Maternal and Child Health Services Title V Block Grant

Utah

FY 2023 Application/ FY 2021 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

State of Utah
SPENCER J. COX
Governor
DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services
TRACY S. GRUBER
Executive Director
NATE CHECKETTS
Deputy Director
DR. MICHELLE HOFMANN
Executive Medical Director
DAVID LITVACK
Deputy Director
NATE WINTERS
Deputy Director

August 1, 2022

Christopher Dykton, MA
Acting 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 Mr. Dykton:

We are pleased to submit Utah's Maternal and Child Health Block Grant Application for Fiscal Year 2023 and the Annual Report for Fiscal Year 2021.

The 2023 application outlines the influence of the Title V Block Grant dollars to the MCH/CSHCN population in Utah and how it positively impacts the health of women, children and youth, especially children with special health care needs and families in our state. It outlines the plan for the coming grant period and the Annual Report for FFY 2021 which gives the results of the planned efforts completed. We are excited to continue our work in addressing the National and State Performance Measures to improve the health of MCH/CSHCN populations.

Sincerely,

Laurie Baksh
Laurie Baksh, MPH
Director, Office of Maternal and Child Health

Amy Nance
Amy Nance, MPH
Director, Office of Children with Special Health Care Needs

State Headquarters: 195 North 1950 West, Salt Lake City, Utah 84116
telephone: (801) 538-4001 | email: dhhs@utah.gov | web: dhhs.utah.gov

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 2021 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: January 31, 2024.

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: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Utah's MCH/CSHCN Program

Utah's Title V Maternal & Child Health Block Grant is administered by the Office's of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) in the Division of Family Health (DFH) of the Utah Department of Health and Human Services (DHHS) and lead the work of this grant. Utah's MCH/CSHCN programs collaborate with other statewide agencies, Local Health Departments, community partners and stakeholders to implement strategies to move the needle for women, infants, children, adolescents and children with special health care needs. The 2020-2025 Title V priorities were selected based on the findings of the 2020 comprehensive statewide needs assessment process. National and State Performance measures and Evidence Based Strategy Measures serve as long-term goals for each priority area.

2021-2025 MCH/CSHCN Needs Assessment and Priorities

The 2020 Utah MCH/CSHCN Needs Assessment used a community-engagement approach to gather information from stakeholders. 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 to achieve the best health outcomes for mothers, children, and families in Utah.

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 the selection of ten state MCH/CSHCN priorities as the focus for Title V activities; seven National Performance Measures (NPM), and three State Performance Measures (SPM).

Title V Block Grant Implementation

Each NPM and SPM developed through the 2020 needs assessment process are assigned to a “core writer” who oversees the implementation/coordination of the evidence-based strategies identified for each measure. The core writer identifies partners who can collaborate on activities, tracks progress, writes reports of achievements, and plans for the future year of work. The evidence-based measures are based on best practices and emerging evidence. Title V funds are leveraged with other federal grants and state funding.

Priorities and Progress

Maternal and Women

Routine preventive care is key to health across the lifespan. A yearly preventive checkup is a time for a person to develop a trusting relationship with their health care provider. The preventive visit is an opportunity for health care providers to screen for early detection and treatment of disease and illness and counsel people on their specific healthcare needs. MCH Staff provide health education on the importance of the well-woman preventive visit at health fairs, when feasible, and through social media outlets. The Office of MCH has formed a Well-Woman Coalition to bring together community partners to work on the development of a Well-Woman strategic plan for Utah.

Postpartum depression is the most common complication of pregnancy. When a mother's mental health complications go undiagnosed, there are serious implications for her and her family. The Office of MCH has worked on providing training for healthcare providers, home visitors, and community health workers on perinatal mental health and referral resources. Education to raise awareness among pregnant and postpartum women is provided through in-person events and social media platforms.

Perinatal and Infant

A mother’s ability to begin and continue breastfeeding can be influenced by a host of factors. Mothers who receive help and support when they need it are more likely to reach their breastfeeding goals. Utah offers support to hospitals to implement breastfeeding friendly practices through the “Stepping Up for Utah Babies” program. The Utah WIC program supports a breastfeeding peer counseling program for its participants. Staff in the Healthy Environments Active Living (HEAL) program in the Office of Health Promotion work with employers to establish worksite lactation accommodations and adopt policies that comply with federal and state lactation laws.

Child

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 a delay in development and further evaluation is necessary. MCH staff works with medical providers to provide education, ongoing training and access to data systems on developmental screening to increase the number of children who receive a developmental screen.

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. MCH and Healthy Environments Active Living (HEAL) staff work to provide parent-youth communication programs.

Adolescent

Bullying is the unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. Staff in the Violence and Injury Prevention Program (VIPP) collaborate to address the risk factors for bullying. These include family connectedness, evidence-based programs for mental health promotion/suicide prevention and economic stability. They work to offer parent education through a parent-youth communications program, provide bystander training to youth, positive youth development programs, and to encourage physical activity, which benefits adolescent mental health.

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. HEAL staff work to support education agencies with advancing the quality of school meals by participating in programs such as Farm to Fork, and educate families on how to receive free or reduced-price breakfast/lunch in schools.

The Utah Oral Health Program promotes oral health education and prevention, increases community awareness of the oral health needs in the state, and improves access to oral health care services.

Children with Special Health Care Needs

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. Providers who understand and promote the medical home concept mark a well-functioning and coordinated system of care for CSHCN. CSHCN staff work to educate providers on the importance of providing care coordination as a component of the medical home and provide direct care coordination support to provider offices, their patients, and any CSHCN family who contacts us when needed.

Our goal related to youth to adulthood transition (12-18 years old) growing from adolescence to young adulthood is to support parents, guardians and empower adolescents during this period in life and educate them on the responsibilities of becoming an adult. Having a transition plan is critical in ensuring seamless transition to adult service providers and daily living responsibilities.

Utah CSHCN employees and stakeholders work on these educational activities to support our adolescents in the following ways: becoming independent and developing one's self-identity; communicating in difficult relationships; determining if higher education (college or trade schools) is a personal goal; developing a safety net for the future (trusts, wills, banking accounts); housing and rent; and identifying the questions to ask and skills needed to transition to adult health care providers and physicians.

In Utah we have formed a collaborative effort with several major stakeholders to address these activities and share information in a uniform and or universal manner to facilitate learning and ease the system navigation process for the public we serve. We have four active strategy groups: curriculum; referral and follow-up; marketing; and quality assurance/improvement, which includes surveying providers and families to meet NPM 12.

Assuring Comprehensive, Coordinated, Family Centered Services

Utah places a high value on family centered partnerships, family feedback, and collaboration. An example includes the Office of CSHCN's 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.

The Office of CSHCN has an Advisory Committee composed of family members and individuals with special health care needs. This committee advises the Office on the family/parent perspective regarding issues, needs, and services, influences the direction of policies, contributes to program improvement, and ensures a voice for families and individuals with special health care needs to improve the system of care. CSHCN programs incorporate surveys to gather feedback from families to identify specific needs and future directions for meaningful services.

Utah's Title V Maternal & Child Health Block Grant staff are committed to ongoing evaluation of data and population needs. We are committed to implementing evidence-based programs and practices for our vulnerable populations in an effort to improve outcomes for MCH/CSHCN families.

III.A.2. How Federal Title V Funds Complement State-Supported 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 in 2020. MCH/CSHCN used this information to select NPMs, SPMs, ESMs for the 2021-2025 needs assessment cycle. For this annual report, state priorities have not changed based on community needs. 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:

- Maternal and Infant Health Program (Perinatal Mortality Review, Preconception Health, Pregnancy Risk Line/MotherToBaby, Utah Women and Newborns Quality Collaborative)
- Oral Health Program
- Safe Haven Program
- Early Childhood Utah
- Data Resources Program
- Bureau Administration

Bureau of Children with Special Health Care Needs:

- Autism System Development Program
- Birth Defects Network
- Early Hearing, Detection and Intervention Program
- Child Health Advanced Records Management Program
- Integrated Services Program
- Bureau Administration

Bureau of Health Promotion:

- Violence and Injury Prevention Program
- Healthy Environments Active Living Program
- Baby Your Baby

And Utah's 13 Local Health Departments

III.A.3. MCH Success Story

The MCH/CSHCN Title V Block grant supports Utah Family Voices (UFV), an organization that provides statewide assistance in a variety of ways to families of children and youth with special health care needs and disabilities as well as professional providers and partners. An example of how UFV serves the MCH/CSHCN population is described below.

A mother of a young child with special health care needs, including an Autism Spectrum Disorder, was referred to the Utah Family Voices projects in the summer of 2021. The family is originally from Sudan, and the parent was in the middle of a difficult divorce. Due to the new stressors in their lives, this was further impacting her child's behavioral and mental health needs as well. This included an increase in hitting and other aggressive actions. One of the parent's difficulties included not being able to take her child to services once she found them. The parent was also struggling with finding community and support services that would help with her son's needs. She was desirous to find appropriate professional expertise to help. She wanted to be able to talk and connect with other parents who go through similar struggles and learn added wisdom from their experience. The parent also shared that she does not do Facebook or social media, since it takes too much time and she would rather do things with her son.

UFV staff provided a linkage to a parent connection website that was different from social media where the parent would not be receiving notifications, etc. The parent stated that she felt lost, and that she had been working so hard for so long and was discouraged by the impact on her son. She expressed a desire to "keep it all together".

UFV staff reassured her that everyone has difficult times and that her son is going through difficulties of his own due to all the new changes. Through receiving information and peer support, the parent was beginning to get connected as she received support in applying for TANF, childcare and financial assistance. UFV was instrumental in connecting the parent to Medicaid, while the child was able to continue under his father's insurance.

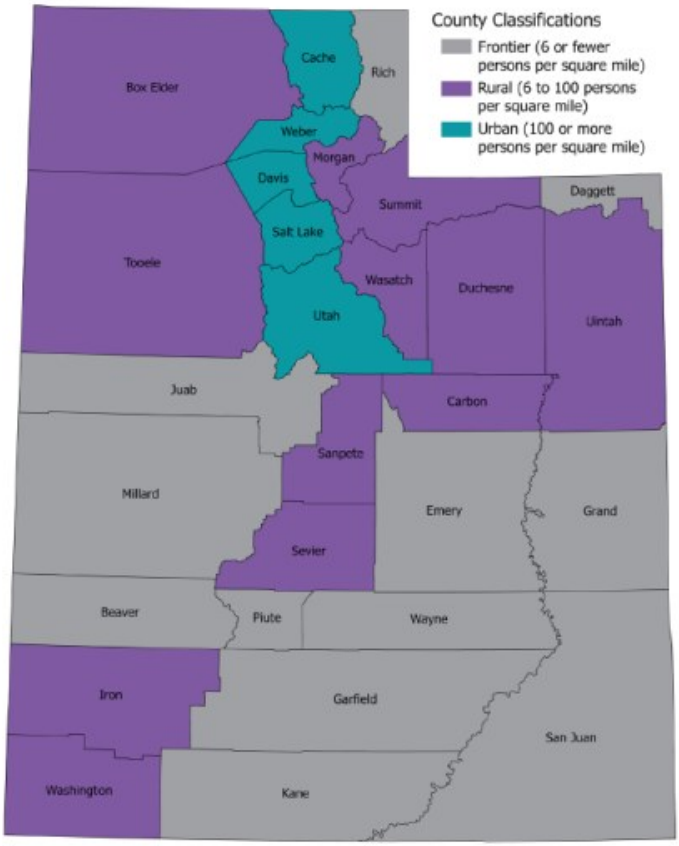
Thanks to the updated resources kept through the up-to-date lists kept by the Utah Department of Health's Children with Special Health care Needs (CSHCN), the parent was able to connect with providers. The young child was able to start receiving ABA services and UFV consultants, along with other staff at the Utah Parent Center specializing in school support, collaborated to help the family with school plan needs and updates, especially in the social-emotional areas of need.

With funding, in part, from the MCH/CSHCN Title V Block Grant, UFV operates Utah's Family-to-Family Health Information Center. Utah Family Voices is staffed by parents of children with special needs who have experience and expertise in navigating the maze of services and programs. With their lived experience, they are able to help parents in need with services and referrals and adapt services to the needs of families who request their help. This is one example of the value this agency serves Utah families.

III.B. Overview of the State

Population Demographics

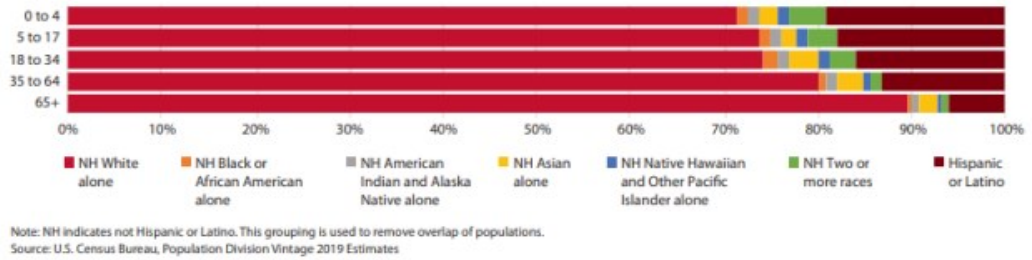
Utah is geographically the thirteenth largest state and is a largely rural and frontier state. Thirty-six percent of the State's population resides in a single county, Salt Lake County, which comprises one percent of the State's land mass. Utah has 5 urban, 11 rural, and 13 frontier counties. Utah's 2020 average population density is 39.7 persons per square mile, compared to 93.8 persons per square mile nationally. Sixty-three percent of Utah's lands are under federal ownership, with 24% privately owned, 8.5% by the State and 4.5% by Utah's tribes.



On April 26, 2021, The Census Office announced the 2020 Census findings (https://www.census.gov/data/tables/time-series/dec/popchange-data-text.html). In their press release, Utah was noted to be the fastest-growing state since the 2010 Census, with an increase of 18.4%. According to the U.S. Census Office, Utah's population increased to 3,271,616.

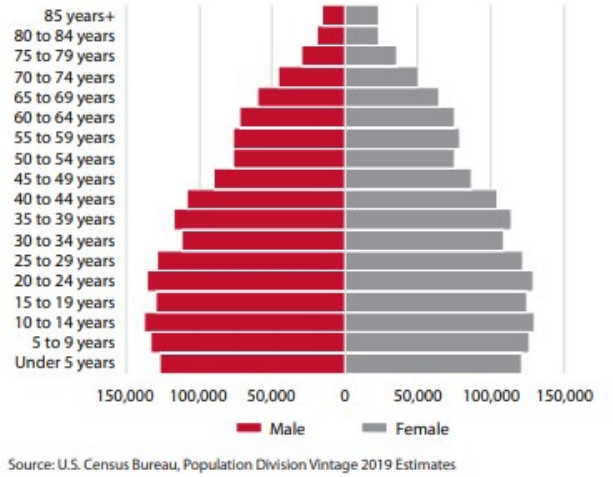
According to the report "Diversity in Utah, Race, Ethnicity and Sex", Utah ranks as the 34th most racially/ethnically diverse state in the nation with 22.3% of the population being of non-White race or Hispanic ethnicity. Utah's younger population is more diverse than older age groups.

Population estimates for 2019 detail Utah's racial/ethnic populations:



Diversity in Utah Race, Ethnicity, and Sex: https://gardner.utah.edu/wp-content/uploads/DiversityDataBook-May2021.pdf?x71849

Utah Population by Age and Sex



Diversity in Utah Race, Ethnicity, and Sex: https://gardner.utah.edu/wp-content/uploads/DiversityDataBook-May2021.pdf?x71849

The 2020 Census results also show that while Utah's population increased by 18.4%, growth was concentrated among racial and ethnic minorities. Utah's Native Hawaiian/Pacific Islander population grew the most between 2010 and 2020 at 50.4%, followed by Asians (45.5%), Black/African Americans, Hispanic/Latinos (37.6%), American Indian/Alaska Natives (26.5%), and Whites (8.1%).

The latest information on religious affiliation in Utah comes from the 2020 Behavioral Risk Factor Surveillance Survey (BRFSS), which reports that 52.2% of Utahns are members of the Church of Jesus Christ of Latter Day Saints (LDS). Utah is the world headquarters of the LDS church. Other Christian faiths (Protestant and Catholic) make up 10.9% of Utah's population. Thirty-seven percent of Utahn's identify as some another religion and less than 1% report no religion. Religious entities are invited to advisory committees and their input is sought out and valued.

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.

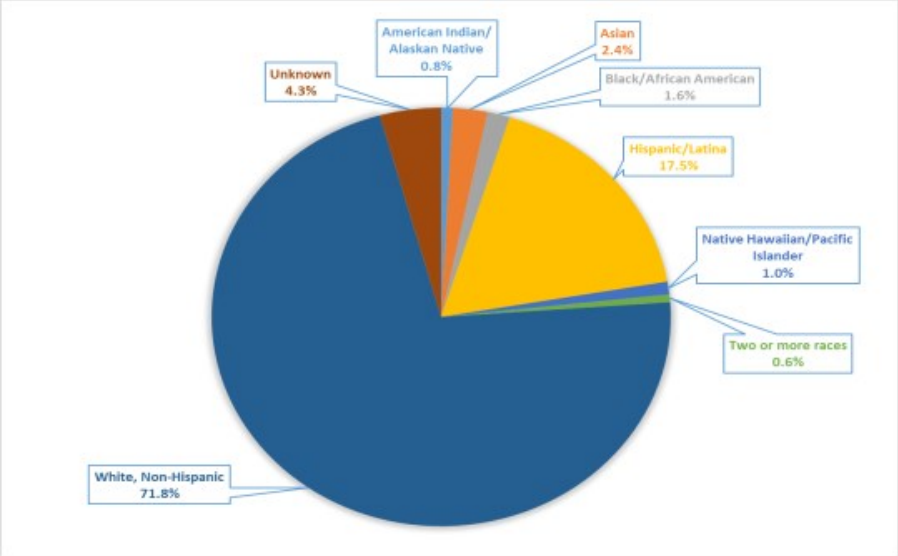
Utah has resettled over 21,501 refugees since 1998 and ranks 24th in refugee arrivals. Recent data shows that the number of refugee arrivals in Utah declined from a high in 2016 of 1,555 to 261 in 2020. Of those arrivals in 2020, 43.7% were female. Children under 18 years old comprise 53% of the refugees arriving in Utah since 2015. Refugees in Utah arrive from countries all over the world, but since 2016 most arrive from African countries (52%), followed by South and Central Asian countries (14%), the Near East (North Africa and Middle Eastern countries) (13%), and Latin American and East Asian/Pacific countries (both at 10%).

In 2020, life expectancy at birth was 77.1 years for males and 80.9 years for females in Utah, compared to 74.5 for US males and 80.2 US females. Utahns under the age of 25 make up 41.1% of Utah's population, compared to 32.1% for the U.S. overall. The younger age structure of the Utah population results in the lowest median age in the nation at 31.2 years, compared to 38.5 years for the U.S. as a whole.

Utah's Births

Utah's 2019 general fertility rate currently ranks 5th highest in the nation. Utah's fertility rate was 64.1 live births per 1,000 women in 2020 compared to 56.0 nationally. Utah continues to have the highest birth rate in the U.S. (14.1 Utah vs.10.9 U.S.). Utah's birth numbers declined for the fifth consecutive year with 45,724 live births to Utah residents in 2020.

Utah Births by Race/Ethnicity, 2020



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

Maternal Race/Ethnicity	Preterm Birth*	Low Birthweight*	Cesarean Section*	Infant Mortality** (Per 1,000)	Adolescent Births* (Per 1,000)
American Indian/ Alaskan Native	12.5%	7.3%	23.0%	3.3	16.8
Asian	19.7%	7.8%	27.7%	5.5	2.4
Black/African American	12.4%	10.7%	24.2%	9.5	23.8
Hispanic/Latina	9.8%	8.0%	25.7%	6.8	17.0
Native Hawaiian/ Pacific Islander	15.5%	8.5%	29.2%	5.1	8.7
Two or more races	8.5%	6.2%	18.6%	***	2.0
White, Non-Hispanic	9.1%	6.9%	17.7%	4.6	6.6
Unknown	9.3%	7.1%	23.9%	8.4	2.0
Statewide	9.3%	7.1%	23.0%	5.4	10.7

*2020 Vital Records data, ** 2018-2020 linked birth-death data, ***Data suppressed due to small numbers

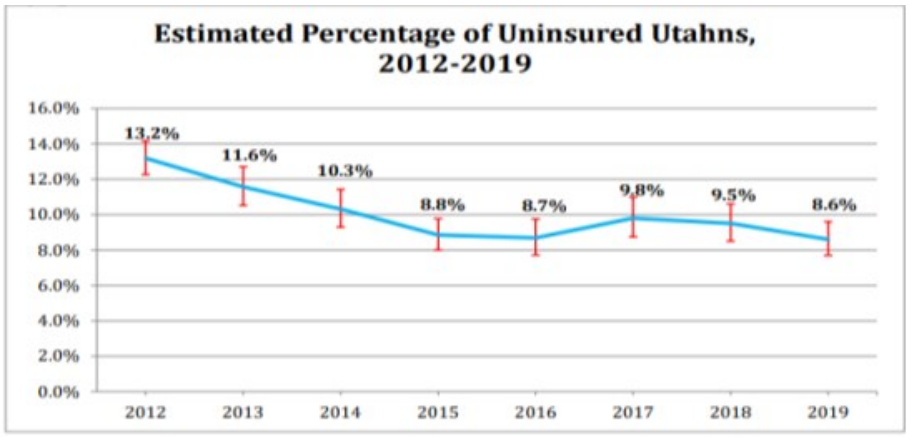
Utah's Economy

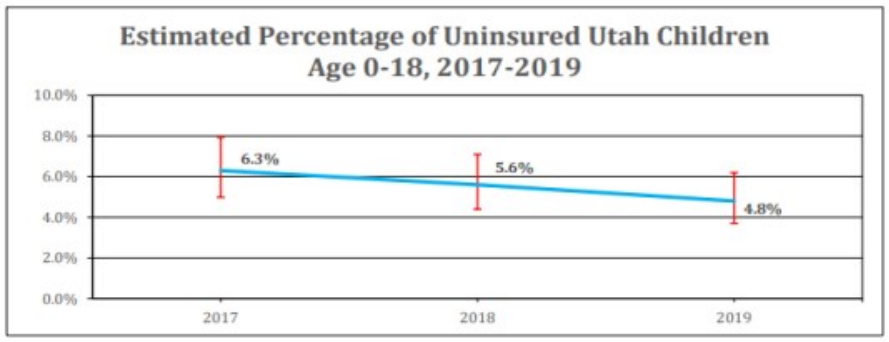
The Office of Labor Statistics notes that the 2019 unemployment rate in Utah was 1.9 compared to 3.9 for the nation. The 2015-2019 American Community Survey (ACS) estimates for median household income put Utah's $71,621 above the U.S. at $62,843. Utah's households are also large, resulting in a significantly lower per capita income ($31,771 vs. $35,672). There is also large variation in median income when broken out by race and ethnicity:

According to the 2015-2019 ACS 5-Year estimates, the percentage of individuals with incomes below the federal poverty level is 9.8% in Utah vs. 13.4% in the U.S. Poverty rates also range widely, depending on the county of residence. Poverty rates in 2019 were lowest in Morgan County (4.0%) and highest in San Juan County (21.9%), with a statewide mean of 8.8%. The 2019-2020 National Survey of Children's Health finds that 8.9% of families had a household income below 100% FPL, compared to 18.4% nationally.

Health Insurance

In 2019, BRFSS data estimated that 8.6% of Utahns were uninsured. Uninsured rates for Utah children ages 0-18 decreased as well during this time.





Rates of uninsured vary by race/ethnicity:

Race/Ethnicity	No Insurance
American Indian/Alaskan Native	18.5%
Asian	8.1%
Black/African American	32.3%
Hispanic	29.8%
Pacific Islander/Native Hawaiian	17.6%
White Non-Hispanic	9.7%

Utah BRFSS data from 2019 estimates that 4.8% of children below 18 years were without health insurance. The 2019-2020 National Survey of Children's Health has higher estimates of no insurance among this group, at 8.6%.

Education

Based on the 2015-2019 ACS, Utah had a higher percentage of residents with a high school diploma, at 92.3% vs. 88.0% nationally among those aged 25 years and older. Utah's population age 25 years and older with a Bachelor's degree is higher than the U.S. (22.5% vs 19.8%) and similar to the U.S. for those with graduate degrees (11.5% vs 12.4%). According to the 2020 Kids Count report, Utah has a higher percentage of children ages 3-4 who are not in school compared to the nation (56% vs 52%). Utah is doing better than the national average for the proportion of fourth graders not proficient in reading (60% vs. 66%). The National Education Association reports Utah having the second-lowest per-student expenditure at $7,247, compared to the national average of $12,978.

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 percentage of Utah family households with one or more persons under the age of 18 is higher at 40.8% vs. 31.0% nationally.

Children and Adolescents

National Survey of Children's Health data from 2019-2020 illustrate many areas where Utah's children differ from the national average:

	Utah %	U.S. %
Race/Ethnicity		
Hispanic	18.1	25.7
White Non-Hispanic	74.1	50.1
Black Non-Hispanic	0.9*	13.3
Asian Non-Hispanic	1.2	4.6
Other Non-Hispanic	5.7	6.4
Primary language spoken in home		
English	94.1	85.7
Non-English	5.9	14.3
Highest Education in Household		
Less than High School	3.6*	9.4
High School	13.0	19.2
Some College	21.8	21.2
College Graduate	61.6	50.3
Family Structure		
Two parent, currently married	79.8	64.3
Two parent, not currently married	3.9	8.4
Single parent	13.5	22.0
Grandparent household	1.6	3.7
Other family type	1.1*	1.6
Not insured at time of NCHS survey	8.6	6.9
Current insurance not adequate	30.0	27.1
2 or more adverse childhood events	15.9	18.1

**Interpret with caution - estimate may be unreliable due to small sample size*

The 2019 Youth Risk Behavior Survey (YRBS) illustrates differences between Utah high school youth and those in the nation: Utah youth were significantly more likely to report that they carried a weapon in the past 30 days (21.5% vs. 13.2%) and were more likely to report having carried a weapon onto school property (6.9% vs. 2.8%). Utah youth were significantly more likely to report having experienced sexual violence (14.3% vs. 10.8%). 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.

Children with Special Health Care Needs (CSHCN)

Data from the 2019-2020 National Survey of Children's Health (NSCH) found 24.3% of Utah children have one or more functional difficulties and 15.8% of Utah children have special health care needs. Utah's percentage of children with special health care needs ranks fourth lowest in the nation. The 2019-2020 NSCH data provides important information on Utah's CSHCN population and their parents:

Comparison of Utah and U.S. Child Demographics Overall and by CSHCN				
	Utah Overall (%)	**Utah CSHCN (%)**	**U.S. Overall (%)**	**U.S. CSHCN (%)**
Race/Ethnicity**				
Hispanic	18.1	20.0	25.7	16.8
White Non-Hispanic	74.1	14.4	50.1	20.2
Black Non-Hispanic	0.9*	--	13.3	23.3
Other Non-Hispanic	6.9	15.1*	10.9	16.7
Household Income				
0-99% FPL	8.9	14.0*	18.4	22.8
100-199% FPL	21.9	15.5	21.5	19.6
200-399% FPL	39.5	16.5	29.1	18.5
400% or greater FPL	29.7	15.5	31.0	18.0

Comparison of Select Indicators by CSHCN and non-CSHCN for Utah and U.S. CSHCN				
	Utah CSHCN (%)	**Utah non-CSHCN (%)**	**U.S. CSHCN (%)**	**U.S. non-CHSCN (%)**
One or More Current or Lifelong Health Conditions	88.0	22.6	92.1	24.9
Current insurance not adequate	34.8	29.1	33.7	25.4
Did not receive needed health care	10.4	2.2	8.8	2.3
Child has coordinated, ongoing, comprehensive care in a medical home	57.2	55.4	42.2	47.9
Problems paying for child's medical or health care bills in past 12 months	19.4	7.5	16.7	8.4
Family member cut back hours, stopped working, or both due to child's health	14.9	3.3	18.1	4.2
Sometimes or often could not afford to eat	7.2*	3.7*	8.8	4.1

-- Dashed lines indicate that the total number of respondents to this measure (unweighted denominator) is less than 30, which does not meet MCHB data display criteria
*Please interpret with caution: estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable.
** Sample size too small to include Asian race category

Autism Spectrum Disorders (ASD) Prevalence Estimates Statewide

The Utah Registry of Autism and Developmental Disabilities (URADD), identifies Autism Spectrum Disorder using a community medical diagnosis and/or autism special education eligibility to indicate a prevalence estimate of 2.2% for individuals aged 0 to 16 years old. Of interest is the 4 years old population, in which the estimated prevalence has dropped from 1.2% in 2012 to 0.9% in 2018. As Utah's overall prevalence estimate has risen, attempts to diagnose children with ASD earlier have not been successful. In 2021, the Autism Systems Development Program (ASDP) developed marketing and educational materials to encourage earlier diagnosis and worked with Help Me Grow Utah (HMG) and early intervention programs to implement the M-CHAT and STAT screeners. In 2021, HMG screened 140 children for ASD and referred 103 of those children to appropriate services. In the past, ASD prevalence estimates in Utah have focused on Salt Lake, Davis, and Tooele Counties.

In an effort to better understand ASD state-wide, URADD produced ASD prevalence estimates for the entire state based on a medical diagnosis of ASD. Autism prevalence estimates in urban and rural areas are similar, however, frontier locations are lower than expected.

The URADD prevalence estimates for 6-year olds (born in 2012) for the entire state.

	Prevalence Estimates		Percent (%) of Population with ASD			
	Rate per 1,000	Ratio	White	Hispanic	Other*	Not-given
State-wide	18.4 per 1,000	1 in 54	71	17.7	6.3	5
Urban	18.8 per 1,000	1 in 53	69	19	6.6	5.4
Rural	17.7 per 1,000	1 in 57	76	13	4.2	10.3
Frontier	10 per 1,000	1 in 100	94	-	6	-

Data Source: The Utah Registry of Autism and Developmental Disabilities and the UDOH Public Health Indicator Based Information System (IBIS)

Urban = Cache, Weber, Davis, SLC and Utah
Rural = Box Elder, Carbon, Iron, Morgan, Sanpete, Sevier, Summit, Tooele, Uintah, Wasatch, Washington
Frontier = Beaver, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, Rich, San Juan, Wayne
*Other is a combination of Black or African American, Asian, Native Hawaiian or Pacific Islander and American Indian or Alaska Native.

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 Offices 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 Office 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 women, 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, as well as producing reports, fact sheets, abstracts, and articles in peer reviewed journals with UDOH staff as authors.

In 2019-2020, 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. A copy of the full Needs Assessment Report can be found here.

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). For this annual report, state priorities have not changed based on community needs. 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 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 Offices collaborate across the UDOH to ensure integrated use of data and population assessment. There is a UDOH Analyst Network that meets monthly for collaboration and learning events.

Utah's Strengths and Challenges

Strengths

Utah's Title V programs have many attributes which contribute to enhancing communities' health and wellness statewide. Utah has strong collaboration efforts with stakeholders and values and incorporates the advice of our peers to develop, implement, and evaluate programs for women, children, and families. The State of Utah has created a hybrid work model which includes both telework and in-person options. Utah continues to find success by being able to conduct our MCH/CSHCN work with stakeholders, the public, and populations we serve through virtual meetings and service provision.

Utah MCH/CSHCN staff are resilient and respond when called on. A specific example this past year was when Omicron was surging in the state. Testing sites were overwhelmed with wait times in lines for people to be tested lasting four or more hours. A call went out to all UDOH staff to assist at testing sites. Dozens of staff stepped up and assisted testing sites with registrations, vehicle movement through the long lines, swabbing (if trained) and distributing home testing kits.

Another example happened when there was a shortage of substitute teachers in the school systems. The Governor asked all State Employees to consider substitute teaching in respective school districts to relieve the burden. With many regular staff out sick, the need was great. Many MCH/CSHCN staff stepped up and answered the call to be a temporary substitute teacher in their respective school districts.

Utah has been able to react quickly to gather needed information. The Utah PRAMS survey was able to add supplemental questions related to the COVID-19 pandemic and a second on COVID-19 vaccinations during pregnancy. This data was important for the Title V program to understand how pregnant women were impacted by the pandemic.

Baby Watch Early Intervention (birth-three)

The biggest change for Utah's early intervention service delivery during the COVID-19 pandemic was the implementation of tele-intervention. Although many providers and families were very skeptical about using tele-intervention, we all learned that there are actually benefits to this type of service provision, including the following:

As Part C Early Intervention is provided through a family coaching model, we found that providers became better "coaches" during tele-intervention sessions. They developed strong skills that supported the parent(s) in providing interventions for their child during daily routines and activities.

Parents became more empowered as they learned that they are capable of supporting their child's growth and development. In some instances, it was less stressful for parents to receive tele-intervention vs having someone come into their home. Services were still able to be delivered even if the provider or family member was not feeling well.

Service delivery can be more efficient by decreasing travel time and allowing more time for providers to deliver services to more children during their work day. Both providers and families were able to increase their skills using technology.

In addition to the positive experiences, we also learned that although most parents were happy with virtual services overall, they also feel that virtual services are most beneficial as a compliment to what can be provided during an in-person service. Another challenge was the family's access to technology in order to support tele-intervention services.

Early Hearing & Detection Intervention

Utah EHDI addressed the COVID-19 pandemic head-on with immediate action.

1) Rapid outreach was conducted to all of the newborn hearing screening (NBHS) programs statewide to determine what the state shutdown would mean to their programs at their hospitals and clinics; some conveyed that NBHS or its follow-up would not be accomplished. Within a few days of the state shutting down, the Utah EHDI program sent out a document, "Newborn Hearing Screening and COVID-19 Guidance" to all stakeholders and providers that serve newborns and infants. This document immediately set forth that NBHS and its appropriate follow-up is considered an essential service and should be completed to the safest extent possible, and that all obligations, laws, and UDOH policies regarding NBHS and all related follow-up remain in place.

2) Several video conferences were held over the ensuing months with NBHS programs to document any forced changes in protocols due to the pandemic and their effects. In order to maintain documentation of COVID-19 affecting NBHS, a "COVID-19" note was created in the Utah EHDI database, HiTrack, in order to make note of COVID positive moms and neonates and track families who did not receive services or timely follow-up due to COVID. These video conferences served as a platform for programs to share concerns that had arisen and brainstorm ideas for improvement with each other. This constant communication was key in ensuring the best possible services for our infants and families.

3) The EHDI Follow-Up Coordinator also completed a needs assessment with families she spoke to while contacting them during the pandemic in the course of conducting EHDI follow-up. During the pandemic, in 2020, 99.93% of newborns in Utah were screened for hearing; in 2021, 99.95%.

Integrated Services Program (ISP)

The COVID pandemic and the accompanying fears of travel and face to face encounters has pushed the healthcare and service delivery systems into a more readily available and accessible telehealth environment. As such, both providers and families have been encouraged to pursue telehealth as a viable alternative to the traditional visit. Staff felt that often services like developmental screenings, evaluations, and diagnoses are easier and better via telehealth because children are in their natural environment. ISP has heard success stories from parents indicating that telehealth has allowed them to have appointments at times that more readily fit their schedules, without the added burden of travel costs and missing school and work.

While telehealth works very well in a wide range of patient encounters, it is NOT the solution for every situation. Some well child visits are not well suited to telehealth as both the hands-on physical evaluation AND subsequent scheduled immunizations cannot be completed virtually. For behavioral health evaluations, some children cannot or will not participate virtually, therefore, live visits become the only option. Our pediatric psychologist had to adapt her face-to-face skill set to telehealth testing and evaluation. This required a lot of re-training, adaptation, and practice to gain confidence in both reliability and validity of test results. Given the time frame to adapt her skill set, the psychologist was unable to test children remotely for almost six months.

With regards to our "Lending Library" which includes Chromebooks and hotspot technology, we've learned that a hotspot is only as good as the wireless/broadband signal in the area. If families reside where there are no or very few cell towers, then a hotspot may not be the best option. In these cases, we have encouraged families and patients to schedule appointments with the local health department (LHD), school, or library and use their wireless or wired connection to the internet. Most of these locations can provide a private room where the family may conduct the telehealth visit to remain HIPAA-compliant. Our care coordinators have helped to coordinate these arrangements between family, service provider, and the school, library, or health department.

Challenges

The geographic distribution of the State's population continues to present 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.

The UDOH continued as the statewide lead on the COVID-19 pandemic and employees across all sections of the department participated in areas of pandemic safety, education, in-person testing, setting up vaccination clinics, and research and media information presentations. Our executive leadership have worked tirelessly hours to address community, legislative, safety needs while acknowledging the efforts of the entire UDOH team.

Face-to-face service provision during the pandemic continues to create challenges due to the variety of safety measures to be considered to reduce transmission of the virus and protect the service providers and population/families we serve. A recent report published by the program highlights the challenges and successes of providing tele-audiology in rural and frontier counties in Utah: https://ibis.health.utah.gov/ibisph-view/pdf/opha/publication/hsu/2022/02_Tele-ABR.pdf#HSU

For the CSHCN population, the COVID-19 pandemic has caused significant adaptations in everyday routines due to school closures, online learning, virtual health, lack of therapy and in-home services and financial hardships. Additionally, the pandemic has raised stress and anxiety in both parents and children, tension in relationships, fear of a CSHCN or family member contracting the virus and finding ways to manage caregiving. Utah is creating a "new" normal service delivery system, i.e. allowing the past to be the past and being open and creative in developing new modern strategies for service and work processes.

A significant challenge this past year is the UDOH and the Department of Human Services within the state are merging to form a Department of Health and Human Services (DHHS), effective July 1, 2022. The Offices of MCH and CSHCN will be co-located, and renamed "Offices", in the new Division of Family Health (this change is reflected throughout the narrative of this document). This restructuring involved a building move for MCH/CSHCN staff in April 2022. The consolidation has created changes in organizational structure, processes, policies, logos, and eventually, websites. One example is the legislature passed a requirement for human resources to implement which changes a schedule B (a "career service" designation) to an AX (an "at-will" designation) classification for supervisory positions. These changes have created stress for supervisors as there is concern for loss of employment protections and the long term consequences are unknown. Fortunately, within MCH/CSHCN overall we have maintained employees, although some have been offered new leadership opportunities within the Department which created turnover of employees, challenges with workloads, timeliness of rehiring, orienting and stabilizing new employees. MCH/CSHCN team members are being positive and engaging with creativity to improve the system with the new Department changes.

Addressing the Needs of a Diverse Population

UDOH has endeavored to include data on subpopulations in an attempt to better quantify the issues faced by various groups. The Office of Health Equity (OHE) works to document and address existing and emerging health disparities among historically and systematically disadvantaged populations. The OHE produced the Health Equity Framework which outlines how structural and social determinants of health impact health equity and quality of life. It guides the vision that Utah's public health, health care, and social systems should be adequate and accessible for all Utahns. The OHE assists the UDOH in identifying priorities and needs of specific key populations in the state through quantitative and qualitative data reporting, assessing the adequacy of race/ethnicity data from common public health

data sources and recommending improvements and guidelines, informing communities about efforts and activities, and developing tools and guidance to promote cultural and linguistic appropriateness for UDOH programs.

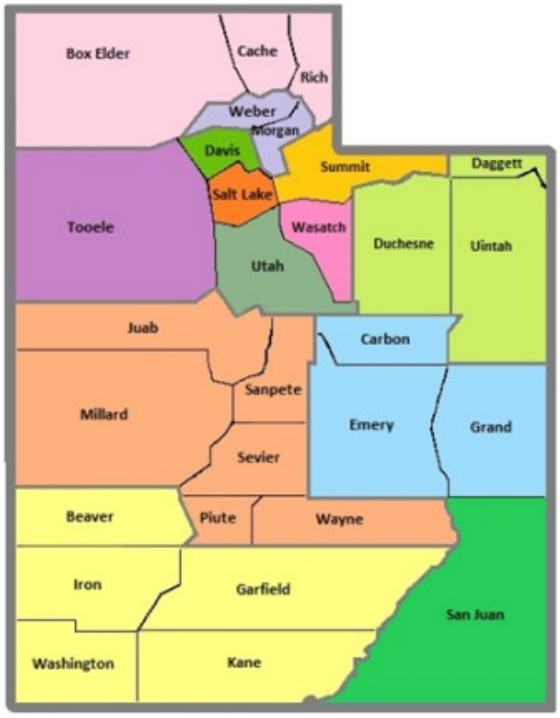
The OHE works to build Utah's public health infrastructure to advance health equity at the state and local levels. It supports the establishment offices of health equity across Utah's LHDs and provides training to UDOH and LHD staff on health equity practices and equity, diversity, inclusion, and access. The OHE also works closely with community health workers (CHWs) to create programs and systems, like the COVID Community Partnership (CCP) project, to integrate CHWs in UDOH efforts. Efforts also include building internal and external infrastructures to support and expand the capacities of the CHW workforce. The OHE developed the It Takes a Village: Giving our babies the best chance (ITAV) project. ITAV is a community education and engagement series to raise awareness about maternal and infant health. It uses a thorough anthropological approach with a cultural framework, which mirrors the Pacific way of life and borrows from traditional Pacific systems for resolving community problems. Additionally, The Embrace Project Study (Embrace) is a community-based participatory research study extending ITAV practices and principles to improve maternal mortality and morbidity and diabetes and gestational diabetes health disparities among NHPI women. Title V program and the OHE work together to identify opportunities to collaborate to address MCH needs among diverse populations.

UDOH works with the Office of American Indian/Alaska Natives (AI/AN) Health Affairs. This office facilitates meetings 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 are provided in various settings, including medical homes/private providers, LHDs, community health centers that serve the homeless and migrant workers, and a number of free clinics. There remains a great need for CSHCN services around the state. The CSHCN Office, in collaboration with its stakeholders, continues to research resources, make community connections, refer and brainstorm ideas for a more comprehensive and accessible service delivery system. During the past year, service needs have grown and the CSHCN Office and stakeholders continue to discuss strategies to meet the current health needs of this population.

Utah's public health system comprises the UDOH and 13 LHDs. The UDOH 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.



Local Health District	Counties in Service Area
Bear River Health Department	Box Elder, Cache, Rich
Central Utah Public Health Department	Juab, Millard, Piute, Sanpete, Sevier, Wayne
Davis County Health Department	Davis
Salt Lake County Health Department	Salt Lake
San Juan Public Health Department	San Juan
Southeastern Utah District Health Department	Carbon, Emery, Grand
Southwest Utah Public Health Department	Beaver, Garfield, Iron, Kane, Washington
Summit County Health Department	Summit
Tooele County Health Department	Tooele
TriCounty Health Department	Daggett, Duchesne, Uintah
Utah County Health Department	Utah
Wasatch County Health Department	Wasatch
Weber-Morgan Health Department	Morgan, Weber

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. 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

To meet the needs of underserved populations, there are many systems which collaborate to increase seamless services for Utah's population. One such system are the Community Health Centers (CHCs) throughout the state and the Wasatch Homeless Clinic in Salt Lake City who 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.

The UDOH provides primary care through the Health Clinic of Utah (HCU), which is located in Salt Lake City. The medical clinic is staffed with a multidisciplinary team. The clinic provides high quality medical care at the lowest cost

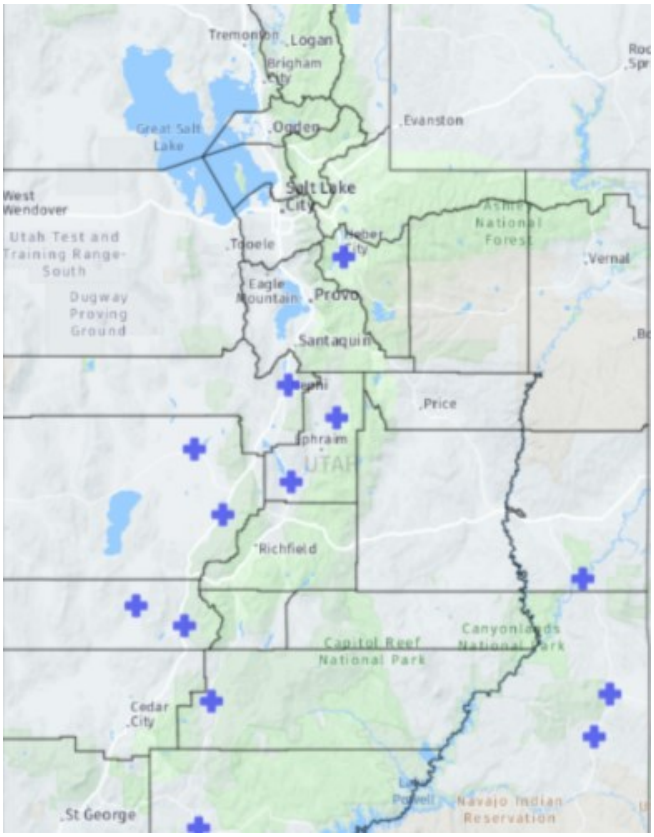
to clients. HCU accepts most forms of insurance including; Medicaid, the Children's Health Insurance Program (CHIP), and Medicare. Among the patients seen in the clinic in FY2020 36% had Medicaid and 26% were uninsured. In addition to regular clinical services, the HCU provides immunizations and health screenings for newly resettled refugees and provides medical screenings for children in protective service care in multiple counties.

The Indian Health System in Utah consists of one IHS outpatient facility, four 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 nearby. 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 below 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, which can be located 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. 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.

Utah has 13 Critical Access Hospitals throughout the state:



Telehealth Capacity

Telehealth capacity is expanding in Utah. The 2021 America's Health Rankings Report notes that Utah has the third highest percentage of households with high-speed internet, with a rate of 93.3%. 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 lack of access to specialists, travel costs, inability to take time off from work, costs of testing, etc. To reduce barriers to early diagnosis after failing newborn hearing screening, the Utah Early Hearing Detection and Intervention (EHDI) program purchased auditory brainstem response equipment to provide diagnostic tele-audiology services for rural/frontier communities. In 2020-2021, EHDI expanded the rural tele-audiology service.

Tele-audiology services are hosted at the CSHCN Office with three pediatric audiologists on staff and a nurse or trained facilitator at the remote sites. During the pandemic, audiologists worked from their homes to provide the services. The facilitator 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 accesses 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 Office 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.

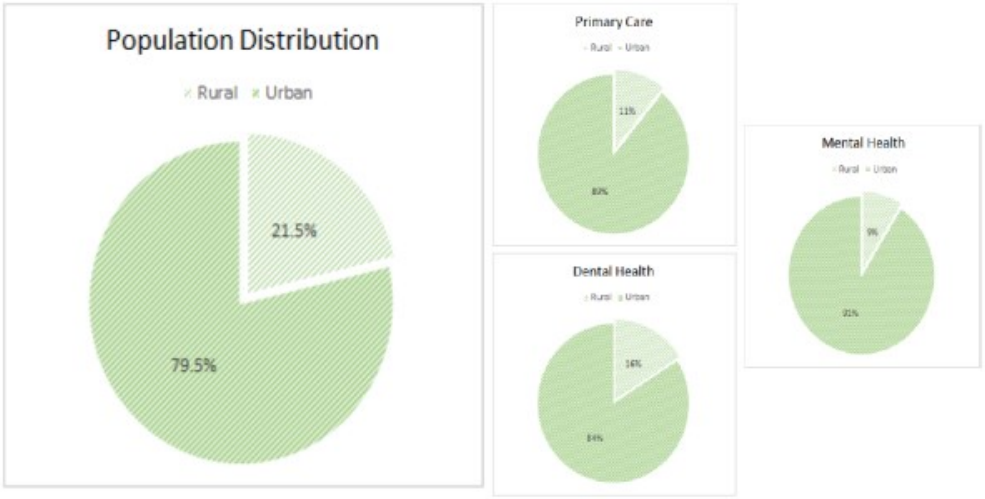
The UDOH funds the University of Utah (UofU) for perinatal mental health screening and counseling via telehealth. The project is now working with five of Utah's rural LHDs to screen women for postpartum depression symptoms using the Edinburgh postnatal depression scale tool, refer women who need support,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

This past year, Utah has continued to utilize a hybrid work model of telework, virtual healthcare, and in-person services. We have found keeping communications open, providing online support and direct services have been invaluable during the past year.

Clinical Workforce Availability

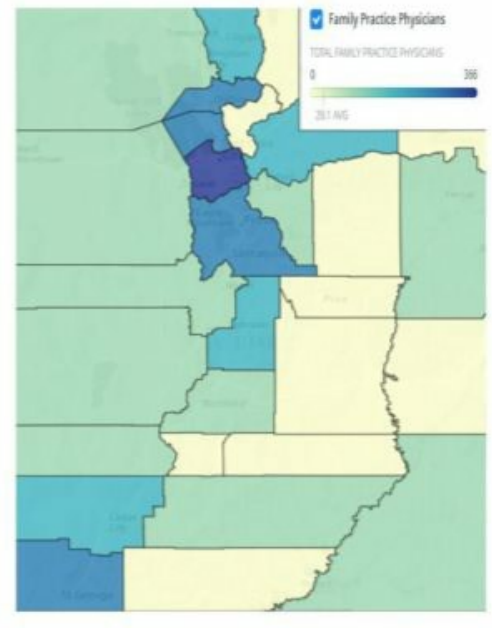
The ratio of physicians to persons in a population is an indication of the adequacy of the health system and the access to care for persons in that population. According to the United Health Foundation's 2021 Annual Report on America's Health Rankings, Utah ranks 49th in the number of Primary Care providers with 194.3 providers per 100,000 population (compared to 252.3 nationally). The ratio of dental care (59.7 per 100,000) and mental health care (367.3 per 100,000) providers for Utah ranks 26th and 14th respectively. The Utah Office of Primary Care & Rural Health 2021 Health Needs Assessment report also finds that the distribution of providers who practice in rural communities is uneven. With 21.5% of the State's population living in rural areas, only 11% of primary care provides practice in rural areas. There are similar disparities for dental and mental health care providers.

Population and Provider Distribution Between Urban and Rural Areas

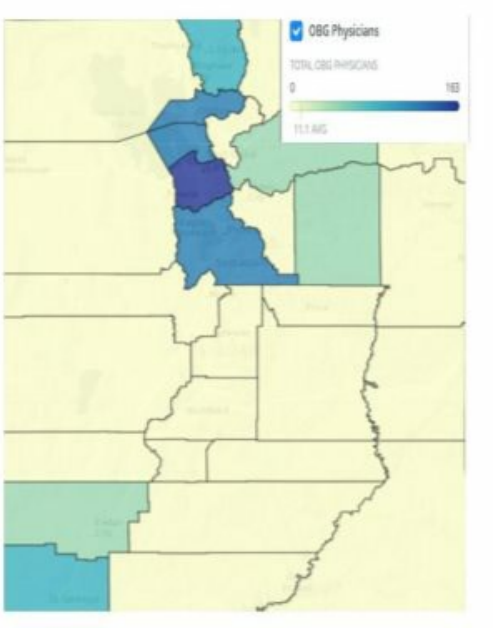


In 2018, the latest data available, the primary care physician to civilian ratio per LHD varied from a low of 1.7 in Tooele LHD to a high of 12.9 in Summit County LHD. While there are primary care physicians at the LHD level, three counties do not have any primary care physicians, resulting in geographic disparities within LHDs.

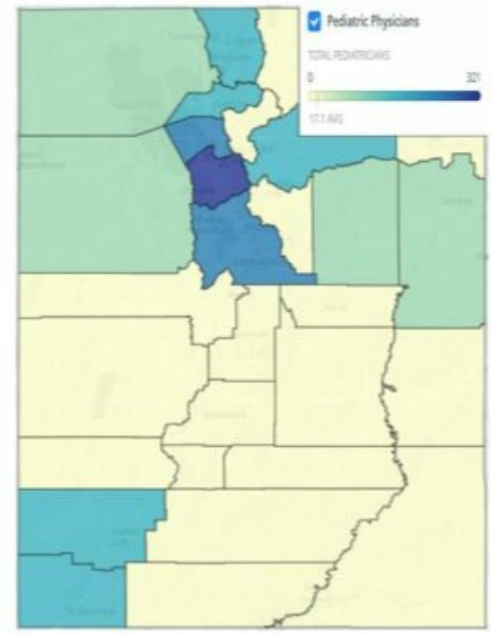
Primary Care: Family Physicians



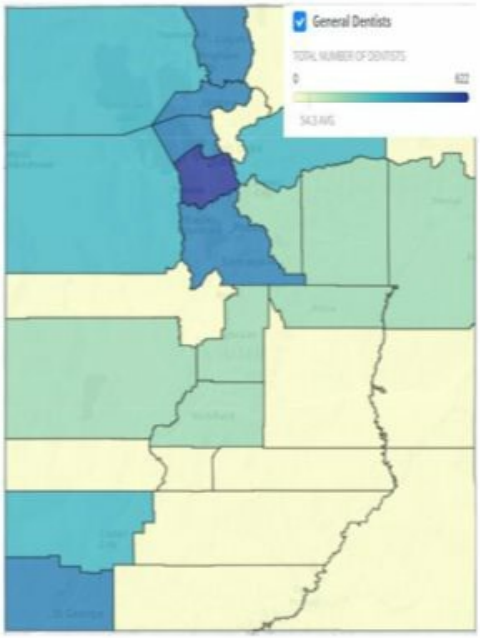
Primary Care: Obstetrics/Gynecology



Primary Care: Pediatricians



Primary Care: Dentists



The Integrated Services Program (ISP) contracts 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. 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 present 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, LHDs 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), but for those living in rural/frontier areas of the state, families must drive long distances to access the same services. In 2021-2022, we provided services through a hybrid model that includes both virtual and in-person services. The program has found this modality has allowed the ISP providers to be more flexible on appointment times and they have met in the evenings with families after the work day. Additionally, it has cut travel time and costs allowing for more service time.

Utah’s Public Behavioral Health System

Utah's public behavioral health systems have a similar structure to 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 LHD.

Utah Medicaid

Utah's Medicaid program is administered through the UDOH. The Medicaid program provides vital support to MCH/CSHCN populations throughout the State. Utah Medicaid contracts with managed care entities to provide medical services to Medicaid members. Utah Medicaid has two types of managed care entities that are relevant: Accountable Care Organizations (ACO) and Utah Medicaid Integrated Care (UMIC). Members enrolled through Adult Expansion living in Davis, Salt Lake, Utah, Washington, or Weber counties must choose a UMIC plan. Non-expansion 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 or UMIC plan is responsible for covering all medically necessary services for their enrolled Medicaid members. Medicaid pays a monthly capitated rate for each Medicaid member enrolled in an ACO or UMIC plan. Each ACO or UMIC plan is allowed to offer more benefits and potentially fewer restrictions than Utah's State Plan benefits, however they are not allowed to provide less benefits. The ACO or UMIC plan must specify services which require prior authorization and the conditions for authorization.

Members enrolled in an ACO or UMIC plan must receive all services through a provider in that plan's network. The provider is paid by the managed care entity. Members enrolled in the Fee for Service Network may use any willing Utah Medicaid provider, Fee for Service providers are paid directly by the State.

The CSHCN Office is designated by Medicaid to provide the following services to children with special health care needs: case management, explaining benefits including eligibility and services, and referral assistance.

On December 23, 2019, the Centers for Medicare and Medicaid Services (CMS) authorized the UDOH to implement full Medicaid expansion, as authorized under the Affordable Care Act, for the State of Utah. More than 110,000 Utah adults have enrolled under the expansion program as of May 2022. Adults ages 19-64 are 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.

Under a program titled the Utah Premium Partnership, the state allows newly eligible adults to enroll in an employer-sponsored health plan if they have access to one. Under this program, Medicaid will then cover the individual's monthly premium and other out-of-pocket expenses like copays and deductibles up to a monthly maximum.

During the Public Health Emergency (PHE) due to the COVID-19 pandemic, Medicaid has sustained a Maintenance of Effort (MOE) requirement for eligibility. From March 2020 until the end of the PHE, all Medicaid cases are kept open unless a member moves out of state, requests closure, or dies. This has led to an approximate 40% increase in enrollment numbers. Closures will increase as the PHE ends and normal eligibility reviews begin again.

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 assessments, capacity surveys and historical experience to make determinations for program capacity, development and funding with the goals to improve access and services throughout Utah.

III.C. Needs Assessment

FY 2023 Application/FY 2021 Annual Report Update

MCH/CSHCN Ongoing Needs Assessment Activities

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

1. Throughout the year, available data is assessed and reviewed related to Block Grant performance and outcome measures. This allows for a 'mini' needs assessment annually through analysis of data trends and identification of demographic and geographic disparities within the domains. This data review process informs program planning and goal setting relative to emerging and unmet MCH/CSHCN population needs. Beginning in 2023, core Block Grant writers will also receive additional training on Health Equity and applying an equity lens when reviewing Federally Available Data and Program Data related to performance and outcome measures.

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

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

4. Programs within the Office of MCH and the Office of CSHCN collaborate to identify data gaps and to develop and conduct ongoing assessments to collect this data. Specific examples include developing and implementing questions related to well-woman care for the Behavioral Risk Factor Surveillance System (BRFSS) survey. Staff participate in several advisory committees, and propose adding new questions to fill identified data gaps.

5. The UDHHS highlights leading health issues in its monthly Utah Health Status Update (HSU) publication. HSUs are sent to the Governor's Office and more than 500 individuals including policy makers, health professionals and state and LHD staff. Because Title V work happens via collaboration among many programs, the HSU publication keeps all readers informed about important and emergent state population health needs across many state health programs.

Each year, a Department wide meeting is held to review ideas for potential HSU articles. The SSDI Project Coordinator/MCH Epidemiologist represents Title V programs. Prior to the meeting, the SSDI Project Coordinator/MCH Epidemiologist requests that all MCH/CSHCN staff submit potential topics, which are then presented at the annual HSU topic meeting. After the meeting, a finalized HSU annual publication schedule is developed.

The following provides a list of articles completed in 2021-2022 related to MCH/CSHCN populations:

- COVID-19 Serving Children with Special Health Care Needs - January 2021
- Postpartum Contraception Use Among Utah Women - January 2021
- 2019 Youth Risk Behavior Survey Report - February 2021
- Breast Cancer Screening in Utah and the Impact of COVID-19 - February 2021
- Postpartum Depression Among Adolescent Mothers - February 2021
- Adolescent Health Report 2019 - March 2021
- Utah E-cigarette or Vaping Product Use-Associated Lung Injury (EVALI) - March 2021
- Use of Postpartum Prescription Pain Relievers - April 2021
- Sociodemographic Disparities in Obtaining Oral Healthcare During Pregnancy - May 2021
- The Effects of the COVID-19 Pandemic on Early Hearing Detection and Intervention Milestones - May 2021
- Women's Experiences of Support Following a Stillbirth - June 2021

- Child Injury Death Trends in Utah - September 2021
- Student Injuries in Utah - September 2021
- Breastfeeding Information Sources - October 2021
- Use of Tele-Audiology for Diagnostic Testing After Failed Newborn Hearing Screening - February 2022
- COVID-19 Pandemic-related Stressful Events Experienced During Pregnancy - March 2022
- Autism Spectrum Disorder and Suicidal Ideation - April 2022
- Prenatal Care Experiences During the COVID-19 Pandemic - 2022
- Cytomegalovirus, and socioeconomic factors affecting longitudinal outcomes of infants failing newborn hearing screening (pending publication)
- Impact of the COVID-19 Pandemic on Postpartum Care in Utah (pending publication)

6. Title V staff meet with community partners to identify and work on emerging issues. The Utah Children's Care Coordination Network, funded through Title V, whose membership serves as a surrogate marker for the Medical Home, convenes monthly as an educational and needs-based forum for care coordinators, commercial and public insurance providers, practice managers, and providers to discuss issues surrounding pediatric care coordination. Participants identify gaps in services for children with special health care needs then work together to problem solve and find solutions that include supports, specialists, and organizations to meet family needs. Educational topics over the past 12 months have included: behavioral health; diagnosis-specific topics; care coordination skills improvement; services in the time of COVID self-care/stress; EIP/504; and leisure activities for CSHCN. The Office of CSHCN established program-specific dashboards that allow outreach, goal setting and progress, and overall accountability to be tracked in real time. These dashboards were vetted with the Department's quality improvement director and used as a working example for other programs and Offices to emulate. The Integrated Services Program (ISP) convenes monthly meetings with a broad group of stakeholders who serve the CSHCN population to promote and implement unified statewide curricula and standards; solicit user feedback to ensure patient satisfaction; and execute quality improvement measures.

Concerning Changes in Utah's MCH/CSHCN Populations

During the past year, Utah continues to face many issues and deficiencies in the system. Lack of access to healthcare, food/hygiene/first aid resources, employment, housing and available resources, stable/reliable internet connections, language/cultural barriers, mistrust due to mistreatment, disparities and inequities have continued to be identified as statewide needs within our communities. Gaps have been identified in the surveillance, data and effective communication systems throughout the State.

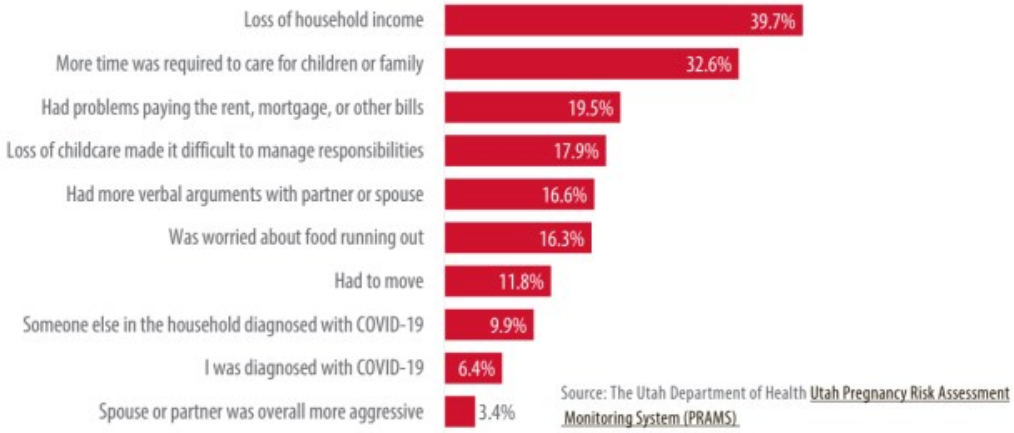
The full impact of COVID-19 on MCH/CSHCN populations is still being investigated. The number of births in 2020 went down slightly from 2019, but preliminary 2021 data suggests the number of births increased somewhat. We also anticipate that with children isolated at home and not attending school, child abuse and adverse childhood experiences may go undetected. Additionally, the Utah Registry of Autism and Developmental Disabilities (URADD), which tracks the prevalence rates for Autism Spectrum Disorder and other Developmental Disabilities, has begun collecting data from 2020. Data collection will be complete in September of 2022. Preliminary data suggests that the COVID-19 pandemic had little or no impact on families obtaining a diagnosis. Title V leadership will continue efforts to address these issues and work with stakeholders to improve the statewide system.

PRAMS data provides valuable and timely information on some of the impacts of COVID-19 on pregnant persons. The frequency of people reporting anxiety before pregnancy had been increasing before the pandemic, but jumped from 27.8% in 2019 to 34.5% in 2020 (the most recent data available). Anxiety during pregnancy also increased sharply from 28.1% in 2019 to 35% in 2020. From July to December 2020 Utah PRAMS included additional questions on maternal experiences related to the COVID-19 pandemic such as impacts on pre and post-natal care and COVID-19 related stressful life events. Overall 61.8% of respondents in that six-month period experienced at least one pandemic related stressor. The most common stressor was the loss of household income (39.7%) due to them or other household members losing a job or having cuts to work hours or pay.

As the prevalence of perinatal mental health conditions was increasing before and possibly exacerbated by the pandemic in Utah, timely access to mental health resources is vital for parents and providers. This data supports the need for continued focus on perinatal mood and anxiety disorders.

Percentage of COVID-19 Pandemic-related Stressful Life Events Experienced During Pregnancy, July–December 2020

Figure 1. More respondents reported a loss of income or added time demands for caring for children and family in the survey.



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

Over the past year, the COVID-19 pandemic has continued to impact the systems of care in the State of Utah, including those for Title V populations. These impacts were especially felt among Utah's Local Health Departments (LHDs).

The COVID-19 pandemic of 2020 (and ongoing into 2022) arrived with force, overwhelmed public health and reduced services capacities especially at the LHD level. LHD's have had a responsibility to protect their residents to the best of their ability and priority was focused on this endeavor. It was an "all hands on deck" situation and every single person at each LHD has assisted in this pandemic. Staff have experienced extreme stress and trauma in the past years and long-term effects of COVID-19 on our public health workforce are a concern, including burnout and retention. As a result, there was significant staff turnover in the past year at many of the LHDs.

LHD nurses were some of the key individuals who were recruited early in the pandemic and continue to be utilized as the vaccination clinics and outbreaks continue. Additional staff were hired to help, but the workload remained at a high level, requiring internal staff to continue their support and MCH programs to be put on hold.

The Office of CSHCN has a lending library offering internet-enabled cellular technology which is allowing for increased access to telehealth services in rural, urban, and underserved communities throughout Utah. Local care coordinators, including Family to Family (F2F) Health Information Centers (HIC), are working with families to ensure the experience with both technology and the telehealth visit meets or exceeds expectations. CSHCN lending library of technology includes internet-ready devices (chrome books and cellular hotspots), available to families who use the telehealth modality. Families are able to connect with primary and specialty care, early intervention, and care coordination to facilitate connection with services and medical providers.

Care coordinators and F2F HIC are educating and practicing with families on how to connect with telehealth providers and, as needed, are physically available to the family during their initial visit. The lending libraries are located at various agencies throughout the State of Utah, which include trained professionals with backgrounds in medicine, nursing, social work, care coordination, family peer support, audiology, physical and occupational therapies, and speech/language pathology. The lending library has been marketed through the hospital systems, Utah Parent Center/F2F HIC, Help Me Grow Utah, state and local health departments, and local primary care providers. In the past three years, the EHDI state audiologists have completed 80 diagnostic Auditory Brain Response (ABR) tests via telehealth (in the rural areas of Blanding and Roosevelt, Utah), which has allowed for timely diagnosis and intervention for infants who failed newborn hearing screening. Utah is the only state currently providing this public health service.

Although these services have greatly helped families living in these two regions, EHDI data showed other Utah areas would also benefit from our teleaudiology program. Three more tele-audiology sites - two rural and one urban site in an underserved, low income, Latino community were added in 2020-2021.

The Utah EHDI Program has been partnering with local health departments to act as remote testing sites, and has trained and continues to train their care coordinators to facilitate the testing between the families and audiologists. As this is a new venture, CSHCN, EHDI, and EI families will be surveyed post-visit to evaluate the patient and family experience with telehealth, ease of use with technology, and overall satisfaction with the lending library concept and tele-audiology service.

The Office of CSHCN Director coordinated with the Utah Parent Center and CSHCN families to continue to educate and coordinate on individuals receiving the SARS-CoV-2 vaccination/booster(s) and being educated on the benefits, side effects, down time and needs for child care support after receiving the shot.

In February 2021, the Office of CSHCN was introduced to a data integration system which was developed at Cincinnati Children's Hospital in Ohio, called IDENTITY and we are looking at the possibilities of adapting the system to fit the State of Utah's needs for data sharing with a variety of stakeholders in order to simplify system care communications between entities and or update current platforms. In the legislative session funding has been identified to improve and collaborate within the new Department of Utah Department of Health and Human Service and therefore, we will wait to update our data sharing system(s) until leadership determines the communication system for the new agency.

Care coordination, on a local level, brings into focus the understanding of community, culture and local customs; and a knowledge of supports, services, and specialists in the area. Care coordinators work with families of children who have not met prescribed well-child visits to work through barriers to service and offer strategies to mitigate these barriers. Care coordinators create care plans with families and provide follow-up to both families and providers to ensure a closed-loop process. Care coordination at Help Me Grow, UPC and LHD's is funded through Title V Maternal and Child Health Block Grant funds.

The Office of CSHCN programs strive to coordinate care for the children, adolescents and families served throughout the State. The ISP contracts with four Local Health Departments in rural Utah to provide Care Coordination in those communities. The Office 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.

The Office also has external partnerships with other State agencies which are working toward reducing redundancies, creating data sharing agreements, utilizing CHARM, holding quarterly meetings and working towards utilizing the clinical Health Information Exchange (cHIE) electronic record to share records in a one-stop shared resource and incorporating the ASQ screeners in CHARM. Additionally, other platforms such as: Hi-Track, monthly meetings, data sharing agreements, CHARM and shared resources to create a system which flows smoothly for Office employees are utilized.

Breadth of the State's Title V Partnership and Collaborations

The Offices of MCH and CSHCN collaborate with other state agencies, key partners, and private organizations on a regular basis to address ways to improve the health of women, infants, and children in the state. Staff regularly meet with new partners to assure the MCH/CSHCN populations are being served.

The 2 plus years of COVID-19 allowed for broader statewide collaborations. With moving all meetings to both remote and hybrid, in offering an online forum and or in-person, programs have seen an increase in partner participation in meetings. This has been especially noticed with our partners in rural areas of the state who can participate without a long drive. Feedback received has supported the online forum for meetings as it is found to be more efficient, time saving with the ability to be as effective as meeting in-person.

The Early Childhood Utah Program has seen an increase in engagement from partners due to the online format for meetings. This has increased collaboration occurring within state and partner programs. Since the COVID-19 pandemic began and persisted (2020 and 2021), Ages and Stages Questionnaire Third Edition (ASQ-3) screens submitted to the UDHHS ASQ Online Enterprise Account have declined by 37% (compared to 2019). Due to a shift in priorities related to pandemic response, one local health department reduced ASQ-3 screens submitted online from 3,476 in 2019 to 316 in 2021. This program's decrease in submitted ASQ-3 screens accounts for 90% of the decrease UDHHS has experienced. However, during the same timeframe, there has been a 35% increase in ASQ

Social Emotional screeners submitted to the UDHHS account by all providers.

Efforts to operationalize the 5 Year Needs Assessment

Each National/State Performance Measure has a lead staff member who coordinates activities and reporting related to their measure. All UDHHS staff who are responsible for working and reporting on activities related to Utah's NPMs/ESMs/SPMs continue to meet on a regular basis to discuss cross-collaboration and teamwork on performance measures. The CSHCN Family Partnership Advisory Committee and UPC advises the Office on understanding the family/parent perspective on issues, needs, and services and influences policies and program improvement. The Data Resources Program administers the WESTT system to track Utah's NPMs/ESMs/SPMs as these evolve or activities change; the WESTT system must be updated to compensate for these natural evolutions and refinements with the Maternal and Child Health Block Grant.

Changes in Organizational Structure and Leadership

The Utah Department of Health and Human Services (UDHHS) is one of many state agencies in the structure of Utah's Government. During the 2021 legislative session, House Bill 365 was passed to combine the UDHHS with the Department of Human Services effective July 1, 2022, creating a Department of Health and Human Services (UDHHS). Tracy Gruber was appointed by Governor Cox as director of the newly formed DHHS.
The Bureaus of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) were housed in the Division of Family Health and Preparedness (DFHP). With the new merged organization structure the "Bureau's" are now changed to "Offices" and will be moved to the new Division of Family Health, which will also include the Office of Coordinated Care and Regional Supports. MCH/CSHCN remain the lead "Offices" responsible for the administration of Title V activities. We are pleased to announce that Noël Taxin was appointed as the new Director for the newly formed Division of Family Health. Starting July 1, 2022, a new Division structure will be implemented and in next year's application we will explain the changes and stability established within the new structure.

The Office of Maternal and Child Health is headed by a new Office Director, Laurie Baksh and the Office of Children with Special Health Care Needs is headed by a new Office Director, Amy Nance. Lynne Nilson, former Title V MCH Director will retire in September 2022.

Maternal and Child Health Office:

A new MCH Epidemiology manager started in October 2021 and replaced the outgoing manager who retired in May 2021. The vacant SSDI grant coordinator position is currently vacant, but in the recruitment process.

Office of Children with Special Health Care Needs:

The Office of CSHCN has had minimal turnover this year. The ISP Psychologist left employment in January 2022 and a few in the foster care system retired but we were able to replace those positions with new members to join the team. Lastly, with the ever changing Department structure changes to the system, moving locations and reducing our space significantly. We have had to look at certain positions, reduce them and or redesign the job descriptions. Overall this year we have maintained the CSHCN staffing and continued service provision with quality.

Office of Health Promotion:

The Bureau of Health Promotion changed to the Office of Health Promotion and Prevention as a result of the merger. Staffing in this Office did not see significant staffing changes in this year. The former Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) Program changed its name and is now the Healthy Environments Active Living (HEAL) Program.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,374,954	$6,160,252	$6,979,388	$6,130,707
State Funds	$18,296,900	$15,490,482	$10,851,188	$15,954,017
Local Funds	$2,429,500	$0	$1,050,094	$4,081,498
Other Funds	$12,442,100	$15,200,399	$10,833,700	$15,143,381
Program Funds	$5,173,800	$947,208	$5,233,600	$999,760
SubTotal	$45,717,254	$37,798,341	$34,947,970	$42,309,363
Other Federal Funds	$57,415,800	$44,894,510	$56,396,200	$48,064,134
Total	$103,133,054	$82,692,851	$91,344,170	$90,373,497

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,561,290	$5,999,329	$6,598,690	
State Funds	$14,630,450	$16,279,475	$16,182,050	
Local Funds	$0	$2,381,253	$4,100,000	
Other Funds	$16,023,900	$15,143,381	$15,214,000	
Program Funds	$1,103,500	$999,760	$1,044,900	
SubTotal	$38,319,140	$40,803,198	$43,139,640	
Other Federal Funds	$50,430,575	$48,228,703	$53,211,500	
Total	$88,749,715	$89,031,901	$96,351,140	

	2023	
	Budgeted	Expended
Federal Allocation	$6,598,690	
State Funds	$16,420,500	
Local Funds	$3,400,000	
Other Funds	$15,214,000	
Program Funds	$1,044,900	
SubTotal	$42,678,090	
Other Federal Funds	$53,211,500	
Total	$95,889,590	

III.D.1. Expenditures

UTAH 2021 EXPENDITURES - FINANCIAL NARRATIVE

Overview

The Title V federal funding, in conjunction with non-federal state monies and other federal funds, were 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 supported Children with Special Health Care Needs (CSHCN) and an additional eighteen percent supported the MCH work of 13 local health departments across the state. The remaining Title V funding supported other critical MCH programs such as: Newborn Safe Haven, Baby Your Baby, Maternal and Infant Health, Mother to Baby/Pregnancy Risk Line, Family Youth Outreach, Oral Health, and Early Childhood Utah. To ensure alignment with Title V requirements, MCH Block Grant leadership and Division of Family Health leadership met throughout the year to review expenditures across all program and budget areas.

Expenditures (FY 2021 Annual Report Year)

Utah's Title V state match (as reflected on Form 2, line 3, "State MCH Funds" in Annual Report Expended) exceeded federal match and Maintenance of Effort requirements. State match is composed of state general funds, including funds for Early Intervention, Home Visiting, Newborn 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 from other agencies. 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) included fee revenue such as Pregnancy Risk Line collections, Baby Watch family fees, CSHCN insurance billings, and Newborn Screening Kit Fees.

Form 2, "Other Federal Funds," showed Utah's MCH work was also supported by a variety of other federal funds in FY 2021 including: Women, Infants and Children (WIC); State Systems Development Initiative; Pregnancy Risk Assessment Monitoring System, Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees, Part C Early Intervention, Early Childhood Utah Developmental Screening, and Maternal, Infant and Early Childhood Home Visitation funds.

Utah tracked 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.

Each program tasked with oversight of activities related to the National and State Performance measures identified budgetary needs to accomplish the objectives outlined in the Evidence-Based Strategy Measures. The funding needs were outlined in internal programmatic budget allocations at the beginning of the fiscal year. Each Program Manager and Bureau Director who are accountable for a line item(s) on the budget met regularly with Division Finance staff to track and monitor expenditures and assure budgets were not overspent.

In FY 2021, 33.53% of Title V expenditures were allocated to CSHCN; 51.86% of expenditures were for preventive and primary care and 8.46% of expenditures were for Title V administrative costs.

To ensure that the 30/30/10 requirement was properly documented and to record expenditures by the MCH Pyramid of Services, the Bureau of Maternal and Child Health allocated MCH Block Grant Funds throughout the Utah Department of Health to the following: the Bureau of Maternal and Child Health, the Bureau of Children with Special Health Care Needs, the Bureau of Health Promotion, and also contracted Title V funds with the 13 Local Health Departments (LHD).

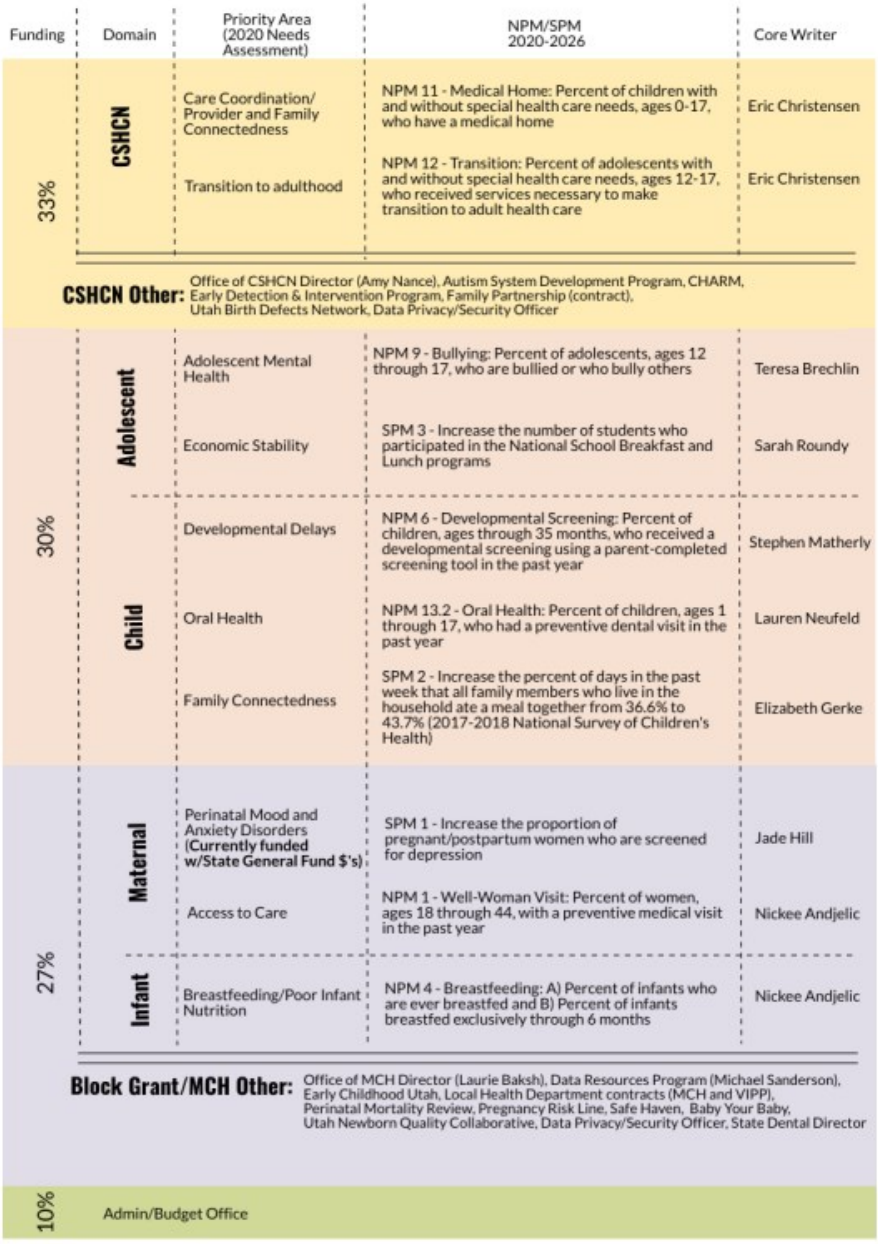
III.D.2. Budget

UTAH BUDGET (FY 2023 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 being used to address the state's MCH needs. The table below illustrates projected Title V funding allocations for FY 2023:

Program	Proposed Budget 10/01/2022 - 09/30/2023
OFFICE OF MATERNAL AND CHILD HEALTH	
MCH Admin	$398,000.00
Maternal and Infant Health (Maternal and Infant, Utah Women's Quality Collaborative, Perinatal Review)	$375,500.00
Newborn Safe Haven	$50,000.00
Pregnancy Risk Line	$245,200.00
Oral Health	$226,700.00
Data Resources	$335,000.00
OFFICE 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
DIVISION OF POPULATION HEALTH	
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, OTHER	
Financial Resources	$150,000.00
LHD Contracts	$1,188,400.00
Child Development	$50,000.00
Indirect Cost	$450,000.00
	$6,598,690

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:



Funding	Domain	Priority Area (2020 Needs Assessment)	NPM/SPM 2020-2026	Core Writer
33%	CSHCN	Care Coordination/ Provider and Family Connectedness	NPM 11 - Medical Home: Percent of children with and without special health care needs, ages 0-17, who have a medical home	Eric Christensen
		Transition to adulthood	NPM 12 - Transition: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transition to adult health care	Eric Christensen
	CSHCN Other:	Office of CSHCN Director (Amy Nance), Autism System Development Program, CHARM, Early Detection & Intervention Program, Family Partnership (contract), Utah Birth Defects Network, Data Privacy/Security Officer		
30%	Adolescent	Adolescent Mental Health	NPM 9 - Bullying: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	Teresa Brechlin
		Economic Stability	SPM 3 - Increase the number of students who participated in the National School Breakfast and Lunch programs	Sarah Roundy
	Child	Developmental Delays	NPM 6 - Developmental Screening: Percent of children, ages through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	Stephen Matherly
		Oral Health	NPM 13.2 - Oral Health: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	Lauren Neufeld
		Family Connectedness	SPM 2 - 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)	Elizabeth Gerke
27%	Maternal	Perinatal Mood and Anxiety Disorders **(Currently funded w/State General Fund $'s)**	SPM 1 - Increase the proportion of pregnant/postpartum women who are screened for depression	Jade Hill
		Access to Care	NPM 1 - Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	Nickee Andjelic
	Infant	Breastfeeding/Poor Infant Nutrition	NPM 4 - Breastfeeding: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months	Nickee Andjelic
	Block Grant/MCH Other:	Office of MCH Director (Laurie Baksh), Data Resources Program (Michael Sanderson), Early Childhood Utah, Local Health Department contracts (MCH and VIPP), Perinatal Mortality Review, Pregnancy Risk Line, Safe Haven, Baby Your Baby, Utah Newborn Quality Collaborative, Data Privacy/Security Officer, State Dental Director		
10%	Admin/Budget Office			

Utah's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2023, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted. For FY 2023, 51.6% of the total Title V budget is designated for preventive and primary care for children; 34.2% 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 ensure that the budget and spending are on track, and to address any new or unplanned MCH/CSHCN needs.

Each program tasked with oversight of activities related to the National and State Performance measures identifies budgetary needs to accomplish the objectives outlined in the Evidence-Based Strategy Measures. The funding needs are outlined in internal programmatic budget allocations at the beginning of the fiscal year. Each Program Manager and Office Director who are accountable for a line item(s) on the budget will meet regularly with Division Finance staff to track and monitor expenditures and assure budgets are not overspent.

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 continually 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 of Family Health Director's Office, Newborn Safe Haven, Informed Consent and Abortion Module, Home Visiting, Maternal Mental Health, Children with Special Health Care Needs, Birth Defects Network, Early Hearing Detection and Intervention, and Early Childhood Utah. Along with other federal funds, these state MCH dollars are 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) includes Teratology collections and donations, Baby Watch Early Intervention Family Fees and other CSCHN fee revenue. Other federal funds anticipated in FY 2023 are indicated in Form 2, line 9, and are similar to funds noted in the Expenditures section.

Challenges

As has been the case for several years now, Utah continues to face challenges related to the Title V budget. The current working MCH budget has been reduced from $7.2 million dollars annually to approximately $6.6 million, while the amount received from HRSA is just over $6.1 million annually. Funding allocations continue to change to ensure we are spending within the level of our annual federal award, as well as prioritizing the outcomes from the Needs Assessment that was conducted in FY 2021. 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 consolidation of space. All MCH/CSHCN programs now reside at the Multi-Agency State Office Building, with cost savings as a result of reduced space needs from a statewide shift to teleworking.
- Cost savings as a result of attrition.

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 Office of Maternal and Child Health experienced a reduction of funding for the State Dental Director position and Maternal Mental Health.

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

On July 1, 2022, the Utah Department of Health (DOH) and the Department of Human Services (DHS) will merge to become the Utah Department of Health and Human Services (UDHHS). The vision for the new department is:

"*The Department of Health and Human Services will advocate for, support, and serve all individuals and communities in Utah. We will ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. We will achieve this through effective policy and a seamless system of services and programs."*

This past year brought new changes and challenges to Utah's health and human services system. New organizational structures and policies are being created and updated to streamline and unify alignment of the two agencies. One of the main goals of the merger is to streamline services for citizens of the state, reduce redundancies making services more robust. The merger process has identified barriers and challenges to accessing care for those most in need and created opportunities to unify services, improve equity and offer more efficient services. Performance driven measures, across all state agencies, allows for better alignment, promotes innovative strategies and enhances our ability to support those who use our services.

For both Maternal and Child Health and Children With Special Health Care Needs Bureaus, now formally called Offices the change will offer more opportunities for new relationships, partnerships and hopefully for the development of grant applications which include a more well-rounded group of statewide stakeholders with proposals of ways to stretch funding to meet communities needs in a more direct manner. Utah is looking forward to new opportunities to more efficiently serve our MCH and CSHCN populations, stakeholders and communities as a result of the merger.

"Change is inevitable, change is constant, change is hardest at the beginning, messiest in the middle and the best in the end." -Maxwell and Sharma.

The new Division of Family Health in the DHHS has three Offices; the Office of Maternal and Child Health (MCH) and the Office of Children with Special Health Care Needs (CSHCN) and the Office of Coordinated Care and Regional Support (CC&RS).

Utah Title V oversight is maintained by the Title V/MCH Office Director and the CSHCN Office Director. Both Directors and their staff serve as conveners, collaborators and partners in addressing MCH/CSHCN issues. The mission of the MCH Office is to improve the health of Utah's mothers, children and families. The mission of the CSHCN Office 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 Office of CC&RS mission is a customized service approach to keep families safely together while effectively helping children with evidence-based approach to family-driven, team based, collaborative planning for developing and implementing individualized care plans for children and youth with significant mental illness, emotional disturbance and/or behavioral disorders. The services are not case management, they are high intensity service coordination with the goal of ensuring youth with acute needs are able to remain in their homes, schools and communities without the need for residential or out-of-home services.

The Offices of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) are the lead programs in Utah that provide leadership and direction for all Title V activities. The MCH/CSHCN Offices assess and assure the health of our populations, provide education, assess current and long-term needs, implement programs, convene stakeholders, and prioritize the issues for our populations. We navigate the public health and political climate of our state 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 limited 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 in Utah over the past 3-5 years that have significantly impacted on service delivery and Title V roles and responsibilities. The transformation of the Block Grant, internal UDOH changes, the

UDOH/UDHS merger, and moving programs between Offices has impacted our ability to do business as usual. The changes at times create instability, delay long-term growth and measurement of successes. And at the same time this allows us the opportunity to “think outside the box” and create a “new normal” for prioritization and provision of services and programs.

The Offices of MCH and CSHCN have the main responsibility for oversight of Title V NPM/SPM implementation and monitoring Staff work with partners in the Office of Health Promotion to accomplish these goals as well as Local Health Departments, and other stakeholders. There is a lead staff person responsible for each NPM/SPM and that person coordinates activities, documents progress for Block Grant reporting, tracks data, and monitors current evidence related to their performance measure.

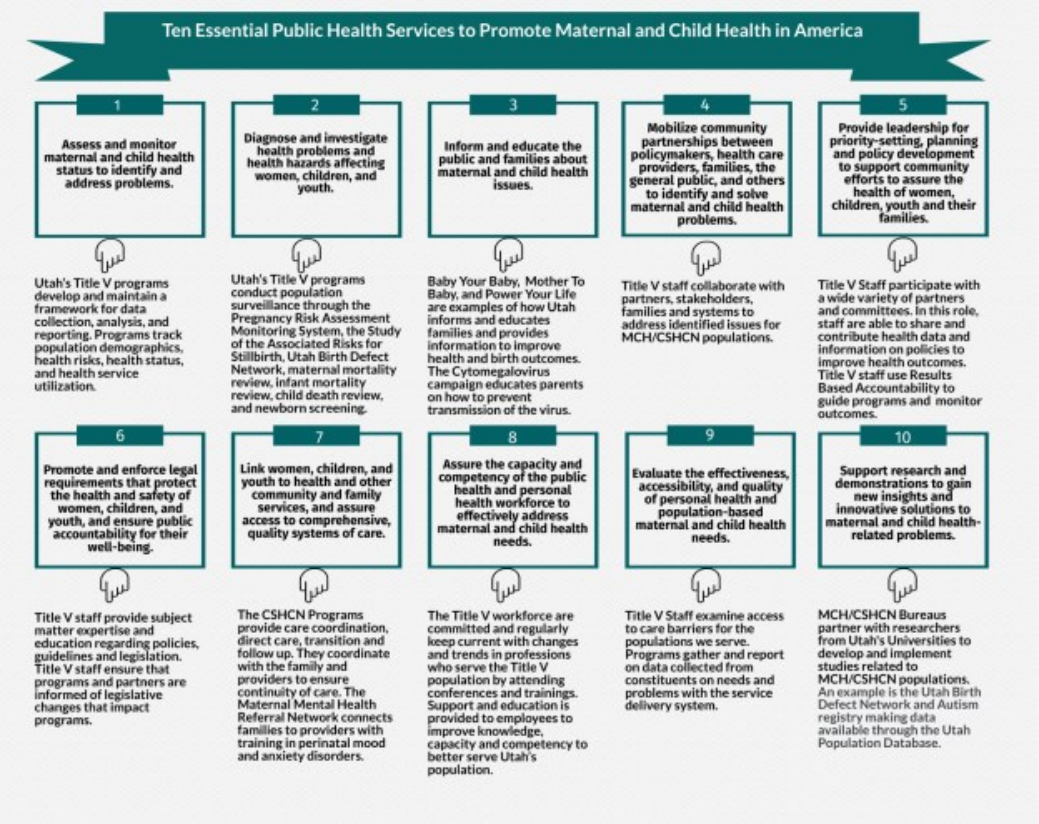
Utah’s Local Health Departments (LHDs) were actively involved in the 2020 Needs Assessment process and their activities are aligned with the NPM/SPM’s selected for the upcoming 5-year period. The Title V/MCH Office Director meets with the Nursing Directors bi-monthly to provide updates and to assess their progress on meeting objectives. The LHD’s provide year-end reports to document outcomes.

The provision of services for Title V populations are provided through UDOH staff, LHDs, memorandums of agreement, service contracts, bids for proposals (when needed) and in-kind contributions from partners and stakeholders.

Title V Framework

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:



Utah's Title V Program supports staff participation in partner workgroups and advisory committees. This collaboration allows staff to share their expertise while also learning about issues facing MCH/CSHCN populations. Their participation assures that the Utah's Title V program priorities are known and that efforts are collaborative, not duplicative. Title V staff participate in the following:

- Autism Council of Utah
- Baby Watch Early Intervention Interagency Coordinating Council
- Coordinating Council for Persons with Disabilities
- Early Childhood Utah Governor's Commission
- Early Childhood Utah Council (which reports to the Early Childhood Governor's Commission)
- Family to Family Network-Utah Parent Center
- Intermountain Adult to Youth Committees
- Intermountain Healing Hearts
- Maternal Mental Health Policy Group
- Medical Home Portal Advisory Committee
- Help Me Grow Utah
- Utah Children's Care Coordination Network
- Utah Developmental Disabilities Committee
- Utah Down Syndrome Foundation
- Utah Oral Health Coalition

Additionally, Title V programs convene/lead numerous committees that work to serve Title V populations. These include:

- Children's Hearing Aid Advisory Committee
- CSHCN Advisory Committee
- Cytomegalovirus Workgroup
- Early Childhood Utah Council (Subcommittees include - Promoting Health and Access to Medical Homes, Early Care and Education, Social Emotional and Mental Health, Parent Engagement Support and Education,

and lastly, Data Research and Policy)
- Early Hearing Intervention & Detection, Baby Watch Early Intervention, Parent Infant Program thru Utah School for Deaf & Blind Work Group
- Fetal Alcohol Spectrum Disorder Collaborative Committee
- Kurt Oscarson Children's Organ Transplant Fund Board
- Medical Home Stakeholder Group
- Newborn Screening Advisory Committee
- Pediatric Audiology Work Group
- Perinatal Mortality Review (infant and maternal mortality)
- Transition to Adult Stakeholder Group and Sub-Committees
- Utah Women and Newborns Quality Collaborative
- Newborn Hearing Screening Advisory Committee
- Utah Autism Initiative Committee
- Utah Registry for Autism and Developmental Disabilities (URADD) Committee
- Well Women Coalition

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. The Integrated Services Program holds weekly meetings in which a variety of State stakeholders and partners come together to work on medical home, transition and care coordination efforts in order to reduce the burdens of the system's diversity on families. Additionally, utilizing virtual technology has reduced travel, coordination of scheduling and allowed for different service providers to be on calls with families. Utah uses evidence-based approaches and values data in supporting initiatives to ensure a solid and robust foundation.

MCH/CSHCN staff work collaboratively with the Office of Health Disparities and the American Indian/Alaska Native Health Liaison to identify and address the needs of Utah's diverse populations. Additionally, when an emerging issue or need arises, MCH/CSHCN staff assess if other programs are currently addressing the same issue with other populations and discuss how to collaborate. MCH and CSHCN Offices take an active role in creating and engaging committees to ensure a diversified perspective is understood in order to effectively implement programmatic activities.

During 2022, select UDHHS staff are participating in the Region VIII Tribal Relations Community of Practice initiative. This initiative is the result of a technical assistance request submitted by Region VIII MCH programs to HRSA. The goal of the Tribal Relations Community of Practice is to increase knowledge, skills and strategies, cultural responsiveness and engagement with Tribal populations. Teams from each of the Region VIII states will participate in multiple meetings during the year with specific tribal consultants. Participants will both learn from and with colleagues, while providing mutual support. Individual state technical assistance will also be available from trainers.

In this past year, the Office of Health Disparities has rolled out and is offering Professional Development trainings and is led by our Health Equity Strategist, Dan Dukes. Topics currently include: • Introduction to Equity, Diversity, Inclusion, & Accessibility • Introduction to Health Equity • Health Equity Strategies • Intersectionality • Stereotypes & Bias. Training is open to any employee who is interested in expanding their knowledge of Health Equity. The purpose of these training is to assist teams, and make the Department a more welcoming, equitable, and inclusive organization.

On a larger State level, Utah's Governor Spencer Cox is committed to providing the best programs and services for customers. The Governor's "One Utah Roadmap" outlines policy priorities for the State of Utah including improving government efficiency to become more responsive to the state's customers by streamlining and modernizing state government, addressing social determinants of health, improving racial and gender disparities, education innovation, health security and many others. The roadmap is contributing to goals and outcomes being put forth with the merger of the Department of Health (DOH) and the Department of Human Services (DHS).

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

The Utah Department of Health and Human Services (UDHHS) senior level managers lead the work of planning, implementation, evaluation, data analysis, and recruitment/retention of qualified program staff. MCH has approximately 56 full-time employees; 23 paid with Block Grant (BG) dollars for a total of 17 FTE. CSHCN has approximately 101 employees; 24 paid with BG dollars for a total of 15 FTE. The Office of Health Promotion has approximately 15 employees paid with BG dollars for a total of 5 FTE. UDHHS 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.

MCH/CSHCN maintains a staffing pattern, which includes long-term employees, nearly half of whom have served at least ten years. Employee retention is accomplished through mentoring, administrative support, and professional development opportunities. Employment with the Utah State Government supports a generous benefits package, 401K contribution and other retirement investment options, an employee assistance program, health and wellness activities, which all contribute to employee satisfaction and retention. All MCH/CSHCN employees must complete training required by UDHHS, including data security, HIPAA, cultural competency, ethics, teleworking, safety and supervision when applicable.

When recruiting and hiring for vacancies, some positions are easier to fill than others are. Because salaries in the private sector are higher than in state government, some positions are difficult to fill and/or staff have left for private sector positions that offer substantially higher salaries. Ability to compete with private sector salaries is limited.

Utah Governor Spencer Cox is dedicated to redesigning how the State of Utah approaches traditional government administration including teleworking policies. The Governor's Office of Planning and Budget launched the "A New Workplace" initiative that aims to update management philosophy. State Employee recruitment, retention, efficiency, effectiveness and productivity is crucial to a desirable workplace where staff want to work and stay. In June 2021, the Governor's Office of Planning and Budget released the "State of Utah Remote Work Guide" to assist agencies with best practices for remote working to enhance employee satisfaction and productivity. Recently the Governor implemented "surge" remote workdays. These are in effect during bad air quality days.

MCH/CSHCN programs are committed to a learning environment in which employees develop professionally. Employees are encouraged to create and maintain individual development plans as a part of their annual performance review process. All professional staff are required or encouraged to attend at least one professional conference or training each year. In the past year, many professional development opportunities have been available in virtual platforms. This has allowed many staff to participate in conferences they would not normally be able to attend due to travel costs.

All Offices working on Title V activities encourage or provide regular educational sessions and empower the Program Managers and staff 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 Offices 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. The Department of Human Resource Management offers their "Off the Shelf" learning sessions that are bi-monthly web-based sessions on topics that have included managing workplace stress, cultivating trust, employee engagement, and purposeful change navigation and many others. Additionally, the State of Utah has a statewide wellness council that encourages each Department, Division and Program to participate. Every month employees receive an invitation to participate in health and wellness activities to improve their wellbeing.

The Integrated Services Program (ISP), Local Health Departments and Utah Parent Center (UPC) hold weekly training, problem solving, and program evaluation meetings with in-house program staff and the care coordinators contracted through four local health departments and UPC. ISP, LHD, UPC 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 in challenging patient and family situations. UCCCN coordinates tele-learning technology, which provides a virtual "face to face" environment in which all parties learn and share information. ISP clinical staff (APRN and psychologist) participate in weekly ongoing autism spectrum disorder training from specialists at the University of Utah through Project ECHO, a distance learning technology. The ISP program offers a hybrid model in which both virtual and in-person services are offered utilizing technology to serve the children with special health care needs and their families.

The CSHCN Office supports Utah Regional Leadership Education in Neurodevelopmental and Related Disabilities (URLEND) Training Programs to train future leaders in MCH and CSHCN. The URLEND program specifically addresses Utah training gaps through a combination of interdisciplinary didactic training, intensive clinical opportunities, and targeted leadership experiences. This past year, the EHDI audiologist and Integrated Services Program social worker delivered monthly hearing screenings conducted at the South Main Clinic, one of Salt Lake City's Community Health Centers serving mainly low-income Hispanic families. Even throughout the pandemic, these services were offered with incorporating protective measures for safety for both the providers and clients.

Starting 2019-present URLEND project year. The CSHCN Office 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, which 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. This collaborative ensures the foster care youth are receiving the support needed to transition to adulthood. In Appendix C you will find a 2020-2021 paper on the work and outcomes, "Transition Planning for Youth with Neurodevelopmental Disabilities Aging Out of Foster Care, Phase Two."

Workforce development and coordination with Local Health Departments is key to maintaining a strong MCH Workforce. Each of the 13 Local Health Departments is required to report on professional development activities conducted during the year as part of their contractual obligation to the MCH Office. A menu of training opportunities were provided to LHD staff to use during the year with the expectation they would participate in at least one training opportunity from the resources provided, or another MCH/CSHCN training opportunity of their choice. Many of the professional development opportunities and training suggested came from MCH Navigator, AMCHP's Training and Leadership Development programs, Advancing Health Transformation (from MCH Navigator) and others. During the past year, the LHD's provided relevant MCH professional development training to staff, despite the staffing challenges of COVID.

When the COVID-19 pandemic hit Utah, the UDOH and its Offices/Programs adapted to the workforce needs, work environment and efficiencies immediately by all employees moving to teleworking. Teleworking was implemented to ensure the safety of our employees and MCH/CSHCN customers served throughout the State. During the past year, we have offered a hybrid model, which allows for telehealth and or in-person visits which is determined by the client unless either the provider or client is sick. Majority of employees have continued to telework this past year. To ensure quality and accountability, each Office 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.

Weekly connection with Office Directors, Program Managers and staff has been highly important and effective. Utah continues to ride the wave of the dynamics of employment expectations, changes and “return to work” policies. Informal input asking employees satisfaction with the telework and telehealth platform and feedback suggests workforce satisfaction and productivity.

Innovations in staffing structures:

The new organizational structure of the merged UDHHS presents several innovative alignments to respond to customer needs. This includes:

- Joining behavioral and physical health in the Division of Integrated Healthcare
- High-quality customer service established through a “no wrong door” approach in a new Division of Customer Experience
- Integration of behavioral and physical health prevention and promotion in the Division of Population Health
- Colocation of Family Health and other community programs within the new Child and Family Services
- Health Clinics of Utah, Center for Medical Cannabis, Office of Primary Care and Rural Health, Health Equity, the Utah Public Health Lab, and the Medical Examiner's Office have all been structurally placed under the DHHS Medical Director
- A new focus on structures that promote a focus on continuous quality improvement, employee development, training and equity
- Centralization of certain functions, some of which include Public Information, Data Privacy/Security, Information Technology, etc.

To address salary parity, the legislature approved targeted salary increases in the 2022 legislative session for certain positions. The positions identified for increases, and funded with Block Grant dollars, include - Epidemiologists I & II, Health Program Specialists I & II, Senior Registered Nurses, Research Consultant III and Financial Analysts.

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

The CSHCN Office values family partnerships and the relationships are woven within the structure and functions of the Office. The following information is provided to outline some activities and collaborations both the CSHCN and MCH Offices 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 Office partners with the Utah Parent Center (UPC), Utah Family Voices (UFV) and has both parents of CSHCN and individuals with special health care needs employed. The UPC/UFV Director participates in the Block Grant writing, review, and improvement processes. CSHCN collaborates with family partners on the development of materials and resources provided to the public. The CSHCN Office, in collaboration with Utah's Family to Family Health Information Center (F2F HIC) and Parent Training and Information Center, provides individual consultations, workshops, publications and web-based educational materials. The program partners with various disability, advocacy, and family organizations in the state in organizing events in various formats. Parent participation and perspective are considered and added into all the programs and services delivered to children and their families.

The CSHCN Office has built capacity in family partnerships by including families and stakeholders in the CSHCN Mission and Strategic Plan. The Office has a CSHCN Advisory Committee which is composed of family members and individuals with special health care needs. This committee advises the Office 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 Office conducts surveys with parents and engages in community discussions to identify needs within the community. The CSHCN Office incorporates its family partners in providing support within Office services and participating in advisory committees. The CSHCN Office Director is an active member of both the state-mandated Coordinating Council for People with Disabilities and Utah Developmental Disabilities Council. Both of 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.

Utah Parent Center- Family Partnership

During the past year the CSHCN Office continued to collaborate with the UPC to find families in need of education related to COVID-19, vaccination locations and paid for another parent partner position to support the high demand of calls and support needed from families. The UPC and CSHCN Office meet regularly to discuss ideas to meet families' needs virtually and in person to ensure continuity of care for the children, youth and families during the pandemic.

Emergency needs for basic essentials were overwhelming in the beginning of the pandemic, followed quickly by

mental health issues in the early days. Adapting messaging and materials to the disability community became imperative.

General community initiatives didn't always reach or provide access to the diversity within the disability community. For example, difficulty with masks (ability to wear them or having clear masks for ease of communication).

People were struggling with the lack of alternatives available to them when the services they relied on were no longer available. For example, not having day programs or respite providers available or accessible to them. It's important to have a plan in place when general programming availability goes away for the population at large.

Telehealth issues were prevalent. The UPC had access to the internet and technology to lend or purchase for families that were not connected. Beyond technology, families also struggled to have fully satisfactory experiences with individuals with developmental disabilities on the other end who were not able to participate in the consultation or evaluation process.

Making COVID vaccine clinics "family friendly" and attractive to attend was crucial. We had tailored themes, brought other partners to help with broadening what was available to families at a clinic than we would have been able to bring on our own. Once it was possible, traveling to locations throughout the state to form networks and foster community relationships was helpful to help establish presence.

Creating a repository of local resources available was extremely important for timely assistance. If we had to summarize the biggest lesson learned we would say that we really say how marginalized our community really is in so many areas.

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 Office Programs, improve the CSHCN Office 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 Office 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

Strategic Goal	Goal Detail	How It Will Be Accomplished
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 Office employee orientation with clear expectations, job description, and performance evaluations, offering frequent praise and feedback to employees, providing annual Office trainings, and monthly program improvement discussions, implementing quality control measures and training to increase accuracy and timeliness in data input into CSHCN Office 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 to 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 both locally and nationally 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 UPC/UFV staff to problem solve and work jointly with families who may be struggling to find and connect with support and services in the community. ISP care coordination staff provide clinic, virtual telehealth and home visits to struggling families in collaboration with UPC/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 UPC/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 access and apply for services for which they may be eligible.

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. Since March 2020, the ISP has integrated telehealth as a platform to support and connect families to services. Families referred into the system by providers or self-referrals 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 Office and other partners. The Portal contains clinical information on more than 55 diagnoses and other issues commonly experienced by CSHCN, along with information on special education, transition, family issues, and coding, as well as a directory of local services 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 Office 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.

CSHCN and MCH Offices connect with and provide funding to support Utah Help Me Grow 211 resources. We collaborate in finding children who need services, assessing and referring those families to needed providers and services as well as conducting developmental screenings for children.

The MCH Office 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.

The Utah Women and Newborns Quality Collaborative (UWNQC) has worked with clinical systems statewide to implement various Quality Improvement (QI) projects. UWNQC has established bylaws, a Board of Directors, and currently has five active committees: Improve Maternal Outcomes, Improve Neonatal Outcomes, Develop Out-of-Hospital Births resources, Improve Maternal Mental Health and Implement Safety Bundles. Patient, family, and community engagement is a key component of the UWNQC approach to enhancing our capacity to make

measurable improvements in perinatal health and health outcomes statewide. To improve patient engagement, the QI Director recently completed the Alliance for Innovation on Maternal Health Community of Learning (COL) on Lived Experience Integration into QI. This educational series provided guidance for state teams on how to perform work that integrates patients and those with lived experience. Through this training, resources were provided on how to incorporate patient partners into QI projects such as frameworks for engaging patients and families, a Lived Experience Integration onboarding checklist, and lessons learned from a systems approach to engaging patients and families in patient safety transformation. Through these partnerships, the patient voice is used to guide efforts to improve maternal health outcomes. The COL training included the ability to send 10 patient partners through a Certified Patient Family Partner training, which UWNQC will utilize in the coming year.

Additionally for MCH, the Early Childhood Program staffs the Early Childhood Utah Advisory Council. This council serves as the advisory entity to the Governor's Early Childhood Commission and makes recommendations to the Commission to improve the lives of children in the state. The ECU Advisory Council has five standing committees:

- Promoting Health and Access to Medical Home
- Data, Research and Policy
- Parent Engagement Support and Education
- Social, Emotional and Mental Health
- Early Care and Education

Membership on the Council is made up of experts in multiple disciplines related to children including physical/mental health, early care and education and families. The MCH Title V Director and the MIECHV (Maternal, Infant and Early Childhood Home Visiting) Program Manager, the CSHCN Integrated Services Program Manager, Oral Health staff and WIC staff also contribute. Additionally, parents of children are represented on the Council and participate in the Parent Engagement workgroup.

The MCH/CSHCN Offices 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. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH epidemiology is the backbone to driving Utah's Title V work. The knowledge and support from all our epidemiologists is highly valued. Each program in Title V either has an internal epidemiologist or is supported by the Data Resources Program (DRP) that has well trained, experienced and collaborative team members. At a minimum, all Epidemiologists in the MCH/CSHCN Offices have a bachelor's degree, most are masters level trained and one is near completion of a doctoral degree.

In the Office of Maternal and Child Health (MCH) there are 5.5 FTE epidemiologists who provide data capacity and support to the MCH Office. The DRP houses the Epi Manager, and 2.5 FTE Epidemiologists. The Maternal and Infant Health Program (MIHP) has 2 FTE epidemiologists.

The Epi Manager, funded by Title V, supervises the activities of the Data Resources Program and is the lead epidemiologist for the Title V Block Grant. The DRP team provides analytic support, grant management, website development and support, research and surveillance and the Web Enabled Systematic Tracking Tool (WESTT) system. WESTT is the online portal that houses the information from the Utah Block Grant core writers to compile data, report outcomes for the past year and write plans for the upcoming grant year. WESTT allows for the output of sections for placement into the Block Grant as well as the system outputs the Public Comment for dissemination.

Michael Sanderson replaced long time program manager, Shaheen Hossain in October 2021 as the new manager of DRP. Mr. Sanderson brings nearly 20 years of experience in epidemiology with a focus on measurement and survey design with the New York City Department of Health and Mental Hygiene.

Robert Satterfield works side by side with the DRP Manager to provide support to the Title V Block grant, and other data projects including but not limited to: WIC Cluster Analysis, WIC Participant Satisfaction surveys, Oral Health Projects, and Pregnancy Riskline surveys and projects.

The DRP also houses the State Systems Development Initiative (SSDI) Epidemiologist and is funded through that grant. The SSDI Grant Coordinator/Epidemiologist, along with other staff in DRP, supports Title V efforts by collecting and compiling data needed for all Block Grant forms, providing data and analytic support for Utah's 2020 selection and development of NPMs/SPMs and related ESM and the 2020 MCH needs assessment, assisting with the preparation of annual applications and reports.

Additionally, the SSDI Grant Coordinator/ Epi supports the data needs for the Utah Women and Newborns Quality Collaborative (UWNQC) quality improvement projects. Finally, the SSDI assists with the expansion of 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. A 0.5 FTE epidemiologist was hired with SSDI supplemental grant funds and is a time-limited position.

Nicole Stone, MIHP, is epidemiologist/data manager for the PRAMS project and the Study of the Associated Risks of Stillbirth (SOARS). This position is funded through a CDC PRAMS grant, state funding, and the Title V Block Grant. The PRAMS epidemiologist supports Title V activities by providing data related to ESMs and NOMs. The PRAMS survey is integral to assessing maternal and infant health and identifying emerging issues.

Amy Solsman, MIHP, provides data support to the Perinatal Mortality Review Program. This position is funded through the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant. This position conducts both quantitative and qualitative data analysis on pregnancy-associated deaths, pregnancy-related

morbidity, and infant mortality to support the MCH Title V Block Grant.

In the Children with Special Health Care Needs (CSHCN) Office, 3 FTE employees provide epidemiological support to their teams and share their knowledge to improve the data and outcomes among CSHCN populations. One of these epidemiologists is partially paid through block grant funding but all of them participate in data groups which support Title V work.

Gregg Reed is an epidemiologist with the Baby Watch Early Intervention program but is hired under the classification of a Sr. Research Analyst and is funded through the Office of Special Education Programs (OSEP). Gregg Reed is the data manager for Baby Watch, He is involved in the MCH Block Grant to help understand data needs within the CSHCN Office, in which Baby Watch is included.

Max Sidesinger, an Epidemiologist with the Early Hearing Detection and Intervention Program and is funded through mixed funding including state newborn screening dollars, CDC and HRSA EHDI funding.

Aubree Boyce, the Utah Birth Defect Network (UBDN) epidemiologist analyzes data collected by the active surveillance program that collects reports of birth defects statewide from a variety of sources and develops recommendations for program planning and policy development from the analysis. The epidemiologist coordinates with the UBDN health educator to design surveys to collect information on program public outreach. Working with the UBDN data team and stakeholders, the epidemiologist designs, conducts, and coordinates research projects in birth defects and creates fact sheets, brief reports and publications as means to disseminate data findings from surveillance and public outreach data. The epidemiologist is part of a core data team within UBDN that coordinates with the National Birth Defect Prevention Network and the CDC.

Gregg Reed and Michael Sanderson jointly coordinate the MCH/CSHCN Data Integration Workgroup (DIW) under the direction of Noël Taxin. The purpose of DIW is to provide a platform for programs within the Division to discuss topics related to health data and come up with more effective strategies to coordinate, cross train, share data, and better serve our populations. DIW members meet regularly to discuss data projects and systems, interpretation of new Agency policies, trouble-shooting analysis problems, and developing data products to be published by the MCH/CSHCN Offices. The DIW has a goal of completing an annual report for the State legislature that highlights the work MCH/CSHCN programs are doing with maternal, infant, child, adolescent, and CSHCN populations in Utah. The first report will be ready to publish by December 2022 for the 2023 legislative session.

In Utah, finding epidemiologists has been difficult due to the lower pay comparisons with the private sector. In the 2022 legislative session, a market adjustment for epidemiologists was implemented and pay increases are effective July 1, 2022. We anticipate this will improve our recruiting and hiring of Epidemiologists in the future.

Epidemiology staff participate in national meetings for professional development, including the CityMatch/MCH Epidemiology conference, the Association of Maternal and Child Health Programs national meeting, the MCH Epidemiology Training Course (sponsored by CityMatch, CDC and MCHB), and subject matter specific opportunities.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The State Systems Development Initiative (SSDI) Grant is managed by the Data Resources Program (DRP) in the Office of Maternal and Child Health. The mission of the DRP is to provide analytic resources and statistical expertise to MCH and CSHCN programs for assessing the health status of maternal and child health populations, and for planning and evaluating services. SSDI funding pays the salary for a full time SSDI Grant Coordinator to manage project activities related to data collection and analysis, and provide additional analytic support to MCH programs. SSDI funding also supports the Five Year MCH Needs Assessment, the submission of the Annual MCH Block Grant (BG) Report and Application, and application of data analysis to program planning for Title V related projects.

There have been staffing changes in the DRP. The SSDI Grant Coordinator position was vacant from October 2020 through March 2021 due to a staff resignation and recruitment time. The new SSDI coordinator accepted another position as the Maternal Mental Health Program Manager in May 2022. The DRP is currently in the process of filling that vacancy. In addition, the previous DRP Manager and SSDI Project Director retired in April 2021 and the position remained open until the current DRP Manager and SSDI Project Director joined the Agency in October 2021.

Due to these staffing changes throughout much of FY 2021, DRP was unable to provide as much analytic support as planned including: conducting analysis on factors associated with intrapartum transfers to hospital for delivery from planned out-of-hospital birth settings, linking birth certificate records by the mother, and serving as the Alliance for Innovation on Maternal Health (AIM) Data Lead.

Data linkages

DRP and the SSDI program plays an important role in ensuring timely and accessible linked MCH data systems. Historically, DRP and the SSDI Coordinator have had consistent annual access to the following data sources for data linkage projects: Vital Records Birth and Death data, Medicaid Data, WIC programmatic data, Newborn Hearing Screening data, Hospital discharge data, and PRAMS data.

More specifically, the DRP Epidemiologist and the SSDI Grant Coordinator routinely links Vital Records Birth and Death data to obtain an infant death data set which is used for analysis by many programs as well as for AIM projects and publications. Additionally, DRP has routinely linked Vital Records and Medicaid data for birth outcomes for the Block Grant and many other State programs, papers, and local/national presentations and discussions, we have begun to link these data sets once again and will continue to do so in the future as an ongoing activity for the DRP and SSDI Project.

Additional linkage projects include the following:

- In FY2021, the SSDI Coordinator linked birth records by the mother to identify mothers who had a preterm birth, rather than solely relying on self-reporting for the Utah Women and Newborns Quality Collaborative (UWNQC). This linkage was used to assess utilization of 17-alpha hydroxyprogesterone in women with a previous preterm birth.
- In the last few years the DRP and the SSDI Coordinator have begun linking Vital Records data with WIC program data to analyze birth outcomes for vulnerable populations in Utah. These data are linked annually when the Vital Records data becomes available.
- DRP and SSDI Grant Coordinator provided Hospital Discharge data for work being done with the AIM project as well as monthly data analysis; DRP continues to link Hospital Discharge and Vital Records data for other programs, papers, presentations, and projects as the need arises.
- The Newborn Hearing Screening program data has also been linked in the past for projects received from the

Newborn Hearing Program and is available to be provided to us monthly, quarterly, or annually for linkage to the Vital Records birth data.

Assessment and monitoring

The SSDI Coordinator plays an important role in Title V program assessment, monitoring, and reporting. In order to help streamline the collection and submission of the yearly requirements for BG Annual Reporting and the Application, DRP developed and implemented the Web-Enabled Systematic Tracking Tool (WESTT). WESTT provides a user-friendly interface for Block Grant Contributors to report on activities for the reporting year and outline activities for the upcoming fiscal year. WESTT also captures NPM, SPM, and ESM performance measures and updates objectives for the coming year. Each year, after the Block Grant has been submitted, a WESTT User Feedback Survey is developed by DRP and sent out to all Block Grant Contributors to obtain feedback on their experience using WESTT. The SSDI Coordinator programs and analyzes responses to the feedback survey and works with other DRP staff to identify and make enhancements to WESTT. Updates are made to WESTT annually based on the results of the survey with the goal of making WESTT as user friendly (for submitters and DRP staff) as possible.

In FY 2021 enhancements made to WESTT included closer alignment with updated MCH Block Grant guidance and adding fields for Block Grant Contributors to highlight challenges and emerging issues encountered in their programmatic work related to performance measures. DRP also added placeholders for new performance measures that came out of the 2020 needs assessment, and updated technical documentation in the manual for the WESTT system. DRP also completed a yearly training for grant contributors on use of the WESTT system.

More recent updates that were made to WESTT in FY 2022 for the FY 2023 Application and FY 2021 Report include automating the required achieved/not-achieved statement for each NPM. Users are no longer required to type “The Performance Measure was/was not achieved. The Performance Objective was XX.X and the Annual Indicator was XX.X”. Block Grant contributors now have a radio button located in the data form. As they enter their respective data for an NPM, there is an “achieved/not-achieved“ button which then populates the sentence with data in the annual report for their respective measures. DRP also added fields for Block Grant Contributors to include work they are doing to understand and address health disparities for NPMs, SPMs, and ESMs. ESMs were also remapped to strategies in the WESTT system.

DRP held a mandatory virtual training session for Block Grant Contributors in March 2022. The training included an overview of basics for new WESTT users and updates that have been made to the application. This year’s training also included additional modules including: incorporating equity into all of the work MCH and CSHCN does; an introduction to logic models for future applications; and an introduction to standardized target setting methods. The SSDI Coordinator developed and presented the health equity module and reviewed and provided feedback for other modules.

Reporting

The Utah Department of Health and Human Services (UDHHS) highlights leading health issues in its monthly Utah Health Status Update (HSU) publication. HSUs are sent monthly to the Governor’s Office and 500+ others including policy makers, health professionals, and state and local health department staff. The SSDI team also contributes regularly to Health Status Updates published by the Agency that focus on MCH/CSHCN populations.

Each year, a Department wide meeting is held to review ideas for potential HSU articles. The SSDI Coordinator

represents Title V programs at this meeting. After the meeting, a finalized HSU annual publication schedule is developed and disseminated to programs.

During FY 2021, MCH/CSHCN staff published nine HSU articles including:

- Infant Mortality - September 2020
- Infant Sleep Safety - November 2020
- Infant Hearing - May 2021
- Trends in contraceptive use - January 2021
- COVID--serving children with special needs - January 2021
- Perinatal mental health by age - February 2021
- PRAMS Opioid survey - April 2021
- Oral health Challenges during pregnancy - May 2021
- Stillbirth Pilot Study Results – June 2021

Starting in January 2022, the SSDI coordinator also provided analytic support to authors of HSU's. Before publishing an article, the SSDI coordinator provided 'de novo' data check by independently writing code to replicate the data being presented in HSU articles. The following HSUs were published in FY 2022 and data checked by the SSDI Coordinator:

- Prenatal Care Experiences During the COVID-19 Pandemic - April 2022
- Pandemic Related Stressful events Experienced During Pregnancy - March 2022
- Use of Tele-Audiology for Diagnostic Testing After Failed Newborn Hearing Screening - February 2022

UWNQC and AIM

As stated earlier, DRP experienced substantial staffing changes over the past two years with the SSDI position vacant between October 2020 and March 2021. Before departing, the former SSDI coordinator provided analytic support during FY 2021 to the Out-of-Hospital (OOH) birth subcommittee for the Utah Woman and Newborn Quality Collaborative (UWNQC). The SSDI coordinator provided quarterly data on transfers to hospitals among mothers who intended to deliver in an OOH setting. Work with the OOH subcommittee also included: updating Utah Best Practice Guidelines on transfers to hospitals for planned OOH births; submitting an abstract on analyzing risks associated with maternal transfer to a hospital; and the development of a patient facing survey to collect data from mothers who experienced transfer to a hospital for an OOH birth setting. This survey was meant to better understand patient experiences related to the OOH transfer process and improve the transfer process. The SSDI coordinator also programmed the survey into REDCap for implementation and assisted with the IRB application.

In FY 2021, the SSDI Coordinator also provided analytic support to the UWNQC Maternal Health subcommittee by using provisional birth data from the Office of Vital Records and Statistics to track and provide quarterly reports on preterm births among Utah mothers, the number and proportion of Utah mothers reporting a previous preterm birth, and the receipt of progesterone.

In FY 2022 the SSDI coordinator provided data collection and analytic support to Utah's Alliance for Innovation on Maternal Health (AIM) and attended planning meetings, trainings, and learning groups for a new AIM Opioid Use Disorder Safety Bundle (which has since been updated to include all substance use disorders), compiled required hospital demographic data and contributed to the development of county-specific resource guides for AIM.

In FY 2022, the SSDI Grant Coordinator also supported the UWNQC Maternal Subcommittee on a quality

improvement project focused on undocumented women needing prenatal and postpartum care. The SSDI Grant Coordinator helped develop and implement key informant surveys and assisted with a qualitative analysis of the data with the goal of creating a two toolkits for providers and undocumented women to navigate health services in a non-threatening manner.

Additionally, UDHHS used SSDI Aim Supplemental funds to hire a part-time AIM Analyst in April 2022. The AIM Analyst has begun working closely with the Quality Improvement Director in the Maternal and Infant Health Program, to implement the new Substance Use Disorder Safety Bundle. The AIM Analyst has been providing analytic support by refining structure and process measures on safety bundle implementation for participating birthing facilities. The AIM Analyst has worked closely with AIM to develop a new Utah AIM Dashboard and will upload structure and process data as well as SMM data cases for each participating facility in the AIM data portal.

Other Support for Title V Program Efforts

The SSDI team continues to assess ongoing data needs by reviewing FAD data to identify trends and demographic disparities within the MCH/CSHCN domains and providing FAD to programs and assisting them with interpretation of the data, including goal setting methodologies as requested.

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	2020-2021
• Established 2020 MCH Needs Assessment Leadership Team • Reviewed needs assessment methodologies and methods used by others states • Trained staff on Needs Assessment methodologies	• Performed as assessment of secondary data and created an indicator report to share with domain leaders and stakeholders • Developed a timeline and wrote contract to work with the University of Utah to conduct key informant interviews, focus groups, and stakeholder meetings.	**OBJECTIVE COMPLETED IN 2019**

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

2018	2019	2020-2021
• Contracted with the University of Utah to conduct key informant interviews, focus groups, and stakeholder meetings • Developed 2019 Stakeholder Survey Questions • Built and implemented a stakeholder survey • Analyzed data from survey and provided rankings of issues by domain to domain leaders • Developed and implement online 2019 CSHCN Parent Survey • Analyzed stakeholder and CSHCN survey data	• Worked with the University of Utah through their conducting of focus groups and key informant interviews • Helped University of Utah to draft needs assessment report including editing methods sections • Complied an overview of ESMs created by other states to assist in Utah's selections of ESMs for newly selected NPMs	**OBJECTIVE COMPLETED IN 2019**

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	2021
• Developed and shared MCH Needs Assessment data fact sheets and reports with stakeholders • Invited critical partners among state, local, and community agencies to MCH Summit to rank state's prioritized needs • Selected appropriate NPMs and SPMs for FY20-FY25 to be reported on the annual Block Grant • Selected and developed appropriate Evidence-based Strategy Measures (ESMs) for the selected NPMs and SPMs	**OBJECTIVE COMPLETED IN 2020**

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	2021
• Annual User Feedback Survey was developed and analyzed • On-going enhancements were added to the system to increase user satisfaction and improve alignment to updated MCH Block Grant guidance • Offered assistance to Block Grant Contributors on use of the WESTT system	• Added on-going enhancements to the system including adding the ability to transfer and change editing permissions and report on challenges and emerging issues • Updated the technical documentation and manual on the use of the WESTT system • Offered assistance to all Block Grant Contributors on use of the WESTT system	• In anticipation of new performance measures, WESTT was modified to include extra fields which allowed contributors to include information related to any newly selected performance measures • Updated the technical documentation and manual on the use of the WESTT system • Offered assistance to all Block Grant Contributors on use of the WESTT system	• Added on-going enhancements to the system including adding the ability to automate achievement statements, adding the data sheet requirement, updating NPM and SPM requirements, and encouraging the reporting of health equity and disparity data

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

2018	2019	2020	2021
• Represented MCH/CSHCN Bureaus in meeting for potential topics of Utah Health Status Update • Published articles in Utah Health Status Update Publication	• Conducted an annual review of Federally Available Data • Published article(s) in Utah Health Status Update Publication	• Conducted an annual review of Federally Available Data • Publish article(s) in Utah Health Status Update Publication • Created a data sharing agreement with the Office of Vital Records and Statistics to ensure data accessibility for all programs within the MCH Bureau	• Conducted an annual review of Federally Available Data • Published article(s) in Utah Health Status Update Publication

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	2020-2021
• Created data sharing agreements with hospitals to collect facility data on synthetic progesterone prescribing and treatment • Created a database in REDCap for data collection to share data on a quarterly basis • Trained hospital staff on using this REDCap database and provided ongoing technical assistance as necessary • Assessed the quality of the synthetic progesterone treatment reporting variable • Prepared a report on findings	• Began also receiving data of 17P use from the University of Utah in addition to Intermountain facilities • Report on 17P use published in Utah Health Status Update • Continue to share data of 17P on a quarterly basis with UWNQC • Collaborated on a return on investment publication for 17P use in Utah Medicaid births • 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 COMPLETED IN 2019**

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

2018	2019	2020-2021
• 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	**OBJECTIVE COMPLETED IN 2019**

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

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

2018	2019-2021
• 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 COMPLETED IN 2018**

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	2021
• Provided analytic support to the UWNQC maternal subcommittee • Provided analytic support to the UWNQC out-of-hospital (OOH) birth subcommittee • Provided analytic support to the UWNQC board/steering committee • Supported Utah's Alliance for Innovation on Maternal Health (AIM) by providing data collection and analytical support	• Attended planning meetings for implementation of the new AIM opioid use disorder safety bundle • Developed letter for reporting to individual hospitals on their OOH transfers and related feedback from providers • Created pilot survey for the new maternal mental health UWNQC subcommittee	• Assist with determination of data to be collected by hospitals with implementation of new safety bundle • Conduct a risk assessment analysis of intrapartum transfers to hospitals in women having an out-of-hospital birth and submitted an abstract • Update and distribute letter for reporting to individual hospitals on their OOH transfers and related feedback from providers	• Provided programmatic support to the UWNQC maternal subcommittee. • Provide programmatic support to the UWNQC out-of-hospital (OOH) birth subcommittee. • Supported Utah's Alliance for Innovation on Maternal Health (AIM) by providing data support.

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	2021
• 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 • Wrote data sharing agreements to obtain hospital discharge data to provide to the CDC • Compare data from hospital discharge to REDCAp VLBW database to assess for data quality and determine a gold standard for future use	• Linked birth certificate data to hospital discharge data for the CDC's LOCATe project • Provided CDC with data for their LOCATe analysis on maternal and neonatal outcomes • Drafted a report on data collected in REDCap on VLBW births to distribute to participating hospitals	**OBJECTIVE COMPLETED IN 2020**

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Data capacity in the Department of Health and Human Services (UDHHS) is strong and is focused around the Division of Data, Systems and Evaluation (DDSE), which serves as the central point for state health data from many sources. The DDSE includes the Offices of Informatics and Data Systems, Information Privacy and Security, Research and Evaluation, and Vital Records and Statistics. The DDSE oversees the legislatively mandated Health Data Committee. The DDSE provides access to large data sets for analysis by DHHS staff and works with programs to assist in data analysis as needed.

The UDHHS maintains numerous public health databases such as birth and death records, an immunization registry, child health registries, and a data warehouse that stores Medicaid Management Information System (MMIS) and other health-related operational data. Each of these databases contains person-specific, identifiable records that are used for management, operational, and public health purposes. Often it is necessary to link information between databases. For example, linking birth certificate data with Medicaid claims data allows for the examination of prenatal care delivery, as well as the assessment of maternal morbidities and birth outcomes.

The UDHHS Master Person Index (DOHMPI) project uses a mix of probabilistic and deterministic record linking technologies to maintain an ongoing repository of high quality linked identity information that facilitates operational and analytic data needs analysis across multiple diverse public health databases in UDHHS. The DOHMPI is designed to uniquely identify each individual in the state receiving healthcare or public health services to support healthcare and public health operations and research.

Currently, the DOHMPI links information from ASQ Questionnaire Screening, Early Intervention Part C (Baby Watch), DWS - Child Care Subsidy, DOPL - Controlled Substance Database, Utah Death Registry, Newborn Hearing Screening, Medicaid, Office of Home Visiting (legacy and current systems), DOPL - Professional Licensing, Utah Cancer Registry (UCR), Utah Birth Registry, Utah Immunization Registry, Women Infant and Children (WIC), Head Start - Centro de la Familia, and Healthcare Facilities Database. Other source systems being added to the DOHMPI include APCD (non-Medicaid), Head Start - DDI Vantage, and Traumatic Brain Injury Registry.

The Health Care Information & Analysis Programs manage and enhance the All Payer Claims Data (APCD). In addition to collecting inpatient hospital discharge data, they have initiated the process of compiling medical and pharmacy claims data across health care insurance providers (payers). Utah is one of the first states in the country to analyze episodes of care (EOC) derived from statewide health insurance claims. An EOC is defined as a complete course of care from the initial diagnosis through treatment and follow-up. For example, in the context of maternity, the EOC would begin with the first prenatal visit and include all other visits, pharmacy claims, lab tests, and special procedures, delivery of the baby and postpartum care of the mother. The Utah APCD represents a rich source of healthcare data.

Another major strength for the UDHHS data infrastructure is the on-line Indicator-Based Information System for Public Health (IBIS-PH). The IBIS-PH website serves as Utah's online public health data and information reporting system. IBIS-PH acts as the primary point of data access and houses numerous data sets all easily accessible for public use (http://ibis.health.utah.gov). The IBIS-PH system was developed to meet recognized public health assessment needs, including tabulation of vital statistics data, tracking of progress on Healthy People goals, and the displaying of data for local communities, down to small area analysis. The system provides access to more than 100 different indicators and data sets, such as birth and death files, BRFSS, PRAMS, YRBSS, hospital and emergency UDHHS data, population estimates, and the Cancer Registry. SSDI grant funds have been used to update IBIS with additional indicators corresponding to the MCH Minimum and Core data set indicators.

Capacity for MCH/CSHCN data collection and analysis is expanded through the DRP. The DRP provides analytic resources and statistical expertise to MCH and CSHCN Offices and Programs for assessing the health status of the MCH population, planning and evaluating services. The DRP is headed by the MCH Epidemiologist with two epidemiology staff and one programmer. The DRP assists staff with survey development, database development, data analysis, and report writing and receives data requests from the Offices of MCH and CSHCN, as well as from outside state agencies, local colleges, and universities.

DRP has assisted programs with survey programming in secure online platforms. For example, in the spring of 2022, DRP reprogrammed a REDCap database for the Maternal and Infant Health Program's Study of the Associated Risks for Stillbirth (SOARS). This CDC sponsored study gathers essential data for monitoring stillbirth and related factors such as prenatal, obstetric and postpartum health care after a pregnancy loss. This survey has been conducted since 2018 using a mail and telephone methodology among women who have experienced a stillbirth. The SOARS program needed to develop a data entry system for the survey data. Moving forward, should Utah choose to continue data collection for SOARS, DRP will make further changes to the REDCap database to enable a web-based response option for participants.

The DRP developed a RedCap reporting system for the Medications for Inmates pilot project. This system allowed participating facilities to report service data required under contracts. The information was easily compiled for reporting to the Department of Workforce Services, who provided funding for the pilot year.

The DRP also conducts surveys, including, but not limited to Oral Health Surveys, WIC Participant Satisfaction Surveys, Developmental Screening Surveys, and the Commodity Supplemental Food Programs Customer Satisfaction Survey. The DRP routinely links Vital Records Birth Certificate data and Medicaid Eligibility data for the annual Maternal and Child Health Block Grant. The DRP also links data sets to assist several programs, e.g. Hospital Discharge data with Vital Records Birth Certificate data; Vital Records Birth data with Infant Death linkage and Death data; Hospital Discharge data with the Birth Defects Network data; and Vital Records Data with the WIC data.

The DRP is responsible for the coordination of Title V MCH Block Grant Application and Report each year. Many years ago staff developed a web-based application titled Web Enabled Systematic Tracking Tool (WESTT) to align better with MCHB TVIS. The use of WESTT has allowed the Offices of MCH/CSHCN to capture and maintain block grant information from numerous sources in one single location, thus increasing efficiency and decreasing the number of person-hours devoted to this effort. WESTT has also increased efficiency and communication among contributors by allowing them to edit data and narratives and communicate with system administrators directly all in one secure place. By providing around-the-clock access, WESTT makes it more convenient for contributors to work on block grant assignments when it fits their schedules. Program staff members have welcomed the system and have reported satisfaction with utilizing the system which has reduced overall assignment completion time. Each year after the Title V Block Grant Application submission, DRP conducts a WESTT User Survey to gather feedback from Block Grant contributors and continuously seeks to improve WESTT through trainings and updates to the system. Some new areas of focus for WESTT in 2022 include: training contributors on applying an equity lens to FAD and program data, the development of logic models for work being done for NPMs, and training on using standardized Target Setting Methods (TSMs) for NPMs, SPMs, and ESMs.

In 2022, the DRP also worked with staff in MCH and CSHCN to create a new working group called the Data Integration Group (DIG). The purpose of DIG is to provide analytic support to MCH and CHSCN staff and a forum for understanding the many data systems that MCH and CSHCN programs work with. Meetings are held every other month with presentations by members of DIG and others in the Agency. Presentations include overviews of programs and the populations they serve [this is especially valuable as UDOH merges with DHS], practice runs for professional

presentations, SAS/Stata/R coding shortcuts and tips, journal article discussions, and presentations around data security and policies. For example, during the May 2022 meeting the new DHHS Chief Data Privacy and Information Security Officer attended and answered questions about the merger regarding data security issues and protocols. DIG is also working on a Utah State legislative data brief that highlights the work being done by the Division for MCH and CSHCN populations, with the goal of having a report ready for the 2023 Legislative Session. As DIG grows, we anticipate many opportunities for collaboration within the Family Health Division on data projects.

MCH/CSHCN Data Systems

The Child Health Advanced Records Management (CHARM) provides 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 CHARM program and system were established in 2000 as a coordinated, Department-wide effort within UDHHS to link identifiable child health data in real time among appropriate health care programs and state agencies. To date, CHARM has linked the databases from the Office of Vital Records (Birth and Death Certificates), the Utah Statewide Immunization Program (USIIS), the Early Hearing Detection and Intervention (EHDI) Program, the Newborn Bloodspot (Heel-stick) Screening Program, the Baby Watch/Early Intervention Program, and the Office of Recovery Services. CHARM is also a conduit for the Office of CSHCN to connect to the Utah-wide clinical Health Information Exchange (cHIE) system. The CHARM system also provides a web interface/portal for providers and programs which enables authorized users to obtain newborn screening results (hearing, heel-stick, heart) and immunization histories for children to facilitate more complete and timely health care services. Lastly, it has been selected to be the State system to collect ASQ screening data. CHARM creates a consolidated electronic health record for children in Utah. This 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.

Utah Birth Defect Network (UBDN), is a statewide population-based active surveillance system administered by UDHHS that monitors all pregnancy outcomes (i.e., live births, stillbirths, pregnancy terminations, and miscarriages) for birth defects since 1994. UBDN also oversees the Critical Congenital Heart Disease Screening (CCHD) program for the state. Birth defects are the leading cause of death in the first year of life and account for millions of dollars spent each year on healthcare costs, thus making birth defects common, costly, and critical. UBDN data provides a unique opportunity to respond to emerging threats to mothers and babies.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS 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 given birth to a live infant. PRAMS data informs Title V programs by providing information on changes in maternal and child health indicators such as maternal mental health, unintended pregnancy, prenatal care, breastfeeding, insurance status, among many others. The PRAMS data also provides important context for many measures. PRAMS data is the source for several Title V National Outcome Measures.

The Study of the Associated Risks of Stillbirth (SOARS) is also a joint surveillance project between the CDC and Utah. 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. Stillbirth is defined as the in-utero death of a baby at 20 weeks of pregnancy or later. SOARS was initiated to help health officials learn more about why stillbirths occur. Understanding the potential causes of stillbirth can lead to recommendations, policies, and services to help prevent them. SOARS data will also help us

learn what support women need after such a loss.

The Perinatal Mortality Review (PMR) Program reviews maternal deaths and infant deaths related to perinatal conditions. Information on deaths is collected from various sources. The PMR committee reviews these deaths to examine contributing factors and make recommendations for prevention. Data related to maternal deaths is collected via the Maternal Mortality Review Information Application (MMRIA), hosted by the CDC. Infant death information is entered into the National Fatality Review Case Reporting System housed at the Michigan Public Health Institute. Utah's Child Fatality Review program also uses the National CFRP system.

The mission of the Utah Early Childhood Integrated Data System (ECIDS) is to better coordinate policy, programming, and funding among all participating programs in Utah through data-driven decision making. To accomplish this aim, the Utah ECIDS works with early childhood programs across Utah to secure data use agreements and to align and strengthen data systems in order to integrate early childhood services data. The integrated data helps Title V programs by improving system-wide coordination and collaboration and works to improve the quality of early childhood programs. Additionally, it allows Title V programs to promote data-driven decision making.

The Mother To Baby/Pregnancy Risk Line provides information about medications and other exposures during pregnancy and breastfeeding. The Utah database collects information on all inquiries made to the program through calls, emails, text messages, and web chats from the public and medical providers. The program also conducts customer satisfaction surveys.

Key challenges

There is limited funding for data and data infrastructure development beyond current funding with the Title V Block grant and SSDI. As a result, Utah has limited staffing capacity to expand beyond current efforts.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

UDHHS has a defined disaster response role to protect public health and support the local public health and healthcare systems during a disaster. To manage this responsibility, UDHHS has emergency plans in place to address natural and man-made disasters. Response plans are developed by response function or hazard-specific. The Population Health Division houses the Office of Emergency Medical Services and Preparedness (EMSP) who is the lead regulatory agency for Utah's emergency medical services (EMS) system and coordinates public health and medical preparedness and response planning for the department and local stakeholders. EMSP's mission is to promote an effective and resilient public health, trauma, and emergency health care system to respond to emergencies and disasters through professional development, preparedness, regulation, quality assurance, and partner coordination.

The Utah Department of Public Safety, Division of Emergency Management manages the state of Utah's Emergency Operations Plan (EOP) in coordination with all state agencies, including the UDHHS. This plan is reviewed and updated every five years or updated as a result of lessons learned during responses.

The current EOP includes an overarching planning assumption that individuals with disabilities and others with access and functional needs may require more assistance before, during, and after an incident in functional areas such as maintaining health, independence, communication, transportation, services, and medical care. They may also be more adversely affected during an incident. This includes, but is not limited to, individuals with a mental or physical impairment, individuals who live in an institutionalized setting, are older adults, are children, are from diverse cultures, have limited English proficiency, are transportation disadvantaged, are homeless, or low-income.

However, Utah is in the process of expanding planning considerations for vulnerable populations in all aspects of the EOP. This includes an expanded understanding of at-risk and functional need populations and collaborating with representatives of these populations when developing emergency plans and responding, including the Offices of MCH and CSHCN.

MCH/CSHCN staff were not involved or consulted in the planning and development of the current state EOP. Leadership of MCH, CSHCN and EMSP are in communication to better address the needs of the MCH population in the Emergency Support Function 8 (health and medical) annex/addendum to the state emergency operations plan. In addition, lessons learned from the COVID-19 response and the merger of the Utah Department of Health with the Utah Department of Human Services will result in improved processes and stakeholders will be integrated into the new functions.

UDHHS has critical operations that must be performed, or rapidly and efficiently resumed in an emergency and has a developed Continuity of Operations Planning (COOP) document. The COOP plan helps to establish guidance to begin the response and recovery of department-wide critical functions in the event of a major incident.

Title V leadership (MCH/CSHCN) is included in the COOP for UDHHS. COOP planning enables agencies to continue their essential functions across a broad spectrum of hazards and emergencies. The plan outlines essential functions, essential positions/personnel, vital records/critical program applications, alternate facility or recovery location, determination of priority functions/recovery time, defines lines of succession and delegation of authority, and reconstitution (return to "normal") planning. The emergency planning effort ensures more involvement with Title V leadership with other emergency operations planning efforts, including revisions to the state EOP.

The Office of CSHCN has developed COOP and department plans to address being able to continue services during an emergency. We have individuals identified for the response as well as duties and data systems which will

require immediate attention. All the newborn screening programs (blood, heart and hearing screenings) and direct care services are involved in this plan. The plans have worked during the pandemic and we have been able to provide continued services to the children, youth and families we serve. Additionally, we have continued to educate providers on screening and maintain compliance with the timeframes of the screeners during the pandemic.

To date, Title V leadership has not been involved in the Incident Command System (ICS). The scope, scale, and nature of the response is determined by UDHHS leadership and they activate various UDHHS programs depending on the incidents. MCH/CSHCN could easily be integrated into the department operations center or ICS structure as needed in the future and this will be reviewed and updated depending on response needs.

The COVID-19 pandemic had an impact on Title V populations. Many programs serving the MCH population experience delayed or disrupted services due to fear and social distancing requirements resulting in fewer interventions for communicable diseases, injury prevention, and preventive screenings; decreased WIC participation; fewer families seeking direct care and care coordination for CSHCN; enrollment and participation in Early Intervention services for the up to age three population; a decrease in families benefiting from home visiting; and fewer children receiving recommended immunizations. Programmatic eligibility systems (such as eREP) required programming changes to override several complex eligibility rules that resulted in case closure. Additionally, in some areas of the state, rural communities did not have the internet bandwidth to support increased telehealth services exacerbated by the pandemic.

The COVID pandemic has highlighted systemic issues and gaps in Utah’s public health and healthcare systems. UDHHS is currently in the process of collecting and analyzing lessons learned and best practices from the response to be incorporated into ongoing programmatic activities and future emergency preparedness efforts.

Moving forward, plans are in place for the Offices of MCH and CSHCN to meet with staff in EMSP to engage the Offices in sharing needs and resources and how MCH/CSHCN population considerations will be integrated into emergency preparedness plans.

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

III.E.2.b.v.a. Public and Private Partnerships

MCH/CSHCN have established partnerships that help expand the work of reaching women, infants, children (including CSHCN), and families. Federal and non-federal funds are leveraged to deliver programs and services in the state. MCH/CSHCN staff maintain working relationships with Title V and non-Title V Programs to create a statewide system of collaboration. The levels of cooperation with various partners can include networking, information sharing, collaboration, integration, formal contractual agreements, joint training or co-sponsorship of events. Most all of the programs/agencies participated in the 5-year needs assessment.

The Utah Women and Newborns Quality Collaborative (UWNQC) is a statewide network of professionals, hospitals and clinics dedicated to improving the health outcomes for Utah women and infants using evidence-based practice guidelines and quality improvement processes. The UWNQC safety bundle sub-committee works to implement maternal safety bundles promoted by the Alliance for Innovation on Maternal Health. Currently, Utah is working to implement the Care for Pregnant and Postpartum People with Substance Use Disorder safety bundle. This statewide collaboration between hospitals, public health, and the Office of Substance Abuse and Mental Health. Other projects include addressing screening and referral for perinatal mental health conditions and identifying and addressing maternal and neonatal safety issues related to out of hospital births.

The Maternal and Infant Health Program (MIHP) convened the Well-woman Coalition with members representing public health, health care, and community organizations. Related to NPM-1, this group will create a strategic plan that defines routine preventive care and describes the most common barriers to receiving that care. They will also recommend changes at the state, local, and systems levels to improve care and encourage all women to view preventive care as self-care. Through this effort, we hope to create a sustainable program with targeted messaging that encourages and empowers women to receive routine preventive care.

Utah’s Perinatal Mortality Review Committee is a committee of doctors, nurses, mental health, and public health professionals who volunteer to review infant and maternal deaths in Utah. The committee reviews each death to determine contributing factors, assess preventability, and make recommendations for prevention of future deaths. A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors. The recommendations from this committee help drive prevention activities.

Pregnancy Risk Line / MotherToBaby Utah (MTB UT) collaborated with various state, national, and international groups and professionals, through workgroups, committees, and projects, to improve the health of pregnant and lactating individuals and their babies. One example was that MTB UT led Utah’s Fetal Alcohol Spectrum Disorders Workgroup to promote avoiding alcohol during pregnancy to prevent fetal alcohol spectrum disorders. Partners included representatives from mental health, birth defect prevention, substance abuse prevention, and other organizations. A second example was that MTB UT led the Organization of Teratology Information Specialists’ / Mother To Baby seminars to provide ongoing professional development through the review of research articles twice a month under the HRSA / MCHB Maternal and Child Environmental Health Network cooperative agreement. Partners from other teratogen information centers, pharmaceutical companies, obstetricians, pediatricians, public health professionals, and others in the United States and Europe participated in the seminars.

The CSHCN Office has found the pandemic to be an opportunity to reduce silos and increase partnerships to be more effective with service provision, working on medical home and transition to adulthood initiatives. CSHCN took the opportunity and initiated engaging with a variety of stakeholders (approximately thirty) and assessed the current system of care. Some of the partners include: University of Utah Medical and Intermountain systems who service the

CSHCN populations; Utah Parent Center, Help Me Grow (United Way), Local Health Departments, Community Health Centers, Human Services, Division of Child & Family Services, Early Intervention and community providers. These medical home and transition focused partnership groups (curriculum, referral, marketing and quality assurance/surveys groups) met monthly throughout the past year. All participating stakeholders are implementing processes in a uniform and consistent manner. We have momentum and excitement as we have found we can provide more to our populations if we team together. We have access to more resources, knowledge, funding and creative ideas.

This past year, the Utah Birth Defect Network in collaboration with the Utah Down Syndrome Foundation has created a new resource for families who have recently received a new diagnosis of Down syndrome. Contents of the guide includes; navigating Down syndrome in the first year, myths and truths, support groups, milestone markers, medical specialists, Medicaid, medical home portal, Utah Parent Center and many CSHCN resources such as Integrated Services, and Baby Watch Early Intervention.
The booklets are available online as well as being distributed across the state at various hospitals, maternal fetal medicine clinics, physician offices and included in new parent gift baskets handed out at the hospital.

The Early Childhood Utah Advisory Council convenes 28 diverse voting members representing different subsets of the Early Childhood Committees. There are five subcommittees: Health and Access to Medical Home, Data and Research, Parent Engagement, Social, Emotional and Mental Health, and Early Care and Education. These subcommittees have additional membership and together represent over 85 people from various early childhood areas. The subgroups meet monthly and work to develop recommendations for the Governor's Commission. These relationships have opened opportunities to bring on new stakeholders who are vested in early childhood development and develop ways to improve the system of care. Three recommendations were brought to the Commission this past year and are in process: early childhood data, comprehensive developmental screening and a trained early childhood workforce.

The Oral Health Coalition continues to meet quarterly with partners and ensure oral health is a priority. The Coalition has been advocating for additional funding from the Governor’s Office to expand State Oral Health Services. This year MCH staff convened partners (community health center, hospitals, local health department, and the University of Utah School of dentistry) to design and submit an application for funding for the HRSA Oral Health Innovation grant (results pending). The application demonstrates the potential for expanded infrastructure, increased workforce development and training to decrease emergency room visits in an area designated as a dental health provider shortage area (HPSA).

As was mentioned above, COVID-19 has provided challenges for service delivery, but has also provided an opportunity for increased engagement from partners. Attendance and access at meetings has significantly increased across all groups and many partners have requested to maintain meetings via teleconference.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Offices 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. The Interagency Agreement (IAA) has been updated to more adequately reflect the partnership and working relationship of these agencies.

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 that include informing eligible/potentially eligible individuals about Medicaid, rural travel and telehealth in support of Medicaid activities, referring, coordinating and monitoring the delivery of Medicaid services, and activities that improve coordination of care and delivery of services.

Some specific activities CSHCN performs for Medicaid enrollees includes:

- 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
- Educating the community
- Participating in or coordinating training which enhances identification, intervention, screening and referral
- 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 Title XIX matching funding to State dollars for several projects in the MCH/CSHCN Bureaus; the Pregnancy Risk Assessment Monitoring System (PRAMS), MotherToBaby, Fostering Healthy Children, 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, virtual and in-person educational training, and one-on-one counseling sessions on obtaining services and how to be an advocate for your child.

The MCH/CSHCN Offices 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.

During Utah's 2022 General Session, House Bill 200 was passed to authorize an expansion of the Medically Complex Children's Waiver (MCCW) program. MCCW serves children with disabilities and complex medical conditions. House Bill 200 also modified the enrollment process for MCCW to allow enrollment year-round. Enrollment in MCCW must be prioritized to the highest medical complexity and critical needs of the family. The CSHCN Bureau has supported Medicaid with outreach and promoted this opportunity with its stakeholders and families we serve. The Integrated Services Program has assisted families in enrolling.

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 Long Acting Reversible Contraception (LARC) insertion and pay for the devices separately from the inpatient hospital stay. The legislation also required Medicaid to submit a waiver to CMS to expand family planning coverage to all women at or below 95% FPL, but due to full expansion being implemented, this waiver was not submitted. Utah Medicaid expanded medical coverage to adults at or below 95% FPL in April 2019.

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 parents/caretakers or the majority of adults without children. Children and pregnant women enrolled in Medicaid have dental benefits.

Medicaid Expansion
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.

Integrated plans

On January 1, 2020, the Utah Medicaid Integrated Care (UMIC) plans started. These plans manage both the physical health and behavioral health benefits of members through integrated managed care plans. Members enrolled in UMIC plans are members that are in Utah's Adult Expansion Medicaid population and that live in Utah's top five urban counties; Davis, Salt Lake, Utah, Washington, and Weber counties. The organizations that operate the UMIC plans are Healthy U, Health Choice, SelectHealth, and Molina.

Public Health Emergency

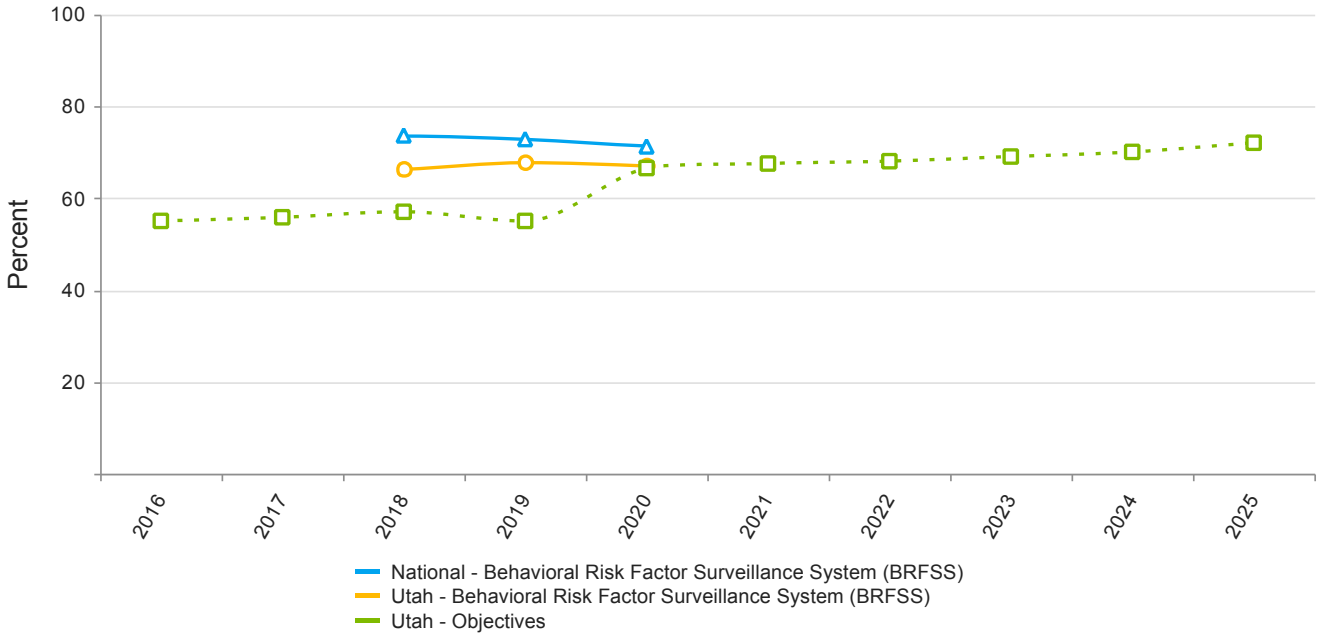
During the federally declared Public Health Emergency (PHE), Utah Medicaid has established a Maintenance of Effort (MOE). For the duration of the PHE, all Medicaid cases will remain enrolled unless a member passes away, moves out of state, or requests closure. As a result, Medicaid enrollment has grown by more than 40% during the PHE. When the PHE expires, Utah Medicaid will begin its plan to unwind cases with the goal of a smooth transition of members to any eligible Medicaid program or a referral to the Federal Marketplace when possible.

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

Women/Maternal Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				66.5	67.5
Annual Indicator			66.1	67.6	67.0
Numerator			394,166	413,656	413,571
Denominator			595,993	612,087	617,227
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	68.0	69.0	70.0	72.0

Evidence-Based or –Informed Strategy Measures

ESM 1.2 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.

Measure Status:	Inactive - We do not have a robust evaluation strategy to measure the effect of the Power Your Life booklets provided to clients.

State Provided Data			
	2019	2020	2021
Annual Objective			250
Annual Indicator	100	200	300
Numerator			
Denominator			
Data Source	Salt Lake County Home Visiting Program Data	Salt Lake County Home Visiting Program Data	Salt Lake County Home Visiting Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

ESM 1.3 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.

Measure Status:	Inactive - Completed

State Provided Data			
	2019	2020	2021
Annual Objective			12
Annual Indicator	0	10	7
Numerator			
Denominator			
Data Source	Maternal and Infant Health Program data	Maternal and Infant Health Program data	Maternal and Infant Health Program data
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Provisional

ESM 1.4 - 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:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			0
Annual Indicator	0	0	1
Numerator			
Denominator			
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Provisional

ESM 1.5 - Develop and offer an educational module to community health care workers as an online supplemental course

Measure Status:		Active	
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	1.0	1.0	1.0

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	2020	2021
Annual Objective			63.8
Annual Indicator	56	60.8	60
Numerator	25,866	27,859	26,909
Denominator	46,186	45,807	44,814
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	63.8	66.8	69.8	72.8

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 76.0%.	
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.	
Train community health workers through an online Maternal and Child Health module on basic preconception and well-woman and the necessary knowledge and skills to advocate for the populations they serve	
ESMs	**Status**
ESM 1.2 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.	Inactive
ESM 1.3 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.	Inactive
ESM 1.4 - 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.	Inactive
ESM 1.5 - Develop and offer an educational module to community health care workers as an online supplemental course	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 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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 78.8%.

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.

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

Annual Report FY21:

This Performance Measure was NOT achieved. The Performance Objective was 67.5% and the Annual Indicator was 67%.

Program Activities:

In 2021, the Maternal and Infant Health Program (MIHP) utilized the social media platforms Facebook and Instagram to share information on preventive health care visits and women's health. These messages were shared under the Power Your Life logo and branding and used the handle @poweryourlifeut, so content on both platforms would be easily identifiable and recognized as a trusted source. Approximately 70,000 people saw at least one post from the Power Your Life social media platforms, and this is nearly double the number of people exposed to Power Your Life content in 2020.

Nickee Andjelic, the certified health education specialist for the Maternal and Infant Health Program (MIHP), did an on-air television spot encouraging women to schedule their well-woman visit, especially if they had been putting it off during the COVID pandemic. This spot was aired during the afternoon news. The news station website posted a link to the segment and a brief written article about well-woman visits.

Due to the ongoing COVID pandemic, many of the yearly community health fairs and other community events MIHP participated in were canceled. However, we fostered new partnerships that allowed us to safely provide educational material to the public. As seen in the list below, MIHP staff provided material and resources to a wide range of community partners. It reached diverse populations of men, women, and young adults with messages about routine preventive care, preconception health, contraception, and birth defects prevention.

- Birth Defect Prevention Month: During National Birth Defects Prevention Month, MIHP and the Utah Birth Defects Prevention Network provided informational packets to three Local Health departments and WIC clinics. We provided 450 educational packets.
- Park City People's Choice Clinic: Educational materials and prenatal vitamins were provided to women who attended the clinic's wellness classes. We provided 100 packets to the clinic.
- Spring PopUp Mom Boutique: This event was held to support maternal Mental Health. We reached 250 people at this in-person event.
- Valley Health and Wellness Fair: This fair is targeted to people in an under-resourced area in the Salt Lake valley. They provide information and resources for a wide variety of community health organizations. We reached approximately 150 people at this event.
- Out of the Darkness Walk: This yearly event brings awareness to maternal mental health. We provided 150 educational packets to the group that sponsored the event for distribution to attendees.
- Islander Health Fair: This event is held yearly by the Pacific Islander Health Coalition. MIHP staff provided materials to an estimated 100 people.
- Partners in the Park: Sponsored by the University of Utah, this community event brings resources to residents on the west side of the valley, a high-need area. We talked about women's health and shared resources with about 100 people at this event.
- Utah Block Party: This health fair was for University of Utah students living in married housing. MIHP staff provided resources to and answered questions from the nearly 100 people that attended.
- Utah Valley University (UVU) Student Health Fair: UVU Student Health Services sponsors this bi-annual health fair to provide students with information and resources to improve their health and wellness. MIHP staff

provided educational packets and other swag to the organizers of these health fairs, reaching approximately 150 UVU students and faculty.

While we do not know if any of these activities directly impact a woman seeking routine preventive care, our ability to meet our target population where they are, talk with them, and answer their questions face-to-face makes a difference in their knowledge and attitudes. During these health fairs, Ms. Andjelic has had meaningful conversations about contraception, when a person should seek a Pap test, and how certain lifestyle behaviors affect immediate health and the health of a future pregnancy with our target population.

The Power Your Life social media accounts, run by Ms. Andjelic, are a trusted source of information. Our followers regularly reach out through direct messaging on the platforms to ask questions and seek more information. In 2021, Ms. Andjelic continued partnering with the Salt County Health Department and the Utah Home Visiting Services and Support Program to provide Power Your Life educational booklets to its home visiting programs. These booklets are geared towards women of reproductive age and are easy to read and understand. Education in these booklets includes evidence-based practices and facts on vitamins, nutrition, preventive care, family history, vaccinations, sleep, healthy relationships, the menstrual cycle, sexually transmitted diseases, mental health, tobacco, alcohol, and birth control methods.

Finally, the MIHP program began regularly meeting with women's health and public health experts to work on a state strategic plan to increase the percentage of women of childbearing age that receive a well-woman visit.

Accomplishments/Successes:

Significant success is the ongoing relationships the MIHP program has developed with community organizations. For example, lasting relationships with Utah Valley University and the University of Utah have provided us an opportunity to reach thousands of women with health messaging through yearly health fairs. These relationships have remained strong throughout the COVID-19 pandemic, and we look forward to continuing working with them when it is safe to do so.

Another success is the inclusion of a question on the Utah Behavioral Risk Factor Surveillance System survey about why women of childbearing age who did not receive routine preventive care in the past year. This question is being asked to all women between 18-and 44 on the 2022 questionnaire.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM - 1:

- Ongoing, mutually beneficial relationships with a local university, Utah Valley University, has allowed the Maternal and Infant Health Program (MIHP) to reach thousands of college-aged women with education and information about the importance of routine preventive care.
- Strong community partnerships allow us to distribute Power Your Life booklets to a wide network of women across the state. We are seen as a trusted resource at numerous community health fairs. Additionally, well-educated and approachable staff at these health fairs allows for education to happen on the spot.
- Successfully added a question to the 2022 Utah Behavioral Risk Factor Surveillance System about why women of childbearing age did not receive routine preventive care in the last 12 months.

Challenges/Gaps/Disparities Report:

Challenges:

The primary challenge faced by MIHP staff during FY21 continued to be the COVID-19 pandemic. Due to federal, state, and local ordinances, all large group gatherings, like health fairs, were canceled for the safety of all citizens. This led to MIHP staff being unable to attend as many health fairs as in previous years, thus resulting in lower

numbers of people who were reached. We also anticipate a decrease in the percentage of women of reproductive age seeking routine preventive care in the next year due to the pandemic.

A secondary challenge of creating an evidence-based strategy for increasing the percentage of women receiving a well-woman visit is our inability to pinpoint why a woman does not schedule a yearly well-woman exam. Without this knowledge, we cannot create messages or programming that will address the needs of our target population. However, with the inclusion of a new question addressing barriers to routine preventive care on the 2022 Utah Behavioral Risk Factor Surveillance System survey, we are hopeful that future programming efforts will be able to use the data collected to create the messages that target the needs of our population.

Agency Capacity/Family Partnerships/Collaboration:

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

The Utah Birth Defects Network (UBDN) is a significant partner for this performance measure. Staff from UBDN attend all health fairs with the Maternal and Infant Health Program 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 vital partner, MotherToBaby Utah (MTB UT), provides information to women about exposures in the preconception period, during pregnancy, and during breastfeeding. In FY21, MotherToBaby Utah answered questions from 458 women and their providers about exposures as they were planning for future pregnancies, 3,080 questions during pregnancy, and 2,132 questions before and during breastfeeding. MTB UT provides information about immunizations, chronic conditions, medications for chronic diseases, prenatal vitamins, and other exposures that might affect the developing fetus or breastfed baby to help women plan for their pregnancies, manage their conditions, and initiate and continue breastfeeding.

Report of ESMs related to NPM-1

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.

Goal/Objective:

Increase the number of home visiting clients that receive education on the Well-Woman Visit.

Significance of ESM:

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 1.1 Progress Summary:

Routine preventive care is key to health across the lifespan. A yearly preventative checkup is a time for a person to develop a trusting relationship with their healthcare provider and an opportunity for healthcare providers to counsel people on their specific healthcare needs and screen for early detection and treatment of disease and illness. The importance of routine preventive care was further addressed in the Affordable Care Act, requiring all insurers to cover 29 preventative services for women, including pregnant women (https://www.healthcare.gov/preventive-care-women/).

During this fiscal year, MIHP staff worked with home visiting staff to educate their clients on women's health and routine preventive care. A booklet called Power Your Life Power Your Health was given to female home visiting clients during their initial visit. These booklets include nutrition, exercise, routine preventive care, family health history, sleep, relationships, sexual health (menstruation, STDs, and contraception), and mental health information. A challenge of this ESM is that we do not have a robust evaluation strategy to measure the effectiveness of providing the Power Your Life booklet to home visiting clients. While we handed out 300 booklets to home visiting clients, we do not know if they effectively encouraged women to seek routine preventive care or a well-woman visit. Therefore, we plan to discontinue this ESM moving forward.

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.

Goal/Objective:

Engage a diverse group of community partners and organizations to develop a strategic plan to increase the percentage of women of reproductive age that reported a well-woman visit.

Significance of ESM:

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 1.2 Progress Summary:

MIHP recognizes that increasing the percentage of women that receive a well-woman visit is a goal that will take work from professionals in the healthcare field, public health, and community organizations. The MIHP began working with diverse stakeholders to create a statewide strategic plan to address routine preventive care in women of reproductive age during this fiscal year. A well-woman coalition was convened in January 2021 with members from public health, healthcare, rural health, and higher education. Stakeholders from each of these organizations regularly attend and participate in the meetings held every other month.

Currently, we are in the final stage of writing the strategic plan and anticipate it being completed in 2022. A previous statewide women's coalition has begun meeting after a couple of years of hiatus. Many of the same members of this well-woman coalition attend this meeting. Since we do not want to duplicate efforts, we will be discontinuing this coalition after the strategic plan is complete. However, work toward improving women's health throughout the state will continue through this previously established women's coalition.

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.

Goal/Objective:

Increase the number of questions on the Utah BRFSS so we can better understand the barriers and facilitators to women in obtaining a well woman visit.

Significance of ESM:

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 resonate with our target population, thus increasing the percentage of women who receive care.

ESM 1.3 Progress Summary:

A challenge in creating an evidence-based strategy for increasing the percentage of women receiving a well-woman visit is our inability to pinpoint why a woman does not schedule a yearly well-woman exam. Without this knowledge, we cannot create messages or programming that will address the needs of our population. To address this challenge, MIHP successfully added a question to the 2022 Utah Behavioral Risk Factor Surveillance Survey, asking women of reproductive age why they did not receive routine preventive care in the last year.

The question the MIHP added follows the core question CHCA.04, "About how long has it been since you last visited a doctor for a routine checkup?" If a woman aged 18-44 answers anything other than "Within the past year (anytime less than 12 months ago), they are asked our added question. This follow-up question is, "You stated that you had not visited a doctor for a routine checkup in the past year. What are the primary reasons you did not receive a checkup?" Possible answers include: (1) I did not know that I needed a yearly routine checkup (2) I could not get an appointment when I wanted one (3) I had no way to get to the clinic or doctor's office (4) I could not take time off from work or school (5) I had no one to take care of my children (6) I didn't want to visit a clinic or doctor's office due to COVID (7) Other (8) Don't know/Not Sure (9) Refused. Because we have successfully completed our objective of adding a question to the BRFSS, we will deactivate this measure as data is currently being collected.

ESM 1.4 - Develop and offer an educational module to community health workers as an online supplemental course.

Goal/Objective:

Creation of a Maternal and Child Health education module that will be available online that will focus on preparing community health workers to educate on preconception health and well-woman care recommendations.

Significance of ESM:

By reaching and mobilizing women of childbearing age within their communities, community health workers can improve access to care and increase utilization of preventive care services like cervical cancer screenings and mammography. By focusing on well-woman care, trained CHWs have the potential to protect and optimize women’s health over the course of their lifetime and reach our underserved communities.

ESM 1.4 Progress Summary: Because this is a new ESM we will be collecting baseline data in FY23 and will be able to report in next year’s application and report.

Local Health Department Activities related to NPM-1:

There are two Local Health Departments (LHDs) who work on activities for NPM 1 – Well Women Visits. One LHD was able to provide 5 IUDs to women that reported they would have otherwise gotten pregnant or had less money for basic needs. They were also able to help 51 women receive well woman exams that they otherwise would not have received. One LHD has contracts with local pharmacies to dispense the birth control methods that they offer. During home visitation visits and WIC appointments women are educated on the importance of women's health, pregnancy spacing and birth control options. Referrals are made to those that cannot afford to pay for their prescription. One LHD was able to provide 62 Depo Provera injections, 19 cycles of oral birth control and 17 NuvaRing prescriptions.

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

Annual Report FY21:

Program Activities:

This Performance Measure was NOT achieved. The Performance Objective was 63.8% and the Annual Indicator was 60.0%.

During FY21, the maternal mental health (MMH) specialist in the Maternal and Infant Health Program (MIHP) conducted numerous trainings and presentations to raise awareness about perinatal mental health in Utah and increase knowledge of the Maternal Mental Health Referral Network, a listing of mental health providers with training in perinatal mental health. Presentation audiences included the Syringe Exchange Network, local health departments, local mental health authorities, staff in the Division of Substance Abuse and Mental Health, home visitors, staff in the Office of Health Disparities and their program volunteers, the Utah Suicide Prevention Coalition, clinical staff in multiple practices, and WIC staff.

Additionally, presentations on the Maternal Mental Health Referral Network were given at national meetings such as the Marce Society's annual conference and Postpartum Support International's bi-monthly summit. The MMH specialist also promoted awareness of perinatal mental health conditions and resources via Instagram and Facebook.

In May 2020, the Utah Department of Health established a maternal mental health Instagram page and by March 2021, the page had over 11,000 followers. With the success of the Instagram page, permission was given to also launch a Facebook page in November 2020. This page had over 1,800 followers by April 2021. The MMH specialist participated in several media events including podcasts, newspaper articles, TV news segments, and social media livestreams. The MMH specialist also participated in Black Mental Health week online to promote awareness and resources.

The Maternal Mental Health Referral Network continued to be promoted in all settings. The MMH specialist worked to encourage providers who were trained in perinatal mental health to list their services on the site to increase available services statewide. The Maternal and Infant Health Program continued to contract with the University of Utah, College of Nursing to address the mental health needs of childbearing women in rural and frontier Utah geographic areas that are designated as Health Professional Shortage Areas for mental health. Through this project, screening for depression among pregnant and postpartum women, using a validated screening tool, is offered through local health departments. Women who have a positive screen for perinatal depression are offered resources in the form of handouts, support groups, or individual mental health services via a telehealth platform. In this time period, the Maternal Mental Health Subcommittee of the Utah Women and Newborns Quality Collaborative worked on development of a maternal mental health screening and referral toolkit. Data related to perinatal mental health was compiled by PRAMS staff and a report, "Maternal Mental Health in Utah", was published on the Maternal and Infant Health program website: https://mihp.utah.gov/wp-content/uploads/Maternal-Mental-Health-Utah-PRAMS-2016-2019.pdf.

MCH staff participated in the Utah Maternal Mental Health Collaborative. This group focused on policy issues surrounding maternal mental health and activities to raise awareness of the issue in Utah. The collaborative includes stakeholders from a wide range of agencies who serve Utah's women and children. Utah Governor Spencer Cox also declared February 2021 as Maternal Mental Health Awareness month. The Utah Maternal Mental Health Collaborative held an event on February 17, 2021 to mark this declaration which generated media coverage. There was a noted increase in the number of visitors (February 17th –19th) to the Utah Maternal Mental Health Referral Network (https://maternalmentalhealth.utah.gov/).

MotherToBaby Utah provided information about exposures, including mood medications, in pregnancy and breastfeeding to help reduce untreated mood conditions, prevent exposures that increase risks for birth defects and developmental delays, prevent other adverse pregnancy outcomes, and increase breastfeeding rates.

Accomplishments / Successes:

A noted success is increasing awareness of the Maternal Mental Health Referral Network. The site has been promoted through training and social media. The site is now linked on the Utah Medical Home Portal and the Postpartum Support International Utah Chapter's webpage.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-1:

- Conducted educational training to raise awareness around perinatal mental health.
- Published a PRAMS Perspectives report, "Maternal Mental Health in Utah"
- Launched Instagram and Facebook pages.

Challenges / Gaps / Disparities Report:

Challenges:

The 2020 PRAMS data was collected during the COVID-19 pandemic. The PRAMS data found that the percentage of women who did not attend a postpartum visit increased from 8% in 2019 to 11% in 2020. This is not an unexpected finding with the impacts the pandemic had on the healthcare system and concerns for pregnant and postpartum women related to avoiding infection from the virus. It is anticipated that the effects of the pandemic will continue to be seen in the 2021 data. Also related to the pandemic was adjusting to remote work in this reporting period. Many opportunities for training were canceled or delayed due to adjusting to a virtual work environment.

Agency Capacity / Collaboration Report:

Critical partners in this work are staff in the Division of Substance Abuse and Mental Health. With the merging of the Utah Department of Health and the Department of Human Services, we anticipate these partnerships to be strengthened.

Local Health Department Activities related to SPM-1:

Eight of Utah's 13 Local Health Departments work on strategy measures and activities to improve outcomes for women experiencing postpartum depression (SPM 1). There were many successes during the year, in spite of the continuing challenges related to COVID. Many staff were trained on the Edinburgh Postnatal Depression Scale (EPDS) screening tool and how to educate women who screen positive. Screenings were offered in the places

where clients connect with the LHD, through WIC programs, Parents as Teachers home visiting sites and Targeted Case Management (TCM) visits. As part of these visits, a postpartum assessment/depression screening (EPDS) was offered. Unfortunately, many LHDs saw significant decreases in women who were willing to participate. Most LHDs did not screen the number of women they had planned, but accommodations were allowed due to COVID.

Upon completion of the EPDS, nurses would score results immediately and anyone who scored ≥10 would be provided a mental health service referral. At least one of the LHD's also implemented an Adverse Childhood Screen (ACE's). Clients served in the MCH program are at higher risk of scoring ≥4 on an ACEs questionnaire and are an essential group to target interventions. Parents/caregivers visited through home visitation programs were also offered the ACE screening tool and other ACEs & Resiliency information materials. If the ACE questionnaire was done in person with the nurse, the results were reviewed with the parent/caregiver. Those scoring ≥4 were also provided the Resilience assessment to help the client identify their existing support systems and were linked to needed supports/resources. During the grant year, 37 ACEs screenings were performed at this particular LHD and although this is a small number, it still identified individuals/families at risk and provided a venue for interventions. The interesting fact is that more women were willing to do the ACEs screening than were willing to complete the EPDS.

Davis County LHD's report sums up most experiences that occurred statewide for all the LHD's.

"With the COVID pandemic still actively occurring in Utah, the US and globally - many public health services continued to be suspended and efforts redirected towards the Coronavirus pandemic work. As a result, the MCH objectives planned for the 2020-2021 grant year here in Davis County were greatly affected. In fact, it was more impacted this grant year than the previous year due to the fact that the grant year began and ended during the most significant and hardest hit months of the pandemic. All nurses who would normally be performing the post-partum depression screenings were reassigned to COVID response efforts. As a safety precaution, no home visits were performed most of the months during the grant year of October 2020 - September 2021. In addition, the COVID vaccine was approved under an FDA EUA in December 2020. The burden of vaccinations fell upon public health. Since nurses are licensed to administer vaccines, they were allocated to the vaccine response efforts. The heavy COVID *vaccine efforts continued for several months into 2021 until other venues were able to onboard and start delivering the COVID vaccines as well. In Utah, we also experienced a decrease in cases during the summer months. At this time, 1-2 MCH nurses were able to start providing services to the Davis County community again. Due to some amendments with the Medicaid contracts, our MCH nurses were able to get telehealth appointments up and running. This method was successful in performing services for the infant/child, but less effective in assessing the mothers. Therefore, less women were willing to do the postpartum depression screenings. As cases increased again with the start of school and with the new guidance on COVID booster vaccines, the MCH nurses were once again redirected to the COVID efforts and MCH services were halted. It is unsure when services will be able to resume."*

For many LHD's staff turnover was a huge issue and finding replacements was a challenge. Either there were not enough nurses in the community who would apply for open positions or many times LHDs were not able to compete with the wages hospital positions were paying and nurses left for a higher salary. Once staffing levels return to "normal" staff will be trained on the EPDS tool and implementation for clients back in place.

For many LHDs, offices were closed most of the year to in-person Targeted Case Management (Medicaid), Parents as Teachers (Home Visiting) and WIC appointments. As you would expect, seeing clients in person was a challenge. While many implemented telehealth appointments there were still challenges. Many clients would not answer phone calls or keep their appointments. Many times longer wait times and decreased access to services made participation worse even though many schedule adjustments were made to accommodate clinic and client needs. During the year quarantine guidelines changed and staffing returned to somewhat normal. This has allowed for in-

person appointments once again. There is hope for the LHDs that there will be an increased number of women being screened using the EPDS.

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 transpire 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 Outreach Program encourages women to receive early and adequate prenatal care through TV, radio, podcasts, and social media. In 2020 and 2021, several spots were created to provide expectant women on how to be safe during the pandemic. The Baby Your Baby Program updated their website to be more modern and easier to use. Podcasts continue to increase in popularity as more topics are added.

MotherToBaby Utah helped reduce maternal morbidity by providing information about exposures in pregnancy and breastfeeding to help reduce untreated conditions.

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

Utah is a member state of the Alliance for Innovation on Maternal Health and works 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. In FY21, learning sessions were presented on the following topics related to the safety bundle:

- Polysubstance Use During Pregnancy: Meth and Marijuana
- Neonatal Abstinence Syndrome and Newborn Care
- Validated Screening Tools
- Patient and Family Education and Resources
- Medications and Treatment Response
- Rural Access and Resources
- Opioid Use Disorder Patient Interaction
- Patient Interactions - Tips and Techniques
- Family Planning
- Naloxone and Utah Support Advocates for Recovery Awareness

Work on the AIM Care for Pregnant and Postpartum People with Substance Use Disorder Safety Bundle included compiling and mailing Helping Opioid Patients Excel (H.O.P.E.) folders and Naloxone to all Utah hospitals and Home Visiting contacts. We translated into Spanish the Substance Use Disorder (SUD) resources and launched a Spanish SUD resources website. We created and published local SUD resources for 9 local health departments with the help of Title V summer interns, who presented their project at the Association of Maternal & Child Health Programs (AMCHP). We hosted a booth at the Utah Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) annual conference and our Maternal Mental Health committee chair presented and shared UWNQC info.

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

Utah has an established maternal mortality review (MMR) committee and all maternal deaths are brought to the committee for review and prevention recommendations. Utah receives Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE-MM) funding from the CDC. Utah partners with the State of Wyoming on this grant and a single maternal mortality review committee to review maternal deaths among residents of both states.

The Office of Health Equity published a report highlighting health disparities in maternal mortality and morbidity. This report (https://healthequity.utah.gov/wp-content/uploads/2022/02/UtahHealthDisparitiesProfileMaternalMortalityMorbidity2021.pdf) was published online.

The Office of Health Equity launched the EMBRACE project in 2021. The Embrace Project Study (Embrace) is a community-based participatory research study focused on addressing health in maternal mortality and morbidity and diabetes. Embrace was developed by the Utah Department of Health Office of Health Equity and the University of Utah Health's The Wellness Bus in partnership with community health workers from community-based organizations. This study focuses on addressing maternal mortality and morbidity and diabetes health disparities among women 18–44 years old who are Native Hawaiian and Pacific Islander, Black/African American, Hispanic or Latina, and Refugee and new American along Utah's Wasatch Front in Salt Lake, Weber, Davis, and Utah counties.

The aim of Embrace is to reduce health disparities among Native Hawaiian and Pacific Islander women by providing culturally responsive health services for the women in this study. Embrace focuses on mental health and self-care for women so they are able to thrive for their current and future generations. Embrace also roots mental and self-care practices in ancestral NHPI cultural traditions and emphasizes culture as a source of resilience.

Through the University of Utah Health's The Wellness Bus, a mobile health clinic which provides chronic disease screenings in key neighborhoods, the study is able to provide biometric screenings and health coaching sessions. Embrace is also partnered with five community-based organizations, National Tongan American Society, Utah Pacific Islander Health Coalition, Comunidad Materna en Utah, Project Success Coalition, and Utah Muslim Civic League, who each serve their community members. Embrace works and supports community health workers (CHWs) who are able to support and engage community members in the study.

The Embrace Project Study's (Embrace) focus is diabetes and maternal mortality and morbidity health disparities among women from racial and ethnic minority backgrounds along Utah's Wasatch Front. A unique aspect of Embrace's curriculum is rooted in Native Hawaiian and Pacific Islander culture and traditions. One component that Embrace focuses on is mental health. Mental health is vital to the health and wellbeing of everyone, particularly among women of childbearing age in these communities. Providing education on mental health and self-care is essential for women in this study. Mental health continues to be stigmatized, and self-care is often seen through a narrow lens. This study focuses on mental health and self-care grounded in cultural practices and beliefs, reimagining and changing the narrative around what self-care should be, and expanding self-care to include everyone.

In FY21, Embrace had two cohorts of women participating in the study. Embrace began in April 2021, and is expected to end June-July 2022. The Embrace project was funded by the Community Program to Improve Minority Health (CFDA No 93.137) from the Office of Minority Health, Office of the Assistant Secretary for Health, Department of Health and Human Services, 2020 – 2022.

Women/Maternal Health - Application Year

Priority Need: Women's Access to Care

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

Annual Plan FY23:

During FY23, the Maternal and Infant Health Program (MIHP) and the Well Woman Coalition will finish their work on a strategic plan that defines routine preventive care and describes the most common barriers to receiving that care. The coalition will also create a distribution plan for the recommended changes at the state, local, and systems levels to improve care and encourage all women to view preventive care as self-care, as detailed in the strategic plan.

MIHP will continue to use social media platforms, Facebook, and Instagram, in their health education outreach to Utah women of reproductive age (18-44 years). Additionally, the MIHP health educator, Ms. Nickee Andjelic will continue participating in local health fairs to share information on the well-woman visit.

Because many COVID-19 restrictions have been lifted, we anticipate participating in more community health fairs and events this year than we did last year. A new approach that we are excited to start is to create an online educational Maternal and Child Health module for community health workers (CHW).

In 2022, Utah Governor Spencer Cox signed a bill that creates a state certification for community health workers. This certification will be given to CHWs who completed a core-skill training consisting of 90 hours of competency-based education and 300 hours of community involvement defined by a rule written by the Utah Department of Health and Human Services. This rule, which is currently being written, will include continuing education requirements. The certified CHW can choose from several supplemental online educational modules, one of which will be the Maternal and Child Health module. This module will educate community health workers on preconception and well-woman care recommendations and the skills necessary to advocate for the populations they serve. We will be using the Women's Preventive Services Initiative (WPSI) Well-Woman Chart as the foundation for building the module. The Well-Woman Chart outlines preventive services recommended by the WPSI, U.S. Preventive Services Task Force (USPSTF), and Bright Futures based on age, health status, and risk factors. The full chart can be found here, https://www.womenspreventivehealth.org/wp-content/uploads/FINAL_WPSI_WWC_11x17_2022Update.pdf.

By reaching and mobilizing women of childbearing age within their communities, CHW can improve access to care and increase utilization of preventive care services like cervical cancer screenings and mammography. By focusing on well-woman care, trained CHWs have the potential to protect and optimize women's health over the course of her lifetime and reach our underserved communities. We are hopeful that innovative approaches, like our plan to create a Maternal and Child Health educational module for community health workers, will address the social determinants of health and health inequities that negatively impact access to healthcare and, ultimately, increase the percentage of women that receive a well-woman visit.

Proposed Activities:

- Use social media platforms and participation at health events to educate women on the well-woman visit.
- Develop an online Maternal and Child Health education module for community health workers (CHWs). This module will educate CHWs on preconception and well-woman care recommendations and the skills necessary to advocate for the populations they serve.

State Priority Area: Perinatal Mood and Anxiety Disorder

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

Annual Plan FY23:

The Maternal and Infant Health Program (MIHP) maternal mental health (MMH) specialist will continue to provide trainings and presentations to raise awareness of perinatal mental health conditions and services available to those needing them. The finalized maternal mental health toolkit and training videos will be rolled out to providers via the Utah Women and Newborns Quality Collaborative maternal mental health subcommittee. The toolkit will be piloted in several settings including an OB clinic, pediatric clinic, local health department, and possibly a Federally Qualified Health Center. Once pilot testing is complete, a broader dissemination plan will be implemented.

The MIHP will continue to use social media platforms to encourage women to seek screening and care from providers. Social media is where we connect with the general public as well as providers across the state and nationally.

The MMH specialist will continue to promote the Maternal Mental Health Referral Network to providers and encourage them to list their services on the site to increase the number and type of providers. https://maternalmentalhealth.utah.gov/

Proposed Activities:

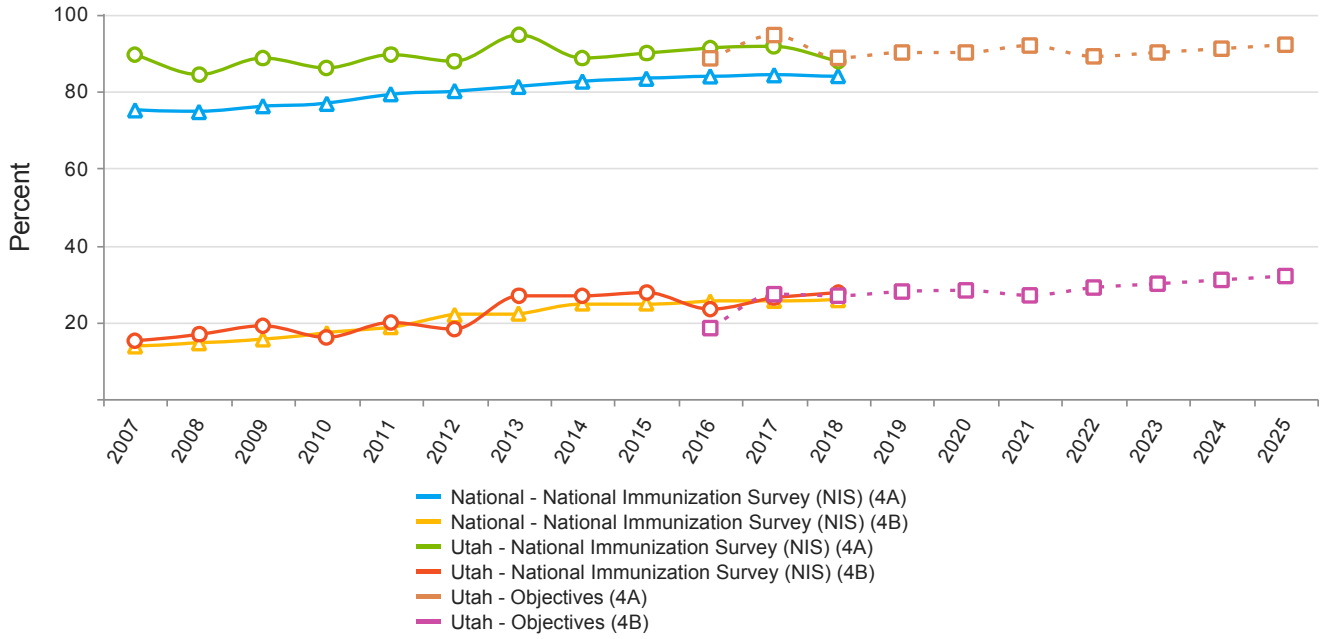
- Pilot the maternal mental health screening and referral toolkit in four different clinical settings. Based on feedback, modify as needed and begin disseminating statewide.
- Provide perinatal mental health awareness training in clinical and educational settings.
- Continue to use social media platforms to encourage women to seek screening and care from providers.
- Increase number and type of providers listed on the Maternal Mental Health Referral Network.

Perinatal/Infant Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	94.5	88.6	90	90	91.8
Annual Indicator	88.4	89.7	91.2	91.8	87.8
Numerator	43,382	43,073	45,052	39,458	38,339
Denominator	49,063	48,030	49,404	42,968	43,665
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	89.0	90.0	91.0	92.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	27.3	26.9	28	28.3	27
Annual Indicator	26.8	27.8	23.5	26.3	27.8
Numerator	12,259	12,643	11,415	10,658	11,442
Denominator	45,790	45,490	48,506	40,597	41,090
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	29.0	30.0	31.0	32.0

Evidence-Based or –Informed Strategy Measures

ESM 4.4 - 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	2020	2021
Annual Objective			27
Annual Indicator	13.2	24.4	67
Numerator	6,225	11,435	30,555
Denominator	47,211	46,832	45,577
Data Source	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	69.0	70.0	71.0	72.0

ESM 4.5 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			14
Annual Indicator	13.9	6.6	52.7
Numerator	983	449	3,182
Denominator	7,093	6,831	6,041
Data Source	WIC Program Data	WIC Program Data	WIC Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

ESM 4.5 - The number of worksites that have federal lactation accommodations and breastfeeding strategies.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	40.0	40.0	40.0

ESM 4.6 - 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:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			7
Annual Indicator	0	7	0
Numerator			
Denominator			
Data Source	EPICC Program Data	EPICC Program Data	EPICC Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

ESM 4.7 - The percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer Counselor.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	47.0	48.0	49.0

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 93.0%. 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 34.0%.	
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).	
Support Local Health Departments in efforts to help worksites meet the requirements of the federal lactation accommodations law. Measured by the number of worksites that meet the requirements.	
ESMs	**Status**
ESM 4.4 - 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 4.5 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.	Inactive
ESM 4.5 - The number of worksites that have federal lactation accommodations and breastfeeding strategies.	Active
ESM 4.6 - 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	Inactive
ESM 4.7 - The percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer Counselor.	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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NPM-4.1: Percent of infants who are ever breastfed

This Performance Measure was NOT achieved. The Performance Objective was 91.8% and the Annual Indicator was 87.8%.

NPM-4.2: Percent of infants breastfed exclusively through 6 months

This Performance Measure was achieved. The Performance Objective was 27.0% and the Annual Indicator was 27.8%.

Annual Report FY21:

Program Activities:

The policies, procedures, and practices a new birthing parent encounters in the first hours and days after childbirth can help or hinder their future breastfeeding success. Implementing evidence-based strategies, like those described by the World Health Organization's "Ten Steps to Successful Breastfeeding," can significantly improve a person's confidence in their ability to initiate and continue exclusive breastfeeding for the recommended 6 months of life.

The Stepping Up for Utah Babies program is a free, Utah-centric program that works with birthing facilities to become designated and recognized as a "Breastfeeding Friendly Facility." The Stepping Up program utilizes quality improvement methods to assist participating birthing facilities in implementing "The Ten Steps to Successful Breastfeeding" through an incremental approach – implementing two steps at a time, with the goal of implementing all 10 steps. Programs that use the "Ten Steps to Successful Breastfeeding," like the Stepping Up for Utah Babies program, have been associated with a decrease in racial disparities in the initiation, continuation, and duration of breastfeeding (Merewood et al., 2019). Birthing facilities that participate in the Stepping Up program are encouraged to create patient education and counseling that is culturally responsive and relevant.

During FY21, the Stepping Up for Utah Babies program staff continued to offer technical assistance to participating birthing facilities. Assistance included but was not limited to additional training for staff on requirements for step certification, sharing up-to-date research and resources, and providing feedback and answering implementation questions as they arise.

The Stepping Up program coordinator was invited to join a national collaborative of state-sponsored breastfeeding programs. This collaboration will allow the coordinator to network and learn from other state breastfeeding programs.

Stepping Up staff also continued their efforts to recruit additional birthing facilities to participate in the program. Contact with the Office of Primary Care and Rural Health at the Utah Department of Health assisted with the identification and outreach to hospitals in the rural areas of Utah. A continued relationship with this group will provide Stepping Up staff with guidance on collaborating with and resources that will enable us to build long-term partnerships with birthing facilities in these high-need areas.

The number of worksites in the state that do not provide lactation accommodations is not known. Local health departments are meeting with worksites and determining if they could use assistance, providing accommodations and offering assistance for worksites that are interested. Local health departments are likely to be more familiar with worksites in their districts and may have better opportunities to build relationships with worksites than the state does. Contracting with local health departments is an efficient and effective way to reach worksites and encourage them to ensure they have appropriate lactation accommodations.

All worksites, regardless of size, should provide lactation accommodations. The Healthy Environments Active Living Program (HEAL) (formally the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) asks

local health departments to work with all worksites, but especially those in small areas with high Health Improvement Index scores (i.e., small areas with large percentages of the population underserved).

The Utah Women Infants and Children (WIC) Program developed a statewide goal in FY21 to ensure that every eligible pregnant and breastfeeding WIC participant received at least one contact from a Utah WIC breastfeeding peer counselor. In FY21, the Utah WIC program encouraged breastfeeding peer counselor contacts for prenatal and postpartum WIC participants in many ways. These included referring prenatal and postpartum WIC participants to the WIC breastfeeding peer counseling program through the Nutrition Interview, Referrals, and Participant Care Plan screens in the Utah WIC VISION computer system; and through referrals by community and partner organizations, such as local hospitals and health care provider offices, community breastfeeding support groups such as La Leche League, and professional organizations such as MotherToBaby Utah, among others.

Additional goals included providing training and educational opportunities to breastfeeding peer counselors and continuing to collaborate with the Utah Department of Health and other community organizations to increase breastfeeding peer counseling referrals and contacts. Furthermore, each local agency offered at least one training on breastfeeding, and many local agencies asked their breastfeeding peer counselors to participate in the trainings through sharing new breastfeeding research with other staff members.

In FY21, 41% of all eligible pregnant and breastfeeding women received at least one breastfeeding contact by a WIC breastfeeding peer counselor, which was a significant increase from the target of 13%. One reason for this increase is that FY21 was the first full year that the new ESM was measured, affecting the number of participants and peer counseling contacts documented over this time period. The Utah WIC Program's prevalence for breastfeeding initiation increased by one percentage point to 87% between FY20 and FY21. Compared to data from the State of Utah, the Utah WIC program's breastfeeding rates are similar to the state's at 87%. However, the data also shows that the Utah WIC Program had a smaller decrease in breastfeeding initiation between FY20 and FY21 compared to the State of Utah.

The Utah WIC Program's prevalence for exclusive breastfeeding at six months was maintained at 18% between FY20 and FY21. Data about the State of Utah's exclusive breastfeeding for six months prevalence shows that WIC's rates of exclusive breastfeeding for six months are significantly less than the state's. Data from the State of Utah shows that women who are eligible for WIC but do not participate have higher rates for breastfeeding initiation and exclusive breastfeeding through six months compared to women who are participating on WIC. This may be related to social perceptions of WIC as "an infant formula program" as opposed to a breastfeeding promotion and support program.

Additionally, women who are not participating in WIC but are eligible for participation may be utilizing other community programs or organizations instead. Both statistics about breastfeeding prevalence differences (between women who participate in WIC and women who are eligible but do not participate) showcase the need for improved education on WIC as a breastfeeding support program, and for outreach to other community breastfeeding organizations that can refer women to WIC and its breastfeeding peer counseling program. Both of these solutions would help to meet the ESM goal of improving the number of contacts that pregnant and breastfeeding WIC participants receive from a WIC breastfeeding peer counselor, which could improve breastfeeding rates and decrease breastfeeding disparities throughout the state of Utah. Please note that in FY21, the VISION computer system received an update that created errors in collecting breastfeeding data, potentially affecting the accuracy of FY21 breastfeeding prevalence statistics. (Merewood, A., Bugg, K., Burnham, L., Krane, K., Nickel, N., Broom, S., Edwards, R., & Feldman-Winter, L. (2019). Addressing racial inequities in breastfeeding in the southern United States. Pediatrics, 143(2).) https://doi.org/10.1542/peds.2018-1897

Accomplishments / Successes:

From the inception of the Stepping Up for Utah Babies in 2015 to the end of FY21, 23 (51%) of Utah birthing facilities have been trained on the program and have successfully implemented a total of 156 steps. Specifically, during FY21, eight (8) birthing facilities completed all ten (10) steps, and 1 met the requirements to be re-designated as a “Breastfeeding Friendly Facility.” Re-designation occurs two years after the birthing facility successfully implements all ten (10) steps and requires 6-months of current data submission. These eight Breastfeeding Friendly Facilities and the one Baby-Friendly facility accounted for 41% of births in Utah. This is significant because research has shown that families exposed to The Ten Steps to Successful Breastfeeding used by the Stepping Up for Utah Babies program have improved breastfeeding rates. Much of this success is due to the ongoing partnership and support from the Intermountain Healthcare System. They continue to encourage their member birthing facilities to continue working on the steps and be certified as a Breastfeeding Friendly Facility.

The HEAL program focuses its lactation efforts on two National Performance Measures, NPM 4.1 and NPM 4.2. HEAL program staff believe this work will move the needle on performance measures specific to Utah.

National Performance Measure 4.1: The goal for NPM 4.1 is to increase the percent of infants born in Utah who are ever breastfed from 89.7% (National Immunization Survey, 2015) to 92.0% in 2025. The latest data available on this performance measure is from 2018, where the rate was 87.8% (81.0%-92.4%). This is a substantial decline from the 2017 rate of 91.8% (87.0%-95.0%). This rate, however, is higher than the 2018 rate for the U.S. 83.9% (82.9%-84.8%).

National Performance Measure 4.2: The goal for NPM 4.2 is to increase the percent of infants born in Utah who are exclusively breastfed through 6 months of age from 27.8% (National Immunization Survey, 2015) to 32.0% in 2025. The percentage for this performance measure in 2018 was 27.8% (21.4%-35.3%), the same percentage as in the base year (27.8%; 21.7% -34.8%). But the 2018 estimate is an increase from 2017, 26.3% (20.6%-32.8%).

In comparison, the U.S. rate for 2018 (NPM-4.2) was 25.8% (24.8%-26.8%). There should be improvement as well in two similar national Healthy People outcome measures in the Maternal, Infant, and Child Health (MICH) topic area (MICH-15 and MICH-16) that aim to increase exclusive breastfeeding for at least six months and increase duration to at least one year.

Too often, women discontinue breastfeeding when they have to return to work. Appropriate lactation accommodations in the worksite can make it possible for them to breastfeed or pump during the workday. HEAL is working to increase the number of worksites that provide time, space and policies for women to breastfeed or pump at work, which should lead to an increase in the percentage of women who breastfeed exclusively for at least six months and increase their duration of breastfeeding.

There were many successes and accomplishments by the Utah WIC breastfeeding peer counseling program in FY21. One significant success was the ability of WIC clinics to begin providing in-person breastfeeding services as COVID-19 restrictions eased. This improved breastfeeding peer counselors’ abilities to contact eligible WIC participants, including in-person contacts, telephone and texting contacts, hospital contacts, and participant home contacts. Additionally, several local agencies were successful in making at least three breastfeeding peer counseling contacts per participant, exceeding the current ESM goal of at least one contact per participant. Local agencies also focused on improving breastfeeding peer counseling outreach to WIC participants in order to ensure that all eligible women were receiving breastfeeding peer counseling services. Outreach included creating and strengthening community partnerships such as local hospitals and health care providers, community events, Early Intervention, La Leche League, the Mountain West Mother’s Milk Bank and other community breastfeeding support groups, and home visiting programs, among others. Improving collaboration and partnerships with community programs and organizations may help improve the number of women referred to the WIC breastfeeding peer counseling program and the number of women who are contacted by a WIC breastfeeding peer counselor.

One especially successful outreach experience was created by the Davis County WIC agency, who worked with the Davis County Breastfeeding Coalition to provide a virtual breastfeeding conference that had an average of 1,037 conference session views. However, the most significant successes reported by local agencies are testimonials from WIC participants about how participating in the WIC breastfeeding peer counseling program helped them to initiate breastfeeding and to meet their breastfeeding duration goals.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-4.1 and NPM-4.2:

- Partnerships between community organizations and WIC breastfeeding peer counseling programs were strengthened, which improved the referrals of WIC participants to the WIC breastfeeding peer counseling program.
- These efforts made it possible for more women who recently gave birth to have appropriate lactation accommodations when they return to work.
- Eight birthing facilities successfully implemented all Ten Steps to Successful Breastfeeding to become certified as a Breastfeeding Friendly Facility.
- One birthing facility met the requirements to become re-designated as a Breastfeeding Friendly Facility.
- The Healthy Environments Active Living (HEAL) Program has also helped worksites, especially those that had a large proportion of employees who were low-paid women, improve their lactation accommodations, affording women a comfortable environment for breastfeeding or pumping.

Challenges / Gaps / Disparities Report:

An ongoing challenge to hospitals that have begun work on the Stepping Up for Utah Babies program is the additional duties administrators, nurses, and educators must take on to accomplish the requirements set by the program. Furthermore, outreach to smaller birthing facilities outside the two major health systems (Intermountain Healthcare and the University of Utah) has proven challenging. Communication attempts by Stepping Up for Utah Babies staff have not been successful.

During FY21, the COVID-19 pandemic continued to disrupt program activities. Birthing facilities were forced to react to the rapidly changing health directives and policies enacted by federal, state, local, and birthing facility officials. Quality improvement projects surrounding the implementation of the Stepping Up for Utah Babies program were halted for birthing facility staff to focus on protecting their patients from this novel virus. Additionally, all training and in-person meetings were canceled due to social distancing requirements, group gatherings and travel restrictions, safeguarding birthing facility staff, and Stepping Up staff's overall safety. As stated earlier, closures due to COVID-19 hampered this work. The prevention of COVID-19 in workplaces that remained open generally required employers' full attention. Worksites did not have the resources to address lactation accommodations during this time.

Despite the increased number of eligible participants who received at least one WIC breastfeeding peer counseling contact, barriers to meeting this goal were still experienced in FY21. Contributing factors to barriers include that FY21 occurred during the COVID-19 pandemic, which interrupted the operations of WIC clinics due to the policy changes required to ensure staff members' and participants' safety. Some interruptions included not seeing participants in person and being unable to host breastfeeding classes or support groups. Additionally, many peer counseling staff members were asked to help with local agency COVID-19 tasks, such as contact tracing, which may have affected their time available for contacting prenatal and postpartum WIC participants.

Furthermore, the number of employed peer counselors decreased from 32 in FY20 to 29 in FY21. Local agencies stated that several peer counselors left their jobs with WIC during FY21 to find jobs with better pay and benefits. The decrease in employed peer counselors exacerbated the difficulty of peer counselors' ability to make breastfeeding contacts to participants, especially in rural areas that contain multiple WIC clinics over a large geographic area

where breastfeeding peer counselors may not be able to see participants in person at every clinic or make hospital and home visits.

Additionally, some agencies were under a hiring freeze while strict COVID-19 precautions were in place while other agencies' breastfeeding peer counseling budgets were reduced, making it difficult to fill open breastfeeding peer counselor positions.

There were difficulties in obtaining accurate data about WIC breastfeeding peer counseling contacts. The Utah WIC computer system, VISION, pulls data from participant records to provide information about the number of breastfeeding peer counseling contacts made for each local agency and clinic. However, when obtaining the data for FY21, some agencies were missing breastfeeding peer counseling contact data or breastfeeding peer counseling contacts were duplicated.

Finally, there was a misunderstanding among clinics about where breastfeeding peer counseling contacts should be documented within VISION, further adding to the potentially inaccurate data pulled from the VISION computer system. To prevent future data inaccuracies, the Utah WIC program is providing clarification within the Utah WIC policy and procedures manual about where breastfeeding peer counseling contacts need to be documented in the VISION computer system and is creating a new report to pull breastfeeding peer counseling contact data accurately.

Emerging Issues:

Breastfeeding peer counselor recruitment and retention remains an ongoing concern within the Utah WIC breastfeeding peer counseling program. During the COVID-19 pandemic there were also mixed messages about the safety of breastfeeding, which may have influenced WIC participants to choose not to breastfeed during FY21.

Agency Capacity/Family Partnerships/Collaboration:

The success of the Stepping Up for Utah Babies program would not be possible without our many partners. Our most important partners are the staff and administration that work to implement the Ten Steps to Successful Breastfeeding in their facilities. Their commitment and dedication to the program positively impact our breastfeeding initiation and continuation rates.

Second, partnerships with WIC and HEAL programs provide Stepping Up staff with expert advice and additional tools that can be shared with participating birthing facilities to assist in implementing the steps. HEAL continues to contract and partner with local health departments and encourages them to reach out to worksites to ensure they have appropriate lactation accommodations. HEAL shares resources to all worksites through its website (See https://heal.health.utah.gov/worksite-wellness).

We also share an ongoing and beneficial partnership with the two most prominent healthcare systems in the state, Intermountain Healthcare and the University of Utah. Intermountain Healthcare strongly encourages all member hospitals to participate in the Stepping Up for Utah Babies program, tracks their progress, and recognizes their achievements and certifications. The University of Utah is our only Baby-Friendly Facility in the state; however, they are supportive of the Stepping Up for Utah Babies program and have also received a designation of being a "Breastfeeding Friendly Facility."

The Utah WIC Program partners with several organizations including state-wide Utah Department of Health organizations, such as Early Intervention; local health department organizations, such as home visiting programs and Nurse Family Partnership programs; county-wide events, such as county fairs and Baby Animal Days; local organizations, such as La Leche League and the Mountain West Mother's Milk Bank; local hospitals; and local health care provider offices, including pediatricians, obstetricians, and IBCLCs.

Improving outreach and partnership between the WIC breastfeeding peer counseling program and other

organizations continues to be a high priority. Local agencies have continued to network and collaborate with partners such as by providing referral cards to the WIC breastfeeding peer counseling program, attending other organizations' events, utilizing social media, and working with organizations and coalitions to provide education and training about breastfeeding. Local agencies have also improved relationships with local hospitals, which has created more opportunities for WIC breastfeeding peer counselors to provide hospital visits to mothers and has improved referrals to the WIC breastfeeding peer counseling program from hospital staff members.

Report of ESMs related to NPM-4.1 and NPM-4.2

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."

Goal/Objective:

Increase the percentage of babies born in hospitals participating in the Stepping Up for Utah Babies program.

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 the 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 4.1 Progress Report:

The policies, procedures, and practices a new birthing parent encounters in the first hours and days after childbirth can help or hinder their future breastfeeding success. Implementing evidence-based strategies, like those described by the World Health Organization's "Ten Steps to Successful Breastfeeding," can significantly improve people's confidence in reaching their breastfeeding goals.

The Stepping Up for Utah Babies program is a free, Utah-centric program that works with birthing facilities to implement the "Ten Steps to Successful Breastfeeding" through quality improvement methods, i.e., work to implement two steps at a time. When the birthing facility meets the certification requirement of all ten (10) steps, they are designated and recognized as a "Breastfeeding Friendly Facility."

From the program's inception in 2015 to the end of FY21, 23 (51%) Utah birthing facilities have been trained on the program and have successfully implemented a total of 156 steps. Specifically, during FY21, eight (8) birthing facilities completed all ten (10) steps, and 1 met the requirements to be re-designated as a "Breastfeeding Friendly Facility." Re-designation occurs two years after the birthing facility successfully implemented all ten (10) steps and requires 6-months of current data submission. Stepping Up for Utah Babies program staff will continue outreach to birthing facilities about the Stepping Up for Utah Babies program and how they can become a designated and recognized "Breastfeeding Friendly Facility." Stepping Up staff remains committed to providing technical assistance, recognition, and additional training opportunities to participating birthing facilities. Stepping Up staff is working on short, on-demand training videos that will be available on the Stepping Up for Utah Babies website. Due to staff capacity, these training videos are still being developed.

A challenge of this program has been the training of smaller, rural birthing facilities. The staff has tried traditional contact methods, including calling and emailing birthing facility staff, which has been unsuccessful due to contacting the incorrect person or the emails/calls not being returned. Stepping Up staff has collaborated with Rural Health Programs to identify the correct contact in the rural hospitals. Outreach is ongoing, and we are hopeful that it will lead

to more rural birthing facilities participating in the Stepping Up for Utah Babies program.

The success of the Stepping Up for Utah Babies program would not be possible without our many partners. Our most important partners are the staff and administration that work to implement the Ten Steps to Successful Breastfeeding in their facilities. Their commitment and dedication to the program positively impact our breastfeeding initiation and continuation rates.

ESM 4.2 - 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 4.2 Progress Report:

The Utah WIC Program refers eligible pregnant and breastfeeding participants to the WIC breastfeeding peer counseling program using multiple methods. These methods include using the Nutrition Interview, Referrals, and Participant Care Plan screens in the Utah WIC Program computer system entitled VISION and through referrals from partner organizations, such as MotherToBaby Utah, local hospitals and health care provider offices, and community breastfeeding organizations, among others.

In FY21, 41% of all eligible pregnant and breastfeeding women received at least one breastfeeding contact by a WIC breastfeeding peer counselor, which was a significant increase from the target of 13%. One reason for this increase is that FY21 was the first full year that the new ESM was measured, affecting the number of participants and peer counseling contacts documented over this time period. Utah WIC's ever breastfed prevalence rate decreased by one percentage point to 87% between FY20 and FY21. This decrease may have been influenced by the fewer employed peer counselors in FY21 [the number of employed WIC breastfeeding peer counselors decreased from 32 to 29 between FY20 and FY21] and by COVID-19 protocols within local agencies that limited the availability of breastfeeding peer counselors to contact WIC participants.

Exclusive breastfeeding at six months was maintained at 18% between FY20 and FY21. Please note that in FY21, the VISION computer system received an update that created errors in collecting breastfeeding data, potentially affecting the accuracy of FY21 breastfeeding prevalence statistics.

While the statewide goal contributing to the current ESM is still relevant to the NPM measure of improving breastfeeding initiation and duration prevalence, it would be beneficial to update the ESM to increase the number of contacts that eligible WIC participants receive throughout the perinatal period. Therefore, this ESM will be deactivated and replaced with ESM 4.4 which aims to increase the number of contacts from one to three.

The Utah WIC Program proposes changing the ESM to the following: The percentage of eligible WIC participants who received at least three contacts from a WIC breastfeeding peer counselor during their pregnancy and while

breastfeeding. To measure the proposed ESM of all eligible WIC participants receiving at least three breastfeeding peer counseling contacts throughout the perinatal period, the number of WIC breastfeeding peer counseling contacts per participant will be documented in VISION and measured. A new data collection report is being created to best gather this data. To achieve the updated ESM goal, the Utah WIC program will continue encouraging referrals to the WIC breastfeeding peer counseling program by WIC staff members and will encourage collaboration and partnership with community organizations that can refer to WIC breastfeeding peer counselors.

Additional plans include increasing efforts to recruit and retain WIC breastfeeding peer counselors, increasing the availability of breastfeeding peer counselors through providing home and hospital visits when possible, and implementing a new curriculum to improve breastfeeding training to WIC staff members, including breastfeeding peer counselors.

ESM 4.3 - Increase the number of worksites that have federal lactation accommodations and breastfeeding strategies.

Goal/Objective:

Support local health departments in efforts to help worksites meet the requirements of the federal lactation accommodations law. Measured by # of worksites that meet the requirements.

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. Returning to work is a major reason for women to discontinue breastfeeding. Women who are employed in worksites with adequate lactation accommodations have a good chance of increasing their duration of breastfeeding.

ESM 4.3 Progress Report:

A number of local health departments reported progress reaching out to businesses. However, follow-up work was delayed as health department staff were called to work on the COVID-19 response. The work was further delayed when worksites needed to direct their resources towards COVID-19 prevention. Unfortunately, in 2020, no worksites that local health department staff reached out to or that participated in the Worksite Wellness Council Recognition Survey were able to be counted.

Two podcasts were produced by HEAL during this time, one on the CDC Breastfeeding Report Card and the other on National Breastfeeding Month. Both were published in August 2020.

In October 2021, the HEAL Program received a second opportunity to apply for ASTHO funding to help worksites improve their lactation accommodations; therefore, the performance objective for 2022 is higher than for other years. The project period runs from December 1, 2021 – July 31, 2022, and lays the groundwork for future plans for ESM 4.3 in Year 5. HEAL will continue to work with local health departments as they reach out to worksites to help them implement/improve lactation accommodations and breastfeeding policies.

Not surprisingly, worksites closed or went out of business during this project period due to COVID-19 restrictions. Worksites that remained open did not have the resources or interest in improving lactation accommodations. Their priority was on limiting employees' exposure to COVID-19 and adjusting for employees who were unable to come to work because of illness or because of isolation or quarantine requirements. This situation created a loss of momentum for worksite lactation accommodations.

This work on lactation accommodations has strengthened partnerships with local health departments but relationships can be improved. HEAL is exploring ways to streamline communication and data sharing with the

health departments.

ESM 4.4 - The percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer Counselor.

Goal/Objective:

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

Significance of ESM 4.4:

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 4.4 Progress Report: Because this is the first year for this ESM, baseline data will be collected in FY2023 and we will report on this in next year's report and application.

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).

MotherToBaby Utah provided information about exposures in pregnancy to help reduce untreated conditions, prevent exposures that increase risks for birth defects, and prevent other adverse pregnancy outcomes including preterm birth and low birth weight.

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

MotherToBaby Utah provided information about exposures in pregnancy and breastfeeding to help prevent exposures that increase risks for birth defects, developmental delays, and fetal 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. Utah continued SOARS data collection in FY21 and was awarded a 3 year grant from the CDC for the project.

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

MotherToBaby Utah provided information about exposures in pregnancy and breastfeeding to help prevent exposures that increase risks for birth defects, developmental delays, and fetal 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. In calendar year 2021, there were 99 prevention recommendations generated from the committee.

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

MotherToBaby Utah provided information about alcohol exposure in pregnancy and breastfeeding to help prevent FASD which may include birth defects and developmental delays. MotherToBaby Utah distributed 1,300 materials during the fiscal year to healthcare providers with information about alcohol use in pregnancy and hosted meetings with partner organizations to plan activities to prevent alcohol use in pregnancy.

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

MotherToBaby Utah provided information about exposures, including mood medications, in pregnancy and breastfeeding to help reduce untreated mood conditions, prevent exposures that increase risks for birth defects and developmental delays, prevent other adverse pregnancy outcomes, and increase breastfeeding rates.

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’s Web Portal provides child specific data in real time from a variety of programs, and presents a consolidated record of newborn hearing, heel-stick (out of range screens are included) and critical congenital heart defect (CCHD) screening results. Authorized private and public health care providers continued to use the CHARM Web Portal (CWP) to look up and view a child's health information/screening results to coordinate care, treatment, and follow-up in a timely manner. Providers also had access to the Medical Home Portal through a link in the CWP to find diagnostic and treatment information for newborn disorders.

The CHARM Program continued to collaborate with the Early Hearing Detection and Intervention (EHDI) and Vital Records (VR) Programs. Through CHARM's data integration with EHDI and 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 in the VR OLIVER system, he/she prints out a letter informing the parents or guardians that their child needs a hearing screening follow-up, and instructs them to contact the EHDI Program. The CHARM Program also prepares a report of these children for the EHDI Program so staff can follow-up with the parent/guardian about obtaining a hearing test. From July 1, 2020 – June 30, 2021, there were 833 hearing alerts generated for children by CHARM and received in the OLIVER system; 424 (51%) of those children went on to complete a hearing screening test after receiving the alert. This linkage has improved follow-up efforts and care coordination for children that are deaf or hard of hearing.

Perinatal/Infant Health - Application Year

Priority Need: Breastfeeding/poor infant nutrition

NPM-4a: Percent of infants who are ever breastfed

NPM-4b: Percent of infants breastfed exclusively through 6 months

Annual Plan FY23:

During FY23, Stepping Up for Utah Babies staff will continue offering technical assistance to participating birthing facilities as they pursue their Breastfeeding Friendly Facility designation, as required by CDC funding. Stepping Up staff will continue outreach to non-participating birthing facilities during this program year. On-going assistance from our partners in WIC, Healthy Environments Active Living (HEAL), and the Office of Primary Care and Rural Health will assist us in reaching birthing facilities, healthcare providers, and community members on the Stepping Up for Utah Babies program and the benefits of breastfeeding.

Stepping Up for Utah Babies staff will also continue to work on culturally relevant training materials that include on-demand pre-recorded videos, and patient education materials that any hospital, community partner, or family can use to improve their knowledge, skills, and attitudes regarding breastfeeding. These materials will be able to be viewed or downloaded from our website.

CDC funding for the HEAL also requires work on lactation strategies that were established at the beginning of the project period. HEAL contracted with local health departments and asked them to reach out to worksites to determine their level of compliance with federal lactation accommodations law and evidence of breastfeeding policies. Local health departments were asked to reach out to worksites in their districts and encouraged to concentrate on worksites located in underserved small areas.

Reaching targeted worksites became especially problematic as COVID-19 closures occurred. Local health departments report their progress and barriers each quarter to HEAL. If there are areas where HEAL staff can help, HEAL provides assistance and helps LHDs overcome barriers in ways that promote continuous quality improvement.

In FY23, the Utah WIC Program will continue maintaining a statewide goal to provide at least three breastfeeding peer counseling contacts to eligible WIC participants throughout the perinatal period. Local WIC programs will continue documenting breastfeeding peer counseling contacts and referrals in the Utah WIC VISION computer system and provide at least one staff training about breastfeeding to all staff members.

Additionally, a new staff training curriculum about breastfeeding will be implemented to all WIC programs for all staff members, including breastfeeding peer counselors. To address disparities found in the NPM data about WIC participants having lower breastfeeding prevalence rates than women who are eligible but not participating on WIC, local agencies will continue to provide outreach and education about WIC's role as a breastfeeding promotion and support program, and improve collaborations with organizations that can refer women to WIC for breastfeeding assistance.

Finally, in FY23, clinics will continue to open and strengthen in-person services provided by breastfeeding peer counselors, such as in-person visits and classes. Doing so will help breastfeeding peer counselors to improve the quantity and quality of breastfeeding peer counseling contacts provided to eligible WIC participants.

Proposed Activities:

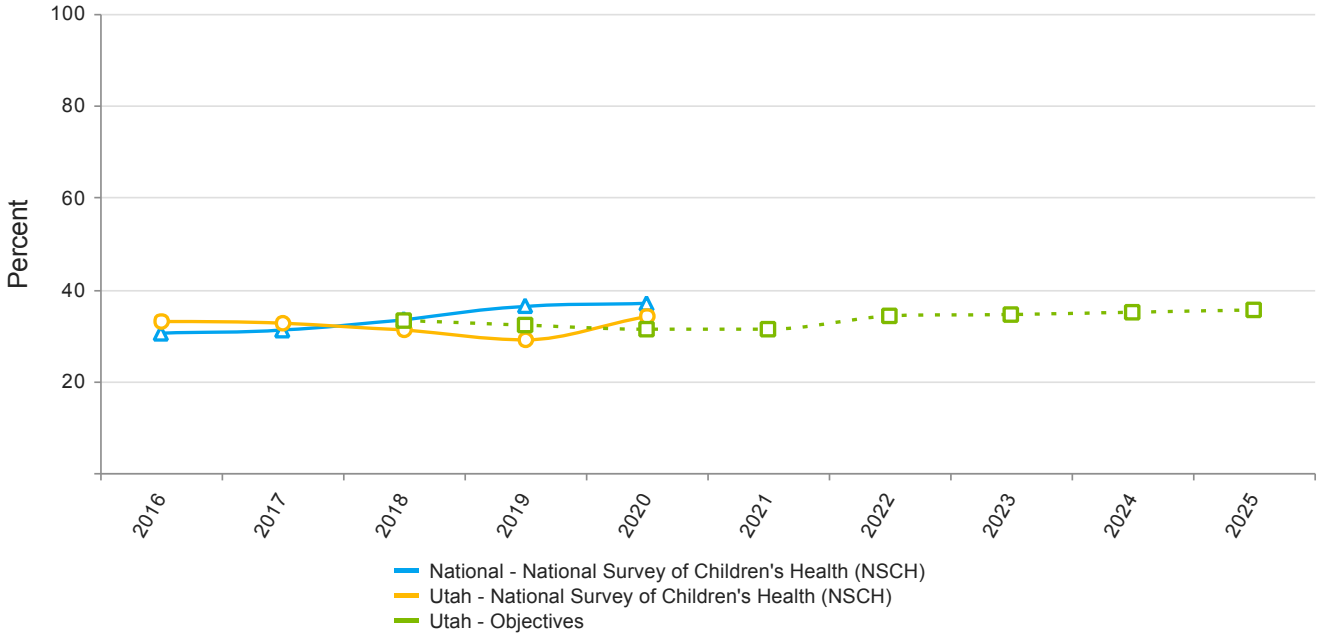
- Maintaining a statewide goal to provide at least three breastfeeding peer counseling contacts to eligible WIC participants throughout the perinatal period.
- Improving outreach and collaboration with other organizations that will refer pregnant and breastfeeding women to WIC and the WIC breastfeeding peer counseling program.
- Continue oversight of the Stepping Up for Utah Babies program by actively recruiting birthing facilities to participate, offering technical assistance to currently participating birthing facilities, and recognizing birthing facilities as they become or are re-designated as a "Breastfeeding Friendly Facility."

These efforts will help women who have recently delivered continue breastfeeding when they return to work.

Child Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		33.2	32.2	31.3	31.3
Annual Indicator	33.1	32.6	31.1	29.1	34.2
Numerator	38,611	32,987	29,418	31,492	39,294
Denominator	116,514	101,171	94,514	108,310	114,782
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	34.2	34.5	35.0	35.5

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	2020	2021
Annual Objective			12
Annual Indicator	0	23	34
Numerator			
Denominator			
Data Source	Early Childhood Utah program data	Early Childhood Utah program data	Early Childhood Utah program data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

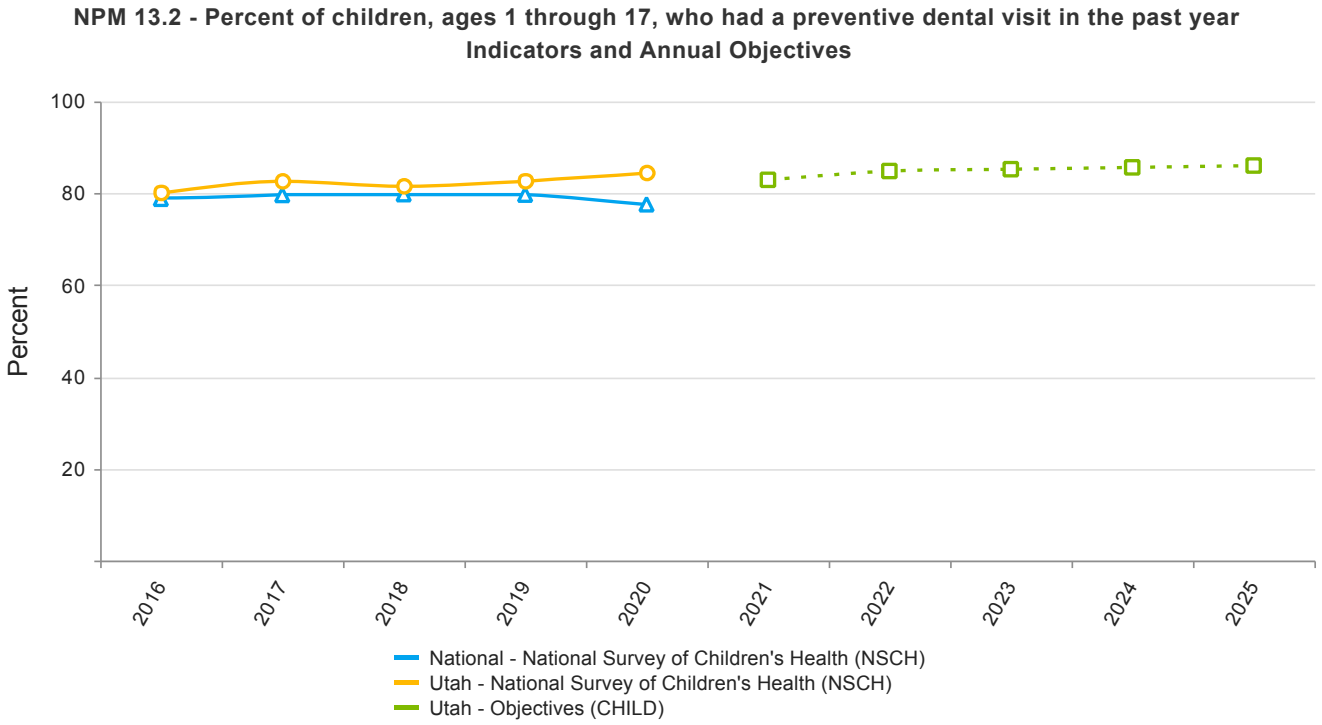
Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0

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	2020	2021
Annual Objective			7,988
Annual Indicator	8,157	7,580	7,877
Numerator			
Denominator			
Data Source	The Brookes Publishing UDOH ASQ Online Enterprise	UDOH Early Childhood Integrated Database	UDOH Early Childhood Integrated Database
Data Source Year	2019	2020	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8,271.0	8,685.0	9,120.0	9,576.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		80.3	84.8	81.6	82.8
Annual Indicator	80.1	82.4	81.4	82.6	84.3
Numerator	684,515	701,280	698,309	726,633	745,902
Denominator	854,160	851,339	857,676	879,310	885,155
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	84.7	85.1	85.5	85.9

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					
	2017	2018	2019	2020	2021
Annual Objective	53.6	51.5	54.4	55.7	52.1
Annual Indicator	51.3	54.2	55.5	51.9	47.1
Numerator	109,115	109,777	105,122	94,832	97,308
Denominator	212,848	202,518	189,242	182,597	206,783
Data Source	CMS 416	CMS 416	CMS-416	CMS-416	CMS-416
Data Source Year	FFY17	FFY18	FFY19	FFY20	FFY20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	48.0	48.2	48.3	48.5

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	2020	2021
Annual Objective			78.8
Annual Indicator	76.7	78.1	81.1
Numerator	692,413	712,908	743,827
Denominator	903,273	912,249	917,210
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	81.0	82.0	83.0	84.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			35
Annual Indicator	32.2	35	41.7
Numerator			281,760
Denominator			675,247
Data Source	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	53.0	56.0	59.0

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 36.5%.	
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 86.8%.

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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Utah) - 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 86.0% (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

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.

Annual Report FY21:

This Performance Measure was achieved. The Performance Objective was 31.3% and the Annual Indicator was 35.5%.

Program Activities:

The 2020 Utah Maternal and Child Health and Children with Special Healthcare Needs, Statewide Needs Assessment identified key needs and top concerns. Among the top concerns identified were Access to Care/Health Insurance and Access to Care/Limited Care. Parents of CSHCN described very long wait times to be determined eligible for services that could help improve their children's ability to reach developmental milestones. Developmental screening opportunities were also described as not comprehensive and/or not readily available, especially in rural areas. Out of the "Top-10" ranked issues for parents of children with special health care needs, access to comprehensive and routine developmental screening opportunities was ranked #7 in the MCH/CSHCN Needs Assessment.

We developed two related strategies to improve outcomes for NPM-6

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 Activities and Effectiveness

Increase ASQ Training

The Early Childhood Utah (ECU) program manager participated in quarterly meetings with the Local Health Departments in order to engage the nursing directors in ASQ training, to share information on the importance of developmental screening and to make developmental health promotion resources available to help them achieve their agency's National Performance Measure #6 (NPM #6) objectives.

The ECU program worked with each LHD on tiered developmental screening goals and objectives.

Tier 1: Increase ASQ Online Training and Promotion

- Promote ASQ Online training and the use of ASQ Online screening with community-based organizations. Attend ECU Advisory Council meetings.

Tier 2: ASQ Trained and Ready to Use ASQ

- Conduct ASQ Online screens with clients through the WIC, Home Visiting, Early Intervention and/or other LHD programs.

Tier 3: Advanced ASQ Utilization

- Establish and implement a schedule to complete screens at 6, 12, 18 and 25 months; along with 3, 4 and 5 years of age.
- Integrate billing Medicaid into the service delivery system, i.e. determine if codes 96110 and 96127 can be utilized by the LHD to bill for developmental screens.

Currently, the 13 LHDs are at various levels within the established tiers; three are at Tier 1, eight are at Tier 2, and two are at Tier 3.

According to the UDOH Early Childhood Integrated Data System (ECIDS) between July 1, 2020 and June 30, 2021 the LHDs collectively facilitated:

- 1,769 ASQ-3 screens to 1,137 distinct-children for children ages five and under.
- 1,226 (69%) of the screens were above Cutoff (no developmental concerns), 321 (18%) of the screens were in the Monitoring Zone (implement developmental practices and retest later), 182 (10%) of the screens were Below Cutoff (implement developmental practices and make appropriate referrals for the developmental areas in need of further assistance).
- 927 (52%) of the ASQ-3 screens listed above, were for 680 distinct-children; ages 9-36 months.
- 642 (69%) of the screens were Above Cutoff, 183 (20%) of the screens were in the Monitoring Zone, 102 (11%) of the screens were Below Cutoff.

525 ASQ Social Emotional screens to 385 distinct-children, ages five and under.

- 431 (82%) of the screens were Above Cutoff, 56 (11%) of the screens were in the Monitoring Zone, 38 (7%) screens were Below Cutoff.
- 316 (60%) of the ASQ Social Emotional screens listed above, were for 231 distinct-children; ages 9-36 months.
- 273 (86%) of the screens were Above Cutoff, 24 (8%) of the screens were in the Monitoring Zone, 19 (6%) were Below Cutoff.

ECU considers the data displayed above to be quite an accomplishment given that during the COVID-19 pandemic of 2020/21, LHDs were tasked with managing immunization clinics, as well as coordinating the regional pandemic response. During this timeframe, some departments/programs had to pull back on facilitating developmental screening opportunities for parents/children while they prioritized addressing the pandemic related needs of their community. For example, one LHD submitted 3,476 screens in 2019; in 2020 they submitted 970 screens and in 2021, only 316 screens. Through April 2022, this LHD had already submitted 780 screens, hopefully an indication of a positive trend. ECU consistently distributes information regarding the importance of screening along with training opportunities offered through the Brookes Publishing company to the LHD directors.

ASQ training for new providers continues to be offered through the ECU program on a quarterly basis or by request. It is important to note, any provider who contacts ECU can participate in this community-based ASQ training opportunity; training information is shared regularly during the LHD quarterly meetings.

The ECU program manager trained 69 providers/caregivers between July 1, 2020 and June 30, 2021. These providers/caregivers represented the UDOH Office of Home Visiting and IDEA Part C Early Intervention grantees, Head Start and childcare providers, LHDs, along with other early childhood service providers.

Additionally, the ECU program manager continued to invite LHD representatives to attend meetings of the Early Childhood Utah Advisory Council. Once an LHD provider has successfully completed ECU's ASQ training course, congratulation emails are distributed and participants are encouraged to enroll in their agency's UDOH ASQ Online Enterprise subaccount. The ECU program supports the enrolled LHDs with technical assistance (TA) and encourages LHDs to reach out for any additional assistance they may need. One example of TA provided, includes a collaboration between ECU and the LHDs to create and share a screening link which can be distributed as a text to parents/caregivers to streamline completing a screen on a parent's/caregiver's cell phone and/or through an email account. The objective of creating and sharing this resource is to help improve access to completing developmental screens for many parents/caregivers.

The ECU program worked closely with the state WIC administrator to inform community-based WIC programs about this ASQ texting capability. The Utah WIC program administers a texting platform that can share messages with WIC enrollees. WIC distributes the ASQ screening link along with other informative messages and resources to the families they are working with.

The Salt Lake County and Southeast LHD directors examined ways to use Medicaid developmental screening billing codes, 96110 and 96127 in order to receive reimbursement for their screening efforts. The ECU program manager worked closely with both of these LHD directors to discover how to implement billing Medicaid into their regular screening practices. Meetings were also held with Utah Medicaid administrators regarding the utilization of these two billing codes. Issues around the billing codes not being open/available in Utah for Medicaid providers to use were explored. This collaborative process and problem-solving meetings led to the billing codes being opened by

Medicaid.

The ECU program manager also attended the United Way of Salt Lake's, prenatal-five workgroup. The focus of this workgroup is on Medicaid and Medicaid billing for a wide variety of providers. United Way facilitates this monthly meeting. This workgroup explores, through collaborations with state Medicaid staff and other stakeholders, ways to enhance and share information on using Medicaid developmental screening billing codes in order to receive reimbursement.

In addition to ECU's comprehensive work with Local Health Departments, ECU enrolled several pediatric providers in the UDOH ASQ Online Enterprise Account. This included three large networks of pediatric providers: 1) Utah Valley Pediatrics, 2) Wasatch Pediatrics, and 3) the People's Health Clinic. A large public mental health agency that serves many young children, Wasatch Behavioral Health, was also enrolled in the UDOH account.

The Early Childhood Utah Advisory Council's, Promoting Health and Access to Medical Homes subcommittee, had a Statewide Coordinated Developmental Screening initiative approved by the Governor's Early Childhood Commission. The ASQ-3 and ASQ SE:2 were also adopted as the recommended statewide screening tools by the ECU Advisory Council and the Governor's Commission. This multi-agency developmental screening initiative lays the foundation for large networks of medical providers and hospitals to establish their own enterprise accounts and, once the appropriate parental disclosure/consents and data sharing agreements are in place, to be able to share/access child level and aggregated screening results through common data repositories. American Rescue Plan Act funds, distributed through Utah's Child Care and Development Block Grant lead agency, are supporting this initiative.

The ECU program assures ASQ materials are available in Spanish for any community-based screening program. The ASQ is also available in other languages as needed/as requested.

Accomplishments / Successes:

According to Federally Available Data (FAD) from the National Survey of Children's Health (NSCH) Utah is trending in a positive direction with regards to improving the state's developmental screening rates.

Year	Utah	National Average
2016-2017	32.6%	31.1%
2017-2018	31.1%	33.5%
2018-2019	29.1%	36.4%
2019-2020	34.2%	36.9%

Throughout calendar year 2021, the UDOH ASQ Online Enterprise Account received the following screens from all enrolled community-based screening programs, for all ages (0-5):

- ASQ-3: 4,738 distinct children received 7,249 ASQ-3 screens
- 3,988 (55%) of the screens were above cutoff
- 1,713 (24%) of the screens were in the monitoring zone
- 1,524 (21%) screens were below cutoff
- ASQ-Social Emotional: 2,872 distinct children received 3,557 screens
- ASQ SE:2 screens 2,571 (72%) of these screens were above cutoff (converted to the same cutoff language used for ASQ-3)
- 492 (14%) of these screens were in the monitoring zone. 494 (14%) of these screens were below cutoff
- Data sources: The Brookes Publishing-UDOH ASQ Online Enterprise Account and the UDOH Early Childhood Integrated Data System

Fourteen new community-based programs enrolled in the UDOH ASQ Online Enterprise Account between July 1, 2020 and June 30, 2021. Forty-six different community-based early care, early health and pediatric providers contributed 10,506 developmental health screens to the UDOH ASQ Online Account.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-6 (July 1st, 2020

- June 30th, 2021):

- Utah's Local Health Departments facilitated 2,294 developmental and social-emotional screens to 1,237 distinct children.
- Forty-six different community-based early care, early health and pediatric providers contributed 10,506 developmental health screens to the UDOH ASQ Online Account.
- The ECU program manager trained 69 providers/caregivers.
- Fourteen new programs enrolled in the UDOH ASQ Online Account
- The ECU Advisory, ECU Subcommittees and many other early childhood leaders and programs aligned their work with Utah's Birth-Five Strategic Plan.
- The Governor's Early Childhood Commission endorsed ASQ as Utah's preferred early childhood developmental screening tool; the Commission also endorsed proposals related to promoting universal and coordinated developmental screening.
- The ECU Advisory and ECU Subcommittees submitted a comprehensive annual report with early childhood system recommendations to the Governor's Early Childhood Commission for consideration.

Challenges / Gaps / Disparities Report:

Challenges:

Challenges that impeded progress in FY21 revolve around agency/program response to COVID-19. Local Health Departments had to establish and prioritize services directly related to the pandemic response, such as managing mass immunization clinics. Additional early childhood service providers such as early head start grantees, preschools and home visitors temporarily paused direct services as they transitioned to virtual services. Challenges of this nature contributed to an overall decline in screens contributed to the UDOH ASQ Online Account.

Emerging opportunities:

In July 2022, the Utah Department of Health and the Utah Department of Human Services were consolidated into one agency. This multi-agency merger creates potential opportunities to address early childhood system gaps and to strengthen relationships between traditional perinatal-maternal-child health programs like WIC, Welcome Baby, home visiting and other systems of care like Child Protective Services, foster care and mental health. Welcome Baby is a free community service offered by United Way in partnership with the Utah County LHD. Welcome Baby provides resources for parents from experienced nurses or trained parent educators to increase family stability.

Agency Capacity/Family Partnerships/Collaboration:

A companion document to Utah’s Birth-Five Strategic Plan is the Birth-Five Deliberative Sessions for Parents Summary. The Birth-Five Deliberative Sessions confirmed the following findings:

1. There are many unknowns for parents: a lack of knowledge of developmental milestones that might indicate the need for early childhood services, a lack of awareness of existing programs and eligibility misconceptions that discourage service application.
2. Variable income poses challenges to maintaining service eligibility. Temporary extra income from seasonal work or year-end bonuses can disqualify families from services.
3. Participants learn about services through family, friends, or acquaintances. Stigma affects parents’ willingness to seek government services. For those who do seek services, negative interactions, particularly towards non-English-speakers applying for services and parents making WIC purchases, can deter them from further service use.
4. Barriers varied by community and parent background. Transportation difficulties are felt in most rural communities and language barriers by migrant workers and refugees.

The ECU Parent Engagement, Support and Education Subcommittee’s goals have been developed to address the disparities/barriers listed above. The goals are to:

1. Ensure families are aware of and have access to high-quality programs and services needed to support the healthy development of their children, and
2. Actively engage families to inform improvements to service delivery systems to improve the overall health, well-being, and early learning outcomes of children.

Program managers from the UDOH and the Department of Human Services actively participate in the ECU Parent Engagement Support and Education subcommittee. The managers have been assigned as Parent Mentors within the group to guide/support parents who are interested in becoming a regular part of the subcommittee. Due to the COVID-19 pandemic, the subcommittee meetings have been virtual. During the reporting timeframe, the number of parents participating in the meetings climbed from zero to nine. Four of these parents are interested in becoming regularly participating members and some may participate in the larger ECU Advisory Council. This subcommittee created a common definition of parent engagement that can be shared through all the entities that serve parents and families. ECU Advisory Council recognizes the definition of family engagement as a collaboration between families, communities, and service providers equally invested in positive outcomes for children and families.

Report of ESMs related to NPM-6

ESM 6.7 - The number of annual ASQ trainings offered by the Early Childhood Utah Program.

Goal/Objective:

Ensure ASQ training opportunities are reasonably available and accessible to community-based providers/caregivers. By tracking this measure, ECU can help to ensure ASQ training opportunities are offered frequently and routinely by ECU and/or in collaboration with other state/community partners.

Significance of ESM 6.7:

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 for 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 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.

ESM Progress Summary:

ECU's Developmental Screening program increases the capacity of early care, early health and pediatric providers to effectively promote early childhood developmental health. ECU does this by educating, training and enrolling programs/caregivers in the Brookes-UDOH ASQ Online Enterprise Account.

The ECU program manager trained 69 providers/caregivers during the reporting period. These providers/caregivers represented the UDOH Office of Home Visiting and IDEA Part C Early Intervention grantees, Head Start and childcare providers, LHDs, along with other early childhood service providers.

The ECU program manager participated in the Local Health Departments' quarterly meetings in order to engage the nursing directors in ASQ training, to share information on the importance of developmental screening and to make developmental health promotion resources available to nursing directors to help them achieve their agency's NPM #6 objectives.

In addition to ECU's comprehensive work with Local Health Departments, ECU enrolled several pediatric providers in the UDOH ASQ Online Enterprise Account. This included three large networks of pediatric providers: 1) Utah Valley Pediatrics, 2) Wasatch Pediatrics, and 3) the People's Health Clinic. A large public mental health agency that serves many young children, Wasatch Behavioral Health, was also enrolled in the UDOH account. Overall, fourteen new programs enrolled in the department's ASQ Online Account.

ESM 6.8: The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs

Goal/Objective:

By analyzing screening data quarterly and outreaching/supporting inactive programs and/or programs whose

screening rates are decreasing, developmental screening rates may be increased.

Significance of ESM 6.8:

Early identification of developmental disorders is critical to the well-being of children and their families. Nationally, the percentage 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; by increasing the number of programs actively participating in the UDOH ASQ Online Enterprise Account the percentage of 9 month - 35 month old children that receive parent-completed developmental health screening opportunities will increase.

ESM Progress Summary:

Between July 1, 2020 and June 30, 2021 forty-six different community-based early care, early health and pediatric providers contributed 10,506 developmental and/or social-emotional health screens to the UDOH ASQ Online Account.

Utah's Local Health Departments facilitated 2,294 developmental and/or social-emotional screens to 1,237 distinct children.

According to Federally Available Data (FAD) from the National Survey of Children's Health (NSCH) Utah is trending in a positive direction with regards to improving the state's developmental screening rates.

The Governor's Early Childhood Commission endorsed ASQ as Utah's preferred early childhood developmental screening tool; the Commission also endorsed proposals related to promoting universal and coordinated developmental screening.

Local Health Department Activities related to NPM-6:

As noted above, all 13 of Utah's Local Health Departments (LHDs) work on activities for NPM 6. As expected COVID slowed progress in this area for most of them. The overall screening numbers did not meet goals set at the beginning of the year for the majority. All LHDs strive to ensure that infants and children served by their departments are provided an opportunity to be assessed for delays and if delays are noted, referred to appropriate agencies for care.

LHDs use the Brooks Online Tool for ASQ screenings. Most children with "positive" screens are referred to Parents as Teachers (home visiting), Early Headstart or Early Intervention programs depending on the need and the child's age. LHDs work to build relationships with outside agencies because many times they give clients the best resource to support children. Many conducted screenings with WIC clients and home visiting families, wherever there are "touch points" with children and families. During visits with families, nurses work with parents in identifying upcoming expected milestones as well as assessing the status of the infant/child. Education materials were provided to the families to help them better prepare and understand the age-appropriate milestones and supporting activities that will benefit their infant/child. Nurses also spent time on educating the parents on the importance of the developmental milestones and how the referral programs can help increase better outcomes for their infant/child.

The pandemic definitely affected LHDs ability to conduct ASQ screenings. Many LHDs limited in person visits and home visitation programs which severely limited the number of screenings they completed. LHDs tried to utilize the online ASQ referral link, but many times did not have a great response in getting the caregivers to complete the survey. As time permitted, follow-up contact would be made to help identify barriers to the family not seeking assistance from the referral services. A challenge is parents not completing the screening tool or not having adequate time during other program visits such as WIC, Targeted Case Management - Medicaid TCM), Parents as Teachers (home visiting) to complete the screening with the parents. Text, phone calls and mailing reminders were sent by WIC and TCM staff to contact and encourage parents to continue with their child's ASQ scheduled screenings. Some families who had infants/children with identified delays would sometimes not follow-through with the nurse referrals.

Many nurses who would normally be performing the developmental milestone assessments (ASQs) were reassigned to COVID response efforts. As a safety precaution, no home visits (or ASQ screenings) were conducted from October 2020 - September 2021. Many LHDs saw over 50% staff turnover last year. Frequently after training a new employee they left before we could get to MCH training.

With all the challenges of the past 12 to 18 months many visits are still by phone or virtual. Home visitors closely monitored when screenings were due and initiated appointments in advance to assure deadlines were met. COVID-19 quarantine prevented in-person contact with parents of children who participated in WIC and TCM visits, which limited the assistance and encouragement to participate in ASQ screenings. With the return to regular operations, MCH nurses will resume the ASQ assessments and work towards reaching their established goals.

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

Annual Report FY21:

This Performance Measure was achieved. The Performance Objective was 82.8% and the Annual Indicator was 84.3%.

Program Activities:

The Utah Medicaid Office provided regular updates at the quarterly meetings of the Utah Oral Health Coalition. These updates include information on those who are Medicaid eligible, what services are covered including updated services, how to become a provider, and updating contact information and resource lists. From June - September of 2021 Silver Diamine Fluoride (SDF) underwent a full review and cost analysis and by December of 2021 it had been evaluated and approved as a covered service effective January 1, 2022 for primary teeth only.

The State Dental Director (SDD) continued to attend the Utah Dental Association board meeting and the state dental licensing board meetings to represent the UDOH. The Oral Health Specialist (OHS) and Oral Health Educator (OHE) presented to 62 Utah Dental Association dental hygiene members on Public Health Dentistry at their annual meeting.

The Oral Health Program (OHP) has several 'Baby Your Baby' and 'Check Your Health' segments on TV each year. They write talking points for local dentists and dental hygienists in leadership to give. Topics include: The importance of baby teeth, setting a good bedtime routine with the American Academy of Pediatrics AAP's brush book bed program, and our OHE gave a segment on choosing healthy beverages and avoiding sugar for children under the age of two. In addition, the oral health specialist partnered with the Maternal and Infant Health Program to provide a Power Your Life segment on pregnancy and the importance of baby teeth. It had approximately 300 views.

The OHS continued to sit on the Early Childhood Utah (ECU) Health subcommittee and share great oral health resources. The OHS also collaborated with Help Me Grow, another ECU partner, to write a blog posting for their website on a structured healthy bedtime routine program set out by the AAP Brush, Book, Bed.

The OHP continues to support the Head Start and Early Head Start (EHS) programs throughout the state by sitting on the health advisory committees, providing staff training, parent educational presentations and screenings and fluoride varnish to some sites. In January of 2021 the OHS presented Empowering Parents (From the National Center of Early Childhood Health and Wellness presentations) to Kids on the Move EHS Staff, reaching 36 staff members. In May and June the OHS and volunteer dental hygienist screened and provided fluoride varnish to 51 Head Start children in Tooele and Grantsville and an additional 26 children in Wendover.

The OHE continued to work with the Office of Home Visiting (OHV) to provide oral health education and training to families with children (0-5) and staff. The OHE sent quarterly educational and dental resource emails to each site. All educational materials shared are evidence-based and include national materials on COVID-19, oral health care considerations and going to the dentist. The OHE supplied 160 donated toothbrushes and toothpaste to the Salt Lake City OHV Site. Additionally, donated toothpaste was mailed to all rural OHV sites ensuring that each location gets donated toothpaste and oral health educational supplies. In addition, a dental hygiene student provided education at a parents' night for the Southeast local health department, reaching 5 families. In addition, the OHE updated the 12 oral health messages magnets and modules. Updated magnets were delivered to four local health departments.

Recorded presentations including Empowering Parents and Oral Health and Pregnancy; (From the National Center of Early Childhood Health and Wellness presentations) in English, Spanish, Nepali and Arabic continued to be shared with several Early Head Starts/HS in Utah, WIC, OHV sites, bountiful pantry and early intervention programs. In September the OHS shared two educational videos for Hispanic Heritage Month at a virtual health event. The presentations were Smiles for Life and Empowering Parents Smiles for Life Spanish (https://byu.zoom.us/rec/share/ufZrH4Hw6khLRrfW5FDcAp8YRpnaX6a80XIW-KENzU8rwOVHCWmbwEghaMcUDNk0?startTime=1596635478000) and Empowering Parents Spanish)

(https://byu.zoom.us/rec/share/6uFEFI3iyCBIBbPx5V6OY5YBN8fBX6a8hyMZ-fVcnTSvBw3oFNRwJGLLviRuKVA?startTime=1591336032000).

The OHP, OHS and OHE continued to share the opioid toolkit for dental professionals. The OHP disseminated the

toolkit through the Utah Dental Association, Utah Dental Hygiene Association, safety net clinics, and dental and hygiene schools. In the fall of 2020 in-person trips were made to disseminate this toolkit in Davis, Tooele, Salt Lake, Utah, Wasatch, Duchesne, Sevier, Weber and Washington Counties. This toolkit includes specific guidelines on opioid prescribing for pregnant women, children and adolescents from the National Maternal and Child Oral Health Resource Center.

Working with The Association for Utah Community Health (AUCH) and their Community Health Workers (CHWs): The OHS and OHE gave a virtual oral health presentation to 29 CHWs. Dental educational materials for families and safety net clinic information were provided.

The Adolescent Oral Health Campaign (AOHC) is an intervention designed to educate middle school aged students about oral health care. In the 2020-2021 school year, all presentations were given virtually or viewed by a recording. A total of 89 in-person presentations were given to over 1,758 students and an additional 383 students viewed the recorded presentation. The OHE managed OHP interns who implemented the program and gave presentations on building program sustainability. To measure the effectiveness of the intervention, the students complete anonymous pre- and post-tests. One page fact sheets were created for each school based on the data collected. Brochures with local safety net dental clinics were provided to all students and teachers physically and electronically.

For the Utah Schools for the Deaf and the Blind one email was sent in the fall and another in the spring. These emails included oral health coloring pages, two educational videos and dental resources for families. These emails were sent by the teachers to over 140 families.

For children's Dental Health Month in February, the OHP sent electronic newsletters to all public elementary school, middle school and high school administrators. Over 1,000 schools were contacted. The OHP interns and OHP Specialists gave virtual and in-person presentations to over 562 students in 12 elementary schools across 7 different counties. These presentations were given to each individual class as assemblies were still not permitted due to COVID-19.

The OHP, OHS and OHE continued to be active members of the Professional Advisory Committees for the different dental hygiene schools. The OHP continues to do presentations at the dental hygiene schools on cultural respect and public health dentistry. In the 2020-2021 school year, the OHS and OHE presented to all 6 of the dental hygiene schools. In September of 2020 the oral health specialist also presented to 3rd year dental students at Roseman University on motivational interviewing. She also shared materials from the National Maternal and Child Oral Health Resource Center.

One of the OHPs greatest strengths is working with many strong partnerships/collaborations. The OHP began its 11th year collaborating with the University of Utah Physician Assistant (PA) Program. In the fall of 2020 the OHS and OHE trained 70 University of Utah PA students from the Salt Lake Campus and St. George Campus to perform oral health risk assessments and apply fluoride varnish. In August both the PA program and the OHP provided screenings and fluoride varnish applications to 120 migrant head start children and over 50 Migrant Farm Workers (parents of the MHS).

Again, the OHP partners with Head Starts, Office of Home Visiting, WIC, and other early intervention programs to share educational resources, as well as, help these populations find dental homes.

The OHS worked with individual Early Headstart/Headstart (EHS/HS) to help them get dental homes and address questions during shut down and pandemics. Because tooth brushing was halted in EHS/HS, educational videos and materials were created and given to address these barriers and concerns. During the pandemic, in spring of 2020, the OHP presented and shared virtually two presentations Empowering Parents and Oral Health and Pregnancy; (From the National Center of Early Childhood Health and Wellness presentations) to several Early Head Starts/HS in Utah and also had local dental hygienists that speak Nepali and Arabic share with vulnerable populations with Early Head Start. These were recorded in English, Spanish & these languages for refugees & other families with EHS/HS. These presentations were also shared with Home Visiting, WIC, and other early intervention programs. The Oral Health Specialist (OHS) and Oral Health Educator (OHE) tried to think outside the box to create outreach to families during the pandemic.

Accomplishments / Successes:

A notable accomplishment of the OHP is its now 10 year collaboration with the University of Utah Physician Assistant Program where direct services are not only provided to head start children but also oral health training of PA students occurred. In addition the oral health program worked with different head start sites to screen and apply fluoride

varnish to an additional 77 children. The Oral Health Program also created oral health videos for families including information on brushing, flossing, nutrition, and age one dental visits. These videos were created in English, Spanish, Nepali and Arabic and shared with all Head Starts, Office of Home Visiting and WIC Sites. In addition the 12 oral health messages materials were updated and shared with the Office of Home Visiting Sites.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-13.2:

- SDF underwent a full review and cost analysis and by December of 2021 it had been evaluated and approved as a covered service effective January 1, 2022 for primary teeth only. (June 1st, 2021 - September 1st, 2021)
- The OHP updated the 12 oral health messages modules and magnets which were disseminated to all of the OHV sites. Quarterly educational and resource emails were sent to each site including information on drinking water instead of sugary beverages, regular snack times, what to expect from a dental visit during COVID-19 and the importance of brushing teeth.
- The OHS gave a round table discussion at the National Oral Health Conference. The OHS spoke on the 2007-2019 Non-traumatic Dental Report. From that round table the OHS was invited to present to the American Dental Association Emergency Department National Committee on her report in June of 2021.
- The OHE also had a roundtable discussion at the National Oral Health Conference on the Adolescent Oral Health Educational Campaign conducted along the Wasatch Front. Materials including the factsheets, end of year reports and pre/posttest were shared with attendants. The OHE was contacted by two other states after the roundtable to share additional information.
- OHP bi-annually provides brief oral health educational spotlights for Utah's AAP newsletter that is sent out to all Pediatricians. The OHE shared Vaping/ Cigarette oral health educational flyers and OHP shared information on Children with Heart Conditions. Dental Care for Children with Heart Conditions. They work closely with pediatrician Dr. Mark Valentine M.D.
- The OHP received over 30 boxes of toothpaste with each box containing 50 full tubes of toothpaste. These boxes were taken or shipped to every office of home visiting site, some Head Starts, Granite Peak Middle and other community organizations including the Road Home (homeless shelter), Bountiful Pantry, 4th Street Clinic, Utah School for the Deaf and the Blind, Somali Self-Management Agency, Utah Navajo Health System, and Confederated Tribes of the Goshute in Ibapah.

Challenges / Gaps / Disparities Report:

Challenges: One of the biggest ongoing challenges of providing access to dental care has been the pandemic. Many safety net clinics did not have the personal protective equipment (PPE) or were very delayed in opening back up. Several of the safety net dental clinics also didn't offer preventive care, only exams and restorative care upon initial opening. This was a nationwide problem. The OHS worked with both dental schools and hygiene schools to see if screenings or other care could be provided. Several live online meetings were done to address this challenge. When the clinics finally opened many families were very hesitant to go to the dentist, let alone take their child. Another challenge for the OHP included reduction in staff. The OHS chose to reduce her hours from a full-time 1FTE to .5 FTE in July of 2020 and resigned from the position in May of 2021. Because of the COVID-19 pandemic and funding concerns, the Oral Health Survey of Utah's school children which was planned for the 2020-21 school year was canceled. During FY20, planning was underway and IRB approval had been obtained, so it was unfortunate to need to cancel the survey. Previously, the survey was done every five years.

Emerging Issues: The increase in PPE and protocols needed to treat patients from the pandemic have remained intact. This increased level of PPE adds patient time and cost to dental providers. Aerosolizing procedures in dentistry are common and many modifications have been and are being made to limit the amount of aerosols produced. Providers have found that preventive products such as Glass Ionomer sealants, Silver Diamine Fluoride (SDF) need to be utilized more as they do not produce aerosols. SDF became a covered service by Medicaid for primary teeth only in January of 2021.

Agency Capacity/Family Partnerships/Collaboration:

Due to organizational changes and the loss of the Oral Health Specialist and State Dental Director, capacity is limited at this time with only 1.0 FTE (Oral Health Educator) working in the Oral Health Program. The Oral Health Program has also moved from the Office of Maternal and Child Health to the Office of Primary Care and Rural Health, which is under the direction of the Executive Director's Office (EDO). Once a new State Dental Director is hired, the EDO has committed to increasing the State Dental Director from 0.2 FTE to 0.5 FTE. Having more time from the State Dental Director and the Oral Health Program in the Office of Primary Care and Rural Health will increase capacity for collaborating with private sector entities; federal, state, and local governments; tribal organizations, etc. to meet the oral health needs of Utah's children.

Report of ESMs related to NPM-13.2

ESM 13.2.1 - 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:

Measures the number of Medicaid children ages 1 - 18 years who have a preventive dental visit

Notes & Comments:

The ESM Performance Measure was not achieved. The Performance Objective was 52.1% and the Annual Indicator was 47.8%. The most recently available data for reporting is from 2020. The 5-Year Annual Projected Performance Objectives have been updated.

ESM Progress Summary:

This ESM is expected to increase the number of Medicaid children ages 1 through 18 years who have preventive dental visits 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 than those of higher economic status. They are part of the population in Utah that is important to concentrate on in improving this measure.

Local Health Department Activities related to NPM-13.2:

Three of thirteen Local Health Departments implement activities for this objective. As expected, COVID slowed down the implementation of planned activities during the year, however, some progress still occurred. Oral health education and materials were given to all parents who had a home visit (COVID restrictions permitting), including telehealth visits. One LHD offered 72 fluoride varnishes and 20 fluoride treatments, while for another 250 children received dental education and or supplies or referrals. In the third LHD, 843 children received dental education and or dental hygiene supplies and provider referral, which more than tripled their goal for the year. Staff, care providers and children really enjoy getting a toothbrush.

LHDs barriers for this objective included – staffing issues, COVID restrictions and the ability to get parents to bring children in for screening and it was hard just to connect with parents in general. During the first part of the year not many children received education and/or supplies, but during the last few months of the year more children are receiving services.

State Priority Area: Family Connectedness

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

Annual Report FY21:

Program Activities:

The Performance Measure was achieved. The Performance Objective was 78.8% and the Annual Indicator was 81.1%.

In this case, Utah has used the measure of family meals as a proxy indicator for connectedness. Family meals are also an opportunity to cultivate communication skills, improve family relationships, bolster self-esteem, decrease obesity rates, and develop life-long healthy eating and lifestyle habits.

Accomplishments / Successes:

Utah's five year goal was to increase the percentage of families who ate a meal together four or more days per week from 76.7% to 81.7% (2017-2018 National Survey of Children's Health). The 2019-2020 data from the National Survey of Children's Health show that 81.1% of Utah families ate a meal together four or more times per week. This nearly achieves the five year goal that Utah set and demonstrates a nearly 4% increase from the 2018-2019 data of 78.1%.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-2.0 (July 1st, 2021 - June 30th, 2022)

- The Family & Youth Outreach Program (FYOP) distributed conversation cards to 45 Utah families. "Conversation Cards" are a deck of cards with pre-printed questions or conversation starters for parents to utilize with their teens or preteens. The cards can be used to promote healthy, relationship-building conversations during family meals. The Conversation Card resource was developed in collaboration with the Missouri Department of Health & Senior Services.
- FYOP, in collaboration with local partners, implemented the Families Talking Together intervention with 98 parents. This evidence-based program increases the ability of parents to communicate about sexual decision making, set boundaries, and engage more positively with their teen(s). Ultimately, increased conversations and stronger relationships with parents decreases the initiation of risky behaviors, such as sexual activity. Local partners are trained in the intervention and assist FYOP in reaching parents more broadly in communities across the state.
- The FYOP team held 24 virtual Teen Speak classes, with 160 parents and youth-serving professionals attending. FYOP also produced one Fostering Communications podcast (https://utahfostercare.org/feed/podcast) to promote the program, in collaboration with Utah Foster Care. The podcast episode reached approximately 150 foster parents. This evidence-based program utilizes motivational interviewing principles to support parents and trusted adults in improving communication skills and strengthening youth-adult relationships. Data suggests that teens who can identify a strong relationship with at least one trusted adult are less likely to use drugs or alcohol, engage in sexual activity, or attempt suicide.
- The Healthy Environments Active Living (HEAL) program (formerly known as EPICC), worked with Utah's governor to proclaim September 2021 as Healthy Meals Month.
- The Healthy Environments Active Living (HEAL) program (formerly known as EPICC), produced and promoted 30 A Way to HEAL Utah podcasts (https://podcasts.apple.com/us/podcast/a-way-to-heal-utah/id1497138073?ign-mpt=uo%3D4).

Challenges / Gaps / Disparities Report:

The COVID-19 pandemic has continued to present challenges to reaching parents and youth-serving professionals through education and other resources. However, virtual classes are proving to be successful in some aspects and even present an opportunity to reach more rural, underserved populations in the long-term, potentially addressing equity concerns.

Agency Capacity / Collaboration Report:

Partnerships include Utah Foster Care, Local Health Departments, the Utah State Board of Education, Local Education Authorities, home visitors, and other youth-serving organizations. The Family & Youth Outreach Program is striving to build and maintain more partnerships that can reach diverse populations and improve program equity, such as Centro Hispano, refugee resettlement agencies, Sacred Circle Health Care (serving the Confederated Tribe

of the Goshute), and more.

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 continued to integrate 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. Similarly, 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 transitioned from part C to part B, the health information provided through CHARM continued to be documented in the child's record when the child moved from infant/toddler services to preschool, which provided continuity of care.

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year. (Reduce the percent of children and adolescents who have dental caries or decayed teeth)

The UDOH Oral Health program partnered with the University of Utah Physician's Assistant Program to see 120 children in the migrant head start program. PA students performed an assessment to identify dental needs and applied fluoride varnish to prevent dental decay.

The UDOH Oral Health Adolescent Educational Campaign ran over the 2020 school year. Educational presentations and local dental resource lists are made available to all middle school students who received the intervention. We reached over 2,141 students.

In March of 2021 the Oral Health Specialist presented to over 36 Early Head Start Staff at Kids on the Move EHS emphasis was placed on tooth brushing in the home since it was not being done in the center due to COVID. In May, the Oral Health Specialist along with volunteer dental hygienists provided screenings and fluoride varnish to 77 children at the Tooele, Grantsville and Wendover Head Starts.

The Baby Your Baby Outreach Program included several news interviews on the importance of taking care of your children's teeth.

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health. (Improve the health status of children)

And

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). (Reduce the percent of children and adolescents who are considered obese)

Teaching Obesity Prevention in Early Childcare and Education Settings, TOP Star for short, is a program created by the DHHS Healthy Environments Active Living (HEAL) program to improve the health of children who are cared for in early childcare and education settings. The program supports childcare providers by improving their nutrition, physical activity and breastfeeding environments and policies to help promote health and prevent obesity in children. Local health department consultants provide individual guidance, support, resources and tools.

The HEAL program also works with the Utah State Board of Education and other partners and organizations to ensure that school health is a priority within the school setting. Best practices to guide schools to develop policies and healthy environmental settings can follow the CDC's framework known as the Whole School, Whole Community,

Whole Child, or WSCC model. The WSCC model is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement and the importance of evidence-based school policies and practices.

The model provides 10 component areas to help address a well-rounded school health environment:

- Physical education and physical activity.
- Nutrition environment and services.
- Health education.
- Social and emotional climate.
- Physical environment.
- Health services (School Nursing and other services).
- Counseling, psychological and social services.
- Employee wellness.
- Community involvement.
- Family engagement

NOM 21 - Percent of children, ages 0 through 17, without health insurance. (Ensure access to needed health care services for children)

Baby Your Baby included an interview with the CHIP and Medicaid director encouraging those who are without insurance to apply. The same staff that answer the MCH phone line also answer the phone line for CHIP. Staff are easily able to provide information on CHIP and Medicaid to those who call about their child through MCH.

NOM 22: a) Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series b) Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza c) Percent of adolescents, ages 13 through 17 years, who have received at least one dose of the HPV vaccine d) Percent of adolescents, ages 13 through 17 years, who have received at least one dose of the Tdap vaccine e) Percent of adolescents, ages 13 through 17 years, who have received at least one dose of the meningococcal conjugate vaccine

The CHARM system continues to link 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 and clinics, that obtain immunization information on the combined 7- vaccine series, seasonal influenza, and adolescent HPV, Tdap, and meningococcal vaccine through the CHARM system, have continued to identify children in need of immunizations, and have followed-up with parents to get their child vaccinated and up-to-date. In addition, health care providers that use USIIS can access and view newborn hearing screening and Critical Congenital Heart Defect (CCHD) through CHARM links that query this information.

Child Health - Application Year

Priority Need: Developmental Delays

NPM-6.0: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Annual Plan FY23:

The Early Childhood Utah (ECU) program's mission statement is: To promote and support a strong foundation of health and wellbeing such that all Utah children enter school ready to learn and go on to lead healthy, happy and productive lives. The ECU program accomplishes this mission by:

- Helping families and early childhood programs understand developmental milestones and how to use the Ages and Stages Questionnaires®; third edition (ASQ®;-3) and the Ages and Stages Questionnaires®; Social-Emotional, second edition (ASQ®;SE-2) to promote optimal child development.
- Developing data infrastructure and data systems in order to effectively collect, analyze and use data to drive smart and effective policy, funding and programmatic decisions.
- Coordinating and facilitating the work of the Early Childhood Utah Advisory Council, which brings statewide early childhood partners together to improve system-wide collaboration and coordination to ensure young children enter school healthy and ready to learn.

The ECU program intends to achieve our objectives by improving collaboration and coordination with community-based early childhood service providers in order to develop a seamless continuum of services for families and children from prenatal to three in Utah. ECU will further develop and unite the early childhood community through the Early Childhood Utah Advisory Council (ECU Advisory) and the Governor's Commission on Early Childhood (Commission).

ECU will engage in the continued development and/or improvement of the many systems of care that families and children come into contact with. These efforts will include the promotion of universal developmental screening with an emphasis on the incorporation of ASQ-3 and ASQ: SE-2 with state and community-based health systems and primary care providers. Finally, ECU will promote the availability and use of early childhood data to guide the decision-making processes.

The ECU program will collaborate and coordinate closely with the child, youth and family division/offices/programs in the new Department of Health and Human Services. Collectively, we will aim to advance a common vision of promoting universal developmental screening. Our programs will strive to reach objectives related to National Performance Measure (NPM) #6, which tracks and aims to increase the percentages of children, ages 9 months through 36 months, who receive a parent-completed developmental screen. Directly related to this objective, over the next three years, ECU will actively participate in a new Statewide Coordinated Developmental Screening Project (ASQ project). This project has been vetted and endorsed by the Early Childhood Utah Advisory Council and the Governor's Early Childhood Commission.

The new ASQ project involves multiple state and community-based agencies along with medical providers and is targeted to receive financial support through the American Rescue Plan Act (ARPA). The new ASQ project calls for the establishment of multiple Brookes ASQ Online Enterprise Accounts hosted by various state agencies, community-based organizations and large scale medical networks (hospitals).

ECU will assist Local Health Departments with reaching tiered ASQ goals and objectives. The ECU program will work closely with the Local Health Departments to help them achieve their NPM #6 related goals and objectives, listed here:

Tier 1 - Goal: Increase ASQ Online Training and Promotion

- Promote ASQ Online training and the use of ASQ Online screening with community-based organizations.
- Attend ECU Advisory Council meetings.

Tier 2 - Goal: ASQ Trained and Ready to Use ASQ

- Conduct ASQ Online screens with clients through the WIC, Home Visiting, Early Intervention and/or other LHD programs.

Tier 3 - Goal: Advanced ASQ Utilization

- Establish and implement a schedule to complete screens at 6, 12, 18 and 25 months; along with 3, 4 and 5

years of age.
- Integrate billing Medicaid into the service delivery system, i.e. determine if codes 96110 and 96127 can be utilized by the LHD to bill for developmental screens.

ECU will provide assistance by participating in regularly scheduled collaborative meetings, by providing ASQ training and individualized, supportive technical assistance. ECU will continue to distribute emails with information regarding the importance of developmental screening along with training information offered through Brookes Publishing. ECU will share the quarterly ASQ training calendar with the LHDs and encourage them to participate, especially new providers/caregivers. ECU will continue to invite LHD staff to participate in the ECU Advisory Council and/or to engage in any of the five ECU Advisory Council subcommittees. The ECU program will track and share reports regarding each LHDs' goals, objectives and screening summary efforts. ECU will provide incentives to programs that increase their screening rates throughout FY23.

ECU will expand ASQ Online enrollment opportunities to new pediatric and early childhood service providers. Throughout FY23, the ECU program will engage with Department of Health and Human Services (DHHS) programs that are either new to the ASQ screening tool or are familiar with ASQ but are not trained/enrolled in the DHHS ASQ Online Enterprise Account. ECU will also continue collaborative work with programs co-located in the Division of Family Health such as WIC, the Home Visiting Services and Supports program, the Maternal and Infant Health program, the Integrated Services program, and the IDEA Part C Early Intervention program (Baby Watch).

Additionally, ECU will continue its outreach and coordination with programs managed by the Division of Child and Family Services, programs such as Child Abuse and Neglect Preventative Services and Foster Care. Through these established and new relationships, ECU will identify new caregivers and programs that are interested in receiving training on the ASQ-3 and ASQ: SE-2. Ideally, training will lead to the enrollment and participation of new programs in the DHHS ASQ Online Account.

With support from the HRSA-MCH based Early Childhood Comprehensive Systems Grant (ECCS), ECU covers the current expenses associated with ASQ training, ASQ onboarding and ongoing costs per screen for programs participating in the DHHS Enterprise Account. Also with support from the ECCS grant, in FY23, ECU will provide a small monetary incentive to select programs that accelerate/broaden their developmental screening practices. In addition to efforts around promoting the healthy development of young children, ECU will also coordinate and align training activities and resources with the Maternal and Infant Health program's Maternal Mental Health Screening initiative. Both programs will share messaging about the importance of screening expectant and new mothers along with screening their newborn babies.

Finally, the ECU program will continue to offer technical assistance to other states that are in the process of developing an ECIDS and/or a statewide developmental screening program. Addressing disparities and inequities in the FAD, ECU will continue to utilize ECIDS, ASQ, and other reports, such as the Prenatal-to-3 Policy Impact Center's Utah Policy Roadmap and focused community-based collaborations to ensure developmental screening opportunities are universal and that communities discovered to be under-resourced are targeted for intervention. ECU will also utilize the Office of Health Disparity's health equity report, the Utah Health Improvement Index along with the Utah Data Research Center's Area Deprivation and the P20 Pipeline research as resources to identify communities that are struggling with helping their children reach developmental milestones and thus, not arriving at school healthy and ready to learn. ECU will also participate in and facilitate the opportunity for additional ECU Advisory Committee Members to participate in formal equity and disparity training developed and endorsed by the department.

- Engaging in quarterly LHD director meetings
- Distributing regular emails with training information
- Provide ASQ onboarding and ongoing technical assistance
- Offer quarterly ASQ training opportunities
- Invite LHD directors to attend ECU Advisory Council and/or ECU Subcommittee meetings quarterly
- Engage in bi-monthly meetings with DHHS partners and share screening information and resources throughout the Division of Family Health and the Division of Child and Family Services
- Share screening information and resources with the Early Childhood Utah Advisory Council
- ECU will share maternal mental health screening information with the Early Childhood Advisory Council to gain additional support and to identify new partners
- Orchestrate the activities of the Early Childhood Utah Advisory Council, engage in subcommittee meetings and work, and guide the development of proposals made to the Governor's Early Childhood Commission
- Develop and deploy new ECIDS reports, modernize the security and functionality of ECIDS, track and improve ECIDS utilization, and offer technical assistance to other states

Priority Need: Oral Health

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

Annual Plan FY23:

In FY23, 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 Oral Health Program will continue to work with the dental group within Utah Medicaid.

The Oral Health Educator (OHE) will work with the Utah Dental Association (UDA) to encourage participation in programs for underserved children in Utah including but not limited to the Give Kids A Smile program operated by the UDA and partners. The OHE will work with the UDA to continue to encourage dentists to see children with Utah Medicaid dental benefits. Efforts will also be continued to encourage first dental visits by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

The OHE and designated 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 educational materials to the Utah School for the Deaf and the Blind. The OHE and future interns will also be available for virtual presentations in other districts. In the 2021-2022 school year the OHE and interns were able to return to in person presentations. Virtual presentations and recordings are available to schools that request them. The OHE continues to collaborate with local dental hygiene programs to provide education resource booths at back to school nights in middle schools.

The OHE will continue to work with and promote teledentistry to increase access to care for school based programs. The OHP will continue inter-professional collaborations and outreach to vulnerable populations with the University of Utah’s PA Program. The OHE in collaboration with Utah’s dental hygiene liaison will provide training to PA students on the AAP’s Oral Health Risk Assessment and applying fluoride varnish. The OHP and PA program will screen migrant farm children through the migrant HeadStart programs and parents through the migrant farm workers screening days.

- The OHE will continue to work with and promote teledentistry to increase access to care for school-based programs.
- The OHP will continue to provide oral health articles bi-annually for the American Academy of Pediatrics Utah Chapter newsletter. As well as bi-annual newsletters for the WIC Wire and Flash.
- The OHP will continue to use the updated 12 Oral Health Messages modules and magnets and share with WICs, Head Start, and Home Visiting etc. Maternal & Infant oral health messages are included in this.
- In the interim, the OHE will work with the Utah Dental Association to encourage participation in programs for underserved children in Utah.
- 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. This will be available in person and virtually.
- The OHP will continue inter-professional collaborations and outreach to vulnerable populations with the University of Utah's PA Program.
- The OHE will continue to work with the State Nurse Collaborator to create an oral health toolkit for all school RNs in Utah. Including information on (American Academy of Pediatrics) Oral Health Risk Assessment, trauma, nutrition and educational posters. Once this is finalized they will collaborate to disseminate the toolkit.

State Priority Area: Family Connectedness

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

Annual Plan FY23:

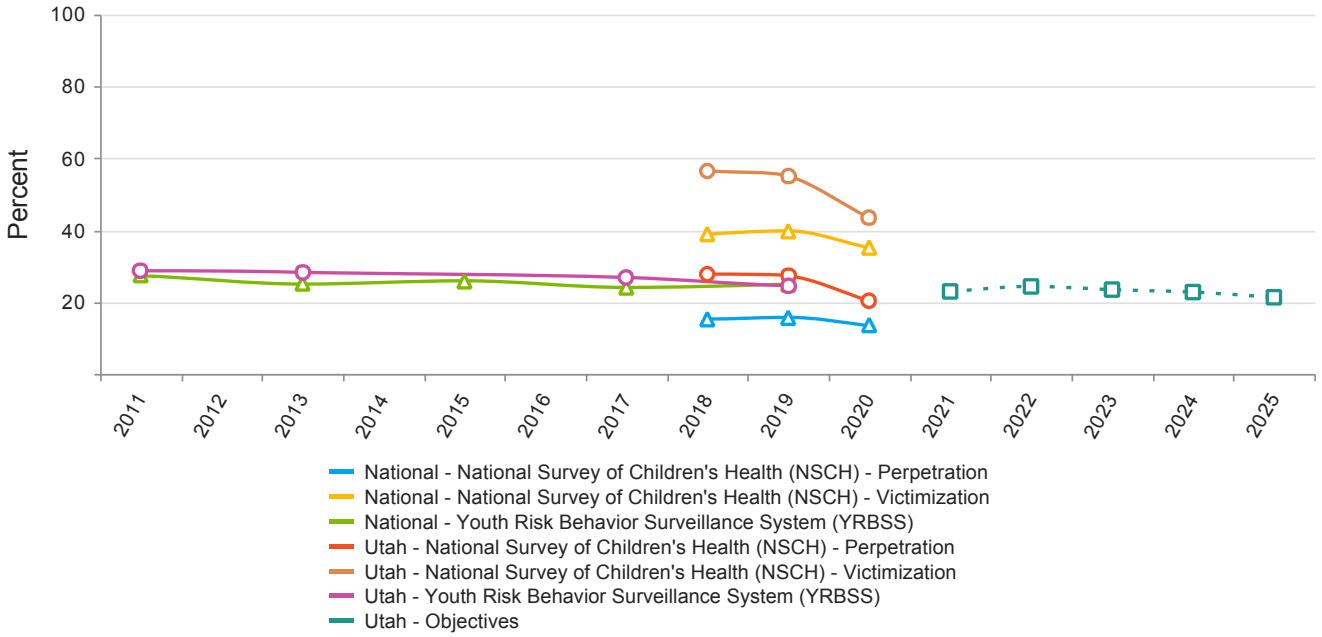
During FY23, the Office of Maternal and Child Health (MCH) in collaboration with the Violence Injury Prevention (VIPP) and Healthy Environments Active Living (HEAL) program (formerly known as EPICC), will continue activities to support increased family meals. The activities planned for July 1, 2022 - June 30, 2023 include HEAL's promotion of family mealtime through A Way to HEAL Utah podcast (https://podcasts.apple.com/us/podcast/a-way-to-heal-utah/id1497138073?ign-mpt=uo%3D4), the Governor's proclamation of September as Healthy Family Meals Month, communication tools for parents, such as conversation cards, Teen Speak and Families Talking Together classes, and partner training by VIPP staff.

- Promote and distribute conversation cards to Utah families. "Conversation Cards" are a deck of cards with pre-printed questions or conversation starters for parents to utilize with their teens or preteens. The cards can be used to promote healthy, relationship-building conversation during family meals. The Conversation Card resource was developed in collaboration with the Missouri Department of Health & Senior Services.
- Promote and implement the Families Talking Together intervention with approximately 100 parents. This evidence-based program increases the ability of parents to communicate about sexual decision making, set boundaries, and engage more positively with their teen(s). Ultimately, increased conversation and stronger relationships with parents decreases the initiation of risky behaviors, such as sexual activity. Local partners are trained in the intervention and assist MCH in reaching parents more broadly in communities across the state.
- Offer at least one virtual Teen Speak class per month to approximately 120 parents and youth-serving professionals. This evidence-based program utilizes motivational interviewing principles to support parents and trusted adults in improving communication skills and strengthening youth-adult relationships. Data suggests that teens who can identify a strong relationship with at least one trusted adult are less likely to use drugs or alcohol, engage in sexual activity, or attempt suicide.
- Maintain relationships with partners, including Utah Foster Care, the Utah State Board of Education, Local Health Departments, Local Education Authorities, home visitors and other youth and family serving agencies in order to effectively promote and implement interventions, strategies, and resources.
- Work with Utah's governor to proclaim September 2022 as Healthy Meals Month.
- Produce and promote bi-monthly to weekly episodes of the A Way to HEAL, Utah podcast (https://podcasts.apple.com/us/podcast/a-way-to-heal-utah/id1497138073?ign-mpt=uo%3D4)

Adolescent Health

National Performance Measures

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



Federally Available Data			
Data Source: Youth Risk Behavior Surveillance System (YRBSS)			
	2019	**2020**	**2021**
Annual Objective			23
Annual Indicator	26.9	24.4	24.4
Numerator	44,345	41,396	41,396
Denominator	164,763	169,914	169,914
Data Source	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2019	**2020**	**2021**
Annual Objective			23
Annual Indicator	27.7	27.5	20.4
Numerator	86,153	84,890	62,745
Denominator	311,307	309,211	307,366
Data Source	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Victimization			
	2019	**2020**	**2021**
Annual Objective			23
Annual Indicator	56.4	54.8	43.3
Numerator	176,896	170,076	133,253
Denominator	313,579	310,347	307,613
Data Source	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.4	23.5	22.8	21.4

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	2020	2021
Annual Objective			100
Annual Indicator	0	129	160
Numerator			
Denominator			
Data Source	Program records, attendance records.	Program records, attendance records	Program records, attendance records
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2020	2021
Annual Objective			350
Annual Indicator	300	300	181
Numerator			
Denominator			
Data Source	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	200.0	250.0	275.0	300.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			23
Annual Indicator	21	21	21.7
Numerator	41,142	41,142	46,356
Denominator	195,912	195,912	213,621
Data Source	Estimates for percent of students physically activ	YRBS	YRBS and National Center for Health Statistics (NC
Data Source Year	2019	2019	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2020	2021
Annual Objective			400
Annual Indicator	400	366	162
Numerator			
Denominator			
Data Source	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	175.0	200.0	250.0	300.0

ESM 9.5 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			76
Annual Indicator	75	75	75
Numerator	171,000	171,000	171,000
Denominator	228,000	228,000	228,000
Data Source	Internal Revenue Service	Internal Revenue Service	Internal Revenue Service
Data Source Year	2018	2018	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	78.0	79.0	81.0	83.0

ESM 9.6 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			300
Annual Indicator	100	340	340
Numerator			
Denominator			
Data Source	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2020	2021
Annual Objective			78.8
Annual Indicator	76.7	78.1	81.1
Numerator	692,413	712,908	743,827
Denominator	903,273	912,249	917,210
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	81.0	82.0	83.0	84.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			35
Annual Indicator	32.2	35	41.7
Numerator			281,760
Denominator			675,247
Data Source	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	53.0	56.0	59.0

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 19.0%.	
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 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit	Active
ESM 9.6 - 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 65.0%.

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.

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

Annual Report FY21:

The performance measure was not achieved. The Performance Objective was 23.0% and the Annual Indicator was 24.4%.

Program Activities:

During FY21, the Family & Youth Outreach Program (FYOP), the Violence Injury Prevention (VIPP) and Healthy Environments Active Living (HEAL) Program, continued implementing strategies to decrease bullying of adolescents. Physical aggression can be common among toddlers, and most children learn alternatives to using violence to solve problems. However, children with higher risk factors can continue to be aggressive, and if their problematic behaviors are not addressed their aggression can persist and increase. Individual and interpersonal risks for perpetrating violence include impulsiveness, youth substance use, antisocial or aggressive beliefs and attitudes, low levels of school achievement, weak connection to school, experiencing child abuse and neglect, exposure to violence in the home or community, involvement with delinquent peers or gangs, lack of appropriate supervision, parental substance abuse, and parental or caregiver use of harsh or inconsistent discipline.

Our strategies are intended to reduce the risk factors known to influence bullying behavior as well as other types of youth violence. Community factors, such as residential instability, crowded housing, density of alcohol-related businesses, poor economic growth or stability, unemployment, concentrated poverty, neighborhood violence and crime, lack of positive relationships among residents, and views that drug use and violence are acceptable behaviors can also contribute to bullying. FYOP, VIPP and HEAL continue to provide training and resources to communities through the following strategies: Bystander Intervention training; gatekeeper training for suicide prevention; increasing physical activity; Wyman Teen Outreach Program; increasing the percentage of Earned Income Tax Credit filers among eligible Utahns; and increasing connectedness in families, schools, and community.

Accomplishments / Successes:

FYOP, VIPP, and HEAL strategies are intended to reduce the risk factors and social determinants of health known to influence bullying behavior. FYOP used the Wyman Teen Outreach Program, which is designed to build teens' educational success, life and leadership skills, and healthy behaviors and relationships. The Wyman Teen Outreach Program® is an evidence-based positive youth development program that allows youth to develop a positive sense of self, positive connections with others, and practice social emotional learning (SEL) skills through lessons, a weekly supportive peer group environment, and community service learning. For FY22, three local partners (Salt Lake County, Weber-Morgan, and TriCounty Health Departments) implemented the program for the entire 2021-2022 school year at ten sites, including schools and other youth-serving organizations. Two sites served refugee youth exclusively. 162 youth participated and over 450 hours of community service were completed by the end of the school year. Data shows improvements in participants' SEL skills, an increase in positive connections with peers and the community, as well as an overall experience of the Wyman Teen Outreach Program as a safe and supportive environment. All these outcomes ultimately lead to more positive and healthy interactions with others, including decreased bullying behaviors.

Teen Speak is a program that equips parents and other trusted adults with communication skills they can use to overcome the common challenges of connecting with a teen. Better communication with teens helps to create a trusted relationship that supports their positive decision-making. Teen Speak is built on sound, science-based techniques and strategies that are taught through a practical, real-world approach.

The HEAL program implements the following strategies: Increasing physical activity shows a positive impact on

adolescent perceived health, health-risk behaviors and mental health. Increased levels of physical activity can play a vital role in adolescent health promotion and schools are an excellent setting to promote and provide physical activity spaces and to encourage students to be more physically active.

Studies show that increasing family connectedness through eating family meals together enhances the health and well-being of adolescents. Family meals are also an opportunity to cultivate communication skills, improve family relationships, bolster self-esteem, decrease obesity rates, and develop life-long healthy eating and lifestyle habits.

The VIPP Bystander Intervention training teaches positive actions to prevent bullying and to address it while it is happening or after it occurs. We are currently adapting the Bystander Intervention training to be provided virtually. We hope this will increase the reach of the program as it has been difficult for local health departments to provide this training in person.

Gatekeeper training for suicide prevention teaches people to identify individuals who are showing warning signs of suicide risk and help these individuals get the services they need. VIPP provides Question, Persuade, Refer (QPR) and Mental Health First Aid training for communities and partners. In FY21, VIPP reached 398 individuals with gatekeeper training.

Concentrated poverty is a known risk factor for bullying, and each year Earned Income Tax Credits (EITC) lift over 60,000 Utahns (half of them children) out of poverty. However, 24.7% of eligible Utahns did not claim the EITC which is higher than the national percentage of 22%. Data show that eligible Utahns of Hispanic Ethnicity had a lower rate of EITC filings than other races/ethnicities in Utah. In response, in FY21, VIPP's EITC awareness activities focused on mediums shown to reach the Latinx community. Unfortunately, data from the IRS on EITC filings has not been updated since 2018 so we can't report on any change in filings.

Other efforts being implemented that are shown to reduce risk factors for bullying are: Increasing connectedness in families, schools, and community. VIPP has developed a "Connectedness Toolkit" for schools to help them implement activities that will increase school cohesiveness and connectedness.

Increasing trauma informed approaches in schools and community organizations working with families can also reduce bullying. VIPP contracts with Trauma Informed Utah to provide technical assistance and training to organizations on implementation of a trauma informed approach. VIPP has conducted an assessment and revised policies in line with the trauma-informed approach.

Increasing family-friendly work policies: VIPP has contracted with the Kem C. Gardner Policy Institute at the University of Utah to conduct a survey of families on family friendly work-policies. Additionally, VIPP is partnering with the Salt Lake Chamber of Commerce to utilize the survey to develop a strategy for increasing family friendly policies among its member companies. Decreasing child abuse and neglect through the Essentials for Childhood program: VIPP facilitates the Utah Coalition for Protecting Childhood, UCPC has released a comprehensive strategic plan for reducing child abuse and neglect through the prevention of risk factors and the promotion of protective factors.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-9 (July 1st 2020 - June 30th, 2021):

- Many Spanish-speaking, working, but low-income individuals and families don't know they are eligible for a tax credit, or that one even exists. The Earned Income Tax Credit campaign targeted the Latinx community to increase awareness of free help available with filing taxes to get the EITC. From 2/22/21 - 5/17/21, Spanish Spots aired more than 450 times on Telemundo: https://youtu.be/igbw5ARfjPg https://youtu.be/qzFpwRNssng https://youtu.be/Uc9Mf4xmhqg.
- In order to provide the Bystander Intervention training to more Utahns, VIPP is partnering with Bonneville Communications to develop virtual training for local health departments and other partners.

- Gatekeeper training for suicide prevention teaches people to identify individuals who are showing warning signs of suicide risk and help these individuals get the services they need. VIPP provides Question, Persuade, Refer (QPR) and Mental Health First Aid training for communities and partners. In FY21, VIPP reached 398 individuals with gatekeeper training.

Challenges / Gaps / Disparities Report:

COVID-19 has continued to present challenges in implementing strategies to students and youth-serving organizations. Many schools have been operating on hybrid or virtual learning platforms and partners have had fewer opportunities to reach these individuals with training and education. Despite these challenges, FYOP, VIPP and HEAL continued to provide training and resources to communities through these strategies.

In terms of victimization there are disparities among those in 11th grade and under. Students in grades 9, 10, and 11 were more likely than those in the 12th grade to be a victim of bullying. Females were much more likely than males to report being bullied (29% and 19.9% respectively). Students who identified as Lesbian, Gay, or Bisexual or who are not sure of their sexual orientation were much more likely than students who identify as straight/heterosexual (36.3% for LGB identifying students and 22.6% for straight identifying students)

Agency Capacity/Family Partnerships/Collaboration:

By targeting the risk and protective factors for bullying, the approaches to prevention are designed to improve outcomes for multiple populations. This is done through collaboration of government, businesses, and community organizations to align efforts justly, equitably, and positively to impact the social determinants of health. This approach requires cooperation across disciplines and sectors. We will continue to partner with the Injury Community Implementation Board and the Utah Coalition for the Protection of Childhood to continue to design and implement cross-collaborating strategies.

Report of ESMs related to NPM-9

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

Goal/Objective:

Implement the training with 500 Utah parents in 5 years. Parents will learn and implement one strategy learned through Teen Speak

Significance of ESM:

Teen Speak is a communications program (total 4 hours: including self-study and in-person presentation) that provides parents a menu of strategies they can use to improve communication with their youth. This evidence-based program utilizes motivational interviewing principles to support parents and trusted adults in improving communication skills and strengthening youth-adult relationships. Data suggests that teens who can identify a strong relationship with at least one trusted adult are less likely to use drugs or alcohol, engage in sexual activity, or attempt suicide.

Notes & Comments:

ESM 9.1 Progress Summary:

Between July 1, 2021 - June 30, 2022, the Family & Youth Outreach Program (FYOP) team held 24 virtual Teen Speak classes, with 160 parents and youth-serving professionals attending. FYOP also produced one Fostering Communications podcast (https://utahfostercare.org/feed/podcast) to promote the program, in collaboration with Utah Foster Care. The podcast episode reached approximately 150 foster parents.

94% of *Teen Speak* participants indicated on a post survey that the workshop provided them with new communication skills that they will use in the future. Additionally, participants indicated that their overall communication skills, sense of self-efficacy when talking with their teen, and quality of their relationship with their teen all improved as a result of the intervention.

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:

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.

Notes & Comments:

ESM 9.2 Progress Summary:

Strengthening youth's skills is an important component of a comprehensive approach to preventing youth violence such as bullying. The likelihood of violence increases when youth have under-developed or ineffective skills in the areas of communication, problem-solving, conflict resolution and management, empathy, impulse control, and emotional regulation and management. Skill-development has an extensive and robust research base, which shows building youth's interpersonal, emotional, and behavioral skills can help reduce both youth violence perpetration and victimization. Enhancing these skills can also impact risk or protective factors for youth violence, such as substance use and academic success. These life skills can help youth increase their self-awareness, accuracy in understanding social situations, ability to avoid risky situations and behaviors, ability to intervene when necessary and capacity to resolve conflict without violence. 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. In one bystander program a longitudinal evaluation found after the second year of implementation, participants had a 31% decrease in bullying and victimization, 36% decrease in non-bullying aggression, and 72% decrease in harmful bystander behavior. A large-scale replication evaluation found significantly lower levels of physical bullying perpetration among participants relative to controls, and significant increases in school anti-bullying policies, positive school climate, and positive bystander behavior.

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 of options throughout the school day.

Significance of ESM:

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 9.3 Progress Summary:

Local Health Departments provided support to local education agencies to get students physically active through Safe Routes to School (SR2S) activities. These include monthly Walk and Roll Challenge, Walk to School Day, offering SR2S K-3 and 4-6 assemblies (virtually or in person), strengthening SR2S policies and maps, and/or assisting in applying for SR2S grant funding to improve infrastructure.

Local Health Department staff continue to have high turnover and difficult to continue training new staff throughout the year. School staff were also cautious as to who could enter school buildings at the beginning of the year. Local Health Departments were able to communicate and offer services virtually.

State staff worked with the Utah State Board of Education to create a Model Wellness Policy for local education agencies to follow when creating new policies.

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 weekly TOP peer meetings and participation in 20 hours of community service learning.

Significance of ESM:

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 9.4 Progress Summary:

The Wyman Teen Outreach Program® (TOP®) is an evidence-based positive youth development program that allows youth to develop a positive sense of self, positive connections with others, and practice social emotional learning (SEL) skills through lessons, a weekly supportive peer group environment, and community service learning.

For FY22, three local partners (Salt Lake County, Weber-Morgan, and TriCounty Health Departments) implemented the program for the entire 2021-2022 school year at ten sites, including schools and other youth-serving organizations. Two sites served refugee youth exclusively. 162 youth participated and over 450 hours of community service are expected to be completed by the end of the school year.

Data shows improvements in participants' SEL skills, an increase in positive connections with peers and the community, as well as an overall experience of (TOP®) as a safe and supportive environment. All these outcomes ultimately lead to more positive and healthy interactions with others, including decreased bullying behaviors.

ESM 9.5 - Strengthen Household Economic Security through an uptick in files for the Earned Income Tax Credit.

Goal/Objective:

Increase the number of Utahns filing for the Federal Earned Income Tax Credit

Significance of ESM:

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 9.5 Progress Summary:

Every year, 1 in 4 eligible Utahns fails to claim the earned income tax credit. In 2019, 171,000 tax filers received the credit, while another 57,000 eligible Utahns did not apply for the credit. Last year, the average credit for a Utah tax filer with children was $2,130. For single people without children earning less than $15,000, the average tax credit was $300. The Violence and Injury Prevention Program has teamed up with the Department of Workforce Services, Utah Tax Help, and the Utah Coalition for Protecting Childhood to raise awareness of the credit among Utahns.

ESM 9.6 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)

Goal/Objective:

Utahns are trained to recognize bullying and suicide ideation and have resources to help them

Significance of ESM:

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, 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 9.6 Progress Summary:

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, 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. The Violence and Injury Prevention Program is a member of the Utah Suicide Prevention Coalition and will continue to use partners from that coalition to advertise availability of QPR training.

State Priority Area: School Lunch

SPM-3: Percent of students enrolled in free or reduced price lunch programs

Annual Report FY21:

Program Activities:

The Performance Measure was achieved. The Performance Objective was 35.0% and the Annual Indicator was 41.7%.

As a response to the novel coronavirus pandemic, USDA Food and Nutrition Service, state agencies, public and private schools, community programs, and advocacy groups worked together to continue program operations that provided meals, snacks, fresh fruits, and vegetables to children throughout Utah.

The Families First Coronavirus Response Act of 2020 (FFCRA, Pub. L. 116-127), enacted March 18, 2020, included a general provision that allows the Department of Agriculture to approve state plans to provide temporary emergency Supplemental Nutrition Assistance Program (SNAP) assistance to households with children who would otherwise receive free or reduced price meals, if not for their schools being closed due to the COVID-19 emergency (also known as Pandemic EBT, or P-EBT). The authority for P-EBT under FFCRA expired on September 30, 2020. The Continuing Appropriations Act, 2021 and Other Extensions Act (Pub. L. 116-159), enacted October 1, 2020, extended the authority for P-EBT through September 30, 2021. This legislation also expanded the program to include childcare facilities affected by the closures and schools with reduced attendance hours. The Consolidated Appropriations Act, 2021 (Pub. L. 116-260), enacted December 27, 2020, provided additional eligibility requirements and state flexibility for both school and childcare components of this program. The American Rescue Plan Act of 2021 (ARPA, Pub. L. 117-2) enacted on March 11, made several significant changes to P-EBT. Among these changes is the extension of P-EBT to the summer of 2021, school year 2021-2022, and summer 2022.

Local Health Departments helped promote school meals by partnering with community organizations such as WIC, DWS, and school districts to provide families information that all students 18 years of age and younger would eat free of charge during the school year. The USDA extended the free meal waiver until the end of the 21-22 school year. Local Health Departments also provided materials, resources and support to encourage students to eat school meals during national school breakfast and lunch week. Many of the health educators are new. Building this relationship has helped strengthen the relationship between the health department and schools. The state and local health departments continue to work with schools to strengthen local wellness policy. WellSAT is an evaluation tool used to facilitate the strength and comprehensive language around school meals. WellSAT scoring reflects best practices. The purpose of using this tool is to identify strengths and weaknesses in the policy.

Accomplishments / Successes:

The USDA Food and Nutrition Service (FNS) issued several nationwide waivers and state waiver requests as a response to the COVID-19. USDA-FNS issued 80 nationwide waivers specific to Child Nutrition Programs between July 2020 and June 2021. Utah chose to opt into all USDA waivers available. The use of USDA waivers allowed all program sponsors with eligible sites to provide meals at no charge for children aged 18 and under from July 2020 through June 2022. Local health departments provided technical assistance and support to local education agencies in a variety of ways during the 21-22 school year.

Many activities included support with the COVID-19 response such as testing, contact tracing, vaccines, and many other tasks. Local Health Departments worked with families to educate them about services and benefits that provided resources to help support hardship during this time. Many provided information regarding free breakfast and lunch for the school year to all students. The Utah State Board of Education provided 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 throughout the school year. Town halls were implemented during the year to help provide technical assistance to child nutrition directors. These were held virtually every month.

Many of our local health departments work with the Seamless Summer Option (SSO) program. This is a component of the National School Lunch Program (NSLP). The purpose of SSO is to ensure that children continue to receive nutritious meals when school is not in session. These sites may be established in the same types of locations such as community centers, libraries, parks, pools, and schools. Sites must be located in low-income areas and sponsors can be reimbursed for up to two meal types per day.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-3 (Oct 1st, 2020 - September 30th, 2021):

- The Start Smart Utah Program was enacted following the passing of House Bill 222 to promote and expand the availability of school breakfast for Utah's children. Start Smart Utah requires schools participating in the National School Lunch Program to offer a breakfast program. House Bill 016 amended Utah Code to expand the use of state funds, which may be used to support breakfast programs. The Start Smart website https://startsmartutah.org/ was created by a variety of partners.
- Local Health Departments (LHDs) provided support and resources to Local Education Agencies to help increase the awareness and participation of sponsored sites who offered seamless summer options (SSO). LHD educated the public about these services by providing information through school newsletters, social media and collaborating with other county programs.
- The Utah Breakfast Expansion Team provided a breakfast conference to Local Education Agencies (LEAs). Breakout sessions included breakfast cycle menus, engaging with community partners, and alternative breakfast models. LEAs were given the opportunity to provide guidance from the Utah State Board of Education Child Nutrition Program and support from the HEAL program.

Challenges / Gaps / Disparities Report:

The COVID-19 pandemic resulted in school closures and contingencies across the U.S. that limited access to school meals for students. While some schools attempted to provide alternative meal access points where students or parents could pick up meals, many students—especially those in low-income households—lacked adequate transportation to these access points. Thus, physical proximity to meal access points was particularly important during the pandemic.

Local Education Agencies (LEA) and schools also were faced with procurement, staffing, and substitute challenges and barriers. Due to the increase of breakfast and lunch programs many child nutrition staff felt the overwhelming burden of increased demands. Although providing free breakfast and lunch was needed during the pandemic the future school years will return to normal and free universal meals will no longer be available to all families starting in the 22-23 school year. This means that families who qualify for this service must apply and provide necessary documentation. This process starts as early as July 1st. Staffing was a huge challenge for the child nutrition program. There were many LEAs that had multiple positions available during the school year. It was difficult to hire and sustain employees as well as provide substitutes for these jobs. This will be an ongoing challenge as we move away from the pandemic. These positions are not enticing and comparable in wages.

Agency Capacity / Collaboration Report:

The COVID-19 response has been a challenge however, some underlining positive outcomes during this time is the

relationship and communication with families in the communities. Local Health Departments were able to interact with the public and understand where there are gaps and needs to help better align programs and services to the community. Building upon the relationship that the local health departments have established with the local education agencies and schools will help position themselves to create breakfast and lunch models that fit the communities' needs.

Priority Area: Mental Health

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

Annual Plan for FY23:

During FY23, the Violence Injury Prevention (VIPP), the Office of Maternal and Child Health (MCH), and the Healthy Environments Active Living (HEAL) Program, will continue to implement strategies to decrease bullying of adolescents in Utah by targeting known risk factors. Risk factors including individual and interpersonal risks for perpetrating violence include impulsiveness, youth substance use, antisocial or aggressive beliefs and attitudes, low levels of school achievement, weak connection to school, experiencing child abuse and neglect, exposure to violence in the home or community, involvement with delinquent peers or gangs, lack of appropriate supervision, parental substance abuse, and parental or caregiver use of harsh or inconsistent discipline.

Our strategies are intended to reduce the risk factors known to influence bullying behavior as well as other types of youth violence. Community factors, or social determinants of health, such as residential instability, crowded housing, poor economic growth or stability, unemployment, concentrated poverty, neighborhood violence and crime, lack of positive relationships among residents, and views that drug use and violence are acceptable behaviors can also contribute to bullying. Addressing social determinants of health is a primary approach to achieving health equity.

VIPP, MCH and HEAL are committed to applying a healthy equity lens to all work through implementation of the Health Equity Framework. The effort will encompass the following:

1. Identify and prioritize health disparities through data and stakeholder feedback.
2. Identify structural and social determinants of health through data and stakeholder feedback.
3. Choose evidence-based or evidence informed health equity strategies to implement that include stakeholders with lived experience.
4. Implement strategic practices to advance health equity.
5. Use evaluation to improve the quality of the strategies being implemented. Building internal capacity and using the framework to guide strategic planning will ensure continuous quality improvement of these strategies.

Proposed Activities:

- Offer at least one virtual Teen Speak class per month to approximately 120 parents and youth-serving professionals. This evidence-based program utilizes motivational interviewing principles to support parents and trusted adults in improving communication skills and strengthening youth-adult relationships. Data suggests that teens who can identify a strong relationship with at least one trusted adult are less likely to use drugs or alcohol, engage in sexual activity, or attempt suicide.

- Increase the number of adolescents receiving a Bystander Intervention program through virtual implementation of training. 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.
- Increase the number of students who are active for at least 60 minutes a day, through a variety of options, throughout the school day. 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.
- Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit (EITC) through a targeted awareness program. 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.
- Increase the number of Utahns who have been trained in a suicide gatekeeper training.
- While the Question, Persuade, Refer (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.

State Priority Area: School Lunch

SPM-3: Percent of students enrolled in free or reduced price lunch programs

Annual Plan FY23:

Local Health Departments (LHDs) will continue to work with local education agencies (LEAs) and the child nutrition program to improve the Local Wellness Policy (LWP). LEAs are on a 5 year cycle to review the Child Nutrition Program Administrative Review. There are about 140 LEA sites that participate in this review. Each review lasts about 4 1/2 months. The LEA can help support the administrative review by evaluating the LWP and updating the requirements to the policy for each LEA.

Schools who have 50% free or reduced percentages will need to implement an alternative breakfast model by the end of the 22-23 school year. LHDs will help promote, encourage, and provide technical assistance to schools who are required to implement breakfast. We will participate in community coalitions that support school meals such as breakfast and lunch. These could be Action for Healthy Kids, Utah Breakfast Expansion Team and Get Healthy Utah. Provide opportunities for educators, families, and communities to learn more about services and programs that support healthy school meals by participating in professional development opportunities and community activities. Continue to work with the child nutrition program to build services and programs that enhance the school meals programs.

- Provide training to local health department health educators on how to use WellSAT, a quantitative assessment tool to help improve school wellness policies. Increase the number of local health departments that provide support to LEA local wellness policies. Coordinate with the Utah State Board of Education Child Nutrition Specialist to help support the LEA's wellness policy section during the Child Nutrition Programs administrative review.
- Collaborate with the State Board of Education Child Nutrition Program to help educate families that meet the qualifications for free and reduced school meals to apply for services. Work with other state agencies to help simplify this process.
- Ensure that schools who are required to implement an alternative breakfast model during the 22-23 school year have the tools and resources to do so successfully. Educate local health departments about Start Smart.

The following NPM/SPMs are addressed in the Child Domain section.

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

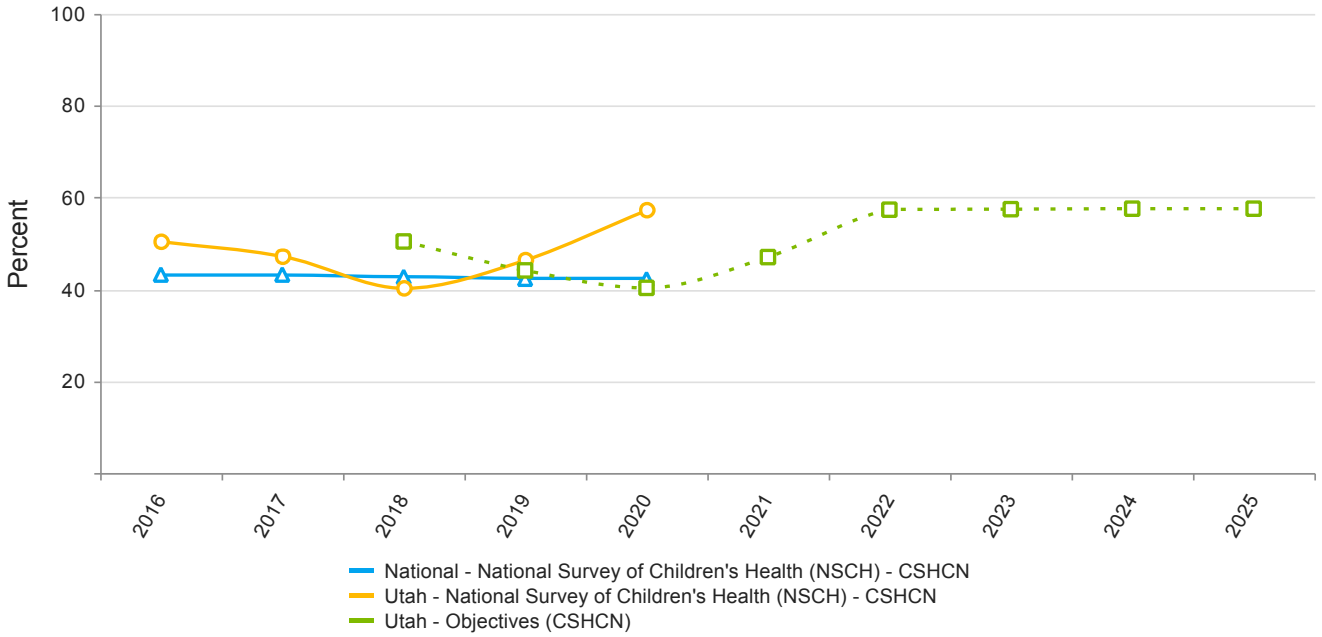
SPM-2: *Percent of family members who live in the household that ate a meal together 4 or more days per week.*

Children with Special Health Care Needs

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		50.4	44.1	40.3	47
Annual Indicator	50.4	47.2	40.2	46.4	57.2
Numerator	75,090	68,219	59,263	69,395	83,681
Denominator	148,990	144,415	147,327	149,671	146,181
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	57.3	57.4	57.5	57.5

Evidence-Based or –Informed Strategy Measures

ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Pre- and Post-training survey	Pre- and Post-training survey	Pre- and Post-training survey
Data Source Year	2020	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional

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	2020	2021
Annual Objective			94.5
Annual Indicator	0	94	97
Numerator		614	426
Denominator		653	439
Data Source	CSHCN EMR or comprehensive database	CSHCN Electronic Medical Record	CSHCN EMR or comprehensive database
Data Source Year	2020	SFY 2021	2021
Provisional or Final ?	Provisional	Final	Final

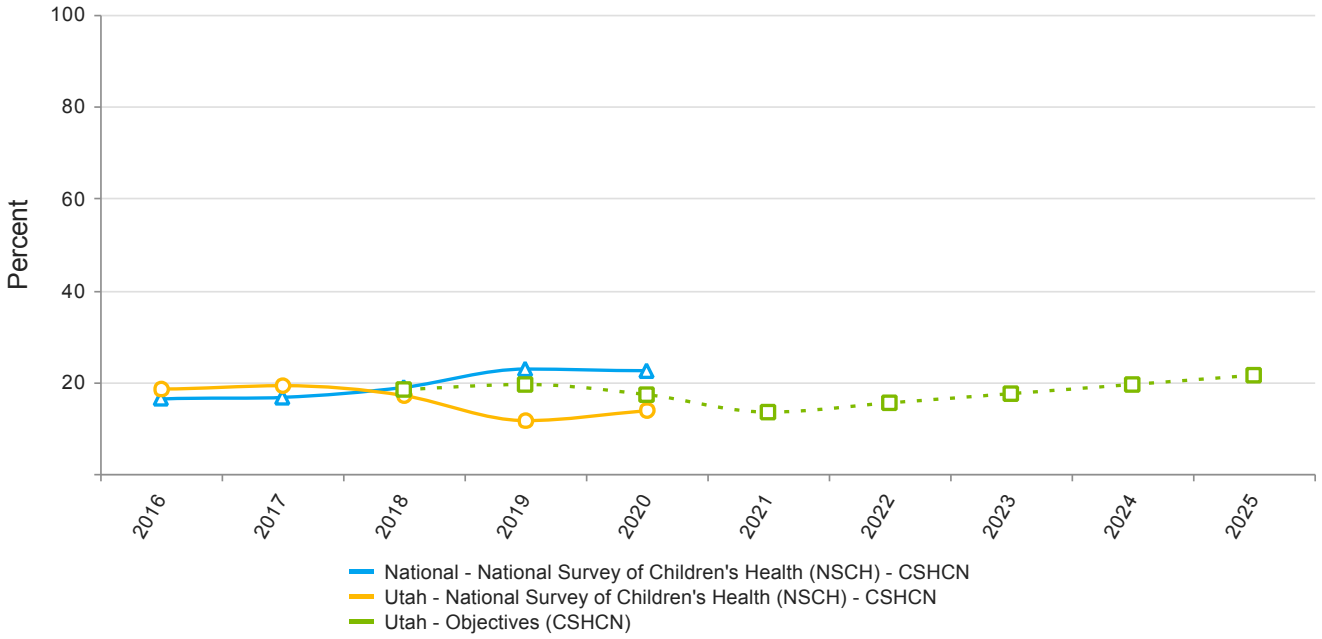
Annual Objectives				
	2022	2023	2024	2025
Annual Objective	97.0	97.5	98.0	98.0

ESM 11.4 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of the medical home.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	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 to prepare for the transition 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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		18.4	19.5	17.3	13.5
Annual Indicator	18.4	19.3	17.1	11.5	14.0
Numerator	11,791	12,760	13,378	8,906	10,487
Denominator	64,109	66,028	78,194	77,434	75,107
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.5	17.5	19.5	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	2020	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Stakeholder work group survey.	Stakeholder work group survey.	Stakeholder work group survey
Data Source Year	2020	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2020	2021
Annual Objective			63
Annual Indicator	0	62.4	74
Numerator		552	347
Denominator		884	469
Data Source	Stakeholder work group survey	ISP electronic medical record, Utah Parent Center	ISP electronic medical record, Utah Parent Center
Data Source Year	2020	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	73.9	75.0	77.0	79.0

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	2020	2021
Annual Objective			0
Annual Indicator	0	0	66.7
Numerator			8
Denominator			12
Data Source	Stakeholder work group survey for transition	Stakeholder work group survey for transition	Stakeholder work group survey for transition
Data Source Year	2020	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.0	72.0	75.0	80.0

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 57.7%.
Strategies
1. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah.
2. CSHCN Bureau creates a stakeholder workgroup to organize and unify existing education materials to market the importance of medical home (primary care, dental, behavioral/mental health).
3. Work group determine best practices and educates the public on the importance of medical home.
4. Work group evaluates and selects a database to track care coordination efforts.
5. Workgroup collaborates and determines collection methods to scan State on providers who utilize or desire to utilize telehealth, and assess best practices, barriers, and capacity.
6. Workgroup reviews and utilizes Baby Watch Early Intervention Program tele-intervention cost study data to assess the benefits and challenges with utilizing virtual platforms for services.
7. Workgroup encourages providers to incorporate the seven components of a medical home after being trained through online learning modules or other educational media.
8. Educate pediatric medical and service providers through the UCCCN and Project Echo on the importance of the components of a medical home and utilize UCCCN and post-training survey data to determine how participating practices are increasing medical home capacity.
9. Promote hybrid telehealth/in-person service delivery model to meet the needs of the family.
10. ISP to track families served who do not have a medical home, are referred to a primary care provider and successfully establish care.
11. Survey families who receive care from UCCCN member practices to evaluate status of and satisfaction with medical home.

ESMs	Status
ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.	Inactive
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 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of the 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 unable to obtain needed health care in the past 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 to prepare for the transition 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 23.5%.

Strategies

1. CSHCN Bureau to create a stakeholder workgroup to organize and unify existing educational materials and market the 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. Workgroup 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

NPM-11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Annual Report FY21:

This Performance Measure was achieved. The Performance Objective was 47.0 and the Annual Indicator was 57.2.

Program Activities:

In FY21, Integrated Services Program (ISP) convened a Children with Special Health Care Needs (CSHCN) General Stakeholder Group that self-divided into two distinct committees: Medical Home Committee and Transition to Adult Healthcare. With statewide transition work underway with major players, the CSHCN Stakeholder Group encouraged efforts on transition work and suggested postponing work on medical home until after the end of the 2020 calendar year.

In February 2021 the Medical Home Committee met monthly to align work with that being done by the Transition subcommittees with a preliminary plan to: (1) organize and unite existing education materials to market to providers and families on importance of medical home; (2) continually research best practices to educate the public on the importance of the medical home; (3) continue to evaluate and identify possibilities of a database to track care coordination efforts for CSHCN in conjunction with statewide efforts to unify and facilitate patient service delivery and interagency communication; (4) scan the state for status on pediatric medical providers and specialists who utilize or desire to utilize telehealth and create an inventory of providers to use as a referral resource; (5) provide ongoing outreach and follow-up to encourage providers who have been trained to continue to incorporate the components of medical home; (6) market to and educate pediatric providers on care coordination support available to them through the Integrated Services Program to enhance their Medical Home.

ISP continued to fund both the Utah Children's Care Coordination Network (UCCCN) and a portion of Utah’s costs to maintain and upgrade the Medical Home Portal. Additionally, ISP collaborated with their staff and family representatives to review and contribute to content and Spanish translation of resources contained on the Portal. ISP staff, including care coordinators, contracted through four local health departments, actively participated in the UCCCN monthly meetings and contributed to statewide care coordination and problem solving through the Network's list serve.

The ISP program manager meets monthly with UCCCN staff to plan and coordinate the yearly agenda and monthly meetings. ISP staff participate in weekly care coordination activities with the University of Utah Developmental Assessment Clinics through their patient case conferences. The CSHCN Bureau meets regularly with the Home Visiting Services and Support Program and the Early Childhood Utah Program (both in the Bureau of MCH), the Family to Family Health Information Center; Utah Parent Center; Help Me Grow, the Utah Oral Health Coalition; the Division of Child and Family Health Services; Child Protective Services; and the Division of Substance Abuse and Mental Health.

Accomplishments / Successes:

In FY21, Utah’s Bureau of Children with Special Health Care Needs (CSHCN) including the Integrated Services Program (ISP), found itself enmeshed in the COVID-19 pandemic and worked with both internal and external partners and stakeholders to adapt to an environment shaped by policy and procedure that changed almost daily. ISP was able to adapt wide care coordination efforts and its small clinical services program to a telehealth/teleconsultation environment while ensuring COVID-infection control policies were implemented, modeled and followed by state staff to safeguard patients and local and rural staff.

ISP, CSHCN, and the Department implemented protocols for virtual visits, how to obtain consent and release of information, documentation of these permissions, and researched nationwide best practices on these legal documents, vetting them with legal counsel with the State's Attorneys General. In February 2021, the Medical Home Committee began to: (1) meet monthly to review the June 2020 Statewide needs assessment; (2) evaluate work that had taken place with the Transition to Adult Healthcare Subcommittees and emulate best practices determined therein; (3) evaluate closed-loop referral systems, both commercial and proprietary; (4) determine how the Utah Children's Care Coordination Network (UCCCN) could be leveraged to promote the medical home and continue to provide ongoing training to care coordinators and practice managers; (5) collaborate with the Medical Home Portal to promote care coordination, care planning, shared resources, and peer to peer support; (6) evaluate the use of telehealth across the state as a means of enhancing the medical home model; and (7) explore training options for providers and practices on enhancing the medical home.

The CSHCN Bureau was the sub-recipient of a HRSA American Rescue Plan Act grant administered through the Association of Maternal and Child Health Programs (AMCHP) through which the Early Hearing Detection and Intervention Program (EHDI) purchased and placed audiology equipment in rural health districts to allow for remote testing and newborn hearing follow up; and ISP purchased Chromebooks and cellular hotspots to allow families with limited access to technology to more readily participate in telehealth and tele-evaluation activities. EHDI trained several of the ISP care coordinators in both the rural health districts and along the populous Wasatch Front, how to place probes and utilize equipment so that remote EHDI audiologists could perform screening and follow-up testing. The ISP team, including the care coordinators at the local health departments, provided 1,889 care coordination encounters; 310 clinical encounters with the nurse practitioner, speech pathologist, and psychologist, to 439 unique patients.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-11 (July 1st, 2020 - June 30th 2021):

- Beginning in February 2021, the Medical Home Committee met monthly to evaluate medical home standards, curricula, databases, care coordination efforts, marketing, and educational efforts for the public, medical, and service providers; and to formulate activities to promote the medical home.
- The CSHCN Bureau adapted policies, procedures, and practices to provide evaluation, assessment, and care in a safe and efficient telehealth environment.
- The CSHCN Bureau was the sub-recipient of a HRSA grant through AMCHP that allowed placement of audiology equipment in rural sites for tele-audiology evaluation; and purchase and placement of Chromebooks and cellular hotspots in rural and underserved urban sites to encourage the use of telehealth where families have limited access to these technologies.

Challenges / Gaps / Disparities Report:

Challenges:

FY21 COVID-19 challenges prevailed. Although CSHCN programs were able to adapt protocols and procedures to function in a locked-down environment, many families were reluctant to participate in home programming activities and telehealth evaluation and assessment because they were in survival mode. Families often found it difficult to fit in other types of visits, including evaluation and diagnosis, while simultaneously juggling on-line classrooms for their children. Many parents were working from home, however, an even bigger challenge was for those who were not: daycare and support services to help families take care of children while they worked made daily living difficult. An overworked and understaffed healthcare workforce also contributed to a lack of available services in the community.

Within the ISP team, many of the care coordinators at the four local health departments with which we have contracts, are also public health nurses. They were pulled away to work on COVID-related activities including surveillance,

tracking, contact tracking, immunization and coverage for other public health nurses and workers who were either sick or quarantined with the virus. As such, some of our medical home work and CSHCN outreach work took a back seat to the pandemic. During this time, three of four local health departments either lost or transferred their CSHCN care coordinators to other public health programs. The hiring process could take weeks to months to replace the position. In the interim, ISP staff and other care coordinators at the local health departments covered the areas with missing staff. Once new staff was hired, ISP then had to train and orient them to bring them up to speed. Even with our best efforts and constant communication, long-distance coverage did not always contribute to the most effective continuity of care that we would have wanted. Ultimately, however, all positions are fully filled at this time.

Emerging Issues:

The increasing shortage of behavioral and mental health providers leaves the medical home less well-supported than it has been in the past. Medical providers are often at a loss as to where to refer their young patients with behavioral and mental health concerns. This shortage includes psychologists, licensed clinical social workers, behaviorists, and others who support families of children with special health care needs. Many behavioral and mental health agencies and practitioners have converted some of their services to telehealth, however, this doesn't completely compensate for the overall shortage of providers or lack of qualified and certified personnel in the workforce.

The COVID pandemic has been divisive along political lines. With conspiracy theory, misinformation, and public opinion across social media and the internet; vaccination, masking, and other public health safety measures have been politicized and families are often left wondering what to believe and whom to trust. Our public health programs appear now to be less trusted and more scrutinized than they have been in the past.

Another challenge presented during FY21 was the impending merger/consolidation between the Department of Health and the Department of Human Services in the state. Preliminary work was begun to address efficiencies and redundancies between the two agencies, however, a certain fear of the unknown had left the workforce unsure about programs, staffing, alignment, and job stability. The current CSHCN Bureau Director was appointed as the Director of the Division of Family Health in the new Department of Health and Human Services, which has helped to ease this transition and provide continuity between programs that had been in the Department of Health and those that had resided in Human Services, looking for ways to improve efficiency and remove redundancy.

In January 2022, the ISP's pediatric psychologist left for employment with another organization. After two months, and three geographically extensive job postings for the position, with no applicants, the position remains unfilled. This presents a challenge for families in our rural health districts who already experience a greater than normal dearth or qualified behavioral health providers within and reaching out to those communities.

Agency Capacity/Family Partnerships/Collaboration:

The CSHCN Bureau consistently seeks 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. The Bureau has enjoyed successful and cooperative collaborations with many community stakeholders and local health departments, including the four that partner with the ISP. 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 houses both Early Childhood Utah and the Home Visiting Programs, both of which affiliate and collaborate with many of the same players. The ISP manager meets weekly with the providers and staff at the University Developmental Assessment Center to provide guidance and support for the children with special health care needs they serve and accept referrals for care coordination within ISP. In addition, the ISP program manager

also serves as a member of the Early Childhood Utah Advisory Council, a multi-organizational council charged with unifying and enhancing the early childhood experience from birth through age 5.

In FY21, the CSHCN Bureau sought to partner with the Utah Department of Human Services, Intermountain Health Care, local health departments, University Department of Psychiatry, Utah Pediatric Partnership to Improve Healthcare Quality, Project ECHO, and The Children's Center to explore a pediatric mental health grant. Ultimately it was decided we would not apply, however, it started a dialogue about pediatric mental health among the partners that has continued.

Report of ESMs related to NPM-11

ESM 11.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.

Goal/Objective:

Families of CSHCN understand and can articulate the importance of seeking care within a medical home.

Significance of ESM 11.1:

Parents who understand the importance of the medical home may encourage their providers to incorporate the components of the medical home.

Notes & Comments:

Baseline was to have been established in Year One, however, the Medical Home Committee determined that this ESM really did not measure how well Utah is doing building and improving "medical homeness."

ESM 11.1 Progress Summary:

Year one was intended to establish a baseline, develop curriculum, marketing strategies, referral processes, follow-up, and QI/satisfaction survey methods. In FY23, this ESM will be discontinued. A new ESM has been added in which families are surveyed to measure how practices participating in the Utah Care Coordination Network are viewed for implementing and improving components of the medical home.

ESM 11.2 - 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:
Families are supported in their efforts to attain comprehensive care in a medical home through supported care coordination.

Significance of ESM 11.2:

Emphasizing care coordination has also been recognized by the Association of Maternal and Child Health Program's (AMCHP) 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.

Notes & Comments:

FY21 established a baseline. FY22 is the first year to report that baseline number.

ESM 11.2 Progress Summary:

All children and youth with special health care needs referred to the Integrated Services Program receive an intake assessment. Not all families require additional care coordination. However, the majority of families received care coordination follow-up after intake.

ESM 11.3 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of the medical home.

Goal/Objective:

As UCCCN practices are trained and improve medical home related services, satisfaction by patients and families will increase.

Significance of ESM 11.3:

The American Academy of Pediatric defines the medical home as:

- Accessible: Care is easy for the child and family to obtain, including geographic access and insurance accommodation.
- Family-centered: The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family.
- Continuous: The same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care.
- Comprehensive: Preventive, primary, and specialty care are provided to the child and family.
- Coordinated: A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.
- Compassionate: Genuine concern for the well-being of a child and family are emphasized and addressed.
- Culturally Effective: The family and child's culture, language, beliefs, and traditions are recognized, valued, and respected. Practices who implement all or strive to achieve at least some of these standards work towards fulfilling a "triple aim": improved patient experience, increased quality, and decreased costs.

Notes & Comments:

Surveys for this new ESM for FY23 have not yet been developed. FY23 will be a baseline year as survey instruments are developed and distributed among pilot practices, then more fully among participating UCCCN practices.

ESM 11.3 Progress Summary:

This is a new ESM for FY23. The partnerships within UCCCN shall be utilized to formulate effective survey instruments and to be distributed and analyzed among participating practices and families served by those practices.

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

Annual Report FY21:

Program Activities:

This Performance Measure was achieved. The Performance Objective was 13.5 and the Annual Indicator was 14.0.

The CSHCN Bureau convened a Stakeholder Workgroup to discuss both National Performance Measures (NPM-11 and NPM-12) aligned with the CSHCN population. The stakeholders selected whether to participate in either a Medical Home Committee or a Transition to Adult Healthcare Committee, with some choosing to serve on both. The Transition Committee initially met and those members then further agreed to participate in one or more of the following sub-committees: Curriculum; Marketing; Referral and Follow-up; and Quality Improvement and Patient Satisfaction. Each of these subcommittees met monthly.

These subcommittees worked diligently to review nationally vetted curricula; investigate marketing strategies that would be inclusive of youth and young adults of color, LGBTQIA+, rural versus urban, and intersectionality; survey instruments to evaluate readiness for transition and progress towards completing transition goals; ways to train and recruit practices that worked with both youth and young adults; researched and linked local resources appropriate for transition-aged youth; and discussed creating a "no wrong door approach" for transition to adult healthcare state wide.

The ISP program manager continued to work with the Utah Parent Center on the Transition University curriculum project which included a multi-faceted team of subject-matter experts from education, vocational rehabilitation, social services, and health. The CSHCN Bureau worked on a transition to adult healthcare website with links to local and statewide resources. ISP continued to fund the Utah Children's Care Coordination Network (UCCCN) which provides education to care coordinators, practice managers, and nurse care managers across the state on topics related to general pediatrics, community resources, and transition support and services.

The CSHCN Bureau Director and the ISP Program Manager participated in the Teen to Adult Healthcare Governance Committee monthly meetings sponsored by Intermountain Health Care. The ISP program manager participates on the Annual Healthcare Transition Summit planning committee with IHC, University of Utah, and Utah Parent Center Staff.

Accomplishments / Successes:

The Curriculum Subcommittee ultimately selected the Got Transition nationally vetted curriculum, and made some modifications to the readiness assessment and age-specific guidelines that were paired with local resources. The Marketing Subcommittee reviewed existing messaging on transition; created a small marketing piece; reviewed the 2020 MCH/CSHCN needs assessment; looked at inclusivity in marketing; reviewed multiple media platforms for distribution of messages. The QI/Satisfaction Subcommittee created several iterations of patient satisfaction surveys, then looked for the best platforms to share the survey with families. The Referral and Follow-up Committee looked at recruitment of practices and families and worked with IHC, the University, UCCCN, the Utah Parent Center to determine the best way to ensure families and youth were given a consistent message and provided with a uniform approach to transition, regardless of where they entered the system.

The Utah Parent Center completed their curriculum for Transition University and piloted the course with parent and youth audiences, albeit in a virtual environment. Feedback allowed for some modification to the curriculum. The Second Annual Health Transition Summit was held in a virtual environment and was considered a success by both speakers, guests, and participants. Several specialty clinics and pediatric practices implemented transition to adult

healthcare policies and/or procedures to standardize the transition process in their respective offices. These included: Spina Bifida Clinic; Colorectal Clinic; Hemophilia Clinic; Cystic Fibrosis Clinic; Wasatch Canyons Behavioral Health; University of Utah South Main Clinic; Wasatch Pediatrics; and Integrated Services Program.

Several clinics worked on transition planning with youth at various ages some of which included readiness assessment, and some clinics actually transitioned young adults to adult medicine: Integrated Services Program-completed 28 transition plans; Cystic Fibrosis- 300 patients ages 0-18 were seen, transition is discussed with all patients ages 15-18, with 16 patients successfully transferring to adult CF clinic; Colorectal Clinic-approximately 50 patients had transition plans, with 3 transitioning to adult medicine; Hemophilia Clinic-88 youth had transition plans, with 16 transitioning to adult hemophilia providers; University South Main Clinic-182 foster care youth with transition plans, 5 transitioning to adult medical providers, 589 youth with transition plans, with 20 transitioning to adult medical providers.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-12 (July 1st, 2020 - June 30th, 2021):

- The CSHCN Bureau successfully convened weekly transition to adult health care subcommittee meetings to establish curriculum, standards, quality improvement measures and patient satisfaction, referral mechanism, and marketing strategies.

- Multiple specialty and primary clinical practices established transition to adult healthcare policies and procedures to work toward creating a statewide standard.
- Baseline data from select clinics who were able to collect indicates approximately 937 youth had transition plans in place in FY21, with 60 young adults successfully transitioning to adult medical providers.

Challenges / Gaps / Disparities Report:

Challenges:

When working with families of youth in transition, transition to adult healthcare alone is not the only topic that needs to be addressed. ISP care coordinators and the program's transition specialist have noted that frequently these families have variable needs that run the full spectrum of services provided by our care coordinators.

Often parents are not able to pursue helping their child/youth/young adult reach healthcare transition milestones when they themselves face personal financial, medical, and behavioral/mental health challenges themselves. ISP care coordinators have worked with some of these parents to achieve stability first, before addressing healthcare transition. This may include applying for disability; finding stable housing; seeking employment; connecting with physical and mental healthcare; and other critical topics.

Many practices and service organizations, ISP included, have found it challenging to track transition-aged patients with existing EMR systems, and then systematically report on those patients. Hence, establishing continuity in reporting continues to be an ongoing discussion with our partners as many track their transition-aged youth on Excel spreadsheets and non-EMR databases. While much progress is being made on the pediatric side of things, much work remains to be done on the adult side of the equation. Many adult providers are reluctant to take on challenging patients with multiple physical challenges, intellectual disability including autism spectrum disorders, and technology-dependent young adults.

Emerging Issues: Through the consolidation of the Departments of Health and Human Services, the CSHCN Bureau and ISP are discovering other transition-related programs that exist within the new organizational structure. ISP is seeking to align and participate with these programs and serve on these committees to provide a more comprehensive service delivery model to our mutual families and patients. The Utah State Board of Education

(USBE) has convened a vocation/post-graduation heavily focused advisory committee to explore outcomes for youth within the special education system. ISP and other CSHCN staff serve on the advisory committee and work on various subcommittees to bring healthcare transition to the table and have it included in a comprehensive discussion and plan. Transition University through the Utah Parent Center has been offered virtually for several sessions, and has now been taken on the road for three live sessions that were funded by the USBE. These have been received favorably by both parents and youth.

Agency Capacity/Family Partnerships/Collaboration:

Collaborative partners included the Utah Parent Center, Utah Family Voices, Help Me Grow, Medicaid, Social Security Administration, Utah State University Center for Persons with Disabilities, Division of Services for People with Disabilities, Utah State Board of Education, Vocational Rehabilitation, Work Ability Utah, and the Utah Developmental Disability Council. These agencies work to support families and the community through outreach, training, mentoring, and services such as support for employment and continued education.

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 held virtual sessions of Transition University (TU) for both parents and youth in transition. The TU curriculum is comprehensive and includes topics such as guardianship, supported decision making, daily living skills, financial awareness and planning, medical transition, housing, employment, and post-high school education and training. ISP participated with two local school districts to provide information to families in transition at virtual transition and agency fairs sponsored by the districts during the height of COVID-19. ISP and the CSHCN Bureau participate with the Utah State Board of Education in their statewide transition work and serve on their advisory board and various sub-committees. This partnership was established through the Coordinating Council for Persons with Disabilities, a state established committee the CSHCN Bureau Director serves on, with their primary goal to coordinate state agencies' work. The CSHCN Bureau also actively works with Intermountain Health Care's Teen to Adult Healthcare Governance Committee that meets monthly to promote transition and recruit and train healthcare providers in a standardized transition curriculum.

Report of ESMs related to NPM-12

ESM 12.1 - Percent 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:

Youth and adolescents with active transition plans will be more likely to complete the steps for successful transition to adulthood.

Significance of ESM 12.1:

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: 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. 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.

Notes & Comments:

Year one established a curriculum, marketing strategy, referral and follow-up mechanisms, and QI/satisfaction

surveys. We have implemented an adapted-for-Utah Got Transition curriculum. Work continues as we create, vet, and implement a consistent statewide survey instrument and platform to measure positive progress toward healthcare transition goals and satisfaction with patient and family experience.

ESM 12.1 Progress Summary:

This was a new ESM for FY21. Robust partnerships have been fostered between ISP/CSHCN and several community partners including two hospital systems to continually assess, develop, market, and implement a universal process, statewide, for transition to adult medicine. A standard statewide survey has yet to be determined and implemented. Work will continue in FY23 to create, vet, and send to families/youth through a mobile platform.

ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.

Goal/Objective:
Youth with special health care needs will have an active and modifiable transition plan in place.

Significance of ESM 12.2:

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:

Notes & Comments:

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. FY21 numbers reflect a decrease in live interactions with families and youth at transition and agency fairs where transition planning is discussed and begun.

ESM 12.2 Progress Summary:

Transition planning numbers for FY2022 were based upon statistics provided by the Integrated Services Program (Utah Department of Health) and the Utah Parent Center/Utah Family Voices.

ESM 12.3 - Percent of providers trained in transition who created a transition policy for adolescents and youth in their practice.

Goal/Objective:

Providers trained on the importance of transition have an active transition policy in place.

Significance of ESM 12.3:

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.
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.

Notes & Comments:

Year one established a curriculum, marketing strategy, referral and follow-up mechanisms, and QI/satisfaction surveys. Provider training curriculum is being refined and will be published on the website, once vetted by

ISP/CSHCN and our community partners, for providers who are seeking to implement transition to adult medicine within their practices. This will be a universal and unified statewide curriculum. Year Two will establish baseline numbers of providers who have implemented the transition to adulthood policy and processes.

ESM 12.3 Progress Summary:

This was a new ESM for FY21. Robust partnerships have been fostered between ISP/CSHCN and several community partners including two hospital systems to continually assess, develop, market, and implement a universal process, statewide, for transition to adult medicine. Several Intermountain Health Care (IHC) clinics were trained in transition, along with a couple pediatric practices, and the Integrated Services Program.

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 transpire in parallel. The following programmatic activities also work to improve outcomes in this domain.

National Outcome Measures (NOM)

NOM 17.2: 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 CHARM system creates an electronic health record for children in Utah that 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. This record increases the effectiveness of child health care services by providing a secure confidential way for authorized health care programs and partners to share public health data and track the health status of children such as: newborn hearing, heel-stick, and critical congenital heart defect (CCHD) screening results, immunization status, referrals, and clinical services received.

CHARM supports the coordination of services the child has received by sharing accurate and real time data with programs and medical home providers that serve MCH and CSHCN populations statewide and in the rural areas of the state. The CHARM system has demonstrated 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 screening tests or referrals have or haven’t been done, and subsequently, 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 by 83% from the previous year, the number of web portal users that have access to immunization histories, and newborn hearing, heel-stick, and CCHD results. This increase was due to funding the CHARM Program received from a CMS HiTech HIT grant to hire an Outreach Coordinator to onboard Medicaid providers, Community Health Centers, other provider clinics, and health programs to use the CHARM Web Portal.

As stated in NOM 13, the CHARM Program 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 of 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 continues 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.

NOM 17.3: Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

The Autism Systems Development Program (ASDP) in the Bureau of CSHCN seeks to advance, educate and empower the lives of individuals affected by Autism Spectrum Disorder (ASD) in Utah by monitoring occurrence, reducing the age at first diagnosis, facilitating research, and providing education and outreach.

ASD prevalence and its dissemination to the public.

Accurate ASD prevalence estimates are critical for driving policy decisions and informing other MCH and CSHCN Programs on NPMs on care coordination and transition.

In Utah, ASD prevalence is measured by The Utah Registry of Autism and Developmental Disabilities (URADD). URADD, a joint effort between the Utah Department of Health and the University of Utah Department of Psychiatry, is a statewide, population-based surveillance system for autism spectrum disorder (ASD) and developmental disabilities (DD) and was established in 2002. In an effort to determine health disparities, URADD has developed ASD prevalence estimates by age and location (Urban, Rural and Frontier) and race/ethnicity.

Autism Spectrum Disorder Prevalence (Statewide)						
Age	Prevalence Estimate	Male	Female	Urban	Rural	Frontier
4	0.40%	0.59%	0.20%	0.46%	0.16%	0.06%
6	1.45%	2.23%	0.63%	1.50%	1.23%	0.83%
8	1.58%	2.49%	0.61%	1.60%	1.54%	**0.81%**
10	1.66%	2.51%	0.73%	1.67%	1.60%	0.85%
12	2.17%	3.26%	0.98%	2.28%	1.71%	1.17%
14	**2.55%**	3.84%	1.19%	2.65%	2.11%	1.44%
16	2.52%	3.89%	1.06%	2.59%	2.05%	1.79%
Data Source: The Utah Registry of Autism and Developmental Disabilities and the Public Health Indicator Based Information System (IBIS) at the Utah Department of Health.						
Urban = Cache, Davis, Salt Lake, Weber and Utah Rural = Box Elder, Carbon, Iron, Morgan, Sanpete, Sevier, Summit, Tooele, Uintah, Wasatch, Washington Frontier = Beaver, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, Rich, San Juan, Wayne						

Autism Spectrum Disorder - Race/Ethnicity						
Age	White	Hispanic	Asian	Black/ African American	American Indian/ Alaskan Native	"Other"
4	54%	22%	4%	2%	2%	1%
6	65%	18%	3%	1%	1%	1%
8	65%	17%	1%	2%	1%	1%
10	74%	14%	1%	2%	1%	1%
12	73%	13%	1%	2%	1%	1%
14	72%	11%	1%	2%	1%	1%
16	66%	11%	1%	1%	1%	0%

In September 2020, the Governor's Early Childhood Utah (ECU) Commission voted to coordinate developmental screenings by asking all early care and education providers to use the same common developmental screening tools, specifically the Ages and Stages Questionnaire ASQ-3 and ASQ-Social and Emotional (SE) tools. Using the same screening tools allows early care and education providers, clinicians and health providers to align efforts by sharing screening data across systems to prevent children from falling through the cracks.

In 2021, the CHARM system was selected by the ECU Health Subcommittee and approved by the Executive Committee of the Governor's ECU Commission to: 1) integrate identifiable child ASQ-3 and ASQ-SE developmental screening results collected by various agencies such as the Department of Health and Human Services, Department of Workforce Services, Help Me Grow, and Head Start, and 2) share the ASQ screening results with USIIS Immunize, the CHARM Web Portal, and up to three integrated EMR systems. Authorized users of these latter systems will use the ASQ data for operational, childcare, intervention, or case management. The overall purpose of the data project is to make identifiable child ASQ-3 and ASQ SE screening data available statewide to early care, development, health care, and education providers, as well as clinicians, for coordination and improving care to individual children and families.

This project builds upon the accomplishments of the CHARM data integration system to integrate developmental screening ASQ results so that better and more consistent referrals, services, treatments, and interventions are provided to children with potential developmental delays. The project will also ensure that Utah's early childhood stakeholders are all working together across the state to identify and close learning gaps early so children and their families are prepared when they enter kindergarten.

The CHARM Program is partnering and currently working with representatives of the Governor's Commission ECU Health Subcommittee and the Department of Workforce Services, Office of Child Care on this effort.

Priority Area: Family and Provider Connectedness/Care Coordination

NPM-11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Annual Plan FY23:

The Office of Children with Special Health Care Needs (CSHCN) through the Integrated Services Program will continue to fund our external partners to further work related to the medical home, particularly care coordination efforts, including: the Utah Parent Center; Help Me Grow, University of Utah, Division of General Pediatrics (Utah Children's Care Coordination Network and the Medical Home Portal); and the four local health departments with which we have contracts for care coordination services.

CSHCN is partnering with the Utah Children's Care Coordination Network (UCCCN) and the Medical Home Portal to promote educational opportunities for care coordinators, practice managers, medical providers, and staff through monthly UCCCN virtual training meetings and ongoing Pediatric Project ECHO online training sessions, utilizing surveys vetted through both the Medical Home Committee and the Pediatric Project ECHO development team to measure learning objectives and implementation of and improvement in medical home standards including care coordination. In conjunction with those projects, emphasis is placed on promoting a hybrid medical and health care model that includes live and virtual assessment and diagnostic visits to meet family needs including time, location, and proximity.

The Integrated Services Program (ISP) will track families referred to the program for evaluative and diagnostic care and/or care coordination, and upon intake, will ascertain whether or not those families are connected with a primary care provider. Where none exists, the ISP team will work to help families establish care with a local provider who can become the family's and patient's medical home.

The Medical Home Committee will establish and vet surveys with UCCCN member practices so that families in those practices may be surveyed to understand their concept of how that practice is implementing the components of a medical home; how that practice is improving and increasing medical homeness; and family satisfaction with their medical home. Feedback on individual practices will be provided for QI purposes, and overall group statistics will be discussed. The Medical Home Committee will review input, guidance, and consultation from the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) in this quality improvement initiative. ISP will continue to promote the use of Chromebooks and cellular hotspots that have been strategically placed across the State to encourage families to use telehealth and tele-evaluation when feasible and appropriate.

Proposed Activities:

- The Office of Children with Special Health Care Needs (CSHCN) through the Integrated Services Program will continue to fund external partners to further work related to the medical home.
- Partner with the Utah Children's Care Coordination Network (UCCCN) and the Medical Home Portal to promote educational opportunities for care coordinators, practice managers, medical providers, and staff through monthly UCCCN virtual training meetings and ongoing Pediatric Project ECHO online training sessions,
- Survey participants of both UCCCN meetings and Pediatric Project ECHO series on medical home to measure learning objectives and implementation of and improvement in medical home standards including care coordination.
- Promote a hybrid medical and health care model that includes live and virtual assessment and diagnostic visits to meet family needs including time, location, and proximity.
- ISP team will work to help families establish care with a local provider who can become the family's and patient's medical home.

Priority Need: Family and Provider Connectedness/Care Coordination

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

Annual Plan FY23:

The Bureau of Children with Special Health Care Needs (CSHCN) will continue to convene a monthly Transition to Adult Healthcare meeting with a focus on refining curriculum, enhancing marketing, ensuring quality improvement and patient/family experience is measured and evaluated, and referral and follow-up for resources and transition planning is assessed. CSHCN will work with stakeholders to coordinate and standardize data collection efforts to determine reach and number of youth and families who are in the transition to adult medicine process, and who have completed and successfully transitioned to adult medicine. CSHCN will continue to fund partner organizations such as the Medical Home Portal, UCCCN, Utah Parent Center, Help Me Grow, and Utah Family Voices to further transition to adult medicine activities. The Integrated Services Program will promote transition activities in-house and with care coordinators at the four local health departments to work with families, youth, and young adults so they may feel prepared to transition to adult medicine The Transition to Adult Healthcare Committee will work to standardize and vet patient and parent surveys to measure satisfaction with the curriculum and transition process; and will seek to measure change in skill longitudinally by administering readiness assessments to transition aged youth annually. The ISP team and CSHCN will continue to partner with key stakeholders and community partners within existing committees such as Utah State Board of Education's Transition Advisory Committee; Intermountain Healthcare's Teen to Adult Healthcare Governance Committee; and the Transition University Planning committee.

- The Bureau of Children with Special Health Care Needs (CSHCN) will continue to convene a monthly Transition to Adult Healthcare meeting with a focus on refining curriculum, enhancing marketing, ensuring quality improvement and patient/family experience is measured and evaluated, and referral and follow-up for resources and transition planning is assessed.
- CSHCN will work with stakeholders to coordinate and standardize data collection efforts to determine reach and number of youth and families who are in the transition to adult medicine process, and who have completed and successfully transitioned to adult medicine.
- CSHCN will continue to fund partner organizations such as the Medical Home Portal, UCCCN, Utah Parent Center, Help Me Grow and Utah Family Voices to further transition to adult medicine activities.
- The Integrated Services Program will promote transition activities in-house and with care coordinators at the four local health departments to work with families, youth, and young adults so they may feel prepared to transition to adult medicine.
- The Transition to Adult Healthcare Committee will work to standardize and vet patient and parent surveys to measure satisfaction with the curriculum and transition process; and will seek to measure change in skill longitudinally by administering readiness assessments to transition aged youth annually.

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

Public input is a valued part of the annual MCH Block Grant application process. This year, the Data Resources Program (DRP) within the Office of Maternal and Child Health used the following mechanisms to collect input from both the general public and key stakeholders for the FY23 Application and FY21 Annual Report through the WESTT system:

1. Email Invitation to Key Stakeholders

An email invitation requesting input and feedback was sent from the Offices of MCH and CSHCN to an extensive list. Recipients included parents, consumers, health care providers, and members of academia, community-based advocacy organizations, community health clinics, local health departments, stakeholders, and various government agencies. We also requested our partner agencies to forward the email with the web link to other contacts who might be interested. DRP worked with the UDHHS Office of Informatics and Data Systems to solicit feedback from Utah's healthcare providers. An email was sent to professionals who are licensed by the Department of Professional Licensing (DOPL). The list of professionals included Pediatricians, OB/GYN's, Family Medicine, General Practice, Psychiatrists, Psychologists, Clinical Therapists, Physicians Assistants, RN's, LPN's, APRN's, Certified Midwives, Direct Entry Midwives, Social Workers, and Marriage and Family Therapists.

In addition to DOPL, DRP contacted and provided outreach materials to a variety of non-profit and professional organizations. Specifically, DRP engaged with and provided materials to colleagues in the following organizations:

- The Utah Parent Center and Help Me Grow - two non-profit (501)(c)(3) organizations that assist parents of children with disabilities by providing accurate information, peer support, advocacy training, care coordination, developmental screenings, and connecting parents to community resources.
- Utah Public Health Association (UPHA)
- Utah Society of Public Health Educators (USOPHE)
- Membership in the Utah Women and Newborns Quality Collaborative (UWNQC)

2. Website Posting/Web Application

A public announcement was posted on the Utah Department of Health's website: https://health.utah.gov/ notifying the public about the Public Comment Period. The announcement included the following language with a link to the comment page hosted on the WESTT system:

"Each year, the Office of Maternal & Child Health submits an application for the federal Maternal and Child Health (MCH) Block Grant. Public input is an important part of the annual MCH Block Grant application process. The proposed activities related to the annual goals for the 2022-2023 grant year are now available for review. Please take a few minutes to review and comment on the proposed activities. Your input is important!"

The website link directed the user to the WESTT FY2023 Annual Goals/Objectives webpage. The webpage outlined the proposed activities for the five health domain areas targeting the three mandatory MCH

populations (pregnant women and infants; children and youth; and children and youth with special health care needs). Visitors were then able to provide commentary via the WESTT system.

3. Newsletter

To increase public awareness about MCH program activities, we additionally requested several MCH programs to add the public comment announcements in their on-line newsletter or web sites.

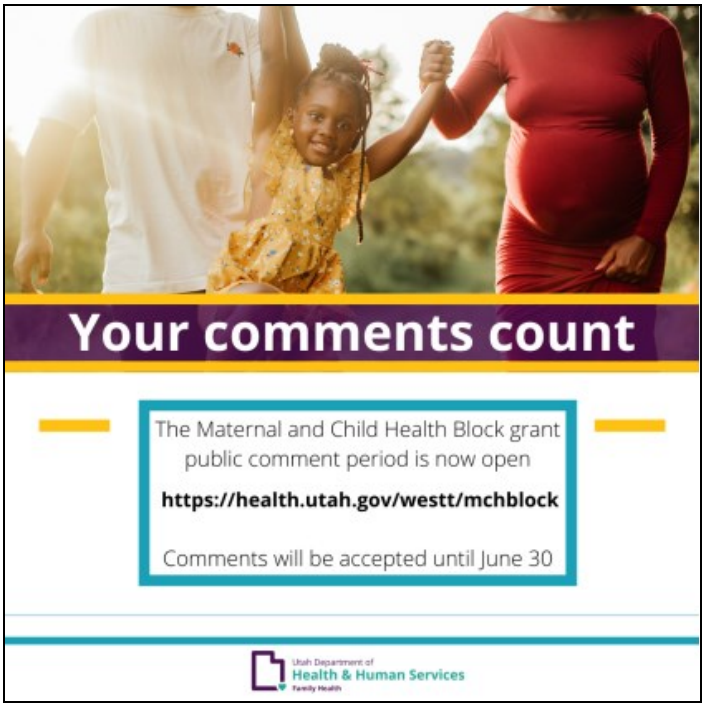
4. Social Media

The UDHHS sought public comment through various social media accounts at the agency level and MCH and CSHCN Facebook and Instagram accounts. We also asked Utah Parent Center, Help Me Grow, Utah Public Health Association, and the Utah Society for Public Health Education to post on their social media accounts using materials we developed.

Internally, we worked with the UDHHS Public Information Office (PIO) to post to the Agency Facebook and Instagram accounts (in addition to posting on the UDOH website). We also posted on the Power Your Life and CSHCN's Utah Birth Defects Network (UBDN) Facebook and Instagram pages. Each of these posts began with the following text:

"Do you want a say in what we do at the Department of Health and Human Services? Each year, the Office of Maternal and Child Health submits an application for the federal Maternal and Child Health Title V Block Grant. Public input is an important part of the annual MCH Block Grant application process. The proposed activities related to the annual goals for the 2022-2023 grant year are now available for review. Please take a few minutes to review and comment on the proposed activities. Your input is important!"

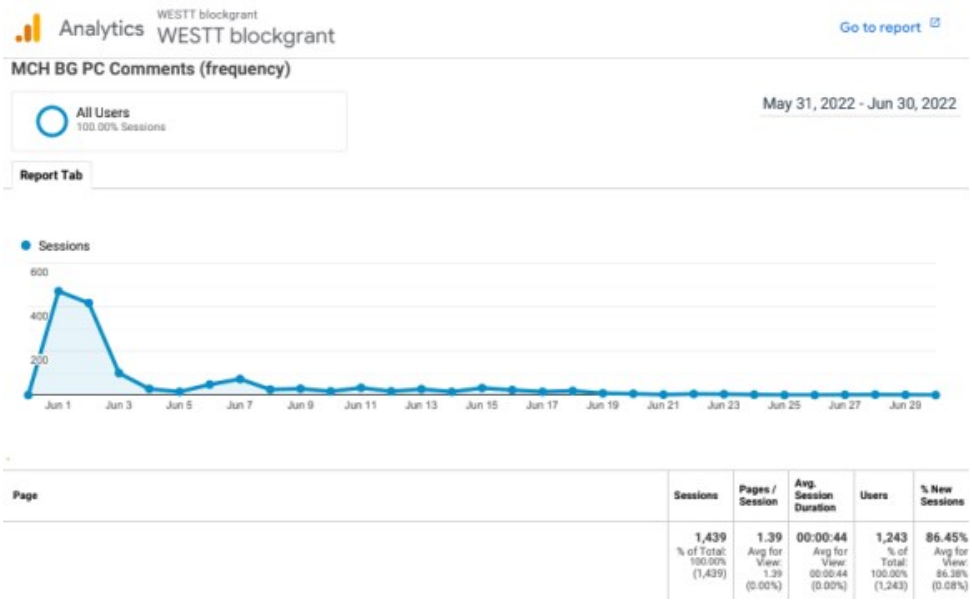
Social media posts included a hyperlink to the WESTT public comment site.



In an attempt to reach more people, we also boosted circulation of the Power Your Life and UBDN social media posts (see example of a boosted post above, with other posts below). The Power Your Life ads resulted in a reach of 17,312 accounts with 72 clicks and the UBDN ads reached 20,352 accounts with 124 clicks. UBDN's non-boosted posts also resulted in 248 clicks.

Public Comment Period Results:

Online comments were accepted from 6/1/2022 – 6/30/2022. We received valuable feedback on needs and emerging issues as well as reaffirmation of the importance of program activities. This year we received 300 comments, a significant increase from 129 comments in the FY 2022 application and report. The *Google Analytics* report below shows there were 1,439 sessions, and 1,243 users who logged-on to the Title V public comment website at least once. Sessions lasted, on average, 44 seconds.



Over forty-one percent of the responses referred to the women and maternal health domain (access to care/well-woman visits and perinatal mood and anxiety disorders/mental health). The next highest percentage of comments (19.0%) related to the adolescent health domain (bullying, oral health, and free and reduced lunch). Sixteen percent of comments were related to the child health domain (developmental screening, family connectedness / family meals), followed by 15% relating to the perinatal and infant health domain (breastfeeding). The remaining 8.7% were focused on children with special health care needs (medical home and transition to adult care).
Nearly 20% (58/300) of the public comments were made by parents, including parents of children with special health care needs.

Changes in Annual Plan based on Public Feedback

A Public Comment Summary Report was prepared in July 2022 based on all public comments received. The report was shared with the lead/core program staff responsible for reporting on specific National and State Performance Measures and requested that they consider this feedback for incorporation in the final 2023 Annual Plans that would be submitted into TVIS. Applicable changes were made by the core writers and incorporated into the current application.

III.G. Technical Assistance

Utah's Title V agency currently has not identified any technical assistance (TA) needs for the FY2023 MCH Block Grant Application. As we identify any needs, we will seek TA.

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

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - UDHHS_Org_Charts_TVIS.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Utah

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,598,690	
A. Preventive and Primary Care for Children	$ 3,343,998	(50.6%)
B. Children with Special Health Care Needs	$ 2,259,657	(34.2%)
C. Title V Administrative Costs	$ 621,900	(9.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,225,555	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 16,420,500	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,400,000	
5. OTHER FUNDS (Item 18e of SF-424)	$ 15,214,000	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,044,900	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 36,079,400	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,897,700		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 42,678,090	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 53,211,500	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 95,889,590	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 153,700
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 345,500
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 387,300
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 671,300
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 251,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 40,856,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 420,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 2,942,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 232,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 6,523,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 140,900
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 186,700

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,561,290 (FY 21 Federal Award: $ 6,101,483)		$ 5,999,329	
A. Preventive and Primary Care for Children	$ 3,404,127	(51.9%)	$ 3,111,036	(51.8%)
B. Children with Special Health Care Needs	$ 2,153,220	(32.8%)	$ 2,011,747	(33.5%)
C. Title V Administrative Costs	$ 621,400	(9.5%)	$ 507,807	(8.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,178,747		$ 5,630,590	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 14,630,450		$ 16,279,475	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 2,381,253	
5. OTHER FUNDS (Item 18e of SF-424)	$ 16,023,900		$ 15,143,381	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,103,500		$ 999,760	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 31,757,850		$ 34,803,869	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,897,700				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 38,319,140		$ 40,803,198	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 50,430,575		$ 48,228,703	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 88,749,715		$ 89,031,901	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 446,500	$ 341,864
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 621,800	$ 543,270
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 186,600	$ 153,790
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 166,700	$ 212,258
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 374,700	$ 164,569
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 325,000	$ 141,967
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 94,741
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 220,000	$ 237,390
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 262,600	$ 285,200
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 38,378,729	$ 37,517,364
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	$ 5,618,179
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 426,600	$ 389,064

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
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	$ 2,529,047

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Includes award for 10/1/2022-9/30/2024 with an anticipated expenditure in first year and anticipated federal amount remaining in budget period 10/1/2021-9/30/2023 to be spent in second year.	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Amount includes all or portions of the following state general funds: Division of Family Health Director's Office and Financial Administrative Services, Newborn Safe Haven, Informed Consent, Pregnancy Risk Assessment Monitoring, Pregnancy Riskline, Maternal Mental Health, Children with Special Health Care Needs Administration, Children's Hearing Aid Program, Baby Watch Early Intervention and Office of Home Visiting.	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Local MCH funds are reported annually by Local Health Departments.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Other Funds include revenue agreements from private non-profit agencies.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Program income includes revenue received from Baby Watch Early Intervention family fees, Newborn Screening kit fee revenue for newborn hearing screening, and Pregnancy Risk Line collections.	

6.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2022 grant. Actual expended only includes amount expended from FFY 2021 grant award.	
7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2022 grant. Actual expended only includes amount expended from FFY 2021 grant award.	
8.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2022 grant. Actual expended only includes amount expended from FFY 2021 grant award.	
9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2022 grant. Actual expended only includes amount expended from FFY 2021 grant award.	
10.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Increases to state funding since FFY 2021 budget include increase to Baby Watch Early Intervention general fund appropriations, Newborn Safe Haven and Informed Consent. New appropriations of general fund including Maternal Mental Health and Office of Home Visiting.	
11.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**

Column Name:	**Annual Report Expended**

Field Note:
Increase to Local MCH funds actually expended from FY 2021 budgeted amount are due to changes in the reporting requirements for Local Health Departments.

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 674,990	$ 568,602
2. Infants < 1 year	$ 588,934	$ 550,735
3. Children 1 through 21 Years	$ 2,276,689	$ 2,179,740
4. CSHCN	$ 2,259,657	$ 2,011,747
5. All Others	$ 176,520	$ 180,698
Federal Total of Individuals Served	$ 5,976,790	$ 5,491,522

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 3,724,978	$ 3,790,395
2. Infants < 1 year	$ 3,405,375	$ 3,387,304
3. Children 1 through 21 Years	$ 8,807,347	$ 8,823,230
4. CSHCN	$ 16,410,700	$ 16,093,232
5. All Others	$ 316,800	$ 328,456
Non-Federal Total of Individuals Served	$ 32,665,200	$ 32,422,617
Federal State MCH Block Grant Partnership Total	$ 38,641,990	$ 37,914,139

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:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: 1. Infants included in Form 2 under Preventative and Primary Care. 2. Utah continues to make budget reductions and modifications as existing MCH Block Grant obligations are currently ~$500,000 in excess of the annual award. To date, reductions have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, along with Utah Women Newborn Quality Collaborative activities. In FFY 2021, the Pregnancy Risk Line (Mother 2 Baby) Program budget 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:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Included in Form 2 under Preventative and Primary Care.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Utah continues to make budget reductions and modifications as existing MCH Block Grant obligations are currently ~$500,000 in excess of the annual award. To date, reductions have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, along with Utah Women Newborn Quality Collaborative activities. In FFY 2021, the Pregnancy Risk Line (Mother 2 Baby) Program budget 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:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Various third party revenue agreements received for Early Childhood Utah activities, specifically relating to resource, referral and Utah ECIDS previously reported under All Others have now been adjusted and are being reported in budget and actuals under Children 1-21.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**

	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Included in Form 2 under Preventative and Primary Care.	
6.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Included in Form 2 under Preventative and Primary Care.	
7.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Utah continues to make budget reductions and modifications as existing MCH Block Grant obligations are currently ~$500,000 in excess of the annual award. To date, reductions have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, along with Utah Women Newborn Quality Collaborative activities. In FFY 2021, the Pregnancy Risk Line (Mother 2 Baby) Program budget 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:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Various third party revenue agreements received for Early Childhood Utah activities specifically relating to resource, referral and Utah ECIDS Development previously reported under All Others, have been adjusted and are now being reported in Children 1-21.	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 1,907,265	$ 1,423,073
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 277,334	$ 222,398
B. Preventive and Primary Care Services for Children	$ 303,969	$ 244,057
C. Services for CSHCN	$ 1,325,962	$ 956,618
2. Enabling Services	$ 3,240,551	$ 3,230,223
3. Public Health Services and Systems	$ 1,450,874	$ 1,346,033
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		$ 1,423,073
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		$ 1,423,073
Federal Total	$ 6,598,690	$ 5,999,329

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 407,000	$ 224,349
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	$ 407,000	$ 224,349
2. Enabling Services	$ 31,094,800	$ 30,974,384
3. Public Health Services and Systems	$ 1,163,400	$ 1,223,883
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		$ 224,349
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		$ 224,349
Non-Federal Total	$ 32,665,200	$ 32,422,616

Form Notes for Form 3b:

None

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: 46,957 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	45,464 (96.8%)	640	96	96 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn hearing screening	46,330 (98.7%)	489	134	128 (95.5%)
CCHD	45,507 (96.9%)	87	5	5 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Diet Monitoring (0-18 yrs)	1,080	84	84	84
Diet monitoring (pregnant women)	1,080	6	6	6

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:**	**Data Source Year**
	Fiscal Year:	**2021**
	Column Name:	**Data Source Year Notes**
	Field Note: 2020	
2.	**Field Name:**	**Newborn hearing screening - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: 6 infants were not referred to Utah Early Intervention because 3 lived out of state and 3 died.	

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 2021

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	6,964	56.7	0.0	4.7	7.5	31.1
2. Infants < 1 Year of Age	10,756	81.5	0.0	5.5	1.5	11.5
3. Children 1 through 21 Years of Age	29,213	36.4	0.3	26.1	11.6	25.6
3a. Children with Special Health Care Needs 0 through 21 years of age^	9,893	49.4	0.0	45.3	5.3	0.0
4. Others	2,387	23.5	0.0	13.5	32.2	30.8
Total	49,320					

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	45,702	Yes	45,702	88.8	40,583	6,964
2. Infants < 1 Year of Age	46,933	Yes	46,933	100.0	46,933	10,756
3. Children 1 through 21 Years of Age	1,080,505	Yes	1,080,505	13.0	140,466	29,213
3a. Children with Special Health Care Needs 0 through 21 years of age^	178,214	Yes	178,214	69.9	124,572	9,893
4. Others	2,121,943	Yes	2,121,943	0.4	8,488	2,387

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: Pregnant women number derived from the following sources: - Pregnancy Risk Line 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=2,447) - 1-800 Call Non-Eligibility Calls (Pregnant Women, Others), FY21 phone calls to Immunizations, CHIP (n=1,311) - Fluoride Varnish Application (n=0) Substantial reduction due to COVID-19 and program cutbacks - Direct Oral Health Screenings (n=0) Substantial reduction due to COVID-19 and program cutbacks - Maternal and Child Health Service Report (n=3,206) Source of coverage came from FAD and the Maternal and Child Health Service Report N=6964	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: Infant's number derived from the following sources: - Hearing Screening by the Utah Early Hearing Detection and Intervention Team (n=62) - Pregnancy Risk Line calls regarding breastfeeding infants under age 1 (n=1,431) - Ages and Stages Screenings (n=3,219) - Maternal and Child Health Service Report Service Report (n=6,044) substantial reduction from last year due to COVID-19. Source of coverage came from FAD and the Maternal and Child Health Service Report N=10,756	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Children 1 through 21 years numbers derived from the following sources: - 1-800 Call Non-Eligibility Calls (CHIP, Immunizations) (n=4059) - Health education (Children 1-21) (n= 224) - Maternal and Child Health Service Report (n=17,012) - Ages and Stages Questionnaire Screenings (n=7,587) - Oral Health Program Direct oral health screenings (n=331) Substantial reduction due to COVID-19 and program cutbacks - Fluoride Varnish Application (n=0) Substantial reduction due to COVID-19 and program cutbacks - Numbers from 3a (n=11,256) Source of coverage came from FAD and the Maternal and Child Health Service Report N=29213	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**

	Fiscal Year:	**2021**

Field Note:
CSHCN
- CSHCN Case Management (Utah Family Voices), Un-duplicated counts of intakes (n=1,121)
- CSHCN Translation, Follow up notes, Cytomegalovirus, records, Family Support (n=7,210)
- CSHCN Autism Referral, Scheduling, monitoring, referral, coordination (n=672)
- CSHCN Autism Explanation of benefits, referral and assistance (n=201)
- Oral Health Program CSHCN direct oral health screenings (n=107)
- CSHCN Transition planning (n=249)
- Rural Pediatric Orthopedics (U of U/PCMC) (n=222)
- Case Management/care coordination (ISP) (n=439)
- Direct Oral Health Screenings (n=28) Substantial reduction due to COVID-19 and program cutbacks
- Fluoride Varnish Application (n=0) Substantial reduction due to COVID-19 and program cutbacks

Source of coverage came from FAD, the Maternal and Child Health Service Report, Rural Pediatric Orthopedics, and Case Management/Care Coordination Integrated Services Program
N=9893

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
"Others" number derived from the following sources:
- Pregnancy Risk Line 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=1,661)
- Pregnancy Risk Line Safe haven calls (n=6)
- MCH Service Report (n=680)
- Direct Oral Health Screenings (n=40) Substantial reduction due to COVID-19 and program cutbacks
- Oral Health Program fluoride varnish applications (n=0) Substantial reduction due to COVID-19 and program cutbacks

Services were impacted significantly by COVID-19.
Source of coverage came from FAD and the Maternal and Child Health Service Report.
N=2,387

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

Field Note:
Pregnant Women
In addition to numbers served from form 5a:
- Maternal and Infant Health Program Safety bundle hospital (n=33,553)
- Oral Health Program Education (50) severely curtailed due to COVID

40,567/45,702 = 88.8% served

88.76416787011509 is the actual calculated percentage. TVIS would not save this number, consequently we gained 16 in the TVIS calculated number based on rounded percentage.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**

	Fiscal Year:	**2021**

Field Note:
Infants under 1
In addition to numbers served from form 5a:
- Critical Congenital Heart Disease screening - Children screened in hospitals (n=47,961)
- Maternal and Infant Health Program Births in participating Baby Friendly hospitals (n=32,741)
- Hearing screening, number of infants screened (n=47,418)

46,933 /46,933 = 100% served

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
Children 1 to 21
In addition to numbers served from form 5a:
- Physical Activity, Percent of adolescents who were physically active 60 minutes, 7 days per week (n=57,123) significantly down due to COVID
- Oral Health Program Group Education Adolescents (n=8,210)
- PREP/Abstinence Education, Number of children enrolled in programs (n=1,457)
- Numbers from CSHCN (n=114,707)

140516/1,080,505 = 13.0% served

13.0046598581219 is the actual calculated percentage. TVIS would not save this number, consequently we lost 50 in the TVIS calculated number based on rounded percentage.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
CSHCN
In addition to numbers served from form 5a:
- Medical Home Portal, users (n=111,461) New and revised tracking system and website overhaul caused an increase in traffic counting
- CSHCN Utah Early Hearing Detection and Intervention Committee, individuals participating (n=204)
- CSHCN Hearing/Speech Training, Coordinated training for screening and referral (n=775)
- CSHCN Autism Downloads, ABA resource and Evaluation Provider downloads (n=0.00) this functionality was disabled for this year only
- Utah Birth Defects Network Surveillance cases (n=866)
- Oral Health Program Education (n=712)
- The number of Telehealth sessions (n=17)
- The number of Parent Center Referrals to the Integrated Services Program (n=672)
124600/178,214 = 69.9% served

0.6991594375301604 is the actual calculated percentage. TVIS would not save this number, consequently we lost 28 in the TVIS calculated number based on rounded percentage.

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
Others
In addition to numbers served from form 5a:
- Utah Birth Defects Network Community Education, Events, # reached, # of vitamins distributed (n=2,251)
- Oral Health Program Outreach Education (n=1,714) this number is again down from last year due to COVID
- Home visiting clients receiving preconception health information (n=450)
- The number of parents or trusted adults served by PREP/AbEd (n=50)
Most of our outreach has been significantly impacted by COVID-19

8,796/2,121,943 = 0.42 % served

0.41452574362271 is the actual calculated percentage. TVIS would not save this number, consequently we lost 96 in the TVIS calculated number based on rounded percentage.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Utah

Annual Report Year 2021

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	46,716	34,078	787	8,330	412	1,307	815	0	987
Title V Served	45,189	33,167	726	8,030	377	1,261	811	0	817
Eligible for Title XIX	11,056	6,142	369	3,493	243	213	376	0	220
2. Total Infants in State	46,957	34,396	797	8,361	413	1,314	820	0	856
Title V Served	45,577	33,466	734	8,089	378	1,268	816	0	826
Eligible for Title XIX	11,456	6,368	391	3,620	262	214	379	0	222

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Utah

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(801) 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"		1,722

B. Other Appropriate Methods	2023 Application Year	2021 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 Have; 4. Immunization Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		9,825
3. State Title V Program Website Address	1. www.health.utah.gov/mch; 2. www.health.utah.gov/cshcn	www.health.utah.gov/mch, www.health.utah.gov/cshcn
4. Number of Hits to the State Title V Program Website		45,742
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		75,122

Form Notes for Form 7:

Baby Your Baby 1722 calls waiting on response.
CHIP 1209 calls
Mother to Baby 5763 calls
Utah Newborn Safe Haven 3 calls
Immunization Hotline had 2850 calls
State Title V MCH Web 1396
State Title V CSHCN Web 41346
State Title V Social Media Facebook 22243
State Title V Social Media Instagram 52879

Form 8
State MCH and CSHCN Directors Contact Information

State: Utah

1. Title V Maternal and Child Health (MCH) Director	
Name	Laurie Baksh
Title	Title V/Director of Maternal and Child Health Office
Address 1	195 North 1950 West
Address 2	PO Box 142002
City/State/Zip	Salt Lake City / UT / 84116
Telephone	(801) 273-2857
Extension	
Email	lbaksh@utah.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Amy Nance
Title	Title V/Director of Children with Special Health Care Office
Address 1	195 North 1950 West
Address 2	PO Box 144610
City/State/Zip	Salt Lake City / UT / 84116
Telephone	(801) 273-2982
Extension	
Email	aenance@utah.gov

3. State Family or Youth Leader (Optional)	
Name	Joey Hannah
Title	Utah Parent Center Executive Director
Address 1	5296 Commerce Drive, Suite 302
Address 2	
City/State/Zip	Murray / UT / 84107
Telephone	(801) 272-1051
Extension	
Email	joey@utahparentcenter.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Utah

Application Year 2023

No.	Priority Need
1.	Perinatal mood and anxiety disorders
2.	Women's 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

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 9 State Priorities – Needs Assessment Year – 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 10
National Outcome Measures (NOMs)

State: Utah

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

The program has a goal of creating 1 educational module per year over the next 3 years for a total of 3 CHW modules.

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
2020	82.0 %	0.2 %	37,061	45,202
2019	82.1 %	0.2 %	38,008	46,303
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
2019	53.7	3.5	240	44,684
2018	47.3	3.3	213	45,051
2017	60.2	3.6	280	46,494
2016	53.7	3.3	260	48,390
2015	55.9	3.9	205	36,684
2014	52.6	3.3	255	48,511
2013	46.9	3.1	225	47,931
2012	46.4	3.1	225	48,522
2011	48.1	3.1	236	49,020
2010	47.3	3.1	237	50,139
2009	50.9	3.2	262	51,497
2008	41.7	2.8	224	53,714

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
2016_2020	11.7	2.2	28	238,786
2015_2019	10.7	2.1	26	243,862
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
2020	7.0 %	0.1 %	3,216	45,688
2019	7.4 %	0.1 %	3,481	46,806
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
2020	9.3 %	0.1 %	4,241	45,699
2019	9.7 %	0.1 %	4,559	46,823
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
2020	29.3 %	0.2 %	13,390	45,699
2019	29.4 %	0.2 %	13,762	46,823
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
2020/Q3-2021/Q2	4.0 %			
2019/Q4-2020/Q3	3.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
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
2019	6.0	0.4	280	46,951
2018	6.9	0.4	325	47,368
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
2019	5.3	0.3	247	46,826
2018	5.5	0.3	259	47,209
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
2019	4.1	0.3	190	46,826
2018	4.1	0.3	194	47,209
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
2019	1.2	0.2	57	46,826
2018	1.4	0.2	65	47,209
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**
2019	196.5	20.5	92	46,826
2018	199.1	20.6	94	47,209
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 - 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
2019	32.0	8.3	15	46,826
2018	55.1	10.8	26	47,209
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 - Percent of women who drink alcohol 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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.6	0.4	253	45,031
2018	5.8	0.4	265	45,372
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
2019_2020	12.6 %	1.3 %	111,472	883,785
2018_2019	12.3 %	1.2 %	108,823	882,113
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**
2020	11.0	1.6	50	452,549
2019	16.8	1.9	77	458,213
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**
2020	34.9	2.6	184	526,744
2019	34.7	2.6	181	521,832
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
2018_2020	7.4	1.0	56	759,951
2017_2019	7.9	1.0	59	744,985
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
2018_2020	22.0	1.7	167	759,951
2017_2019	22.7	1.8	169	744,985
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
2019_2020	15.8 %	1.3 %	146,181	927,304
2018_2019	16.2 %	1.4 %	149,671	924,951
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
2019_2020	22.6 %	4.1 %	33,017	146,181
2018_2019	15.9 %	3.8 %	23,737	149,671
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
2019_2020	1.8 %	0.4 %	13,790	779,847
2018_2019	2.0 %	0.5 %	15,565	773,731
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
2019_2020	7.9 %	1.2 %	61,270	775,138
2018_2019	8.2 %	1.3 %	63,749	774,326
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
2019_2020	40.5 %	4.9 %	44,769	110,440
2018_2019	46.7 %	4.9 %	56,716	121,445
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
2019_2020	93.8 %	0.9 %	867,951	925,611
2018_2019	92.6 %	1.1 %	854,376	922,657
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
2018	8.5 %	0.2 %	1,560	18,455
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
2019	9.8 %	0.9 %	15,980	162,482
2017	9.6 %	0.8 %	15,119	157,588
2013	6.4 %	0.9 %	9,582	148,869
2011	8.6 %	0.8 %	12,711	147,981
2009	6.3 %	0.9 %	9,374	148,628
2007	8.6 %	1.8 %	11,888	138,875
2005	5.5 %	0.9 %	7,700	140,637

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
2019_2020	10.3 %	1.9 %	41,303	402,215
2018_2019	9.6 %	1.8 %	39,442	410,447
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
2019	7.7 %	0.5 %	71,681	929,592
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 who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	77.1 %	3.6 %	38,000	50,000
2016	72.9 %	3.4 %	37,000	51,000
2015	68.0 %	3.9 %	35,000	52,000
2014	71.8 %	3.5 %	38,000	52,000
2013	63.9 %	4.1 %	33,000	52,000
2012	68.7 %	3.7 %	35,000	51,000
2011	67.2 %	3.9 %	35,000	51,000

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
2020_2021	60.0 %	2.0 %	526,348	877,246
2019_2020	60.0 %	2.0 %	526,678	877,796
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
2020	68.6 %	3.4 %	184,624	269,174
2019	68.8 %	3.5 %	181,207	263,298
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
2020	91.3 %	1.9 %	245,678	269,174
2019	86.8 %	2.7 %	228,669	263,298
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
2020	90.3 %	2.0 %	243,132	269,174
2019	86.6 %	2.6 %	228,134	263,298
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
2020	10.8	0.3	1,363	126,536
2019	12.0	0.3	1,498	124,535
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
2020	15.1 %	1.1 %	6,667	44,106
2019	15.2 %	1.1 %	6,876	45,296
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 unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	3.5 %	0.6 %	32,247	925,308
2018_2019	3.9 %	0.8 %	35,900	920,266
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				66.5	67.5
Annual Indicator			66.1	67.6	67.0
Numerator			394,166	413,656	413,571
Denominator			595,993	612,087	617,227
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	68.0	69.0	70.0	72.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	94.5	88.6	90	90	91.8
Annual Indicator	88.4	89.7	91.2	91.8	87.8
Numerator	43,382	43,073	45,052	39,458	38,339
Denominator	49,063	48,030	49,404	42,968	43,665
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	89.0	90.0	91.0	92.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	27.3	26.9	28	28.3	27
Annual Indicator	26.8	27.8	23.5	26.3	27.8
Numerator	12,259	12,643	11,415	10,658	11,442
Denominator	45,790	45,490	48,506	40,597	41,090
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	29.0	30.0	31.0	32.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		33.2	32.2	31.3	31.3
Annual Indicator	33.1	32.6	31.1	29.1	34.2
Numerator	38,611	32,987	29,418	31,492	39,294
Denominator	116,514	101,171	94,514	108,310	114,782
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	34.2	34.5	35.0	35.5

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	**2020**	**2021**
Annual Objective			23
Annual Indicator	26.9	24.4	24.4
Numerator	44,345	41,396	41,396
Denominator	164,763	169,914	169,914
Data Source	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2019	**2020**	**2021**
Annual Objective			23
Annual Indicator	27.7	27.5	20.4
Numerator	86,153	84,890	62,745
Denominator	311,307	309,211	307,366
Data Source	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Victimization			
	2019	**2020**	**2021**
Annual Objective			23
Annual Indicator	56.4	54.8	43.3
Numerator	176,896	170,076	133,253
Denominator	313,579	310,347	307,613
Data Source	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.4	23.5	22.8	21.4

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		50.4	44.1	40.3	47
Annual Indicator	50.4	47.2	40.2	46.4	57.2
Numerator	75,090	68,219	59,263	69,395	83,681
Denominator	148,990	144,415	147,327	149,671	146,181
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	57.3	57.4	57.5	57.5

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 to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		18.4	19.5	17.3	13.5
Annual Indicator	18.4	19.3	17.1	11.5	14.0
Numerator	11,791	12,760	13,378	8,906	10,487
Denominator	64,109	66,028	78,194	77,434	75,107
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.5	17.5	19.5	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		80.3	84.8	81.6	82.8
Annual Indicator	80.1	82.4	81.4	82.6	84.3
Numerator	684,515	701,280	698,309	726,633	745,902
Denominator	854,160	851,339	857,676	879,310	885,155
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	84.7	85.1	85.5	85.9

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	2020	2021
Annual Objective			63.8
Annual Indicator	56	60.8	60
Numerator	25,866	27,859	26,909
Denominator	46,186	45,807	44,814
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	63.8	66.8	69.8	72.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Healthy People 2030: Similar to Health People MICH-D01: Increase the proportion of women who get screened for postpartum depression. No objective as the measure is still developmental.

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	2020	2021
Annual Objective			78.8
Annual Indicator	76.7	78.1	81.1
Numerator	692,413	712,908	743,827
Denominator	903,273	912,249	917,210
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	81.0	82.0	83.0	84.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Healthy People 2030: Reduce household food insecurity and hunger (NWS-01) and eliminate very low food security in children (NWS-02).	

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			35
Annual Indicator	32.2	35	41.7
Numerator			281,760
Denominator			675,247
Data Source	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	53.0	56.0	59.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Healthy People 2030: Increase the proportion of students participating in the School Breakfast Program - AH-04It was determined by the State Board of Education Child Nutrition program that the annual objective should include students who participate in the NSLP. Including the number of paid students provides many benefits to the school meals program. During the pandemic meals were offered to all students for free. Offering free meals to all students removes the stigma often associated with the means-tested school breakfast and lunch, opens the program to children from families who would struggle to pay the reduced-price copayment or the paid breakfast and lunch charges, and streamlines the implementation of alternative breakfast models. School meals which include breakfast and lunch Seamless Summer options should all be included to increase participation.

Data Notes: As we move into the 2022-2023 school year school meals will no longer be free of charge to all students. Policies and best practices to increase alternative breakfast models will be enforced. Schools who participate in the NSLP and have 50% of students who qualify for free and reduced meals will need to implement an alternative breakfast model. We should think about changing our data source to measure the participation in school breakfast.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Utah

ESM 1.2 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.

Measure Status:	**Inactive - We do not have a robust evaluation strategy to measure the effect of the Power Your Life booklets provided to clients.**

State Provided Data			
	2019	**2020**	**2021**
Annual Objective			250
Annual Indicator	100	200	300
Numerator			
Denominator			
Data Source	Salt Lake County Home Visiting Program Data	Salt Lake County Home Visiting Program Data	Salt Lake County Home Visiting Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			12
Annual Indicator	0	10	7
Numerator			
Denominator			
Data Source	Maternal and Infant Health Program data	Maternal and Infant Health Program data	Maternal and Infant Health Program data
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - 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:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			0
Annual Indicator	0	0	1
Numerator			
Denominator			
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Develop and offer an educational module to community health care workers as an online supplemental course

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.4 - 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	2020	2021
Annual Objective			27
Annual Indicator	13.2	24.4	67
Numerator	6,225	11,435	30,555
Denominator	47,211	46,832	45,577
Data Source	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	69.0	70.0	71.0	72.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.5 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			14
Annual Indicator	13.9	6.6	52.7
Numerator	983	449	3,182
Denominator	7,093	6,831	6,041
Data Source	WIC Program Data	WIC Program Data	WIC Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 4.5 - The number of worksites that have federal lactation accommodations and breastfeeding strategies.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	40.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
FY 2023 is a baseline year for this ESM

ESM 4.6 - 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:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			7
Annual Indicator	0	7	0
Numerator			
Denominator			
Data Source	EPICC Program Data	EPICC Program Data	EPICC Program Data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 4.7 - The percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer Counselor.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	47.0	48.0	49.0

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	2020	2021
Annual Objective			12
Annual Indicator	0	23	34
Numerator			
Denominator			
Data Source	Early Childhood Utah program data	Early Childhood Utah program data	Early Childhood Utah program data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Currently our capacity is offering one live training per month. We are operating at current capacity. We offer recorded sessions as well as live monthly trainings.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: In FY 2021 there were more ASQ trainings offered by the Early Childhood Utah (ECU) Program than in previous years. The COVID-19 pandemic made it impossible to continue in-person trainings, which resulted in a move to virtual trainings and a recorded webinar. Many of the 34 trainings were attended by only 1 or 2 people. Moving forward the ECU program will move back to in-person training and anticipates 6 trainings per year with approximately 10 participants per training.	

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	2020	2021
Annual Objective			7,988
Annual Indicator	8,157	7,580	7,877
Numerator			
Denominator			
Data Source	The Brookes Publishing UDOH ASQ Online Enterprise	UDOH Early Childhood Integrated Database	UDOH Early Childhood Integrated Database
Data Source Year	2019	2020	2022
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8,271.0	8,685.0	9,120.0	9,576.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The data source has been changed from "The Brooks Publishing UDOH ASQ Online Enterprise" from an in-house database, "UDOH Early Childhood Integrated Database 2020".

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	2020	2021
Annual Objective			100
Annual Indicator	0	129	160
Numerator			
Denominator			
Data Source	Program records, attendance records.	Program records, attendance records	Program records, attendance records
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2020	2021
Annual Objective			350
Annual Indicator	300	300	181
Numerator			
Denominator			
Data Source	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	200.0	250.0	275.0	300.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The ability to conduct bystander training was affected by the COVID-19 pandemic in 2021. The programming is currently developing an online training to make it more accessible.

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			23
Annual Indicator	21	21	21.7
Numerator	41,142	41,142	46,356
Denominator	195,912	195,912	213,621
Data Source	Estimates for percent of students physically activ	YRBS	YRBS and National Center for Health Statistics (NC
Data Source Year	2019	2019	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	23.0	25.0	25.0	27.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2019 and 2020 denominators come from school enrollment numbers. The 2021 denominator comes from a collaborative agreement with the National Center for Health Statistics and the Census Bureau and accessed through IBIS-PH: https://ibis.health.utah.gov/ibisph-view/query/result/pop/PopMain/Count.html

Query date: Fri, 22 Jul 2022 15:17:31 MDT

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			400
Annual Indicator	400	366	162
Numerator			
Denominator			
Data Source	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	175.0	200.0	250.0	300.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The reduction in numbers for this ESM is due to COVID-19

ESM 9.5 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			76
Annual Indicator	75	75	75
Numerator	171,000	171,000	171,000
Denominator	228,000	228,000	228,000
Data Source	Internal Revenue Service	Internal Revenue Service	Internal Revenue Service
Data Source Year	2018	2018	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	78.0	79.0	81.0	83.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019 Data not yet available	

ESM 9.6 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			300
Annual Indicator	100	340	340
Numerator			
Denominator			
Data Source	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	300.0	400.0	500.0	600.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Pre- and Post-training survey	Pre- and Post-training survey	Pre- and Post-training survey
Data Source Year	2020	2021	2021
Provisional or Final ?	Provisional	Provisional	Provisional

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.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Year one was intended to establish a baseline, develop curriculum, marketing strategies, referral processes, follow-up, and QI/satisfaction survey methods. It would be premature to reach out to families prior to ensuring stable program offerings. A baseline will be established in Year Two.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2021 was intended to establish a baseline, develop curriculum, marketing strategies, referral processes, follow-up, and QI/satisfaction survey methods. In FY23, this ESM is discontinued. A new ESM has been added in which families are surveyed to measure how practices participating in the Utah Care Coordination Network are viewed for implementing and improving 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.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			94.5
Annual Indicator	0	94	97
Numerator		614	426
Denominator		653	439
Data Source	CSHCN EMR or comprehensive database	CSHCN Electronic Medical Record	CSHCN EMR or comprehensive database
Data Source Year	2020	SFY 2021	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	97.0	97.5	98.0	98.0

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 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of the medical home.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Surveys for this new ESM for FY23 have not yet been developed. FY23 will be a baseline year as survey instruments are developed and distributed among pilot practices, then more fully among participating UCCCN practices.

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	2020	2021
Annual Objective			0
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Stakeholder work group survey.	Stakeholder work group survey.	Stakeholder work group survey
Data Source Year	2020	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Year one established a curriculum, marketing strategy, referral and follow-up mechanisms, and QI/satisfaction surveys. We have begun to implement an adapted-for-Utah Got Transition curriculum. In Year two we will implement the survey created in Year One to determine the effectiveness of the transition care coordination offered statewide. Due to COVID issues the survey was delayed.

3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This was a new ESM for FY21. Robust partnerships have been fostered between UDOH and several community partners including two hospital systems to continually assess, develop, market, and implement a universal process, statewide, for transition to adult medicine. A standard statewide survey has yet to be determined and implemented. Work will continue in FY23 to create, vet, and send to families/youth through a mobile platform.

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	2020	2021
Annual Objective			63
Annual Indicator	0	62.4	74
Numerator		552	347
Denominator		884	469
Data Source	Stakeholder work group survey	ISP electronic medical record, Utah Parent Center	ISP electronic medical record, Utah Parent Center
Data Source Year	2020	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	73.9	75.0	77.0	79.0

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.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data includes those who received transition planning funded with Title V dollars.	

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	2020	2021
Annual Objective			0
Annual Indicator	0	0	66.7
Numerator			8
Denominator			12
Data Source	Stakeholder work group survey for transition	Stakeholder work group survey for transition	Stakeholder work group survey for transition
Data Source Year	2020	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.0	72.0	75.0	80.0

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.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Year one established a curriculum, marketing strategy, referral and follow-up mechanisms, and QI/satisfaction surveys. Provider training curriculum is being refined and will be published on the website, once vetted by UDOH and our community partners, for providers who are seeking to implement transition to adult medicine within their practices. This will be a universal and unified statewide curriculum. Year Two will establish baseline numbers of providers who have implemented the transition to adulthood policy and processes. Stakeholder work group survey for transition trained providers was not competed this year Due to COVID related issues.	

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	53.6	51.5	54.4	55.7	52.1
Annual Indicator	51.3	54.2	55.5	51.9	47.1
Numerator	109,115	109,777	105,122	94,832	97,308
Denominator	212,848	202,518	189,242	182,597	206,783
Data Source	CMS 416	CMS 416	CMS-416	CMS-416	CMS-416
Data Source Year	FFY17	FFY18	FFY19	FFY20	FFY20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	48.0	48.2	48.3	48.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Denominator includes Medicaid children ages 1-18 years eligible for 90 days or more.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>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.</td></tr>
<tr><td>Denominator:</td><td>Number of resident women who delivered a live birth in Utah.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Similar to MICH-D01: Increase the proportion of women who are screened for postpartum depression at their postpartum checkup. No 2030 target has been established to date.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Utah PRAMS data.</td></tr>
<tr><td>Significance:</td><td>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 Obstetricians 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.</td></tr>
</table>

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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children whose family eats meals together 4 or more days out of the week **Denominator:** Children age 0-17 years
Healthy People 2030 Objective:	There is no corresponding Healthy People 2030 measure.
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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of eligible students who participate in the National School Lunch Program **Denominator:** The total number of students enrolled in schools
Healthy People 2030 Objective:	Related to AH-04: Increase the proportion of students participating in the 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. Additionally, 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 Outcome Measure (SOM) Detail Sheets

State: Utah

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Utah

ESM 1.2 - 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:	Inactive - We do not have a robust evaluation strategy to measure the effect of the Power Your Life booklets provided to clients.
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:	**Unit Type:** Count **Unit Number:** 300 **Numerator:** Count of women enrolled in Salt Lake County Home Visiting who receive education on the well-woman visit. **Denominator:**
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 1.3 - 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:	Inactive - Completed
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:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of community partners and organizations engaged in a coalition to create a well-woman visit strategic plan for the State of Utah **Denominator:**
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 their lifespan.

ESM 1.4 - 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:	Inactive - Completed
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:	**Unit Type:** Count **Unit Number:** 9 **Numerator:** Number of questions on survey **Denominator:**
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 facilitators and barriers to receiving a well-woman visit. With this information it is possible to create programming that will resonante with our target population, thus increasing the percentage of women who receive care.

ESM 1.5 - Develop and offer an educational module to community health care workers as an online supplemental course
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Creation of a Maternal and Child Health education module that will be available online that will focus on preparing community health workers to educate on preconception health and well-woman care recommendations.
Definition:	**Unit Type:** Count **Unit Number:** 3 **Numerator:** FY23 is a baseline year for ESM 1.4 **Denominator:**
Data Sources and Data Issues:	Community Health Worker Program
Evidence-based/informed strategy:	Maternal and Child Health education module developed and offered to community health workers as an online supplemental course.
Significance:	By reaching and mobilizing women of childbearing age within their communities, community health workers can improve access to care and increase utilization of preventive care services like cervical cancer screenings and mammography. By focusing on well-woman care, trained CHWs have the potential to protect and optimize women's health over the course of their lifetime and reach our underserved communities.

ESM 4.4 - 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

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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants born in a facility that has met the requirements set by the Stepping up for Utah Babies program **Denominator:** Number of live births
Data Sources and Data Issues:	Numerator: Maternal and Infant Health Program Data/Vital Records Birth Certificate Data 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 4.5 - 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:	Inactive - Replaced
Goal:	Increase the percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of eligible pregnant and postpartum WIC participants who receive at least one contact from a WIC Breastfeeding Peer Counselor **Denominator:** The number of eligible pregnant and postpartum WIC participants
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 4.5 - The number of worksites that have federal lactation accommodations and breastfeeding strategies. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Support local health departments in efforts to help worksites meet the requirements of the federal lactation accommodations law. Measured by the number of worksites that meet the requirements.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** This ESM is new and FY2023 is a baseline year. **Denominator:**
Data Sources and Data Issues:	EPICC Program Data
Evidence-based/informed strategy:	Increase the number of worksites that have federal lactation accommodations and breastfeeding strategies.
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. Returning to work is a major reason for women to discontinue breastfeeding. Women who are employed in worksites with adequate lactation accommodations have a good chance of increasing their duration of breastfeeding.

ESM 4.6 - 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

Measure Status:	Inactive - Replaced
Goal:	Increase the number of surveys received from women who utilize lactation policies and/or lactation rooms at the workplace
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of surveys received **Denominator:**
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 policies 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 4.7 - The percentage of eligible pregnant and postpartum WIC participants who received at least three contacts 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 three contacts from a WIC Breastfeeding Peer Counselor.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** This is a new ESM for FY23 **Denominator:** This is a new ESM for FY23
Data Sources and Data Issues:	WIC program data
Evidence-based/informed strategy:	Increase the percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer Counselor.
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 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

Measure Status:	Active
Goal:	Conduct at least 12 ASQ trainings per year
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of trainings **Denominator:**
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:	**Unit Type:** Count **Unit Number:** 99,999 **Numerator:** Number of ASQ screens in UDOH ASQ Online Enterprise Account **Denominator:**
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 percentage 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:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak). **Denominator:**
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-person 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:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of adolescents who receive the Upstanding training **Denominator:**
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 of options throughout the school day.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** TBD **Denominator:** TBD
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:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of youth participating in the Teen Outreach Program **Denominator:**
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 - 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Utahns who filed for the EITC **Denominator:** # of Utahns who qualify for the EITC
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 9.6 - 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:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of Utahns who have been trained in Question, Persuade, Refer (QPR) **Denominator:**
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 11.2 - 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:	Inactive - Replaced
Goal:	Increase the percentage of families of CSHCN who report a change in knowledge on the importance of the medical home.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families surveyed post-Medical Home training who report a positive change in knowledge. **Denominator:** Number of families who complete both the pre- and post test for Medical Home training.
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
Goal:	Increase the percentage 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:	**Unit Type:** Percentage **Unit Number:** 100 **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. **Denominator:** Number of children with special health care needs served by the Bureau.
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 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN</td></tr>
<tr><td>Goal:</td><td>As UCCCN practices are trained and improved medical home related services, satisfaction by patients and families will increase.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>UCCCN member practice families who reported positively on medical home experiences.</td></tr>
<tr><td>Denominator:</td><td>Total UCCCN member practice family surveyed</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>UCCCN Member Practice Survey</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of a medical home.</td></tr>
<tr><td>Significance:</td><td>The American Academy of Pediatric defines the medical home as:
-Accessible: Care is easy for the child and family to obtain, including geographic access and insurance accommodation.
-Family-centered: The family is recognized and acknowledged as the primary caregiver and support for the child, ensuring that all medical decisions are made in true partnership with the family.
-Continuous: The same primary care clinician cares for the child from infancy through young adulthood, providing assistance and support to transition to adult care.
-Comprehensive: Preventive, primary, and specialty care are provided to the child and family.
-Coordinated: A care plan is created in partnership with the family and communicated with all health care clinicians and necessary community agencies and organizations.
-Compassionate: Genuine concern for the well-being of a child and family are emphasized and addressed.
-Culturally Effective: The family and child's culture, language, beliefs, and traditions are recognized, valued, and respected.
Practices who implement all or strive to achieve at least some of these standards work towards fulfilling a "triple aim": improved patient experience, increased quality, and decreased costs.

Surveys for this new ESM for FY23 have not yet been developed. FY23 will be a baseline year as survey instruments are developed and distributed among pilot practices, then more fully among participating UCCCN practices.</td></tr>
</table>

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 to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth and adolescents with an active transition plan who report positive outcomes on stakeholder work group survey.</td></tr>
<tr><td>Denominator:</td><td>Number of youth and adolescents surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Stakeholder work group survey.</td></tr>
<tr><td>Significance:</td><td>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:

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.

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.</td></tr>
</table>

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 to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Survey of youth with special health care needs who have an active transition plan. **Denominator:** All youth with special health care needs surveyed.
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 to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Survey of providers trained who indicate they have an active transition policy in place.</td></tr>
<tr><td>Denominator:</td><td>All providers trained in transition.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Stakeholder work group survey for transition trained providers.</td></tr>
<tr><td>Significance:</td><td>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.

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.</td></tr>
</table>

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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Medicaid children aged 1-18 who had a preventive dental visit</td></tr><tr><td>**Denominator:**</td><td>Number of Medicaid children aged 1-18 eligible for Medicaid for 90 days or more</td></tr></table>
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 than those of higher economic status. They are part of the population in Utah that is important to concentrate on in improving this measure.

Form 11
Other State Data

State: Utah

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Utah

Annual Report Year 2021

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	9		
2) Vital Records Death	Yes	Yes	Annually	9	Yes	
3) Medicaid	Yes	Yes	Monthly	1	Yes	
4) WIC	Yes	Yes	Monthly	1	Yes	
5) Newborn Bloodspot Screening	No	No	Never	NA	No	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Monthly	1	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Monthly	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Data obtained through ongoing joint MCH and OVRS data agreement. Data is available in September for the data year ending in January.
Data Source Name:	**2) Vital Records Death**
	Field Note: Data obtained through ongoing joint MCH and OVRS data agreement. Data is available in September for the data year ending in January.
Data Source Name:	**3) Medicaid**
	Field Note: Data obtained through DRP and Medicaid Eligibility data sharing agreement.
Data Source Name:	**4) WIC**
	Field Note: Data obtained through a joint data sharing agreement through the DRP and the Utah WIC program.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: We currently do not have access to this data.
Data Source Name:	**7) Hospital Discharge**
	Field Note: This data is obtained annually with a data sharing agreement between DRP and the Office of Informatics and Data Systems and monthly through Utah Women's and Newborn Quality Collaborative and Office of Informatics and Data Systems.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: Data is available annually through the MIHP and CDC.