 care coordination-related patient encounters across the state.

**Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-11:**

- Established contracts with four local health departments to hire care coordinators to provide coordination for CSHCN at a local level.
- MCH Bureau renewed the contract with the University of Utah to ensure continued funding for the Utah Children's Care Coordination Network (UCCCN).
- MCH Bureau renewed the contract to fund enhancements to the Medical Home Portal including adding content, adding and expanding local services listings, enhancing family ability to create and save lists of

resources, and adding partners.

- The Integrated Services Program, including local health departments, served over 800 unique CSHCN families with over 2800 care coordination encounters.

**Challenges / Gaps / Disparities:**

The term “medical home” continues to be a foreign concept for many families of children with special health care needs. The same concept often feels unattainable to providers who operate on a tight financial margin coupled with limited staff and time that is even more limited. Given that there is little financial incentive for a provider to invest in full medical home implementation, those who do pursue this challenge often do so for altruistic reasons. Local help exists to support the medical home such as (1) care coordination through the four rural health departments and Integrated Services Program staff, (2) the Medical Home Portal, which serves as an online support for the provider who may not have a large CSHCN population, and (3) the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) which partners with pediatric offices to promote evidence-based best practices, such as establishing a medical home. However, many pediatricians are unaware of these resources, and therefore, do not participate. Marketing to those offices can be difficult, as time, human resources, technology, and capital make finding the time to listen to or read marketing materials difficult at best. National Survey of Children’s Health data reflects lack of knowledge on the part of parents as to the very definition of a medical home. Often, they fail to fully comprehend the components of the medical home, and when surveyed, underrepresent the medical homeness of their primary care provider’s office. Finally, with no universal way to share data and information between the multidisciplinary providers who care for the same patient, because of disparate EMRs and databases, even loosely defined medical homeness at a care coordination level is difficult, and renders the “shared plan of care” practically impossible.

**Agency Capacity / Collaboration:**

The MCH and CSHCN Bureaus consistently seek to partner with other organizations such as those focused on physical or behavioral/mental health, social services, support and referral, and parent-led and peer to peer organizations. Many of these organizations work together on committees to improve the system of services and better serve families of children with special health care needs. The Medical Home Portal includes developmental and social support information written and drafted by parents of children with special health care needs. Both the Utah Parent Center and Utah Family Voices (F2F HIC) partner with parents to provide peer to peer support and develop curricula that supports both the Medical Home and transition. The MCH Bureau and CSHCN provide financial support for these organizations. The MCH Bureau houses both Early Childhood Utah and the Home Visiting Programs, both of which affiliate and collaborate with many of the same players. The Integrated Services Program (ISP) manager met weekly with the providers and staff at the University Developmental Assessment Center to provide guidance and support for the CSHCN they serve and accept referrals for care coordination within ISP.

**Summary Progress Report (2020) of ESMs related to NPM-11***

The following ESMs have been deactivated as we have completed the related activities.

**ESM 11.1 - UESC Family Survey: Number of responses to the Utah Enhanced Services for CSHCN (UESC) Family Survey**

**Goal/Objective:**

Increase number of children with medical home access by increasing responses to the Family Survey.

**Significance of ESM 11.1:**

Children with a medical home receive coordinated, comprehensive, and culturally competent care. Families that are unaware of the components of a medical home are not expecting or working together to achieve the components of a medical home.

**ESM 11.1 Progress Report:**

NPM-11 is a composite score of several questions. The survey attempts to determine family understanding of components of a medical home in order to provide education about expectations through the survey, and to determine needs that will guide outreach and training efforts. The Utah Enhanced Services for CSHCN (UESC) Family Survey was conducted in FY17 with 383 responses. Results indicated that many families with CSHCN do not

have access to a care coordinator and do not have a shared plan of care. The Integrated Services Program (ISP) and Utah Family Voices (UFV) provide care coordination services, and the ISP works with served families to develop a shared plan of care as needed. A second UESC Family Survey was completed in FY18 as part of the UESC/ Integrated Services grant. Social media methods and collaboration with partner agencies were used to distribute the survey to families to increase the number of responses. Families noted an increase in help in managing their child's care (care coordination), and involvement in decisions about their child's care, while noting a decrease in the need for referrals to community services. The 2016 survey resulted in 383 Family surveys started, and 276 Family surveys completed. The repeat of the survey, completed in August 2017, resulted in 530 completed Family surveys. The number of surveys completed increased from 2016 to 2017 by 38%. The goal of a 10% increase was met. The survey noted an increase from 60% in 2016 to 68% in 2017 for the item, "Families reported that someone from their provider's office helped to manage their child's care or treatment." The survey noted an increase from 82% in 2016 to 86% in 2017 for the item, "Families reported that they were definitely or somewhat involved in the decision about what was best for their child's health and treatment." The survey noted a decrease from 66% in 2016 to 55% in 2017 for the item, "Percentage of families that identified a need for a referral to community services."

**ESM 11.2 - UESC Practitioner Survey: Number of responses to the Utah Enhanced Services for CSHCN (UESC) Practitioner Survey**

**Goal/Objective:**

Increase number of children with medical home access by increasing responses to the Practitioner Survey.

**Significance of ESM 11.2:**

Children with a medical home receive coordinated, comprehensive, and culturally competent care. Providers that are unaware of the components of a medical home are not working together to provide the components of a medical home.

**ESM 11.2 Progress Report:**

NPM-11 is a composite score of several questions. The survey attempts to determine provider understanding of components of a medical home in order to provide education about the components through the survey, and to determine needs that will guide outreach and training efforts. The UESC Provider Survey was conducted in FY17 with 7 responses from the direct emailing to the advisory committee for the UESC/ Integrated Services grant. Results indicated perceived challenges in accessing and using services for CSHCN. The Shared Resource of the Medical Home Portal worked with partner states, ISP staff, and UFV staff to add Page 205 of 371 pages Created on 9/19/2018 at 4:48 PM additional listing categories for services, and worked to improve the search functionality of the services listed on the website. A second UESC Provider Survey was planned for FY18 as part of the UESC/ Integrated Services grant. Providers were asked, at advisory committee meetings, for input on improving the system of services including their agency plans, and suggested updates to the Integrated Services (medical home) State Plan. Responses indicated successes in adding content to the shared resource (Medical Home Portal), increased participation in training for care coordinators, and continued exploration of Shared Plans of Care (SPoC). The 2016 survey resulted in 7 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 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, and expanded exploration of platforms for a SPoC. With the end of the UESC grant, and moving the ISP to the MCH Bureau, discussions will need to explore the available of staff and resources to administer the survey again in light of the challenges of encouraging practitioners to respond to the survey.

**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's ISP and 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. 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. Data was reported on an ongoing basis through SurveyMonkey to the national Academy for State Health Policy as part of the UESC/ Integrated Services grant. The total percentage for FY17 was 67% (115/171).

During FY18, 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 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.

*All previous ESMs for NPM-11 have been discontinued. Following the 2020 MCH/CSHCN Needs Assessment five ESMs were developed for this measure and are listed in the Annual Plan section.

## CSHCN Domain

### NPM-12: Medical Home: *Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care*

**FY19 Annual Report**

**Program Activities:**

The Performance Measure was not achieved. The Performance Objective was 19.5% and the Annual Indicator from the 2017-18 (combined data set) National Survey of Children's health was 17.1%.

In FY19, the CSHCN Bureau continued to provide funding for the Utah Parent Center in support of the ongoing development and dissemination of training materials targeted at transition-age youth. The Integrated Services Program (ISP) staff attended several local and regional school district agency and transition fairs to promote coordination services and obtain referrals from families in need of assistance for their youth of transition age. Families of youth with special health care needs who were referred to ISP were provided with care coordination, which included tools and processes outlined in the Six Core Elements of Health Care Transition 2.0. Families were educated on Supplemental Security Income, Medicaid, ACA insurance provisions, and a list of adult providers who may be able to help facilitate the transition process. Statewide, families are encouraged to use the Medical Home Portal, Utah's shared resource, for additional supports, documents, and resources, and links targeting transition-age youth. ISP continued to fund the Utah Care Coordination Network (UCCCN) to further educate care coordinators around the state on topics related to general pediatrics, community resources, and transition services available. In FY19 the Integrated Services Program (ISP) sponsored articles written by MCH Bureau staff in the Growing Times newsletter, a publication of the Utah Chapter of the American Academy of pediatrics to educate providers and families on topics related to the Medical Home including transition.

**Accomplishments / Successes:**

The MCH and CSHCN Bureaus continued to work with partner organizations that serve youth and young adults in transition. These include the Employment Partnership (Utah Office of Rehabilitation), Child Mental Health (Utah Department of Human Services), the Utah Children's Care Coordination Network and the Medical Home Portal (University of Utah Department of Pediatrics), the Utah Parent Center, Utah Family Voices, the Utah State Board of Education, and the Coordinating Council for Persons with Disabilities. Collectively, these groups worked together on several committees that target activities and preparation for transition-age youth. The Medical Home Portal is a wealth of information for families seeking to understand and navigate the world of transition. The ISP team made direct contact with several families at the school districts agency and transition fairs, and were able to guide several families through some steps of transition. The Utah Parent Center provided ongoing workshops for interested families, and the staff of Utah Family Voices, several of whom have children of transition age, helped families navigate issues surrounding transition.

**Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-12:**

- Utah's Maternal and Child Health Bureau and the Bureau of Children with Special Health Care Needs collaborated with multiple medical, vocational, educational, and behavioral health organizations to address transition-related issues.
- The Medical Home Portal / Shared Resource was 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.
- Partner organizations provided direct transition training and referral for families of youth and young adults with special health care needs.
- The Integrated Services Program, including care coordinators at four local health departments, helped guide families of youth in transition through information dissemination, referral, and follow-up.

**Challenges / Gaps / Disparities:**

While vocational transition planning through the educational system remained relatively robust, transition to adult

health care continued to be challenging. The secondary education system, vocational rehabilitation, and other social services agencies coordinate post-secondary training, education, and employment plans well for youth with special health care needs. However, in that collaborative effort, the transition to adult medical care is often lacking. Limited funding, staff time, and technological limitations have been constantly a challenge for educating families on the preparation needed to successfully navigate transition. ISP care coordinators rely heavily on referral from community service organizations and medical providers, including pediatric and family practice offices, to find families who may be in need of transition assistance and coordination. Typically, referrals are made to the care coordinators for very young children and pre-adolescents, not youth of transition age. As the UESC (D-70) grant ended, subsequent family surveys about the medical transition process did not occur.

**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 (2020) of ESMs related to NPM-12***

**ESM 12.1 - UESC Family Survey: Number of responses to the Utah Enhanced Services for CYSHCN (UESC) Family Survey**

**Goal/Objective:**

Increase number of children with transition plans by increasing number of responses to the Family Survey.

**Significance of ESM 12.1:**

Children with a medical home are more likely to be aware of and have a written transition plan.

**ESM 12.1 Progress Report:**

National Performance Measure #12 is a composite score of several questions. The Survey attempts to determine family and understanding of components of a medical home in order to provide education about expectations through the survey and to determine needs that will guide outreach and training efforts. Children with a medical home are more likely to be aware of and have a written transition plan. The UESC Family Survey was conducted in FY17 with 383 responses. Results indicated that many families with CYSHCN do not have access to a care coordinator and do not have a shared plan of care. The Integrated Services Program (ISP) and Utah Family Voices provide care coordination services and the ISP works with served families to develop a shared plan of care as needed.

**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:**

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.

**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.

*All previous ESMs for NPM-12 have been discontinued. Following the 2020 MCH/CSHCN Needs Assessment, three new ESMs were developed for this measure and are listed in the Annual Plan section.

## CSHCN Domain

**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***

**FY19 Annual Report**

**Program Activities:**

SPM-02 was discontinued. The contract between the Utah Department of Health and the University of Utah, Developmental Assessment Center (UDAC), for the provision of clinical services to CSHCN around the state including rural and frontier areas, was not renewed for FY18. As such, SPM-02, as reported in the previous two years, will not continue into FY18. Given the relatively short notice of the current contractual arrangement, there has not been sufficient time to craft a new SPM for children with special health care needs. Work will continue in FY18 to develop an appropriate SPM that reflects public health models and changes in service delivery for CSHCN in rural areas of the state.

**Other activities in the Children With Special Health Care Needs 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 14: Percent of children with special health care needs (CSHCN), ages 0 through 17**

CHARM's 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 program's 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 as follows: 2015 – 99.6%; 2016 – 99.6%, 2017 – 99.7%, 2018 – 99.7%, 2019 –99.8%, and 2020 – 99.8%. CHARM continues to reach 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 2019, MotherToBaby Utah distributed 1,810 English CMV brochures and 804 Spanish CMV brochures to help prevent cytomegalovirus exposures and reduce the number of potential, future CSHCN.

**NOM 17: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

The mission of the Child Health Advanced Records Management (CHARM) is to provide public health data through an integrated, secure electronic system to health care providers to coordinate care and improve efficiencies and health outcomes of the children and families they serve. The 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 haven't been done, and subsequently, saves the family money and reduces health care costs. It also eliminates referring families for services they don't 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 9% (from 80-87 health care providers/users). This was achieved by adding more pediatric and ENT clinics. Also, during this grant year, the CHARM Program reached out to Medicaid and began working on a proposal to on-board Medicaid providers to use the CWI. The CHARM Program also collaborated with the Utah Statewide Immunization Information System (USIIS) program and successfully linked the Critical Congenital Heart Defect (CCHD) results to the USIIS system, this past grant year. Therefore, when health care providers are accessing immunization information in USIIS, they can now also obtain CCHD results. This is in addition to being able to obtain hearing screening results in the USIIS system, which CHARM added a few years ago. Adding these results to USIIS further supports CHARM's efforts to improve care coordination and treatment between CSHCN programs, families, and providers. As stated in NOM 13, the CHARM Program also 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 continued to assist these efforts to support special health care needs children, parents, and providers. 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 BTOTS system. 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 IFSP 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 in-take. The sharing of the BW/EI information continued to help 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. Lastly, CHARM developed a work plan to extract the WIC status and other WIC related information of children from Vital Records to send to the EHDI Program. CHARM will electronically add the WIC data to EHDI's HiTrack system. This will enable the EHDI program to coordinate care and follow-up on children in need of hearing screenings that are receiving WIC services.

**NOM 17.3: Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

The Child Health Advanced Records Management (CHARM) Program continued to collaborate with the Autism Program in the CSHCN Bureau to determine how CHARM can assist with getting autism screening alerts and the Modified Checklist for Autism in Toddlers (MCHAT) result to providers. The CHARM Program met with the USIIS Program to see if alerts could be sent from CHARM to the Utah Statewide Immunization Information System (USIIS), to remind a child's health care provider during well child visits to conduct the autism screenings at the appropriate ages. USIIS was supportive of this effort and it would be technically feasible. In addition, the CHARM Program worked with Help Me Grow to explore methods for integrating results from the Ages and Stages Questionnaire (ASQ) with other health information systems. ASQ developmental screening results could be shared from the Help Me Grow database through CHARM for health care providers to access in another information system. Sharing the ASQ results could help health care providers accurately identify young children who need further evaluation and determine if they are eligible for early intervention services. CHARM plans to continue to work on these types of integration projects to support developmental screenings and meet the health needs of children/families.

**NOM 17.4: Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

The Utah Registry of Autism and Developmental Disabilities (URADD) developed a prevalence estimate of Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD). Identification of ADD/ADHD was based on a community medical ADD/ADHD diagnosis (ICD-9: 314.00, 314.01 and ICD-10: F90.0, F90.1, F90.2, F90.8, F90.9).

**NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

In Fiscal Year 2019, MotherToBaby Utah provided education to children through age 17 about medications used during pregnancy or breastfeeding to treat mental health conditions. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated mental health conditions in an effort to help women remain healthy and avoid complications that could result in adverse outcomes for women of childbearing age including children through age 17.

## MCH Block Grant FY21 Application & FY19 Report

### CSHCN Domain

### NPM-11: Medical Home: *Percent of children with special health care needs having a medical home*

**FY21 Annual Plan**

**Annual Plan:**

The Bureau of Children with Special Health Care Needs (CSHCN) will provide funding support to internal and external partners to increase care coordination efforts throughout Utah. CSHCN will do the following, (1) form a stakeholder work group to organize and unite existing education materials to market to providers and families on importance of medical home; (2) determine best practices to educate the public on the importance of the medical home; (3) evaluate and select a database to track care coordination efforts for CSHCN; (4) collaborate and determine best method to scan State for status on providers who utilize or desire to utilize telehealth and will structure questions to discuss opportunities, capacity, and barriers to implementation; (5) review and evaluate Baby Watch Early Intervention Program tele-intervention cost study data to assess the benefits and challenges of utilizing virtual platforms for services; and (6) provide ongoing outreach and follow-up to encourage providers who have been trained to continue to incorporate the seven components of medical home.

**Proposed Activities:**

- The Bureau of Children with Special Health Care Needs will provide funding support to partners to increase care coordination throughout Utah.
- The Bureau of Children with Special Health Care Needs will create a stakeholder work group to address the promotion of the medical home.
- The CSHCN Medical Home work group will gather existing educational materials to educate, train, and support providers and families of children with special health care needs on importance of and implementation of a medical home.
- The CSHCN Medical Home work group will scan the state to evaluate the use of telehealth for providers serving children with special health care needs.

**New ESMs related to NPM-11***

*The following five ESMs (11.1 – 11.5) are new for FY21. These ESMs were developed following the 2020 MCH Needs Assessment.

**ESM 11.1 – Provider Education: Percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home.**

**Goal/Objective**:

Increase the percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home.

**Significance of ESM 11.1:**

The medical home model promotes high quality primary care that promotes coordination and partnership between the family, the patient, and health care and other service providers. The percent of providers who understand and promote the medical home concept is a marker of a well-functioning and coordinated system of care for CSHCN.

**ESM 11.2 – Family Knowledge: Percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home.**

**Goal/Objective**:

Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.

**Significance of ESM 11.2:**

Parents who understand the importance of the medical home may encourage their providers to incorporate the seven components of the medical home.

**ESM 11.3 – Care Coordination: Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.**

**Goal/Objective**:

Increase the percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.

**Significance of ESM 11.3:**

Emphasizing care coordination has also been recognized by Innovation Station through projects in Virginia and Oregon as emerging and promising practices. Similar components to their care coordination programs will be modeled by Utah in developing our programs.

**ESM 11.4 – Telehealth: Percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs.**

**Goal/Objective**:

Increase the percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs.

**Significance of ESM 11.4:**

Many families of CSHCN may lack access to primary and specialty services due to distance, reliable transportation, financial variables. Telehealth may bridge that gap.

**ESM 11.5 – Provider Training: Percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home.**

**Goal/Objective**:

Increase the percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home.

**Significance of ESM 11.5:**

Training and follow-up may encourage providers to implement a medical home model, or at least some of the components.

## CSHCN Domain

### NPM-12: Transition: *Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care*

**FY21 Annual Plan**

**Annual Plan:**

The Bureau of Children with Special Health Care Needs (CSHCN) will do the following, (1) convene a stakeholder work group to organize and unify existing education materials on transition to adulthood; (2) determine best practices for educating the public on the importance of medical transition to adulthood through a variety of traditional and on-line marketing, informational, and learning modules; (3) evaluate and select database to collect data on transition efforts; and (4) survey families of transition age youth to assess progress and for quality improvement. CSHCN will continue to fund a portion of the Medical Home Portal and the Utah Children's Care Coordination network in support of transition education and resource dissemination. CSHCN will continue to fund parent partners at Utah Family Voices, and the ongoing development of transition curriculum and educational modules at the Utah Parent Center. 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 Bureau of Children with Special Health Care Needs (CSHCN) will convene a stakeholder work group to evaluate, unify, and integrate existing educational materials dedicated to transition.
- CSHCN will evaluate and select a database to collect data on statewide transition efforts.
- CSHCN will continue to fund partner organizations such as the Medical Home Portal, UCCCN, Utah Parent Center, and Utah Family Voices.
- The Integrated Services Program will promote transition activities in-house and with care coordinators at the four local health departments.

**New ESMs related to NPM-12***

*The following three ESMs (12.1 – 12.3) are new for FY21. These ESMs were developed following the 2020 MCH Needs Assessment.

**ESM 12.1 – Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.**

**Goal/Objective**:

Increase the percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.

**Significance of ESM 12.1 – 12.3:**

Having a transition plan is critical for services to be seamlessly transferred to adult-serving providers. There is strong, recent evidence as summarized by the literature in Jones et al. (2017)[1] and Lemke et al. (2018)[2] that speak to the importance of sharing the plan with youth and families and for having a transition policy within a practice.

**ESM 12.2 – Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.**

**Goal/Objective**:

Increase the percent of adolescents and youth with special health care needs ages 12-18 who receive a transition

plan.

**ESM 12.3 – Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.**

**Goal/Objective**:

Increase the percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.

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[1] Jones, M. R., Robbins, B. W., Augustine, M., Doyle, J., Mack-Fogg, J., Jones, H., & White, P. H. (2017). Transfer from pediatric to adult endocrinology. Endocrine Practice, 23(7), 822– 830. https://doi.org/10.4158/EP171753.OR.
[2] Lemke, M., Kappel, R., McCarter, R., D'Angelo, L., & Tuchman, L. K. (2018). Perceptions of health care transition care coordination in patients with chronic illness. Pediatrics, 141(5). https://doi.org/10.1542/peds.2017-3168.

### 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 Process

Input from the general public and key stakeholders have always played an important part in the work coordinated by the Utah Department of Health (UDOH), Bureau of Maternal and Child Health (MCH). The information from the public, gathered through multiple collection strategies, is a valued part of the annual MCH Block Grant application process. During CY2019 and 2020, the 2020 MCH Needs Assessment activities required new means and strategies of collecting public input and alternative methods were designed. An important step for the 2020 Needs assessment was the MCH Bureau's collaboration with the University of Utah (UofU). The University was contracted to conduct various components of the Needs Assessment and they assisted in the process by conducting key informant interviews and focus groups. They also held stakeholder meetings to select health priorities, as well as assisting in the analysis of qualitative data obtained from the various surveys distributed by the MCH Bureau.

The methods began first with the comprehensive General Stakeholder Needs Assessment survey with key stakeholders. This survey was coordinated through the Utah MCH Bureau's Data Resources Program (DRP) with MCH/Children with Special Health Care Needs (CSHCN) Bureau staff. The survey instrument allowed participants to choose between five health domains they had interest in responding to and provide their input. Along with questions inquiring on general demographics of the participant, each domain listed possible domain specific issues and participants were able to select and prioritize their top seven issues. These issues were those that the recipient perceived as significant issues and barriers in their communities. The survey provided opportunity for participants to list an issue that was not addressed in the prepared list. Open-ended questions allowed respondents to identify needed services in their communities. The Needs Assessment survey was distributed online and made available in both English and Spanish. A link to the survey was posted on the UDOH website and also made accessible to public via Facebook in order to "boost" for increased visibility for potential participants. The MCH Bureau received 1,892 surveys from participants where specific issues were ranked in at least one of the health domains.

Second, the DRP worked with members of the CSHCN Bureau and Utah Family Voices to implement a statewide survey to parent and caregivers of children with special health care needs. The survey instrument questioned participants on topics such as; health insurance coverage, care coordination, transition, availability of care providers and services and challenges faced in obtaining care. The survey was distributed online and individuals identified as caregivers for special needs children, or youth up to age 21, were invited to participate by the CSHCN Bureau and Utah Family Voices. This survey was also made accessible to the public through the CSHCN Bureau website and the link was posted on Facebook for increased visibility. The DRP received 1,161 completed surveys for data analysis. Several infographics were developed by the DRP based on the results of these two major surveys.

# Needs Assessment
# STAKEHOLDER SURVEY 2019

## Overall Respondent Demographics

Total Responses: 1892
83% Non-Hispanic
83% Female

**Top 4 Participant Roles:**

- Healthcare Professional (38%)
- Parent/Guardian (19%)
- Local/State & Agency Staff (17%)
- Community-Based Organization or Community Health Center (6%)

84% Urban

16% Rural

## Response By Domain

Maternal Health 54%

Child Health 43%

Access to Care 36%

Infant Health 34%

Adolescent Health 32%

CSHCN 22%

## Maternal Health: Top 10 Ranked Issues

- Depression, anxiety, or other mental health issues
- Access to health care
- Not having health insurance
- Access to family planning services
- Domestic violence/partner abuse
- Parenting knowledge
- Drug use: illicit use during pregnancy or postpartum
- Not getting immunizations
- Environmental exposures
- Prenatal care

"Depression, anxiety, or other mental health issues" remained the number one issue from respondents across age, participant role and urban/rural demographics.

## Infant Health: Top 10 Ranked Issues

- Access to health care
- Infants not receiving immunizations
- Infant abuse and neglect
- Not having health insurance
- Developmental delays
- Environmental exposures
- Poor nutrition during infancy
- Breastfeeding: lack of initiation
- Breastfeeding exclusively at 6 months of age
- Neonatal abstinence/withdrawal

"Access to health care" was the number one issue for Community Members/Parents while "Infants not receiving immunizations" ranked first for Public Health Professionals.

Data source: 2019 Stakeholder Survey Results, MCH 2020 Needs Assessment. Data Resources Program
Utah Department of Health, N=1892

## Child Health: Top 10 Ranked Issues

- Depression or other mental health problems
- Abuse and neglect
- Parental involvement
- Immunizations
- Access to safe preschool or child care
- Bullying
- Dental care
- Overweight/Obesity
- Air quality
- After school supervision
- Optimal nutrition*

*Tied for rank at 10th

"Bullying" was the number one issue for Community Members/Parents while "Depression or other mental health problems" ranked first for Clinicians/PH Professionals.

## Adolescent Health: Top 10 Ranked Issues

- Depression or other mental health problems
- Suicide
- Bullying
- Sexual health education
- Drug use
- Social isolation
- Abuse and neglect
- Overweight/Obesity
- Alcohol use

"Depression, anxiety, or other mental health issues" remained the number one issue regardless of respondent's across age, participant role, race/ethnicity and urban/rural demographics.

## CSHCN: Top 10 Ranked Issues

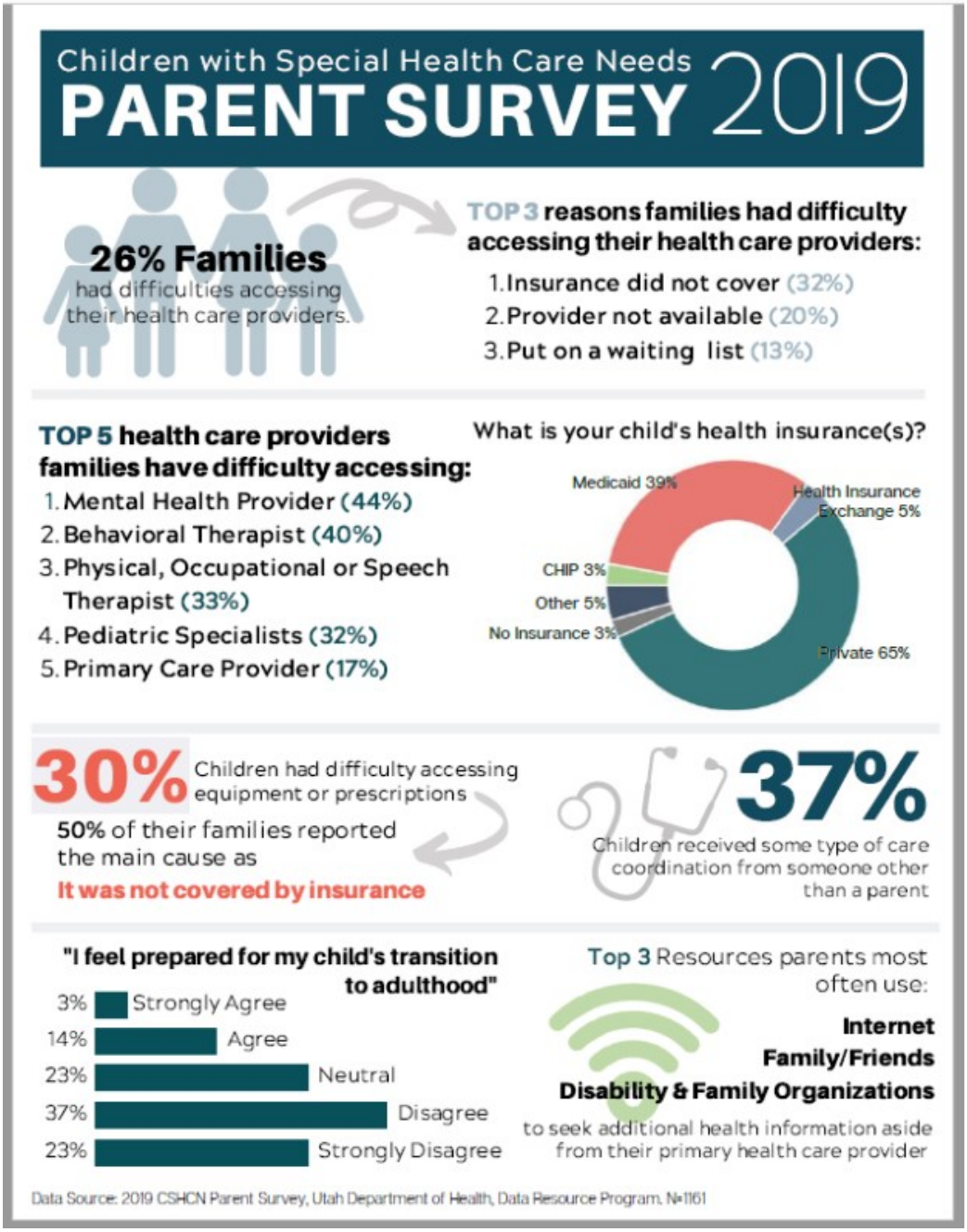
- Community resources and services
- Autism spectrum disorder
- Care coordination
- Early intervention services
- Health insurance
- Mental health
- Developmental screening
- Violence, abuse, or neglect
- Suicide
- Bullying

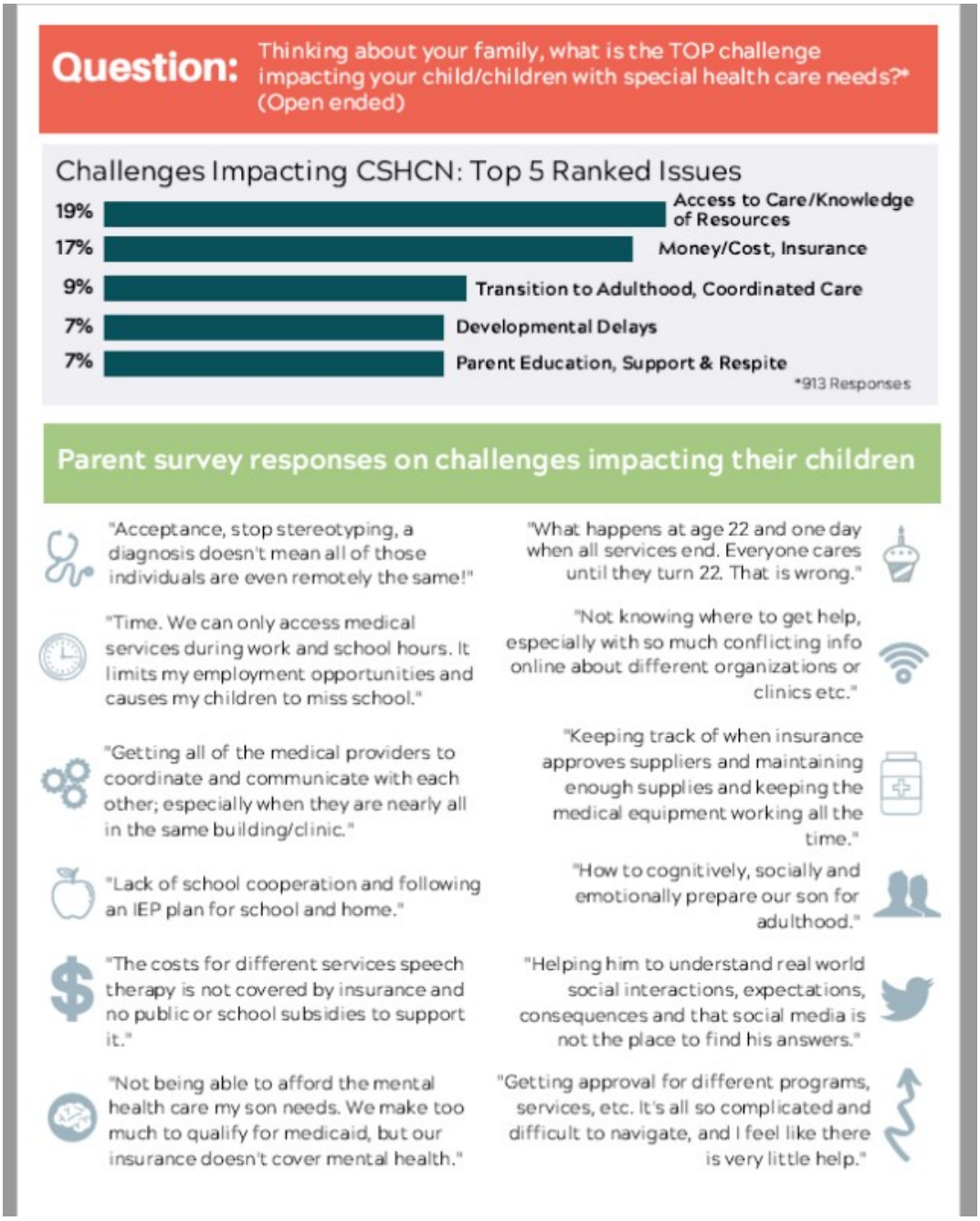
"Community resources and services" was the number one issue for respondents 25 years and over in age while "Oral/Dental health" was the number one issue for respondents under 25 years.

## Access to Care: Top 10 Ranked Issues

- High out of pocket expenses for health care
- Mental health services for adolescents
- Not having health care insurance
- Dental care
- Mental Health services for young children
- High insurance deductible
- Maternal mental health services
- Not having information about community resources
- Child care availability
- Rehabilitation treatment for drug and/or alcohol abuse

"High out of pocket expenses for health care" was the number one issue for respondents of non-Hispanic ethnicity while "Not having health care insurance" was number one for respondents who identified as Hispanic ethnicity.


Children with Special Health Care Needs
PARENT SURVEY 2019
26% Families
had difficulties accessing their health care providers.
TOP 3 reasons families had difficulty accessing their health care providers:
1. Insurance did not cover (32%)
2. Provider not available (20%)
3. Put on a waiting list (13%)
TOP 5 health care providers families have difficulty accessing:
1. Mental Health Provider (44%)
2. Behavioral Therapist (40%)
3. Physical, Occupational or Speech Therapist (33%)
4. Pediatric Specialists (32%)
5. Primary Care Provider (17%)
What is your child's health insurance(s)?
Medicaid 39%
Health Insurance Exchange 5%
CHIP 3%
Other 5%
No Insurance 3%
Private 65%
30% Children had difficulty accessing equipment or prescriptions
50% of their families reported the main cause as
It was not covered by insurance
37%
Children received some type of care coordination from someone other than a parent
"I feel prepared for my child's transition to adulthood"
3% Strongly Agree
14% Agree
23% Neutral
37% Disagree
23% Strongly Disagree
Top 3 Resources parents most often use:
Internet
Family/Friends
Disability & Family Organizations
to seek additional health information aside from their primary health care provider
Data Source: 2019 CSHCN Parent Survey, Utah Department of Health, Data Resource Program, N=1161




Third, key informant interviews were conducted across the state and involved professionals from various working sectors, such as; healthcare and health department personnel, community leaders, mental health professionals, community leaders and social services professionals. These guided interviews addressed questions on the professional's role in MCH, the needs and characteristics of the populations they served and recommendations for improving the services of MCH.

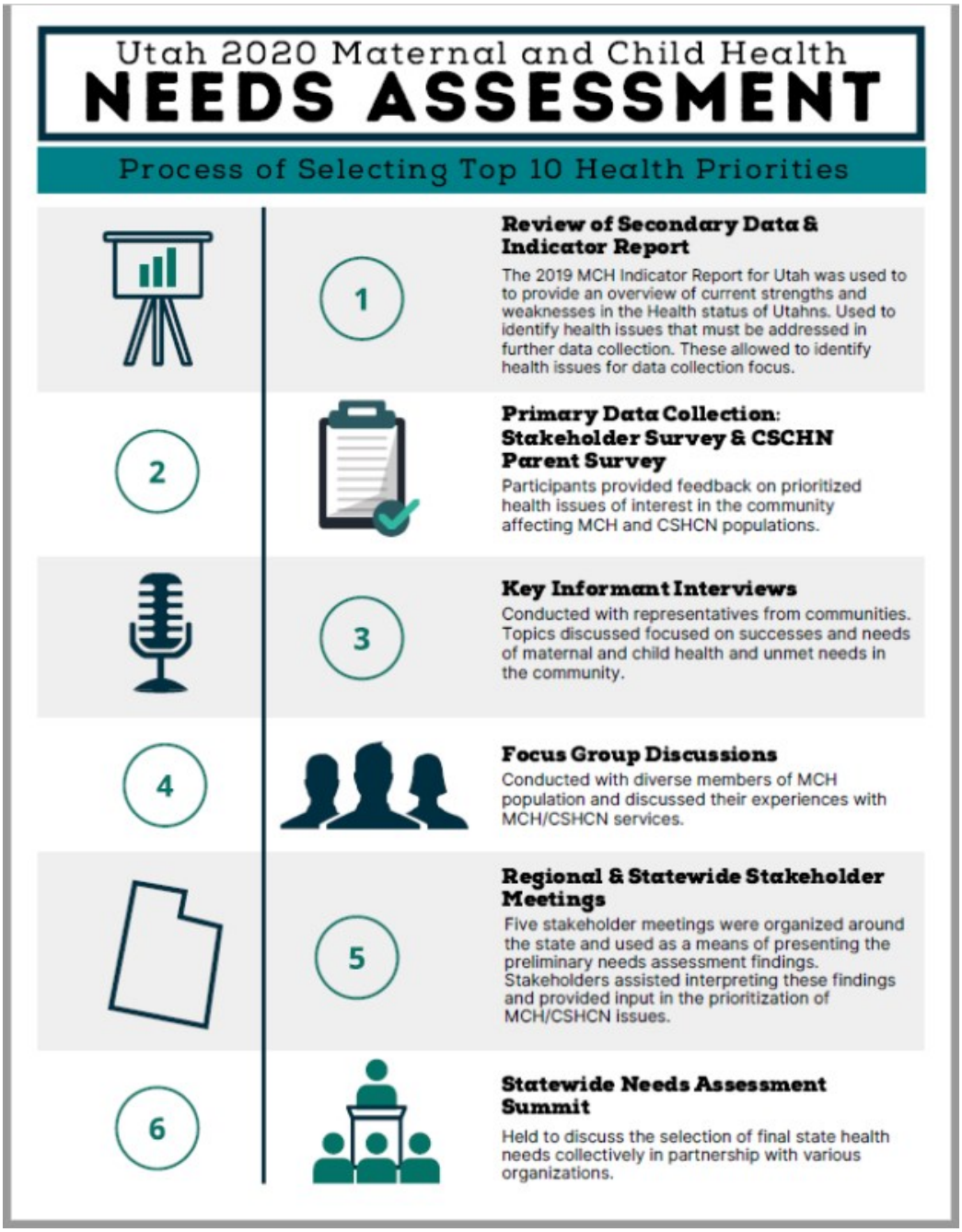
Fourth, focus groups organized by the UofU worked to obtain a more complete understanding of health needs and issues of MCH populations by targeting individuals and special groups. The majority of participants to these groups were members of the MCH population; mothers of young children, adolescents, parents of CSHCN. The groups involved open discussion on key topics such as MCH/CSHCN services, perceptions and opinions about MCH needs, MCH gaps and assets, and recommendations of improving services in the community. Using the notes from the focus groups, the UofU analyzed and synthesized information to assist in identifying and selecting priority health domains for the MCH populations.

Fifth, stakeholder meetings played an important role in the prioritization of health domains for the MCH Bureau. The UofU organized regional meetings around the state and offered virtual attendance through video conferencing and by phone. Preliminary results of the Needs Assessment were presented to those participation and participants were asked to engage in interpreting the findings. Responses from the stakeholder meetings were used to further prioritize health issues.

Finally, these stakeholder meetings led to a statewide summit meeting and findings from the surveys conducted for the Needs Assessment and information from focus groups were presented. The MCH Bureau domain leaders presented the recommendations they had on selecting state and national performance measures for the health domains. Summit participants were encouraged to consider five criteria as they considered which health priorities should be addressed by Title V: 1) data-driven, the need is supported by data, 2) feasibility/capacity – Title V 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. Those in attendance at the summit were polled in order to collect their input on these recommendation from the bureau and was used to inform on further selection of measures.

From the input gathered from these strategies, the MCH Bureau was able to select 10 of the top health performance measures that will be priority for the MCH over the next five years (FY21-FY25).

1. Perinatal mood and anxiety disorders
2. Access to care
3. Breastfeeding/poor infant nutrition
4. Developmental delays
5. Adolescent mental health
6. Family connectedness
7. Economic stability
8. Family and provider connectedness/Care coordination
9. Transition to adulthood
10. Oral health


Utah 2020 Maternal and Child Health
NEEDS ASSESSMENT
Process of Selecting Top 10 Health Priorities
1
Review of Secondary Data & Indicator Report
The 2019 MCH Indicator Report for Utah was used to to provide an overview of current strengths and weaknesses in the Health status of Utahns. Used to identify health issues that must be addressed in further data collection. These allowed to identify health issues for data collection focus.
2
Primary Data Collection: Stakeholder Survey & CSCHN Parent Survey
Participants provided feedback on prioritized health issues of interest in the community affecting MCH and CSHCN populations.
3
Key Informant Interviews
Conducted with representatives from communities. Topics discussed focused on successes and needs of maternal and child health and unmet needs in the community.
4
Focus Group Discussions
Conducted with diverse members of MCH population and discussed their experiences with MCH/CSHCN services.
5
Regional & Statewide Stakeholder Meetings
Five stakeholder meetings were organized around the state and used as a means of presenting the preliminary needs assessment findings. Stakeholders assisted interpreting these findings and provided input in the prioritization of MCH/CSHCN issues.
6
Statewide Needs Assessment Summit
Held to discuss the selection of final state health needs collectively in partnership with various organizations.

Maternal and Child Health & Children with Special Healthcare Needs

# PERFORMANCE MEASURES

## FINAL TOP 10 HEALTH PRIORITIES

1. Perinatal Mood & Anxiety Disorders
2. Access to Care
3. Breastfeeding
4. Developmental Delays
5. Economic Stability
6. Family Connectedness
7. Dental Care
8. Mental Health
9. Family & Provider Connectedness/Care Coordination
10. Transition

## STATE & NATIONAL PERFORMANCE MEASURES

**NPM 1** Maternal

**Well-Woman Visit**

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

**SPM 1** Maternal

**Perinatal Mood & Anxiety Disorders**

Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care.

**NPM 4** Infant

**Breastfeeding**

A: Percent of infant who are breastfed.
B: Percent of infants' breastfed exclusively through 6 months.

**NPM 11** CSHCN

**Medical Home**

Percent of children with and without special health care needs, ages 0-17, who have a medical home

**NPM 12** CSHCN

**Transition to Adulthood**

Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.

**NPM 6** Child

**Developmental Delays**

Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year.

**NPM 13** Child

**Oral Health**

Percent of children, ages 1-17, who had a preventive dental visit in the past year

**SPM 2** Child

**Family Connectedness**

Percent of days that all family members in the household eat together in one week.

**NPM 9** Adolescent

**Bullying**

Percent of adolescents, ages 12-17, who are bullied or who bully others.

**SPM 3** Adolescent

**School Lunch**

Number of students enrolled in the free or reduced price lunch program.

### III.G. Technical Assistance

During the 2020 MCH Needs Assessment (NA) process, the MCH and CSHCN Bureaus received technical assistance (TA) from the MCH Evidence Center. This TA was provided to help UDOH staff acquire knowledge and skills to develop, implement, improve, and evaluate Evidence-based/informed Strategy Measures (ESMs). From January 10-13, 2020, the TA team outlined methods on how to develop meaningful ESMs that are measurable and activities based on published evidence. Training was hands on and interactive, involving exercises such as determining possible measures and identifying available resources. Additionally, guidance available on the MCH Evidence website was also shared, providing attendees resources for easily identifying evidence, practices, and sample ESMs for all fifteen NPMs.

## 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 - AppendixA.pdf

Supporting Document #02 - AppendixB.pdf

Supporting Document #03 - AppendixC.pdf

Supporting Document #04 - AppendixD.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FHP Org Chart 4.13.20.pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: Utah**

| | FY 21 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 6,561,290 | |
| A. Preventive and Primary Care for Children | $ 3,404,127 | (51.8%) |
| B. Children with Special Health Care Needs | $ 2,153,220 | (32.8%) |
| C. Title V Administrative Costs | $ 621,400 | (9.5%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 6,178,747 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 14,630,450 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 16,023,900 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 1,103,500 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 31,757,850 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 3,897,700 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 38,319,140 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 50,430,575 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 88,749,715 | |

| OTHER FEDERAL FUNDS | FY 21 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program | $ 446,500 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 621,800 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities | $ 186,600 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 166,700 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees | $ 374,700 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 325,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 220,000 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP) | $ 262,600 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC) | $ 38,378,729 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 5,697,746 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration | $ 426,600 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 3,223,600 |

| | FY 19 Annual Report Budgeted | | FY 19 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 7,374,954 | | $ 6,160,252 | |
| A. Preventive and Primary Care for Children | $ 3,496,346 | (47.4%) | $ 2,757,934 | (44.7%) |
| B. Children with Special Health Care Needs | $ 2,655,223 | (36%) | $ 2,288,568 | (37.1%) |
| C. Title V Administrative Costs | $ 654,700 | (8.9%) | $ 604,602 | (9.9%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 6,806,269 | | $ 5,651,104 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 18,296,900 | | $ 15,490,482 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 2,429,500 | | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 12,442,100 | | $ 15,200,399 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 5,173,800 | | $ 947,208 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 38,342,300 | | $ 31,638,089 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 3,897,700 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 45,717,254 | | $ 37,798,341 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 57,415,800 | | $ 44,894,510 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 103,133,054 | | $ 82,692,851 | |

| OTHER FEDERAL FUNDS | FY 19 Annual Report Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program | $ 628,800 | $ 426,962 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 550,000 | $ 659,512 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 132,000 | $ 203,524 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities | $ 50,000 | $ 226,831 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration | $ 420,200 | $ 329,227 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 97,300 | $ 95,563 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 223,000 | $ 255,985 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants | $ 1,250,100 | $ 2,724,888 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 142,500 | $ 137,916 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC) | $ 47,165,000 | $ 34,001,819 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP) | $ 194,000 | $ 195,344 |
| US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA) | $ 6,562,900 | $ 5,636,939 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1. FEDERAL ALLOCATION** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>Includes Award for 10/01/2020-09/30/2022 with anticipated expenditure in first year and anticipated federal amount remaining in budget 10/01/2019 - 09/30/201 to be spent in second year | |
| 2. | **Field Name:** | **4. LOCAL MCH FUNDS** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>Local Health Departments were provided quarterly fixed price payments with reconciliation to actual expenditures reported and did not fully expend contract amount. No Local MCH funds reported. | |
| 3. | **Field Name:** | **5. OTHER FUNDS** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>Including revenue agreements from private non profits as other funds that have historically been reported as program income. | |
| 4. | **Field Name:** | **6. PROGRAM INCOME** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>Adjusted revenue agreements and revenue transfers to the other funds categories that had been historically reported as program income. Program income now includes:<br>Parent Fees, CSHCN Insurance Billings, Kit Fee Revenue, and Pregnancy Risk Line Collections. | |
| 5. | **Field Name:** | **1.FEDERAL ALLOCATION** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |

| | | |
|---|---|---|
| | **Field Note:**<br>Budgeted amount included estimated unexpended from year 2 of FFY 2018.<br>Actual Expended only includes amount reported in FFY 2019 grant award | |
| 6. | **Field Name:** | **Federal Allocation, A. Preventive and Primary Care for Children:** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Budgeted amount included estimated unexpended from year 2 of FFY 2018.<br>Actual Expended only includes amount reported in FFY 2019 grant award | |
| 7. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Budgeted amount included estimated unexpended from year 2 of FFY 2018.<br>Actual Expended only includes amount reported in FFY 2019 grant award.<br><br>Increased expenditure in Children with Special Health Care Needs due to transition of CSHCN clinics from University to Health Department while setting up provider agreements with private insurance and billing fee for service. | |
| 8. | **Field Name:** | **3. STATE MCH FUNDS** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Reduction in budgeted to actual as state general funds were used as matching funds for Medicaid Seed for Baby Watch Early Intervention program. | |
| 9. | **Field Name:** | **4. LOCAL MCH FUNDS** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Due to COVID-19, Local Health Departments are redirecting Local Funds to the Coronavirus response. We do not anticipate any additional funds being allocated to MCH Block grant at this time. | |
| 10. | **Field Name:** | **5. OTHER FUNDS** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |

| | | |
|---|---|---|
| | **Field Note:**<br>Including revenue agreements from private non profits as other funds that have historically been reported as program income.<br><br>Continual reduction of WIC Food Rebates due to participation decline. | |
| 11. | **Field Name:** | **6. PROGRAM INCOME** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Adjusted revenue agreements and revenue transfers to the other funds categories that had been historically reported as program income. Program income now includes:<br>Parent Fees, CSHCN Insurance Billings, Kit Fee Revenue, and Pregnancy Risk Line Collections. | |

**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 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 347,443 | $ 381,819 |
| 2. Infants < 1 year | $ 307,610 | $ 312,222 |
| 3. Children 1 through 21 Years | $ 3,096,517 | $ 2,445,711 |
| 4. CSHCN | $ 2,153,220 | $ 2,288,568 |
| 5. All Others | $ 35,100 | $ 127,330 |
| Federal Total of Individuals Served | $ 5,939,890 | $ 5,555,650 |

| IB. Non-Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 3,956,162 | $ 3,380,609 |
| 2. Infants < 1 year | $ 3,569,655 | $ 3,224,119 |
| 3. Children 1 through 21 Years | $ 9,138,683 | $ 9,994,617 |
| 4. CSHCN | $ 14,655,600 | $ 14,284,520 |
| 5. All Others | $ 437,750 | $ 754,224 |
| Non-Federal Total of Individuals Served | $ 31,757,850 | $ 31,638,089 |
| Federal State MCH Block Grant Partnership Total | $ 37,697,740 | $ 37,193,739 |

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **IA. Federal MCH Block Grant, 2. Infant < 1 Year** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>1. Infants included in Preventative and Primary Care Form 2<br><br>2. The State continues to make budget reductions and modifications as existing MCH Block Grant annual expense obligations are currently approximately $500,000 in excess of the annual award. To date, reductions taken have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, as well as a reduction of Utah Women Newborn Quality Collaborative activities. Beginning in FFY 2021 - the Pregnancy Risk Line Program was reduced by $110,000 in contractual costs with the University of Utah. | |
| 2. | **Field Name:** | **IA. Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>Included in Preventative and Primary Care Form 2 | |
| 3. | **Field Name:** | **IA. Federal MCH Block Grant, 5. All Others** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:**<br>The State continues to make budget reductions and modifications as existing MCH Block Grant annual expense obligations are currently approximately $500,000 in excess of the annual award. To date, reductions taken have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, as well as a reduction of Utah Women Newborn Quality Collaborative activities. Beginning in FFY 2021 - the Pregnancy Risk Line Program was reduced by $110,000 in contractual costs with the University of Utah. | |
| 4. | **Field Name:** | **IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2021** |
| | **Column Name:** | **Application Budgeted** |

| | | |
|---|---|---|
| | **Field Note:**<br>Private Revenue Agreements received for Early Childhood Utah activities specifically relating to resource, referral, and Utah ECIDS Development previously reported under All Others, adjusted reporting in budget and actual to Children 1-31 | |
| 5. | **Field Name:** | **IA. Federal MCH Block Grant, 2. Infant < 1 Year** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Infants included in Preventative and Primary Care Form 2<br><br>The State continues to make budget reductions and modifications as existing MCH Block Grant annual expense obligations are currently approximately $500,000 in excess of the annual award. To date, reductions taken have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, as well as a reduction of Utah Women Newborn Quality Collaborative activities. Beginning in FFY 2021 - the Pregnancy Risk Line Program was reduced by $110,000 in contractual costs with the University of Utah. | |
| 6. | **Field Name:** | **IA. Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Included in Preventative and Primary Care Form 2 | |
| 7. | **Field Name:** | **IA. Federal MCH Block Grant, 5. All Others** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>The State continues to make budget reductions and modifications as existing MCH Block Grant annual expense obligations are currently approximately $500,000 in excess of the annual award. To date, reductions taken have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, as well as a reduction of Utah Women Newborn Quality Collaborative activities. Beginning in FFY 2021 - the Pregnancy Risk Line Program was reduced by $110,000 in contractual costs with the University of Utah. | |
| 8. | **Field Name:** | **IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Private Revenue Agreements received for Early Childhood Utah activities specifically relating to resource, referral, and Utah ECIDS Development previously reported under All Others, adjusted reporting in budget and actual to Children 1-31 | |

**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 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 1,273,200 | $ 1,249,617 |
| 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 | $ 0 | $ 0 |
| C. Services for CSHCN | $ 1,273,200 | $ 1,249,617 |
| 2. Enabling Services | $ 2,868,590 | $ 2,980,411 |
| 3. Public Health Services and Systems | $ 2,419,500 | $ 1,930,224 |
| 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 | | $ 1,249,617 |
| 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 | | $ 1,249,617 |
| **Federal Total** | $ 6,561,290 | $ 6,160,252 |

| IIB. Non-Federal MCH Block Grant | FY 21 Application Budgeted | FY 19 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 529,800 | $ 252,706 |
| 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 | $ 0 | $ 0 |
| C. Services for CSHCN | $ 529,800 | $ 252,706 |
| 2. Enabling Services | $ 29,809,700 | $ 29,835,115 |
| 3. Public Health Services and Systems | $ 1,418,350 | $ 1,550,268 |
| 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 | | $ 252,706 |
| 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 | | $ 252,706 |
| **Non-Federal Total** | $ 31,757,850 | $ 31,638,089 |

**Form Notes for Form 3b:**

Enabling Services – Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Services Block Grant funds are used to finance these services. Enabling services for Utah include, but are not limited to the following program expenditures: Bureau of Health Promotion Physical Activity, Violence and Injury Prevention, Community Injury, Baby Your Baby Information and referral resource, Family Youth Outreach including Pregnancy Risk Line, Early Hearing Detection, Birth Defects, and other CSHCN case coordination and case management.

Public Health Services and Systems – Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Public Health Services and Systems for Utah include: Early Childhood Utah development, Utah Health Indian Advisory, Health Disparities, Local Health Department coordination, Utah Womens Quality Collaborative, Perinatal Review.

**Field Level Notes for Form 3b:**

None

## Form 4
## Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

**State: Utah**

**Total Births by Occurrence: 48,218** **Data Source Year: 2018**

**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 | 47,172 (97.8%) | 936 | 63 | 63 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| Argininosuccinic Aciduria | Biotinidase Deficiency | Carnitine Uptake Defect/Carnitine Transport Defect | Classic Galactosemia | Classic Phenylketonuria |
| Congenital Adrenal Hyperplasia | Cystic Fibrosis | Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency | Medium-Chain Acyl-Coa Dehydrogenase Deficiency | Methylmalonic Acidemia (Methylmalonyl-Coa Mutase) |
| Primary Congenital Hypothyroidism | S,C Disease | | | |

**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 |
|---|---|---|---|---|
| Critical Congenital Heart Disease (CCHD) | 46,689 (96.8%) | 79 | 4 | 4 (100.0%) |
| Newborn Hearing | 47,769 (99.1%) | 559 | 87 | 85 (97.7%) |

### 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 for PKU | 1,332 | 127 | 127 | 127 |

### 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:** | **Total Births by Occurrence** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total Births by Occurrence Notes** |
| | **Field Note:** Data retrieved from the Information-Based Indicator System (IBIS): https://ibis.health.utah.gov | |
| 2. | **Field Name:** | **Newborn Hearing - Referred For Treatment** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** 2 cases not referred to early intervention; 1 lives out of state and one child was not referred due to a parental demise. | |

**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 2019**

### 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 | 9,293 | 68.2 | 0.0 | 14.1 | 4.0 | 13.7 |
| 2. Infants < 1 Year of Age | 18,088 | 81.9 | 0.2 | 3.4 | 0.7 | 13.8 |
| 3. Children 1 through 21 Years of Age | 40,818 | 38.9 | 0.6 | 17.1 | 10.9 | 32.5 |
| 3a. Children with Special Health Care Needs | 7,492 | 43.8 | 0.0 | 56.2 | 0.0 | 0.0 |
| 4. Others | 4,458 | 37.5 | 2.0 | 11.1 | 44.0 | 5.4 |
| Total | 72,657 | | | | | |

### 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 | 47,209 | Yes | 47,209 | 98 | 46,265 | 9,293 |
| 2. Infants < 1 Year of Age | 48,209 | Yes | 48,209 | 100 | 48,209 | 18,088 |
| 3. Children 1 through 21 Years of Age | 1,074,433 | Yes | 1,074,433 | 18 | 193,398 | 40,818 |
| 3a. Children with Special Health Care Needs | 184,802 | Yes | 184,802 | 40 | 73,921 | 7,492 |
| 4. Others | 2,036,512 | Yes | 2,036,512 | 1 | 20,365 | 4,458 |

**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:**<br>Pregnant women number derived from the following sources:<br>- 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=2906)<br>- HRC 1-800 Call Non-Eligibility Calls (Pregnant Women, Others), FY 19 phone calls to Immunizations, CHIP (n=3464)<br>- OHP Direct Oral Health screenings (n=11)<br>- MCH Service Report (n=2912) | |
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:**<br>Infants number derived from the following sources:<br>- MCH Service Report (n=10603)<br>- Hearing Screening by the EHDI Team (n=98)<br>- ASQ Screenings (n=5637)<br>- PRL calls regarding breastfeeding infants under age 1 (n=1750) | |
| 3. | **Field Name:** | **Children 1 through 21 Years of Age** |
| | **Fiscal Year:** | **2019** |
| | **Field Note:**<br>Children 1 through 21 years number derived from the following sources:<br>- 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=212)<br>- HRC 1-800 Calls (n=4899)<br>- OHP Direct oral health screenings (n=1641)<br>- ASQ Screenings (n=11458)<br>- MCH Service Report (n=15116)<br>- OHP CSHCN Direct oral health screenings (n=252)<br>- ISP Rural Pediatric Orthopedics (U of U/PCMC), unique children seen through rural U of U peds ortho clinics (n=231)<br>- CSHCN Case Management (Utah Family Voices), Un-duplicated counts of intakes (n=1024)<br>- CSHCN Case Management/care coordination (ISP), (n=746)<br>- CSHCN Translation, F/U notes, CMV Records, Family Support (n=5187)<br>- CSHCN Autism Referral, Scheduling, monitoring, referral, coordination (n=17)<br>- CSHCN Autism Explanation of benefits, referral and assistance (n=35) | |
| 4. | **Field Name:** | **Children with Special Health Care Needs** |

| | | |
|---|---|---|
| | **Fiscal Year:** | **2019** |

**Field Note:**
- OHP CSHCN Direct oral health screenings (n=252)
- ISP Rural Pediatric Orthopedics (U of U/PCMC), unique children seen through rural U of U peds ortho clinics (n=231)
- CSHCN Case Management (Utah Family Voices), Un-duplicated counts of intakes (n=1024)
- CSHCN Case Management/care coordination (ISP), (n=746)
- CSHCN Translation, F/U notes, CMV Records, Family Support (n=5187)
- CSHCN Autism Referral, Scheduling, monitoring, referral, coordination (n=17)
- CSHCN Autism Explanation of benefits, referral and assistance (n=35)

| | | |
|---|---|---|
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
"Others" number derived from the following sources:
- OHP Direct oral health screenings (n=1630)
- MCH Service Report (n=811)
- 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=1997)
- PRL Safe haven calls (n=20)

| | | |
|---|---|---|
| 6. | **Field Name:** | **Total_TotalServed** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
Primary Source of Coverage determined by LHD MCH Service Report.

**Field Level Notes for Form 5b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
In addition to numbers served from form 5a:
- MIHP PMR (# of cases viewed) (PW) (n=23)
- MIHP PRAMS (# of women who get survey (n=2321)
- MIHP SOARS (# of women who get survey (n=277)
- MIHP Safety bundle hospital (n=43689)
- OHP outreach education (n=47)

46357/47209 = 98.2% served

| | | |
|---|---|---|
| 2. | **Field Name:** | **InfantsLess Than One Year** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
In addition to numbers served from form 5a:
- MIHP Number of infant cases reviewed in PMR (n=48)
- MIHP Births in participating Stepping Up hospitals (n=34190)
- Hearing screening, number of infants screened (n=46994)
- CCHD screening - Children screened in hospitals (n=46689)

48209/48209 = 100% served

| | | |
|---|---|---|
| 3. | **Field Name:** | **Children 1 Through 21 Years of Age** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
In addition to numbers served from form 5a:
- VIPP LHD Counts, # of people reached via LHD implementation of evidence-based programs (n=43797)
- Physical Activity, Percent of adolescents who were physically active 60 minutes, 7 days per week (n=30959)
- OHP Group Education Adolescents (n=5603)
- PREP/Ab ED, # of children enrolled in programs (n=2055)
- Medical Home Portal, users (n=37190)
- CSHCN EHDI Committee, individuals participating (n=195)
- CSHCN Hearing/Speech Training, Coordinated training for screening and referral (n=541)
- CSHCN Community Education, autism council, grand rounds, health fairs (n=1276)
- CSHCN Autism Downloads, ABA resource and Eval Provider downloads n=(26855)
- UBDN Surveillance cases (n=905)

190194/1074433 = 17.7% served

| | | |
|---|---|---|
| 4. | **Field Name:** | **Children With Special Health Care Needs** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
In addition to numbers served from form 5a:
- Medical Home Portal, users (n=37190)
- CSHCN EHDI Committee, individuals participating (n=195)
- CSHCN Hearing/Speech Training, Coordinated training for screening and referral (n=541)
- CSHCN Community Education, autism council, grand rounds, health fairs (n=1276)
- CSHCN Autism Downloads, ABA resource and Eval Provider downloads n=(26855)
- UBDN Surveillance cases (n=905)

74184/184801 = 40.1% served

| | | |
|---|---|---|
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2019** |

**Field Note:**
In addition to numbers served from form 5a:
- Professional Development for Teachers (EPICC), 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=34)
- EPICC Breast Feeding Policy, number of employers that provide space and time for nursing mothers to express breast milk (n=20)
- UBDN Community Education, Events, # reached, # of vitamins distributed (n=15212)
- OHP Outreach Education (n=2900)

22624/2036512 = 1.1% served

**Data Alerts: None**

## Form 6
## Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

**State: Utah**

**Annual Report Year 2019**

### 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 | 47,366 | 34,727 | 700 | 8,068 | 457 | 1,263 | 780 | 0 | 1,371 |
| Title V Served | 46,183 | 33,891 | 649 | 7,875 | 435 | 1,242 | 779 | 0 | 1,312 |
| Eligible for Title XIX | 12,151 | 6,872 | 348 | 3,654 | 277 | 245 | 396 | 0 | 359 |
| 2. Total Infants in State | 48,218 | 35,381 | 714 | 8,189 | 459 | 1,279 | 797 | 0 | 1,399 |
| Title V Served | 46,996 | 34,523 | 661 | 7,986 | 437 | 1,256 | 796 | 0 | 1,337 |
| Eligible for Title XIX | 12,341 | 6,992 | 353 | 3,701 | 279 | 246 | 405 | 0 | 365 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1. Total Deliveries in State** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:** Office of Vital Records and Statistics, Utah Birth Certificate Data, Total deliveries 2018 | |
| 2. | **Field Name:** | **1. Title V Served** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:** Office of Vital Records and Statistics, Utah Birth Certificate Data, Resident Deliveries 2018 | |
| 3. | **Field Name:** | **1. Eligible for Title XIX** |
| | **Fiscal Year:** | **2019** |
| | **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, 2018. | |
| 4. | **Field Name:** | **2. Total Infants in State** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:** Office of Vital Records and Statistics, Utah Birth Certificate Data, Occurrent births, 2018 | |
| 5. | **Field Name:** | **2. Title V Served** |
| | **Fiscal Year:** | **2019** |
| | **Column Name:** | **Total** |
| | **Field Note:** Office of Vital Records and Statistics, Utah Birth Certificate Data, Resident Births, 2018 | |
| 6. | **Field Name:** | **2. Eligible for Title XIX** |
| | **Fiscal Year:** | **2019** |
| | **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, 2018. | |

## Form 7
## State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

**State: Utah**

| A. State MCH Toll-Free Telephone Lines | 2021 Application Year | 2019 Annual Report Year |
|---|---|---|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (800) 826-9662 | (800) 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" | | 3,464 |

| B. Other Appropriate Methods | 2021 Application Year | 2019 Annual Report Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | 1. Children's Health Insurance Program (CHIP), 2. Mother To Baby, 3. Utah Newborn Safe Haven, 4. Immunization Hotline | 1. Children's Health Insurance Program (CHIP), 2. Mother To Baby, 3. Utah Newborn Safe Haven, 4. Immunization Hotline |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | 15,248 |
| 3. State Title V Program Website Address | www.health.utah.gov/mch, www.health.utah.gov/chscn | 1. www.health.utah.gov/mch, 2. www.health.utah.gov/cshcn |
| 4. Number of Hits to the State Title V Program Website | | 6,041 |
| 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 | | 729,001 |

**Form Notes for Form 7:**

Number of Calls to Other Toll Free Hotlines:
1. Children's Health Insurance Program (CHIP): 2,230
2. Mother To Baby: 6,865
3. Newborn Safe Haven: 20
4. Immunization Hotline: 2,669

Number of hits to the Title V Website:
MCH: 962
CSHCN: 5,079
Hits defined as number of sessions from Google Analytics report.

## 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 | 3760 South Highland Drive |
| Address 2 | PO Box 144610 |
| City/State/Zip | Salt Lake City / UT / 84114 |
| Telephone | (801) 273-2955 |
| Extension | |
| Email | ntaxin@utah.gov |

| 3. State Family or Youth Leader (Optional) | |
|---|---|
| Name | Joey Hanna |
| Title | Program Director, Family to Family/Utah Family Voices |
| Address 1 | 230 W 200 S #1101 |
| Address 2 | |
| City/State/Zip | Salt Lake City / UT / 84101 |
| Telephone | (801) 272-1051 |
| Extension | |
| Email | joey@utahparentcenter.org |

**Form Notes for Form 8:**

None

## Form 9
## State Priorities – Needs Assessment Year

**State: Utah**

**Application Year 2021**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Perinatal mood and anxiety disorders | New |
| 2. | Women's access to care | New |
| 3. | Breastfeeding/poor infant nutrition | Continued |
| 4. | Developmental delays | Continued |
| 5. | Adolescent mental health | Continued |
| 6. | Family connectedness | New |
| 7. | Economic stability | New |
| 8. | Family and provider connectedness/Care coordination | Revised |
| 9. | Transition to adulthood | New |
| 10. | Oral health | New |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

**Field Name:**

Priority Need 4

**Field Note:**
Priority need from 2015-2020 was "Developmental Screening". Continued.

**Field Name:**

Priority Need 5

**Field Note:**
2015-2020 priority need was "Suicide, mental health issues, and access to mental health services"

**Field Name:**

Priority Need 8

**Field Note:**
Based on the results of the 2020 Utah Statewide Needs Assessment

## Form 10
## National Outcome Measures (NOMs)

**State: Utah**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

For NPM 4a and 4b: Data in narrative is for, 2015 National Immunization Survey. 2016 data was not publicly available at the time the narrative was written.

For NPM 13.2, the objective is missing from the table, the objective was 84.8%.

**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 |
|---|---|---|---|---|
| 2018 | 82.2 % | 0.2 % | 38,337 | 46,643 |
| 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 |
|---|---|---|---|---|
| 2017 | 58.1 | 3.5 | 270 | 46,493 |
| 2016 | 52.7 | 3.3 | 255 | 48,370 |
| 2015 | 55.6 | 3.9 | 204 | 36,666 |
| 2014 | 52.0 | 3.3 | 252 | 48,501 |
| 2013 | 47.3 | 3.2 | 227 | 47,944 |
| 2012 | 46.0 | 3.1 | 223 | 48,516 |
| 2011 | 46.7 | 3.1 | 229 | 49,018 |
| 2010 | 46.5 | 3.1 | 233 | 50,135 |
| 2009 | 51.7 | 3.2 | 266 | 51,494 |
| 2008 | 42.3 | 2.8 | 227 | 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**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2014_2018 | 10.9 | 2.1 | 27 | 248,190 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**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 |
|---|---|---|---|---|
| 2018 | 7.2 % | 0.1 % | 3,385 | 47,189 |
| 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 |
|---|---|---|---|---|
| 2018 | 9.4 % | 0.1 % | 4,445 | 47,206 |
| 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 |
|---|---|---|---|---|
| 2018 | 28.9 % | 0.2 % | 13,619 | 47,206 |
| 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 |
|---|---|---|---|---|
| 2018/Q2-2019/Q1 | 2.0 % | | | |
| 2018/Q1-2018/Q4 | 2.0 % | | | |
| 2017/Q4-2018/Q3 | 2.0 % | | | |
| 2017/Q3-2018/Q2 | 2.0 % | | | |
| 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:**

**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 |
|---|---|---|---|---|
| 2017 | 6.0 | 0.4 | 294 | 48,703 |
| 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 |
|---|---|---|---|---|
| 2017 | 5.9 | 0.4 | 286 | 48,585 |
| 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 |
|---|---|---|---|---|
| 2017 | 4.5 | 0.3 | 218 | 48,585 |
| 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 |
|---|---|---|---|---|
| 2017 | 1.4 | 0.2 | 68 | 48,585 |
| 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 |
|---|---|---|---|---|
| 2017 | 183.2 | 19.4 | 89 | 48,585 |
| 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 |
|---|---|---|---|---|
| 2017 | 67.9 | 11.8 | 33 | 48,585 |
| 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 |
|---|---|---|---|---|
| 2017 | 6.1 | 0.4 | 288 | 46,978 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 12.2 % | 1.4 % | 105,553 | 861,827 |
| 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 |
|---|---|---|---|---|
| 2018 | 12.1 | 1.6 | 56 | 461,922 |
| 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 |
|---|---|---|---|---|
| 2018 | 33.5 | 2.6 | 173 | 515,784 |
| 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 |
|---|---|---|---|---|
| 2016_2018 | 9.5 | 1.1 | 69 | 729,516 |
| 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 |
|---|---|---|---|---|
| 2016_2018 | 20.0 | 1.7 | 146 | 729,516 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 16.2 % | 1.4 % | 148,920 | 920,136 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 8.4 % | 2.2 % | 12,494 | 148,920 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 2.1 % | 0.6 % | 16,038 | 760,249 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 9.6 % | 1.4 % | 73,377 | 767,017 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 40.1 % | 4.8 % | 50,473 | 125,957 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 91.7 % | 1.3 % | 842,930 | 918,989 |
| 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 |
|---|---|---|---|---|
| 2016 | 7.9 % | 0.2 % | 1,709 | 21,599 |
| 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 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: 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 |
|---|---|---|---|---|
| 2017_2018 | 8.7 % | 1.5 % | 35,757 | 412,538 |
| 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 |
|---|---|---|---|---|
| 2018 | 6.9 % | 0.5 % | 64,299 | 931,248 |
| 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 |
|---|---|---|---|---|
| 2018 | 74.2 % | 3.1 % | 54,881 | 73,917 |
| 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 width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable 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 |
|---|---|---|---|---|
| 2018_2019 | 55.8 % | 1.9 % | 485,480 | 870,660 |
| 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 because the relative standard error is >0.3.

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 |
|---|---|---|---|---|
| 2018 | 66.7 % | 3.2 % | 170,867 | 256,187 |
| 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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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 |
|---|---|---|---|---|
| 2018 | 89.9 % | 2.1 % | 230,401 | 256,187 |
| 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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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 |
|---|---|---|---|---|
| 2018 | 85.2 % | 2.6 % | 218,203 | 256,187 |
| 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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 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 |
|---|---|---|---|---|
| 2018 | 13.1 | 0.3 | 1,604 | 122,027 |
| 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 |
|---|---|---|---|---|
| 2018 | 14.7 % | 1.2 % | 6,621 | 45,080 |
| 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 |
|---|---|---|---|---|
| 2017_2018 | 3.7 % | 0.8 % | 33,332 | 912,111 |
| 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** | **2019** |
| Annual Objective | 55 | 55.8 | 57 | 55 |
| Annual Indicator | 55.6 | 56.9 | 54.7 | 66.1 |
| Numerator | 313,251 | 328,066 | 321,738 | 394,166 |
| Denominator | 563,258 | 576,406 | 588,467 | 595,993 |
| Data Source | BRFSS | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 66.5 | 67.0 | 67.5 | 68.0 | 68.5 | 69.0 |

**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** | **2019** |
| Annual Objective | 88.5 | 94.5 | 88.6 | 90 |
| Annual Indicator | 94.4 | 88.4 | 89.7 | 91.2 |
| Numerator | 43,550 | 43,382 | 43,073 | 45,052 |
| Denominator | 46,122 | 49,063 | 48,030 | 49,404 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 90.0 | 90.3 | 90.6 | 91.0 | 91.3 | 91.7 |

**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** | **2019** |
| Annual Objective | 18.5 | 27.3 | 26.9 | 28 |
| Annual Indicator | 27.0 | 26.8 | 27.8 | 23.5 |
| Numerator | 11,890 | 12,259 | 12,643 | 11,415 |
| Denominator | 44,056 | 45,790 | 45,490 | 48,506 |
| Data Source | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 28.3 | 29.0 | 29.6 | 30.2 | 31.0 | 31.5 |

**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** | **2019** |
| Annual Objective | | | 33.2 | 32.2 |
| Annual Indicator | | 33.1 | 32.6 | 31.1 |
| Numerator | | 38,611 | 32,987 | 29,418 |
| Denominator | | 116,514 | 101,171 | 94,514 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 31.3 | 31.5 | 31.7 | 31.9 | 32.1 | 32.3 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| Federally Available Data | |
|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 26.9 |
| Numerator | 44,345 |
| Denominator | 164,763 |
| Data Source | YRBSS |
| Data Source Year | 2017 |

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Perpetration** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 27.7 |
| Numerator | 86,153 |
| Denominator | 311,307 |
| Data Source | NSCHP |
| Data Source Year | 2018 |

| Federally Available Data | |
|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 56.4 |
| Numerator | 176,896 |
| Denominator | 313,579 |
| Data Source | NSCHV |
| Data Source Year | 2018 |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 27.0 | 26.0 | 25.0 | 24.0 | 23.0 |

**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** | **2019** |
| Annual Objective | | | 50.4 | 44.1 |
| Annual Indicator | | 50.4 | 47.2 | 40.2 |
| Numerator | | 75,090 | 68,219 | 59,263 |
| Denominator | | 148,990 | 144,415 | 147,327 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 40.3 | 40.4 | 41.0 | 41.5 | 42.0 | 42.5 |

**Field Level Notes for Form 10 NPMs:**

None

**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** | **2019** |
| Annual Objective | | | 18.4 | 19.5 |
| Annual Indicator | | 18.4 | 19.3 | 17.1 |
| Numerator | | 11,791 | 12,760 | 13,378 |
| Denominator | | 64,109 | 66,028 | 78,194 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | | |
|---|---|---|---|---|---|---|
| | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 17.3 | 17.5 | 18.5 | 19.5 | 20.5 | 21.5 |

**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 - Child Health**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 80.3 | |
| Annual Indicator | | 80.1 | 82.4 | 81.4 |
| Numerator | | 684,515 | 701,280 | 698,309 |
| Denominator | | 854,160 | 851,339 | 857,676 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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 | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 81.6 | 81.8 | 82.0 | 82.2 | 82.4 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

**State: Utah**

**2016-2020: 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 | 2019 |
| Annual Objective | 90 | 92.8 | 91.7 | 90 |
| Annual Indicator | 92.7 | 91.6 | 89.1 | 90 |
| Numerator | 480 | 522 | 521 | 448 |
| Denominator | 518 | 570 | 585 | 498 |
| Data Source | IBIS, Utah Birth Certificate Data | IBIS, Utah Birth Certificate Data | IBIS, Utah Birth Certificate Data | IBIS, Utah Birth Certificate Data |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | 19.9 | 19.9 | 18.9 | 20 |
| Annual Indicator | 19.7 | 19.7 | 19.1 | 19.1 |
| Numerator | 29,466 | 29,466 | 30,959 | 30,959 |
| Denominator | 149,852 | 149,852 | 162,207 | 162,207 |
| Data Source | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT | YRBSS-ADOLESCENT |
| Data Source Year | 2013 | 2013 | 2017 | 2017 |
| **Federally Available Data** | | | | |
| **Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT** | | | | |
| | **2016** | **2017** | **2018** | **2019** |
| Annual Objective | | | 18.9 | 20 |
| Annual Indicator | | 13.6 | 8.7 | 5.7 |
| Numerator | | 37,056 | 25,092 | 17,632 |
| Denominator | | 272,391 | 287,812 | 311,115 |
| Data Source | | NSCH-ADOLESCENT | NSCH-ADOLESCENT | NSCH-ADOLESCENT |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | 59.6 | 56.7 | 56.9 | 53.8 |
| Annual Indicator | 56.5 | 61.2 | 53.6 | 53.2 |
| Numerator | 27,701 | 29,790 | 25,341 | 24,250 |
| Denominator | 49,001 | 48,710 | 47,301 | 45,610 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2018 |

**Field Level Notes for Form 10 NPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | | 80.3 | 84.8 |
| Annual Indicator | | 80.1 | 82.4 | 81.4 |
| Numerator | | 684,515 | 701,280 | 698,309 |
| Denominator | | 854,160 | 851,339 | 857,676 |
| Data Source | | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 |

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.

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: Utah**

**SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 56 |
| Numerator | 25,866 |
| Denominator | 46,186 |
| Data Source | Pregnancy Risk Assessment Monitoring System |
| Data Source Year | 2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 57.0 | 58.0 | 59.0 | 62.0 | 65.0 |

**Field Level Notes for Form 10 SPMs:**

None

**SPM 2 - Percent of family members who live in the household that ate a meal together 4 or more days per week.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 76.7 |
| Numerator | 692,413 |
| Denominator | 903,273 |
| Data Source | National Survey of Childrens Health |
| Data Source Year | 2017-2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 77.7 | 78.7 | 79.7 | 80.7 | 81.7 |

**Field Level Notes for Form 10 SPMs:**

None

**SPM 3 - Percent of students enrolled in the free or reduced price lunch program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 32.2 |
| Numerator | |
| Denominator | |
| Data Source | USBE, Child Nutrition Program Database |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 32.2 | 32.7 | 33.2 | 33.7 | 34.0 |

**Field Level Notes for Form 10 SPMs:**

None

## Form 10
## State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: 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** | **2019** |
| Annual Objective | | 9 | 9.4 | 9.4 |
| Annual Indicator | 9.3 | 9.6 | 9.4 | 9.4 |
| Numerator | 4,712 | 4,852 | 4,582 | 4,434 |
| Denominator | 50,776 | 50,486 | 48,578 | 47,211 |
| Data Source | Utah Birth Certificate Data, OVRS | Utah Birth Certificate Data, OVRS | Utah Birth Certificate Data, OVRS | Utah Birth Certificate Data, OVRS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 SPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 3.3 | 1 | 2 |
| Annual Indicator | 1.9 | 0.8 | 1.6 | 0 |
| Numerator | 550 | 272 | 533 | 0 |
| Denominator | 28,704 | 35,870 | 34,275 | 35,988 |
| Data Source | CSHCN/UDAC Billing Data | CSHCN/UDAC Billing Data (2017) and Pop Est (2016) | ISP Utilization Data | ISP Utilization Data |
| Data Source Year | 2015 | 2016-17 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**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. | |

**2016-2020: 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** | **2019** |
| Annual Objective | | 14.7 | 15.1 | 14.9 |
| Annual Indicator | 15.1 | 15.8 | 15.7 | 15 |
| Numerator | 144 | 152 | 152 | 147 |
| Denominator | 950,511 | 960,913 | 967,283 | 977,706 |
| Data Source | Utah Death Certificate Database, OVRS | Utah Death Certificate Database and Pop estimates | Utah Death Certificate Database and Pop estimates | Utah Death Certificate Database and Pop estimates |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 SPMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 21 | 16.7 | 21.5 |
| Annual Indicator | 21 | 17.2 | 21.5 | 21.3 |
| Numerator | 49 | 41 | 52 | 53 |
| Denominator | 233,809 | 238,378 | 242,153 | 248,985 |
| Data Source | Utah Death Certificate Database, OVRS | Utah Death Certificate Database, OVRS | Utah Death Certificate Database, OVRS | Utah Death Certificate Database, OVRS |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 SPMs:**

None

## Form 10
## Evidence-Based or –Informed Strategy Measure (ESM)

**State: Utah**

**ESM 1.1 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.**

| Measure Status: | Active |
|---|---|
| **State Provided Data** | |
| | **2019** |
| Annual Objective | |
| Annual Indicator | 100 |
| Numerator | |
| Denominator | |
| Data Source | Salt Lake County Home Visiting Program Data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** |
| Annual Objective | 150.0 | 225.0 | 300.0 | 400.0 | 450.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 1.2 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Maternal and Infant Health Program data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 5.0 | 7.0 | 11.0 | 13.0 | 15.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 1.3 - Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Behavioral Risk Factor Surveillance System |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 2.0 | 3.0 | 3.0 | 3.0 | 3.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 4.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a “Breastfeeding Friendly Facility.”**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 13.2 |
| Numerator | 6,225 |
| Denominator | 47,211 |
| Data Source | Vital Records Birth Certificate Data |
| Data Source Year | 2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 20.0 | 23.0 | 26.0 | 29.0 | 32.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 13.9 |
| Numerator | 983 |
| Denominator | 7,093 |
| Data Source | WIC Program Data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 14.0 | 15.0 | 16.0 | 17.0 | 18.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 4.3 - Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | EPICC Program Data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 20.0 | 40.0 | 60.0 | 80.0 | 100.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Early Childhood Utah program data |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 12.0 | 12.0 | 12.0 | 12.0 | 12.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 6.2 - The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 8,157 |
| Numerator | |
| Denominator | |
| Data Source | The Brookes Publishing UDOH ASQ Online Enterprise |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 8,565.0 | 8,993.0 | 9,443.0 | 9,915.0 | 10,411.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Program records, attendance records. |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.2 - The number of adolescents who receive bystander training (Upstanding)**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 300 |
| Numerator | |
| Denominator | |
| Data Source | Program Data |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 350.0 | 400.0 | 450.0 | 500.0 | 550.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.3 - Percent of adolescents who are physically active at least 60 minutes per day.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 21 |
| Numerator | 41,142 |
| Denominator | 195,912 |
| Data Source | Estimates for percent of students physically activ |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 23.0 | 23.0 | 25.0 | 25.0 | 27.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.4 - The number of youth participating in the Wyman Teen Outreach Program (TOP)**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 400 |
| Numerator | |
| Denominator | |
| Data Source | PREP and SRAE Reports Wyman Connect |
| Data Source Year | 2019 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 400.0 | 400.0 | 400.0 | 400.0 | 400.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.5 - The proportion of Utah students participating in an evidence-based school based prevention program (PAX Good Behavior Game).**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0.7 |
| Numerator | 5,000 |
| Denominator | 666,858 |
| Data Source | Utah State Board of Education, Student Violence |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 1.5 | 2.0 | 3.0 | 4.0 | 5.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.6 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 75 |
| Numerator | 171,000 |
| Denominator | 228,000 |
| Data Source | Internal Revenue Service |
| Data Source Year | 2018 |
| Provisional or Final ? | Final |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 76.0 | 78.0 | 79.0 | 81.0 | 83.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.7 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 100 |
| Numerator | |
| Denominator | |
| Data Source | Program Data |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 200.0 | 300.0 | 400.0 | 500.0 | 600.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 11.1 - Percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN stakeholder workgroup survey |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Year one (2021) will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.

**ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Pre- and Post-training survey |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
This is a new ESM based off of the Utah MCH And CSHCN Needs Assessments conducted in 2019-2020. A baseline will be established in FY2021, and subsequently projected performance objectives will be calculated for FY 2022-25.

**ESM 11.3 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | CSHCN EMR or comprehensive database |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.

**ESM 11.4 - Percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Survey/Scan of pediatric and family practice provi |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
This is a new ESM based off of the Utah MCH And CSHCN Needs Assessments conducted in 2019-2020. A baseline will be established in FY2021, and subsequently projected performance objectives will be calculated for FY 2022-25.

**ESM 11.5 - Percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Follow-up survey of providers who participated in |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
This is a new ESM based off of the Utah MCH And CSHCN Needs Assessments conducted in 2019-2020. A baseline will be established in FY2021, and subsequently projected performance objectives will be calculated for FY 2022-25.

**ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Stakeholder work group survey. |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.

**ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Stake holder work group survey of transition-age y |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.

**ESM 12.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.**

| Measure Status: | Active |
|---|---|

| State Provided Data | |
|---|---|
| | 2019 |
| Annual Objective | |
| Annual Indicator | 0 |
| Numerator | |
| Denominator | |
| Data Source | Stakeholder work group survey for transition train |
| Data Source Year | 2020 |
| Provisional or Final ? | Provisional |

| Annual Objectives | | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.

**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 | 2019 |
| Annual Objective | | 53.6 | 51.5 | 54.4 |
| Annual Indicator | 53.4 | 51.3 | 54.2 | 55.5 |
| Numerator | 116,623 | 109,115 | 109,777 | 105,122 |
| Denominator | 218,295 | 212,848 | 202,518 | 189,242 |
| Data Source | CMS 416 | CMS 416 | CMS 416 | CMS-416 |
| Data Source Year | FFY16 | FFY17 | FFY18 | FFY19 |
| Provisional or Final ? | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
| Annual Objective | 55.7 | 55.9 | 56.1 | 56.3 | 56.5 | 56.7 |

**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
## Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: 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** | **2019** |
| Annual Objective | | 1 | 1 | 2 |
| Annual Indicator | 1 | 1 | 1 | 1 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Program Level Data | Program Level Data | Program Level Data | Program Level Data |
| Data Source Year | 2015 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Provisional | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 100 | 100 | 100 |
| Annual Indicator | 100 | 100 | 100 | 100 |
| Numerator | 518 | 585 | 593 | 498 |
| Denominator | 518 | 585 | 593 | 498 |
| Data Source | REDCap VLBW Infant Morbidity Database | REDCap VLBW Infant Morbidity Database | REDCap VLBW Infant Morbidity Database | REDCap VLBW Infant Morbidity Database |
| Data Source Year | 2015 | 2016 | 2017 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 100 | 100 | 100 |
| Annual Indicator | 0 | 0 | 0 | 0 |
| Numerator | 0 | 0 | 0 | 0 |
| Denominator | 10 | 10 | 10 | 10 |
| Data Source | Program Level Data | Program Level Data | Program Level Data | Program Level Data |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**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.

**2016-2020: 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** | **2019** |
| Annual Objective | | 22 | 28 | 25 |
| Annual Indicator | 14 | 18 | 23 | 27 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Program Level Data | Program Level Data | Program Level Data | Program Level Data |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | | 178 | 126 |
| Annual Indicator | 26 | 89 | 114 | 67 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Healthy Utah Worksite Assessment Survey | Healthy Utah Worksite Assessment Survey | Healthy Utah Worksite Assessment Survey | Healthy Utah Worksite Assessment Survey |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 9,400 | 10,800 | 9,700 |
| Annual Indicator | 9,335 | 10,771 | 9,700 | 9,026 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | Utah WIC Program Computer Report | Utah WIC Program Computer Report | Utah WIC Program Computer Report | Utah WIC Program Computer Report |
| Data Source Year | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**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

**2016-2020: 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 |
|---|---|

**Baseline data was not available/provided.**

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.**

| Measure Status: | Active |
|---|---|

**Baseline data was not available/provided.**

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 10 | 25 | 25 |
| Annual Indicator | 7.1 | 25 | 25 | 25 |
| Numerator | | 1 | 1 | 1 |
| Denominator | | 4 | 4 | 4 |
| Data Source | School Health Profiles | UDOH Policy Database | UDOH Policy Database | UDOH Policy Database |
| Data Source Year | 2016 | 2017 | 2017 | 2017 |
| Provisional or Final ? | Provisional | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 4 | 35 | 36 |
| Annual Indicator | 6 | 34 | 31 | 34 |
| Numerator | | | | |
| Denominator | | | | |
| Data Source | EPICC Training Database | EPICC Training Database | EPICC Training Database | EPICC Training Database |
| Data Source Year | 2016 | 2017 | 2018 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 69 | 67 | 68 |
| Annual Indicator | 68.8 | 67.3 | 68.1 | 68.1 |
| Numerator | 99 | 115 | 286 | 286 |
| Denominator | 144 | 171 | 420 | 420 |
| Data Source | Program Level Data | Program Data, Integrated Services Program | Program Data, Integrated Services Program | Program Data, Integrated Services Program |
| Data Source Year | FFY17 | FY2017 | FY2018 | FY2018 |
| Provisional or Final ? | Provisional | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 23.5 | 20 | 76.5 |
| Annual Indicator | 23.5 | 23.5 | 76.2 | 76.2 |
| Numerator | 16 | 16 | 16 | 16 |
| Denominator | 68 | 68 | 21 | 21 |
| Data Source | Program Level Data | Program Level Data | Program Level Data | Program Level Data |
| Data Source Year | 2016 | 2016 | 2018 | 2018 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 69 | 67 | 68 |
| Annual Indicator | 68.8 | 67.3 | 68.1 | 68.1 |
| Numerator | 99 | 115 | 286 | 286 |
| Denominator | 144 | 171 | 420 | 420 |
| Data Source | Program Level Data, UESC Family Survey | Integrated Services Program Data | Integrated Services Program Data | Integrated Services Program Data |
| Data Source Year | FFY17 | FY2017 | 2018 | 2018 |
| Provisional or Final ? | Provisional | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

**2016-2020: 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** | **2019** |
| Annual Objective | | 45.3 | 37.1 | 25.2 |
| Annual Indicator | 45.1 | 36.9 | 25 | 25.9 |
| Numerator | 69 | 58 | 38 | 43 |
| Denominator | 153 | 157 | 152 | 166 |
| Data Source | Utah Office of Head Start, Program Report | 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 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: Utah**

**SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care**
**Population Domain(s) – Women/Maternal Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of women who self-report if a healthcare provider asked them if they were feeling down or depressed both during prenatal and postpartum care from 56% to 59% (2019 PRAMS data) |
| **Definition:** | **Numerator:** Number of women who self-report that a healthcare provider asked them if they were feeling down or depressed both during prenatal and postpartum care.<br>**Denominator:** Number of resident women who delivered a live birth in Utah.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | No Healthy People 2020 equivalent measure |
| **Data Sources and Data Issues:** | Utah PRAMS data. |
| **Significance:** | Postpartum depression is the most underdiagnosed and most common complication of pregnancy. Nationally, one in five women experience a perinatal mood and anxiety disorder. When a mother's mental health complications goes undiagnosed, there are serious implications on her birth (preterm birth, low birth weight, miscarriage), development of their baby postpartum (sleep, growth, behavioral issues, mother-infant bonding), and on the mother herself (low breastmilk supply, marital problems, substance use issues, low compliance in following medical advice and missing routine care for herself and baby). Additionally, the two leading causes of death in Utah for perinatal moms from 2015-2016 were accidental drug overdose and suicide, with 75% of the women who died during those same years having had a previous mental health issue. Screening has been recommended by The American College of Obstetrics and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). ACOG notes that "screening alone can have clinical benefits," and it is a way to connect mothers who are suffering to appropriate behavioral health resources, medication, and normalize an issue that is often not talked about due to heavy stigma and shame. |

**SPM 2 - Percent of family members who live in the household that ate a meal together 4 or more days per week.**
**Population Domain(s) – Child Health, Adolescent Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the percent of family members who live in the household that ate a meal together 4 or more days per week from 76.7% to 81.7% (2017-2018 National Survey of Children's Health) |
| **Definition:** | **Numerator:** Children whose family eats meals together 4 or more days out of the week<br>**Denominator:** Children age 0-17 years<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | Similar to AH-3: Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver |
| **Data Sources and Data Issues:** | National Survey of Children's Health |
| **Significance:** | When people feel connected with their communities, they may feel more inclined to participate in actions that help the community. As an upstream factor, it impacts multiple levels of social ecology. Connectedness encompasses both family connection and support, as well as community violence. It is a shared protective factor. Family meals are a way to increase connectedness in families. This connectedness is a protective factor for youth and onset of risky behaviors. Connectedness is a protective factor for reducing suicide. |

**SPM 3 - Percent of students enrolled in the free or reduced price lunch program**
**Population Domain(s) – Child Health, Adolescent Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of students who participate in the National School Lunch Program |
| **Definition:** | **Numerator:** The number of eligible students who participate in the National School Lunch Program<br>**Denominator:** The total number of students enrolled in schools<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | Similar to AH-6: Increase the proportion of schools with a school breakfast program |
| **Data Sources and Data Issues:** | Utah State Board of Education Child Nutrition Program Database |
| **Significance:** | Students who participate in the school meal programs consume more milk, fruits, and vegetables during meal times and have better intake of certain nutrients, such as calcium and fiber, than nonparticipants. And, eating breakfast at school is associated with better attendance rates, fewer missed school days, and better test scores. School lunch is a proxy for economic stability. |

## Form 10
## State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

**2016-2020: SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation**
**Population Domain(s) – Perinatal/Infant Health**

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|---|---|
| **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)<br>**Denominator:** Total number of live births<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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<br>**Denominator:** Total number of CSHCN children in the rural areas of the state<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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<br>**Denominator:** Total number of children and adolescents ages 1 to 19<br>**Unit Type:** Rate<br>**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. |

**2016-2020: SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)**
**Population Domain(s) – Adolescent Health**

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|---|---|
| **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<br>**Denominator:** Total number of youths ages 15 to 19<br>**Unit Type:** Rate<br>**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 1.1 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.**
**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 home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff. |
| **Definition:** | **Numerator:** Count of women enrolled in Salt Lake County Home Visiting who receive education on the well-woman visit.<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | Salt Lake County Home Visiting Program Data |
| **Significance:** | A trusted professional, like a home visitor is an effective messenger on the importance of a well-woman visit. Educating and encouraging home visiting clients to schedule and attend a well-woman exam can help them maintain a healthy lifestyle and minimize health risks. |

**ESM 1.2 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.**
**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 community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah. |
| **Definition:** | **Numerator:** Number of community partners and organizations engaged in a coalition to create a well-woman visit strategic plan for the State of Utah<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | Maternal and Infant Health Program data |
| **Significance:** | Public health issues are best addressed by developing and sustaining partnerships between community organizations, medical experts, and government. Programs that develop and sustain these partnerships provide opportunities to improve the health of women during her lifespan. |

**ESM 1.3 - Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.**
**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 question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care. |
| **Definition:** | **Numerator:** Number of questions on survey<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 9 |
| **Data Sources and Data Issues:** | Behavioral Risk Factor Surveillance System |
| **Significance:** | Success of public health messaging must include input from the population it is trying to reach. Using the Utah Behavioral Risk Factor Surveillance Survey (BRFSS), program staff will be able to ask a diverse group of women on the facilitator and barriers to receiving a well-woman visit. With this information it is possible to create programming that will resonant with our target population, thus increasing the percentage of women who receive care. |

**ESM 4.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a "Breastfeeding Friendly Facility."**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

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|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a "Breastfeeding Friendly Facility." |
| **Definition:** | **Numerator:** Number of infants born in a facility that has met the requirements set by the Stepping up for Utah Babies program<br>**Denominator:** Number of live births<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Numerator: Maternal and Infant Health Program Data/Vital Records Birth Certificate Data<br>Denominator: Vital Records Birth Certificate Data |
| **Significance:** | Hospital policy and practice significantly affect whether a woman feels confident enough to reach her breastfeeding goals. The Stepping Up for Utah Babies program encourages and recognizes hospitals that offer an optimal level of care for lactation based on the World Health Organization (WHO)/United Nations Children's Fund (UNICEF) Ten Steps to Successful Breastfeeding. To be designated as a "Breastfeeding Friendly Facility," facilities must meet the requirements set by Stepping Up program staff for each of the Ten Steps. By fully implementing all Ten Steps, the participating hospitals can help new mothers successfully start and continue breastfeeding. |

**ESM 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.**
**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 percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor. |
| **Definition:** | **Numerator:** The number of eligible pregnant and postpartum WIC participants who receive at least one contact from a WIC Breastfeeding Peer Counselor<br>**Denominator:** The number of eligible pregnant and postpartum WIC participants<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | WIC Program Data |
| **Significance:** | Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Mothers who receive help and support when they need it are more likely to reach their breastfeeding goals and meet their infant's complete nutritional needs. A mother's ability to begin and continue breastfeeding can be influenced by a host of community factors, and programs like WICs breastfeeding peer counselors can provide important coaching to enable and sustain breastfeeding efforts in WIC clients. Peer counseling interventions greatly improve breastfeeding initiation, duration, and exclusivity. |

**ESM 4.3 - Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

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|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of surveys received from women who utilize lactation policies and/or lactation rooms at the workplace |
| **Definition:** | **Numerator:** Number of surveys received<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | EPICC Program Data |
| **Significance:** | The U.S. Surgeon General calls for employers to have high-quality employee lactation support programs and policies that work towards reducing breastfeeding barriers for working mothers. The effectiveness of these polices in supporting the needs of breastfeeding mothers is currently unknown in Utah. By getting their input, we can encourage workplaces to update current policies that meet the needs of lactating workers so they can reach their personal breastfeeding goals. |

**ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program**
**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**

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|---|---|
| **Measure Status:** | Active |
| **Goal:** | Conduct at least 12 ASQ trainings per year |
| **Definition:** | **Numerator:** Number of trainings<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | Training enrollment and attendance records kept by Early Childhood Utah program staff |
| **Significance:** | Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected or if there is cause of concern and further evaluation is necessary. This ESM is significant to increasing the number of developmental screens received by children ages 9 months - 35 months. In order to increase the number of screens received by infants/toddlers we need to increase the number of Early Care & Education (ECE) and Health programs that offer developmental screening services to families with young children. ECE and Health programs cannot provide ASQ online services without first being trained in ASQ online. If UDOH can sponsor an increased number of ASQ online training opportunities, additional ECE and Health providers will enroll in the UDOH ASQ online account and hopefully, actively participate. Ideally, increased ASQ online training opportunities will lead to an increase in the number of developmental health screening opportunities for 9 month - 35 month year old children. |

**ESM 6.2 - The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.**
**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 ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs. |
| **Definition:** | **Numerator:** Number of ASQ screens in UDOH ASQ Online Enterprise Account<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 99,999 |
| **Data Sources and Data Issues:** | UDOH ASQ Online Enterprise Account |
| **Significance:** | Early identification of developmental disorders is critical to the well-being of children and their families. Nationally, the percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit. This measure is significant because only by monitoring and increasing the number of programs participating and the number of screens contributed to our ASQ online Enterprise account will we be able to increase the percentage of 9 month - 35 month year old children that receive parent-completed developmental health screening opportunities. |

**ESM 9.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Implement the Teen Speak training with 500 Utah parents in 5 years. |
| **Definition:** | **Numerator:** The number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | Program records, attendance records. Information from the developer on those that complete the on-line pre-work |
| **Significance:** | Teen Speak is a communications program (total 8 hours: including self-study and in-peron presentation) that provides parents a menu of strategies they can use to improve communication with their youth |

**ESM 9.2 - The number of adolescents who receive bystander training (Upstanding)**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of adolescents who have received the Upstanding curriculum. |
| **Definition:** | **Numerator:** The number of adolescents who receive the Upstanding training<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | Program records |
| **Significance:** | Bullying is the unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. Passive bystanders provide the audience a bully craves and the silent acceptance that allows bullies to continue their hurtful behavior. A bystander to bullying is anyone who witnesses bullying either in person or in digital forms like social media, websites, text messages, gaming, and apps. When bullying occurs, bystanders are present 80 percent of the time. A bystander has the potential to make a positive difference in a bullying situation, particularly for the youth who is being bullied. Studies show, when youth who are bullied are defended and supported by their peers, they are less anxious and depressed. The Upstanding Program teaches children simple strategies for standing up to bullying that effectively removes, rather than provides, more peer attention. |

**ESM 9.3 - Percent of adolescents who are physically active at least 60 minutes per day.**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of students who are active for at least 60 minutes a day through a variety options throughout the school day. |
| **Definition:** | **Numerator:** TBD<br>**Denominator:** TBD<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Program records, Utah Youth Risk Behavior Surveillance System, Utah State Office of Education |
| **Significance:** | Physical activity has brain health benefits for school-aged children, including improved cognition (e.g., academic performance, memory) and reduced symptoms of depression. Regular physical activity in childhood and adolescence can also be important for promoting lifelong health and well-being and preventing risk factors for various health conditions like heart disease, obesity, and type 2 diabetes. |

**ESM 9.4 - The number of youth participating in the Wyman Teen Outreach Program (TOP)**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the opportunities for 400 youth to build positive connections with others through the Wyman Teen Outreach Program. |
| **Definition:** | **Numerator:** Number of youth participating in the Teen Outreach Program<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | PREP & SRAE Reports/Wyman Connect |
| **Significance:** | The Wyman Teen Outreach Program (TOP) increases teens' ability to build positive connections with others through weekly peer group meetings and community service learning. |

**ESM 9.5 - The proportion of Utah students participating in an evidence-based school based prevention program (PAX Good Behavior Game).**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the proportion of Utah students participating in an evidence-based school based prevention program to reduce referrals for fighting, bullying, and other forms of aggression. |
| **Definition:** | **Numerator:** Number of students participating in an evidence-based prevention program<br>**Denominator:** Number of Utah students<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Utah State Board of Education, Student Violence and Injury Reporting System |
| **Significance:** | Multiple systematic reviews of various universal school-based programs demonstrate beneficial impacts on youth's skills and behaviors, including delinquency, aggression, bullying perpetration and victimization, and bystander skills that lower the likelihood of violence and support victims. For example, the Task Force for Community Preventive Services found a 15% relative reduction in violent behavior among students in pre-kindergarten through high school. Using different outcome measures, the median relative reduction in aggression and violent behavior associated with universal school-based programs varied by grade level, with a 32% reduction for pre-kindergarten and kindergarten students, 18% reduction for elementary students, 7% reduction for middle school students, and 29% reduction for high school students. Researchers suggest the benefits of these school-based approaches could be strengthened if programs implemented at early grade levels are continued into the critical high school years. These programs were effective in reducing youth violence in different types of school environments, including ones with varying socioeconomic status, crime rates, or predominant race/ethnicity of students. Examples of effective classroom-based programs are Good Behavior Game (GBG), Promoting Alternative Thinking Strategies®; (PATHS), Life Skills®; Training (LST), and Steps to Respect (STR). The GBG has demonstrated that participants had significantly lower levels of classroom aggression in elementary school, and some studies of the long-term effects of GBG showed significantly lower levels of aggression in middle school and lower prevalence of antisocial personality disorder and violent crime by age 19 to 21.These effects were for male youth with relatively higher levels of earlyaggression when compared to youth in alternative intervention conditions. These participants also had lower prevalence of alcohol abuse, smoking, and suicidal ideation by the time they reached young |

**ESM 9.6 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the percent of Utahns who qualify and file for the Earned Income Tax Credit from 75% to 83%. |
| **Definition:** | **Numerator:** # of Utahns who filed for the EITC<br>**Denominator:** # of Utahns who qualify for the EITC<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Internal Revenue Service, Utah Tax Help, Program Records |
| **Significance:** | Bullying is associated with a number of community-level risks, such as concentrated poverty, residential instability, and density of alcohol outlets. Reducing exposure to these community-level risks can potentially yield population-level impacts on youth violence outcomes. Prevention approaches to reduce these risks include changing, enacting, or enforcing laws, city ordinances and local regulations, and policies to improve household financial security, safe and affordable housing, and the social and economic sustainability of neighborhoods. Public-private partnerships and community-driven needs and services are important elements of these approaches. Strengthening household financial security through tax credits, such as the Earned Income Tax Credit (EITC), can help families increase their income while incentivizing work or offsetting the costs of child-rearing and help create home environments that promote healthy development. The evidence suggests that the EITC can lift families out of poverty. Simulations show that a Child Tax Credit of a $1000 allowance per child, paid to each household regardless of income or tax status, would reduce child poverty in the United States from 26.3% to 23.2%; a $2000 allowance per child would reduce child poverty to 20.4%; a $3000 allowance per child would reduce child poverty to 17.6%; and a $4000 allowance per child would reduce child poverty to 14.8%. |

**ESM 9.7 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of Utahns who have been trained in Question, Persuade, Refer (QPR) |
| **Definition:** | **Numerator:** The number of Utahns who have been trained in Question, Persuade, Refer (QPR)<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 999 |
| **Data Sources and Data Issues:** | Program Records |
| **Significance:** | While the QPR intervention was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely applied as a universal intervention for anyone who may be experiencing emotional distress. It has been suggested by independent researchers and federal leadership that originally funded and conducted QPR studies, that the QPR intervention could be useful in a much broader application, and not just for the detection of persons at risk for suicide. When QPR is applied to distressed youth with informed compassion and understanding, the intervention becomes useful for the detection of a wide range of "troubled" behavior, e.g., non-suicidal self-injury (NSSI), perfectionism, eating disturbances, sleep problems, bullying, and other behavioral indices of youth who may be at risk, identified, and treated "upstream" of the onset of suicidal ideation. |

**ESM 11.1 - Percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of providers who educate their patients (CSHCN parents) on the importance of having a medical home. |
| **Definition:** | **Numerator:** # of providers who respond affirmatively about educating CSHCN families on medical home, when surveyed by stakeholder work group.<br>**Denominator:** # providers surveyed by stakeholder work group who respond to survey.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | CSHCN stakeholder workgroup survey |
| **Significance:** | The medical home model promotes high quality primary care that promotes coordination and partnership between the family, the patient, and health care and other service providers. The percent of providers who understand and promote the medical home concept is a marker of a well functioning and coordinated system of care for CSHCN. |

**ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of families of CSHCN who report a change in knowledge on the importance of the medical home. |
| **Definition:** | **Numerator:** Number of families surveyed post-Medical Home training who report a positive change in knowledge.<br>**Denominator:** Number of families who complete both the pre- and post test for Medical Home training.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Pre- and Post-training survey |
| **Significance:** | Parents who understand the importance of the medical home may encourage their providers to incorporate the seven components of the medical home. |

**ESM 11.3 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care. |
| **Definition:** | **Numerator:** Number of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.<br>**Denominator:** Number of children with special health care needs served by the Bureau.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | CSHCN EMR or comprehensive database |
| **Significance:** | Emphasizing care coordination has also been recognized by Innovation Station through projects in Virginia and Oregon as emerging and promising practices. Similar components to their care coordination programs will be modeled by Utah in developing our programs. |

**ESM 11.4 - Percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of pediatric Medicaid providers who utilize telehealth to provide services in line with the medical home model to children with special health care needs. |
| **Definition:** | **Numerator:** Number of pediatric Utah Medicaid providers who utilize telehealth<br>**Denominator:** Number of pediatric Utah Medicaid Providers<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Survey/Scan of pediatric and family practice providers developed by CSHCN Medical Home work group. |
| **Significance:** | Many families of CSHCN may lack access to primary and specialty services due to distance, reliable transportation, financial variables. Telehealth may bridge that gap. |

**ESM 11.5 - Percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of providers who have been trained by the Bureau who indicate that they practice the components of a medical home. |
| **Definition:** | **Numerator:** Providers trained on the importance of the medical home who indicate they have implemented at least some components.<br>**Denominator:** Providers trained by the Bureau on medical home who participated in follow-up survey.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Follow-up survey of providers who participated in training. |
| **Significance:** | Training and follow-up may encourage providers to implement a medical home model, or at least some of the components. |

**ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning 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 |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood. |
| **Definition:** | **Numerator:** Number of youth and adolescents with an active transition plan who report positive outcomes on stakeholder work group survey.<br>**Denominator:** Number of youth and adolescents surveyed.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Stakeholder work group survey. |
| **Significance:** | Having a transition plan is critical for services to be seamlessly transferred to adult-serving providers. There is strong, recent evidence as summarized by the literature in Jones et al. (2017) and Lemke et al. (2018) that speak to the importance of sharing the plan with youth and families and for having a transition policy within a practice:<br><br>Jones, M. R., Robbins, B. W., Augustine, M., Doyle, J., Mack-Fogg, J., Jones, H., & White, P. H. (2017). Transfer from pediatric to adult endocrinology. Endocrine Practice, 23(7), 822–830. https://doi.org/10.4158/EP171753.OR.<br><br>Lemke, M., Kappel, R., McCarter, R., D'Angelo, L., & Tuchman, L. K. (2018). Perceptions of health care transition care coordination in patients with chronic illness. Pediatrics, 141(5). https://doi.org/10.1542/peds.2017-3168. |

**ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.**
**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 |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan. |
| **Definition:** | **Numerator:** Survey of youth with special health care needs who have an active transition plan.<br>**Denominator:** All youth with special health care needs surveyed.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Stakeholder work group survey of transition-age youth. |
| **Significance:** | Having a transition plan is critical for services to be seamlessly transferred to adult-serving providers. There is strong, recent evidence as summarized by the literature in Jones et al. (2017) and Lemke et al. (2018) that speak to the importance of sharing the plan with youth and families and for having a transition policy within a practice. |

**ESM 12.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.**
**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 |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | Increase the percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice. |
| **Definition:** | **Numerator:** Survey of providers trained who indicate they have an active transition policy in place.<br>**Denominator:** All providers trained in transition.<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Stakeholder work group survey for transition trained providers. |
| **Significance:** | Jones, M. R., Robbins, B. W., Augustine, M., Doyle, J., Mack-Fogg, J., Jones, H., & White, P. H. (2017). Transfer from pediatric to adult endocrinology. Endocrine Practice, 23(7), 822–830. https://doi.org/10.4158/EP171753.OR.<br><br>Lemke, M., Kappel, R., McCarter, R., D'Angelo, L., & Tuchman, L. K. (2018). Perceptions of health care transition care coordination in patients with chronic illness. Pediatrics, 141(5). https://doi.org/10.1542/peds.2017-3168. |

**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<br>**Denominator:** Number of Medicaid children aged 1-18 eligible for Medicaid for 90 days or more<br>**Unit Type:** Percentage<br>**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 10
## Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

**2016-2020: 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<br>**Denominator:** N/A (number of institutions of higher learning partnered with MIHP.)<br>**Unit Type:** Count<br>**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:<br><br>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. |

**2016-2020: ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered**
**2016-2020: 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<br>**Denominator:** Total number of VLBW infants born in Utah<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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**
**2016-2020: 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<br>**Denominator:** The total number of level III hospital facilities in the State (UT)<br>**Unit Type:** Percentage<br>**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.<br>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. |

**2016-2020: 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<br>**Denominator:** N/A (Number of steps implemented)<br>**Unit Type:** Count<br>**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. |

**2016-2020: 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<br>**Denominator:** N/A/ (Number of worksites with a policy)<br>**Unit Type:** Count<br>**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.<br>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. |

**2016-2020: 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<br>**Denominator:** N/A/ (Number of referrals)<br>**Unit Type:** Count<br>**Unit Number:** 99,999 |
| **Data Sources and Data Issues:** | Utah WIC Program Computer Reports<br><br>*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. |

**2016-2020: 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.<br>**Denominator:** The number of programs that are enrolled in the UDOH ASQ online program.<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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.<br>**Denominator:** n/a<br>**Unit Type:** Count<br>**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. |

**2016-2020: ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP**
**2016-2020: 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<br>**Denominator:** Total number of schools within the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake<br>**Unit Type:** Percentage<br>**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. |

**2016-2020: 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)**
**2016-2020: 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<br>**Denominator:** N/A (Number of local education agencies (LEAs) in the state that received professional development on CSPAP)<br>**Unit Type:** Count<br>**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. |

**2016-2020: 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<br>**Denominator:** Families that allowed a follow-up contact (call, email, etc.) to determine if they were connected with a community resource<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Program data, Integrated Services Program, CSHCN.<br><br>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. |

**2016-2020: 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:** | <table><tr><td>**Numerator:**</td><td>Number of respondents with a child over 15 years old who report having a written transition plan.</td></tr><tr><td>**Denominator:**</td><td>Number of respondents with a child over 15 years old who responded to the question about a written transition plan.</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table> |
| **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. |

**2016-2020: 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>
<tr><td>Goal:</td><td>Increase the percentage of families connected to community resources by June 2017.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Families who were connected with a community resource</td></tr>
<tr><td>Denominator:</td><td>Families that allowed a follow-up contact (call, email, etc.) to determine if they were connected with a community resource</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program level data<br><br>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

**2016-2020: ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy**
**2016-2020: 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<br>**Denominator:** EHS total enrollment of pregnant women<br>**Unit Type:** Percentage<br>**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. |

## Form 11
## Other State Data

### State: Utah

The Form 11 data are available for review via the link below.

Form 11 Data