Maternal and Child Health Services Title V Block Grant

Utah

FY 2024 Application/ FY 2022 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

July 15, 2023

Shirley Payne, PhD, MPH
Director, Division of State and Community Health
Maternal & Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Payne:

We are pleased to submit Utah's Maternal and Child Health Block Grant Application for Fiscal Year 2024 and the Annual Report for Fiscal Year 2022.

The 2024 application outlines how Title V Block Grant dollars are used to positively impact the health of women, children with and without special health care needs, adolescents and families in our state. It outlines the plan for the coming grant period and the Annual Report for FFY 2022, which details the results of planned efforts. We are excited to continue our work in addressing the National and State Performance Measures to improve the health of Utah's MCH/CSHCN populations.

Sincerely,

Tracy S. Gruber (Jul 14, 2023 06:08 MDT)

Tracy Gruber
Executive Director
Utah Department of Health and Human Services

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

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

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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 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: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Utah's MCH/CSHCN Program

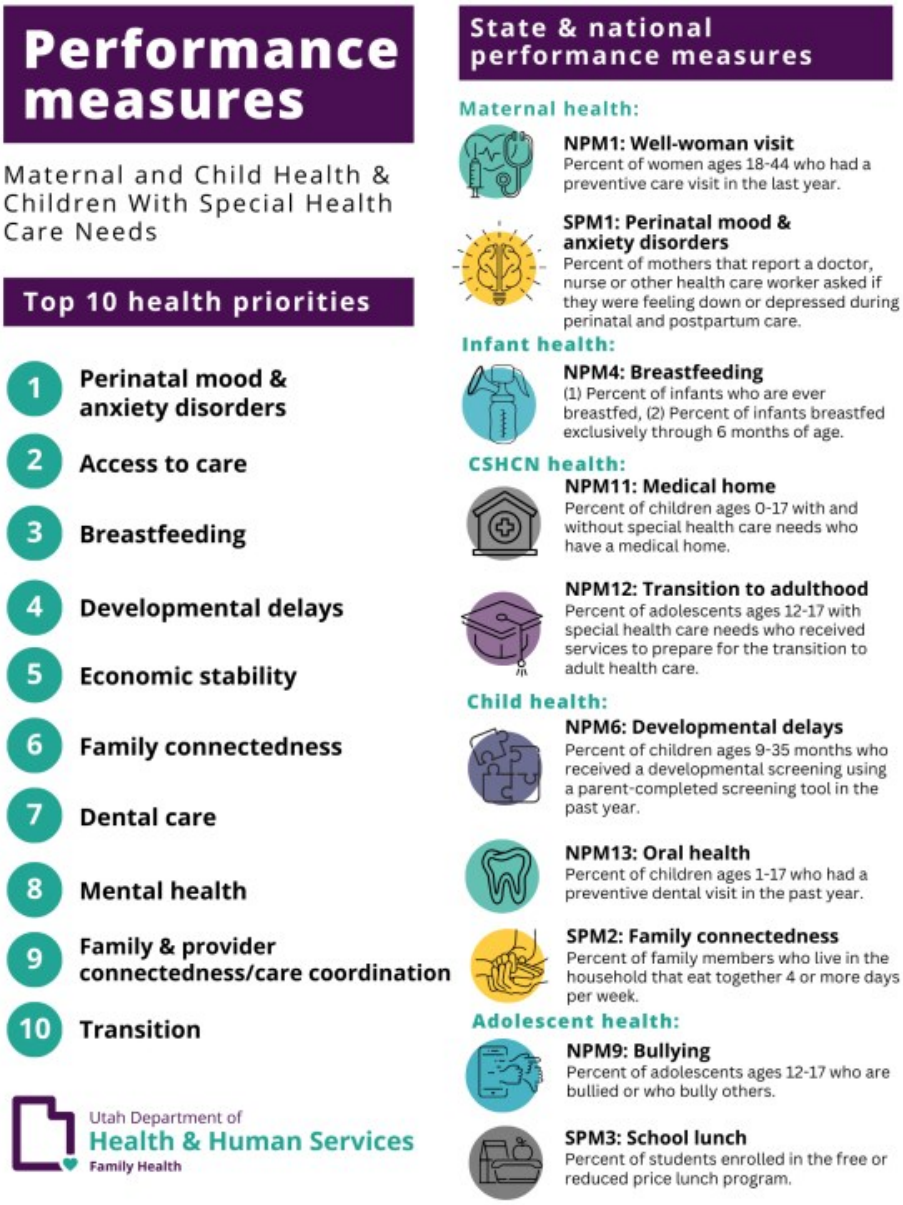
Utah's Title V Maternal & Child Health Block Grant is administered by the Offices of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) in the Division of Family Health (DFH) of the Utah Department of Health and Human Services (DHHS). Utah's MCH/CSHCN programs collaborate with other statewide agencies, Local Health Departments, community partners, and stakeholders to identify and implement strategies to move the needle for women, infants, children, adolescents and children with special health care needs. The 2021-2025 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 determining 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).

Image 1. State and National Performance Measures



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 the annual report 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 and through social media outlets. The Office of MCH formed a Well-Woman Coalition to bring together community partners and produced a Well-Woman strategic plan for Utah. Data is being collected through the Behavioral Risk Factor Surveillance System survey to better understand the barriers women experience in accessing routine preventive care.

Postpartum depression is the most common complication of pregnancy. When a mother's mental health complications go undiagnosed, there can be 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 awareness, screening, and referral resources. Education to raise awareness among pregnant and postpartum women is provided through in-person events and social media platforms. The Maternal and Infant Health Program developed a website listing providers with training in perinatal mental health to assist citizens in finding support.

Perinatal and Infant

The ability to begin and continue breastfeeding can be influenced by a host of factors. Parents who receive help and support when they need it are more likely to reach their breastfeeding goals. Utah supports hospitals in implementing 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 and Prevention 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. 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. Staff in the Office of Early Childhood work 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 family connectedness. This connectedness is a protective factor for youth and onset of risky behaviors. Connectedness is a protective factor for reducing suicide. MCH and 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 school meal programs consume more milk, fruits, and vegetables during meal times and have a better intake of certain nutrients, such as calcium and fiber, than nonparticipants. Eating breakfast at school is also 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 educating 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, and 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 a 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. The Office of CSHCN partners with Utah Family Voices to support statewide family-centered care for all children and youth with special health care needs and/or disabilities.

While the Office of CSHCN has an established Advisory Committee composed of family members and individuals with special health care needs, the committee has not met recently due to COVID. After consulting with the staff, it has been determined that Utah Family Voices will now be utilized to enlist parents to provide guidance and support in matters concerning CSHCN. This decision highlights the valuable role parents and youth with special health care needs play in shaping and enhancing services for children and youth with special needs.

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 used to identify Title V population needs. The budget outlines where Block Grant dollars are distributed. Utah conducted a comprehensive five-year needs assessment in 2020. MCH/CSHCN used this information to select NPMs, SPMs, and ESMs for the 2021-2025 needs assessment cycle. For this annual report, state priorities have not changed based on community needs. The MCH/CSHCN Offices 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:

Office of Maternal and Child Health:

- Maternal and Infant Health Program
    - Perinatal Mortality Review
    - Preconception Health
    - MotherToBaby
    - Breastfeeding Friendly Hospital Initiative
- Data Resources Program
- Utah Women and Newborns Quality Collaborative
- Office Administration

Office of Children with Special Health Care Needs:

- Autism System Development Program
- Early Hearing, Detection and Intervention Program
- Integrated Services Program
- Office Administration
- Utah Birth Defect Network
- Utah Parent Center (Contracted)

Office of Early Childhood:

- Early Childhood Utah
- Child Health Advanced Records Management Program (CHARM)

Office of Health Promotion and Prevention:

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

Office of Public Affairs and Education:

- Safe Haven Program

Office of Primary Care and Rural Health:

- Oral Health Program

Utah’s 13 Local Health Departments

III.A.3. MCH Success Story

In Utah, an estimated 1 in 40 8-year-old children have an autism spectrum disorder (ASD). In children with ASD, agitation is the final common pathway for several different issues. Children with ASD are more likely to experience agitation and are less likely to be able to explain why they are agitated than neurotypical children. This can lead to children with ASD being prescribed high doses of antipsychotics while they continue to be agitated, which can lead to side effects from long-term antipsychotic use.

To address this issue, the MCH/CSHCN Title V Block grant supports the Sources of Distress (SD). The SD was developed in Utah by Dr. Deborah Bilder at the University of Utah, Department of Psychiatry. The SD aims to identify underlying treatment targets to reduce agitation as effectively and safely as possible. The SD guides parents and professional caregivers through a series of questions to describe what they know about the affected individual. The responses are then used to determine the potential presence of one or more conditions that commonly contribute to irritability and agitation.

Following the completion of the SD, parents and professional caregivers receive a report that can be used to discuss ways to reduce agitation with their general practitioner (GP). In some cases, this can lead to a “curbside consult” between Dr. Bilder and the GP to discuss medication management.

In 2022, the SD was accessed and completed through the CSHCN website by 141 unique users. Here are two examples:

1) A young individual with ASD and severe intellectual disability developed an acute behavioral decompensation during a family vacation. This continued to worsen during the weeks following their return home. The youth lived in a rural area of Utah and the family had a trusting relationship with the primary care physician. The youth had been placed on several sedating psychiatric medications in a very short time in hopes of interrupting this behavior escalation, but no positive response occurred. The family blamed themselves for the decompensation because they attributed the behavior to their vacation. Following SD, it became clear that the youth was suffering from a psychiatric condition that was being fueled by one of the psychiatric medications that had been started a few months before this trip. This medication was stopped and his other psychiatric medications were switched to target specific indications identified through SD. The youth subsequently stabilized without needing inpatient hospitalization.

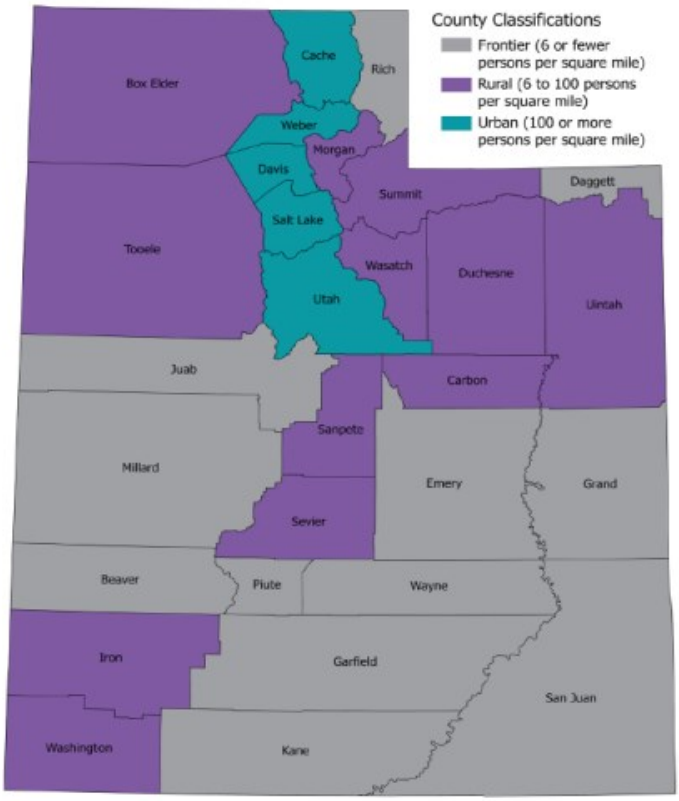
2) With the SD, Dr. Bilder was able to support the medical decision-making of a dedicated psychiatric nurse practitioner who serves several children with ASD. Feedback from the nurse practitioner described the support for one child as “nothing short of miraculous”. This child experienced severely disruptive behaviors that led to two psychiatric hospitalizations. The child was heavily medicated, but there had been little improvement in their behavior. The family even began an experimental alternative medication in their desperate attempt to help their child. The SD indicated multiple psychiatric conditions for which two of the medications were exacerbating. After stopping these medications and starting another, their behavior, mood, and anxiety disorders stabilized.

III.B. Overview of the State

Population Demographics

Geographically, Utah is the thirteenth largest state consisting of primarily rural and frontier land. Utah has 5 urban, 11 rural, and 13 frontier counties (figure 1). In 2020, Utah's average population density was 39.7 persons per square mile, compared to 93.8 persons per square mile nationally. While geographically the state is largely rural and frontier, 89.8% of the population lives in the five urban counties that make up the Wasatch Front, with 36% residing in Salt Lake County. Sixty-three percent of Utah's lands are under federal ownership, with 24% privately owned, 8.5% by the State and 4.5% by tribal governments. According to the U.S. Census Office, Utah's population increased to 3,271,616 in 2020, an 18.4% increase since 2010, making Utah the fastest-growing state in the nation.

Figure 1. Classification of Utah's Counties as Urban, Rural, and Frontier



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.

The 2020 Census results showed 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 (36.8%), Hispanic/Latinos (37.6%), American Indian/Alaska Natives (26.5%), and Whites (8.1%).

Data on religious affiliation in Utah comes from the 2021 Behavioral Risk Factor Surveillance Survey (BRFSS),

which reports that 49.5% of Utahns are members of the Church of Jesus Christ of Latter-day Saints (LDS). Utah is home to the world headquarters for the LDS church. Other Christian faiths (Protestant and Catholic) make up 10.7% of Utah's population. Thirty-nine percent of Utahns identify as some other religion and less than 1% report no religion.

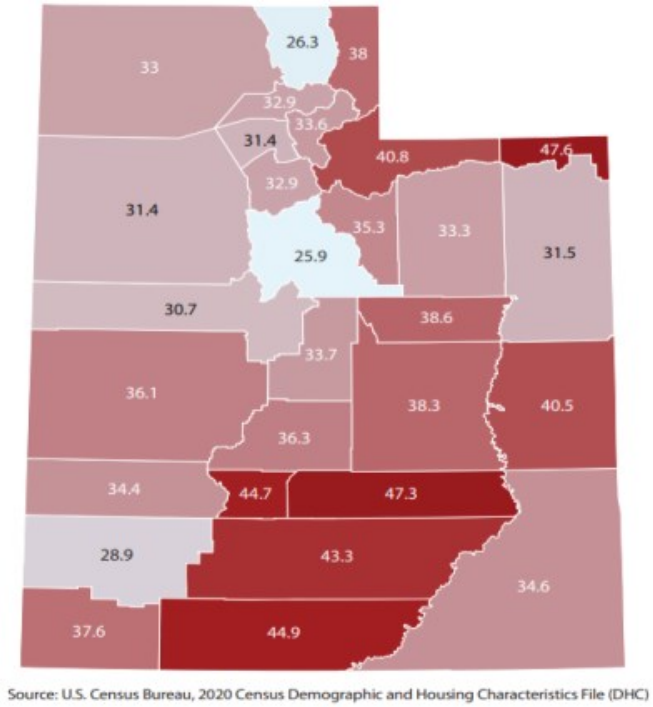
There are eight sovereign tribal governments within Utah: Confederated Tribes of the Goshute Reservation, Navajo Nation, Northwestern Band of Shoshone Nation, Paiute Indian Tribe of Utah, San Juan Southern Paiute, Skull Valley Band of Goshute, Ute Mountain Ute Tribe, and Ute Indian Tribe. Census data shows the largest tribal communities indigenous to Utah are the Navajo Nation, Ute Indian Tribe, and Paiute Indian Tribe of Utah. Figure 2 provides a map of Utah Tribal lands.

Figure 2. Map of Utah Tribal Lands

Utah has resettled over 22,561 refugees since 1998 and ranks 24th in refugee arrivals. Of those arrivals in 2021, 45.6% were female. Children under 18 years old comprise 46.7% of the refugees arriving in Utah since 2015. While refugees in Utah arrive from countries all over the world, since 2016 most have arrived from African countries (47%), followed by South and Central Asian countries (23%), the Near East (North Africa and Middle Eastern countries) (12%), and East Asian/Pacific Island and Latin American countries (11% and 7%, respectively).

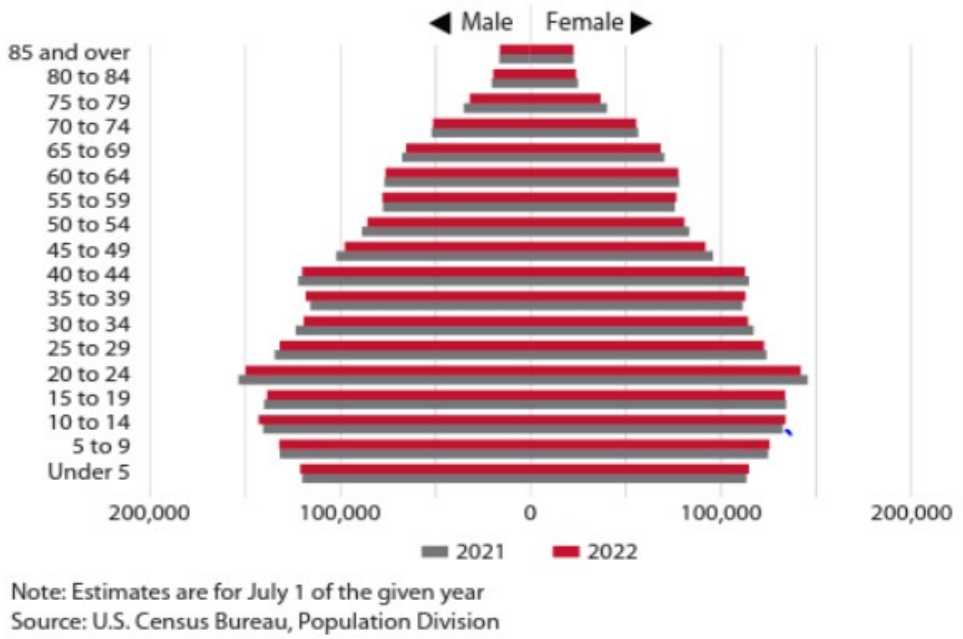
In 2020, life expectancy at birth was 77.1 years for males and 80.9 years for females in Utah, compared to 74.5 for U.S. males and 80.2 U.S. females. Utahns under the age of 25 make up 39.8% of Utah's population, compared to 31.7% of the U.S. overall. The younger age structure of the Utah population results in the lowest median age in the nation at 31.8 years, compared to 38.8 years for the entire US. Median ages by county are shown below in figure 3. Graph 1 illustrates the Utah population by age and sex based 2020 Census data.

Figure 3. Median Age by County, 2020.



First Insights - 2020 Census Demographic and Housing Characteristic File, Kem Gardner Policy Institute, 2023

Graph 1. Utah Population by Age and Sex, 2021-2022



Kem Gardner Policy Institute, 2023

Table 1. State of Utah Selected Age Groups by Race and Hispanic or Latino Origin, July 1, 2022

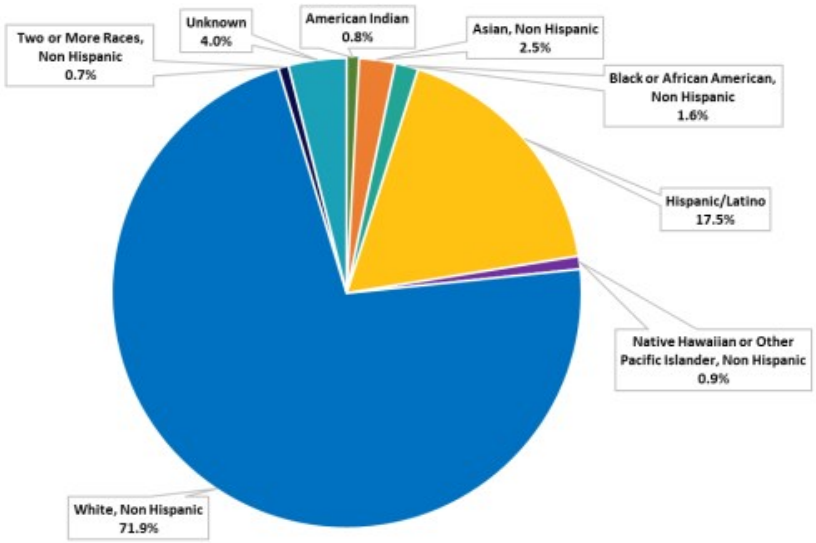
Race and Ethnicity	Total	Under Age 18		Over Age 18	
		Estimate	Share	Estimate	Share
Total	3,380,800	931,608	27.6%	2,449,192	72.4%
White Alone	2,592,896	665,470	25.7%	1,927,426	74.3%
Hispanic or Latino	512,087	180,038	35.2%	332,049	64.8%
Asian Alone	89,094	18,688	21.0%	70,406	79.0%
Two or More Races	79,404	37,165	46.8%	42,239	53.2%
Black or African American Alone	41,138	11,588	28.2%	29,550	71.8%
Native Hawaiian and Other Pacific Islander Alone	35,994	11,228	31.2%	24,766	68.8%
American Indian or Alaska Native Alone	30,187	7,431	24.6%	22,756	75.4%

Note: Share is of total race or ethnic population. Individuals claiming Hispanic, Latino, or Spanish origin are categorized as Hispanic and can be of any race. Non-Hispanic persons can be classified as a single race alone—White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander—or as two or more races. This table presents the non-Hispanic, single-race alone categories. Source: U.S. Census Bureau, Population Division, Kem Gardner Policy Institute, 2023

Utah's Births

Utah's 2021 general fertility rate ranked fifth highest in the nation. Utah's 2021 general fertility rate was 63.2 live births per 1,000 women in 2020 compared to 56.3 nationally. Utah continues to have the highest birth rate in the U.S. (13.9 Utah vs.11.0 U.S.). For the first time in six years, the number of live births to Utah residents rose from 45,724 to 46,719 in 2021. Graph 2 illustrates the 2021 Utah births by race and ethnicity.

Graph 2. Utah Births by Race/Ethnicity, 2021



Utah's birth outcomes are generally favorable, yet disparities emerge when examined by race and ethnicity (table 2):

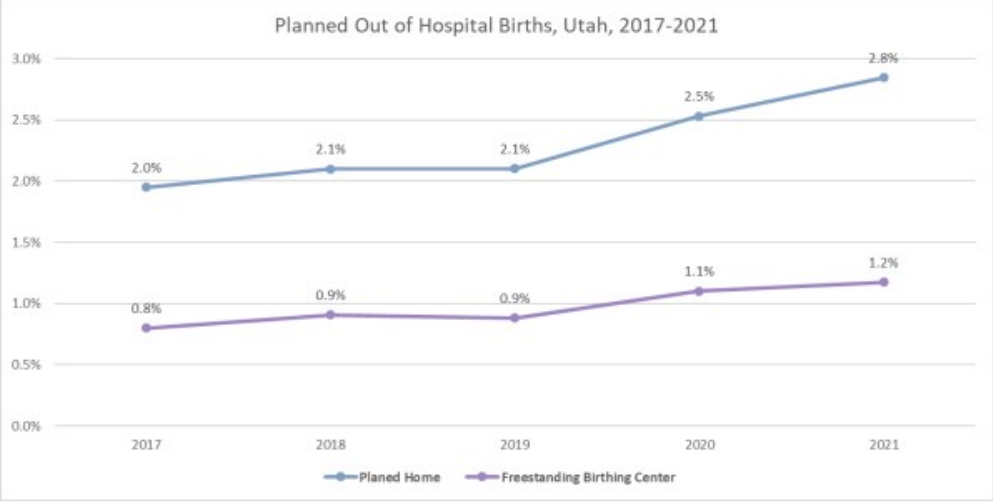
Table 2. Birth Outcomes by Race/Ethnicity, 2021

Maternal Race/Ethnicity	Preterm Birth*	Low Birthweight*	Cesarean Section*	Infant Mortality** (Per 1,000)	Adolescent Births* (Per 1,000)
American Indian/ Alaskan Native	11.9%	8.1%	26.4%	6.9/1,000	19.8/1,000
Asian	10.8%	10.5%	28.0%	4.8/1,000	2.0/1,000
Black/African American	12.0%	9.5%	29.8%	8.2/1,000	21.4/1,000
Hispanic/Latina	10.0%	8.3%	25.3%	5.9/1,000	22.5/1,000
Native Hawaiian/ Pacific Islander	13.4%	8.4%	27.5%	8.6/1,000	12.6/1,000
Two or more races	12.8%	10.3%	23.6%	***	0.9/1,000
White, Non-Hispanic	9.6%	7.0%	22.5%	4.5/1,000	6.3/1,000
Unknown	11.0%	7.8%	22.9%	5.1/1,000	***
Statewide	9.9%	7.4%	23.3%	4.9/1,000	9.7/1,000

*2021 Vital Records data, ** 2019-2021 linked birth-death data, ***Data suppressed due to small numbers

The proportion of Utah births that occur in an out-of-hospital setting are increasing (graph 3). Over the past five years, planned home births increased by 46% and freestanding birth center deliveries increased by 47%.

Graph 3. Planned Out of Hospital Births in Utah, 2017-2021

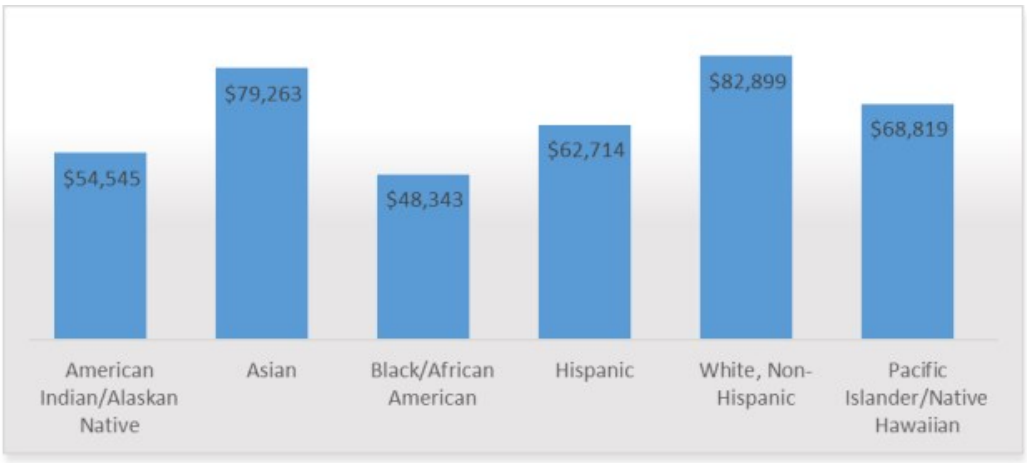


Utah's Economy

The Office of Labor Statistics noted that the 2022 unemployment rate in Utah was 2.2 compared to 3.5 nationally. The 2017-2021 American Community Survey (ACS) estimates for median household income put Utah's $79,133

above the U.S. at $69,021. As Utah's households are large, there is a significantly lower per capita income in Utah ($33,378) compared to the U.S. ($37,638). There is also a large variation in median income when broken out by race and ethnicity as shown in graph 4.

Graph 4. Median Household Income by Race and Ethnicity, American Community Survey, 2017-2021

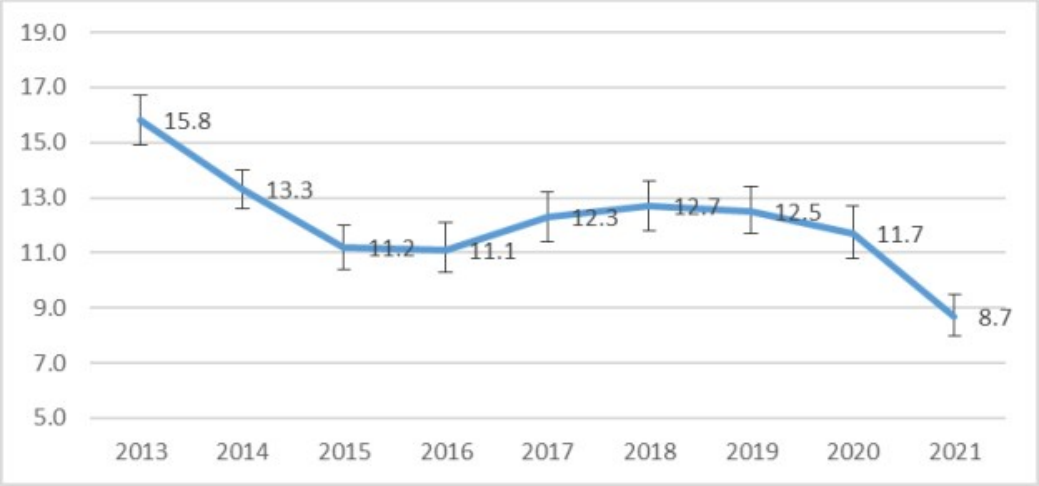


According to the 2017-2021 ACS 5-Year estimates, the percentage of individuals with income below the federal poverty level (FPL) is 8.7% in Utah vs. 12.8% in the U.S. Poverty rates range widely across counties of residence. In 2020, poverty rates were lowest in Morgan County (4.5%) and highest in San Juan County (26.8%), with a statewide mean of 10.2%. The 2020-2021 National Survey of Children's Health finds that 9.2% of families had a household income below 100% FPL, compared to 18.4% nationally.

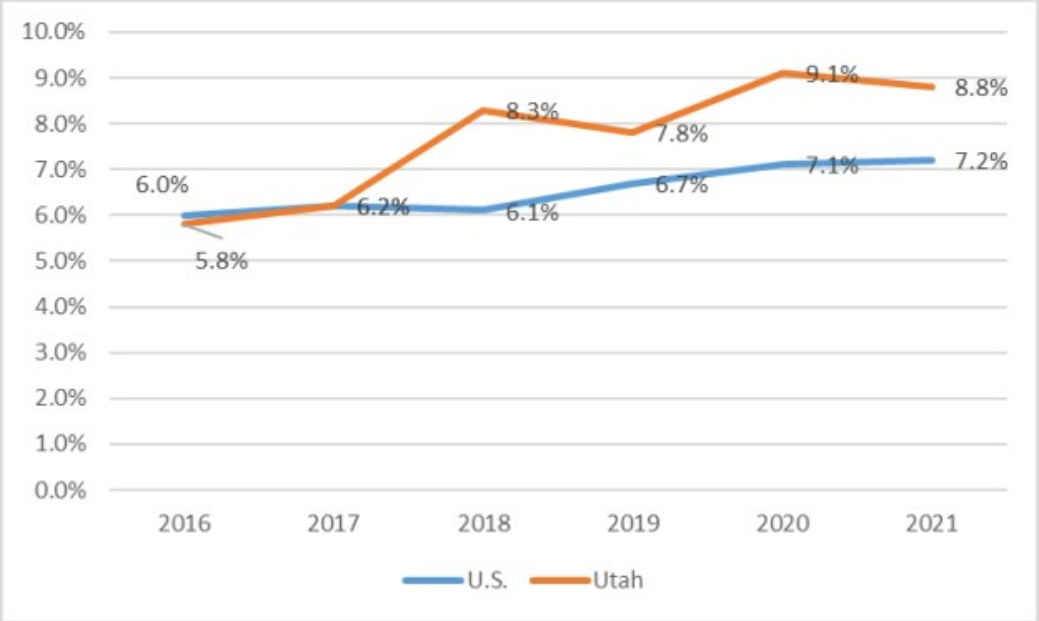
Health Insurance

In 2021, BRFSS data estimated that 8.7% of adult Utahns were uninsured, continuing a decreasing trend over the past several years (graph 5). However, there is variation in insurance status by race and ethnicity. Graph 7 illustrates Asian adults being the least likely to be uninsured (3.8%) followed by White adults (6.4%). Pacific Islander, Black, American Indian/Alaska Native, and Hispanic adults all have higher uninsured rates compared to the Utah average. Uninsured rates for Utah children ages 0-17 have been gradually increasing since 2016 (graph 6) and are slightly higher than the national average.

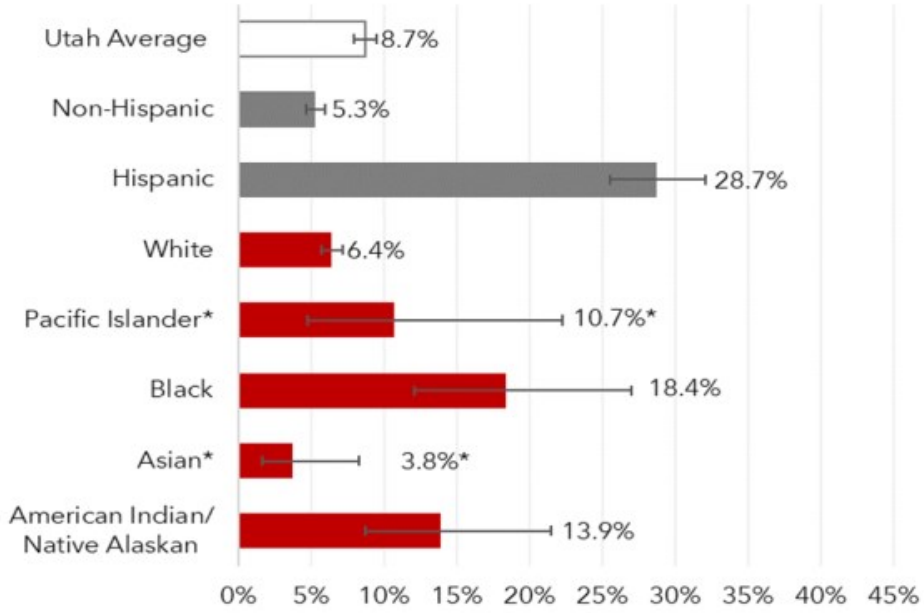
Graph 5. Percentage of Adult Utahns without Health Insurance, BRFSS 2013-2021



Graph 6. Percentage of Children (ages 0-17) without Health Insurance, Utah vs. U.S. NSCH 2016-2021



Graph 7. Utah Uninsured Rates for Adults by Race and Ethnicity, BRFSS 2021



Note: Health insurance is defined as including private coverage, Medicaid, Medicare, and other government programs. Age-adjusted. No comparable U.S. average is provided.

*Use caution when interpreting. Estimates have a coefficient of variation greater than 30% and less than or equal to 50% and are therefore deemed unreliable by Utah Department of Health standards.

Source: Utah Behavioral Risk Factor Surveillance System, Office of Public Health Assessment, Utah Department of Health and Human Services. Retrieved Wed. 7 June 2023 from the Utah Department of Health and Human Services, Indicator-Based Information System for Public Health Web site: http://ibis.health.utah.gov, Kem Gardner Policy Institute, 2023

Education

Based on the 2017-2021 ACS, Utah had a higher percentage of residents with a high school diploma (93.1%) compared to what is seen nationally (88.9%) among those aged 25 years and older. A higher percentage of Utah's age 25 and older population obtained a Bachelor's degree (35.4%) compared to the U.S. (33.7%), though the proportion of Utahns with a graduate degree (12.7%) is similar to the U.S. (11.7%). According to the 2022 Kids Count report, Utah has a higher percentage of children ages 3-4 who are not in school compared to the nation (57% vs 53%). However, the proportion of fourth graders not proficient in reading is lower in Utah (60%) as compared to the national average (66%). The June 2022 National Education Association Report lists Utah as having the lowest per-student expenditure at $8,968, compared to the national average of $14,360.

Household and Family

Utah has the largest household size in the country at 2.9 persons per household compared to 2.5 nationally. Utah's average family size is also larger than the U.S. (3.51 vs 3.15). The percentage of family households with one or more persons under the age of 18 is higher in Utah (38.3%) than nationally (29.5%).

Children and Adolescents

Table 3 uses National Survey of Children's Health (NSCH) data from 2020-2021 to illustrate many areas where Utah's children differ from the national average:

Table 3. Demographic Characteristics of Children Ages 0-17, Utah and U.S., NSCH 2020-2021

	Utah	U.S.
Race / Ethnicity		
Hispanic	18.2	25.7
White Non-Hispanic	75.5	50.1
Black Non-Hispanic	1.0*	13.3
Asian Non-Hispanic	1.1	4.6
Other Non-Hispanic	4.1	6.4
Primary Language Spoken in the Home		
English	92.2	84.7
Non-English	7.8	15.3
Highest Education in Household		
Less than High School	4.6	9.6
High School	12.4	19.5
Some College	22.2	20
College Graduate	60.7	50.9
Family Structure		
Two Parent, Currently Married	80	64
Two Parent, Not Currently Married	2.8	7.3
Single Parent	15.5	23.7
Grandparent Household	1.3*	3.4
Other Family Type	0.5*	1.6
Not Insured at Time of Survey	9.1	7.1
Current Insurance Not Adequate	30.0	25.6
2 or More Adverse Childhood Events	14.0	17.2

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

The 2021 Youth Risk Behavior Survey (YRBS) illustrates differences between Utah high school youth and those in the nation. Compared to national estimates, Utah youth were significantly more likely to report texting or emailing while driving (47.0% vs. 36.1%), but less likely to report driving after drinking alcohol (1.0% vs 4.6%). Utah youth were also more likely to report having carried a weapon onto school property (8.0% vs. 3.1%). Utah youth were also significantly more likely to report having experienced sexual violence (14.8% vs. 11.0%). Utah youth were less likely than their U.S. peers to report any form of tobacco (9.5% vs. 18.7%), alcohol use (8.1% vs. 22.7%), or to ever misuse prescription pain medication (8.2% vs. 12.2%).

Children with Special Health Care Needs (CSHCN)

Data from the 2020-2021 NSCH found 23.3% 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 seventh lowest in the nation. The 2020-2021 NSCH data provides important information on Utah's CSHCN

population and their parents in table 4.

Compared to their non-CSHCN counterparts, CSHCN in Utah were more likely to experience one or more current or lifelong health conditions (CSHCN 84.9% vs. non-CSHCN 23.9%) and to not have received needed health care (CSHCN 9.1% vs. non-CSHCN 3.9%). Their families were also more likely to have problems paying for medical bills and health care in the past 12 months (CSHCN 20.5% vs. non-CSHCN 7.9%). Families of CHSCN were also likely to report cutting back on hours or stopping working due to the child's health (CSHCN 12.6% vs. non-CSHCN 4.0%), and to report food insecurity (CSHCN 7.5% vs 2.2%). These findings reflect broader U.S. conditions for CSHCN and their families.

Table 4. Comparison of Utah and U.S. Child Demographics and Other Select Characteristics by CSHCN and Non-CSHCN, NSCH 2020-2021

Comparison of Utah And U.S. Child Demographics by CSHCN and Non-CSHCN				
	Utah Overall (%)	**Utah CSHCN (%)**	**U.S. Overall (%)**	**U.S. CSHCN (%)**
Race/Ethnicity				
Hispanic	18.2	19.2	25.7	23.0
White Non-Hispanic	75.5	73.5	50.1	51.8
Black Non-Hispanic	1.0*	2.1*	13.3	16.0
Other Non-Hispanic	5.3	5.2*	10.9	9.2
Household Income				
0-99% FPL	9.2	19.0	18.4	20.6
100-199% FPL	21.5	12.7	21.2	20.6
200-399% FPL	39.2	16.6	29.0	19.4
400% or greater FPL	30.1	19.7	31.5	18.2
One of More Current or Lifelong Health Indicators	84.9	23.9	92.0	24.3
Current Insurance not Adequate	37.0	28.5	32.7	23.8
Did not Receive Needed Health Care	9.1	3.9	8.8	3.8
Child Has Coordinated, Ongoing, and Comprehensive Care in a Medical Home	55.7	54.4	42.0	47.7
Problems Paying for Child's Medical or Health Care Bills in Past 12 Months	20.5	7.9	14.3	6.8
Family Member Cut Back Hours, stopped Working, or Both Due to Child's Health	12.6	4.0	17.1	3.9
Sometimes or Often Could not Afford to Eat	7.5*	2.2	7.4	3.6

** Indicates the total number of respondents is less than the criteria set by MCHB

* 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

Autism Spectrum Disorders (ASD) Prevalence Estimates Statewide

The Utah Registry of Autism and Developmental Disabilities (URADD) uses a passive, population-based system to identify persons with Autism Spectrum Disorder (ASD) based on a community medical diagnosis of ASD and/or an autism special education eligibility. As previously reported, early identification of ASD in Utah continues to be lower than expected.

In Utah, 1 in 40 8-year-olds in Salt Lake, Davis, and Tooele counties was identified with ASD. Only about 1 in 79 4-year-olds in the same counties were identified[1]. For every two children identified with ASD who were age 4, there was one child who was suspected but not confirmed to have ASD. This is lower than national estimates, indicating that fewer Utah children are being diagnosed early.

To further explore these trends, URADD investigated longitudinal data for two previously studied birth cohorts from 2006 and 2008 at ages 4 and 12, and 4 and 10, respectively. These data demonstrate that 4-year-old children with ASD are not diagnosed until later in life (table 4).

Table 5. Utah Registry of Autism and Developmental Disabilities (URADD) 4-year-old follow up

Utah Registry of Autism and Developmental Disabilities (URADD) 4-year-old follow up			
2006 birth cohort*		2008 Birth cohort*	
4-year-olds	1.2%[2]	4-year-olds	1.3%[2]
12-year-olds	3.3%[3]	10-year-olds	2.7%[3]
*Salt Lake and Tooele Counties			

Data Sources:

1. Maenner MJ, Warren Z, Williams AR, et al. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. MMWR Surveill Summ 2023;72(No. SS-2):1–14. DOI: http://dx.doi.org/10.15585/mmwr.ss7202a1
2. Christensen DL, Maenner MJ, Bilder D, Constantino JN, Daniels J, Durkin MS, Fitzgerald RT, Kurzius-Spencer M, Pettygrove SD, Robinson C, Shenouda J, White T, Zahorodny W, Pazol K, Dietz P. Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 4 Years - Early Autism and Developmental Disabilities Monitoring Network, Seven Sites, United States, 2010, 2012, and 2014. MMWR Surveill Summ. 2019 Apr 12;68(2):1-19. doi: 10.15585/mmwr.ss6802a1. PMID: 30973853; PMCID: PMC6476327.
3. The Utah Registry of Autism and Developmental Disabilities and the DHHS Public Health Indicator Based Information System (IBIS)

As an essential first step, 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 2022, HMG screened 176 children for ASD and referred 233 children to appropriate services.

Moving forward, additional steps need to be taken in working with diagnosis partners to help diagnose children at a younger age.

Utah Title V Capacity

The Department of Health and Human Services' and Utah's Title V unified vision 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."

With the merger into the Utah Department of Health and Human Services, Utah statute was recodified in the 2023 legislative session. Statutes supporting Title V efforts are now woven into the new section 26B, Health and Human Services Code, Chapters 4 (Health Care - Delivery and Access) and 7 (Public Health and Prevention). Offices within the Division of Family Health (DFH) - Maternal and Child Health (MCH), Children with Special Health Care Needs (CSHCN), and the Office of Early Childhood- collaborate to serve mothers, infants, teens, children and children with special health care needs. Other DHHS programs that collaborate and contribute to the Title V work include the Office of Health Promotion and Prevention in the Division of Population Health and the Oral Health Program in the Office of Primary Care and Rural Health.

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 DHHS 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 entire Needs Assessment Report can be found here: 2020 Utah MCH_CSHCN Needs Assessment.pdf.

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, reassess, 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.

Data capacity is strong and focused around the Division of Data, Systems and Evaluation (DSE), which serves as the central point for state health data. DSE includes four Offices: Vital Records and Statistics, Informatics and Data Systems, Information Privacy and Security, and Research and Evaluation. The DSE 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, hospital and emergency department data, hospital performance data, population estimates, and the Utah Cancer Registry. The DSE also conducts the Behavioral Risk Factor Surveillance System. The DSE is responsible for health plan surveys and reporting plan performance annually, as well as inpatient, ambulatory, and emergency room data. The DFH has strong working relationships with the DSE. The MCH/CSHCN Offices collaborate across the Department to ensure integrated use of data and population assessment.

Utah’s Strengths and Challenges

Strengths

Utah’s Title V programs have many attributes that contribute to enhancing communities' health and wellness

statewide. Utah has strong collaboration efforts with stakeholders and values and incorporates the advice of our partners to develop, implement, and evaluate programs for women, children, and families. The State of Utah maintains a hybrid work model which includes both telework and in-person options. Utah continues to find success by conducting our MCH/CSHCN work with stakeholders, the public, and the populations we serve through both in-person and virtual meetings and service provision.

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, means 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 holding cultural beliefs that impact seeking these services.

Addressing the Needs of a Diverse Population

The Department has endeavored to include data on subpopulations in an attempt to better quantify the issues faced by various groups. The Office of Health 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 that outlines how structural and social determinants of health impact health equity and quality of life in Utah. 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 Department 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 programs.

The OHE works to build Utah's public health infrastructure to advance health equity at the state and local level. It supports the establishment of health equity offices across Utah's LHDs and provides training to Department 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 into Department 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 Native Hawaiian/Pacific Islander women. The Title V programs and the OHE work together to identify opportunities to collaborate to address MCH needs among diverse populations.

The Department works with the Office of American Indian/Alaska Natives Health and Family Services (AI/AN). 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 Department, 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 to promote 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 unhoused 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, establish community connections, refer to services, 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 Department and 13 LHDs (figure 4). The DHHS and four 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.

Figure 4. Map/Table of Utah Counties to Local Health Departments

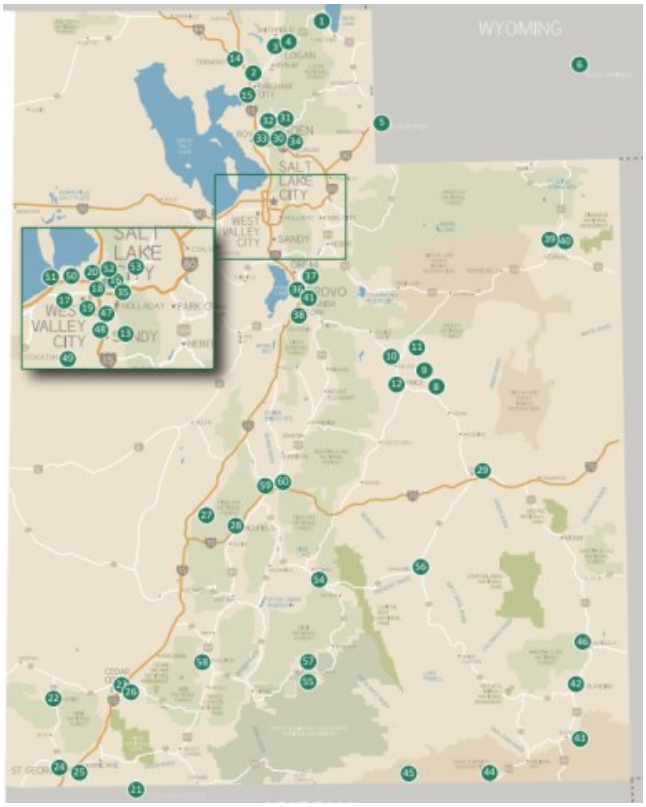
Local Health Department	Counties in Service Area
Bear River Health Department	Box Elder, Cache, Rich
Central Utah Public Health Department	Juab, Millard, Piute, Sanpete, Sevier, Wayne
Davis County Health Department	Davis
Salt Lake County Health Department	Salt Lake
San Juan Public Health Department	San 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

Contracts with the LHDs include developing SMART objectives for Title V measures. The specific objectives vary by district and include postpartum depression education/screening, breastfeeding, family planning, home visiting, oral health/sealants, vision/hearing screening for children. All 13 LHDs have the same developmental screening objective. 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 that collaborate to increase seamless services for Utah's population. One such system is the Community Health Centers (CHCs) throughout the state and the Wasatch Homeless Clinic in Salt Lake City that provides primary care to underinsured and uninsured MCH populations. Utah has fourteen CHCs that operate 60 clinics throughout the state. In 2021, these health centers served 118,906 adults and 48,009 children. The Association for Utah Community Health (AUCH), the state's primary care association, works to promote the development of new or expansion of existing community health centers in Utah. Figure 5 provides a map of CHCs and clinics across the state.

Figure 5. Map of Utah Community Health Centers and Clinics



The Office of Primary Care and Rural Health maintains publicly available listings of Utah's primary care safety net sites, dental safety net sites, and mental health safety net sites.

The Department provided primary care through the Health Clinic of Utah (HCU), which was located in Salt Lake City. This clinic closed in May 2023. The clinic location now houses the University of Utah Population Health Clinic. This new clinic will provide primary care services through a student-run primary care clinic (physicals, immunizations, diabetes care, cancer screenings, etc.). The New American Clinic for refugees will provide health screenings and

medical care for newly arrived refugees, and an intensive outpatient clinic will provide long-term medical and mental health care tailored to the individual needs of patients.

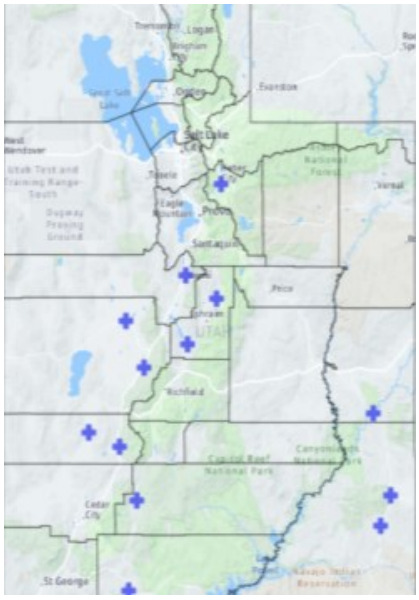
The Indian Health System in Utah consists of one IHS outpatient facility, four Tribal and Tribal Organization operated facilities, and one Urban Indian Organization located in Salt Lake City. Not all reservation communities have a health care facility nearby. While some Tribal programs operate health 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 an individual lives a significant distance or arrives later in the day, running the risk of not being seen and potentially 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 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, one University medical school/facility and one college of osteopathic medicine. All but 12 hospitals are part of the four 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’s five Steward hospitals will be acquired by Centura Health (CommonSpirit Health) in 2023. One urban Utah hospital ended labor and delivery services in 2022.

As shown in figure 6, Utah has 13 Critical Access Hospitals throughout the state:

Figure 6. Map of Utah’s Critical Access Hospitals



Telehealth Capacity

Telehealth capacity is expanding in Utah. The 2022 America's Health Rankings Report notes 95.2% of Utah households have high-speed internet, the highest in the nation. 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 infant diagnostic tele-audiology services for rural/frontier communities. There are now seven tele-audiology sites across Utah.

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. The facilitator provides direct face-to-face contact with the family and infant. The nurse connects the electrodes to the infant and stays with the family throughout the evaluation, while the audiologist remotely accesses the computer to conduct the testing. If the testing reveals that the infant is 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 offers medical providers.

The Department allocates funds to 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 online support groups and counseling using telehealth.

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 2022 Annual Report on America's Health Rankings, Utah ranks 49th in the number of Primary Care providers, with 208.8 providers per 100,000 population (compared to 265.3 nationally). The ratio of dental care (56.7 per 100,000) and mental health care (382.5 per 100,000) providers for Utah ranks 27th and 14th, respectively. The Utah Office of Primary Care & Rural Health 2021 Health Needs Assessment report found that the distribution of providers who practice in rural communities is disproportionate to where the population resides.

Table 6. Population and Provider Distribution between Urban and Rural Areas

	Urban	Rural
Population Distribution	78.5%	21.5%
Primary Care Provider Distribution	89.0%	11.0%
Dental Provider Distribution	84.0%	16.0%
Mental Health Provider Distribution	91.0%	9.0%

The Integrated Services Program (ISP) contracts with four rural LHDs within the State to provide care coordination and clinical coordination for direct care services to the CSHCN population residing within their service delivery areas. 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, which quite frequently are not readily available in their local communities, as the CSHCN specialty and subspecialty pediatric providers, including the state's tertiary pediatric care centers, are mostly located along the Wasatch Front. There is one comprehensive

women and children's health center located in the southern part of the state, serving a five-county rural area. Many rural 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 2022-2023, ISP provided services through a hybrid model that includes both virtual and in-person services. ISP has found this modality allows ISP providers to be more flexible on appointment times, with the ability to meet with families in the evening after the workday. Additionally, it has cut travel time and costs, subsequently allowing for more service time.

Utah's Public Behavioral Health System

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

Utah Medicaid

Utah's Medicaid program is administered through the Department. 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 accountable to provide physical health benefits: 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 fewer 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.

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: women, children (including those with special health care needs), and families. 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 2024 Application/FY 2022 Annual Report Update

MCH/CSHCN Ongoing Needs Assessment Activities

Utah Title V staff employ various mechanisms to assess the ongoing needs of MCH/CSHCN 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 also began receiving additional training on Health Equity and applying an equity lens when reviewing Federally Available Data (FAD) and program data related to performance and outcome measures.

2. Needs assessment activities include updating MCH/CSHCN 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 through the Public Health Outcome Measures Report. Updating these indicators enables staff to stay current on data trends and identify areas where renewed focus may be needed.

3. Collaboration and partnership with Local Health Departments (LHDs) enables the State to become more aware of needs and issues affecting MCH/CSHCN populations at the local level and creates a unified focus for meeting needs. Title V staff meets quarterly with the 13 LHD Nursing Directors for regular communication and collaboration.

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 such data. One identified data gap involved COVID-19 vaccine uptake among pregnant individuals. Early clinical research on COVID-19 vaccines excluded pregnant persons. Because of this, clinicians and pregnant individuals were left to weigh the risks of COVID-19 against the unknown safety of vaccination during pregnancy. As more data was published indicating vaccines were safe to administer during pregnancy, the Utah PRAMS team received funding from the Council of State and Territorial Epidemiologists (CSTE) to collect information about pregnancy experiences related to COVID-19 vaccines in FY 2022. These questions provided important information on whether a respondent received a vaccine and, if they did not, what the reasons were for not getting a vaccine. Questions also assessed different sources of COVID-19 vaccine information among pregnant people. A summary of findings was published in the January 2023 Health Status Update.

5. The Department 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 activities happen via collaboration across multiple programs, the HSU publication keeps all readers informed about important and emergent state population health needs across many 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 2022-2023 related to MCH/CSHCN populations:

- 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 - April 2022
- Newborn hearing screening in underserved populations - June 2022
- Reduced incidence of congenital Cytomegalovirus (CMV) infections during the COVID-19 pandemic - August 2022
- Firearm-related deaths among children ages 0-18 in Utah, September 2022
- Influenza vaccination coverage during pregnancy in Utah, PRAMS 2016-2020 - October 2022
- Sudden unexpected infant deaths in Utah, 2020 - October 2022
- Experiences of anxiety during pregnancy in Utah, PRAMS 2016-2020 - November 2022
- COVID-19 vaccination during pregnancy - January 2023
- Positive childhood experiences data from the 2021 Youth Risk Behavior Survey - February 2023
- The Embrace Project Study: Supporting the well-being of minority women along Utah's Wasatch Front through mental health and self-care practice, April 2021-October 2022 - February 2023
- Streamlined training to help Head Start childcare centers receive TOP Star endorsement - March 2023
- Trends and characteristics of gestational diabetes: Utah, 2012-2021- April 2023
- Out-of-hospital births in Utah: Newborn hearing screening, diagnostics, and cCMV testing - May 2023
- Sociodemographic factors associated with frequent bullying, Utah, 2018-2021 - May 2023

6. Title V staff meet with community partners to identify and work on emerging issues. The Utah Children's Care Coordination Network, which is funded through Title V, serves as a surrogate marker for the medical home and 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 support, specialists, and organizations to meet family needs. Educational topics over the past 12 months have included: asthma resources; autism; Utah State legislative session update; enhancing referrals; a day in the life of a care coordinator; the power of care coordination in the medical home; mental and behavioral health resources; IEPs, special education, and 504s; quality improvement; transition to adulthood; motivational interviewing; and self-care. All meetings are recorded and made available through the Utah Children's Care Coordination Network YouTube channel for later viewing. The Office of CSHCN has 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) also convenes monthly Transition workgroup meetings with a broad group of stakeholders who serve the CSHCN population. The goal is to build a community standard for every teen living with a chronic condition and build systems of care that consistently provide transition. There is much work being done throughout the department, Intermountain Health, University of Utah Health, the Utah Parent Center, and the pediatric and adult community. Many from these organizations, along with young adults who have transitioned and parents of CSHCN youth in the community, have participated in the following efforts: Teen to Adult Healthcare Transition Summit, Project ECHO Transition series, and Transition University.

Concerning Changes in Utah's MCH/CSHCN Populations

The frequency of people reporting anxiety before pregnancy had been increasing before the COVID-19 pandemic occurred, but jumped from 27.8% in 2019 to 35.0% in 2021. While there was a slight decrease in anxiety during pregnancy in 2021, it remained high (33.7%). The proportion of individuals experiencing depression before, during, and after pregnancy also increased and has likely been exacerbated by the pandemic. In 2021, 23.2% of women experienced depression before pregnancy, 24.5% experienced it during pregnancy, and 16.2% experienced postpartum depression symptoms (up from 17.6%, 18.8%, and 15.1% in 2019 respectively). 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.

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

In the past three years, the EHDI state audiologists have completed 80 diagnostic Auditory Brainstem Response (ABR) tests via telehealth, which has allowed for timely diagnosis and intervention for infants who failed newborn hearing screening. The Utah EHDI Program has also partnered with LHDs 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. Utah is currently the only state providing this public health service.

The Utah Parent Center (UPC) and CSHCN families continue to educate and coordinate on individuals receiving vaccination/booster(s) and being educated on the benefits, side effects, down time, and needs for childcare support after receiving vaccinations.

On the local level, care coordination brings into focus the understanding of community; culture and local customs; and a knowledge of support, services, and specialists in the area. Care coordinators support families of children who have not met prescribed well-child visits in order to identify 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 LHDs 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 LHDs 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, ensuring clear communication and follow-through methods to reduce loss to follow-up.

The Office also has external partnerships with other State agencies which work toward reducing redundancies, creating data sharing agreements, utilizing CHARM (including incorporating the ASQ screeners) and holding quarterly meetings to share records in a one-stop, shared resource. Additional platforms, such as Hi-Track, monthly meetings, data sharing agreements, and shared resources are utilized to create a system that flows smoothly for Office employees.

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.

Ages and Stages Questionnaire Third Edition (ASQ-3) screenings submitted to the DHHS ASQ Online Enterprise Account declined significantly in 2020 and 2021 (11,039 and 10,866 respectively), compared to 2019 levels. This was likely due in large part to the COVID-19 pandemic. However, submitted screenings have since returned to pre-pandemic levels with 15,345 screenings submitted to the Enterprise Account in 2022. The pandemic also raised awareness and need for Social Emotional Screening, which resulted in a 35% increase of ASQ Social Emotional Screenings being submitted.

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

Changes in Organizational Structure and Leadership

During the 2021 legislative session, House Bill 365 was passed to combine the Department of Health with the Department of Human Services effective July 1, 2022, thus creating the Department of Health and Human Services (DHHS) led by Executive Director Tracy Gruber.

The Offices of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) are housed in the Division of Family Health (DFH). Noël Taxin is the Director for the Division of Family Health. In 2022, DFH added a new Office of Early Childhood (EC) and welcomed the Office of Coordinated Care and Regional Supports (CC&RS) which was formerly housed in the Department of Human Services. MCH/CSHCN remain the primary Offices responsible for the administration of most Title V activities, but EC is also responsible for Title V activities surrounding developmental screening for NPM 6.

Laurie Baksh is the director for the Office of Maternal and Child Health, Amy Nance directs the Office of Children with Special Health Care Needs, Nune Phillips is the director for the Office of Early Childhood, and Kim Kettle directs the Office of Coordinated Care and Regional Supports.

Office of Maternal and Child Health:

The Office of Maternal and Child Health has experienced minimal turnover this year. Two new staff were added to the UWNQC program with the receipt of a new Perinatal Quality Collaborative grant from the CDC. The SSDI Grant Coordinator position was vacated in May 2022 but was filled in August 2022.

Office of Children with Special Health Care Needs:

The Office of CSHCN did not see significant staffing changes this past year. A few nurses in the foster care program retired, but replacements were hired for those positions. The Utah Birth Defect Network Program Manager position had been filled but that person later resigned. CSHCN is currently actively recruiting for the position. Overall, this year we have maintained the CSHCN staffing and continued service provision with quality.

Office of Early Childhood:

The new Office of Early Childhood, formally launched in November 2022, comprises the Baby Watch Early Intervention program, the Child Health Advanced Records Management (CHARM) program, the Home Visiting Program, and Early Childhood Utah. In December 2022, Utah was awarded a three-year Preschool Development Grant B-5 (PDG). Utah's PDG is focused on ensuring all Utah children have access to high quality early childhood care and education programs and services beginning at birth, which serve to ensure they are prepared for kindergarten with a foundation for academic success and positive health and well-being outcomes. PDG activities include an early childhood learning pilot which implements culturally responsive and equitable practices for diverse communities, statewide implementation of the Pyramid Model, creating a one stop early childhood resource website, piloting online developmental enhancement activities for families, expanding parent engagement support services, and increasing capacity for statewide early childhood care coordination. The PDG activities will also include a comprehensive early childhood needs assessment and strategic plan, both to be released in early 2024.

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,979,388	$6,130,707	$6,561,290	$5,999,329
State Funds	$10,851,188	$15,954,017	$14,630,450	$16,279,475
Local Funds	$1,050,094	$4,081,498	$0	$2,381,253
Other Funds	$10,833,700	$15,143,381	$16,023,900	$15,143,381
Program Funds	$5,233,600	$999,760	$1,103,500	$999,760
SubTotal	$34,947,970	$42,309,363	$38,319,140	$40,803,198
Other Federal Funds	$56,396,200	$48,064,134	$50,430,575	$48,228,703
Total	$91,344,170	$90,373,497	$88,749,715	$89,031,901

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,598,690	$4,834,481	$6,598,690	
State Funds	$16,182,050	$17,533,063	$16,420,500	
Local Funds	$4,100,000	$2,685,117	$3,400,000	
Other Funds	$15,214,000	$14,812,671	$15,214,000	
Program Funds	$1,044,900	$1,128,697	$1,044,900	
SubTotal	$43,139,640	$40,994,029	$42,678,090	
Other Federal Funds	$53,211,500	$47,428,630	$53,211,500	
Total	$96,351,140	$88,422,659	$95,889,590	

	2024	
	Budgeted	Expended
Federal Allocation	$6,575,790	
State Funds	$16,404,400	
Local Funds	$3,400,000	
Other Funds	$15,241,900	
Program Funds	$1,146,500	
SubTotal	$42,768,590	
Other Federal Funds	$55,333,600	
Total	$98,102,190	

III.D.1. Expenditures

UTAH 2022 EXPENDITURES - FINANCIAL NARRATIVE

Overview

The Title V federal funding, in conjunction with non-federal state monies and other federal dollars, was 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: Newborn Safe Haven, Baby Your Baby, Maternal and Infant Health, Mother to Baby, Violence and Injury Prevention, 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 2022 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, Pregnancy Risk Assessment Monitoring System, Mother to Baby, Informed Consent and Abortion Module Development, Maternal Mental Health, Contraception for Inmates, Fetal Exposure Reporting and Treatment, 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, revenue from other State Agencies (Department of Workforce Services, Department of Human Services and Utah State Board of Education), as well as revenue agreements with private nonprofits. Program Income (Form 2, line 6) included fee revenue such as Mother To Baby collections, Baby Watch family fees, 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, Sexual Risk Avoidance Education, Personal Responsibility Education, Universal Newborn Hearing, Birth Defects Surveillance, Women and Newborns Quality Collaborative, and Maternal, Infant and Early Childhood Home Visitation funds.

Utah tracked expenditures to ensure compliance 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 Office 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 2022, 36.97% of Title V expenditures were for CSHCN activities; 51.28% of expenditures were for preventive and primary care and 6.01% 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 Office of Maternal and Child Health allocated MCH Block Grant Funds throughout the Utah Department of Health and Human Services to the following: the Office of Maternal and Child Health, the Office of Children with Special Health Care Needs, the Office of Health Promotion and Prevention, and also contracted Title V funds with the 13 Local Health Departments (LHD).

III.D.2. Budget

UTAH BUDGET (FY 2024 Application Year)

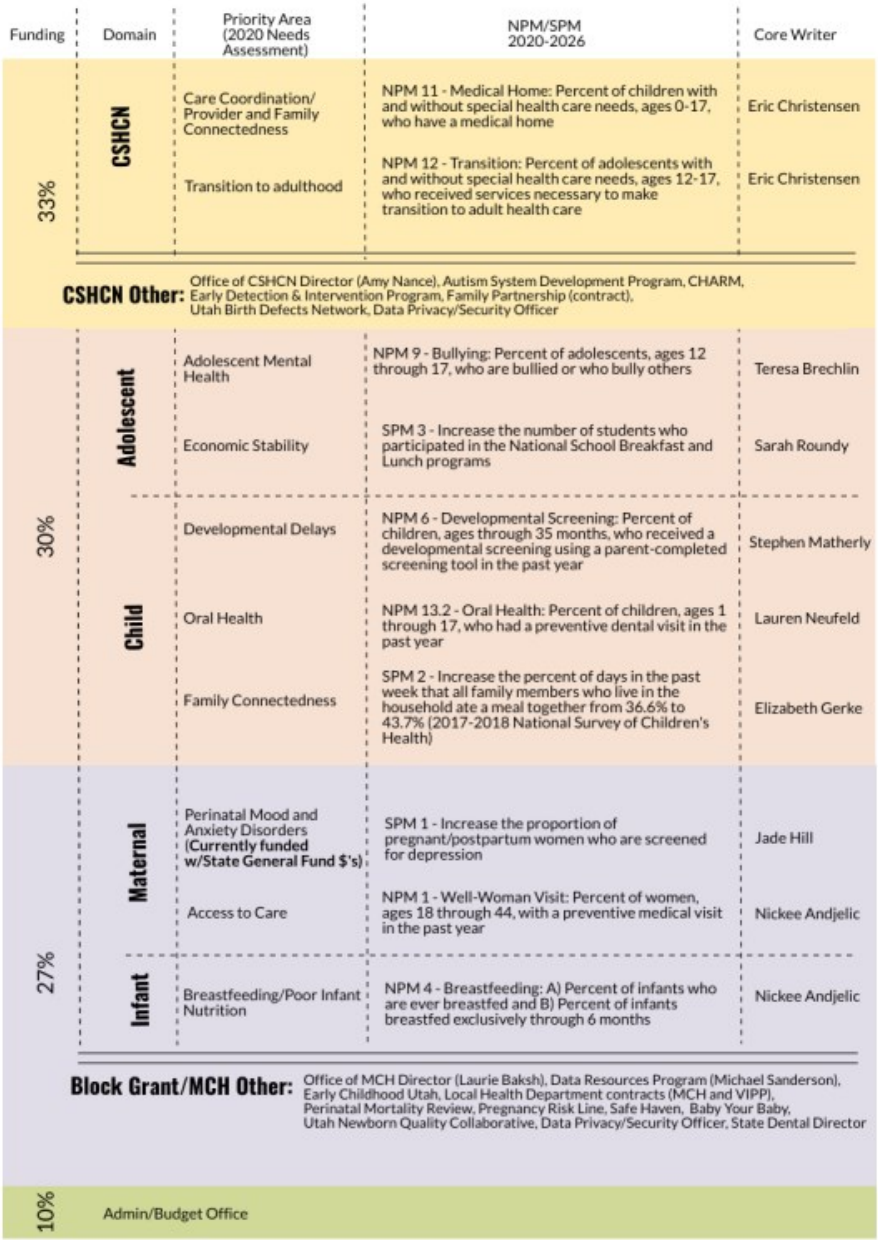
Together with state general funds and other federal funds, the Title V MCH/CSHCN block grant is used to address Utah's MCH/CSHCN priority needs, improve performance related to targeted MCH/CSHCN outcomes, and expand systems of care for the MCH/CSHCN populations. Utah's Title V Leadership Team meets on a regular basis to discuss all aspects of Title V, including the budget and how federal and non-federal funds are utilized to address the state's MCH needs. The table below illustrates projected Title V funding allocations for FY 2024:

Table 7: FY24 Projected Title V Funding Allocations

Program	Proposed Budget 10/01/2023 - 09/30/2024
OFFICE OF MATERNAL AND CHILD HEALTH	
MCH Admin	$398,000.00
Maternal and Infant Health (Maternal and Infant, Perinatal Review, Mother to Baby)	$532,700.00
Adolescent Health	$118,000.00
Utah Women's Quality Collaborative	$99,800.00
Data Resources	$386,500.00
OFFICE OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS	
CSHCN Admin	$70,100.00
CSHCN Integrated Services	$1,234,200.00
Early Hearing Detection and Intervention	$44,900.00
Birth Defects	$544,800.00
OFFICE OF EARLY CHILDHOOD	
Early Childhood	$50,000.00
CHARM	$97,700.00
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
OFFICE OF PUBLIC AFFAIRS AND EDUCATION	
Newborn Safe Haven	$50,000.00
OFFICE OF PRIMARY CARE AND RURAL HEALTH	
Oral Health	$172,500.00
FINANCIAL, LOCAL, OTHER	
Financial Resources	$150,000.00
LHD Contracts	$1,188,400.00
Indirect Cost	$300,000.00
TOTAL BUDGETED	$6,575,790

Through state level programs and initiatives, in addition to 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:

Figure 7: Funding Allocations by Domain, Utah



Utah's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2024, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted. For FY 2024, 51.88% of the total Title V budget is designated for preventive and primary care for children; 34.37% is designated for Children with Special Health Care Needs; and 7.18% 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, Children's Hearing Aid Program, Pregnancy Risk Assessment Monitoring System state funding, Contraception for Inmates, Fetal Exposure Reporting and Treatment and Baby Watch Early Intervention. 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, multiple revenue agreements with outside organizations and WIC Formula Rebates. "Program Income" (Form 2, line 6) includes Teratology collections and donations, newborn screening kit fee collections for newborn hearing screening and critical congenital heart defect screening, and Baby Watch Early Intervention Family Fees. Other federal funds anticipated in FY 2024 are indicated in Form 2, line 9, and are similar to funds noted in the Expenditures section.

Challenges

Utah continues to face challenges related to the Title V budget. The current annual working Title V budget is $6.5 million. Utah continues to modify the budget to align with the annual $6.1 million award from HRSA. 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.
- Indirect cost savings as a result of the consolidation of Utah's Department of Health and Department of Human Services.
- Cost savings as a result of attrition.

Additional challenges Utah faces in the coming year include budgetary constraints created as a result of legislatively mandated cost of living increases and targeted market compensation increases for certain positions. Programs are continually working through these concerns and strive to diversify funding to address these changes while continuing to support Title V activities in Utah.

III.E. Five-Year State Action Plan

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

State: Utah

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The vision of the Utah Department of Health and Human Services:

> "*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."*

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

Utah Title V oversight is maintained by the Title V/MCH and CSHCN Office Directors. 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 Department programs, our goal is to improve the health outcomes of all Title V populations.

In November 2022, the DHHS established the Office of Early Childhood. This Office promotes and enhances positive growth, development, and learning for every Utah child from birth through age eight.

The Office of CC&RS's mission is to provide intensive care coordination to children, youth and families with serious emotional disorders, conduct independent review for residential placement, improve access to evidence-based treatment, identify service gaps, develop service plans, and identify resources and services.

The MCH/CSHCN Offices assess 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.

The MCH/CSHCN Offices work with Department staff, local health departments (LHD), and stakeholders, to accomplish NPM/SPM goals. 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 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 LHDs provide year-end reports to document outcomes.

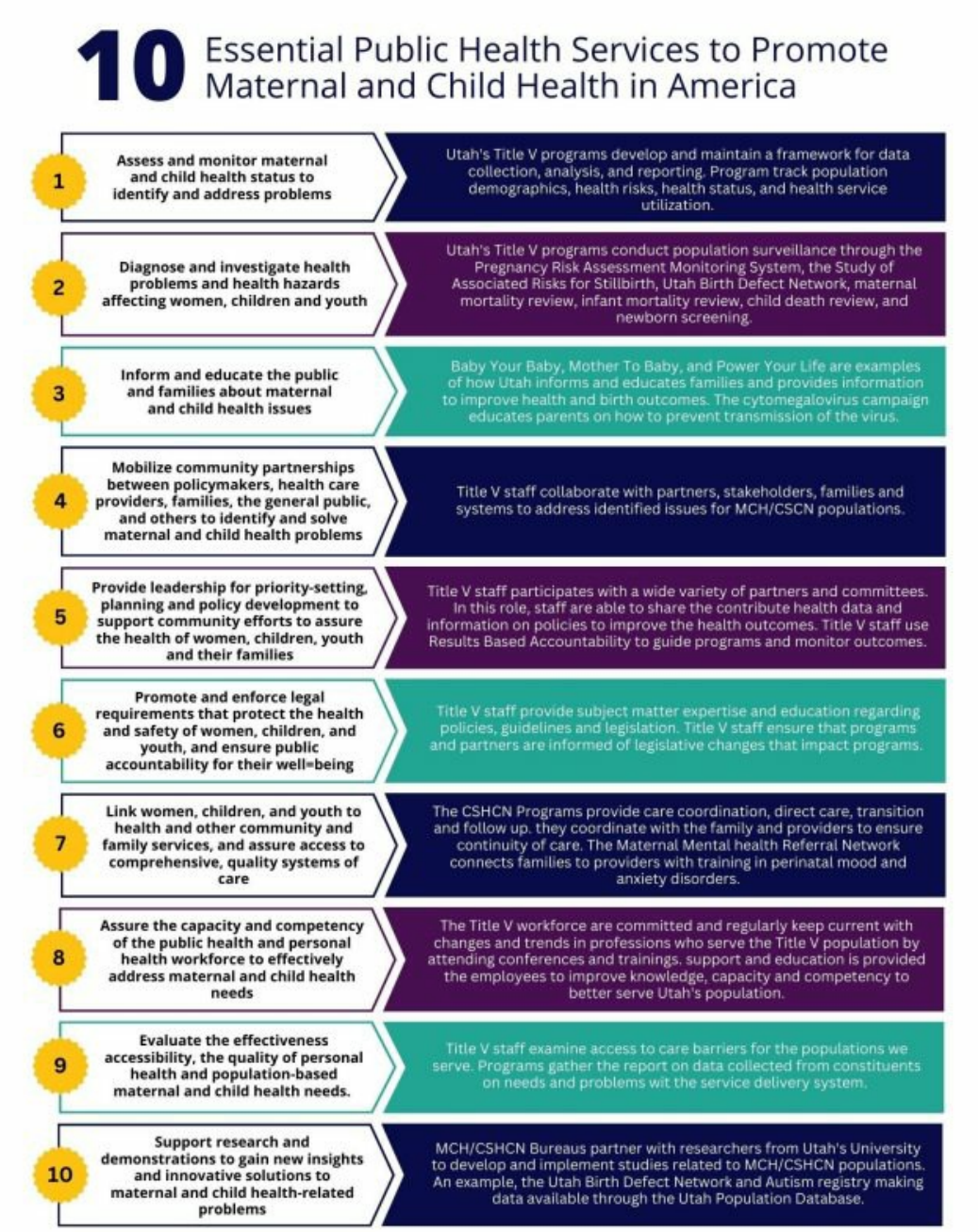
The provision of services for Title V populations are provided through Department staff, LHDs, memorandums of agreement, service contracts, bids for proposals (when needed) and in-kind contributions from partners and stakeholders.

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 that 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:

Image 2. Essential Public Health Services to Promote Maternal and Child Health in America



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 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 Council
- 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 Advisory 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
- Utah Women and Newborns Quality Collaborative
- Newborn Hearing Screening Advisory Committee
- Utah Autism Initiative Committee
- Adult Autism Treatment Account
- Utah Registry for Autism and Developmental Disabilities (URADD) Committee

Utah aligns its CSHCN services with AMCHP's National Consensus Standard for Systems of Care for CYSHCN. Utah supports a coordinated care model that 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 to support initiatives to ensure a solid and robust foundation.

MCH/CSHCN staff work collaboratively with the Office of Health Equity and the Office of American Indian/Alaska Native Health and Family Services 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.

The Office of Health Equity offers professional development trainings through their website. Training is open to any employee interested in expanding their knowledge of Health Equity. The purpose of these training is to assist teams, make the Department a more welcoming, equitable, and inclusive organization. Topics currently include:

- Health in 3-D: Understanding Diversity, Determinants and Disparities
- A Class about CLAS
- For Me, For Us: Promoting healthy weight, access to health care and healthy births to diverse Utah communities
- Coming soon: Health equity professional development video series and registration tool for state employees and local health departments

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. In February 2023, Governor Cox announced a new initiative for state employees to be 'Recklessly Good'. Governor Cox is encouraging staff to look at their roles from the customer's perspective and to use a creative and resourceful mindset to explore how to serve customers better; to think outside the box to help customers solve their concerns.

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

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

Senior level managers in the Utah Department of Health and Human Services (DHHS) lead the work of planning, implementation, evaluation, data analysis, and recruitment/retention of qualified program staff. DHHS staff are experienced and well-seasoned professionals. In addition, both MCH and CSHCN collaborate with staff at the local health department (LHD) level who work to improve the health of MCH/CSHCN populations. Current staffing funded with Title V Block Grant dollars is outlined below.

Table 8: Current Employees by Office and Title V Funding

Office	Total number of full time employees	Number of employees paid with Title V Block Grant	Total FTE effort paid with Title V Block Grant
Maternal and Child Health	37	22	11.1
Children with Special Health Care Needs	80	23	12.8
Early Childhood	28	4	1.15
Office of Health Promotion and Prevention	154	20	5.85
Office of Primary Care and Rural Health	7	1.25	1.25

MCH/CSHCN maintains a staffing pattern that 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 offers a generous benefits package, 401K contribution and other retirement investment options, an employee assistance program, and health and wellness activities, which all contribute to employee satisfaction and retention. All MCH/CSHCN employees must complete training required by DHHS, including privacy and 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 often higher than in state government, some positions are difficult to fill and/or staff have left for private sector positions that offer higher salaries. Recent market adjustments for some positions as well as cost of living adjustments approved by the legislature may help with this issue.

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, productivity, and improve air quality.

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. 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.

Both MCH and CSHCN Offices are providing regular educational sessions and empowering teams to understand systems change and improve services to ensure the mission to serve women, infants, children with and without special health care needs, 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 requires all supervisors to hold monthly one-on-one meetings with staff to provide opportunities to discuss workload, needs for working successfully, and development goals. The Department of Human Resource Management offers their Leadership Development “Off the Shelf” learning sessions. These are bi-monthly web-based sessions on topics that have included ‘Recklessly Good’ government, innovation and customer experience, the positive impact of behavioral expectations, holding successful one-on-ones, leading and influencing remote teams, managing workplace stress, cultivating trust, employee engagement, 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. This past year, 12 hours of paid leave for mental health and wellness was provided to each employee. Department staff are also offered the opportunity to use 1.5 hours/week of release time to participate in healthy physical activities.

The Integrated Services Program (ISP), LHDs, 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, and 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 support, 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 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 ISP social worker delivered monthly hearing screenings conducted at the South Main Clinic, one of Salt Lake City’s Community Health Centers that serves mainly low-income Hispanic families.

Workforce development and coordination with LHDs is key to maintaining a strong MCH workforce. Each of the 13 LHDs are required to report on professional development activities conducted during the year as part of their contracted funding from Title V. 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 suggested trainings come from MCH Navigator, AMCHP’s Training and Leadership Development programs,

Advancing Health Transformation (from MCH Navigator) and others.

Local Health Departments utilized the following resources for offering workforce development activities:

- Online webinars and trainings
- Regular staff meetings to provide training information
- Project specific trainings offered through other programs such as MIECHV, Parents as Teachers, and WIC
- State agency, non-profit organization, and university sponsored trainings on topics such as infant mental health, interpersonal violence, cultural competence, QPR, preparedness, and ASQ screenings

During the COVID-19 pandemic, teleworking was implemented to ensure the safety of our employees and MCH/CSHCN customers served throughout the State. Since the pandemic, we have offered a hybrid model, which allows for telehealth and/or in-person visits which are determined by the client unless either the provider or client is sick. The majority of MCH/CSHCN employees have continued to telework. To ensure quality and accountability, each office director meets weekly with program managers to ensure programs are functioning as efficiently as possible and with leadership support. Office directors and program managers hold team meetings as well as meet with each staff member individually at least monthly to discuss performance, review tasks, and simply check-in, given that most staff are continuing to telework.

With the creation of DHHS, staff have access to policies through an online system to ensure they have the most current information. The Department shares a weekly staff email with updates and information and holds a monthly all staff Q & A session to ensure staff have the most current information for their work.

Title V staff participate in learning opportunities to help improve the quality of services to Title V populations, some of which are as follows:

- During 2022, Division staff participated in the Region VIII Tribal Relations Community of Practice initiative. In this learning series, staff learned how to improve engagement activities with Utah's Tribal populations.
- During 2023, MCH/CSHCN and Emergency Preparedness staff participated in the Emergency Preparedness and Response Action Learning Collaborative through AMCHP. As part of this learning collaborative MCH/CSHCN staff were able to attend NACCHO's Preparedness Summit and participate in a day-long tabletop exercise addressing the needs of maternal and child health populations during a public health emergency.
- The CSHCN and MCH Office Directors participated in the AMCHP new leader cohort. One MCH program manager participated in the next generation cohort and a staff member from Utah Family Voices participated in the family leader cohort.

In 2023, a short survey on training needs was conducted among staff funded with Title V dollars and through other sources, including staff at the Utah Parent Center. The survey was designed to get a picture of the employees' needs across numerous topics used in their respective jobs to assess the knowledge and emerging training needs for employees who work in and around the Maternal and Child Health Block Grant. Among respondents, employees identifying as CSHCN had been in their current positions longer than employees from MCH with 13.2% from CSHCN having worked less than 1 year vs. 17.4% for MCH. Looking at those having worked 1-9 years, 60.5% for CSHCN compared to only 39.1% for MCH. When looking at having been in the same position 10 years or greater 26.3% CSHCN vs. 21.7% for MCH. Staff indicated training needs among a list of competencies. Those with the highest need/desire for training included:

- Community resources - understanding resources and partners in the state
- Supporting research to gain new insights and solutions to MCH/CSHCN related problems

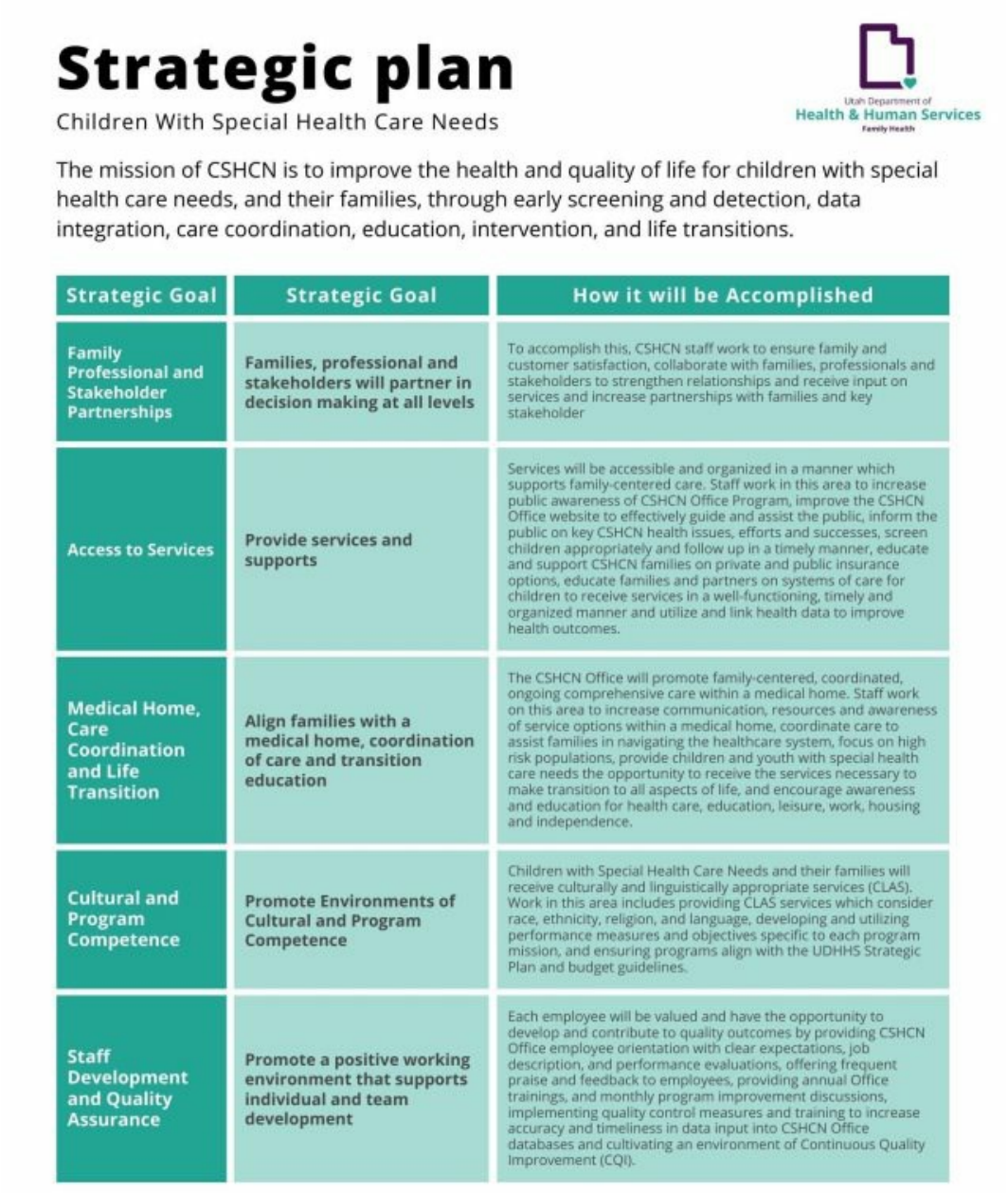
- Informing and educating the public and families about MCH/CSHCN issues
- Linking MCH/CSHCN populations to health and other community and family services, and assuring access to comprehensive, quality systems of care
- Evaluating the effectiveness, accessibility, and quality of personal health and population based MCH/CSHCN services

Based on this feedback, in the coming year, Office Directors will begin seeking training opportunities to offer related to these topics.

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

The CSHCN Office values family partnerships and those relationships are woven within the structure and functions of the Office. The following information outlines some activities and collaborations both the CSHCN and MCH Offices participate in that encourage support of family partnerships and collaborations with stakeholders.

Image 3. CSHCN Strategic Plan



Strategic plan

Children With Special Health Care Needs

Utah Department of Health & Human Services

The mission of CSHCN 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.

Strategic Goal	Strategic Goal	How it will be Accomplished
Family Professional and Stakeholder Partnerships	Families, professional 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 stakeholder
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 Program, 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.
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 UDHHS 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 CSHCN Office partners with Utah Family Voices (UFV), under the Utah Parent Center (UPC). Both organizations strongly encourage employees to either be an individual/self-advocate with a disability or a parent of a child with special health care needs. 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 within the state to organize 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 Strategic Plan. The Office has a CSHCN 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. 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 the Utah Developmental Disabilities Council. The committees' purposes include the alignment and coordination of professionals, agencies, and families to better serve the disability populations.

Utah Parent Center- Family Partnership

The Office of CSHCN continues to work toward strengthening its relationship with the UPC. The CSHCN office supported the attendance of the UPC Associate Director as well as a parent consultant at the 2023 AMCHP conference. The parent consultant also participated in the 9-month long AMCHP Leadership Lab within the Family Leaders Cohort. UPC continues to support efforts towards gathering MCH/CSHCN public comment by sharing social media messages and emails.

The Office of CSHCN is also participating in the UPC Family Links conference in September 2023. CSHCN is excited to partake in this event which provides training and hosts conferences for parents of families of children, youth, and adults with disabilities and special needs and the professionals that serve them. This year's event will be over the span of a week through a virtual training platform, culminating on Friday evening with a family social at a local park.

The Early Hearing and Detection Intervention (EHDI) Program enhances family support and engagement by partnering with the UPC/UFV to provide parent-to-parent support and leadership opportunities within the EHDI system. Two parent consultants work to support the needs of families with infants/children who are deaf or hard-of-hearing. They are integral members of the Utah EHDI team, providing the family perspective on all aspects of Utah EHDI projects. Loss to follow-up is reduced when parent consultants call families to determine barriers in completing the screening/diagnostic process and facilitate its completion. Parent consultants can guide families through this potentially traumatic, painful process in a way that professionals cannot. In addition, the EHDI parent consultants host family events and informational “WebinEARS”. They also have an active social media presence that provides additional support and resources. New this year is the EHDI Parent Volunteer Network, created by the parent consultants, to provide parent leadership opportunities and to have a local parent that can host events for families with children that are deaf or hard-of-hearing in their own communities. 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 chairs the long-standing collaborative committee, the Utah Autism Initiative, which meets quarterly and is composed of 32 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 in Utah.

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 and Youth Services; 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 U.S. Citizenship and Immigration Services to ensure families access and apply for services for which they may be eligible.

ISP and four 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, 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. Once needs and priorities are assessed, families 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 community organizations and services around the state.

The Office of Substance Use and Mental Health targets youth struggling with behavioral health concerns, and partners with internal and external groups that support housing stability; substance use treatment; direct clinical services, including mental health treatment; Juvenile Justice and Youth Services; foster care; diversion services; and youth leadership. The ISP program manager has served on a cross-agency coordination committee to share ideas and resources among partners and helped plan the April 2023 DHHS-sponsored two day Policy Summit, which focused on connecting dynamic youth leaders from several states to review policy submitted by youth-serving organizations and governmental entities from across the country. This not only provided youth with a leadership and collaborative opportunity with their peers, but allowed youth voice and perspective to be heard by policy makers who may have had varying degrees of youth experience considered in the development, vetting, and implementation of their agency, regional, or state policies. This was held as a hybrid event with both live and online participants. Based upon the positive feedback and recommendations from both participants and attendees, we anticipate this may become an annual or bi-annual DHHS hosted event.

The University of Utah's Department of Pediatrics hosts 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 80 diagnoses and other issues commonly experienced by CSHCN, along with information on special education, transition, family issues, and medical billing 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 in turn, assists and supports professionals and families in working together to care and advocate for CSHCN.

The Medical Home Portal staff, UPC Parent Consultant, and CSHCN staff co-presented a poster Medical Home Portal: Improving Equity and Access for Utah's Children and Youth with Special Health Care Needs at the 2023 AMCHP meeting.

The CSHCN Office has continued to provide financial support to 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. The UCCCN can assist with job descriptions, guidelines related to care coordination, and finding tools and other resources. There is no charge for UCCCN membership.

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 ISP and Baby Watch Early Intervention Program to improve service access to those with Down syndrome and their families. Another family organization that the UBDN works with is the Intermountain Healing Hearts, an organization for families of children and adults with congenital heart defects and childhood onset heart disease.

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 (PRAMS) 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 (UWNQC) is a statewide network of professionals, hospitals, and clinics dedicated to improving health outcomes for Utah women and babies using evidence-based practice guidelines and quality improvement processes. 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 Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles. Patient, family, and community engagement is a key component of the UWNQC approach to enhancing capacity to make measurable improvements in perinatal health outcomes statewide. A key success in enhancing family engagement was applying for and receiving a CDC Perinatal Quality Collaborative (PQC) grant to improve health disparities. A key focus area of this grant is incorporating family voices into projects with the ability to compensate family/patient advocates. We presented at a town hall for Utah neonatologists on how to increase family engagement in the NICU that included sharing best practices from Dr. Colby Day, a neonatologist in Florida. Our Neonatal Committee Chair has been tracking various data aspects of the quality improvement project, such as day of first hold. The UWNQC Quality Improvement Director completed the Alliance for Innovation on Maternal Health Community of Learning (COL) on Lived Experience Integration into QI and is scheduled to attend the alumni cohort in 2023. 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 includes the ability to send 10 patient partners through a Certified Patient Family Partner training. A person with lived experience shares their story at each UWNQC board meeting.

Additionally, the Early Childhood Utah (ECU) Program in the Office of Early Childhood, staffs the Early Childhood Utah Advisory Council. The Council serves as Utah's State Advisory Council as required by the Improving Head Start for School Readiness Act of 2007 and is responsible for improving and coordinating the quality of early childhood programs and services across the state. The Council's duties include facilitating improved coordination between state agencies and community partners, sharing and analyzing early childhood information, and providing recommendations for a comprehensive delivery system of services for young children. The ECU Advisory Council has five standing committees:

- Promoting Health and Access to Medical Homes
- Data and Research
- 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 and mental health, early care, and education. Representation on the council includes the MCH Title V Director, Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program Manager, CSHCN Integrated Services Program Manager, IDEA Part C Baby Watch Early Intervention Program Manager, oral health staff, and WIC. Additionally, parents are represented on the Council and participate in the Parent Engagement Support and Education subcommittee.

The MCH/CSHCN Offices will continue to ensure 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 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 completing work on a doctoral degree.

In the Office of Maternal and Child Health (MCH), 5.5 FTE epidemiologists 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 two 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, and research and surveillance. DRP also developed and maintains the Web Enabled Systematic Tracking Tool (WESTT) system. WESTT is an online portal that houses the information from the Utah Block Grant and allows 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 dissemination of information for Public Comment.

Michael Sanderson has served as the DRP Epi Manager since October 2021. Mr. Sanderson brings nearly 20 years of experience in epidemiology with a focus on measurement and survey design. His primary role is to coordinate annual reporting for performance measures in the Block Grant. He also coordinates research and surveillance activities for the DRP.

Robert Satterfield is funded through the Title V Block Grant and works side by side with the DRP Manager to provide support to the Block Grant and other data projects including but not limited to: WIC Cluster Analysis, WIC Participant Satisfaction surveys, Oral Health Projects, the Commodity Supplemental Food Program Nutrition Education Survey, ASQ equity analyses, and data linkages of key MCH/CSHCN data sets with birth records.

The State Systems Development Initiative (SSDI) grant is housed within the DRP and funds one epidemiologist. Erica Bennion is the SSDI Grant Coordinator/Epidemiologist and supports Title V efforts by collecting and compiling data needed for Block Grant forms, providing data and analytic support for Utah's selection and development of National and State Performance Measures (NPMs/SPMs) and related Evidence-Based Strategy Measures (ESMs) and the 5-year MCH needs assessment, and assisting with the preparation of annual applications and reports. Ms. Bennion also provides data support for the Utah Women and Newborns Quality Collaborative (UWNQC) on quality improvement projects and Alliance for Innovation on Maternal Health (AIM) safety bundle implementation and data collection.

Caitlin Pratt is a 0.5 FTE epidemiologist within DRP and is funded by a five-year Perinatal Quality Collaborative Cooperative Agreement with the CDC. The Cooperative Agreement focuses on expanding data capacity for the Utah Women and Newborns Quality Collaborative (UWNQC) with a focus on health equity and working with minority-owned community based organizations. Ms. Pratt's primary duties for the Cooperative Agreement include developing data collection plans, identifying baseline data needs and data sources for performance measures, and strengthening data systems to improve the identification and documentation of disparities in birth outcomes among minority communities. She also provides data assistance for Title V data projects on an as-needed basis.

Within the MIHP is the epidemiologist/data manager for the Pregnancy Risk Assessment Monitoring System (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 Evidence-Based Strategy Measures (ESMs) and National Outcome Measures (NOMs). The PRAMS survey is integral to assessing maternal and infant health and identifying emerging issues. The staff member in this position retired in May 2023 and Danielle Urbie assumed the role in June.

Amy Solsman, also in MIHP, provides data support to the Perinatal Mortality Review (PMR) 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 Office of Children with Special Health Care Needs (CSHCN), 4.0 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 participate in data groups that support Title V work.

Max Sidesinger is the Cytomegalovirus (CMV) data coordinator and an epidemiologist with the Early Hearing Detection and Intervention (EHDI) Program and is funded through mixed funding, including state newborn screening dollars, CDC EHDI, and CDC Surveillance for Emerging Threats to Mothers and Babies (SET-NET) funding. He collects information on every CMV test completed on a child under 1 year of age in Utah and works with providers and families to ensure CMV testing for children who fall under Utah's CMV Public Education and Testing mandate. Mr. Sidesinger provides data analyses for both CMV and EHDI related data, including a breakdown of all tests and positive cases of congenital CMV for the 2022 Public Health and Policy Conference, and a diversity and inclusion study used to create a work plan for targeting underserved populations as part of the EHDI HRSA grant. He has collaborated with researchers at the University of Utah on multiple newborn hearing-related projects and is currently working with the CDC on both a CMV pilot surveillance project and a CSTE position statement for standardized surveillance of congenital CMV.

Jacinda Miller also works in the EHDI program as a CMV epidemiologist and receives funding through the CDC SET-NET grant. Ms. Miller abstracts data from HiTrack and other medical record databases of children with positive CMV results. During data abstraction, she monitors for congenital CMV (cCMV) cases by performing surveillance on short and long-term outcomes of cCMV. Ms. Miller also reviews all HiTrack records for children tested for CMV and records the reason for CMV testing as part of surveillance efforts.

Aubree Boyce is the primary epidemiologist for the Utah Birth Defect Network (UBDN) and is funded through CDC grants and Title V funds. Ms. Boyce analyzes data collected by the active surveillance program that collects reports of birth defects statewide and develops recommendations for program planning and policy development. Working with the UBDN data team and stakeholders, Ms. Boyce 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. Ms. Boyce is part of a core data team within UBDN that coordinates with the National Birth Defect Prevention Network and the CDC.

Stephanie Pocius is the other epidemiologist who works in the UBDN program and is funded through the SET-NET grant. While providing epidemiological support within UBDN, she focuses on data collection, management, and analysis of maternal and infant data related to COVID-19 infection during pregnancy, which is used to inform and improve policies and programs.

Gregg Reed is an epidemiologist and data manager for the Baby Watch Early Intervention (BWEI) program that was recently relocated to the Office of Early Childhood. Gregg was hired under the classification of a Sr. Research Analyst and is funded through the Office of Special Education Programs (OSEP). He is involved in the MCH Block Grant and helps the CSHCN Office with other data needs.

Gregg Reed and Michael Sanderson jointly coordinate the MCH/CSHCN Data Integration Workgroup (DIW) under the direction of Noël Taxin, Family Health Division Director. 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 merger of the Department of Health with the Department of Human Services has resulted in the Office of Coordinated Care and Regional Supports (CC&RS - formally a Bureau in DHS) joining the Division of Family Health. DIW now has additional members from CC&RS who are active participants in the group providing additional opportunities for collaboration.

Epidemiology staff participate in national meetings for professional development, including the CityMatch/MCH Epidemiology conference, the Association of Maternal and Child Health Programs (AMCHP) national meeting, and subject matter specific opportunities. In June 2023, the Council of State and Territorial Epidemiologists (CSTE) annual meeting was held in Salt Lake City, Utah, which offered a unique opportunity for additional epidemiology staff to attend.

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 (MCH). The mission of DRP is to provide analytic resources and statistical expertise to Division 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/Epidemiologist to manage project activities related to data collection and analysis, and provide additional analytic support to MCH/CSHCN programs and other programs working with Title V populations. 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 were staffing changes in the DRP in FY 2022. The SSDI Grant Coordinator position was vacant from May 2022 to August 2022. Due to the SSDI Coordinator vacancy in FY 2022, DRP was unable to provide as much analytic support as planned including: conducting analysis on factors associated with intrapartum transfers to the hospital for delivery from a 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. Since hiring the new SSDI Coordinator, these tasks have resumed.

Data linkages

DRP and the SSDI program play an important role in ensuring timely and accessible linked MCH data systems. Historically, DRP staff, including the SSDI Coordinator, have had access to the following data sources for data linkage projects: Vital Records Birth and Death data, Medicaid data, WIC programmatic data, hospital discharge data, and PRAMS data.

More specifically, the DRP Epidemiologist and the SSDI Grant Coordinator routinely link Vital Records Birth and Death data to obtain an infant death data set that is used for analysis by many programs. Additionally, DRP has routinely linked Vital Records with Medicaid data for birth outcomes for the Block Grant. DRP is in the process of establishing a new data sharing agreement with the Office of Medicaid Operations to continue linking Vital Records with Medicaid eligibility data and plan to analyze birth outcomes among women whose births were paid for by Medicaid as compared to other women.

DRP is currently in the planning stages of replicating a report published in 2018 on Severe Maternal Morbidity (SMM). The previous report linked hospital discharge data with birth records from 2013-2015. DRP is in the process of establishing a new data sharing agreement with the Division of Data Systems and Evaluation to link hospital discharge data with birth records from 2016 to 2022. While it is possible to calculate SMM rates with hospital discharge data alone, linking to birth records provides a rich source of data for understanding risk factors for SMM that are only available on the birth record, including (but not limited to): pre-pregnancy weight and gestational weight gain, pre-existing chronic conditions of the mother, prenatal care, gestational age, and the number of other live births.

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 the 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, DRP develops a

WESTT User Feedback Survey and sends it 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 2022, enhancements made to WESTT included adding the ability to more easily map ESMs to strategies as well as adding and editing strategies within an ESM. Block Grant contributors can now link to a cloud-based supporting document to provide additional materials for their Block Grant reporting.

DRP held a mandatory virtual training session for Block Grant contributors in March 2023. The training included an overview of the basics for new WESTT users and updates that have been made to the application. This year's training also included additional modules: health equity, an introduction to the evidence continuum and a results-based accountability (RBA) framework for strengthening ESMs, an overview of logic models and how they can be used to conceptualize NPMs, and standardized target setting methods. The SSDI Coordinator developed and presented the logic model and RBA modules and reviewed and provided feedback for other modules.

The SSDI team continues to assess ongoing data needs by reviewing Federally Available Data (FAD) to identify trends and demographic disparities within the MCH/CSHCN domains and providing the FAD to programs and assisting them with interpretation of the data. For this year's Block Grant application and report, the SSDI Coordinator provided programs with a brief summary analysis of NPM and NOM trends and disparities using FAD, which are included in the state action plan. The SSDI Coordinator also assisted the DRP Program Manager and MCH Epidemiologist to consult with programs on their NPM and SPM targets, offering assistance using standardized target setting methodologies for programs wishing to update their NPM and SPM targets.

Reporting

The Utah Department of Health and Human Services (DHHS) 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 contributes regularly to Health Status Updates published by the agency that focus on MCH/CSHCN populations, and the SSDI project director coordinates potential HSU topics at the division level.

Each year, a Department-wide meeting is held to review ideas for potential HSU articles. The DRP Manager/SSDI Project Director attends this meeting, along with other MCH/CSHCN staff. After the meeting, a finalized HSU annual publication schedule is developed and disseminated to programs.

Starting in January 2022, the SSDI Coordinator also provided analytic support to authors of HSUs. Before publishing an article, the SSDI Coordinator provides either a careful review of the code or performs a 'de novo' data check by independently writing code to replicate the data being presented in HSU articles.

During FY 2022, MCH/CSHCN staff published five HSU articles including:

- 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
- Prenatal care experiences during the COVID-19 pandemic - April 2022
- Autism spectrum disorder and suicidal ideation - April 2022
- Newborn hearing screening in underserved populations - June 2022

DHHS has a self-administered hormonal contraceptive standing order which is issued by the Executive Medical Director. The standing order authorizes participating pharmacists and pharmacy interns to dispense self-administered contraception (pills, patch, or ring) to women ages 18 or older without a prescription. Pharmacists are required to report to the state on how many women they counseled and how many received contraceptives under the order annually. DRP manages the REDCap database used to collect this information and produces a yearly dispensing report highlighting the number of pharmacists and interns who enrolled in the program, the number and types of contraceptives dispensed, and a breakdown of age groupings of women receiving contraceptives under the order.

UWNQC and AIM

The SSDI Coordinator provides analytic support to the Out-of-Hospital (OOH) birth subcommittee for the Utah Women and Newborns Quality Collaborative (UWNQC). During FY 2022, this included drafting and sending letters to hospitals with available data on transfers from intended out-of-hospital births, and aggregate data from analysis of a patient facing survey, which collects feedback data from mothers who experienced a transfer to a hospital from an OOH birth setting. In FY 2023, the SSDI Coordinator began to develop transfer letters similar to those sent to hospitals that will be sent to freestanding birth centers, and a report using six years of data on a variety of out-of-hospital birth outcomes in Utah.

In FY 2022, the SSDI Coordinator provided data collection and analytic support to Utah's implementation efforts of the Alliance for Innovation on Maternal Health (AIM) safety bundles. The SSDI Coordinator attended planning meetings, trainings, and learning groups for the AIM Substance Use Disorder (SUD) Safety Bundle, and contributed to the development of county-specific resource guides for AIM. The SSDI Coordinator is currently managing data collection for process and structure measures for the SUD bundle from participating hospitals in a secure REDCap database. The coordinator also works with an analyst in the Division of Data Systems and Evaluation to provide outcome measures on severe maternal morbidity using hospital discharge data. This data is uploaded into the secure AIM Data Portal so that hospitals can compare themselves to hospitals with a similar volume of births in an effort to improve care for mothers.

Other Support for Title V Program Efforts

The SSDI Coordinator has begun planning for the upcoming five-year Needs Assessment. The coordinator has made progress on developing an indicator report that will be used during the Needs Assessment process to inform stakeholders on the current state of MCH and CSHCN populations. The report compares indicators between the State of Utah and the U.S. as well as racial and ethnic comparisons. Each MCH/CSHCN domain has indicators for a variety of topics relevant to their respective populations. Data sources for the indicator report include: Census and American Community Survey, PRAMS, Vital Statistics, BRFSS, NIS, NVSS, NSCH, YRBS, and programmatic data.

The SSDI Team also completed a literature review of seven other states' 2020 five-year Needs Assessment summaries from the 2020 Block Grant application. We selected the seven states based on Block Grant funding received from HRSA that was similar to Utah. During the literature review, we provided a synopsis of common methodologies used by other states, as well as highlighted innovative methodologies used for the 2020 Needs Assessment to inform the upcoming 2025 Needs Assessment.

The SSDI Coordinator attends, and occasionally presents at, monthly meetings for the DHHS Health Equity Workgroup and Health Equity Studios, a presentation and discussion format hosted by the same group. The Health

Equity Workgroup strategizes ways to build organizational capacity to advance health equity and provides training to representatives from operational units throughout DHHS. As part of this group, the SSDI Coordinator will attend the Utah Regional Health Equity Conference this year.

The SSDI Coordinator also had an abstract accepted for the Council of State and Territorial Epidemiologists (CSTE) 2023 Annual Conference, which analyzed data from the National Survey for Children's Health to assess risk factors for being bullied among children and adolescents in Utah.

Finally, the new five-year grant cycle for SSDI began in December 2022 and includes a new work plan of activities that the program will focus on. Current and upcoming SSDI grant activities include continued assistance with the five-year Title V needs assessment activities, strengthening data linkages, developing an MCH/CSHCN agency data catalog which includes data sources for social determinants of health, and enhancing capacity for timely data collection to inform emergencies and emerging issues for MCH and CSHCN populations.

Related to the upcoming 2025 five-year Needs Assessment, the SSDI team has already made significant progress on an indicator report highlighting a variety of health indicators for the five Title V population domains, which will help identify new priority areas for the next five-year Title V grant cycle.

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

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

DHHS maintains numerous public health databases such as birth and death records, an immunization registry, child health registries, and a data warehouse that stores the 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 DHHS Master Person Index (DOHMPI) uses 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. 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, DOPL - Professional Licensing, Utah Cancer Registry, 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 the All Payer Claims Data (APCD) (non-Medicaid), Head Start - DDI Vantage, and Traumatic Brain Injury Registry.

The Health Care Information & Analysis Programs manage and enhance the APCD. In addition to collecting inpatient hospital discharge data, they have begun compiling medical and pharmacy claims data across health 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, special procedures, delivery of the baby, and postpartum care of the mother. The APCD represents a rich source of healthcare data.

Another major strength for the DHHS data infrastructure is the online 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, serving as the primary point of data access and houses numerous data sets for public use (http://ibis.health.utah.gov). IBIS-PH was developed to meet recognized public health assessment needs, including tabulation of vital statistics data, tracking 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, Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS), Youth Risk Behavior Surveillance System (YRBSS), hospital and emergency DHHS data, population estimates, and the Cancer Registry. The State Systems Development Initiative grant (SSDI) Coordinator/Epidemiologist works with the Maternal and Infant Health Program (MIHP) to update IBIS indicators and develop new indicators to fill data gaps.

Capacity for MCH/CSHCN data collection and analysis is expanded through the Data Resources Program (DRP). DRP provides analytic resources and statistical expertise to division offices and programs for assessing the health

status of the MCH population and planning and evaluating services. DRP is headed by a program manager experienced in epidemiology, who oversees three additional epidemiologists and one health informaticist/programmer. DRP assists staff with survey development, database development, data analysis, and report writing and receives data requests from the Division's Offices (mostly within MCH and CSHCN), and outside state agencies, local colleges, and universities.

DRP also conducts surveys and data analysis including, but not limited to, Oral Health Surveys, WIC Participant Satisfaction Surveys, Developmental Screening Surveys, and the Commodity Supplemental Food Programs Customer Satisfaction Survey. DRP routinely links Vital Records Birth Certificate data and Medicaid Eligibility data for the annual Maternal and Child Health Block Grant. DRP also links datasets to assist several programs, such as 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 Utah Birth Defect Network (UBDN) data; and Vital Records Data with the WIC data.

DRP is in the process of developing a Severe Maternal Morbidity (SMM) indicator in the IBIS-PH system. SMM is a topic of growing interest at the national and state levels. DHHS has provided periodic reports on SMM, but has not historically had a consistent surveillance system. Having this IBIS-PH indicator will help fill a data gap for future program planning and surveillance.

DRP is also working with the Office of Early Childhood in DFH to conduct an equity focused analysis of the DHHS developmental screening program using Ages and Stages Questionnaires (ASQ). This analysis will involve calculating the likelihood that children in rural and frontier communities, children in poverty, and children who are racial/ethnic minorities are receiving this important screening using 2010-2022 data. This analysis will be included in the Early Childhood Utah program's strategic plan.

Annual coordination of the Title V MCH Block Grant Application and Report is the responsibility of DRP. A web-based application titled Web Enabled Systematic Tracking Tool (WESTT) was developed by DRP 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. 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 training and updates to the system. Some new areas of focus for WESTT in 2023 include mapping Evidence-based Strategy Measures (ESMs) to strategies for National Performance Measure (NPM) targets and uploading supporting documents to be included in the state action plan narrative for Title V Block Grant domains.

In 2022, DRP also worked with staff in MCH and CSHCN to create a new collaborative group called the Data Integration Workgroup (DIW). The purpose of DIW is to provide analytic support to Division 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 DIW and others in the Agency. The merger of the Department of Health with the Department of Human Services resulted in two additional offices falling under the Division of Family Health: Office of Early Childhood (EC) and Office Coordinated Care and Regional Supports (CCRS). DIW now has members representing all Division Offices and is seeking ways to bridge data silos and work more closely together. Over the past year, several presentations have been given by DIW including topics such as: High Fidelity Wrap-Around (CCRS), EHDI Diversity and Inclusion Plan (EC), The Independent Assessment Program (CCRS), Data Quality Analysis of Birth Defect Surveillance data (UBDN), and a training from the Office of Vital Records and

Statistics on the different forms and components that go into creating a birth record. As DIW grows, continued opportunities for collaboration are anticipated within the Family Health Division on data projects.

Data Systems

The Division of Family Health has several data systems used for surveillance and other projects. The Child Health Advanced Records Management (CHARM) system securely integrates public health data within DHHS, and external agencies to coordinate care, and improve efficiencies and health outcomes of children and families. The CHARM system creates a consolidated electronic health record for every child in Utah. This record increases the effectiveness of child health care services by providing a secure, confidential way for authorized health care programs, providers, and partners to share public health data and track the health status of children. The health record can be printed and given to parents/guardians to assist MCH/CSHCN populations and programs with continuity of care and follow-up.

Last year, the CHARM system was selected to be the state system to collect and share the Ages and Stages Questionnaire (ASQ-3) and ASQ Social and Emotional-2 (ASQ SE-2) developmental screening results. The CHARM Program is currently working to integrate the ASQ data through the CHARM system and make the results available to early care, development, health care, and education providers, as well as clinicians. This will ensure that more effective and consistent referrals, services, treatments, and interventions are provided to children with potential developmental delays. The CHARM system has shown that it improves services to children, reduces the number of children lost to follow-up, reduces duplicate services, promotes timely access to needed services, and improves patient care. It supports programs and medical home providers that serve MCH and CSHCN populations statewide.

Utah Birth Defect Network (UBDN) is a statewide population-based active surveillance system administered by DHHS 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, making birth defects common, costly, and critical. UBDN data provides a unique opportunity to respond to emerging threats to mothers and babies. UBDN is collaborating with ISP to identify children who could benefit from transition to adult healthcare services. The two programs are establishing a data-sharing agreement to share data to work on outcomes related to NPM 12.

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 these measures. PRAMS data is the source for several Title V National Outcome Measures.

SOARS is 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 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 also helps us learn what support women and families need after such a loss. In 2022, DRP programmed a REDCap database for SOARS data entry.

The Perinatal Mortality Review (PMR) Program reviews maternal deaths and infant deaths related to perinatal conditions. Information on deaths is collected from various sources. A multidisciplinary 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 (CFRP) housed at the Michigan Public Health Institute. Utah's Child Fatality Review program also uses the 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 MotherToBaby Utah program provides information about medications and other exposures during pregnancy and breastfeeding. This 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

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

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

The Utah Department of Public Safety, Division of Emergency Management (DEM) is the lead state government agency in Utah for prevention, mitigation, preparedness, response (including state-to-state mutual aid), and recovery actions and activities. DEM oversees and manages Utah's Emergency Operations Plan (EOP) and Continuity of Operations (COOP) plans in coordination with all state agencies including the Utah Department of Health and Human Services (DHHS). The state EOP plan is reviewed and updated every five years or updated as a result of lessons learned during responses. COOP plans are reviewed and updated annually by each state agency.

As most incidents have a potential health impact, DHHS has a defined disaster response role to protect public health and support the local public health and healthcare systems during a disaster. The Division of Population Health houses the Office of Emergency Medical Services and Preparedness (EMSP) who is the lead regulatory agency for Utah's emergency medical services system and coordinates public health and medical preparedness and response planning for the department and local stakeholders. The Preparedness and Response Program in the Division of Population Health is responsible for the management of all-hazards planning, training and exercises for the department. As a newly merged agency, the Preparedness and Response Program has developed a departmental EOP encompassing activities with both emergency support functions (ESF) 6 - mass care and sheltering, and 8 - public health and medical. This plan is reviewed and updated every three years or as needed. MCH/CSHCN staff were not involved in the planning and development of the current departmental EOP.

The current state and departmental EOPs include overarching planning assumptions that individuals 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 pregnant women, 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.

This year brought new collaborative efforts between MCH/CSHCN programs and Emergency Preparedness. The MCH/CSHCN Directors were invited to attend the monthly Preparedness Coordination meeting and have been provided a standing spot on the agenda for providing MCH/CSHCN updates. This meeting is an opportunity to bring together various programs from across the department and discuss important preparedness and response topics.

In addition, the two Divisions are currently participating in the AMCHP Emergency Preparedness action learning collaborative. The Utah team comprises two team members from Emergency Preparedness and three team members from MCH/CSHCN. Staff have attended working sessions to identify opportunities for improvement and collaboration. Three MCH/CSHCN staff attended a NACCHO sponsored Tabletop Exercise for the Inclusion of MCH Populations in Emergency Preparedness and Response at NACCHO's Preparedness Summit. Two Title V staff attended the full Preparedness Summit. Participation in the AMCHP learning collaborative has provided a platform for learning among the participating programs and developing plans for future collaboration. Opportunities for collaboration in the coming year have been discussed among the participating team members and include preparing fact sheets for each of Utah's Local Health Departments that contain information on the number of pregnant women, children and children with special healthcare needs in the district; creating a list of key jurisdictional MCH partners and stakeholders that is shared between Title V and PHEP staff; outlining a communication plan for the September 2023 Preparedness month, and proposing the addition of disaster preparedness questions to the 2024 BRFSS

survey.

As an opportunity to learn from the COVID-19 response, MCH/CSHCN staff participated in a debrief with Emergency Preparedness staff to discuss gaps encountered during the pandemic response related to the populations we serve. The recurring themes identified through the debrief were related to the response, continuity of operations, and workforce. The identified recommendations will improve capabilities which will impact both future public health responses and continuity of operations across all hazards within the MCH/CSHCN programs. The recommendations also align with the strategies and action items from being discussed in the AMCHP emergency preparedness and response action learning collaborative.

Historically, MCH/CSHCN programs were involved in the incident management structures for the Zika response in 2016-2017. However, Title V leadership has not been involved in the Incident Command System (ICS) as of late. The scope, scale, and nature of the response is determined by DHHS leadership who activate various DHHS 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. To further prepare staff to respond to emergencies the MCH/CSHCN programs will identify key personnel and implement preparedness and response training. This will include an emergency response basics course about the role of DHHS in an emergency response and FEMA independent study (IS) courses (IS-700 and IS-100). Familiarity with preparedness and response concepts will allow for seamless integration in the event of MCH/CSHCN staff integrating into the ICS.

Leadership of MCH, CSHCN and EMSP are in communication to better address the needs of the MCH/CSHCN populations in the ESF 8 annex/addendum to the state EOP and departmental EOP. One area to close the gap is better coordination with the ESF 6 leads to pose MCH/CSHCN considerations for mass care and sheltering considerations.

DHHS has critical operations that must be performed, or rapidly and efficiently resumed, in an emergency and has a developed COOP plan for the department as well as for the divisions. 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 DHHS. 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 that will require immediate attention. All the newborn screening programs (blood, heart and hearing screenings) and direct care services are involved in this plan.

Given Utah’s heavy snowpack in the winter of 2023, spring flooding was a concern. Social media messaging related to flood emergency resources and education developed and disseminated for pregnant people, families and infant feeding (also in Spanish).

Image 4. Flooding Social Media Post

Image 5. Flooding Social Media Post

Image 6. Flooding Social Media Post (Spanish)

Image 7. Flooding Social Media post

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, children with special health care needs, 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.

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 quality improvement processes. The UWNQC safety bundle sub-committee works to implement maternal safety bundles promoted by the Alliance for Innovation on Maternal Health (AIM). Utah continues work on implementing the Care for Pregnant and Postpartum People with Substance Use Disorder safety bundle. This is a statewide collaboration between hospitals, public health, and the DHHS Office of Maternal and Child Health as well as the Office of Substance Use and Mental Health. Other projects include addressing screening and referral for perinatal mental health conditions, identifying and addressing maternal and neonatal safety issues related to out of hospital births, and developing a toolkit with resources to improve maternity care for Latina women in Utah.

Utah's Perinatal Mortality Review (PMR) Committee is a committee of experts in clinical care, mental health, and public health 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 direct prevention activities.

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. MTB UT led Utah's Fetal Alcohol Spectrum Disorders Workgroup to promote avoiding alcohol use during pregnancy to prevent fetal alcohol spectrum disorders. In April 2022, the group became the steering committee for the Drinking in Pregnancy Prevention project funded by partners in substance abuse prevention. The group includes representatives from mental health, birth defect prevention, substance abuse prevention, and other organizations. MTB UT also led the Organization of Teratology Information Specialists'/MotherToBaby seminars to provide ongoing professional development through the review of research articles twice a month. 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. International members of the Organization of Teratology Information Specialists collaborated to publish "Paracetamol use in pregnancy - caution over causal inference from available data" to educate the public and providers about the use of acetaminophen during pregnancy.

Over the past few years, the Office of CSHCN has found an opportunity to reduce silos and increase partnerships to be more effective with service provision, such as working on medical home and transition to adulthood initiatives. CSHCN initiated engagement with a variety of stakeholders (approximately 30) and assessed the current system of care. Some of the partners include: University of Utah Medical and Intermountain Healthcare systems, who service the CSHCN populations; Utah Parent Center, Help Me Grow (United Way), local health departments, Community Health Centers, community providers, and DHHS programs, including Child & Family Services and Early Intervention. These medical home and transition focused partnership groups meet monthly. All participating

stakeholders are implementing processes in a uniform and consistent manner. There is a sense of momentum and excitement as the potential for greater impact by collaborating as a team is discovered. By joining forces, there is access to a wider range of resources, knowledge, funding, and innovative ideas. This allows us to provide enhanced support and services to our populations, maximizing our collective abilities to make a meaningful difference.

The Utah Birth Defect Network, in collaboration with the Utah Down Syndrome Foundation, created a resource for families who have recently received a new diagnosis of Down syndrome. Contents of the guide include navigating Down syndrome in the first year, myths and truths, support groups, milestone markers, medical specialists, Medicaid, medical home portal, Utah Parent Center, and CSHCN resources such as Integrated Services, and Baby Watch Early Intervention. The booklets are available statewide.

The Child Health Advanced Records Management (CHARM) program continues to collaborate with multiple state programs and agencies. During the past year, the CHARM program partnered with stakeholders from the Utah Governor's Early Childhood Utah Commission and its Health Subcommittee on a project to make the Ages and Stages Questionnaire (ASQ-3) and ASQ Social and Emotional-2 (ASQ SE-2) developmental screening results available to early care, development, health care, and education providers, as well as clinicians. This will help ensure that more effective and consistent referrals, services, treatments and interventions are provided to children with potential developmental delays. CHARM has been collaborating with the Utah Department of Workforce Services' Office of Childcare, Help Me Grow Utah, and the Utah Head Start Association, which will all use the ASQ developmental screening tool across their programs. The results of those screenings will then be shared through CHARM's integration system with users of 1) the Utah Statewide Immunization Information System (USIIS), 2) the CHARM Web Portal, 3) the Baby Watch Early Intervention's Baby & Toddler Online Tracking System database, and 4) Electronic Medical Records systems, including those of Intermountain Healthcare and a Community Health Center. Data Sharing Agreements with all the organizations and partners listed above are being established. This project further integrates the program with appropriate state and community databases so that better and more consistent services are provided to children and youth with special health care needs and their families.

The Oral Health program continues to be an active participant in the Utah Oral Health Coalition and in organized dentistry through the Utah Dental Association (UDA) and Utah Dental Hygienist Association (UDHA). The Oral Health Educator (OHEd) and State Dental Director (SDD) have regularly attended quarterly Oral Health Coalition meetings and monthly steering committee meetings as non-voting advisory members. The Oral Health program regularly provides updates at coalition meetings and coordinates with the office of Medicaid to have a representative provide updates.

The SDD regularly attends UDA board meetings and the OHEd and new program coordinator started attending UDHA board meetings to stay connected with organized dentistry, better understand local needs, and provide updates. The OHEd has written articles on the importance of age one dental visits and promoting the opioid toolkit for dental providers, which includes prescribing guidelines during pregnancy, childhood and adolescence. This information was shared through the UDA action magazine, UDHA Facebook page, and educational booths at both associations' annual conferences.

The HRSA Oral Health Innovation grant began in the fall of 2022 and a dental hygienist program coordinator was hired. The program coordinator is working with the University of Utah School of Dentistry, two rural hospitals, and a community health center within a dental health professional shortage area. The project goals are to increase capacity and knowledge among emergency department personnel by training them to conduct oral health assessments for people coming to the emergency department for oral health problems. The project will also increase capacity for emergency and preventative dental care by adding three new dental operatories in the community health center, and working with emergency departments to refer people coming in for oral health problems to the community health

center where they can receive restorative and preventive care and establish a dental home.

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) was renewed on January 1, 2023. 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 include:

- 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 Office of CSHCN 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 Offices of MCH/CSHCN; the Pregnancy Risk Assessment Monitoring System, MotherToBaby, Integrated Services Program (ISP), Fostering Healthy Children, Baby Watch Early Intervention (BWEI), and WIC. The ISP, BWEI, and Fostering Healthy Children all provide administrative case management services, assistance, monitoring, coordination, referrals, and community education for Medicaid enrollees. These programs provide extensive outreach throughout the state via 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.

Title V Offices and Medicaid jointly participate in committees that include stakeholders with diverse expertise who provide feedback and action to improve Utah's health outcomes. As an example, DHHS initiated a new homeless task force which both CSHCN and Medicaid are a part of, and the ISP team now provides consultation services at

the homeless youth shelter.

While the MCH/CSHCN database systems do not have the capacity to collect and report on the percent of services delivered by Managed Care Organizations and Primary Care Case Management entities, 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 (HB) 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. HB 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. Senate Bill (SB) 290 (Medicaid Waiver for Medically Complex Children Amendments), passed in 2023, amends the MCCW program for children with disabilities and complex medical conditions to provide greater ongoing funding and allow approximately 190 more children to be served on the Medically Complex Children's Waiver by the end of FY 2024. The Office of CSHCN has supported Medicaid with outreach and promoted this opportunity with its stakeholders and families being served. Additionally, the Integrated Services Program has assisted families in enrolling.

Public Health Emergency

During the COVID-19 Public Health Emergency (PHE), Medicaid sustained a Maintenance of Effort (MOE) requirement for eligibility. From March 2020 until the end of the PHE, all Medicaid cases were kept open unless a member moved out of state, requested closure, or died. This led to an approximate 40% increase in enrollment numbers. With the end of the PHE, the Utah Medicaid program developed a plan to resume normal state Medicaid eligibility determination processes. The Medicaid program sent out public information asking members to pay close attention to their mail and update their information on file. Providers and partners were asked to assist with spreading the word and a toolkit was developed with key messages and social media posts that could be used.

ISP is communicating with their families to provide support in completing forms and applications submitted as the documents arrive with the families. ISP is supporting any possible way they are able.

Changes to the Utah Medicaid Program

In past years, Utah has expanded Medicaid coverage to include more parents and adults without dependent children. In recent years, Utah has increased Medicaid eligibility and benefits through state legislation, as well as a statewide ballot initiative.

The following legislation passed in 2023 impacts MCH/CSHCN populations:

Caregiver Compensation Amendments

The Medicaid Caregiver Compensation program allows caregivers of individuals enrolled in home and community-based services waivers to be paid for time spent providing their loved one personal care services that constitute extraordinary care. Program participants and their support coordinators have reported significant benefits of the program, including increased system capacity, more autonomy and individualized services, improved wellbeing and financial stability, and an overall increase in quality of life.

Currently, Utah Code 26B-3-222, "Medicaid waiver expansion for extraordinary care reimbursement" allows spouses to be compensated for providing care, and the Utah Legislature has already appropriated ongoing funding to support the program long-term. Caregiver compensation for parents and guardians, however, was a temporary program

under the COVID-19 PHE, funded by a one-time appropriation through the end of FY 2023.

SB 106 ‘Caregiver Compensation Amendments’, passed in 2023, directs DHHS to apply for authority from the Centers for Medicare & Medicaid Services (CMS) to make caregiver compensation for parents and guardians of waiver enrollees a permanent program. $2,250,000 was appropriated for this program.

Division of Services for People with Disabilities Waitlist Funding

There are currently about 6,600 people receiving home and community-based services waiver from the Division of Services for People with Disabilities, and approximately 4,600 people are on the waitlist. This year, the legislature appropriated $3,581,300 to move people off the waitlist and into services.

Other Legislation

SB 133 ‘Modifications to Medicaid Coverage’ directs the Medicaid program to apply for a waiver or state plan amendment with CMS to extend postpartum Medicaid coverage from 60 days to 1 year, which will match the duration of continuous eligibility provided to newborns. SB 133 also directs the Medicaid program to apply for a waiver that will provide family planning services to uninsured and underinsured individuals up to 185% of the Federal Poverty Level (FPL).

SB 19 ‘Medicaid Dental Waiver Amendments’ directs the Medicaid program to seek a waiver with CMS that will extend dental care to all adults 21+ year who qualify for Medicaid and do not already have the dental benefit.

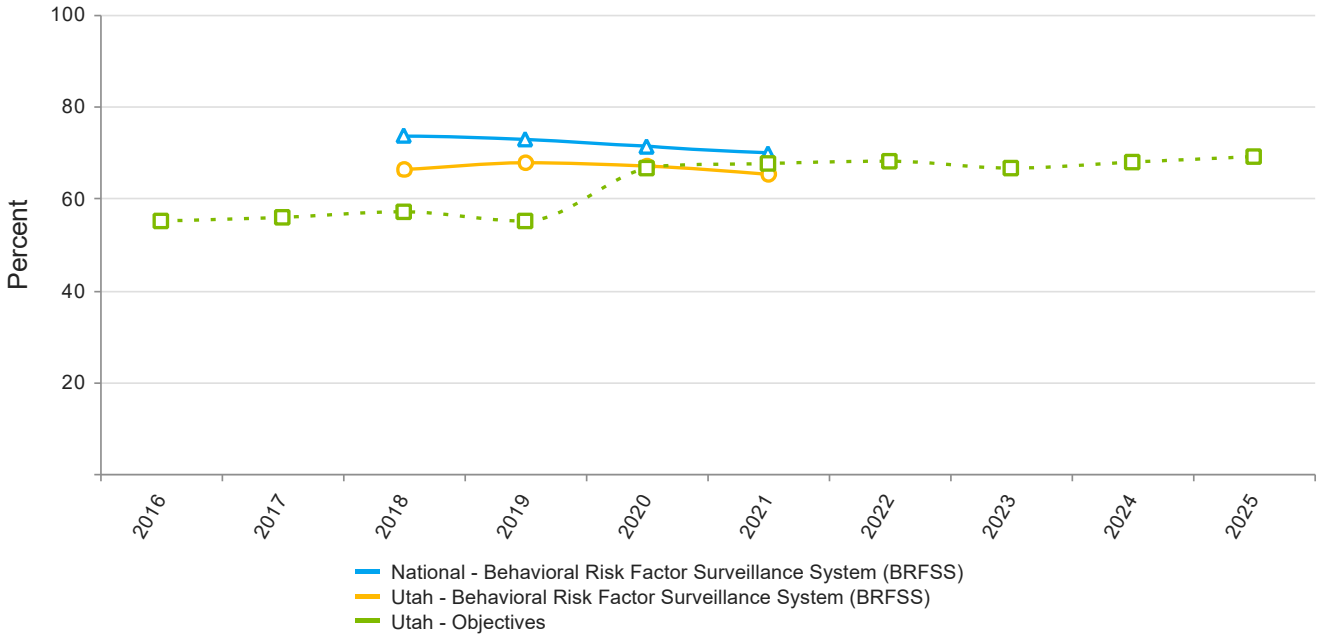
SB 217 ‘Children’s Health Coverage Amendments’ extends health insurance through the Children's Health Insurance Program (CHIP) to children who meet financial eligibility requirements, but do not meet the citizenship requirement. This bill provides funding to provide coverage to children with CHIP-like coverage. The bill has a residency requirement, requiring enrollees to have lived in Utah for at least 180 days.

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			66.5	67.5	68
Annual Indicator		66.1	67.6	67.0	65.3
Numerator		394,166	413,656	413,571	408,264
Denominator		595,993	612,087	617,227	625,335
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

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

Annual Objectives			
	2023	2024	2025
Annual Objective	66.5	67.8	69.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	2.0	2.0	2.0

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	2022
Annual Objective			63.8	63.8
Annual Indicator	56	60.8	60	63.6
Numerator	25,866	27,859	26,909	29,131
Denominator	46,186	45,807	44,814	45,771
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	65.2	66.7	68.3

State Action Plan Table

State Action Plan Table (Utah) - Women/Maternal Health - Entry 1	
Priority Need	
Women's access to care	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By 2025, increase the percent of Utah women, ages 18-44, who had a preventive medical visit within the past 12 months from 66.1% (BRFSS, 2018) to 69.0%.	
Strategies	
1. Engage community partners to develop a well-woman visit strategic plan.	
2. Improve understanding of barriers to receipt of routine preventive care.	
3. 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 1.1 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.	Inactive
ESM 1.2 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.	Inactive
ESM 1.3 - 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.	Inactive
ESM 1.4 - 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 68.3%.

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 FY22:

This Performance Measure was NOT achieved. The Performance Objective was 68.0% and the Annual Indicator was 65.3%.

Program Activities:

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 educate people on their specific healthcare needs and screen for early detection and treatment of certain conditions. The importance of routine preventive care cannot be overstated.

During FY22, the Maternal and Infant Health Program (MIHP) utilized multiple approaches to educate Utahns on the importance of well-woman visits.

MIHP utilized Facebook and Instagram to share information on preventive healthcare 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. The Power Your Life social media accounts have become a trusted source of information. Our followers regularly reach out through direct messaging on the platforms to ask questions and seek more information.

In December of 2021, Nickee Andjelic, the certified health education specialist for 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. This segment reached thousands of people throughout the state of Utah.

During April of 2022, Ms. Andjelic did another on-air television spot on the afternoon news that educated viewers on urgent maternal warning signs, as outlined in the CDC's HEAR HER Campaign. This segment was also viewed by thousands of people, and encouraged them to seek immediate medical care if they themselves or someone around them show certain urgent warning signs during pregnancy or within one year after birth.

Due to the ongoing COVID pandemic, many of the yearly community health fairs and other community events MIHP has participated in historically were canceled, but FY22 did see several events start back up, sometimes at smaller capacity or in a socially distanced manner. The list below shows the events that MIHP participated in, and the number of materials handed out or people reached. These events reached diverse populations of men, women, and young adults with messages about routine preventive care, preconception health, contraception, and birth defects prevention.

- Pacific Islander Health Fair. Held yearly by the Utah Pacific Islander Health Coalition. MIHP staff provided materials to an estimated 200 people.
- Partners in the Park. Sponsored by the University of Utah, this community event brings resources to residents on the west side of the Salt Lake valley, which is a high-need area. We talked about women's health and shared resources with about 100 people at this event.

- University of Utah Block Party. This health fair was for University of Utah students living in married housing. MIHP staff were unable to attend this event, but provided educational materials that were given to about 100 people.
- Utah Valley University (UVU) Student Health Fair. UVU Student Health and Wellness 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, reaching approximately 300 UVU students and faculty.
- Hometown Community Center Health Fair. This fair is targeted at people in an under-resourced area in the Salt Lake valley. We reached approximately 100 people at this event, including distributing some Spanish language materials.
- Climb out of the Darkness Walk. This yearly event brings awareness to maternal mental health. We provided 100 educational packets to Postpartum Support International Utah, who sponsored the event.

While it is difficult to know if any of these activities directly impact a woman seeking routine preventive care, the ability to meet the target population where they are, talk with them, make them aware of the program, and answer their questions face-to-face makes a difference in their knowledge and attitudes. During these events, MIHP staff were able to have 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.

Accomplishments / Successes:

A significant accomplishment of MIHP during FY22 was completing the Well-Woman Strategic Plan (Appendix C). In the early stages of creating this plan, it was recognized that increasing the percentage of women that receive a well-woman visit was a goal that will take collaboration from professionals in the healthcare field, public health, and community organizations. MIHP began working with diverse stakeholders to create a statewide strategic plan to address routine preventive care in women of reproductive age during FY22. A well-woman coalition was established in January 2021 with members from public health, healthcare, rural health, and higher education. Stakeholders from these fields regularly attended and participated in meetings held every other month. Conversations from these meetings were compiled into best practices and goals in the Well-Woman Strategic Plan. The plan outlines a 5-year (2022-2026), multi-level strategy that includes policy, community, organizational, interpersonal, and individual approaches that work to improve women's health and wellness over their entire lives. Upon completion, the strategic plan was posted to the MIHP website for public viewing. The plan was advertised on Power Your Life social media pages to tell community members where to find the plan.

An ongoing need of MIHP has been to pinpoint why women do not schedule a yearly well-woman exam. Without this knowledge, the program cannot create messages or programming that will address the needs of this specific population. To address this need, MIHP successfully added a question to the 2022 Utah Behavioral Risk Factor Surveillance Survey (BRFSS) asking women of reproductive age why they did not receive routine preventive care in the last year. The question that 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 the follow-up question:

"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?"

(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 did not want to visit a clinic or doctor's office due to COVID.
(7) Other
(8) Don't know/not sure
(9) Refused

The BRFSS is conducted every year on a calendar year schedule. This question was included in the BRFSS the entirety of 2022 and has been included for the current year, 2023. Data from both years will be used to guide activities for MIHP to address the barriers women face to receiving routine preventive care.

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

- The Well-Woman Strategic Plan for 2022-2026 was completed and published.
- The Maternal and Infant Health Program reached hundreds of people at in-person health fair events and provided education on contraception, preventive healthcare, birth defects prevention, and how certain lifestyle behaviors affect immediate health and the health of a future pregnancy.
- A question addressing why women of reproductive age do not receive regular preventive care was included in the 2022 Utah BRFSS.

Challenges / Gaps / Disparities Report:

Challenges: A challenge faced by MIHP staff during FY22 continued to be the COVID-19 pandemic. Due to federal, state, and local ordinances, many large group gatherings, like health fairs, were canceled for safety. This led to MIHP staff being unable to attend as many health fairs as in previous years, thus resulting in lower numbers of people reached. While this challenge was not as prevalent as it was during FY21, it still had an impact. As scientific advances are made and restrictions are lifted, we are optimistic that in the coming year we will be able to reach more people.

Another 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 BRFSS 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.

MIHP has experienced some recent staffing changes within the program. The former health educator, Nickee Andjelic, became the MIHP program manager. In turn, Megan Tippetts accepted the vacant health educator position in December of 2022. Staffing changes can often bring a brief pause to regular program activities, but MIHP activities have been proceeding well since the staffing changes have occurred.

Disparities: Based on Federally Available Data, Utah is ranked 43rd out of 51, with 65.3% of women of reproductive age receiving a preventive medical visit compared to 69.7% in the U.S. overall in 2021. Within Utah in 2021, uninsured women had a significantly lower percentage of receiving a preventive visit (42.9%) compared to insured women (67.4%). Women with less than a high school diploma were also less likely than women with higher levels of education to receive a preventive visit.

Agency Capacity/Family Partnerships/Collaboration:

The Utah Birth Defect Network (UBDN) is a significant partner for this performance measure. Staff from UBDN attend all health fairs with the MIHP staff. Program staff work together and often share resources and educational material.

Another vital partner, MotherToBaby Utah (MTB UT), provides information to the public about exposures in the preconception period, during pregnancy, and during breastfeeding. The public can ask questions through email, phone calls, text, or online chats. During FY22, MotherToBaby Utah answered hundreds of questions from the public about exposures as they were planning for future pregnancies, questions during pregnancy, and questions before and during breastfeeding. MTB UT provides information free of charge 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 1.4: Develop and offer an education module to community health care 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 1.4:
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:
MIHP has received upper management approval for the project, as well as approval for the adequate funding. Moving forward with the project is dependent on the readiness of the CHW education team. The company that is used to build CHW modules, Talance, requires four modules to be added at a time. The CHW education team is working to gather the required materials to begin work on the other three modules that will be added in addition to MIHP's module. It is anticipated that MIHP will be able to begin writing the module in partnership with Talance during summer 2023.

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 FY22:

This Performance Measure was NOT achieved. The Performance Objective was 63.8% and the Annual Indicator was 63.6%.

Program Activities:
During FY22, 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. Presentation audiences included local health departments, local mental health authorities, staff in the Division of Substance Abuse and Mental Health, home visitors, the Utah Suicide Prevention Coalition, clinical staff in multiple practices, and WIC staff.

The MMH specialist 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 as of March 2023, the page had over 12,400 followers.

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.

MHIP 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 screen positive for perinatal depression are offered resources in the form of handouts, support groups, or individual mental health services via a telehealth platform.

In FY22, the MMH subcommittee of the Utah Women and Newborns Quality Collaborative (UWNQC) finished their development of a MMH Provider Toolkit, to aid in screening and referrals, and published it publicly. As of May 2023, there have been 158 downloads of this toolkit.

MCH staff participated in the Utah MMH Policy Committee. This group focused on policy issues surrounding MMH and activities to raise awareness of the issue in Utah. The committee includes stakeholders from a wide range of agencies who serve Utah's women and children.

Utah Governor Spencer Cox declared February as Maternal Mental Health Awareness month. The Utah MMH Collaborative held an event on February 9, 2023 to mark this declaration, which generated media coverage. There was a noted increase in the number of visitors to the Utah Maternal Mental Health Referral Network (https://maternalmentalhealth.utah.gov/) after this event.

Accomplishments / Successes:
Due to the groundswell and statewide support from providers and policy and advocacy groups surrounding MMH, funding for a maternal mental health specialist at the state-level switched from temporary funding (three years) to ongoing funding during the 2021 legislative session.

This means work in MMH has continued with many successes including increasing the number and types of providers trained in maternal mental health and the information and training materials for providers statewide.

The MMH Provider Toolkit was released to the public along with training videos. The download count as of May 2023 was 158. This toolkit has been downloaded by community based organizations and provider offices.

Enhancements to the MMH web page were made to be more user friendly; it now includes links to social media, additional resources, and links to the MMH Provider Toolkit and training videos.

Social media has driven a lot of the work for educating the general public on the importance of screening, and educating providers on how and what to screen on.

With all the high success rate of previous efforts, the top priorities have been to address gaps in the program's efforts and create new partnerships. This upcoming fiscal year efforts will be expanded to ensure peer support specialists, community health workers, and doulas are trained in addressing MMH.

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

- Maternal Mental Health Provider Toolkit and training videos were released to the public with 158 downloads as of May 2023.
- The number of providers featured on the Maternal Mental Health Provider Network increased.
- WIC clinics have reported increased screening rates.

Challenges / Gaps / Disparities Report:

One of the main challenges in FY22 was the departure of the previous maternal mental health program specialist. The position was filled in June 2022 and with that brought the challenges of settling into the role, making new connections, and learning the position.

Emerging issues include providing access to care for specific populations including: Latina populations, the veteran population, and partner mental health support. The program is looking to address new providers who are screening for MMH, who may need assistance with medication management. Additionally, there will be a new collaboration on a new project focused on individuals who have experienced birth trauma.

Agency Capacity / Collaboration Report:

A new partnership was formed with the Office of Substance Use and Mental Health. MIHP has been focused on collaborating on mental health efforts from a multi-generational perspective.

A partnership was also formed with the suicide prevention coalition. MIHP presented to their group on maternal mental health and the Maternal Mental Health Provider Toolkit.

The partnership with the Early Childhood Programs and committees was strengthened, providing cross-collaborative training on ASQ and maternal mental health.

Local Health Department Successes and Challenges related to SPM-1:

Successes:

Several LHDs are using targeted case management (TCM) home visits and WIC appointments to conduct screenings. When a woman has screening scores that are concerning, they are referred to counselors to start counseling services or connect to other services.

In one LHD, the nurses on their MCH team have embraced Edinburgh screening for all new parents. They are actively screening parents for postpartum depression at higher rates than any other year. The registered nurses have become familiar with the screening and scoring. Their MCH team found a referral system with their local mental health authority so parents are receiving the support that is needed after a screen of concern.

LHDs are also using their CHW staff to implement screenings. Use of CHWs can increase warm hand-offs and help clients navigate barriers. In another district, they are using text messaging for WIC clients to text a link to the EPDS screener.

One district noted that the topic of Maternal Mental Health has become more common to bring up at visits and they indicate that people are more accepting of help.

Challenges:

The effects of the COVID-19 pandemic continue to present barriers to services. In late 2021, many LHD staff were still working on COVID response activities such as vaccination clinics and contact tracing. Many clients express that they remain more comfortable via telehealth. The pandemic limited home visits, as there is hesitancy to allow home visiting staff into homes. Despite this, several LHDs indicate that their home visiting services did increase in 2022.

Other challenges noted:

- Clients not keeping appointments or following up with referrals
- Increasing rates of depression with longer wait times for services
- Staff turnover
- Reorganization of services within a department
- Low interest for in-office screening and low completion rate of link-based screening

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

During FY22, MotherToBaby Utah (MTB UT) provided information to pregnant and prospectively pregnant individuals as part of comprehensive prenatal care and services, including to individuals who were referred by their providers for information before they were able to meet with their providers.

The UBDN recognizes the importance of prenatal care and advocates for folic acid uptake by providing education to Utah women. UBDN provides free vitamins upon request and has these available at any health event UBDN

participates in.

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 (AIM) and works to implement maternal patient safety bundles. In FY22, hospitals continued to work on implementation of the Care for Pregnant and Postpartum People with Opioid Use Disorder Safety Bundle. In FY22, learning sessions were presented on the following topics related to the safety bundle:

- Effects of Substance Use during Pregnancy and Breastfeeding
- Tobacco Cessation Resources
- Fentanyl in Utah
- Intimate Partner Violence and Resources

UWNQC compiled and mailed Helping Opioid Patients Excel (H.O.P.E.) folders and Naloxone to all Utah and Wyoming hospitals and Home Visiting contacts. Substance Use Disorder (SUD) resources were professionally translated into Spanish and a Spanish SUD resources website was launched. Community Substance Use Disorder resources were developed by Title V summer interns for all Local Health Departments. These resources focused on the maternal population with info on treatment options that prioritize pregnant persons and accept families. The Title V interns presented this resource at AMCHP and it has been replicated by other states as a best practice.

UWNQC also worked with Division of Data, Systems and Evaluation staff on an updated data reporting process for SMM. This has streamlined our ability to track, report, and analyze SMM.

In FY22, MotherToBaby Utah provided education to women and providers about medications used to treat chronic conditions before and during pregnancy and while breastfeeding including cardiovascular, autoimmune, psychiatric, endocrine, respiratory, substance dependence, genetic, neurological, and other conditions. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to the untreated chronic conditions in an effort to help women remain healthy and avoid unnecessary acute episodes or hospitalizations due to questions about continuing medication treatments.

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 reviews maternal deaths among residents of both states.

MotherToBaby Utah provided education to women and providers about medications used to treat chronic conditions (some women had multiple co-occurring chronic conditions) before and during pregnancy and while breastfeeding including cardiovascular, autoimmune, psychiatric, endocrine, respiratory, substance dependence, genetic, neurological, and other conditions. MTB Utah also provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to the untreated chronic conditions in an effort to help women remain healthy and avoid complications and death due to questions about continuing medication treatments.

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 FY24:

During FY24, the Maternal and Infant Health Program (MIHP) will continue to work to understand the knowledge, attitudes, and behaviors of women of reproductive age regarding the well-woman visit. This will be done by continuing to administer the Behavioral Risk Factor Surveillance System (BRFSS) question that asks women if they have received preventive care, and if they have not, what their barriers have been. The MIHP has been able to gather critical information on barriers to preventive care for women in Utah, and looks forward to collecting more data on this issue in the coming year.

During FY23, the MIHP well-woman visit strategic plan was finished and added to the MIHP website for public viewing. The document was advertised on Power Your Life social media platforms to increase public awareness of its availability. During FY24, the document will remain available to download on the MIHP website. This plan will also be presented to local health department nursing directors across Utah.

MIHP will continue their well-woman visit education outreach to women of reproductive age in Utah to share the information collected as part of the strategic plan. These educational activities will mainly take place on social media platforms and during in-person health fair events.

MIHP is excited about a new approach that is in the works, creating an online educational module on women's preventive healthcare for community health workers (CHWs). CHWs work to increase their clients' health knowledge and help them to be self-sufficient through community and individual education, counseling, support, and advocacy. CHWs have a unique influence on the communities they serve and often share socioeconomic backgrounds, ethnicities, and languages with their clients.

Individuals must be certified in order to work as CHWs. The certified CHWs can choose from several available supplemental online education modules, one of which will be the women's preventive health care module. This module will be available to educate CHWs on the recommendations for what preventive care women should receive. This module will help them be able to advocate for the populations that they serve to be able to receive recommended preventive care. By learning about well-woman care from this module, trained CHWs have the potential to protect and optimize women's health over the course of their lifetime and reach previously underserved communities.

This module will be based on the Women's Preventive Services Initiative (WPSI) Well-Woman Chart. The Well-Woman Chart outlines preventive services recommended by the WPSI, U.S. Preventive Services Task Force, and Bright Futures based on age, health status, and risk factors. The full chart can be found here: https://www.womenspreventivehealth.org/wellwomanchart/.

MIHP has received approval and adequate funding to develop this module. Program staff are currently in the process of working with the CHW training coordinator to start building this module.

Proposed Activities:

- The Behavioral Risk Factor Surveillance System question that asks women if they have received preventive care, and if they haven't, what their barriers have been will be administered throughout FY24 to aid in understanding barriers to preventive healthcare.
- The well-woman strategic plan will remain on the Maternal and Infant Health Program website for public viewing. The plan will be presented to local health department nursing directors.
- A community health worker (CHW) education module focused on women's preventive healthcare will be created and distributed to CHWs.

Table 9: Logic Model for National Performance Measure 1

NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year				
Goal: Increase the percent of women in Utah, ages 18 through 44, who have had a preventive medical visit in the past year.				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Qualified staffing Funding to develop and maintain CHW module Printed educational materials Funding and staffing to maintain MIHP website	Administer BRFSS women's preventive care question. Maintain well-woman strategic plan on MIHP website for public viewing. Distribute health education materials on social media platforms and during in-person events. Create a supplemental CHW module on women's preventive care.	Number of survey respondents who answer women's preventive care BRFSS question. Number of views of well-woman strategic plan on MIHP website. Number of health education posts distributed on Power Your Life social media platforms. Number of educational materials distributed at in-person events. Number of CHWs who complete supplemental module on women's preventive care.	NPM 1: Increased proportion of women in Utah who receive a preventive medical visit in the past year Data collected for a year's worth of asking BRFSS women's preventive care question. Increased knowledge of women's health basics among the general Utah population. Increased proportion of CHW clients with increased knowledge of women's preventive care.	Favorable outcomes in the following NOMs: NOM 2: SMM; NOM 3: Maternal mortality; NOM 4: Low birth weight; NOM 5: Preterm birth; NOM 6: Early term birth; NOM 8: Perinatal mortality; NOM 9.1: Infant mortality; NOM 9.2: Neonatal mortality; NOM 9.3: post neonatal mortality; NOM 9.4: Preterm related mortality; NOM 10: Drinking during pregnancy; NOM 11: NAS Decreased proportion of women in Utah with preventable or treatable health conditions, such as cervical cancer and high blood pressure. Decreased number of unplanned pregnancies in Utah, due to contraceptive care received according to the WPSI well-woman chart.
Assumptions and Contextual Factors: If women screen positive for treatable conditions, they will have access to adequate treatment. We assume these women will take advantage of treatment options.				

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 FY24:

In addition to continuing all of the activities currently ongoing in the program (ongoing training of providers, creating new collaborations, social media education, etc.), some services will be finalized and expanded to better serve the providers who will be implementing maternal mental health screening.

Promoting Utah's Maternal Mental Health toolkit, which includes statewide screening and referral protocols, for the Utah Women and Newborns Quality Collaborative (UWNQC), will continue to be a top priority. UWNQC will be monitoring and implementing QI practices to gather feedback on the utilization of the toolkit.

Training efforts will be focused on pediatricians and primary care providers, ensuring they are familiar with and utilizing the Maternal Mental Health Provider Toolkit. There are also goals to expand the number of Spanish-speaking providers trained in maternal mental health as the number of providers in the maternal mental health referral network grows.

Expansion of online screening use in local health departments through a contract with the University of Utah is also on the horizon. This online screening tool is vital for rural and frontier health departments who are under-staffed and do not have a lot of time to hold full screenings. This way, they can refer someone who needs help depending on the score from an online screener before arriving at their appointment.

Funding to ensure community health workers, doulas, and substance use peer support specialists are trained in maternal mental health will be a priority. UWNQC has contracted with a local community-based organization that serves the Hispanic/Latino maternal community to evaluate the usefulness of perinatal mental health support group services for the Hispanic/Latina perinatal community. An additional contract with a non-profit organization that serves the Hispanic/Latino population in rural Utah will be established. This organization will provide education through parenting classes and community events to provide a supportive environment for mothers' mental and emotional health.

Staff in the Office of Maternal and Child Health (MCH) will be launching a Birth and Postpartum Trauma Quality Improvement Project in collaboration with UWNQC. A team at the University of Utah, that includes a Maternal-Fetal Medicine Specialist, will lead the needs assessment process. This includes compiling a literature review, conducting interviews with key informants (including clinical care providers and patients), and presenting a summary report of the interview findings to the UWNQC committee. The goal is to inform the quality improvement project to develop resources for patients who have experienced birth or postpartum trauma.

Social media platforms will also continue to be used to encourage women to seek screening and care from providers. Social media is where program staff connect with the general public and providers across the state and nationally.

Proposed Activities:

- Promote the toolkit for the Utah Women and Newborns Quality Collaborative, and assess the toolkit for improvements.
- Train at least one more: OB, midwife, psychotherapist, Pediatrician, TriCare (Veteran population) on the

Maternal Mental Health Provider toolkit, and look for trained Spanish-speaking providers to be included on the maternal mental health referral network.

- Expand the use of online screening through the University of Utah to other rural districts.
- Implement two projects to address maternal mental health in Hispanic/Latino individuals.
- Continue to use social media platforms to encourage women to seek screening and care from providers.
- Train community health workers, doulas, and substance use peer support specialists in maternal mental health.

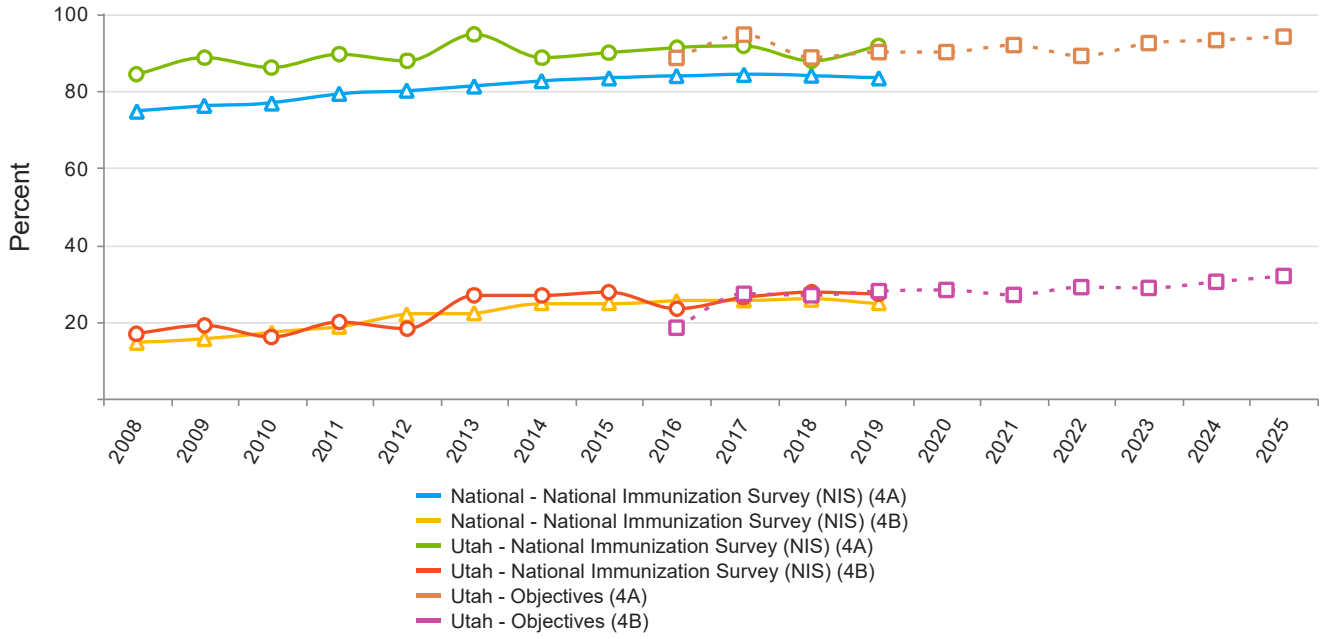
Table 10: Logic Model for State Performance Measure 1

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				
Goal: Increase the percent of mothers who are asked by a doctor, nurse, or other health care worker if they were feeling down or depressed during prenatal or postpartum care				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Funding and qualified DHHS staffing: Maternal Mental Health Program Specialist and other staff Local Health Departments facilities and staff Telemental/health Program Maternal touchpoints (such as prenatal and postpartum visits) Equipment and supplies Training Technology for Telehealth Evidence based interventions	Develop statewide screening, response, triage, treatment protocol, and referral network Train providers on universal protocols and perinatal mental health Expand Telemental/health services Expand referral network of trained providers Surveillance and evaluation for quality improvement Maternal mental health project focused on Hispanic/Latina population Train Community Health Workers and USARA Peer Support Specialists on maternal mental health	Statewide standardized validated screening protocol, treatment algorithm (MMH Provider Tookit) distributed and evaluated Number of urban and rural maternal touchpoint providers trained and utilizing new protocols Number of new perinatal mental health specialists throughout Utah Number of Hispanic/Latina women reached through maternal mental health project Number of Community Health Workers and USARA Peer Support Specialists trained in maternal mental	SPM 1: more mothers are screened for depressed during prenatal and postpartum care Pregnant and postpartum women are screened at least once during each trimester and the first 12 months after delivery Burden of screening distributed among Maternal Touchpoints Providers are trained to respond appropriately to screening results and effectively triage their patients or refer to appropriate resources Programs become more targeted and effective	SPMs are not tied to specific SOMs or NOMs. However, it is reasonable to assume the following NOMs will be impacted by this work: NOM 2: severe maternal morbidity; NOM 3: maternal mortality; NOM 10: drinking during pregnancy; and NOM 24: postpartum depression. Other impacts include: Increased timely detection, treatment, and referral Fewer complications from perinatal mental health issues in Utah Frontline healthcare providers will have increased efficacy through training Rural and frontier communities will have the resources available to support women with perinatal mood disorders Substance use during pregnancy and postpartum period are better managed with more resources to support optimal health
Assumptions and Contextual Factors: If women are screened regularly during the prenatal and postpartum periods, those who screen positive for depression or other perinatal mood disorders will have access to adequate treatment. We assume these women will take advantage of available resources and achieve optimal health.				

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	88.6	90	90	91.8	89
Annual Indicator	89.7	91.2	91.8	87.8	91.4
Numerator	43,073	45,052	39,458	38,339	35,912
Denominator	48,030	49,404	42,968	43,665	39,289
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	92.3	93.1	94.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.9	28	28.3	27	29
Annual Indicator	27.8	23.5	26.3	27.8	27.3
Numerator	12,643	11,415	10,658	11,442	10,531
Denominator	45,490	48,506	40,597	41,090	38,540
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	28.8	30.4	31.9

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			27	69
Annual Indicator	13.2	24.4	65.4	67
Numerator	6,225	11,435	30,555	30,555
Denominator	47,211	46,832	46,716	45,577
Data Source	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	70.0	71.0	72.0

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	40.0	40.0

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

Measure Status:	Active

Baseline data was not available/provided.

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 94.0%. 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 31.9%.	
Strategies	
1. Implement the Stepping Up for Utah Babies program in delivering hospitals in Utah.	
3. Increase access to, and use of, Utah WIC Breastfeeding Peer Counselor Program (BFPCP).	
4. 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 4.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a “Breastfeeding Friendly Facility.”	Active
ESM 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.	Inactive
ESM 4.3 - The number of worksites that have federal lactation accommodations and breastfeeding strategies.	Active
ESM 4.4 - 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 4.5 - 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-4a: Percent of infants who are ever breastfed

This Performance Measure was achieved. The Performance Objective was 89.0% and the Annual Indicator was 91.4%.

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

This Performance Measure was NOT achieved. The Performance Objective was 29.0% and the Annual Indicator was 27.3%.

Annual Report FY22:

Program Activities:

NPM-4.1 and NPM-4.2 are linked to NOMs 9.1 - Infant mortality, 9.3 - Postneonatal mortality, and 9.5 - Sudden Unexpected Infant Death (SUID) mortality. Utah is ranked 8th of 51 for breastfeeding initiation, which corresponds to a significantly higher prevalence (91.4%) compared to 83.2% in the U.S. overall in 2019. Utah is also ranked 21st out of 51 for exclusive breastfeeding through six months of age, which corresponds to 27.3% compared to 24.9% for the U.S. overall.

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 parents' confidence to reach their breastfeeding goals. Parent exposure to these ten steps significantly increases the likelihood that their infant will ever be breastfed and be exclusively breastfed until six months of life.

The Stepping Up for Utah Babies (SUUB) program works with birthing facilities across the state to implement the Ten Steps to Successful Breastfeeding through quality improvement methods. When a birthing facility meets the certification requirement of all ten steps, they are designated and recognized as a Breastfeeding Friendly Facility. Once this designation is met, the facility is recognized on the SUUB website and is given a certificate of achievement to display in the facility.

From the program's inception in 2015 to the end of FY22, 24 (53%) Utah birthing facilities have been trained on the program and have successfully implemented a total of 210 steps. During FY22 specifically, two birthing facilities completed all 10 steps, and three met the requirements to be re-designated as a "Breastfeeding Friendly Facility." To date, 20 hospital facilities have implemented all 10 steps. Re-designation occurs two years after the birthing facility successfully implemented all 10 steps and requires six months of current data submission that meets specified thresholds.

The Utah Women, Infants, and Children (WIC) program developed a statewide goal for FY22 to increase or maintain the number of International Board Certified Lactation Consultants (IBCLCs) working for local WIC agencies and to increase access and utilization of WIC peer-counselors. These goals support and promote breastfeeding to ensure that every eligible pregnant and breastfeeding WIC participant receives at least one contact from a Utah WIC breastfeeding peer-counselor.

WIC 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. The VISION system generates a report that easily allows WIC peer-counselors to access a list of pregnant and breastfeeding participants that are eligible to receive services. WIC assigns pregnant and breastfeeding participants to a specific peer-counselor that provides personalized breastfeeding support services. Utah WIC also uses referrals from partner organizations, such as MotherToBaby Utah, local hospitals, health care provider offices, and community breastfeeding organizations.

In FY22, the Utah WIC program encouraged breastfeeding peer-counselors to contact prenatal and postpartum WIC participants in many ways. The best way that WIC improved this outcome is through a policy requiring peer-counselors to document their contacts in the computer system. Another way that WIC encouraged peer-counselor contacts to participants throughout the state is through referrals by community and partner organizations. These included referring prenatal and postpartum WIC participants to the WIC breastfeeding peer-counseling program through 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 WIC breastfeeding peer-counselors to increase their knowledge and skills. Each local agency offered at least one training on breastfeeding. USDA has also provided a new WIC Breastfeeding Support curriculum that requires an introductory level of completion for all WIC staff. WIC breastfeeding peer-counselors were required to complete two levels of the four level training series. Many local agencies had their peer-counselors begin working on the curriculum in FY22 and the targeted completion date was April 30, 2023.

The Healthy Environments Active Living (HEAL) program oversees a home-grown program called Teaching Obesity Prevention (TOP Star) in Early Child Care and Education Settings (ECEs).The HEAL program began to work with Head Start to implement TOP Star in facilities in 2020. Head Start provides services to support early development and positive health outcomes for children from lower income families. Existing Head Start curriculum has limited content on breastfeeding, so during FY22, the HEAL program created a training curriculum on breastfeeding for ECEs, specifically for Head Start providers. This training was developed to help Head Start providers be better equipped to help families achieve higher breastfeeding rates. Training modules are online and provide continuing education credits for staff. Trained breastfeeding consultants provide assistance to Head Start staff. Many early child care resources are included, such as breastfeeding lesson plans, handouts, and materials. In the past, much of the focus has historically been on facilities in the four main urban counties of Utah, but HEAL has recently reached out to providers in the rural areas of the state.

Accomplishments / Successes:
The SUUB program has seen consistent success since the program’s implementation in birthing facilities across the state. Twenty-four out of 45 (53%) birthing facilities are participating, with 20 facilities meeting all 10 steps. During September 2021, SUUB staff were able to provide initial program training for Fillmore Community Hospital and Delta Community Hospital, both of which are small, rural facilities.

In the spring of 2022, a shortage of infant formula occurred that affected families across the country. SUUB staff created educational materials, including fact sheets and answers to frequently asked questions, for parents, caregivers, and clinicians to help them navigate the shortage. These included information on safe alternatives to feed infants, tips on how to find formula, and infant feeding resources. During April 2022, Stepping Up staff partnered with the HEAL program and released a podcast episode available to the public that focused on breastfeeding education and information about the formula shortage.

One significant success in the WIC program was the ability of WIC clinics to begin providing in-person breastfeeding

services as COVID-19 restrictions eased. This allowed breastfeeding peer-counselors the ability to contact eligible WIC participants in-person, at the hospital, and at home. This was in addition to contacts made via telephone and texting. Additionally, several local agencies were successful in making at least three breastfeeding peer-counseling contacts per participant, helping move the needle on our current ESM goal of at least three contacts per participant.

Local agencies also focused on improving breastfeeding peer-counseling outreach to WIC participants in order to ensure that all eligible parents were receiving breastfeeding peer-counseling services. Outreach included creating and strengthening community partnerships with local hospitals and health care providers, at community events, Early Intervention, La Leche League, the Mountain West Mother's Milk Bank, other community breastfeeding support groups, and home visiting programs, among others.

Improving collaboration and partnerships with community programs and organizations helps increase the number of women referred to the WIC breastfeeding peer-counseling program and subsequently the number of women who are contacted by a WIC breastfeeding peer-counselor. Weber-Morgan Health Department had an especially successful outreach program by hosting their first WIC Breastfeeding Fair to celebrate World Breastfeeding Week. 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.

In FY22, 74.5% of all eligible pregnant and breastfeeding WIC participants received at least one breastfeeding contact by a WIC breastfeeding peer-counselor, which was a significant increase from FY21, which was 41%. Due to the global pandemic of COVID-19, which was at its height throughout 2020 and 2021, many peer-counselors in the state of Utah were deployed to other efforts throughout their local health departments. During FY22, many peer-counselors were able to receive laptops and began to work remotely, which allowed significant increases for their work and caseload. The state WIC office also required that peer-counselors document their contacts in a consistent manner in the VISION system. The number of employed WIC breastfeeding peer-counselors also increased from 29 to 31 between FY21 and FY22.

Comparing breastfeeding rates for Utah WIC participants to the state of Utah as a whole, finds breastfeeding initiation rates lower among women participating in the WIC program. The State of Utah had a 91.4% initiation rate, compared to 86% among WIC participants. The Utah WIC Program's prevalence for exclusive breastfeeding at six months increased from 18% to 23% between FY21 and FY22, an increase of 5% in one year, which we consider a success. However, exclusive breastfeeding through six months remains higher for the state overall at 27.3%

The HEAL program performed outreach to obtain professionals to volunteer and restart the Utah Breastfeeding Coalition (UBC), which has been inactive since 2018. This included recruiting members, the board of directors, and committee chairs. States are supported and strongly encouraged by the U.S. Breastfeeding Committee, the CDC, and USDA to have a state breastfeeding coalition to work on a statewide collaboration to support, protect and promote breastfeeding. MCH leveraged HEAL's state Registered Dietician, IBCLC representative to support the reinvigoration of the UBC.

UBC's collaboration with DHHS is significant because it can leverage other lactation and non-traditional partners that extend beyond DHHS's reach to provide synergy to achieve similar goals, such as sharing statewide breastfeeding resources and unified message campaigns and other significant work that complement DHHS work. Specific to MCH's work, UBC plays a significant role in promoting and supporting the SUUB program, where MIHP does not have the reach, access, or capacity. By leveraging other experienced and expert professionals across the state, DHHS has more leverage and work power to accomplish a broader continuum of support across services and

programs that would otherwise not be possible.

A known disparity includes low rates of breastfeeding among lower wage ($20 per hour or less) working women. HEAL successfully applied for funding for the past three years to help worksites with a high percentage of women with low wages establish or enhance their lactation accommodations. This will help in reaching longer duration and exclusivity in breastfeeding rates.

HEAL's TOP Star in ECEs program has made good progress to expand its reach to 12 of the 13 local health departments in Utah with one-third of this curricula focused on breastfeeding. HEAL has also made great strides in creating a Spanish curriculum with many resources.

During FY22, 41 worksites across the state established or enhanced their lactation accommodations (or at a minimum added a breastfeeding policy). Through local health department contracts and Association of State and Territorial Health Officials grant funding, HEAL has been able to provide training and funding to support these worksites in their endeavors.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-4a and NPM-4b:

- Utah Women, Infants, and Children breastfeeding peer-counselors were able to utilize multiple modes of communication and partnerships with community partners to increase the number of women who were contacted by a WIC breastfeeding peer-counselor.
- MIHP provided SUUB training to small, rural birthing facilities in the state.
- SUUB and WIC staff provided education and guidance to the state during the nationwide infant formula shortage.
- The HEAL program reached a significant number of worksites throughout the state to help them implement or improve their lactation accommodations for employees.

Challenges / Gaps / Disparities Report:

During FY22, the COVID-19 pandemic continued to prove a challenge to SUUB program activities. During the pandemic, birthing facilities were forced to react to the rapidly changing health directives and policies enacted by federal, state, local, and birthing facility officials. Projects surrounding the implementation of the SUUB program were temporarily halted for birthing facility staff to focus on protecting their patients from COVID-19. Additionally, all training and in-person meetings were canceled due to social distancing requirements, travel restrictions, safeguarding birthing facility staff, and SUUB staff's overall safety.

During FY22, an urban birthing facility that had been trained in Stepping Up practices and was working towards achieving the ten steps to a Breastfeeding Friendly certification, closed their labor and delivery unit for financial reasons.

Despite the increased number of eligible participants who received at least one WIC breastfeeding peer-counseling contact, there were barriers to meeting the goal of three contacts in FY22. The COVID-19 pandemic interrupted the operations of WIC clinics. This included not seeing participants in-person and being unable to host in-person 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 availability for contacting prenatal and postpartum WIC participants.

Local agencies stated that several peer-counselors left their jobs with WIC during FY22 to find jobs with better pay

and benefits. The turnover in employed peer-counselors exacerbated the difficulty of peer-counselors' abilities to make breastfeeding contact to participants. This was especially difficult in rural areas that contain fewer WIC clinics over a large geographic area. Breastfeeding peer-counselors in these rural areas were not able to see all participants in-person at every clinic or make hospital and home visits. Additionally, some agencies were under a hiring freeze related to strict COVID-19 precautions. Agencies' breastfeeding peer-counseling budgets were also reduced, making it difficult to fill open breastfeeding peer-counselor positions. Breastfeeding peer-counselor recruitment and retention remains an ongoing concern within the Utah WIC breastfeeding peer-counseling program.

There were also mixed messages during the COVID-19 pandemic about the safety of breastfeeding and COVID-19. Some mothers and babies were separated after birth due to these concerns. Combating these mixed messages was difficult and caused some residual concern about COVID-19 transmission, which may have influenced some WIC participants' choice not to breastfeed during FY22.

There were also 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 FY22, some agencies were either missing breastfeeding peer-counseling contact data or breastfeeding peer-counseling contacts were duplicated. This was due to a VISION update that created errors in collecting breastfeeding data, affecting the accuracy of the data collected. To prevent future data inaccuracies, the Utah WIC program is working with the developers of VISION to correct this issue and is creating a new report to pull breastfeeding peer-counseling contact data accurately. The goal is to have the new report updated and in use for FY24.

The HEAL program has also experienced challenges implementing the TOP Star program in worksites. Worksites often have priorities other than lactation accommodations for breastfeeding. Offering funding, even small amounts, can dramatically encourage interest in establishing workplace breastfeeding policies and accommodations.

An additional challenge occurred when the TOP Star curriculum contracted vendor did not meet expectations and was deficient in fulfilling the scope of work. This prevented the program from publishing the planned English and Spanish online modules. Creative in-house efforts were made to complete the work.

Birthing facilities in the state of Utah are diverse in size. There are many large facilities in urban areas, as well as small facilities in rural areas. Staff has observed that small, rural facilities often struggle to implement SUUB practices, due to their limited number of staff and resources. However, Stepping Up staff have begun to see success in rural facilities, and have gained knowledge from birthing facility staff on how to best help other rural facilities become successful in the program.

Data from the state of Utah shows that women who are eligible for WIC, but do not participate have higher rates of breastfeeding initiation and exclusive breastfeeding through six months compared to women who are participating in 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. Differences in breastfeeding initiation and exclusivity between women who participate in WIC and women who are eligible but do not participate highlight the need for improved education about WIC as a breastfeeding support program. More outreach is needed to other community breastfeeding organizations that can refer women to WIC and its breastfeeding peer-counseling program. These solutions would help to meet the ESM goal of increasing 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.

Utah WIC's ever-breastfed prevalence rate decreased by one percentage point to 86% between FY21 and FY22. This decrease may have been influenced by COVID-19 protocols within local agencies that limited the availability of breastfeeding peer-counselors to contact WIC participants.

An emerging issue for the HEAL program is the lack of resources in Spanish for TOP Star participants. As the program grows, it will be critical to create materials that are accessible to Spanish speaking participants.

Based on Federally Available Data, Utah is ranked 8th out of 51 for children who were ever breastfed, which corresponds to a significantly higher prevalence (91.4%) compared to the U.S. overall (83.2%) in 2019. However, breastfeeding initiation is lower for unmarried mothers (79%) compared to mothers who are married (89.9%).

Utah is also ranked 21st out of 51 for children who are exclusively breastfed through six months.

Agency Capacity/Family Partnerships/Collaboration:

The success of the SUUB program immensely benefits from the program's many partners. The 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 influence the state's breastfeeding initiation and continuation rates. Second, partnerships with the WIC and HEAL programs are important to the program's success. Their teams provide SUUB staff with expert advice and additional tools that are shared with participating birthing facilities to assist in implementing the steps. They are integral in many ways, especially in helping families achieve exclusive breastfeeding through six months of the infant's life. This work would not be possible without their partnerships.

The program also shares a beneficial partnership with the two most prominent healthcare systems in the state, Intermountain Health and the University of Utah. Intermountain Health strongly encourages all of their hospitals to participate in the SUUB program, tracks their progress, and recognizes their achievements and certifications. The University of Utah is the largest birthing facility in the state and the only Baby-Friendly Facility in the state; however, they are supportive of the SUUB program and have also received a designation of being a Breastfeeding Friendly Facility.

The Utah WIC Program partners with several organizations including the state-wide Utah Department of Health and Human Services (DHHS) organizations, such as Early Intervention; local health agency 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 providers, including pediatricians, obstetricians, and International Board Certified Lactation Consultants.

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 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, among other efforts. 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.

The HEAL program has long-term collaborations focused on lactation training and support in place with the Utah

Breastfeeding Coalition, Mountain West Mother's Milk Bank, and the University of Utah Baby Friendly Hospital Initiative. The Utah DHHS Early Childhood Utah Advisory Council, Weber State University, and Brigham Young University support the program's breastfeeding educational components. Worksite partners include the Association of State and Territorial Health Officials (ASTHO) and the Utah Worksite Wellness Council. Established community based partnerships include Centro de la Familia de Utah, Boys & Girls Clubs of Greater Salt Lake, Utah Private Child Care Association, Refugee Health, Utah Adverse Childhood Experiences Program, and the Utah Society for Environmental Education. HEAL also received ASTHO funding for breastfeeding support three years in a row. This funding provided grants to 100+ worksites to ensure they were compliant with the federal lactation accommodation law.

Report of ESMs related to NPM-4a and NPM-4b

ESM 4.1: The proportion of live births that occur in facilities that have met all requirements set by the SUUB program to become a "Breastfeeding Friendly Facility."

Goal/Objective:
Increase the percentage of babies born in hospitals participating in the SUUB program.

Significance of ESM 4.1:
Hospital policies and practices significantly affect whether a woman feels confident enough to reach her breastfeeding goals. The SUUB 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 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 Summary:
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 SUUB program is a free, Utah-centric program that works with birthing facilities to implement the "Ten Steps to Successful Breastfeeding" through quality improvement methods, such as working 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 FY22, 24 (53%) Utah birthing facilities have been trained on the program and have successfully implemented a total of 210 steps. Specifically, during FY22, two birthing facilities completed all 10 steps, and three met the requirements to be re-designated as a "Breastfeeding Friendly Facility."

SUUB program staff will continue outreach to birthing facilities about the SUUB 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 SUUB 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 SUUB program.

The success of the SUUB program would not be possible without our many partners including WIC and the HEAL programs. Their teams provide Stepping Up staff with expert advice and additional tools to assist in implementing the steps. We also share an ongoing and beneficial partnership with the two most prominent healthcare systems in the state, Intermountain and the University of Utah. They are both supportive of the SUUB program.

ESM 4.3: The number of worksites that have federal lactation accommodations and breastfeeding strategies.

Goal/Objective:
Increase the number of worksites that have federal lactation accommodations and breastfeeding strategies.

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 Summary:
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.

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.

Future Plans: In October 2021, the HEAL Program received a second opportunity to apply for funding from the Association of State and Territorial Health Officials (ASTHO) to help worksites improve their lactation accommodations; therefore, the performance objective for 2022 is higher than for other years. The project period ran from December 1, 2021 – July 31, 2022, and laid the groundwork for future plans for ESM towards 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.

Barriers and Challenges: 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.

Partnerships: 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 4.5: 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 4.5:
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 Progress Summary:
In FY22, the Utah WIC program encouraged breastfeeding peer-counselors to contact prenatal and postpartum WIC participants in many ways. The best way that we have improved this outcome is the required policy for peer-counselors to document their contacts in the computer system entitled VISION. Another way that we have encouraged peer-counselor contacts throughout the state is through referrals by community and partner organizations such as La Leche League and MotherToBaby Utah.

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 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.

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 including 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 among other efforts. 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.

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 transpire 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)
NOM 5 - Percent of preterm births (<37 weeks gestation). (Reduce the percent of all preterm deliveries)
NOM 6 - Percent of early term births (37, 38 weeks gestation). (Reduce the percent of early term deliveries)

In FY22 MotherToBaby Utah provided education to women and their providers about medications used during current pregnancies or while planning a pregnancy to treat conditions that could result in preterm birth or low birth weight deliveries such as mental health conditions, cardiovascular conditions, respiratory conditions, and the use of tobacco and other drugs. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated conditions during pregnancy in an effort to help women remain healthy and avoid complications that could result in babies with preterm birth or lower birth weight.

UBDN works to provide education to Utah residents on birth defect prevention and how to strive for a healthy pregnancy, efforts of which include preventing preterm birth and/or low birth weight. UBDN's health educator participates in health fair events statewide to reach Utah residents who could become pregnant.

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

MotherToBaby Utah provided education to women and their providers about medications used during the perinatal period. Education was provided about the risks of the untreated conditions, such as hypertension, diabetes, tobacco and other substance use, and maternal infections, and the potentially teratogenic medications used to treat those conditions, such as angiotensin converting enzyme (ACE) inhibitors, non-steroidal anti-inflammatory drugs (NSAIDS including aspirin and ibuprofen), and valproate, that could result perinatal complications and/or death.

MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks of medications compared to untreated conditions during the perinatal period in an effort to help women remain healthy and avoid complications that could result in perinatal deaths.

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 FY22.

UBDN works to provide education to Utah residents on birth defect prevention and how to strive for a healthy pregnancy in efforts to prevent infant death. UBDN's health educator participates in health fair events statewide to reach Utah residents who could become pregnant.

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

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.

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

MotherToBaby Utah provided education to women and their providers about the risks of alcohol use during pregnancy. They provided information through in-person, telephone, email, chat and text contacts. They provided information through printed brochures, newsletters, social media posts, and television news segments.

MotherToBaby Utah and the Division of Substance Abuse and Mental Health received funding to create a campaign to reduce alcohol use in pregnancy and reduce Fetal Alcohol Syndrome/disorder. During FY22, a steering committee composed of staff from UBDN, MotherToBaby Utah, Utah substance use prevention networks, and MCH began meeting bi-weekly to develop a scope of work for a statewide educational media campaign that focuses on the risks associated with drinking alcohol while pregnant. Work continues to contract with a media company that will work with the steering committee to implement the campaign as detailed in the scope of work.

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

MotherToBaby Utah provided education to women and their providers about medications used during current pregnancies or while planning a pregnancy to treat mental health conditions and pain. MotherToBaby Utah provided education to women, their providers, their partners, and other clients regarding the benefits and risks, including neonatal abstinence syndrome, of medications for mental health, substance abuse conditions, and pain compared to the risks of untreated conditions during pregnancy to promote healthy outcomes**.**

NOM 12: Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner.

The Child Health Advanced Records Management (CHARM) Program'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 Medical Home Portal is a resource for professionals and families who care for children and youth with special health care needs and want to achieve the best possible outcomes for their health, well-being, and success. The CHARM Program also continued to collaborate with the Early Hearing Detection and Intervention (EHDI) and Vital Records (VR) Programs.

Through the CHARM system'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 the CHARM system, 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, 2021 – June 30, 2022, there were 1,011 hearing alerts generated for children by CHARM and received in the OLIVER system; 641(63.4%) 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. In addition, the CHARM system provided hearing screening alerts through its linkages with other health program databases and through the CWP. Physicians, audiologists and public health providers who use these databases, or the CWP, are notified in real time when a child needs a hearing

screening test and follow-up efforts can occur in a timelier manner.

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 FY24:

During FY24, Stepping Up for Utah Babies (SUUB) staff will continue offering any needed assistance to participating birthing facilities as they pursue their Breastfeeding Friendly Facility designations and re-certifications every two years. SUUB staff will continue outreach to non-participating birthing facilities during this program year and seek to understand how they can help these facilities be successful in the program. Ongoing assistance from the Women, Infants, and Children (WIC) and the Healthy Environments Active Living (HEAL) programs will assist in reaching birthing facilities, healthcare providers, and community members with the SUUB program and sharing the benefits of breastfeeding.

There are exciting, continued opportunities to reach small hospitals in rural areas of Utah. During FY23, Fillmore Community Hospital, an 18-bed facility in rural Fillmore, Utah, received their Breastfeeding Friendly designation. SUUB staff was able to learn from the staff at Fillmore Community Hospital about the unique factors that helped them be successful in achieving this designation. During FY24, SUUB plans to help other small, rural facilities be successful in this program using knowledge gained from this experience. Program staff is optimistic about the positive impact this will have on families and infants living in rural areas of Utah.

SUUB staff 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 the SUUB website.

SUUB staff are in the process of expanding the program into Neonatal Intensive Care Units (NICUs) across the state. By learning what other states have implemented in order to bring the 10 Steps to Successful Breastfeeding successfully into these settings, the program aims to continue program expansion and improve the breastfeeding initiation and continuation rates of the state’s most vulnerable infants.

In FY24, 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 agencies 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 annually. Additionally, the new staff-training curriculum about breastfeeding will be implemented to all local agencies for all staff members, including breastfeeding peer-counselors.

To address disparities found in the national performance measure 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.

In FY24, clinics will continue to be open for in-person services provided by breastfeeding peer-counselors. The state

WIC office plans to provide in-person training to peer-counselors to more effectively engage with participants during in-person visits and classes. The state WIC office would also like to develop a Utah WIC Breastfeeding Peer-counselor online directory for local agency peer-counselors to easily connect with one another and share best practices. Doing so will help breastfeeding peer-counselors improve the quantity and quality of breastfeeding peer-counseling contacts provided to eligible WIC participants.

The HEAL program is in the process of applying for CDC funding to address racial and ethnic disparities in breastfeeding. HEAL staff completed an assessment that made it clear there is a need to focus on the American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, Black, and Hispanic/Latinx populations to reduce disparities. A breastfeeding strategy was included in the proposal to help increase breastfeeding continuity of care for these under-resourced populations. Additionally, to address some disparities, HEAL is enhancing its Teaching Obesity Prevention (TOP) Star program by adding a Spanish language curriculum. All content has been created and is planned for publication in the fall of 2023.

HEAL has been working with Weber State University to create the first university course on human lactation in Utah. This will provide students seeking professions in clinical health services, public health, nutrition, etc., to gain access to evidence-based information on human nutrition and breastfeeding. The goal is for this course to be available to students by FY25.

HEAL is working with the Utah Breastfeeding Coalition (UBC) on a new UBC website that includes supporting resources and information that will be shared with WIC, Head Start, and other community partners that reach underserved populations. HEAL will continue to support, promote, and collaborate with the Mountain West Mother's Milk Bank, which is now a fully-functioning brick and mortar 501-C facility.

Proposed Activities:

- Stepping Up for Utah Babies staff will offer specific assistance to small, rural birthing facilities in the state to help them find success in the program.
- The WIC program will expand their available in-person trainings and resources to better effectively engage with their participants.
- The WIC program will develop a Utah Breastfeeding Peer-counselor online directory for local agency peer-counselors to easily connect with one another and share best practices.
- The HEAL program will work with Weber State University to offer the state's first university course on human lactation.
- The HEAL program will address racial and ethnic disparities in breastfeeding by making Spanish educational resources available to the public and applying for specific funding to address disparities.

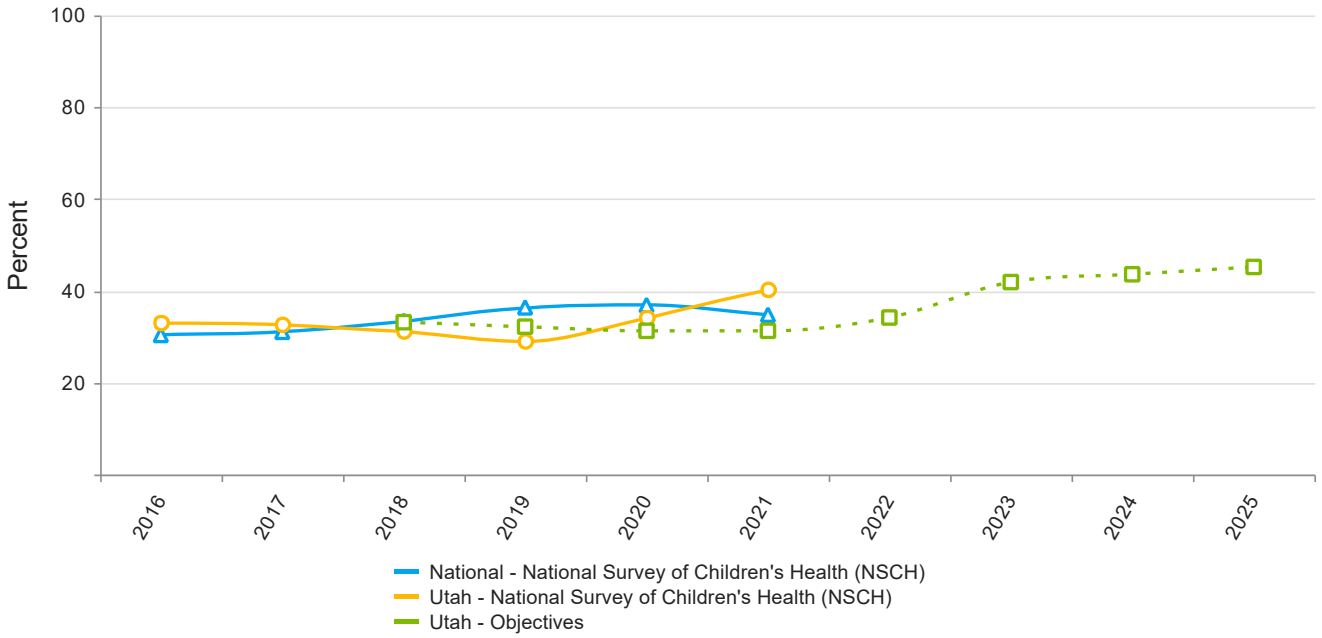
Table 11: Logic Model for National Performance Measures 4a and 4b

NPM 4a/b: Percent of infants who are ever breastfed. Percent of infants breastfed exclusively through 6 months.				
Goal: Increase the percent of infants in Utah who are ever breastfed and the percent of infants breastfed exclusively through 6 months.				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Funding and qualified staffing Collaboration with HEAL and WIC programs Relationships with birthing facilities Partnership with Weber State University	Provide training and guidance to birthing facilities and provide information to prospective breastfeeding friendly facilities Create educational materials for communities, families, and clinicians to learn about breastfeeding and translate to Spanish. Ensure eligible WIC participants receive 3 contacts from peer counselors over the perinatal period. Create Utah WIC Breastfeeding Peer Counselor online directory Administer a human lactation course at Weber State University	Proportion of live births in breastfeeding friendly facilities Eligible WIC participants receive breastfeeding assistance from peer counselors Emerging health professionals educated on breastfeeding Minority families receive access to breastfeeding educational materials	NPM 4a: Increased proportion of infants who are ever breastfed NPM 4b:Increased proportion of infants who are breastfed exclusively through six months	NOM 9.1 and 9.3: Decrease in infant and post neonatal mortality NOM 9.5: Decreased SUID mortality Lowered health disparities for infants in minority groups
Assumptions and Contextual Factors: Families who don't qualify for WIC services may have access to breastfeeding services that families who qualify for WIC don't have access to due to financial differences. We assume our programmatic work will help bridge the gap in resources between those qualifying and those not qualifying for WIC				

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	33.2	32.2	31.3	31.3	34.2
Annual Indicator	32.6	31.1	29.1	34.2	40.3
Numerator	32,987	29,418	31,492	39,294	48,466
Denominator	101,171	94,514	108,310	114,782	120,307
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	41.9	43.6	45.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			12	6
Annual Indicator	0	23	34	27
Numerator				
Denominator				
Data Source	Early Childhood Utah program data	Early Childhood Utah program data	Early Childhood Utah program data	Early Childhood Utah program data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

ESM 6.2 - The number of ASQ screens, for 0-3 year olds, contributed to the DHHS ASQ Online Enterprise Account by participating partners and enrolled programs.

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			7,988	8,271
Annual Indicator	8,157	7,580	8,354	9,156
Numerator				
Denominator				
Data Source	The Brookes Publishing UDOH ASQ Online Enterprise	UDOH Early Childhood Integrated Database	UDOH Early Childhood Integrated Database	DHHS Early Childhood Integrated Database
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

ESM 6.3 - Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	110.0	121.0

ESM 6.4 - The number of ASQ screenings, for children 0-5, contributed to the DHHS ASQ Online Enterprise Account annually.

Measure Status:	Active

Baseline data was not available/provided.

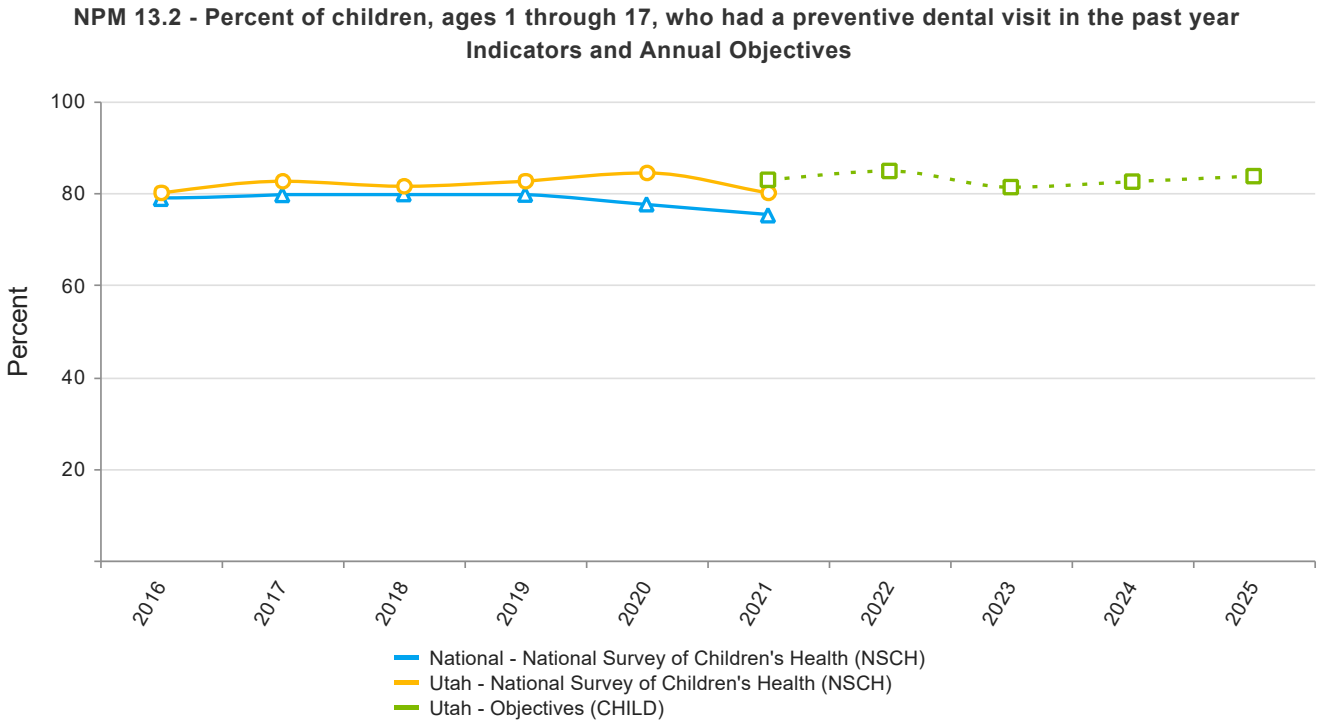
Annual Objectives		
	2024	2025
Annual Objective	6,600.0	7,260.0

ESM 6.5 - The number of new programs enrolled in the DHHS ASQ Online Enterprise Account Annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	6.0	7.0



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.3	84.8	81.6	81.8	84.7
Annual Indicator	82.4	81.4	82.6	84.3	80.0
Numerator	701,280	698,309	726,633	745,902	706,928
Denominator	851,339	857,676	879,310	885,155	883,614
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.2	82.4	83.6

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					
	2018	2019	2020	2021	2022
Annual Objective	51.5	54.4	55.7	52.1	48
Annual Indicator	54.2	55.5	51.9	47.1	43
Numerator	109,777	105,122	94,832	97,308	98,757
Denominator	202,518	189,242	182,597	206,783	229,733
Data Source	CMS 416	CMS-416	CMS-416	CMS-416	CMS-416
Data Source Year	FFY18	FFY19	FFY20	FFY21	FFY22
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	45.1	47.1	48.2

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	2022
Annual Objective			78.8	81
Annual Indicator	76.7	78.1	81.1	80.6
Numerator	692,413	712,908	743,827	737,820
Denominator	903,273	912,249	917,210	915,409
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	81.7	82.9	84.0

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			35	50
Annual Indicator	32.2	35	41.7	86.1
Numerator			281,760	170,802
Denominator			675,247	198,354
Data Source	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	87.0	87.8	88.7

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 45.2%.	
Strategies	
1. Increase the number of parent-completed developmental health screens received by children, ages 9 months - 35 months, by increasing the number of programs/providers that are trained to facilitate ASQ Online screenings.	
2. Increase the number of parent-completed developmental health screens received by children ages 9 months - 35 months, by increasing the number of new programs enrolled in the DHHS ASQ Online Enterprise Account.	
3. Increase the number of parent-completed developmental health screens received by children, ages 9 months - 35 months, submitted to the DHHS ASQ Online Enterprise Account.	
ESMs	**Status**
ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program	Inactive
ESM 6.2 - The number of ASQ screens, for 0-3 year olds, contributed to the DHHS ASQ Online Enterprise Account by participating partners and enrolled programs.	Inactive
ESM 6.3 - Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually	Active
ESM 6.4 - The number of ASQ screenings, for children 0-5, contributed to the DHHS ASQ Online Enterprise Account annually.	Active
ESM 6.5 - The number of new programs enrolled in the DHHS ASQ Online Enterprise Account Annually	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 83.6%.

Strategies

1. The Oral Health Program (OHP) will collaborate with Utah Medicaid with the goal to increase the percentage 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, Utah Dental Hygienist Association, Head Start, the Office of Health Equity, WIC, and the Utah Office of Home Visiting to reach these goals.

2. Collaborate and work with high risk populations in Early Head Start, Head Start, Early Intervention, WIC, Office of Home Visiting, and school based prevention programs to share resources and provide education and training to agency staff on the importance of dental care for children. The goal is to increase the percent of children who have had a preventive dental visit in the past year by providing education and local dental resources.

3. The Oral Health Educator (OHEd) works 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. The OHEd also presents at several of the dental hygiene schools to students on topics including loan repayment programs, social justice, health equity and cultural empathy.

4. The OHEd along with the Dental Hygiene Liaison for Utah 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 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

State Action Plan Table (Utah) - Child Health - Entry 3

Priority Need

Family connectedness

SPM

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

Objectives

By 2025, increase the percent of family members who live in the household that ate a meal together 4 or more days per week from 76.7% (2017-2018 National Survey of Children's Health) to 84.0%

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

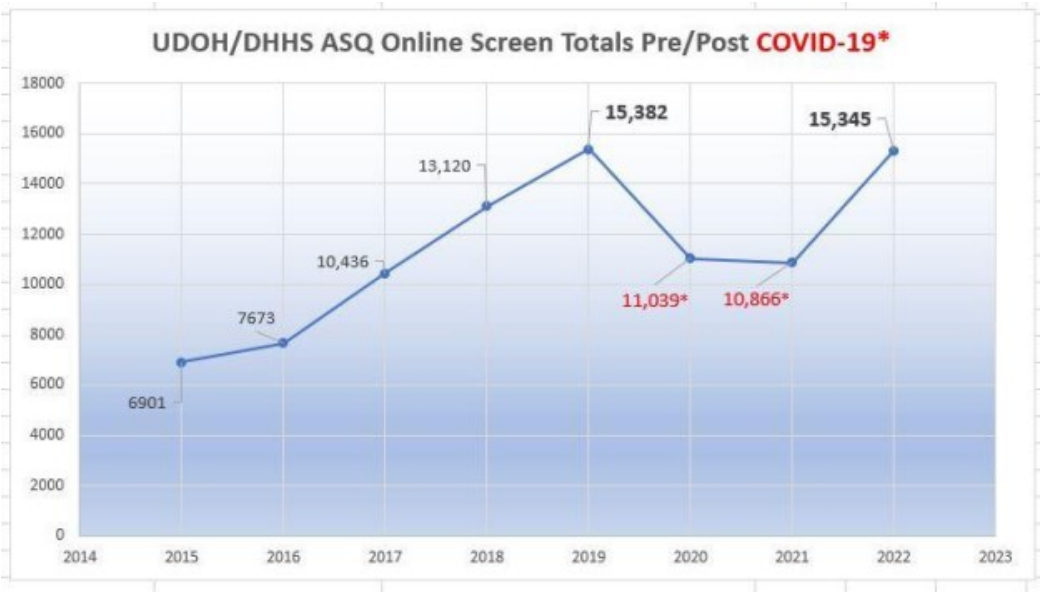
Annual Report FY22:

This Performance Measure was achieved. The Performance Objective was 34.2% and the Annual Indicator was 40.3%.

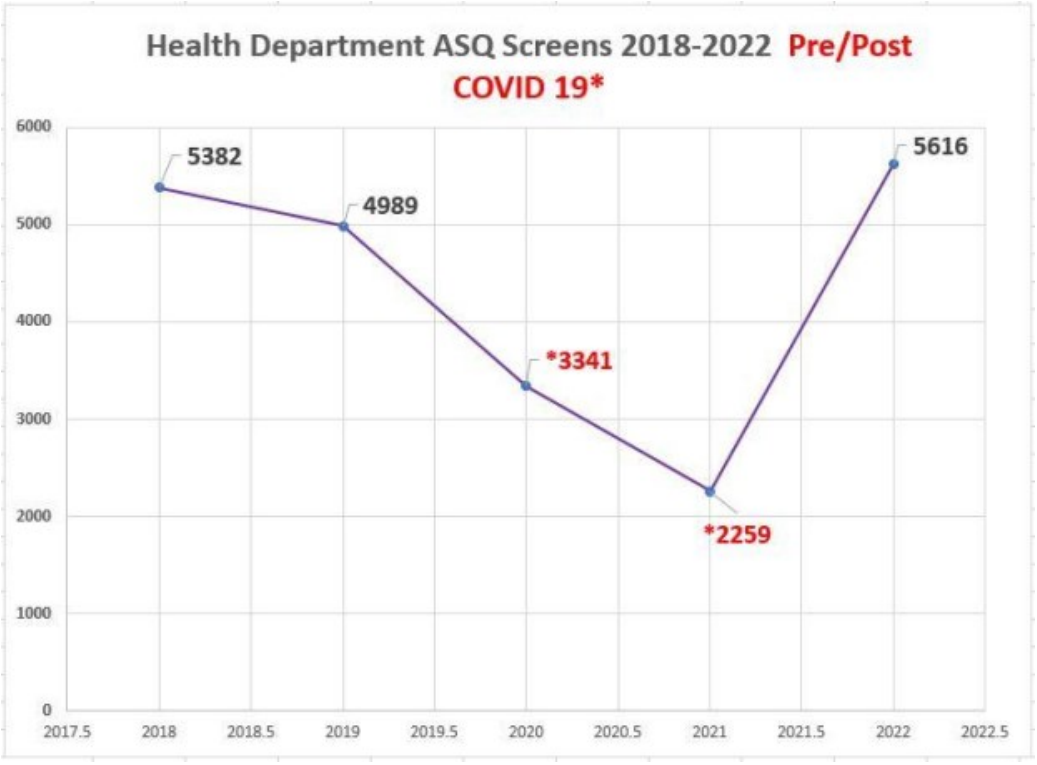
Program Activities:
NPM-6 objectives advance a common vision of improving early childhood developmental health outcomes and include the following activities in FY22: 1) increasing the level of ASQ Online participation by the local health departments (LHD), 2) offering ASQ training and technical assistance, 3) onboarding/enrolling programs in the DHHS ASQ Online Enterprise account, and 4) increasing the number of screens contributed to the enterprise system.

During the COVID-19 pandemic, the number of overall screenings initiated by DHHS ASQ Online providers decreased, leveled off, and then began to increase again in a positive direction in 2022. The two graphs below show these recovering trends. Graph 1 illustrates eight-year screening trends and totals for all DHHS screening programs. The second figure illustrates five-year trends and totals specific to those being completed by LHDs.

Graph 8. Trend in ASQ online screens pre and post COVID-19



Graph 9. Local Health Department ASQ screens pre and post COVID-19

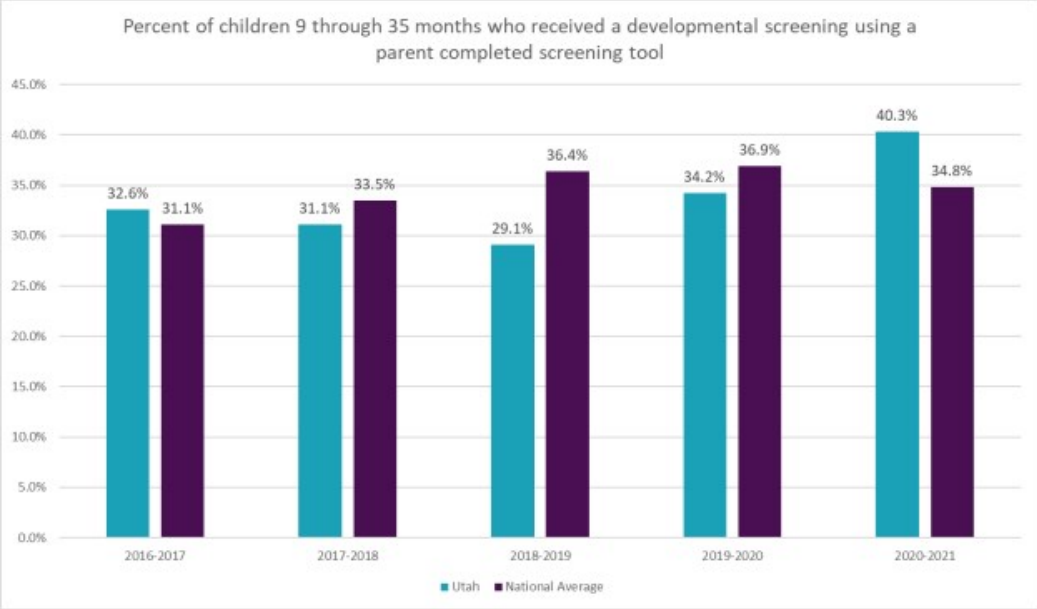


In FY22, the Early Childhood Utah (ECU) Program Manager continued to offer monthly, quarterly, and “as needed” ASQ training. ECU provided 27 training courses attended by 129 participants. Targeted outreach and training efforts continued to focus on health care providers, pediatric providers, home visitors, and early intervention providers.

Once providers are trained in ASQ, their program's subaccount is established and they can enroll in their program’s ASQ Online subaccount. Throughout FY22, ECU on boarded and enrolled 11 new programs in the DHHS enterprise account. ECU also provides technical assistance to new (11) and currently enrolled programs (57). Newly enrolled programs included Baby Watch Early Intervention (IDEA Part C) community-based grantees, internal CSHCN programs, home visiting, LHDs, and childcare centers.

Federally Available Data from the National Survey of Children’s Health appear to align with the positive trends in Utah (graph 10). National screening trends are also included below for reference.

Graph 10. Historical developmental screening rates for Utah and the U.S. (average)



Prenatal to 3/early childhood system stakeholders have also been involved in advancing developmental health outcomes. The Institute for Disability Research, Policy, and Practice at Utah State University (USU) is part of the IDEA Part C and Part B section 619 Child Find network and administers Utah's Learn the Signs Act Early program as funded by the Centers for Disease Control and Prevention. The Learn the Signs Act Early program provides developmental health resources to parents and caregivers and to programs/providers. Resources include developmental milestone checklists and free training. USU, ECU, and Help Me Grow Utah (HMGU) developmental screening resources are coordinated through staff collaboration and end-user websites.

Additional community-based partners, United Way of Northern Utah and Weber State University, have been integral partners with developmental screening promotion activities since 2016. The ECU program works closely with both stakeholders to generate, de-identify, and distribute ASQ Online data needed to guide their community objectives. The group's overall aims are to increase family/child enrollment in local services while also increasing the number of young children that receive a developmental health screen for the first time.

Accomplishments / Successes:

In FY22 Utah began to successfully implement the statewide coordinated, "ASQ Project."

Utah is investing in a developmental screening initiative to increase the number of developmental screenings. The ASQ Project was developed by the ECU Advisory Council's Promoting Health and Access to Medical Homes subcommittee, and was endorsed by the Governor's Early Childhood Commission. Implementation of the screening initiative is supported with American Rescue Plan Act funds, through the Department of Workforce Services Office of Child Care (DWS-OCC, Utah's Child Care and Development Block Grant lead agency). The project aims to help early childhood programs and providers, in partnership with families across the state, work together to promote healthy child development through appropriate screening and referral to services. All professionals working with young children and their families are invited to participate by promoting developmental screening, helping parents screen their children, and using information gathered by screenings to connect families to needed services.

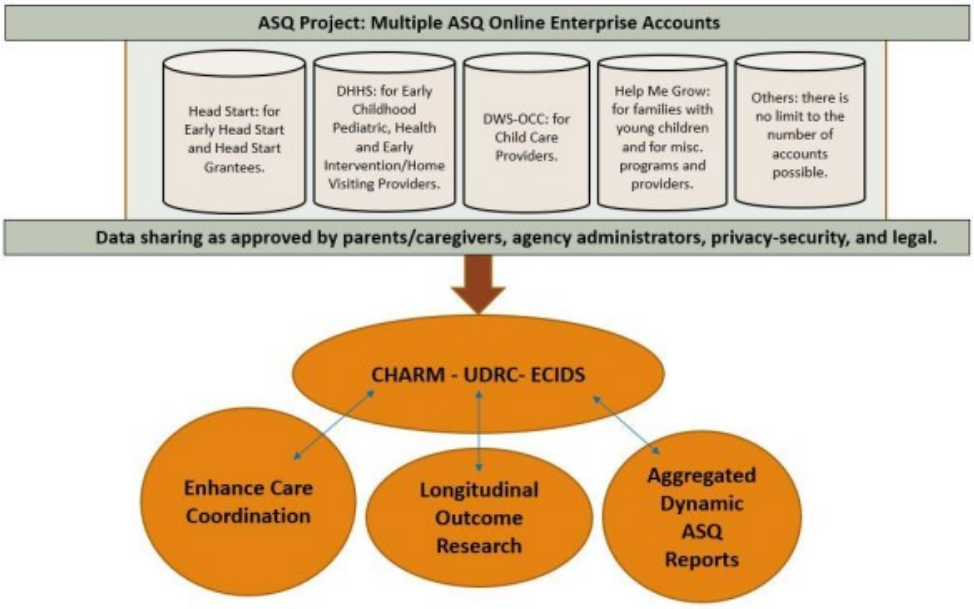
Throughout FY22, DHHS, DWS-OCC, HMGU, Brookes Publishing, and Multi-Dimensional Software Creations

(MDSC) were actively involved in the day-to-day implementation of the statewide project. Implementation involved expanding from one statewide ASQ Online Enterprise Account, currently hosted by DHHS, to at least three additional statewide Enterprise accounts hosted by: 1) DWS-OCC for childcare providers, 2) the Head Start Association for Early Head Start and Head Start grantees, and 3) Help Me Grow Utah for any provider or family accessing HMGU services.

In addition to launching three additional enterprise accounts, screening data will be integrated to improve care coordination and to increase Utah's data analytics and research capabilities.

As illustrated in the figure below, the Child Health Advanced Records Management Program (CHARM) will integrate ASQ data and share child-level results with approved providers. The Early Childhood Integrated Data System (ECIDS) will integrate ASQ data that will be included in cross-agency, dynamic, and aggregated reports.

Figure 8. Logic model of Early Childhood Integrated Data Systems (ECIDS) through multiple ASQ Online Enterprise Accounts



Project support includes funding for many of the resources needed for programs to facilitate completion of online screens, such as ASQ-3 and ASQ-SE:2 kits in English and Spanish, and the Family Access feature. APIs (data sharing portals) are also included with each enterprise subscription to help Utah reach its integrated data objectives.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-6:

- The number of developmental screenings completed for young children, which trended downward during COVID-19, are now trending in a positive direction. The number of developmental screenings dropped from 15,283 in 2019 to 11,039 and 10,866 in 2020 and 2021, respectively. However, the number of screenings increased to 15,345 in 2022.
- In FY22, the ECU Program Manager facilitated 27 ASQ training courses attended by 129 participants.
- Throughout calendar year 2022, 11 new programs enrolled and on boarded into the DHHS ASQ Online Enterprise Account. These programs provide pediatric, early health-care, and/or early intervention services to young children.
- According to the National Survey of Children's Health, Utah has steadily increased its annual developmental screening rate for children ages 9 to 35 months from 29.1% in 2018-2019 to 40.3% in 2020-2021.

- DHHS is the coordinating agency engaged in the implementation of a new statewide ASQ Project.
- The enhancements that accompany the ASQ Project have the potential to increase the number of developmental health screens for children ages 9 to 35 months.

Challenges / Gaps / Disparities Report:

There were no challenges that interfered with Utah's ability to complete planned activities. Challenges revolve around growing pains that are naturally associated with significant changes, such as preparation for the July 2022 merger between the Utah Department of Health and the Utah Department of Human Services. Additional changes included the restructuring of agency divisions, offices, and programs. Personnel changes, including new and departing staff, typically create transitional periods and gaps in programmatic expertise. Fortunately, DHHS provides the support needed to work through these types of challenges, including thoughtful and hands-on leadership as well as encouragement to maintain work-life balance.

There are emerging opportunities associated with the new statewide coordinated ASQ Project. In order to increase the number of programs and providers actively promoting developmental screening opportunities, multiple ASQ Online Enterprise Accounts are in the process of being established. Once the various accounts are launched, historical child profiles and screening data will need to be transferred to the respective accounts, training courses and records will need to be centralized, technical assistance networks will need to be implemented, and ultimately cross-agency and cross-program screening data will need to be integrated and utilized. All of these steps represent emerging opportunities that influence program activities related to this NPM.

Based on Federally Available Data (FAD), children born outside of the U.S. are less likely (38.3%) than those born in the U.S. (56.7%) to receive a development screening. Forty percent (40.3%) of parents reported completing a developmental screening for their child, which places Utah as 18th in the country for developmental screening. This represents an increase of 25 ranked points using NSCH 2020-2021 data compared to 2018-2019 data.

Agency Capacity/Family Partnerships/Collaboration:
The ECU Program also coordinates ECU Advisory Council and Subcommittee activities. The ECU Advisory Council, the ECU Executive Committee, and five ECU Subcommittees help to develop, orchestrate, and often assist in the implementation of Prenatal to 3/early childhood initiatives, such as the promotion of early childhood developmental health.

The ECU Advisory Council also serves as the State Advisory Council and as such, all of the entities required by the Improving Head Start for School Readiness Act of 2007, along with other stakeholders, are engaged in the Council as voting members. There are 29 ECU Advisory voting members and up to 90 ECU Advisory Subcommittee members (inclusive of the 29 voting members). Partners include the Governor's Office, Title V MCH, CSHCN, MIECHV, IDEA Parts B and C, and childcare leadership. Additional collaborators include private sector pediatricians, health department and WIC directors, higher education and head start representatives, early education professionals, human services and mental health administrators, and families.

ECU Advisory and Subcommittee activities are informed by Birth to Five needs assessments, strategic plans, and deliberative parent and family qualitative sessions. Some engaged parent-representatives receive a stipend for their time and participation.

A critical Prenatal to 3/early childhood partner and stakeholder, which connects families to a continuum of services, is Help Me Grow Utah (HMGU). HMGU is hosted by United Way of Utah County and provides a free information and

referral helpline for parents, physicians, and community partners with resources for children under 8 years old. In FY22, HMGU worked with 1,565 new families, facilitated 3,160 developmental screening questionnaires, and made 5,599 care coordination referrals.

Report of ESMs related to NPM-6

ESM 6.1: 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 and 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 and community partners.

Significance of ESM 6.1:
Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected or if there is cause for concern and further evaluation is necessary.
This ESM is significant to increasing the number of developmental screens received by children ages 9-35 months. In order to increase the number of screens received by infants/toddlers it is necessary 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 6.1 Progress Summary:
We are deactivating ESM 6.1 because ASQ training modules are now continuously available online through a recorded webinar. A new ESM (6.3), outlined below, will replace this ESM. Live/in-person training is also available. The state's ASQ training resources and attendance records have been centralized. The previous measure tracked the number of trainings offered, and now that training is continuously available, a measurement change is taking place to track and increase the number of participants trained annually.

In FY22, the Early Childhood Utah Program Manager continued to offer monthly, quarterly and “as needed” ASQ training. ECU provided 27 training courses attended by 129 participants. DHHS’ targeted outreach and training efforts continued to focus on health department care providers, pediatric providers, home visitors, and early intervention providers.

ESM 6.2: The number of ASQ screenings, for 0-3 year olds, contributed to the DHHS ASQ Online Enterprise Account by participating partners and enrolled programs.

Goal/Objective:
Increase the number of ASQ screens for children 0-3 years old contributed to the Utah DHHS ASQ Online Enterprise Account by participating partners and enrolled programs.

Significance of ESM 6.2:
This measure is significant because it demonstrates the culmination of Utah's ASQ training, enrollment, and implementation efforts. Tracking this data will show if Utah is increasing the number of developmental screenings received by children ages 9 to 35 months.

ESM 6.2 Progress Summary:
This ESM is being deactivated and will be replaced with ESM 6.4 (outlined below). Due to work being done by the Early Childhood Utah Advisory Council, many subaccounts are being transferred out of the current DHHS ASQ Online Enterprise Account into their own accounts. This measure tracked the number of screenings contributed to the DHHS ASQ Online account for children ages 0-3 and the new ESM 6.4 will track screenings for those ages 0-5. The DHHS account will host pediatric and early care providers such as health departments, home visitors, and early interventionists.

ESM 6.3: Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually.

Goal/Objective:
By tracking this measure, the Office of Early Childhood can better engage in the continuous improvement process, such as increasing the number of participants that complete ASQ training annually.

Significance of ESM 6.3:
Facilitating developmental screening, with a parent-completed screening tool, is a critical part of early childhood care and a great opportunity to engage families in the promotion of their child's developmental health. Developmental screening is used to determine if a child is reaching age-related milestones as anticipated or if there is a reason to coordinate additional assessment/intervention.

This ESM is significant to increasing the number of developmental screens received by children ages 9 to 35 months. In order to increase the number of screens received by infants/toddlers we need to increase the number of programs/providers that are appropriately trained to offer developmental screening opportunities to parents with young children.

ESM 6.3 Progress Summary:
This is a new strategy and measure replacing the former ESM 6.1. It is important to track and continually increase the number of new programs that are enrolled in the DHHS ASQ Online account. Increasing the number of enrolled programs increases the likelihood that additional children between ages 9 to 35 months will be afforded the opportunity to participate in developmental health screening opportunities.

ESM 6.4: The number of ASQ screenings, for children ages 0-5, contributed to the DHHS ASQ Online Enterprise Account annually.

Goal/Objective:
Increase the number of ASQ screens (for children ages 0-5) contributed to the Utah DHHS Online Enterprise Account annually.

Significance of ESM 6.4:
This measure is significant because it demonstrates the culmination of Utah’s ASQ training, enrollment, and implementation efforts. Tracking this data will show if Utah is increasing the number of developmental screenings received by children 9 months to 5 years. A new baseline is being established for ESM 6.4 due to many subaccounts being transferred out of the current DHHS ASQ Online Enterprise Account into their own Enterprise Accounts in 2023. Care types being transferred include Help Me Grow Utah, Head Start grantees, and childcare providers.

ESM 6.4 Progress Summary:
This is a new strategy and measure replacing the former ESM 6.2. FY2024 will serve as a new baseline for the expanded child population this ESM is targeting. ESM 6.2 targeted children aged 0-3 years and this ESM will target children between the ages of 0-5 years.

ESM 6.5: The number of new programs enrolled in the DHHS ASQ Online Enterprise Account annually.

Goal/Objective:
By tracking this measure, the effectiveness of Utah's training and program recruitment practices can be evaluated and improved upon.

Significance of ESM 6.5:
Enrolling new programs in the DHHS ASQ Online Enterprise Account increases the chances that developmental screening practices will be implemented into additional programs' early care/early education routines. Increasing the number of enrolled programs increases the likelihood that additional children between ages 9 to 35 months will be afforded the opportunity to participate in developmental health screening opportunities.

ESM 6.5 Progress Summary:
This is a new strategy and measure. The structure and composition of the statewide ASQ Program is changing and it is important to track and continually increase the number of new programs that enroll in the DHHS ASQ Online account. These changes are described in the Annual Report for NPM 6. Because of these changes, it will be imperative for DHHS to monitor and increase the number of new pediatric, health, and early care providers that enroll and participate in the DHHS ASQ Online Enterprise Account.

Local Health Department Successes and Challenges related to this performance measure:

Successes:

LHDs offer ASQs through mail or email in an effort to make screening as convenient as possible for the families. One district provides parents with a postage-paid envelope in an effort to ease the burden of sending the questionnaire back with the goal of improving follow-up.

During visits with families, nurses work with parents and caregivers to encourage age-appropriate activities to encourage development in categories where the child may have scored in the 'monitor' range. Nurses also encouraged parents to work on all areas to promote activities to help keep their children on pace with their milestones.

LHDs identified and worked with community partners and State partners to ensure staff were refreshed and trained on ASQs and the importance of administering the questionnaires. They are also working to train CHWs on ASQ screenings. One district is working to collaborate with Head Start, has created a local ASQ campaign, and added information to their website to promote ASQs.

Challenges:

A primary difficulty is the lingering COVID fears, as clients have said they are more comfortable with phone call visits. Home visits are now being offered but many parents still prefer telehealth.

Other challenges noted include:

- Getting parents to follow through with filling out the ASQ paper/computer work and returning it to the nurse.
- Screening can be overwhelming to some families.
- Some families state that it is too time consuming.
- Parents are leery of home visiting due to an increase of cellular scams.
- Staff turnover in several districts was noted. This creates a need to hire and train new staff on ASQ processes.
- Inability to meet in homes and actually see the children that were being screened.

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

Annual Report FY22:

This Performance Measure was NOT achieved. The Performance Objective was 84.7% and the Annual Indicator was 80.0%.

Program Activities:

The State Dental Director (SDD) regularly attended the Utah Medicaid Medical Care advisory committee and CHIP advisory council meetings and communicated with the Office of Medicaid for the Oral Health Program (OHP) team. In March of 2022, the previous SDD stepped down from the position. DHHS hired a new SDD in August of 2022. She has connected with the Medicaid office and is attending Utah Dental Association (UDA) board meetings.

The Utah Medicaid Office Director or a representative has been giving regular updates at the Utah Oral Health Coalition quarterly meetings including eligibility requirements for Medicaid members, covered services and updates to coverage, how to become a Medicaid provider, contact information, and resource lists.

The Oral Health Educator (OHEd) has continued to collaborate with the UDA on the opioid toolkit for dental providers, which includes prescribing guidelines for children, adolescents, and pregnant women from the National Oral Health Resource Center. Copies of an educational trifold with QR codes to the toolkit were provided to each dentist who attended the UDA regional Continuous Quality Improvement (CQI) meetings, reaching approximately 1,000 dentists. Additionally, mailed toolkits were sent to 1,300 Utah-licensed dentists with the help of our office support specialist and four volunteer dental hygiene students. All active licensed dentists will receive a mailed toolkit by the end of FY23.

In October 2021, the OHEd and a volunteer hygienist provided an educational booth at the Utah Dental Hygienists' Association (UDHA) annual conference including information on the opioid toolkit, naloxone, and encouraging providers to educate their patients on the safety of dental care during pregnancy and to establish a dental home by age one. This same educational booth was provided by the oral health educator and oral health specialist interns in March of 2022 at the Utah Dental Association annual conference. The OHEd also presented to 26 individuals at the Utah Public Health Association annual conference on the opioid toolkit for dental providers.

The OHEd wrote an article for the UDA Action magazine, which goes to UDA member dentists state wide, on the importance of age one dental visits. The OHEd also collaborated with the diabetes prevention program to write and submit a screening for prediabetes in dental offices to the Action magazine.

OHP provides two ‘Baby Your Baby’ or ‘Check Your Health’ segments on KUTV each year. OHP staff provide the segments or write talking points and coordinate with local dentists or dental hygienists to provide segments. Topics include: The importance of baby teeth, strategies to prevent tooth decay, how to get safe dental care during pregnancy, and the importance of age one dental visits.

In FY22, the OHEd started attending the Early Childhood Utah (ECU) Advisory Council meetings and participating in the Promoting Health and Access to Medical Homes subcommittee. The OHEd provides educational resources and updated dental resource lists to ECU members. The OHEd created a poster for October dental hygiene month with 10 simple messages discussing positive oral health behaviors in English and Spanish. This was disseminated through ECU, WIC, Head Start Programs, LHDs, and the teen success program.

OHP continues to support the Head Start and Early Head Start programs throughout the state by sitting on health advisory committees, providing staff training, parent educational presentations and screenings, and fluoride varnish to some sites. A local dentist and dental hygienist have been providing services within the DDI Vantage headstart programs in Salt Lake and Tooele. Utilizing teledentistry, they provide exams, prophylaxis, sealants, fluoride varnish, and appropriate referrals. The OHEd provided 12 oral health messaging educational materials for DDI vantage families and coordinated with these local providers.

In March of 2022, the OHEd, along with two OHP intern hygienists, provided dental screenings, fluoride varnish, referrals, and toothbrushes to 125 Head Start children within the Salt Lake Community Action Program.

The OHEd continues to work with the Office of Home Visiting to provide oral health education and training to families with children (ages 0-5) and staff. The OHEd sends quarterly educational and dental resource emails to each site. All educational material shared is current and evidence-based. The OHEd and OHP dental hygienist intern created a Care About Your Child's Teeth presentation for parents and staff in English and Spanish. This presentation was given at the Salt Lake City Parents as Teachers Home Visiting Site to 11 families and six staff members. OHP later recorded and shared the presentation with all OHV sites, migrant Head Start sites, Head Start sites, and WIC sites. National materials were also shared with OHV sites including; the National Oral Health Resource Center, Early Childhood Learning and Knowledge Center, and the National Institute of Dental and Craniofacial Research. In May of 2022, the OHEd presented at the first-ever peer dialogue session with 20 OHV site managers statewide.

In June of 2022, the OHEd provided a presentation to the Association for Utah Community Health (AUCH) leadership team with 14 in attendance. This presentation included information on the relocation of the Oral Health Program from the Office of Maternal and Child Health to the Office of Primary Care and Rural Health (OPCRH), introducing the program, and sharing educational materials for dissemination to families. These materials included healthy oral hygiene habits, healthy food choices, and encouraging regular dental visits during pregnancy and by age one.

The Adolescent Oral Health Campaign (AOHC) is an intervention designed to educate middle school aged students about oral health care. In the 2021-2022 school year, all presentations moved back to in-classroom presentations. A total of 140 presentations were given to over 3,723 students in 19 different schools. The OHEd managed OHP interns who implemented the program and gave presentations, building sustainability into the program. To measure the effectiveness of the intervention, the students completed anonymous pre- and post-tests. OHP created one-page fact sheets 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 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 OHEd gave virtual and in-person presentations to over 1,016 students in 11 elementary schools. These presentations were given to each individual class as assemblies were still not permitted due to COVID-19.

In the Spring of 2022, an OHP intern and two volunteer dental hygiene students provided an education and dental resource booth at Harry S. Truman Elementary School. They provided interactive brushing, flossing, and nutrition activities for families along with a list of safety net clinics in English and Spanish. They were able to talk to 100 students and parents at the event. The OHEd also collaborated with and provided educational materials to four dental hygiene students who presented on the oral health effects of vaping to 27 middle school students in Salt Lake.

In April of 2022, the OHEd visited Westmore Elementary school to support the fluoride varnish program and meet

with stakeholders. More than 80 children received services that day. Additionally, Community Health Connect, in partnership with Mountainlands Technical College, provides basic oral health risk assessments and fluoride varnish in all Utah County Title 1 schools. It is a fantastic partnership the OHP and SDD has supported for many years.

The OHEd continues to be an active member of the Professional Advisory Committees for the different dental hygiene schools within Utah. OHP continues to do presentations at the dental hygiene schools on cultural empathy, and public health dentistry. In the 2021-2022 school year, the OHEd presented at three dental hygiene schools. In September of 2021, the OHP intern and Dental Hygiene Liaison for Utah presented to 80 third-year dental students at Roseman University on motivational interviewing. They shared materials from the National Maternal and Child Oral Health Resource Center.

OHP coordinates with local dental hygiene programs to create outreach events for students. In February 2022, the OHP intern and four dental hygiene students from Salt Lake Community College presented to over 60 refugees at the Latter-day Saint Humanitarian Center. The presentations were focused on preventive oral health strategies including hygiene habits, nutrition, not letting babies sleep with a bottle, and dental safety during pregnancy. Six dental hygiene students from Fortis College were able to give this same presentation to 60 refugees at the Granite Peaks Adult Learning Center.

An event was held at the Utah College of Dental Hygiene for Utah County Give Kids a Smile, where volunteer dentists and dental hygiene students provided preventive and restorative care to 56 children. The OHEd contacted local Head Starts, WIC, and Home Visiting programs to promote the event to participant families.

In April 2022, Fortis College Dental Hygiene School, Roseman School of Dentistry, and the University of Utah School of Dentistry all participated in a Team Smiles event providing preventive and restorative dental services to 300 children. The OHEd promoted this event with local WIC, Head Starts, and Office of Home Visiting staff to share with participant families.

One of OHP’s greatest strengths is working with many strong partnerships and collaborations. OHP continues its now 12-year collaboration with the University of Utah Physician Assistant Program. In the fall of 2021, the OHEd and Dental Hygiene Liaison (DHL) for Utah trained 70 University of Utah PA students from the Salt Lake and St. George campuses on performing oral health risk assessments and applying fluoride varnish. In September, the PA students with faculty, DHL, and, OHEd provided oral health risk assessments and fluoride varnish applications to 280 migrant Head Start children. Migrant Head Start locations include Providence, Genola, Honeyville and a new participating program in Holden, UT. These same partners provided oral health assessments, blood glucose, cholesterol screenings, and flu shots to over 40 migrant farm workers (parents of the migrant Head Start children) in September of 2022.

Accomplishments / Successes:

OHP’s successes lie in working with partners to provide educational resources, focusing on prevention, and connecting families and staff to dental services. OHP works closely with Head Start, Office of Home Visiting, WIC, and other early intervention programs.

In January 2021, OHP submitted a workforce grant to HRSA to create an emergency department diversion program for non-traumatic oral health concerns in three rural hospitals. With this grant, OHP was able to hire a 1.0 FTE dental hygienist program coordinator and increase the position of the new SDD from .25 FTE to .5 FTE.

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

- In January 2022 OHP, SDD, Office of Home Visiting program manager and staff, MCH Office Director, MCH data program manager and partners submitted a HRSA workforce grant for an emergency department diversion program for non-traumatic oral health concerns in three rural Utah Hospitals. This grant was awarded and the first cycle of funding started September 1, 2022. With this grant award, the OHP hired a program coordinator at 1.0 FTE to manage the grant and the SDD position increased from .25 FTE to .5 FTE. The SDD position is funded at .25 FTE through the MCH block grant and .25 FTE through the HRSA workforce grant.
- From June - September 2021 Silver Diamine Fluoride (SDF) underwent a full review and cost analysis under Medicaid. By December 2021, SDF had been evaluated and approved as a covered service effective January 1, 2022 for primary teeth only.
- Teledentisty dental codes that opened in April 2020 will remain open post-pandemic.
- 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.
- Primary Children's Hospital and the Utah Tobacco Free Alliance created a Spot the Vape Campaign. The OHEd disseminated this campaign material to school nurses, middle school health teachers in the AOHC, and to every dental hygiene school to promote to their students and patients.
- The OHEd presented at the Diabetes and Education Specialist Annual Conference to medical providers and diabetes specialists on the bi-directional relationship of diabetes and periodontal disease reaching 10 providers.

Challenges / Gaps / Disparities Report:

One of the biggest ongoing challenges has been the reduction in staff. The former State Dental Director continued to work at .2 FTE during 2021 and resigned in March of 2022. The State Dental Director position was then filled in August 2022 at .2 FTE and moved to .5 FTE in September 2022 with the award of a Health Resource and Services Administration (HRSA) workforce grant. OHP was staffed at 1.0 FTE during the six-month span between dental directors, and staffed at only 1.5 FTE for the remainder of 2022. In addition, during 2021-2022 the OHEd was on full and intermittent FMLA working 20 to 40 hours a week due to personal circumstances.

In April 2022, in preparation for DHHS (Department of Health and Human Services) merger, the oral health program was moved from the Maternal and Child Health Bureau to the Office of Primary Care and Rural Health (OPCRH). OPCRH is one of six programs in the clinical service section of the department directly under the Executive Medical Director. This has been a good transition for OHP, but it has come with a new learning curve as OHP adapts to OPCRH and integrates its work.

Funding concerns and staff capacity have all played a role in the continued delay of the oral health survey of Utah's schoolchildren. With additional staff and support, OHP is optimistic that planning and implementation of the oral health survey can take place in FY24. Historically the survey had been done every five years.

Effective January 1, 2021 Silver Diamine Fluoride (SDF) became a covered service by Medicaid for primary teeth only and remains a covered service. Integration of this and other preventive services such as oral health risk assessments, topical fluoride varnish, and establishing dental homes are still central to medical-dental integration.

Based on FAD, several subgroups within Utah face significant disparities for children receiving a preventative dental visit, including homes where the highest education level attained is high school (66.5%) compared to a college degree (83.9%). Children of mothers born outside the U.S. have a lower proportion of children receiving a preventative dental visit (70.7%) compared to children of mothers born in the U.S. (82.4%). Central city metropolitan statistical areas (70.9%) appear to be underserved in this area relative to non-central city metropolitan statistical areas (82.4%). Proportionally fewer Hispanic children receive preventive dental services (72.2%) compared to non-Hispanic White children (82.8%). Finally, dental visits are more common for children aged 6-11 years (93.3%) and 12-17 years (92.2%) compared to 1-5 years (75.8%).

Effective January 1, 2021 members who are age 21 or older and are eligible for Medicaid due to disability or blindness will transition and receive services through the University of Utah School of Dentistry network.

During the 2022 general session, the legislature appropriated funding for better dental restoration materials for crowns and fillings. Effective July 2022, composite fillings became available for all populations eligible for full dental services, meaning that members are no longer required to do ‘spend-ups’ from amalgam fillings to composite fillings. Effective July 2022, porcelain crowns also became covered for Early and Periodic Screening, Diagnostic, and Treatment and pregnant Medicaid members.

The legislature passed Senate Bill 103 Dental Hygienist Amendments during the 2021 general legislative session. This bill enacts provisions related to Medicaid reimbursement for billable services provided by a dental hygienist. In the new Medicaid PRISM system, hygienists will be billable providers for services they provide. This will add sustainability to programs and incentivize hygienists to work in public health settings.

OHP will conduct a needs assessment and create a state oral health improvement plan. Available data, stakeholders, and community members will be gathered to discuss the needs in Utah and help in the development of this plan.

Agency Capacity/Family Partnerships/Collaboration:
In the fall of 2021, the oral health educator presented at the diabetes and education specialist annual conference on the correlation between oral health and diabetes. Ten healthcare providers attended the presentation.

Spot the Vape campaign was a direct collaboration between Primary Children's Hospital, UTFA, and the tobacco prevention and control program. The OHEd disseminated campaign materials to the Utah Oral Health Coalition, Dental Schools, Dental Hygiene Schools, and AOHC participating middle schools for dissemination to families.

The OHEd continues to work with staff in the Home Visiting Program and WIC providing professional development around oral hygiene, nutrition recommendations, educational materials, and local dental resources.

OHP and the MCH team applied for, and were awarded, a HRSA workforce grant with a four-year performance period September 1, 2022 through August 31, 2026. Partners on this project will include three rural emergency departments (Ashley Regional Medical Center and Uintah Basin Medical Center), two Federally Qualified Health Centers (FQHCs) (Mountainlands Community Health Center Dental Clinic and IHS Fort Duchesne Health Center), and the University of Utah School of Dentistry. Activities during this grant period include creating a CME education curriculum for ED personnel to appropriately assess and address oral health concerns, Hospital and FQHC staff being available to help eligible individuals enroll in Medicaid, the creation of a statewide public resource and referral map, and increasing the local capacity within the FQHC to see ED patients in a timely manner.

Report of ESM 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 13.2.1:
The Medicaid population is a group that has higher dental needs than those with higher economic status. They are part of the population of Utah that is important to concentrate on in improving this measure.

ESM 13.2.1 Progress Summary:
This ESM is expected to increase the number of Medicaid children ages 1 through 18 years who have preventive dental visit in the past year. This includes an additional year of age 18 years, but it is close to the age range for NPM 13b. The Medicaid population is a group that has higher dental needs that those of higher economic status. They are part of the population in Utah that is important to concentrate on in improving this measure.

Local Health Department Successes related to this performance measure:

One health district is providing dental vouchers for uninsured children. This district provided 265 dental services through their dental providers. Their staff called and met with dental providers to promote their program.

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 FY22:
This Performance Measure was NOT achieved. The Performance Objective was 81.0% and the Annual Indicator was 80.6%.

Program Activities:
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.

The state and local health departments have been working to promote family mealtime to Utah residents. More specifically, they have worked with schools and childcare centers and used social media to provide families with materials and resources to apply for programs such as the Supplemental Nutrition Assistance Program (SNAP), WIC, and the National School Breakfast and Lunch Programs.

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% (2017-2018 National Survey of Children's Health) to 84%. The 2020-2021 data from the National Survey of Children's Health show that 80.6% of Utah families ate a meal together four or more times per week. This comes close to achieving the five-year goal that Utah set and demonstrates nearly a 4% increase from the baseline data.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-2

- Members of the Healthy Environments Active Living (HEAL) team have been meeting monthly with other health educators from LHDs who work directly with schools. Ideas were discussed and the group brainstormed ways to better collaborate.
- LHDs have attended conferences related to school health and have found ways to promote SNAP at local events in their communities.
- LHDs have expanded the reach of SNAP and WIC and have invited school district representatives to be stakeholders in those discussions.

Challenges / Gaps / Report:

LHDs and the state have encountered significant staff turnover, which has created a knowledge gap between new staff and remaining staff. Vital institutional knowledge is less available as staff members have left the program for new positions.

Agency Capacity / Collaboration Report:

Funding from the State Physical Activity and Nutrition and Prevention (SPAN) program and Title V Block Grant provides funding to LHDs to improve physical activity and nutrition among children ages 0-18. The state of Utah has an early childcare center program called TOP Star, which stands for Teaching Obesity Prevention in Early Child Care Settings. TOP Star is a free Utah-based program that helps early childcare facilities improve their nutrition, physical activity, and breastfeeding policies. TOP Star also offers free technical assistance and resources to participants.

Utah funds childcare facilities with incentives to improve physical activity and nutrition services for families. By providing educational services to young families, nutrition improves in homes. School health is also a priority. School wellness policies are created to guide schools efforts in creating supportive school nutrition and physical activity environments, which includes foods on school campuses, rules on snacking in classrooms, and special occasion snack protocols. Utah recognizes and partners with schools because they play an important role in helping children make healthy eating choices and establish physical activity habits while they are young.

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 transpire 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

In 2022, CSHCN contracted with Help Me Grow Utah (HMGUT) to screen children using the Modified Checklist for Autism in Toddlers-Revised (M-CHAT R/F) and make referrals as appropriate. HMGUT screened 176 children for autism spectrum disorder and referred 233 children to appropriate services. The M-CHAT R/F is designed for children 16 to 30 months of age. If an M-CHAT R/F is properly administered, these children can get appropriate Part-C and Part-B services. If this screener leads to appropriate testing and diagnosis, these children can enter school with an appropriate classification (General Education, 503 or Special Education).

The DHHS Office of Early Childhood, the Department of Workforce Services-Office of Child Care, the Utah State Board of Education-Early Childhood Department, Early Childhood Utah, and dozens of community based programs such as: Help Me Grow Utah, Local Health Departments, Head Starts, Child Care Providers, Home Visitors, Early Interventionists, and Pediatric Providers are engaged in statewide efforts to facilitate early and routine developmental health screening. The tools for this project used are Brookes Publishing ASQ-3 and ASQ Social-Emotional. Children that need further assessment and/or services are connected to additional resources. When developmental delays are discovered and treated early, children have increased opportunities to arrive at school healthy and ready to learn.

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. The CHARM program also began work on a project to integrate the Ages and Stages Questionnaire (ASQ-3) and ASQ Social and Emotional-2 (ASQ SE-2) developmental screening results from various State of Utah agencies through the CHARM system and share those results with DHHS health program database systems and Electronic Medical Record (EMR) systems. The overall purpose of the data project is to make ASQ-3 and ASQ SE-2 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.

The 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. This 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. This ASQ developmental screening project is detailed more in NOM 17.3.

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)

OHP continues to support the Head Start and Early Head Start programs throughout the state by sitting on the health advisory committees, providing staff training, parent educational presentations and screenings, and providing fluoride varnish to some sites. A local dentist and dental hygienist have been providing services within the DDI Vantage headstart programs in Salt Lake and Tooele. Utilizing teledentistry, they provide exams, prophylaxis, sealants, fluoride varnish, and appropriate referrals. The OHEd provided 12 oral health messaging educational materials for DDI vantage families and coordinated with these local providers. In March 2022, the OHEd along with two OHP intern hygienists provided dental screenings, fluoride varnish, referrals, and toothbrushes to 125 Head Start children within the Salt Lake Community Action Program.

The OHEd continues to work with the Home Visiting program to provide oral health education and training to staff and families with children (0-5). The OHEd sends quarterly educational and dental resource emails to each site. All educational material shared is current and evidence-based. The OHEd and OHP dental hygienist intern created a Care About Your Child's Teeth presentation for parents and staff in English and Spanish. This presentation was given at the Salt Lake City Parents as Teachers Home Visiting Site to 11 families and 6 staff members. It was then later recorded and shared with all OHV sites, migrant Head Start sites, Head Start sites, and WIC sites. National materials were also shared with OHV sites including; the National Oral Health Resource Center, Early Childhood Learning and Knowledge Center, and the National Institute of Dental and Craniofacial Research educational materials. In May of 2022, the OHEd presented at the first-ever peer dialogue session with 20 OHV site managers statewide.

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

The Department of Health and Human Services-Office of Early Childhood, the Department of Workforce Services-Office of Child Care, the Utah State Board of Education-Early Childhood Department, Early Childhood Utah and dozens of community based programs such as Help Me Grow Utah, Local Health Departments, Head Starts, Child Care Providers, Home Visitors, Early Interventionists, and Pediatric Providers are engaged in statewide efforts to facilitate early and routine developmental health screening. The tools used for this project are Brookes Publishing ASQ-3 and ASQ Social-Emotional. Children that need further assessment and/or services are connected to additional resources. When developmental delays are discovered and treated early, children have increased opportunities to arrive at school healthy and ready to learn.

NOM 22.2-22.5 - 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 continued to link immunization histories of children, ages 0-18, from the Utah Statewide Immunization Information System (USIIS) and provide them electronically to the Baby Watch/Early Intervention Program, the Early Hearing Detection and Intervention Program, the Fostering Health Children Program, the WIC Program, Newborn Screening Heel-stick Program, private provider clinics, and Community Health Centers. 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 utilize USIIS continue to be able to view newborn hearing screening and Critical Congenital Heart Defect (CCHD) through CHARM links that query this information.

Priority Need: Developmental Delays

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 Plan FY24:

Throughout FY24, DHHS, along with several partner agencies, will continue to implement the statewide, coordinated, developmental screening initiative (ASQ Project).

Objectives of the ASQ project include:

- Increase the number of ASQ screenings for young children throughout Utah.
- Enhance and centralize ASQ training materials and information/resources.
- Make child-level screening information available to approved pediatric providers through the DHHS Child Health Advanced Records Management System (CHARM).
- Integrate ASQ data from all participating entities with the DHHS Early Childhood Integrated Data System (ECIDS) and with the Utah System of Higher Education's Utah Data Research Center (UDRC) to inform future research opportunities and improvements to Utah's early childhood system.

Implementation will consist of outreach and engagement with programs and providers that serve and support families with young children. Providers will be encouraged to participate in virtual or live ASQ training, at no cost, hosted by a partner organization. Once providers have met training requirements, pediatric, early health care, home visitors, and early intervention providers will be solicited to re-enroll or initially enroll their program in the DHHS ASQ Online Enterprise Account. Additional care-types will be supported in their efforts to enroll in an Enterprise Account that best aligns with the services they provide; for example, child care providers with the Department of Workforce Services - Office of Child Care's account or Head Start grantees with the Utah Head Start Association's account.

Once providers successfully complete Utah's ASQ training course and agencies/programs enroll in their respective Enterprise Accounts, Early Childhood Utah (ECU) will offer onboarding technical assistance to assist programs with implementing routine developmental health screening into their practice or curriculum. Technical support will include assistance with ASQ Online technology, such as creating the program's subaccount, adding providers, and generating the program's web-based landing pages and internet links that parents will use to complete developmental health screens. Both ASQ-3 and ASQ-SE 2 will be available to programs in English and Spanish.

In FY24, DHHS and multiple state and community-based partners will also be engaged in the implementation of activities supported by the Preschool Development Birth through Five Grant (PDG B-5). PDG B-5 goals and activities align with NPM-6 objectives and will improve Utah's overall early childhood infrastructure.

PDG B-5 major goals include:

1. Updating the PDG B-5 Needs Assessment and Strategic Plan
2. Implementing the Pyramid Model statewide; those interacting with children have the skills needed to provide nurturing and responsive care and to reduce challenging behaviors
3. Expanding the cultural competence and responsiveness of early childhood programs in tribal communities and developing best practices for implementation in other communities

4. Expanding early childhood care coordination efforts at a statewide and community level by assisting families with children under age 8 to navigate existing systems so they can have access to and be referred to the programs and resources needed
5. Piloting and measuring effectiveness of tools intended to support a family's engagement with their children to advance developmental milestones
6. Moving forward with Utah's plan to create an early childhood online resource hub with options for program triage and referrals

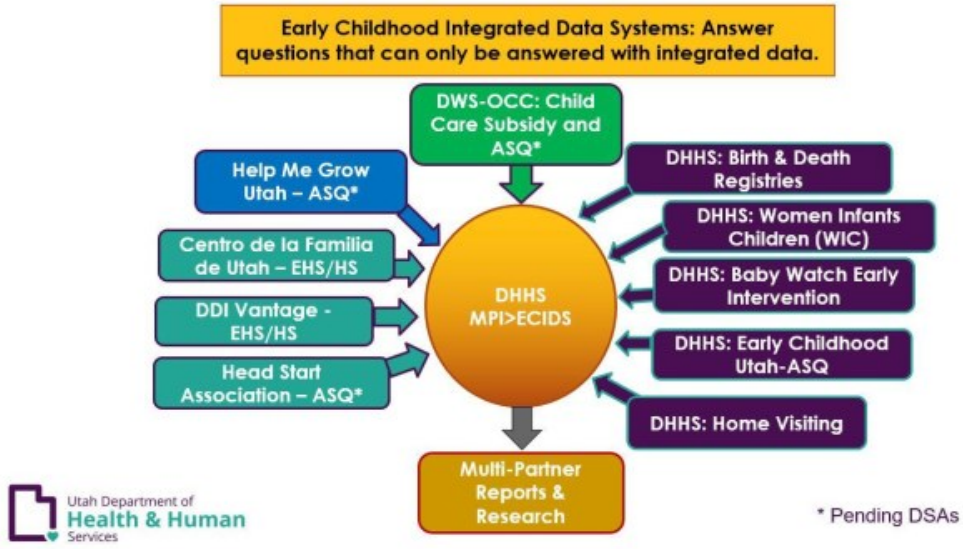
To better understand issues related to equity and health disparities, several DHHS programs will also work together to facilitate data analysis of the ASQ Online Legacy Program. As the new ASQ project takes shape and is implemented by multiple agencies and programs across the state, DHHS program leaders have agreed to conduct an equity-focused analysis of the historical DHHS ASQ Online Legacy Program to inform and guide future efforts. As a result of this analysis, early childhood leaders will be able to determine the likelihood that young children receive a developmental screening if they:

- Reside in a rural or frontier community, compared to those residing in an urban community,
- Live in poverty, compared to children not living in poverty, or
- Are a young child of color, compared to white, non-Hispanic children.

The DHHS Master Person Index, ECIDS and the ECIDS technology contractor will all be involved in the efforts to produce distinct-child (non-duplicated), unit-level, screening data that will be used for this targeted analysis. Historical data will be extracted from the DHHS ASQ Online Enterprise Account through an API and stored in a protected and secure database. This data will be transformed into a legacy extract that MCH epidemiologists will use, along with custom SAS code, to perform the analysis.

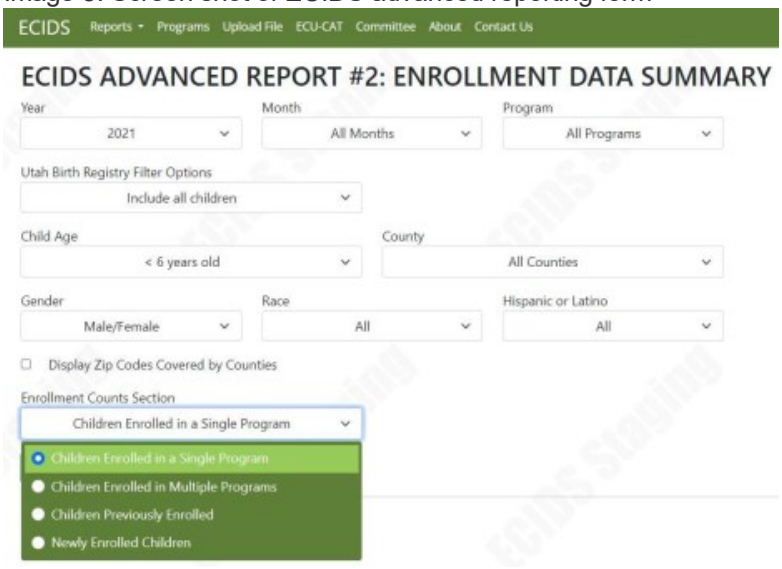
Additionally, ECIDS will release a new set of dynamic report templates, the ECIDS Advanced Reports. ECIDS Advanced Reports will assist Prenatal-3/early childhood system leaders with understanding equity-based issues by making de-identified, distinct child, cross-agency, service and enrollment data readily available by: 1) year, 2) month, 3) program(s), 4) location of birth (in or out of Utah), 5) age (under age six), 6) county, 7) gender, 8) race, and 9) ethnicity. ECIDS Advanced Reports will supplement a program's race and ethnicity data when program(s) do not have this data available, but another ECIDS program does, such as the Utah Birth Registry. Figure 1 outlines current and projected ECIDS data sources.

Figure 9. Logic model of Early Childhood Integrated Data Systems



We have also included a snapshot of the ECIDS Advanced Enrollment Report filtering page (see image 1).

Image 8. Screen shot of ECIDS advanced reporting form



Proposed Activities:

- Implement the new statewide, coordinated ASQ Project
- Implement Preschool Development Grant B-5 activities
- Conduct an equity-focused analysis of the DHHS ASQ Online Legacy Program
- Release and market ECIDS equity-focused Advanced Reports

Table 12: Logic Model for National Performance Measure 6

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				
Goal: Increase the percentage of children, ages 9 months through 35 months, who receive a developmental screening using a parent-completed screening tool in the past year.				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Dedicated funding for cross-agency staff to promote developmental health activities. A statewide, coordinated, cross-sector, developmental screening initiative (ASQ Project) and early childhood advisory council and working subcommittees. Early childhood integrated data systems Technical expertise.	Coordinate with programs that serve families with young children. Provide screening training/resources to programs/providers that serve young families. Promote developmental activities at a systems level. Develop early childhood needs assessment and strategic plan and use to develop early childhood initiatives. Enhance data systems to integrate screening data for care coordination and outcome analytics. Leverage technical assistance enhance outcomes and/or to mitigate emerging issues.	Increased awareness and participation in developmental activities by programs that serve young families. Increased number of programs/providers gain access to screening tools/resources and engage in routine developmental screening. Early childhood initiatives are aligned and have a collective impact. Reports with integrated developmental screening data are available to approved end-users. Early childhood initiatives are designed and implemented effectively.	NPM 6: An increased percentage of children, ages 9-35 months, receiving a developmental screening in the past year. Increased screenings are facilitated. Young families connected to screening opportunities, services and resources, to improve developmental outcomes. Data and reports are leveraged to increase the number of developmental screenings that take place in targeted communities. Data and reports are utilized to facilitate care-coordination.	NOM 13: School Readiness – More children are ready to for kindergarten NOM 19: Overall Health Status – Children have improved overall health status Parents are supported in their efforts to assist their children in reaching their optimal potential.
Assumptions and Contextual Factors: If developmental screening resources are readily accessible to programs that serve families with young children, providers will utilize and implement these resources into their routine practices or curriculum.				

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 FY24:

In FY24, the Oral Health Program (OHP) will continue collaborating with Medicaid, and the Medicaid dental team to increase the number of children who receive preventive dental visits and receive needed dental treatments. The Oral Health Program and State Dental Director (SDD) will work with the Utah Dental Association (UDA) and the Utah Dental Hygienist Association by attending board meetings in an advisory capacity. The OHP and SDD will encourage providers to participate in programs for underserved children in Utah, such as the Give Kids a Smile program. The OHP will also continue to encourage providers to see children by age one, and encourage pregnant persons to receive dental care.

The OHP Oral Health Educator (OHEd) will continue to sit on Professional Advisory boards for four of the six dental hygiene schools and collaborate with the other two schools. The OHEd will continue to provide presentations on public health dentistry, and cultural empathy to dental hygiene students. The OHEd will support and encourage schools to develop a public health minded workforce.

The OHP OHEd will continue to provide oral health education and dental resources to middle school students in select schools within Canyons, Granite, Weber, and Tooele School Districts and educational materials to the Utah School for the Deaf and the Blind. The OHEd is available for virtual presentations in other districts. Virtual presentations and recordings are available to schools that request them. The OHEd continues to collaborate with local dental hygiene programs to provide education and resource booths at back-to-school nights in elementary and middle schools. The OHEd will also continue to promote teledentistry to support school-based programs.

OHP will continue interprofessional collaborations and outreach to vulnerable populations with the University of Utah's Physician Assistant (PA) Program. In collaboration with Utah's dental hygiene liaison, the OHEd will provide training to PA students on the American Academy of Pediatrics (AAP), Oral Health Risk Assessment, and fluoride varnish application. The OHP and PA programs will screen migrant farm children through the migrant Head Start programs and parents through the migrant farm workers screening days.

In the fall of 2024, the OHP plans to conduct a Basic Screening Survey (BSS) of first through fourth grade children in Utah public schools. Partnerships will include the Association of State and Territorial Dental Directors (ASTDD), school administrators, school RNs, Dental and Dental Hygiene Schools, the Utah Oral Health Coalition (UOHC), Federally Qualified Health Centers (FQHC) and other safety net clinics, and local community organizations.

Proposed Activities:

- OHP will continue to provide oral health articles for the monthly newsletter "Women Infant and Children (WIC) Wire" and educational material for WIC participants.
- OHP will continue to use the updated 12 oral health message modules and magnets and share with WIC, Head Start, and Home Visiting Program etc. Maternal and infant oral health messages are included in this.
- The State Dental Director and OHEd will work with the Utah Dental Association and Utah Dental Hygienist Association to encourage participation in programs for underserved children in Utah.
- The OHEd will continue to work with all dental hygiene schools on advisory committees and presenting on public health dentistry to students. The OHEd will continue to create opportunities for dental hygiene students to attend community events such as providing educational and resource booths at local elementary schools.

- The OHEd will oversee and provide middle school students with the adolescent oral health campaign, educational intervention, and local dental resources. This will be available in person and virtually.
- OHP will continue interprofessional collaborations and outreach to vulnerable populations with the University of Utah's PA Program.
- OHP will plan and implement the BSS of first through fourth graders in FY24. Results will be analyzed and a report will be created and disseminated publically.
- The OHEd will work with the state school nurse collaborator to create an oral health toolkit for all school RNs in Utah. The toolkit will include information on AAP Oral Health Risk Assessment, trauma, nutrition, and educational posters. Once the kit is finalized, they will collaborate to disseminate the toolkit.
- OHP will conduct a needs assessment and create a state oral health improvement plan.

Table 13: Logic Model for National Performance Measure 13.2

NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year				
Goal: Increase the percent of infants and children, ages 1 to 17, who had a preventive dental visit in the past year				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Funding and qualified DHHS staffing: Oral Health Educator, State Dental Director, volunteer interns Partners and stakeholders: Utah Oral Health Coalition, Utah Dental Association, Utah Dental Hygienist Association, Head Start, Office of Health Equity, WIC, Office of Home Visiting, U of U School of Dentistry, Roseman School of Dentistry, U of U Physician Assistant program, dental hygiene programs	Regular planning meetings and updates to Utah Oral Health Coalition Development of oral health messages including early intervention and prevention techniques Oral Health screenings in Salt Lake, Tooele, Ute Tribe, and Migrant Head Starts Development of sharing of educational materials and safety dental net clinics for presentations, trainings, and newsletters	Number of Utahns reached through oral health messaging Number of oral health screenings in Salt Lake, Tooele, Ute Tribe, and Migrant Head Starts Number reached with educational materials	NPM 13.2: Increase in percent of children who receive an preventive dental visit	NOM 14: Decrease in percent of children who have decayed teeth or cavities in the past year NOM 17.2: More families benefit from a well-functioning care system NOM 19: Overall Health Status – Children have improved overall health status
Assumptions and Contextual Factors: If children are screened for dental conditions and appropriate referrals are made, they will have access to adequate treatment. Establishing and maintaining a regular dental home (usual place of care) will reduce the risk of dental decay and other oral diseases. If oral health educational resources are readily accessible to programs that serve families especially those with young children, staff/providers will utilize and implement these resources in their routine practices and curriculum.				

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 FY24:

During FY24, the Office of Maternal and Child Health (MCH) in collaboration with the Violence Injury Prevention (VIPP) and Healthy Environments Active Living (HEAL) program, will continue activities to support increased family meals.

Proposed Activities:

- Utilize Community Health Workers (CHW's) to assist in bridging the gap between programs offered by the state and Local Health Departments (LHD's) and families. CHW can help connect families with resources to enable them to find WIC and SNAP programs and can aid in filling out applications.
- If CDC funding is renewed through the State Physical Activity and Nutrition and Prevention Block Grants, the state will continue to work with LHDs to provide funding to LHDs to improve physical activity and nutrition among children 0-18. This funding is used to educate families about health nutrition, encourage and increase the number of individuals who assist Early Childcare Centers with educational nutritional resources, and to help people understand how they can become more physically active.

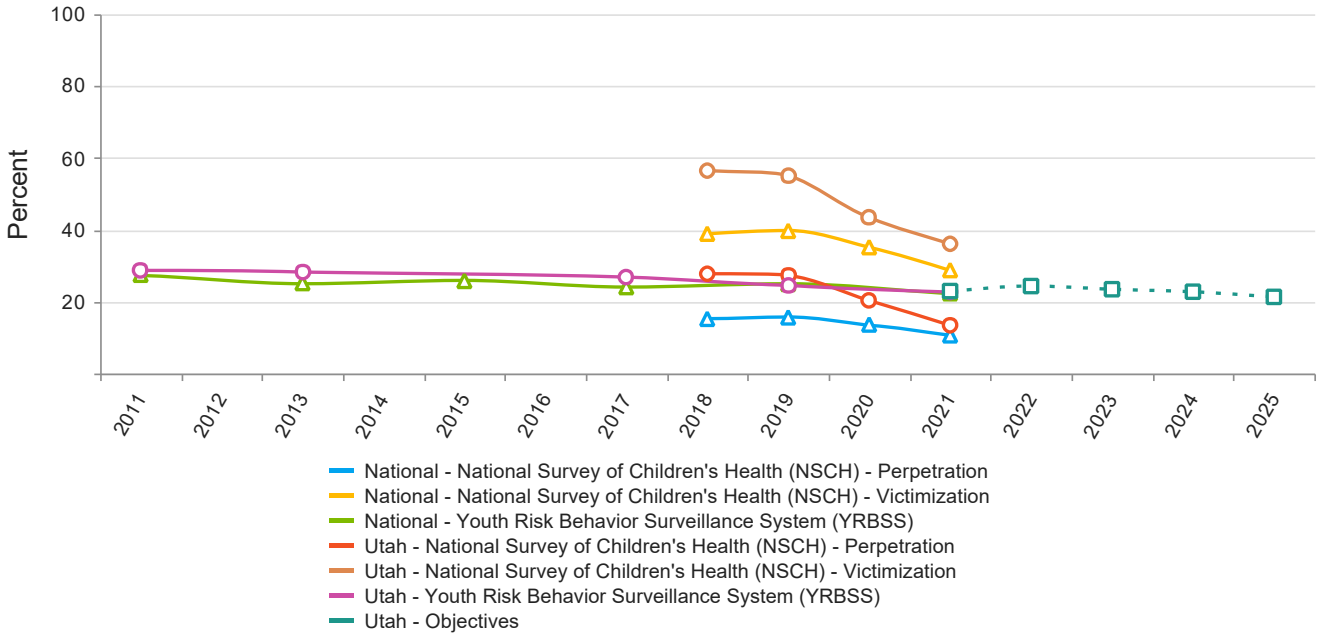
Table 14: Logic Model for State Performance Measure 2

SPM 2: Percent of family members who live in the household that ate a meal together 4 or more days per week				
Goal: Increase the percent of family members who live in the household that ate a meal together 4 or more days per week.				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
LHD buy in and interest in addressing the question Opportunity to add questions to BRFSS. Expert advice from the survey center and BRFSS advisory committee on the question Multiple data sources for family meals data (e.g. YRBS)	Family Meals Declaration signed by the Governor Ensure that family meals are on BRFSS for odd years Send questions to BRFSS advisory committee for approval on BRFSS. Revise question as needed to measure isolation for those who live alone. Explore all data sources of family meals	Signed declaration of September as Family Meals Month Data on Family Meals IBIS indicator on family meals (pending)	More families are eating meals together Data are available for tracking changes in family meals since 2013 Data on family meals are available to public and partners	SPMs are not tied to specific SOMs or NOMs. However, it is reasonable to assume the following NOMs will be impacted by this work: NOM 13: School readiness; NOM 19: overall health status
Assumptions and Contextual Factors: Sharing data and having a declaration to inform the public and partners about family meals will contribute to an increase in the percentages of families who regularly eat meals together. Families have busy schedules and are sometimes working multiple jobs. This may make it harder to have family meals on a regular basis.				

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**	**2022**
Annual Objective			23	24.4
Annual Indicator	26.9	24.4	24.4	22.9
Numerator	44,345	41,396	41,396	40,261
Denominator	164,763	169,914	169,914	175,774
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2019	**2020**	**2021**	**2022**
Annual Objective			23	24.4
Annual Indicator	27.7	27.5	20.4	13.7
Numerator	86,153	84,890	62,745	42,471
Denominator	311,307	309,211	307,366	309,906
Data Source	NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2019	**2020**	**2021**	**2022**
Annual Objective			23	24.4
Annual Indicator	56.4	54.8	43.3	36.2
Numerator	176,896	170,076	133,253	112,098
Denominator	313,579	310,347	307,613	309,917
Data Source	NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator	0	129	160	0
Numerator				
Denominator				
Data Source	Program records, attendance records.	Program records, attendance records	Program records, attendance records	Program records, attendance records
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

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

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective				
Annual Indicator	300	300	181	6,651
Numerator				
Denominator				
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	6,000.0	6,000.0	6,000.0

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**	**2022**
Annual Objective			23	23
Annual Indicator	21	21	21.7	21.7
Numerator	41,142	41,142	46,356	46,356
Denominator	195,912	195,912	213,621	213,621
Data Source	Estimates for percent of students physically activ	YRBS	YRBS and National Center for Health Statistics	YRBS and National Center for Health Statistics
Data Source Year	2019	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			400	175
Annual Indicator	400	366	162	138
Numerator				
Denominator				
Data Source	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	175.0	175.0	175.0

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	2022
Annual Objective			76	78
Annual Indicator	75	75	75	78.9
Numerator	171,000	171,000	171,000	180,000
Denominator	228,000	228,000	228,000	228,000
Data Source	Internal Revenue Service	Internal Revenue Service	Internal Revenue Service	Internal Review Service
Data Source Year	2018	2018	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			300	300
Annual Indicator	100	340	340	365
Numerator				
Denominator				
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	400.0	500.0	600.0

ESM 9.7 - The number of parents who participate in the Families Talking Together intervention

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	112
Numerator	
Denominator	
Data Source	Registration and attendance records, numbers serve
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	130.0	140.0

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	2022
Annual Objective			78.8	81
Annual Indicator	76.7	78.1	81.1	80.6
Numerator	692,413	712,908	743,827	737,820
Denominator	903,273	912,249	917,210	915,409
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	81.7	82.9	84.0

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			35	50
Annual Indicator	32.2	35	41.7	86.1
Numerator			281,760	170,802
Denominator			675,247	198,354
Data Source	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	87.0	87.8	88.7

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 21.4%.	
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).	Inactive
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
ESM 9.7 - The number of parents who participate in the Families Talking Together intervention	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 eligible students enrolled in the free or reduced price lunch program

Objectives

By 2025, increase the number of eligible students who participate in the National School Breakfast and Lunch Programs from 26.5% (Utah State Board of Education Child Nutrition Program Database) to 88.7%.

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 FY22:

This Performance Measure was achieved. The Performance Objective was 24.4% and the Annual Indicator was 22.9%

Program Activities:

The Violence and Injury Prevention Program (VIPP), the Healthy Environments through Active Living program (HEAL) program, and the Office of Maternal and Child Health use MCH funding to implement primary prevention activities shown to reduce the risk of bullying. Primary prevention of bullying refers to the various measures and strategies implemented to prevent bullying from happening in the first place. This includes interventions that aim to create a safe and positive family, school or community environment, promote positive social and emotional skills among children and youth, and increase awareness and understanding of bullying and its harmful effects. MCH's strategies to prevent bullying include 1) policy support, 2) increasing positive relationships, 3) Increasing family, school, and community connectedness, 4) increasing conflict resolution skills, and 5) increasing awareness and education. We have provided a more thorough description of these strategies below:

1) Policy support: Developing and implementing school-wide anti-bullying policies and procedures that clearly define what bullying is and how it will be addressed. Utah anti-bullying laws require districts to include training regarding bullying, cyber-bullying, hazing, abusive conduct, and retaliation in Utah schools. VIPP has been involved in educating lawmakers on evidence-based policies to reduce bullying. In addition, VIPP has participated on the SafeUT Commission since its inception. SafeUT is a crisis chat and tip line that provides real-time crisis intervention for students, parents/guardians, and educators through live chat and a confidential tip line through a smartphone app.

2) Increasing positive relationships: Children who have positive relationships with parents, adults, peers, and family members are less likely to engage in bullying behavior or become victims of bullying. Parenting practices that are warm, supportive, and involve clear expectations and consistent discipline can help children develop positive social skills and reduce the likelihood of engaging in bullying behavior.

Economic instability creates stress on the family and may contribute to poor parenting and familial relationships. The Earned Income Tax Credit (EITC) is a federal tax credit for working people with low and moderate incomes. It boosts the incomes of workers paid low wages while offsetting federal payroll and income taxes. There are several reasons why families who qualify for the federal EITC may not file for it, including lack of awareness, the complexities of filing, a fear of audits, lack of technology access, or language barriers. VIPP and the Office of Health Promotion and Prevention (OHPP) have actively engaged in increasing awareness and support for families to file for the federal EITC and to connect families with free-tax help.

The Adolescent Health Program (AHP) in the Office of Maternal and Child Health worked with parents on Teen Speak. Teen Speak was a program that equipped parents and other trusted adults with communication skills they could use to overcome the common challenges of connecting with a teen. Better communication with teens helps create a trusted relationship that supports their positive decision-making. Teen Speak was built on sound, science-based techniques and strategies that were taught through a practical, real-world approach. Due to funding issues, AHP has transitioned to working with a different program called Families Talking Together. This evidenced-based program focuses on helping parents communicate about sexual decision-making.

AHP also provides the Wyman's TOP program. Wyman’s Teen Outreach Program (TOP) promotes the positive development of adolescents through curriculum-guided, interactive group discussions; positive adult guidance and support; and community service learning. TOP is designed to meet the developmental needs of middle and high school teens. The TOP Curriculum is focused on key topics related to adolescent health and development, including building social, emotional, and life skills; developing a positive sense of self; and connecting with others.

Emotional intelligence: Children who are emotionally intelligent, can recognize and regulate their own emotions, and have empathy for others, are less likely to engage in bullying behavior.

3) Increasing family, school, and community connectedness: Children who feel connected to their family, school and community, have positive relationships with parents, neighbors, teachers and staff, and feel like they belong, are less likely to engage in bullying behavior or become victims of bullying. Families, schools, and communities can create a culture of respect, inclusion, and empathy, which will increase connectedness and in turn decrease bullying.

The HEAL program works with schools to increase physical activity. Practicing physical activity is a fundamental factor in health promotion in childhood and adolescence (Ramos et al., 2016). Non-competitive team sports promote social relationships for adolescents, which may reduce the incidence of bullying.

VIPP has created a connectedness toolkit for families, schools, and communities. This toolkit gives concrete recommendations for increasing connectedness for children and adolescents and can be accessed at health.utah.gov/vipp.

4) Increase conflict resolution skills: Children who have skills in conflict resolution and problem-solving are less likely to engage in bullying behavior and are better equipped to resolve conflicts in a peaceful and respectful manner.

The Safe Dates program is a school-based intervention program designed to prevent dating violence among teenagers. The program covers topics such as the prevalence and consequences of dating violence, communication and conflict resolution skills, and gender roles and expectations. The program also includes interactive activities, role-plays, and discussions to engage students in the learning process. The goal of the Safe Dates program is to help students recognize the warning signs of dating violence, develop healthy relationships, and prevent future incidents of dating violence.

VIPP's Upstanding curriculum is a school-based program designed to prevent bullying and promote positive social norms among students. The program was developed by the Utah Department of Health (prior to the formation of DHHS) in collaboration with the Utah State Office of Education and community partners. The Upstanding curriculum consists of four modules, each of which focuses on a specific aspect of bullying prevention. The modules cover topics such as recognizing and reporting bullying, promoting empathy and kindness, developing positive social skills, and creating a safe and inclusive school climate. The curriculum includes interactive activities, role-plays, and discussions to engage students in the learning process. It also provides teachers with lesson plans, handouts, and other resources to support the implementation of the program. The goal of the Upstanding curriculum is to help students become "Upstanders" rather than bystanders when they witness bullying or other negative behaviors. The program aims to empower students to take positive actions to intervene in bullying situations and promote a culture of respect and inclusion in their school communities.

5) Increase awareness and education: Providing training for school staff, parents, and students on how to recognize, prevent, and respond to bullying.

Mental Health First Aid is a training program designed to help people identify and respond to signs of mental illness and substance use disorders. The program covers topics such as identifying risk factors and warning signs of mental health disorders, crisis intervention and de-escalation techniques, and effective communication strategies for helping individuals in distress.

QPR stands for Question, Persuade, and Refer, and it is a suicide prevention program that aims to educate individuals on how to recognize and respond to warning signs of suicide. The QPR program provides individuals with a simple and effective way to intervene when they suspect that someone may be at risk for suicide. The program teaches participants how to ask the right questions, persuade the person to seek help, and refer them to appropriate resources and services.

Overall, primary prevention of bullying involves a comprehensive and proactive approach that involves all members of the community in creating a culture of respect, empathy, and inclusion.

Accomplishments/Successes:

1. Increase the number of Adolescents who receive bystander training (Upstanding). During this time the pandemic hindered VIPP's and sub-recipient's ability to provide the Upstanding program to adolescents because students were remote learning. In response, and with some unexpended funding in another grant, we began the process of converting the training to an online delivery. This effort is still in progress and will likely be another year before it is ready to implement. VIPP and partners delivered Upstanding to 6,651 students.

2. Percent of adolescents who are physically active at least 60 minutes per day. According to YRBSS, 21.7% (20.0-23.4%) of 9-12th graders are physically active 7 days a week 60+ minutes per week in 2022.

3. The number of youth participating in the Wyman Teen Outreach Program (TOP). In the 2022-2023 school year, DHHS worked with local partners to implement the program at nine sites, reaching 138 youth served and completing over 1,300 hours of community service.

4. Strengthen household economic security through an uptick in Utah filings for the EITC. In 2021-2022 VIPP distributed 11,000 flyers to partners with information on the benefits of filing for the EITC and how to access free tax help through the Volunteer Income Tax Assistance (VITA) program. In addition, we ran television and radio spots with Spanish-speaking channels because the Hispanic population has higher rates of not filing for the EITC. EITC filings increased from 178,000 in 2020 to 249,000 in 2021. Much of this increase may be due to the availability of stimulus funding.

5. Number of Utahns who have been trained in QPR. In FY 2022, VIPP staff have trained 350 people in QPR and an additional 135 people in Mental Health First Aid. In addition, our partners in the Office of Substance Use and Prevention provided funding to community partners to provide the QPR and MHFA programs in their own communities.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-9:

- In 2021-2022 VIPP distributed 11,000 flyers to partners with information on the benefits of filing for the EITC and how to access free tax help through the VITA program. EITC filings increased from 178,000 in 2020 to 249,000 in 2021. (January 1st, 2022 - April 15th, 2022)
- VIPP and partners provided the Upstanding curriculum to 6,651 students. We are working to provide a

digital Upstanding program to reach more students that are not able to receive the program for a variety of reasons. (July 1st, 2021 - June 30th, 2022)

- VIPP worked with partners, CDC, and researchers to develop a "Connectedness Toolkit." The toolkit was in development and completed during FY22 but just received final approval for distribution. (July 1st, 2021 - June 30th, 2022)

Challenges/Gaps/Disparities Report:
Challenges: COVID created conditions that made it difficult to meet some of our objectives. As a result, we are working on creating an online delivery option for our Upstanding program.

Disparities: Based on Federally Available Data, parents of Children with Special Healthcare Needs (CSHCN) report more bullying victimization (55.5%) compared to parents of non-CSHCN (28.7%). YRBS data also shows disparities with adolescents in grades 9, 10, and 11 more likely to report being bullied compared to those in grade 12. Females were also more likely (29%) than males (19.9%) to report being bullied. Adolescents who identify as lesbian, gay, or bisexual (36.3%) or who are not sure of their sexual orientation (35.9%) were also much more likely than adolescents who identify as straight (22.6%) to report being bullied.

Agency Capacity/Collaboration:

We are committed to ensuring a statewide system of service. We do this through engaging stakeholders from across the state, identifying and prioritizing disparities through data and stakeholder feedback, and including stakeholders with lived experience. We work with multi-disciplinary, multi-sectoral partners across the state and the country. Additionally, we will use evaluation to identify and improve our partnerships.

Report of ESMs related to NPM-9

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

Goal/Objective:
Implement the Teen Speak training with 500 parents in Utah over 5 years. Parents will learn and implement one strategy learned through TEEN SPEAK.

Significance of ESM 9.1:
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 9.1 Progress Summary: Due to a lack of funding, the program was unable to complete any work around Teen Speak in FY2022. We are therefore deactivating this ESM and replacing it with ESM 9.7.

ESM 9.2 - Increase the number of Adolescents who receive bystander training (Upstanding).

Goal/Objective:
Increase the number of adolescents who have received the Upstanding curriculum.

Significance of ESM 9.2:

Bullying is the unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. Passive bystanders provide the audience a bully craves and the silent acceptance that allows bullies to continue their hurtful behavior. A bystander to bullying is anyone who witnesses bullying either in person or in digital forms like social media, websites, text messages, gaming, and apps. When bullying occurs, bystanders are present 80 percent of the time. A bystander has the potential to make a positive difference in a bullying situation, particularly for the youth who are 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 9.2 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, a 36% decrease in non-bullying aggression, and a 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. We have been able to contract with local health departments (LHD) and community-based organizations to provide bystander programs. Because of this, we have far exceeded our projection of 200 for FY 2022.

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 9.3:
Physical activity has brain health benefits for school-aged children, including improved cognition (e.g., academic performance, memory) and reduced symptoms of depression. Regular physical activity in childhood and adolescence can also be important for promoting lifelong health and well-being and preventing risk factors for various health conditions like heart disease, obesity, and type 2 diabetes.

ESM 9.3 Progress Summary:
Local Health Departments (LHDs) provided support to local education agencies to get students physically active through Safe Routes to School (SR2S) activities. These included monthly the Walk and Roll Challenge, Walk to School Day, safety assemblies, strengthening SR2S policies and maps, and/or assisting in applying for SR2S grant

funding to improve infrastructure. They also participated in community meetings and coalitions to encourage city planners to incorporate active transportation with city improvements and new infrastructures. Local health departments ensure that SR2S are included in city master plans.

LHD staff continue to have high turnover, and it has been difficult to continue training new staff throughout the year. However, by the end of 2022, most LHD staff have been trained to provide support, resources, and technical assistance to local education agencies to strengthen policies and procedures around physical activity. They help assess local wellness policies by using an assessment tool that provides comprehensive language to enhance policies.

State staff worked with the Utah State Board of Education to create a Model Health and Wellness Policy for local education agencies to follow when creating new policies. An educational meeting was held with three local education agencies to begin the process of improving their health and wellness policies.

State staff also chaired the SHAPE Utah conference and provided health, PE teachers, and athletic coaches sessions on various health and wellness topics. There were over 500 people that attended the conference.

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

Goal/Objective:
Increase the opportunities for 175 youth to build positive connections with others through weekly TOP peer meetings and participation in 20 hours of community service learning.

Significance of ESM 9.4:
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. The program addresses risk and protective factors that contribute to various adolescent health outcomes, such as teen pregnancy, sexual activity, substance abuse, bullying, mental health, and academic performance.

ESM 9.4 Progress Summary:
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 SEL skills through lessons, a weekly supportive peer group environment, and community service learning.

For the 2022-2023 school year, three local partners (Davis County, Weber-Morgan, and TriCounty Health Departments) implemented the program at nine sites, including schools and other youth-serving organizations. 138 youth participated and completed over 1,300 hours of community service.

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 Utah filings for the Earned Income Tax Credit.

Goal/Objective:

Increase the number of Utahns filing for the federal EITC.

Significance of ESM 9.5:
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, local regulations, 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 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 fail 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.

VIPP 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. We saw a huge uptake in EITC filings since last year. While we would like to take the credit for that, stimulus money played a big part in an increase of tax filings.

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 9.6:
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 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., 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.

VIPP is a member of the Utah Suicide Prevention Coalition and will continue to use partners from that coalition to advertise the availability of QPR training.

ESM 9.7: Number of parents who participate in the Families Talking Together intervention

Goal/Objective:
Increase the number of parents participating in the Families Talking Together intervention.

Significance of ESM 9.7:
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 MCH in reaching parents more broadly in communities across the state.

ESM 9.7 Progress Summary:
This is a new ESM, which replaces ESM 9.1. Work was already being done in FY 2022, and the program was able to enroll and train 112 parents in Families Talking Together.

State Priority Area: School Lunch

SPM-3.0: Percent of eligible students enrolled in the free or reduced price lunch program

Annual Report FY22:

This Performance Measure was achieved. The Performance Objective was 50% and the Annual Indicator was 86.1%.

Program Activities:

LHDs helped promote school meals by collaborating with community organizations such as the Women, Infant and Children program (WIC), Department of Workforce Services, community partners, and Local Education Agencies (LEA) to provide families with information about all of the school meals that are offered at school.

Start Smart Utah is an initiative promoting the expansion and availability of breakfast for Utah children. The main goal is to empower community leaders, school leadership, educators, and parents to provide kids with breakfast every day. With accessible breakfast to fuel kids, we fuel their learning. LHDs encourage LEAs to adopt best practices such as breakfast in the classroom, grab-n-go breakfast, and second chance breakfast.

LHDs also provided materials, resources and support to encourage students to eat school meals during national school breakfast and lunch week. These efforts have helped strengthen the relationship between the health department and schools.

The State and LHDs 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:

Two legislative actions have affected access to school meal programs:

- Utah Code 53G-9-205.1 Start Smart Utah Breakfast Program: This legislation requires all Utah schools operating the National School Lunch Program to also begin operating the School Breakfast Program by May 2023. Additionally, schools with 70%, 50%, and 30% free and reduced percentages will be required to provide an Alternative Breakfast Service Model, defined as service after the start of the instructional day begins, over the next 3 years, consecutively.
- Utah Code 32B-2-304 School Meals Program Amendments: This legislation allows state Child Nutrition funds to be used for reimbursement in meal programs outside of lunch, such as the School Breakfast Program. Prior to Utah Code 32B-2-304, these funds could only be used for lunch meals. This means, in future years, state reimbursement amounts may drop for lunches and the start of state reimbursement rate for breakfasts or other child nutrition programs.

LHDs continue to promote school meals within WIC, SNAP, double-up food bucks as well as food pantries and other government assistance programs. Many have created brochures that are shared by CHW's at community events and school districts for their use.

These programs focus on the targeted population and will help provide services and programs as needed.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-3.0:

- Continue working with other government agencies to increase the number of families that participate in school meals. Offer services to families that need help with school meal applications. (July 1st, 2023 - June 30th, 2024)
- Work with LEAs to adopt the Utah State Board of Education Health and Wellness Model Policy. Provide training and technical assistance to LEA to create health and wellness teams, policy and implementation. (July 1st, 2023 - June 30th, 2024)
- Work with LEAs to strengthen Local Wellness Policies that promote student wellness, prevent and reduce childhood obesity, and provide assurance that school meal nutrition guidelines meet the minimum federal school meal standards by using the WellSAT tool to assess current policies. (July 1st, 2023 - June 30th, 2023)

Challenges / Gaps / Disparities Report:

Challenges: Employment became a challenge for the workforce during and after the pandemic. Hiring, training, and sustaining qualified individuals have made it difficult for LHD and LEAs to build trust between the two organizations. Local school boards' processes and procedures can also be daunting and time-consuming for LHD staff. LHDs face political issues and lack of coordination and trust between LEAs, LHDs, and community based organizations.

Because of the pandemic, all students received school meals from 2020-2022. In October 2022, USBE advised us that data will only be available for income eligible students. This is the reason that the percentage participating increased from 2021 to 2022. Moving forward, our reporting will reflect the estimated percentage of eligible children who participate in school meal programs and have adjusted our targets accordingly (at or below 130 percent of the federal poverty level).

Emerging issues: Food Nutrition Services administers the child nutrition programs (CNP) in partnership with the State Board of Education, local School Food Authorities (SFA), other program sponsors, and local program operators. There were several operational challenges for institutions that operate or administer child nutrition programs, including state agencies, SFAs, and Summer Food Service Program (SFSP) sponsors. The operational challenges include but are not limited to supply chain disruptions, food costs, and labor shortages. Access to a timely and reliable source of data on these topics has become particularly important following the COVID–19 pandemic. In addition to changing the ways that school meal programs operated, the pandemic has contributed to lasting supply chain issues and substantial changes in the cost and availability of food and labor.

Agency Capacity / Collaboration Report:

Building relationships with the community has multiple benefits. During the pandemic, LHDs around the state were able to brand their health departments by providing services in their local jurisdictions in a variety of ways. LHDs were able to gain name recognition and a positive reputation. LHDs informed the community of local events and community resources, which enhanced their organization's credibility.

LHDs were able to develop partnerships with community organizations and agencies. They offered referrals to community organizations such as connecting families/consumers to WIC and SNAP services, school and community food pantries, school meals, and other services that promote health and wellness to families. They coordinated events, publicized information, and invited representatives of community organizations and agencies to attend and

participate in events and workshops.

The key to creating reciprocal relationships is to build mutual respect and appreciation for the common goal of providing the best experiences and resources for the community. LHDs and LEAs need parents and families to support schools and contribute in meaningful ways to the planning and implementation of programs and events. Family members also provide insight into the families' diverse cultural, linguistic, structural, and economic backgrounds.

Adolescent Health - Application Year

Priority Area: Mental Health

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

Annual Plan FY24:

The Violence and Injury Prevention Program (VIPP), the Healthy Environments through Active Living program (HEAL), and the Adolescent Health Program (AHP), will continue to use MCH funding to implement primary prevention activities shown to reduce the risk of bullying. Strategies to prevent bullying in FY24 will include:

Proposed Activities:

- Policy support: VIPP will continue to advocate for anti-bullying policies and procedures that clearly define what bullying is and how it will be addressed and
  continue to participate on the SafeUT Commission.

- Increasing positive relationships: VIPP will continue to work on economic instability, specifically through raising awareness of the federal Earned Income Tax Credit and child care tax credits, especially to populations who are disproportionately affected by poverty or populations who are shown to qualify for the credit but have lower rates of filing. Program staff will also work to connect these families with free tax-filing services.

- The Adolescent Health Program will continue to offer the Families Talking Together program for parents and Wyman's Teen Outreach Program (TOP).

- Increasing family, school, and community connectedness: VIPP will promote the connectedness toolkits to LHDs and other partners implementing primary prevention programs. VIPP will present the information among Utah's community partners.

- The HEAL program will work with schools to increase physical activity.

- Increase conflict resolution skills: Children who have skills in conflict resolution and problem-solving are less likely to engage in bullying behavior and are better equipped to resolve conflicts in a peaceful and respectful manner.

- VIPP will continue to offer the Upstanding program and provide funding to LHDs and other community partners to implement the program. Development of a digital delivery method for the program is also in progress.

- Increase awareness and education: VIPP will provide training for school staff, parents, and students on how to recognize, prevent, and respond to bullying through the Question, Persuade, Refer (QPR) and Mental Health for First Aid programs.

- Work with the LGBTQ community to develop a connectedness toolkit specifically for LGBTQ adolescents. This toolkit will provide guidance to individuals, families, schools, and communities on how to create a culture

of connectedness for LGBTQ youth within the home, school, and broader community by increasing understanding of the importance of fostering enabling environments that allow LGBTQ youth to thrive.

Table 15: Logic Model for National Performance Measure 9

NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others			
Goal: Decrease the percent of adolescents, ages 12 through 17, who are bullied or who bully others			
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Federal funding	Collect and dissemination of data on bullying and risk factors for bullying and suicide	Number of Utahns trained in suicide prevention	NPM 9: Decreased rate of bullying	NOM 16.1: Decreased adolescent mortality rate
Public health and evaluation expertise and guidance	Increase positive relationships for children	Number of youth participating in the Wyman Teen Outreach Program (TOP) and Bystander intervention	Increased positive relationships	NOM 16.3: Decreased adolescent suicide rate
Technical assistance on policy and program development	Increase family, school, and community connectedness	Number of connectedness toolkits distributed	Fewer numbers of poor mental health days	Improved health equity among underserved groups and those disproportionately affected by the suicide epidemic
Partners/Stakeholders	Strengthen household economic security through an uptick in Utah filings for the Earned Income Tax	Number of Utahns reached by EITC Awareness campaigns	Improved economic stability for Utahns	
Access to data sources	Increase conflict resolution skills for adolescents	Number of students who are physically active		
Assumptions and Contextual Factors: If parents, youth, and schools are engaged in various prevention strategies the rate of bullying among adolescents in Utah will decrease. This will lead to lower adolescent mortality and suicide rates.				

State Priority Area: Economic Stability

SPM-3.0: Percent of eligible students enrolled in the free or reduced price lunch program

Annual Plan FY24:

HEAL will use the Whole School, Whole Community, Whole Child Model as the framework for the strategies and activities that will be implemented at the state. HEAL will work with organizations such as the Utah State Board of Education (USBE), Child Nutrition Program (CNP), Society of Health and Physical Educators (SHAPE) Utah, School Nurses Association, Action for Healthy Kids (AFHK), Get Healthy Utah, School Nurses Association, and other partners to educate and disseminate professional development and technical assistance to Local Education Agencies (LEA). HEAL will strive to incorporate members from diverse organization and backgrounds, including but not limited to: LEA staff, parents, local health departments (LHDs), local governments, representatives from the American Indian/Alaska Native Family Health and Family Services, community members with diverse racial and ethnic backgrounds, and those living in an underserved and underrepresented community. HEAL will work with LEAs, LHDs and other state agencies to build and establish a statewide school health team to provide guidance, support, and technical assistance (TA) to implement strategies that support the Whole School Community Child (WSCC) with an emphasis to increase school meals.

Proposed Activities:

- Provide professional development and technical assistance using to disseminate and support implementation of evidence-based school health guidance, strategies, tools, and resources across the state. These could include WellSAT, WSCC, creating school health councils, local wellness policy, school health index, and many other tools.
- Work with LEAs to strengthen local wellness policies that promote student wellness, prevent and reduce childhood obesity, and provide assurance that school meal nutrition guidelines meet the minimum federal school meal standards by using tools such as a WellSAT to assess the policies,
- Provide technical assistance, best practices, and resources to school's food authorities to implement innovative service models to make breakfast and lunch more convenient and appealing to students. Work with other state agencies and departments to streamline services to families. LHDs will 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.
- Educate and encourage LHDs and LEAs to participate and attend 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.

Table 16: Logic Model for State Performance Measure 3

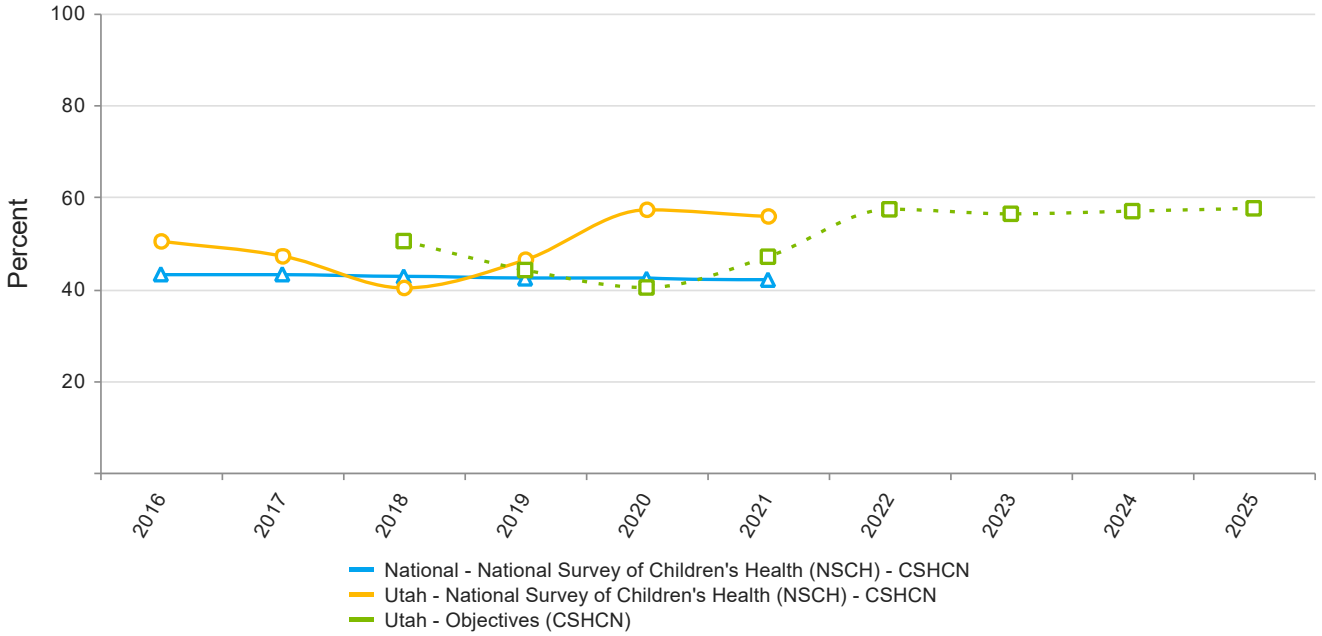
SPM 3: Percent of students enrolled in the free or reduced price lunch program				
Goal: Increase the percent of eligible students enrolled free or reduced price lunch programs				
Inputs	Activities	Outputs	Outcomes	Impacts
Funding	Collaboration with USBE, local educational agencies (LEA) to coordinate programing and services that promote school meals	Increase the opportunity to attend training and receive technical assistance	Cohesive relationship between organizations	SPMs are not tied to specific SOMs or NOMs. However, it is reasonable to assume that this work will impact NOM 19: overall health status
Collaboration with USBE child nutrition program (CNP)	Coordinate with USBE CNP and LEAs to asses compliance with the local school wellness policy	Ensure that assessment results are available to the public.	Increased number of comprehensive local school wellness policies	Implementation of evidence-based strategies to increase healthy behaviors
Technical assistance and support	Provide training and guidance to LHD on how to use WellSAT 3.0	Quantitative data to improve local School Wellness Policy	Increased comprehensive local school wellness policies	School meal participation increases Comprehensive local wellness policies. Increase in school meal programs.
Assumptions and Contextual Factors: If students participate and consume school meals, they will have access to healthy food options. Those students that qualify for free and reduced meals should have the opportunity to receive at least two healthy meals throughout the day. Establishing school meal programs with all students will help foster the overhead costs and ensure that meals are health and taste good.				

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	50.4	44.1	40.3	47	57.3
Annual Indicator	47.2	40.2	46.4	57.2	55.7
Numerator	68,219	59,263	69,395	83,681	87,339
Denominator	144,415	147,327	149,671	146,181	156,906
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	56.3	56.9	57.5

Evidence-Based or –Informed Strategy Measures

ESM 11.2 - Percent of children with special health care needs population served by the Office of CSHCN 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	2022
Annual Objective			94.5	97
Annual Indicator	0	94	97	96.8
Numerator		614	426	91
Denominator		653	439	94
Data Source	CSHCN EMR or comprehensive database	CSHCN Electronic Medical Record	CSHCN EMR or comprehensive database	CSHCN EMR or comprehensive database
Data Source Year	2020	SFY 2021	2021	2022
Provisional or Final ?	Provisional	Final	Final	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	97.5	98.0	98.0

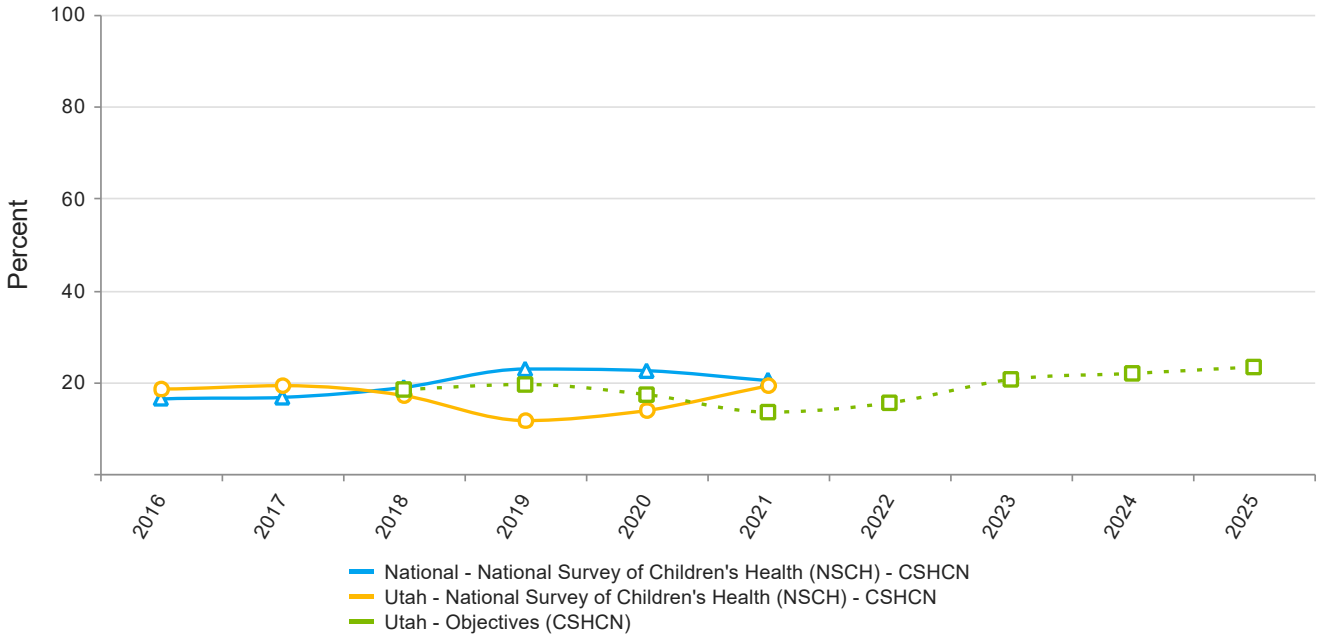
ESM 11.3 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of the medical home.

Measure Status:	Active

Baseline data was not available/provided.

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	18.4	19.5	17.3	13.5	15.5
Annual Indicator	19.3	17.1	11.5	14.0	19.2
Numerator	12,760	13,378	8,906	10,487	16,766
Denominator	66,028	78,194	77,434	75,107	87,157
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	20.6	21.9	23.3

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:	Inactive - Robust partnerships have been fostered between the Utah Department of Health and Human Services and several community partners including two hospital

State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Stakeholder work group survey.	Stakeholder work group survey.	Stakeholder work group survey	Stakeholder work group survey
Data Source Year	2020	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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	2022
Annual Objective			63	73.9
Annual Indicator	0	62.4	74	95.7
Numerator		552	347	377
Denominator		884	469	394
Data Source	Stakeholder work group survey	ISP electronic medical record, Utah Parent Center	ISP electronic medical record, Utah Parent Center	ISP electronic medical record, Utah Parent Center
Data Source Year	2020	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			0	70
Annual Indicator	0	0	66.7	71.4
Numerator			8	10
Denominator			12	14
Data Source	Stakeholder work group survey for transition	Stakeholder work group survey for transition	Stakeholder work group survey for transition	Stakeholder work group survey for transition
Data Source Year	2020	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	73.0	74.0	75.0

State Action Plan Table

State Action Plan Table (Utah) - Children with Special Health Care Needs - Entry 1
Priority Need
Family and provider connectedness, Medical Home, and 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 57.5%.
Strategies
1. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah.
2. CSHCN Office 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. Work group review and utilize Baby Watch Early Intervention Program tele-intervention cost study data to assess the benefits and challenges with utilizing virtual platforms for services.
6. Workgroup encourages providers to incorporate the seven components of a medical home after being trained through online learning modules or other educational media.
7. Work group collect data on pediatric Medicaid providers who utilize telehealth and survey those providers to assess capacity, barriers, and best practices.
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 11.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.	Inactive
ESM 11.2 - Percent of children with special health care needs population served by the Office of CSHCN who have documented care coordination follow up as part of a medical home model of care.	Active
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.	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 23.3%.

Strategies

1. CSHCN Office 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. 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.

4. Ensure that youth of transition to adult healthcare age who receive services funded by Title V are offered care coordination and transition education.

5. ISP Transition Specialist to offer transition planning to target diagnosis groups within the Birth Defect Network registry.

6. ISP team to provide consultation, care coordination, and transition planning and support for homeless youth in Salt Lake City.

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.	Inactive
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 FY22:

This Performance Measure was NOT achieved. The Performance Objective was 57.3% and the Annual Indicator was 55.7%.

Program Activities:

The Medical Home Committee has been meeting monthly since February 2021 to mirror work being done by the Transition subcommittees. Alignment with the Transition work plan was a logical choice to (1) organize and evaluate existing evidence and educate providers, families, care coordinators, and other partners on the importance of the medical home; (2) research best practices to educate the public on the importance of participating in a medical home; (3) continue to evaluate and select 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 to incorporate components of the medical home into their practices; and (6) market to and educate pediatric providers on care coordination support available to them through the Integrated Services Program (ISP) 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 and began negotiations with the University of Utah to establish a new five-year contract beginning in FY23. Medical Home Portal staff began attending Integrated Services Program (ISP) team meetings once a month to provide ongoing training and solicit feedback and input for both directory and content. The ISP team, which includes care coordinators from four local rural health departments, attended the monthly UCCCN training and information sessions and contributed to statewide group knowledge both through formal presentations on Medical Home, care coordination principles and practices, Title V, transition to adult healthcare, and provided solutions and resource links for care coordinators seeking help with challenging cases for CYSHCN in their respective practices and communities. The ISP program manager is actively involved each month with the planning team for the monthly UCCCN meetings, and helps to develop the agenda and survey and membership activities. ISP continued to fund a portion of family advocacy and leadership activities through the Utah Parent Center/ Utah Family Voices.

The ISP Program Manager participates in weekly care coordination activities with the University of Utah Developmental Assessment Clinics through their patient case conferences, and many patients are subsequently referred to ISP care coordinators to help families connect with supports, services, and specialists. With preliminary work being done on the consolidation between the Utah Department of Health and the Department of Human Services, ISP staff met with and coordinated services for CYSHCN with Coordinated Care and Regional Supports, Wraparound Services, the Division of Child and Family Services (DCFS), Juvenile Justice and Youth Services, Office of Substance Use and Mental Health, and Child Protective Services.

Collaboration continued within our CSHCN Office with Early Hearing Detection & Intervention (EHDI), Fostering Health Children, Utah Birth Defect Network (UBDN), and Autism Systems Development, and Early Intervention. Our MCH partners included Home Visiting, WIC, and Maternal Mental Health.

Accomplishments / Successes:
Although the FY22 performance measure was not achieved, Utah's rate of 55.7% of CSHCN having a medical home compared to 42.0% in the U.S. overall from 2020 to 2021, ranks Utah as the highest in the nation. Specifically, Utah performed better than the U.S. in the usual source of care component, at 80.6% compared to 73.4%. Within Utah, the components of family-centered care (87.1%) and referrals if needed (90.2%) had the highest prevalence.

In FY22, ISP was well on its way to providing direct clinical services and care coordination through remote technology, and was also able to add in limited live consultation with the Attending Physician or Registered Nurse (APRN) and psychologist when needed. The program's clinical staff including the APRN, psychologist, occupational therapist (OT), and speech pathologist were scheduling and coordinating services with families through both in-house and rural care coordinators via the four contracted local health department sites.

With a great need statewide for autism evaluation and diagnosis, ISP clinical and care coordination staff were faced with the challenge of scheduling multiple virtual visits with families to create an acceptable diagnostic report to ensure both public and private payers would cover the costs for evaluation and diagnosis and subsequent therapies based upon that diagnosis but performed in a virtual, not physical world. Diagnosing autism and other developmental disabilities is time consuming even in the best of circumstances, and it became even more so in an almost virtual environment. However, the team rose to the occasion by problem solving on the fly when technology went askew, school testing or parent reports had not been submitted or other incidental events occurred that might delay evaluation or diagnosis. Ultimately, the ISP team ensured family needs were met with the least amount of disruption to service possible.

Unfortunately, the ISP psychologist left in January 2022 to take a position with another organization, and the position remained unfilled after several nationwide attempts to recruit. Ultimately, ISP was unable to provide in-house behavioral health diagnosis. Fortunately, we were able to partner with a private entity in Northeastern Utah, who has worked with our team to see rural families for autism evaluation, and has provided testing and evaluation appointments specifically for our rural patients. Virtual visits for both evaluation and diagnosis for not just autism, but other developmental delays, allowed the ISP team to meet families where they are and at times that are convenient for them without additional travel costs, time lost from work and school, and most often in a home environment comfortable to the child, should families choose virtual instead of a live visit.

In FY22, the ISP team provided a combined total of 2,825 patient encounters to 553 unique patients. The work of the ISP team, from care coordination to the consultative role of the APRN for developmental pediatric support, enhances the medical home particularly in rural communities where often pediatric offices are sparse or do not exist and the local family practice providers may have limited experience with the CYSHCN population. Frequently, rural community health care providers have a small staff unable to provide the level of coordination required by young patients with more complex needs. The Medical Home Committee met monthly to set priorities for NPM 11, and worked to expand the reach of the medical home through the activities outlined in the previous section. The monthly UCCCN meetings and listserv have been utilized as forums to reach and educate care coordinators and practice managers and share best practices such as care plans, CSHCN registries within the practice, and care notebooks; strategies such as motivational interviewing; community, statewide, and national resources; and peer-to-peer support.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-11:

- Utah is ranked first in the nation, with 55.7% of CSHCN having a medical home compared with 42% in the U.S. overall. (NSCH 2020-21 combined data set)
- Utah performed better than the U.S. in the usual source of care component for CYSHCN at 80.6%

compared with 73.4%. (NSCH 2020-21 combined data set)

- Families of CYSHCN in Utah indicate a high level of receiving family-centered care and referrals as needed at 87.1% and 73.4% respectively. (NSCH 2020-21 combined data set)
- The ISP team delivered supportive care and care coordination to 553 unique patients through 2,825 patient encounters.

Challenges / Gaps / Disparities Report:

FY22 continued without a pediatric psychologist on the ISP team and a shift in how ISP served CYSHCN families with direct behavioral health needs, including autism evaluation and diagnosis. The pediatric psychologist role had been open since January 2022, with no applicants even after a nationwide search. Unfortunately, unless families have $1500-2500 cash in hand, the wait for an autism evaluation billed through commercial insurance or Medicaid, from behavioral health providers affiliated elsewhere, could be up to six months. Often, receiving Applied Behavioral Analysis (ABA) therapy or enrolling in other therapeutic services post-diagnosis, if available at all in rural or frontier communities, may also have a significant delay. With no apparent in-house psychological provider option, the team chose to give support to our CYSHCN population through our APRN, OT, and speech pathologist while families waited pre- and post-diagnosis.

While not a perfect solution, families were given some home-based strategies to curb or re-train undesired behaviors. The APRN was able to consult with local rural providers with limited CYSHCN experience to help with medication management as warranted. With more families and children immunized for COVID-19, FY22 also found many families seeking more traditional face-to-face services instead of telehealth; however, this could add time onto a family's wait for a diagnosis when a telehealth visit may be more readily available.

Utah's most rural local health department lost a care coordinator in August and was unable to fill the position until December. The combined ISP team, both in-house staff and the remaining three LHD care coordinators, provided continuity of care for the families in the area, yet not with the same impact that comes with local knowledge of community resources, customs, culture, and connection.

The lack of behavioral health providers including psychologists, licensed clinical social workers, and behaviorists continues to be a problem across the State, and even more so in rural and frontier areas. Families have long wait times to get appointments for behavioral health and insurance payments can be a challenge. In Utah, behavioral health is a "carve out" service that is contracted by Medicaid with a particular agency in each area of the state. Families on Medicaid must use that service in their area, or be referred by that agency to another organization, if available, that can support the family's needs. However, many rural communities have no behavioral health support other than the Medicaid contracted agency, which creates a wait time for appointments.

In late 2020, CSHCN received a grant to purchase Chromebooks and remote hotspots that were placed in four local health departments, the ISP office in Ogden, and the Utah Parent Center. Although initially received with great fanfare, and after much notice of their availability, use was not as robust as anticipated. The families that utilized the technology were grateful for the loaned equipment, but many who could have benefitted and knew of the service did not take advantage. Additionally, in the most remote parts of the state where cell coverage is sparse or non-existent, hotspots are unusable where there is no cell tower close enough to send a signal.

Emerging opportunities: The merger/consolidation between the Departments of Health and Human Services, effective July 1, 2022, had many of the staff involved in workgroups and committees to help foster change, reduce redundancies, and create a more efficient workplace. However, there remained an uneasiness with what the overall

consolidation would bring, and many questioned where their current programs would align with a new office, division, manager, or other leadership. A general fear of the unknown was pervasive, and some distrust prevailed. CSHCN and ISP felt slightly more reassured when the current CYSHCN Director was appointed as the new Division Director of Family Health. Other partner organizations also felt an unease not knowing how contracts, alignment with programs, current projects, and other tangibles would be affected.

The COVID-19 pandemic helped contribute to a nationwide workforce accustomed to working from home. This meant that many qualified, often licensed or credentialed professionals could live in one state, and work in another. However, to work for the State of Utah, an employee must reside in-state. Given this mandate, many positions for which we posted, such as our ISP psychologist, were difficult, if not impossible to fill, as many qualified in-state candidates could find better paying jobs out of state.

Interestingly, though, this brought about new opportunities, both within ISP and how jobs are posted and hired within State employment. Within ISP we had to look for more creative ways to provide psychological care to our families utilizing our community partners. This has strengthened our partnership with those organizations and demonstrated the ongoing tenacity and ability to change and update programs and systems as policy, procedure, and circumstances often dictate, frequently on the fly.

Children with special health care needs who lived in households where the highest level of education was a college degree were more likely than others to have a medical home (62.1%), compared to those where high school (49.2%) or some college (45%) was the highest level of education. We did not find any other significant disparities with our review of available data. Based on Federally Available Data, Utah is ranked first in the nation, with 55.7% of CSHCN having a medical home compared to 42.0% in the U.S. overall from 2020 to 2021. Specifically, Utah performed better than the U.S. in the usual source of care component, at 80.6% compared to 73.4%. Within Utah, the family-centered care (87.1%) and referrals if needed (90.2%) components had the highest prevalence. However, CSHCN with two or more Adverse Childhood Experiences (ACEs) were less likely than one with either one or no ACEs to have a medical home. CSHCN who live in homes with a single parent (39.1%) were also less likely than those in homes with two-parents (59%) to have a medical home.

Agency Capacity / Family Partnerships / Collaboration:
The CSHCN Office 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. In FY22, the Office was presented with even greater opportunities to partner with sister programs in the Department of Human Services that would eventually be part of a combined Health and Human Services. The Office has enjoyed successful and cooperative collaborations with many local health departments, including the four that partner with the ISP. Many of these organizations, including the local health departments, 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 to adult healthcare. The newly formed Office of Early Childhood houses both Early Childhood Utah and the Home Visiting Programs, both of which affiliate and collaborate with many of the same players, and ISP is working with them to facilitate early childhood care coordination through a newly funded grant their Office received.

The ISP manager meets weekly with the providers and staff at the University Developmental Assessment Center to provide guidance and support for the CSHCN they serve and accept referrals for care coordination within ISP. 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 five, and is currently the chair of one of its subcommittees. He also meets monthly with the Office of Substance Use and Mental Health to coordinate pediatric and youth efforts for CYSHCN.

Report on ESMs related to NPM-11

ESM 11.2: Percent of children with special health care needs population served by the Office 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 office supported care coordination.

Significance of ESM 11.2: Emphasizing care coordination has been recognized by the 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 11.2 Progress Summary: All children and youth with special health care needs referred to the ISP 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 a 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 that 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.

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 FY22:

This Performance Measure was achieved. The Performance Objective was 15.5% and the Annual Indicator was 19.2%.

Program Activities:

The formative work that had taken place in the various CSHCN-sponsored inter-agency transition subcommittees (Marketing, Quality Improvement, Curriculum, and Referral and Follow-up) was consolidated into a single Transition Committee in October 2021. This allowed the combined group to meet once a month to further work on progress and focus on strategizing with our partners. Work on transition continued statewide with robust interagency partnership and increased collaboration to align efforts across public and private health systems, and social and support systems and networks.

With the GotTransition curriculum selected, and continued technical assistance from The National Alliance to Advance Adolescent Health through an agreement with Intermountain Health (IH), the statewide effort felt more unified as everyone sought to deliver the same message to providers, the public, our families and youth. Both CSHCN and IH began discussions with the Medical Home Portal to consolidate transition-related information on one site, including Utah-specific resources, the Provider Toolkit, and the sample transition policy for practices, along with resource links to information and support. ISP began discussions with the UBDN to see how we could reach target populations in their registry that were within transition age, and began work on a data sharing agreement to do so. The ISP Transition Coordinator continued outreach efforts to former CSHCN patients in the electronic health record who were approaching the upper end of the transition period (ages 17-18) to offer transition assistance.

Transition University, through the Utah Parent Center, a comprehensive 101 of all things transition, including health care, began offering their courses both virtually, and then on the road in several rural communities; and a companion workbook vetted by youth was being distributed. The third annual Transition to Adult Health Care Summit was being planned by the multi-agency planning committee, with an October 2021 save the date on the calendar.

Accomplishments / Successes:
In reviewing FY22, the most salient success and marker of progress for transition to adult living in Utah is the buy-in and vested interest in promoting transition guidance and support from many public and private sectors that have a profound impact on youth lives. These are state and local educational systems; public, physical, and behavioral health systems; social service and supportive systems; parent support groups; public and commercial third-party payers; and many others. These disparate groups have been able to join various committees, work groups, and forums to dialogue, collaborate, problem solve, produce tangible products and messaging, and create common goals to build a united front to support our youth through this challenging time.

Previously, transition work felt disjointed at many levels. Each of the stakeholders had been working on their own mission- and grant-driven transition work, and working hard, but not as effectively, and with a limited niche or reach. Working together has allowed organizations to braid funding; create a standard data dictionary or vernacular for the many facets of transition; share best practices; seek ways to break down barriers for sharing data between

organizations; and understand how each part of transition is important and interconnected. We have more awareness of what each other does, and are better able to refer youth and families to one another, which serves their best, interest, and ultimately, establishes best and replicable practices and produces quantifiable and qualifiable data. This contributes to the “no wrong door” approach we are building through consistent messaging. The ultimate takeaway is that together we are stronger.

The Transition Committee continued to meet monthly to plan, evaluate, and promote transition activities across the state in conjunction with our partners and stakeholders. The ISP Manager and CSHCN Office Director continued to meet with the Intermountain Teen to Adult Healthcare Governance Committee each month, and were part of the Teen to Adult Healthcare Summit Planning Committee. The Third Annual Health Transition Summit was held in October 2021 in a hybrid live/virtual environment with several panel discussions from clinics that have implanted transition policies and procedures into their practices; family and parent perspective; and participant question and answer sessions. Once again, reviews indicated that these summits are needed, valuable, and should be ongoing.

Transition University through the Utah Parent Center (UPC) was able to continue their transition series virtually, then take it on the road to several rural communities where it was felt live interaction may be the best option. As with all things produced by UPC, Transition University is well received by parents, youth, and health and community providers. Planning sessions were underway with multiple partners to develop a four-session Transition to Adult Health Care Pediatric ECHO (Extension for Community Healthcare Outcomes) series that was set to begin in September 2022. IH hired a Teen to Adult Healthcare Transition Program Manager in May of 2022 to unify efforts across both pediatric specialty and primary care clinics in the IH system and to encourage more practices to adopt transition policies and procedures into their workflows. The ISP team also attended virtual transition/agency fairs through two school districts to offer care coordination and support for transition to adult health care activities.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-12:

- The concept of transition to adulthood took on a unified front throughout the State with increased visibility across multiple sectors. (July 1st, 2021 - June 30th, 2022)
- The Transition Committee continued to meet monthly to plan, evaluate, and promote transition activities across the state in conjunction with our partners and stakeholders. (July 1st, 2021 - June 30th, 2022)
- Transition University, through the Utah Parent Center, provided both live and virtual courses for families and youth on all facets of adult living, including the transition to adult healthcare, with a focus on the youth with special health care needs population. (July 1st, 2021 - June 30th, 2022)

Challenges / Gaps / Disparities Report:

The concept of transition to adult healthcare is expanding across practices, albeit slowly. The clinics and organizations that tend to fare well and move more quickly along the policy to implementation trajectory are those who have a “champion” in the practice at a management or otherwise influential level, and multiple staff who are trained and can cross-cover for each other when a transition-aged patient is in the office. There are still practices where one or both of these is missing, and progress or even initiation is nonexistent. It is thought that institutional standardization may help, such as in the case of IH, with the implementation of a formal transition program manager and staff to support reluctant or reticent clinics.

Although we continue to meet, plan, evaluate, re-evaluate, and implement strategies across systems, it is still evident that one size does not fit all for tracking data on youth transition, whether that is public health; specialty care; pediatrics; behavioral health; or social services. Gathering data at any point in time is a challenge for everyone. As we continue to meet in committees and work groups, this continues to be a point of discussion to seek and replicate

best practices. Initially, we anticipated we might create a statewide transition tracking system, however, we gave up that idea early on, as we realized that yet another database with the accompanying data entry would be cumbersome. Most organizations want a single point of data entry that allows multiple ways to pull data from a patient encounter, student Individualized Education Plan, training, or other youth development event.

Family care capacity continues to be a very real concern. COVID has affected not only children and youth and their accompanying mental health and lack of coping mechanisms and strategies, but also their parents and caregivers. The adults in our youths' lives are often the products of adverse childhood experiences themselves; may lack financial stability; work multiple jobs and have limited time to spend with their child/youth; have a fundamental lack of knowledge of how educational, health, social, and other systems and infrastructure work and interrelate; and a general inability to take on "planning for the future", when daily subsistence is tough. This limited capacity to support and guide their transitioning youth may mean that the only times the youth hears about or practices transition to adult healthcare is in the health or social service provider's office. Overall, keeping families motivated on the transition journey can be a difficult ask from care coordination and transition support staff.

ISP faced two challenges in FY22: slow movement internally for approval of a data sharing agreement (DSA) between the UBDN and ISP to begin to contact youth of transition age in the UBDN database to offer support and guidance from the ISP transition specialist; and the loss of our full-time transition specialist due to job transfer out of state. The DSA process took much longer than anticipated. Ultimately, by the time we had a fully approved DSA, our full-time transition specialist moved out of state, ISP program revenue shifted to cover other expenses, and we brought on a 0.50 FTE transition specialist who is shared with another program in another role. With one-half the staff now available, outreach and capacity were greatly diminished.

We also found that one of our historical mainstays for reaching families about care coordination including transition to adult healthcare services was school district transition fairs, where families are able to attend and meet vocational, recreational, educational, healthcare, and social service organizations that support youth post-high school. Pre-COVID, these had been live events. In FY21, almost none were held. In FY22, several were held virtually. However, many organizations, ISP included, found that virtual events were poorly attended. Given the paucity of attendance, many potential beneficiaries of ISP support were missed.

It has been challenging at the Office of CSHCN, and particularly our work on transition to adult healthcare, to include youth voice. Our current challenge is to not create yet another youth board, but rather tap into an existing and well-functioning board and request their input, view, voice, and lived experience on our work. Some possibilities include the youth advisory board at the Utah Parent Center and existing youth boards through the Office of Substance Use and Mental Health at DHHS.

We are concerned about the end of the COVID-19 public health emergency on May 11, 2023, and the ramifications that may accompany it, as many previously qualified individuals will fall off of public assistance including Medicaid. We have worked with our existing families to encourage them to read all correspondence from Medicaid, comply with any requests, complete forms, and, if necessary, reach out to us for support in complying.

Disparities: Utah currently ranks 38th and 47th in the nation for CSHCN and non-CSHCN (respectively) adolescents who receive services necessary to make transitions to adult health care.

Agency Capacity / Family Partnerships / Collaboration:

Collaborative partners included the Utah Parent Center, Utah Family Voices, Medicaid, Social Security Administration, Utah State University Center for Persons with Disabilities, Division of Services for People with

Disabilities, Utah State 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. ISP is actively partnering with several sister programs in the former Department of Human Services: Juvenile Justice and Youth Services; Division of Child and Family Services, including Child Protective Services; Wraparound Services that work to keep youth in home and out of state custody; Youth Empowered Solutions for Success; and the Office of Substance Use and Mental Health through their pediatric and youth service administrators.

The Utah Children's Care Coordination Network and Medical Home Portal provide training and support for care coordinators and family partners from a variety of private provider offices and healthcare organizations in the state and include topics of transition to adult healthcare, motivational interviewing, and working with youth. ISP and the CSHCN Office participate with the Utah State Board of Education in their statewide transition work and serve on their advisory board and various sub-committees. The CSHCN Office also actively works with IH's Teen to Adult Healthcare Governance Committee that meets monthly to promote transition and recruit and train healthcare providers in a standardized transition curriculum, and are involved in the planning and execution of the annual Teen to Adult Healthcare Summit.

Report of ESMs related to NPM-12

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 adult health care.

Goal/Objective: Youth and adolescents with active transition plans will be more likely to complete the steps for successful transition to adult health care.

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.

ESM 12.1 Progress Summary: This was a new ESM from FY21. Robust partnerships have been fostered between the Utah Department of Health and Human Services and several community partners including two hospital systems to continually assess, develop, market, and implement a universal process, statewide, for transition to adult medicine; however, it has been difficult to reach consensus. For this reason, the program would like to deactivate this ESM, but will continue to work with stakeholders on developing a method for evaluating the success of transition plans for youth and young adults. Work will continue in FY24 to determine whether a "standard" survey instrument is the best way to measure, or if an "exit interview" developed by each clinic may be a better alternative, with each clinic reporting statistics on patient satisfaction and skill development once transition to the adult provider has occurred. This ESM will be reactivated once a data collection plan is developed and solidified.

ESM 12.2: Percent of adolescents and youth with special health care needs ages 12-18 who receive 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:

ESM 12.2 Progress Summary: Transition planning numbers for FY23 were based upon statistics provided by the Integrated Services Program (Utah Department of Health and Human Services) and the Utah Parent Center/Utah Family Voices.

ESM 12.3: Percent of providers trained in transition who created a transition policy for the 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.

ESM 12.3 Progress Summary: This was a new ESM for FY21. Robust partnerships have been fostered between DHHS 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 IH 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 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17. (Track the percent of children and youth with special health care needs, autism spectrum disorder, and attention deficit disorder/attention deficit hyperactivity disorder)

Based on data collected by the Utah Registry of Autism and Developmental Disabilities URADD (Birth Years 2001-2018), 16.5% of children and youth 0-17 are Children and Youth with Special Health Care Needs.

NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system. (To ensure access to needed and continuous systems of care for children and youth with special health care needs)

The Department of Health and Human Services-Office of Early Childhood, the Department of Workforce Services-Office of Child Care, the Utah State Board of Education-Early Childhood Department, Early Childhood Utah and dozens of community-based programs such as: Help Me Grow Utah, Local Health Departments, Head Starts, Child Care Providers, Home Visitors, Early Interventionists, and Pediatric Providers are engaged in statewide efforts to facilitate early and routine developmental health screening. The tools for this project used are Brookes Publishing ASQ-3 and ASQ Social-Emotional. Children that need further assessment and/or services are connected to additional resources. When developmental delays are discovered and treated early, children have increased opportunities to arrive at school healthy and ready to learn.

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 do not need which saves parents time.

During the past grant year, the CHARM program increased by 12.2% from the previous year, the number of web portal users that have access to immunization histories, newborn hearing, and CCHD results. 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 children, parents, and providers. In addition, CHARM provides immunization information and hearing screening results to the Baby Watch/Early Intervention (BW/EI) Program via a CHARM tab in their BTOTS system. EI providers in urban and rural areas of the state can click on the tab to get this information on a child they are already looking up in their BTOTS system. The BW/EI program also shares limited IFSP information (enrollment and referral date, and EI advisor name) with the EHDI Program through CHARM. EI Providers get consent from parents to share this information with the EHDI program during in-take. The sharing of the BW/EI information continued to help the EHDI program follow-up on children they have referred to BW/EI to make sure these kids are receiving services, and timely treatment that they need, to maximize their developmental and communication potential.

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

In order to help plan resources, and determine diagnostic trends statewide ASD estimates based on a community medical diagnosis of ASD and/or an autism special education eligibility (2018) are obtained through the work of URADD.

Age	Prevalence
3	0.8%
4	1.3%
5	1.5%
6	2.0%
7	1.9%
8	2.2%
9	2.0%
10	2.3%
11	2.4%
12	2.8%
13	2.8%
14	3.2%
15	2.0%
16	3.0%
17	2.0%
18	1.4%

In response to the lack of early identification of ASD, in 2022, CSHCN contracted with Help Me Grow Utah (HMG-UT) to screen children using the Modified Checklist for Autism in Toddlers-Revised (M-CHAT R/F) and make referrals as appropriate. HMG-UT screened 176 children for autism spectrum disorder and referred 233 children to appropriate services. The M-CHAT R/F is designed for children 16 to 30 months of age. If an M-CHAT R/F is properly administered, these children can get appropriate Part-C and Part-B services. If this screener leads to appropriate testing and diagnosis, these children can enter school with an appropriate classification (General Education, 503 or Special Education).

During the past grant year, the CHARM Program partnered with stakeholders from the Utah Governor's Early Childhood Utah Commission and its Health Subcommittee on a project to make Ages and Stages Questionnaire (ASQ-3) and ASQ Social and Emotional-2 (ASQ SE-2) developmental screening results available to early care, development, health care, and education providers, as well as clinicians. This will help ensure that more effective and consistent referrals, services, treatments and interventions are provided to children with potential developmental delays. CHARM collaborated with the Utah Department of Workforce Services – Office of Childcare, Help Me Grow Utah, and the Utah Head Start Association which will all use the same ASQ developmental screening tool across their programs and share the results of those screenings through CHARM's integration system with users of: 1) the Utah Statewide Immunization Information System (USIIS), 2) the CHARM Web Portal, 3) the Baby Watch Early Intervention's BTOTS database, and 4) Electronic Medical Record (EMR) systems, including Intermountain's and a Community Health Center's system. A parent consent form was developed for those agencies utilizing the ASQ screening tool and collecting developmental screening results. A parent/guardian must sign the consent form before their child's ASQ screening results are shared. In addition, Data Sharing Agreements began to be established between the agencies collecting and sharing the data with CHARM and the programs/organizations receiving the data in their systems.

This project further expands and integrates the CHARM system with appropriate state and community databases so that better and more consistent services are provided to children and youth with special health care needs and their families. Using the same ASQ developmental screening tools will allow early care and education providers, clinicians and health providers to align efforts by sharing screening results across systems to prevent children from falling through the cracks.

Children with Special Health Care Needs - Application Year

Priority Need: Family and provider connectedness, medical home, and 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 FY24

The Office of Children with Special Health Care Needs (CSHCN) through the Integrated Services Program (ISP) will continue to fund external partners to further work related to the medical home, particularly care coordination efforts, including the Utah Parent Center; Utah Children's Care Coordination Network (UCCCN), and the Medical Home Portal; and the four local health departments with which DHHS has contracts for care coordination services. CSHCN is partnering with the 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. Surveys vetted through both the Medical Home Committee and the Pediatric Project ECHO development team will be utilized to measure learning objectives, and implementation and improvement of medical home standards including care coordination.

In conjunction with these 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. 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 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 and administer them to the families they serve to understand (1) how the practice implements components of a medical home; (2) how the practice improves and increases medical homes; and (3) family satisfaction with their medical home. Feedback on individual practices will be provided for quality improvement purposes, and overall trends will be discussed. The Medical Home Committee will look to include input, guidance, and consultation from the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) in this quality improvement initiative.

- ISP will continue to fund external partners that further the role of the medical home.
- The UCCCN will serve as an educational forum to promote care coordination and the tenets of the medical home.
- Pediatric Project ECHO will continue to provide online training sessions that include medical home principles and practices, and will survey participants to measure achievement of learning objectives.
- Through member practices of the UCCCN, the Medical Home Committee will survey families about their perceptions of medical home including care coordination services.
- The Medical Home Committee will request consultation from the UPIQ to create a quality improvement project for practices desiring to enhance their medical home model.

Table 17: Logic Model for National Performance Measure 11

NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home				
Goal: Increase the percent of children with special health care needs who receive care within a medical home				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Funding and qualified DHHS staffing: Program manager, NP, transition specialist, care coordinators, Division leadership, epidemiologists	Monthly planning meetings	Websites hosted: DHHS, Utah Parent Center, Medical Home Portal with resources and guidance	NPM 11: More CSHCN have a medical home	NOM 17.2: More families benefit from a well-functioning care system
Partners and stakeholders: Intermountain Health, University of Utah, Utah Parent Center, USBE Transition Committee, LHDs	Funding Title V Community Partners	Number of care coordinators trained	Care coordinators gain skills, knowledge, and resources	NOM 18: Increase in percent of children with mental/behavioral condition receiving treatment or counseling
Technical assistance on policy and program development	Contracting with LHDs	Number of families who receive care coordination	Fewer numbers of poor mental health days	NOM 19: Overall Health Status – Children have improved overall health status
Committees: Transition committee, IHC transition steering committee, USBE transition committee	Care coordination activities and case sharing UCCN participant surveys	Number of patients who establish a PCP and medical home	Improved economic stability for Utahns	NOM 25: Decrease in percent of children unable to obtain needed care
Access to data sources	Referrals to PCP for patients with none	Number of providers who understand components of medical home	Families benefit from comprehensive medical homes and receive needed services	
Assumptions and Contextual Factors: If care coordination is fostered statewide, families of children and youth with special health care needs will have access to a more comprehensive medical home. We assume the enhanced provision of coordinated services will be reflected in the family responses within National Survey of Children's Health.				

Priority Need: Transition to adulthood

NPM-12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Annual Plan FY24

The Office of CSHCN will continue to convene a monthly interagency Transition to Adult Healthcare meeting with a focus on curriculum dissemination, promoting standard messaging, evaluating the best way to gather patient/family experience across disparate systems, and planning ways to improve systems and collaboration statewide. CSHCN will work with stakeholders to coordinate and standardize data collection efforts to determine the 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, and Utah Family Voices to further transition to adult medicine activities. CSHCN will fund the development of educational short videos and animations through Transition University on transition-related themes to be stored on the Utah Parent Center website, and links provided to care coordinators and service providers to share with families for educational purposes.

ISP will promote transition activities in-house and with care coordinators at the four local health departments to prepare families to meet the ISP Transition Specialist so that youth and young adults may feel prepared to transition to adult healthcare. The ISP Transition Specialist will begin outreach efforts to targeted youth within the Utah Birth Defect Network registry through an approved data sharing agreement. The ISP team will continue to support care coordination and transition guidance in tandem with staff at the Homeless Youth Resource Center through Volunteers of America.

The Transition to Adult Healthcare Committee will work in conjunction with the Intermountain Health Teen to Adult Healthcare Governance Committee to determine the best method to measure patient satisfaction with the transition education, skill building, and eventual transition to adult provider processes. The ISP team and CSHCN will continue to partner with key stakeholders and community partners within existing committees such as DHHS's Youth Empowered Solutions for Success, Utah State Board of Education’s Transition Advisory Committee, Intermountain Healthcare’s Teen to Adult Healthcare Governance Committee, and the Transition University Planning committee; and will seek to foster other partnership opportunities.

- The Office of CSHCN will continue to convene a monthly interagency Transition to Adult Healthcare meeting with a focus on curriculum dissemination, promoting standard messaging, evaluating the best way to gather patient/family experience across disparate systems, and continuously seek ways to improve systems and collaboration.
- CSHCN will fund the development of educational short videos and animations through Transition University on transition-related themes to be stored on the Utah Parent Center website, and links provided to care coordinators and service providers to share with families for educational purposes.
- The ISP Transition Specialist will begin outreach efforts to targeted youth within the Utah Birth Defect Network registry through an approved data sharing agreement.
- The ISP team will work with the staff at the Homeless Youth Resource Center (Volunteers of America) to establish a system to provide consultation, care coordination, and transition guidance for homeless youth in Salt Lake City.

Table 18: Logic Model for National Performance Measure 12

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				
Goal: Increase the percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care				
Inputs	**Activities**	**Outputs**	**Outcomes**	**Impacts**
Funding and qualified DHHS staffing: Program manager, NP, transition specialist, care coordinators, Division leadership, epidemiologists Partners and stakeholders: Intermountain Health, University of Utah, Utah Parent Center, USBE Transition Committee, LHDs, Division of Services for People with Disabilities, school districts, Volunteers of America Committees: Transition committee, IHC transition steering committee, USBE transition committee	Monthly planning meetings UCCCN meetings and trainings Annual Teen to Adult Healthcare Summit Curriculum assessment/evaluation Public awareness via partner websites and roundtables Care coordination activities Provider toolkit developed	Websites hosted: DHHS, Utah Parent Center, Medical Home Portal with resources and guidance Transition policy created Standardized curriculum approved Number of youth and parent readiness assessments distributed Number attending Teen to Adult Healthcare Summit Number of transition plans created with youth Number of provider toolkits distributed	NPM 12: Increase in percent of adolescents with special health care needs who transition successfully to adult health care Providers understand where families are in the transition process Parents and youth are able to create transition plans Transition process is replicable statewide	NOM 17.2: More families benefit from a well-functioning care system Fewer ED visits Cost savings to individuals and systems Independence for the individual
Assumptions and Contextual Factors: If the transition to adult healthcare is a unified approach across the state, regardless of healthcare provider affiliation, youth with special health care needs and their families will receive consistent messaging and planning throughout their adolescence. We assume this will better prepare youth, pediatric, AND adult providers to make a seamless transition with consistent results.				

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 utilized the following methods to collect input from both the general public and key stakeholders for the FY24 Application. Public comments were collected using the Web Enabled Systematic Tracking Tool (WESTT) system:

1. Email Invitation to clinicians licensed through the Department of Occupational and Professional Licensing

DRP worked with the DHHS Office of Informatics to email 26,953 professionals licensed through the Department of Occupational and Professional Licensing and invite them to review and comment on the FY2024 planned activities. Professional specialties who received the survey 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.

DRP engaged with and provided materials to the following DHHS partner non-profit 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.
- Project Success Coalition - a community-based organization with a focus on addressing the needs of African Americans in Utah
- Communidad Materna en Utah - an organization that provides resources for Hispanic moms and their families which seeks equity in access to prenatal care and promoting physical and emotional well-being.
- Utah Pacific Islander Health Coalition - an organization that seeks to reduce health disparities and increase access to affordable and culturally responsive wellness services for Utah Pacific Islanders
- Latino Behavioral Health Services - an organization that seeks to raise awareness about mental illness and substance use disorders in Latino populations in Utah

The Office of Early Childhood also sent an email to members of the Early Childhood Utah Advisory Council notifying them of the public comment period and asking them to review the FY2024 plans and comment.

2. Website Posting/Web Application

A public announcement was posted on the Utah Department of Health and Human Services' website (https://dhhs.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 2023-2024 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 FY2024 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, several MCH programs added the public comment announcement in their on-line newsletter or web sites.

4. WIC Texting Service

The Utah WIC Program utilizes a texting service to notify participants of their WIC appointments. WIC uses the texting service to alert participants to closed clinics and/or agencies should they be affected by natural disasters or other schedule changes. WIC also uses the texting service to sometimes request information via survey links for purposes of program operations, customer service, and other local agency-specific reasons. This year, the Utah WIC program allowed for use of the texting service to invite 25,163 WIC clients throughout the state to review Utah's FY2024 plan and provide comments.

The Utah WIC program also distributed flyers in their clinics with a QR code that linked directly to the WESTT public comment webpage.

We believe this outreach boosted the response to the public comment period significantly. The number of comments was significantly higher than previous years, and many of these comments came from parents.

5. Social Media

The DHHS 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 to post on their social media accounts using materials we developed.

Internally, we worked with the DHHS Public Affairs and Education Office (PAE) to post to the Agency Facebook and Instagram accounts (in addition to posting on the DHHS website). Multiple agencies shared the posting on their own platforms. We also posted on the Power Your Life and CSHCN's Utah Birth Defect Network (UBDN) Facebook and Instagram pages. Each of these posts began with the following text:

"Do you have ideas to improve the lives of moms and children? This is your chance to tell us how you'd like funding to be used to help families in Utah thrive!

The public comment period for the Maternal and Child Health Block Grant (also called Title V) is now open. Each state receives Title V funding to provide a variety of services and programs on things like youth suicide prevention, maternal mental health, preventive health screenings, prenatal and postnatal care, childhood immunizations, injury and violence prevention, family-centered coordinated care for children with special healthcare needs, and so much more.

Let your voice be heard at https://health.utah.gov/westt/mchblock. We will accept public comments until June 17th."

Image 9: Examples of social media posts in English and Spanish


Your voice matters!
Tell us what you feel is most important to help families thrive in Utah. The Maternal and Child Health Block Grant public comment period is now open.
Public comments accepted until June 17.


¡Su voz importa!
Díganos cuáles son los aspectos más importantes para ayudar a las familias a prosperar en Utah. Ya está abierto el periodo de comentarios del público respecto a la subvención de fondo general para la salud materno-infantil.
Se aceptan comentarios públicos hasta el 17 de junio.


Your voice matters!
Tell us what you feel is most important to help families thrive in Utah. The Maternal and Child Health Block Grant public comment period is now open.
Public comments accepted until June 17.

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 and UBDN posts resulted in a reach of 25,800 accounts with 72 clicks.

Language accessibility:

Spanish is the second most common language spoken in Utah, with 10.1% of residents 5 years and older speaking Spanish at home. To improve accessibility to the public comment materials, DRP worked with PAE to have the public comment materials translated into Spanish. The Health Informaticist in DRP also integrated Google translate into WESTT, enabling viewers to read and comment in Spanish and other languages.

Public Comment Period Results:

Online comments were accepted from 5/17/2023 – 6/17/2023. We received valuable feedback on needs and emerging issues as well as reaffirmation of the importance of program activities. This year we received 576 comments, a significant increase from 300 comments in the FY 2023 application and report. The *Google Analytics* report below shows there were 6,100 users who logged-on to the Title V public comment website at least once. Sessions lasted, on average, 39 seconds.

A plurality (38.7%) of comments were made for 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 (21.5%) related to the child health domain (developmental screening, family connectedness / family meals). Just over eighteen percent (18.6%) of comments were related to the perinatal/infant health domain (breastfeeding), followed by twelve percent of comments related to adolescent health (bullying, oral health, and free or reduced lunch). The remaining 9.2% were focused on children with special health care needs (medical home and transition to adult care).

A total of 30 comments were made by Spanish speakers with the plurality of comments made (n=17) about the women and maternal health domain.

In total, there were 181 unique users who provided 576 comments on the FY2024 plans. These comments came from many (though not all) of the 29 Utah counties. Before adding a comment, the WESTT system asked the users to identify themselves using broad categories. Among those who disclosed, parents and parents of children with special health care needs made up a majority of comments (73.6% or n = 351). Other comments came from health care providers, state agencies, consumers of healthcare, and local health departments (among others) (see table 1).

Table 19. Breakdown of comments by category of commentator

Category	No. Cmnts	Percent
Parent	302	52.4%
DID NOT DISCLOSE	99	17.2%
Parent of child or youth with special health care needs	49	8.5%
Health care providers	37	6.4%
Other	20	3.5%
Other state agency	17	3.0%
Community health centers/clinic	14	2.4%
Consumer of health care	12	2.1%
Local health department	9	1.6%
University faculty	5	0.9%
Community-based organization	5	0.9%
School	3	0.5%
State health department	2	0.3%
Advocacy group	2	0.3%
Total	576	100.0%

Changes in Annual Plan based on Public Feedback

A Public Comment Summary Report was prepared in June 2023 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 DRP requested that they consider this feedback for incorporation in the final 2024 Annual Plans that would be submitted into TVIS. Some programs gave feedback to DRP that while they would like to make changes to current plans based on public feedback, they are restricted by structural barriers such as the lack of licensed providers in rural areas, a lack of funding for specific CSHCN populations, and families making just a few dollars too much to qualify for subsidized services. However, the VIPP program did add a strategy to develop a connectedness toolkit specifically for LGBTQ adolescents based on public comments. This is something the program had been considering, but receiving public comments supportive of a toolkit helped the program make the decision to move forward. 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 FY2024 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 - MCH-CSHCN Medicaid MOA.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Appendix_A.pdf

Supporting Document #02 - Appendix_B.pdf

Supporting Document #03 - Appendix_C.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DHHS_Organizational_Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Utah

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,575,790	
A. Preventive and Primary Care for Children	$ 3,411,818	(51.8%)
B. Children with Special Health Care Needs	$ 2,259,977	(34.3%)
C. Title V Administrative Costs	$ 471,900	(7.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,143,695	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 16,404,400	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,400,000	
5. OTHER FUNDS (Item 18e of SF-424)	$ 15,241,900	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,146,500	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 36,192,800	
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)	$ 42,768,590	
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)	$ 55,333,600	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 98,102,190	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 259,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 374,700
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 442,800
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 644,800
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 273,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 171,500
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 42,224,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 255,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 3,162,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 363,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 6,470,700
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 180,400
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	$ 275,000

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,598,690 (FY 22 Federal Award: $ 6,174,456)		$ 4,834,481	
A. Preventive and Primary Care for Children	$ 3,343,498	(50.7%)	$ 2,479,242	(51.2%)
B. Children with Special Health Care Needs	$ 2,254,407	(34.2%)	$ 1,787,541	(36.9%)
C. Title V Administrative Costs	$ 621,900	(9.4%)	$ 290,456	(6.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,219,805		$ 4,557,239	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 16,182,050		$ 17,533,063	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 4,100,000		$ 2,685,117	
5. OTHER FUNDS (Item 18e of SF-424)	$ 15,214,000		$ 14,812,671	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,044,900		$ 1,128,697	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 36,540,950		$ 36,159,548	
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)	$ 43,139,640		$ 40,994,029	
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		$ 47,428,630	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 96,351,140		$ 88,422,659	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 153,700	$ 189,532
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 345,500	$ 290,266
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 387,300	$ 370,137
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 671,300	$ 460,051
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 251,500	$ 250,630
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 40,856,800	$ 36,186,397
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 107,537
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 420,200	$ 203,301
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	$ 3,179,166
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 232,000	$ 234,706
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 186,700	$ 308,582
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	$ 5,496,569

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 140,900	$ 151,756

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Includes anticipated award for 10/1/2023-9/30/2025 with anticipated expenditures in first year and anticipated federal amount remaining from budget period 10/1/2022-9/30/2024 to be spent in second year.	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Amount includes all or portions of budgets for the following state general funds: 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, Children’s Hearing Aid Program, Pregnancy Risk Assessment Monitoring System state funding, Contraception for Inmates, Fetal Exposure Reporting and Treatment and Baby Watch Early Intervention.	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Local MCH funds are reported annually as part of the required reporting for Utah's 13 local health departments.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Other funds include various revenue agreements with other state agencies and private non-profit organizations, as well as rebates for WIC formula.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**

	Field Note: Program income includes revenue collected for Baby Watch Early Intervention family fees, Mother to Baby collections and kit fee revenues from newborn hearing screenings and critical congenital heart defects.	
6.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Actual expended only includes amount expended from FFY 2022 grant award. Utah has experienced a significant reduction in annual expenditures, due to staff being redirected to COVID funds and activities. With the end of the pandemic, we anticipate expenditures resuming normal levels over the next 1-2 years.	
7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: FY22 expended amount includes expenditures through May 2023. With 4 months remaining on the period of availability of FY22 funds, we anticipate this amount being more in alignment with the amount budgeted.	
8.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: FY22 expended amount includes expenditures through May 2023. With 4 months remaining on the period of availability of FY22 funds, we anticipate this amount being more in alignment with the amount budgeted.	
9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: FY22 expended amount includes expenditures through May 2023. With 4 months remaining on the period of availability of FY22 funds, we anticipate this amount being more in alignment with the amount budgeted.	
10.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

	Field Note: Reduction in budgeted amount in FFY24 state funds in comparison to actual expenditures in FFY22 is a result of increased Medicaid eligibility in multiple programs, resulting in additional state funds being used for match on Medicaid eligible revenue.	
11.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Increase in projected local funds in FFY 2024 is a result of refined financial reporting from 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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 702,510	$ 489,351
2. Infants < 1 year	$ 609,804	$ 467,420
3. Children 1 through 21 Years	$ 2,323,639	$ 1,642,104
4. CSHCN	$ 2,259,977	$ 1,787,541
5. All Others	$ 207,960	$ 157,609
Federal Total of Individuals Served	$ 6,103,890	$ 4,544,025

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 3,517,786	$ 4,517,410
2. Infants < 1 year	$ 3,161,629	$ 3,074,257
3. Children 1 through 21 Years	$ 9,431,385	$ 9,285,029
4. CSHCN	$ 16,420,200	$ 16,330,417
5. All Others	$ 157,609	$ 267,317
Non-Federal Total of Individuals Served	$ 32,688,609	$ 33,474,430
Federal State MCH Block Grant Partnership Total	$ 38,792,499	$ 38,018,455

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: 1. Infants are 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. The Utah team is currently working through funding allocations and preparing for the 5 year needs assessment to ensure alignment with current and future MCH Block Grant priorities.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	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. The Utah team is currently working through funding allocations and preparing for the 5 year needs assessment to ensure alignment with current and future MCH Block Grant priorities.	

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 1,920,672	$ 1,603,647
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 328,537	$ 266,911
B. Preventive and Primary Care Services for Children	$ 238,186	$ 193,964
C. Services for CSHCN	$ 1,353,949	$ 1,142,772
2. Enabling Services	$ 3,110,107	$ 2,347,129
3. Public Health Services and Systems	$ 1,545,011	$ 883,705
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		$ 1,603,647
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		$ 1,603,647
Federal Total	$ 6,575,790	$ 4,834,481

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 406,600	$ 107,615
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	$ 406,600	$ 107,615
2. Enabling Services	$ 31,331,400	$ 32,426,917
3. Public Health Services and Systems	$ 1,054,800	$ 939,898
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		$ 107,615
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		$ 107,615
Non-Federal Total	$ 32,792,800	$ 33,474,430

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: 47,969 **Data Source Year: 2021**

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	46,677 (97.3%)	644	99	99 (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)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	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 I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
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	46,458 (96.9%)	455	118	111 (94.1%)
CCHD	46,376 (96.7%)	125	9	9 (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
PKU Diet Monitoring (0-18 years)	1,268	76	76	76
PKU Diet Monitoring (pregnant women)	1,268	2	2	2

4. Long-Term Follow-Up

Long-term follow-up (follow-up beyond referring an infant for treatment) varies based on State policy and practice. Briefly describe your State's practice for monitoring infants with confirmed diagnoses, including what information is obtained and for how long infants are monitored.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Newborn Hearing Screening - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**

Field Note:
Infants were not referred to Utah Early Intervention for reasons such as out of state residence, death, undetermined diagnoses, and declining referrals.

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 2022

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	5,207	42.8	0.0	14.7	38.3	4.2
2. Infants < 1 Year of Age	11,519	74.4	0.0	1.9	5.9	17.8
3. Children 1 through 21 Years of Age	37,372	41.4	0.2	8.5	5.1	44.8
3a. Children with Special Health Care Needs 0 through 21 years of age^	11,254	51.2	0.0	48.8	0.0	0.0
4. Others	2,261	42.8	0.0	14.7	38.3	4.2
Total	56,359					

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	46,712	Yes	46,712	93.0	43,442	5,207
2. Infants < 1 Year of Age	47,955	Yes	47,955	100.0	47,955	11,519
3. Children 1 through 21 Years of Age	1,108,936	Yes	1,108,936	21.2	235,094	37,372
3a. Children with Special Health Care Needs 0 through 21 years of age^	195,006	Yes	195,006	72.5	141,379	11,254
4. Others	2,184,093	Yes	2,184,093	0.4	8,736	2,261

^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:	**2022**
	Field Note: Direct Services Direct Oral Health Screenings (Includes varnish) = 4 Local Health Department MCH Service Report = 2,090 Enabling Services Mother to Baby 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 = 2,137 1-800 Call Non-Eligibility Calls (Baby Your Baby) = 976 Total = 5,207	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Direct Services Hearing Screening by EHDI team = 64 Local Health Department MCH Service report = 6,334 Ages and Stages Questionnaire screenings = 3,626 Enabling Services Mother-To-Baby Utah health education = 1,495 Total = 11,519	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**

	Field Note: Direct Services Children 1-21 / Children CSHCN 1-21 Direct oral health screenings includes Varnish = 435 Local Health Department MCH Service report = 12,471 Children receiving Hearing aids or ear molds = 65 Ages and Stages Questionnaire screenings = 7,500 Baby Watch Early Intervention = 4,206 Direct oral health screenings includes Varnish = 60 Peds Ortho Clients = 310 ISP Patients = 553 Enabling Services Children 1-21 / Children CSHCN 1-21 Mother To Baby Health education (Children 1-21, women not pregnant yet, or breastfeeding more than 60 days postpartum) = 205 Number of referrals given by EHDI Program = 37 1-800 Call Non-Eligibility Calls (CHIP, Immunizations) = 1,199 Case Management (Utah Family Voices) = 1,214 Translation, F/U notes, CMV Records, Family Support = 8,031 Autism Referral = 758 Autism Explanation of benefits = 237 Transition planning (Parent Center) = 91 Total = 37,372	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Direct Services Direct oral health screenings includes Varnish = 60 Peds Ortho Clients = 310 ISP Patients = 553 Enabling Case Management (Utah Family Voices) = 1,214 Translation, F/U notes, CMV Records, Family Support = 8,031 Autism Referral = 758 Autism Explanation of benefits = 237 Transition planning (Parent Center) = 91 Total = 11,254	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

	Field Note: Direct Services Direct oral health screenings includes Varnish = 61 Local Health Department MCH Service report = 719 Enabling Mother To Baby Health education (men/partners/relatives, women 22+ not pregnant yet or more than 60 days postpartum, professionals) = 1,128 Safe Haven Calls / Emails / Trainings = 333 Parents who were sent the Hearing Aid savings guide = 20 Total = 2,261	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: Form 5a = 5,207 Public Health Service Number of deliveries occurring in hospitals implementing AIM Safety Bundle = 33,338 Oral Health Program Education = 4 Home Visiting services = 37 Number of views - Informed Consent module = 4,862 Total 5b = 43,448	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Form 5a = 11,519 Public Health Services Infants screened for CCHD = 47,970 Births in participating Baby Friendly Hospitals = 29,269 Newborn Hearing Screening = 47,418 Home Visiting services = 37 5b Total = 47,955	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

	Field Note: Form 5a = 37,372 Public Health Services 1-21 Number of children trained in the Bystander Program = 6,000 Oral Health Program Group Education Adolescents = 3,927 Contracted Medical Home Services in 4 counties = 56,179 Participants in Teen Pregnancy Prevention programs = 1,498 Home Visiting services = 38 Total = 67,642 Public Health Services 1-21 CSHCN Medical Home Portal = 118,018 Contracted Medical Home Services in 4 counties= 9,494 Hearing/Speech Training = 1,084 Community Education = 2 Autism Downloads = 39 Autism Sources of Distress = 141 Oral Health Program Education = 400 UCCN Subscribers = 217 Parent Center Referrals to ISP = 758 Total = 130,153 Total 5b = 235,167	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Form 5a = 11,254 Public Health Services 1-21 CSHCN Medical Home Portal = 118,018 Contracted Medical Home Services in 4 counties = 9,494 Hearing/Speech Training = 1,084 Community Education = 2 Autism Downloads = 39 Autism Sources of Distress = 141 OHP Education = 400 UCCN Subscribers = 217 Parent Center Referrals to ISP = 758 5b Total = 141,407	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**

Field Note:
Form 5a = 2,261
Public Health Services
UBDN Community Education = 1,810
Mental Health tool-kit downloads = 161
Oral Health Program Education = 532
Number of participants in trainings and workshops, The Utah Parent Center = 621
Number of participants in Teen Pregnancy Prevention programs = 1,610
UCCN Attendance Live and Recording Views = 425
Individuals participated in EHDI Advisory Committee = 168
5b Total = 7,588

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Utah

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	47,556	34,368	771	8,424	434	1,187	422	336	1,614
Title V Served	46,165	33,417	742	8,140	398	1,158	420	330	1,560
Eligible for Title XIX	10,867	5,952	338	3,442	234	164	218	84	435
2. Total Infants in State	47,969	34,681	779	8,484	438	1,194	425	340	1,628
Title V Served	46,559	33,715	750	8,197	401	1,165	423	334	1,574
Eligible for Title XIX	10,958	6,004	340	3,468	235	165	220	86	440

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2021 Occurrent deliveries	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2021 Resident deliveries	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2021 Resident Medicaid (Self indicator variable from the birth certificate)	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2021 Occurrent infants	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2021 Resident infants	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2021 Resident Medicaid infants/births (Self indicator variable birth certificate)	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Utah

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 826-9662	(800) 826-9662
2. State MCH Toll-Free "Hotline" Name	Baby Your Baby	Baby Your Baby
3. Name of Contact Person for State MCH "Hotline"	Marie Negata	Marie Nagata
4. Contact Person's Telephone Number	(801) 538-6519	(801) 538-6519
5. Number of Calls Received on the State MCH "Hotline"		976

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	1. Children's Health Insurance Program (CHIP), 2. Mother To Baby, 3. Utah Newborn Safe Haven, 4. Immunization Hotline	1. Children's Health Insurance Program (CHIP); 2. Mother To Baby; 3. Utah Newborn Safe Haven; 4. Immunization Hotline
2. Number of Calls on Other Toll-Free "Hotlines"		7,295
3. State Title V Program Website Address	www.health.utah.gov/mch, www.health.utah.gov/chscn	1. www.health.utah.gov/mch; 2. www.health.utah.gov/cshcn
4. Number of Hits to the State Title V Program Website		43,132
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		9,671

Form Notes for Form 7:

The number of hits to the State Title V Program Social Media Websites were drastically reduced in this reporting year due to a staff member moving to a new position and the time to rehire than train their replacement. The frequency of posting and views was reduced from 75,122 to 9,671.

The Number of calls received on the State MCH Hotline in the last year was 1,722

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/Office of Maternal and Child Health Director
Address 1	195 North 1950 West
Address 2	PO Box 142002
City/State/Zip	Salt Lake City / UT / 84116
Telephone	(385) 222-6915
Extension	
Email	lbaksh@utah.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Amy Nance
Title	Title V/Office of Children with Special Health Care Needs Director
Address 1	195 North 1950 West
Address 2	PO Box 144611
City/State/Zip	Salt Lake City / UT / 84116
Telephone	(385) 377-2801
Extension	
Email	aenance@utah.gov

3. State Family Leader (Optional)	
Name	Joey Hannah
Title	Utah Parent Center Executive Director
Address 1	230 West 200 South #1101
Address 2	
City/State/Zip	Salt Lake City / UT / 84101
Telephone	(801) 272-1051
Extension	
Email	joey@utahparentcenter.org

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Utah

Application Year 2024

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, Medical Home, and 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.

None

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
2021	83.4 %	0.2 %	38,548	46,238
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
2020	59.0	3.7	256	43,398
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
2017_2021	14.9	2.5	35	235,034
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**
2021	7.4 %	0.1 %	3,465	46,702
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**
2021	9.9 %	0.1 %	4,621	46,711
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
2021	30.2 %	0.2 %	14,102	46,711
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**
2021/Q1-2021/Q4	3.0 %			
2020/Q4-2021/Q3	3.0 %			
2020/Q3-2021/Q1	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 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2020	5.7	0.4	260	45,815
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
2020	5.4	0.4	248	45,702
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
2020	3.9	0.3	180	45,702
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
2020	1.5	0.2	68	45,702
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
2020	179.4	19.8	82	45,702
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
2020	63.5	11.8	29	45,702
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
2020	4.8	0.3	210	43,719
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
2020_2021	12.5 %	1.2 %	110,408	882,341
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**
2021	13.7	1.7	62	453,173
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
2021	35.2	2.5	194	551,215
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**
2019_2021	8.6	1.1	67	781,317
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
2019_2021	20.4	1.6	159	781,317
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
2020_2021	16.9 %	1.1 %	156,906	928,123
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
2020_2021	19.5 %	2.9 %	30,612	156,906
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
2020_2021	1.8 %	0.4 %	14,054	772,880
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
2020_2021	6.6 %	0.8 %	51,172	771,976
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
2020_2021	42.1 %	3.9 %	49,463	117,491
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
2020_2021	93.4 %	0.8 %	866,348	927,576
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
2020	8.3 %	0.3 %	968	11,707
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 <20 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
2021	10.2 %	1.5 %	16,823	164,560
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
2020_2021	12.0 %	1.7 %	47,587	398,145
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**
2021	7.9 %	0.6 %	75,011	944,043
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
2018	79.0 %	3.2 %	38,000	48,000
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
2021_2022	58.5 %	2.1 %	511,511	873,969
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
2021	80.9 %	2.7 %	219,838	271,597
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
2021	92.9 %	1.9 %	252,418	271,597
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
2021	94.0 %	1.6 %	255,378	271,597
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
2021	9.7	0.3	1,282	132,487
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
2021	16.5 %	1.2 %	7,406	44,875
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
2020_2021	3.9 %	0.7 %	36,080	924,811
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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			66.5	67.5	68
Annual Indicator		66.1	67.6	67.0	65.3
Numerator		394,166	413,656	413,571	408,264
Denominator		595,993	612,087	617,227	625,335
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	66.5	67.8	69.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Targets were updated using minimum statistical significance method

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	88.6	90	90	91.8	89
Annual Indicator	89.7	91.2	91.8	87.8	91.4
Numerator	43,073	45,052	39,458	38,339	35,912
Denominator	48,030	49,404	42,968	43,665	39,289
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	92.3	93.1	94.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Targets were updated using the percentage point improvement method	

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	26.9	28	28.3	27	29
Annual Indicator	27.8	23.5	26.3	27.8	27.3
Numerator	12,643	11,415	10,658	11,442	10,531
Denominator	45,490	48,506	40,597	41,090	38,540
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	28.8	30.4	31.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Targets were updated using the percentage point improvement method

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	33.2	32.2	31.3	31.3	34.2
Annual Indicator	32.6	31.1	29.1	34.2	40.3
Numerator	32,987	29,418	31,492	39,294	48,466
Denominator	101,171	94,514	108,310	114,782	120,307
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	41.9	43.6	45.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Targets were updated using the percentage point improvement method

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**	**2022**
Annual Objective			23	24.4
Annual Indicator	26.9	24.4	24.4	22.9
Numerator	44,345	41,396	41,396	40,261
Denominator	164,763	169,914	169,914	175,774
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2019	**2020**	**2021**	**2022**
Annual Objective			23	24.4
Annual Indicator	27.7	27.5	20.4	13.7
Numerator	86,153	84,890	62,745	42,471
Denominator	311,307	309,211	307,366	309,906
Data Source	NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2019	**2020**	**2021**	**2022**
Annual Objective			23	24.4
Annual Indicator	56.4	54.8	43.3	36.2
Numerator	176,896	170,076	133,253	112,098
Denominator	313,579	310,347	307,613	309,917
Data Source	NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	23.5	22.8	21.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
No adjustments were made to targets for NPM 9

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	50.4	44.1	40.3	47	57.3
Annual Indicator	47.2	40.2	46.4	57.2	55.7
Numerator	68,219	59,263	69,395	83,681	87,339
Denominator	144,415	147,327	149,671	146,181	156,906
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	56.3	56.9	57.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Adjustments were made to interval year targets, but not 2025

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	18.4	19.5	17.3	13.5	15.5
Annual Indicator	19.3	17.1	11.5	14.0	19.2
Numerator	12,760	13,378	8,906	10,487	16,766
Denominator	66,028	78,194	77,434	75,107	87,157
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	20.6	21.9	23.3

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Targets were updated using the percentage point improvement method

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.3	84.8	81.6	81.8	84.7
Annual Indicator	82.4	81.4	82.6	84.3	80.0
Numerator	701,280	698,309	726,633	745,902	706,928
Denominator	851,339	857,676	879,310	885,155	883,614
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.2	82.4	83.6

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Targets were updated using the minimum statistical significance method	

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	2022
Annual Objective			63.8	63.8
Annual Indicator	56	60.8	60	63.6
Numerator	25,866	27,859	26,909	29,131
Denominator	46,186	45,807	44,814	45,771
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	65.2	66.7	68.3

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.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Targets were updated using the percentage point improvement method	

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	2022
Annual Objective			78.8	81
Annual Indicator	76.7	78.1	81.1	80.6
Numerator	692,413	712,908	743,827	737,820
Denominator	903,273	912,249	917,210	915,409
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	81.7	82.9	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).	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2025 target was not adjusted, however changes were made to interval year targets.	

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			35	50
Annual Indicator	32.2	35	41.7	86.1
Numerator			281,760	170,802
Denominator			675,247	198,354
Data Source	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database	USBE, Child Nutrition Program Database
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	87.0	87.8	88.7

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-04. It 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.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Utah State Board of Education (USBE) Child Nutrition October Survey indicates the number of eligible students who receive a free/reduced meals. Children in a household with incomes at or below 130 percent of the federal poverty level are eligible to receive at least 2 healthy meals a day at school.

School food authorities (public or charter school sites) report the eligibility data to USBE every year. In October USBE advised us to report data only on eligible students moving forward. Previously, because of the pandemic, all students received school meals during that time period (2020-2021, 2021-2022).

The reason for the increase in SPM 3 between 2021 and 2022 is due to the new definition: the estimated number of eligible children participating/total estimated number of eligible children.

Note: Calculating the percentage participating among the percentage eligible required a complex calculation and is a proxy number.

3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Targets were adjusted using the percentage improvement method.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Utah

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	2.0	2.0	2.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			27	69
Annual Indicator	13.2	24.4	65.4	67
Numerator	6,225	11,435	30,555	30,555
Denominator	47,211	46,832	46,716	45,577
Data Source	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	70.0	71.0	72.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives			
	2023	2024	2025
Annual Objective	47.0	48.0	49.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
2023 is a baseline year for this ESM and we will report on this in the FY23 Report/FY25 Plan

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

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			12	6
Annual Indicator	0	23	34	27
Numerator				
Denominator				
Data Source	Early Childhood Utah program data	Early Childhood Utah program data	Early Childhood Utah program data	Early Childhood Utah program data
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

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.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: We are deactivating this measure because training opportunities have moved to primarily available online through a recorded webinar.	

ESM 6.2 - The number of ASQ screens, for 0-3 year olds, contributed to the DHHS ASQ Online Enterprise Account by participating partners and enrolled programs.

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			7,988	8,271
Annual Indicator	8,157	7,580	8,354	9,156
Numerator				
Denominator				
Data Source	The Brookes Publishing UDOH ASQ Online Enterprise	UDOH Early Childhood Integrated Database	UDOH Early Childhood Integrated Database	DHHS Early Childhood Integrated Database
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

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".	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Previously, this ESM was mislabeled and only included ASQ screening numbers for children 0-3. We are deactivating this ESM and replacing it with ESM 6.5 which includes 0-5 year olds. It is anticipated that the numbers will go down for a few years (even with the inclusion of ages up to 5), because DHHS only has the ability to collect screening numbers from those they are directly funding as the ASQ Project gets off of the ground.	

ESM 6.3 - Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	110.0	121.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
This is a new ESM and FY24 will be a baseline year

ESM 6.4 - The number of ASQ screenings, for children 0-5, contributed to the DHHS ASQ Online Enterprise Account annually.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	6,600.0	7,260.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
This is a new strategy and measure and replaces the former ESM 6.2. FY2024 will serve as a new baseline for the expanded child population this ESM is targeting.

ESM 6.5 - The number of new programs enrolled in the DHHS ASQ Online Enterprise Account Annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	6.0	7.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
This is a new ESM and FY24 will be used to collect a baseline

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

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			100	100
Annual Indicator	0	129	160	0
Numerator				
Denominator				
Data Source	Program records, attendance records.	Program records, attendance records	Program records, attendance records	Program records, attendance records
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Due to a lack of funding, no work was done on this ESM in 2022. We are therefore deactivating the ESM and replacing it with ESM 9.7

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective				
Annual Indicator	300	300	181	6,651
Numerator				
Denominator				
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6,000.0	6,000.0	6,000.0

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	2022
Annual Objective			23	23
Annual Indicator	21	21	21.7	21.7
Numerator	41,142	41,142	46,356	46,356
Denominator	195,912	195,912	213,621	213,621
Data Source	Estimates for percent of students physically activ	YRBS	YRBS and National Center for Health Statistics	YRBS and National Center for Health Statistics
Data Source Year	2019	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 and 2022 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	2022
Annual Objective			400	175
Annual Indicator	400	366	162	138
Numerator				
Denominator				
Data Source	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	175.0	175.0	175.0

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	2022
Annual Objective			76	78
Annual Indicator	75	75	75	78.9
Numerator	171,000	171,000	171,000	180,000
Denominator	228,000	228,000	228,000	228,000
Data Source	Internal Revenue Service	Internal Revenue Service	Internal Revenue Service	Internal Review Service
Data Source Year	2018	2018	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			300	300
Annual Indicator	100	340	340	365
Numerator				
Denominator				
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2020	2020	2020	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	400.0	500.0	600.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.7 - The number of parents who participate in the Families Talking Together intervention

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	112
Numerator	
Denominator	
Data Source	Registration and attendance records, numbers serve
Data Source Year	2022
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	130.0	140.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
This ESM is new and replaces work previously done under ESM 9.1 called Teen Speak. Due to a lack of funding, no work was done with the Teen Speak program in 2022.

ESM 11.2 - Percent of children with special health care needs population served by the Office of CSHCN 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	2022
Annual Objective			94.5	97
Annual Indicator	0	94	97	96.8
Numerator		614	426	91
Denominator		653	439	94
Data Source	CSHCN EMR or comprehensive database	CSHCN Electronic Medical Record	CSHCN EMR or comprehensive database	CSHCN EMR or comprehensive database
Data Source Year	2020	SFY 2021	2021	2022
Provisional or Final ?	Provisional	Final	Final	Provisional

Annual Objectives

	2023	2024	2025
Annual Objective	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.

2. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   Previously the program looked at every case it had in their EHR. They have switched to a random sample of approximately 10% of clients served at ISP locations. This is why the numerator and denominator are smaller than previous years, but the proportion remains roughly the same.

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.

Measure Status:	Active

Baseline data was not available/provided.

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.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: This is a new ESM for FY23 and we will report on this in the FY23 report/FY25 plan	

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:	Inactive - Robust partnerships have been fostered between the Utah Department of Health and Human Services and several community partners including two hospital

State Provided Data				
	2019	2020	2021	2022
Annual Objective			0	0
Annual Indicator	0	0	0	0
Numerator				
Denominator				
Data Source	Stakeholder work group survey.	Stakeholder work group survey.	Stakeholder work group survey	Stakeholder work group survey
Data Source Year	2020	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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	2022
Annual Objective			63	73.9
Annual Indicator	0	62.4	74	95.7
Numerator		552	347	377
Denominator		884	469	394
Data Source	Stakeholder work group survey	ISP electronic medical record, Utah Parent Center	ISP electronic medical record, Utah Parent Center	ISP electronic medical record, Utah Parent Center
Data Source Year	2020	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			0	70
Annual Indicator	0	0	66.7	71.4
Numerator			8	10
Denominator			12	14
Data Source	Stakeholder work group survey for transition	Stakeholder work group survey for transition	Stakeholder work group survey for transition	Stakeholder work group survey for transition
Data Source Year	2020	2020	2021	2022
Provisional or Final ?	Provisional	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	73.0	74.0	75.0

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					
	2018	2019	2020	2021	2022
Annual Objective	51.5	54.4	55.7	52.1	48
Annual Indicator	54.2	55.5	51.9	47.1	43
Numerator	109,777	105,122	94,832	97,308	98,757
Denominator	202,518	189,242	182,597	206,783	229,733
Data Source	CMS 416	CMS-416	CMS-416	CMS-416	CMS-416
Data Source Year	FFY18	FFY19	FFY20	FFY21	FFY22
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	45.1	47.1	48.2

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 eligible 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 eligible 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 eligible 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 The Utah State Board of Education (USBE) Child Nutrition October Survey indicates the number of eligible students who receive a free/reduced meals. Children in a household with incomes at or below 130 percent of the federal poverty level are eligible to receive at least 2 healthy meals a day at school. School food authorities (public or charter school sites) report the eligibility data to USBE every year. In October USBE advised us to report data only on eligible students moving forward. Previously, because of the pandemic, all students received school meals during that time period (2020-2021, 2021-2022). This is the reason there was such a drop in participation between 2021 and 2022. Moving forward, we will only report on the percent of eligible children who participate in school meal programs and have adjusted our targets accordingly.
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 1.4 - 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 4.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a "Breastfeeding Friendly Facility."
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

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 4.3 - 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 4.5 - 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:	Inactive - Replaced
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, for 0-3 year olds, contributed to the DHHS 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:	Inactive - Replaced
Goal:	Increase the number of ASQ screens contributed to the Utah DHHS 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 6.3 - Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually
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 participants that complete ASQ training annually
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of participants that complete ASQ training annually. **Denominator:**
Data Sources and Data Issues:	Training participant data will be maintained and shared by Help Me Grow Utah
Evidence-based/informed strategy:	Facilitating developmental screening, with a parent-completed screening tool, is a critical part of early childhood care and a great opportunity to engage families in the promotion of their child's developmental health. Developmental screening is used to determine if a child is reaching age-related milestones as anticipated or if there is a reason to coordinate additional assessment/intervention.
Significance:	This ESM is significant to increasing the number of developmental screens received by children ages 9 to 35 months. In order to increase the number of screens received by infants/toddlers we need to increase the number of programs/providers that are appropriately trained to offer developmental screening opportunities to parents with young children.

ESM 6.4 - The number of ASQ screenings, for children 0-5, contributed to the DHHS ASQ Online Enterprise Account annually.
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 (for children 0-5) contributed to the Utah DHHS Online Enterprise Account annually.
Definition:	**Unit Type:** Count **Unit Number:** 9,999 **Numerator:** Number of ASQ screens (0-5) in UDOH ASQ Online Enterprise Account **Denominator:**
Data Sources and Data Issues:	Brookes Publishing ASQ Online Enterprise Account, ECIDS, and/or CHARM.
Evidence-based/informed strategy:	Evidence informed strategy: Support activities to collect and report on ASQ screenings for the DHHS Online Enterprise Account.
Significance:	This measure is significant because it demonstrates the culmination of Utah's ASQ training, enrollment and implementation efforts. Tracking this data will show if Utah is increasing the number of developmental screenings received by children ages 9 months to 5 years. It is important to note that a new "screenings received" baseline is being established. A new baseline is being established due to many subaccounts being transferred out of the current DHHS ASQ Online Enterprise Account into their own Enterprise Accounts in 2023. Care types being transferred include Help Me Grow Utah, Head Start grantees and Child Care providers. This measure will track the number of screenings contributed to the DHHS ASQ Online account. The DHHS account will host pediatric and early care providers such as health departments, home visitors and early interventionists.

ESM 6.5 - The number of new programs enrolled in the DHHS ASQ Online Enterprise Account Annually
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 new programs enrolled in the DHHS ASQ Online Enterprise Account Annually
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of new programs enrolled **Denominator:**
Data Sources and Data Issues:	Office of Early Childhood Program enrollment records
Evidence-based/informed strategy:	Enrolling new programs in the DHHS ASQ Online Enterprise Account increases the chances that developmental screening practices will be implemented into additional programs' early care/early education routines.
Significance:	Increasing the number of enrolled programs increases the likelihood that additional children, ages 9 to 35 months, will be afforded the opportunity to participate in 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:	Inactive - Replaced
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:** 9,999 **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:** The number of students who were physically active for at least 60 minutes per day on 7 of the past 7 days **Denominator:** The number of students enrolled
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 9.7 - The number of parents who participate in the Families Talking Together intervention
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the number of parents participating in Families Talking Together
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of parents participating in Families Talking Together **Denominator:**
Data Sources and Data Issues:	Registration and attendance records, numbers served reporting tools from PREP/SRAE grants
Evidence-based/informed strategy:	Increase the number of parents with youth who registered and participate in Families Talking Together
Significance:	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 MCH in reaching parents more broadly in communities across the state.

ESM 11.2 - Percent of children with special health care needs population served by the Office of CSHCN 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

<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 population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.</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 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.</td></tr>
<tr><td>Denominator:</td><td>Number of children with special health care needs served by the Bureau.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CSHCN EMR or comprehensive database</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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.
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:	As UCCCN practices are trained and improved medical home related services, satisfaction by patients and families will increase.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** UCCCN member practice families who reported positively on medical home experiences. **Denominator:** Total UCCCN member practice family surveyed
Data Sources and Data Issues:	UCCCN Member Practice Survey
Evidence-based/informed strategy:	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.
Significance:	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.

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

Measure Status:	Inactive - Robust partnerships have been fostered between the Utah Department of Health and Human Services and several community partners including two hospital
Goal:	Increase the percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.
Definition:	<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>
Data Sources and Data Issues:	Stakeholder work group survey.
Significance:	Having a transition plan is critical for services to be seamlessly transferred to adult-serving providers. There is strong, recent evidence as summarized by the literature in Jones et al. (2017) and Lemke et al. (2018) that speak to the importance of sharing the plan with youth and families and for having a transition policy within a practice: 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.

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

Measure Status:	Active
Goal:	Increase the percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Survey of providers trained who indicate they have an active transition policy in place. **Denominator:** All providers trained in transition.
Data Sources and Data Issues:	Stakeholder work group survey for transition trained providers.
Significance:	Jones, M. R., Robbins, B. W., Augustine, M., Doyle, J., Mack-Fogg, J., Jones, H., & White, P. H. (2017). Transfer from pediatric to adult endocrinology. Endocrine Practice, 23(7), 822–830. https://doi.org/10.4158/EP171753.OR. Lemke, M., Kappel, R., McCarter, R., D'Angelo, L., & Tuchman, L. K. (2018). Perceptions of health care transition care coordination in patients with chronic illness. Pediatrics, 141(5). https://doi.org/10.1542/peds.2017-3168.

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the percent of Medicaid children ages 1 - 18 who had a preventive dental visit
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Medicaid children aged 1-18 who had a preventive dental visit **Denominator:** Number of Medicaid children aged 1-18 eligible for Medicaid for 90 days or more
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 2022

	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	1	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