Maternal and Child Health Services Title V Block Grant

Utah

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

State of Utah
Spencer J. Cox
Governor
Deidre Henderson
Lieutenant Governor

Utah Department of Health
Nate Checketts, MPA
Acting Executive Director

Division of Family Health and Preparedness
Sarah Woolsey, MD, MPH, FAAFP
Division Director

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

August 1, 2021

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

Dear Mr. Dykton:

We are pleased to submit Utah's Maternal and Child Health Block Grant Application for Fiscal Year 2022 and the Annual Report for Fiscal Year 2020.

The 2022 application shows the influence of the Title V Block Grant dollars to the MCH/CSHCN population in Utah and how it positively impacts the health of women, children and youth, especially children with special health care needs and families in our state. It outlines the plan for the coming grant period and the Annual Report for FFY 2020 which gives the results of the planned efforts completed. We are excited to continue our work in addressing the National and State Performance Measures to improve the health of MCH/CSHCN populations.

Sincerely,

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

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

UTAH DEPARTMENT OF HEALTH

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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Utah's MCH/CSHCN Program

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

Five-Year MCH/CSHCN Needs Assessment

The 2020 Utah MCH/CSHCN Needs Assessment used a community-engagement approach to gather information from stakeholders. Components of the comprehensive Needs Assessment included data collection via surveys, key informant interviews, tribal consultation, and focus groups. Regional and statewide stakeholder meetings were held both in person and virtually with activities culminating in a MCH/CSHCN Stakeholder Summit. Over 3,000 people participated in the assessment process and included stakeholders and partners who are parents, caregivers, health service professionals, community organizations, public health professionals, and mental health professionals. Data gathered from this process was used to select state health priorities to achieve the best health outcomes for mothers, children, and families in Utah.

The input provided by stakeholders and members of the MCH/CSHCN populations allowed many different perspectives on community health issues and needs. This input played a critical role in figuring out the most effective state priorities and performance measures.

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

Title V Block Grant Implementation

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

Priorities and Progress

Maternal and Women

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

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

Perinatal and Infant

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

Child

Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected or if there is a delay in development and further evaluation is necessary. MCH staff works with medical providers to provide education, ongoing training and access to data systems on developmental screening to increase the number of children who receive a developmental screen.

When people feel connected with their communities, they may feel more inclined to participate in actions that help the community. As an upstream factor, it impacts multiple levels of social ecology. Connectedness encompasses both family connection and support, as well as community violence. It is a shared protective factor. Family meals are a way to increase connectedness in families. This connectedness is a protective factor for youth and onset of risky behaviors. Connectedness is a protective factor for reducing suicide. MCH and EPICC staff work to provide parent-youth communication programs.

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. The Oral Health Program works with the Utah Medicaid program to increase the percentage of children enrolled in Medicaid who have preventive dental visits.

Adolescent

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

Students who participate in the school meal programs consume more milk, fruits, and vegetables during meal times

and have better intake of certain nutrients, such as calcium and fiber, than nonparticipants. And, eating breakfast at school is associated with better attendance rates, fewer missed school days, and better test scores. School lunch is a proxy for economic stability. EPICC staff work to support education agencies with advancing the quality of school meals by participating in programs such as Farm to Fork, and educate families on how to receive free or reduced price breakfast/lunch in schools.

Children with Special Health Care Needs

The medical home model promotes high quality primary care that promotes coordination and partnership between the family, the patient, and health care and other service providers. Providers who understand and promote the medical home concept mark a well-functioning and coordinated system of care for CSHCN. CSHCN staff work to educate providers on the importance of providing care coordination as a component of the medical home and provide direct care coordination support to provider offices, their patients, and any CSHCN family who contacts us when needed.

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

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

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

Assuring Comprehensive, Coordinated, Family Centered Services

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

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

Title V Partnerships

The strength of MCH/CSHCN lies in the established and new partnerships that help expand the work of reaching women, infants, children, and families. Federal and non-federal funds are leveraged to deliver programs, services and create a statewide system of collaboration. Utah Title V partnerships include: health care systems (University of Utah, Intermountain Healthcare, Community Health Centers), non-profit agencies (YWCA, Utah Family Voices, Help Me Grow, Utah Parent Center, Utah Maternal Mental Health Policy Group), advisory groups (Newborn Screening,

Utah Autism Initiative, CSHCN Advisory Committee, Newborn Hearing Screening and Transition/Medical Home stakeholder groups), and other public health systems and programs (Local Health Departments, Utah Indian Health Advisory Board, Home Visiting-MIECHV, Child Development).

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Title V funds support many MCH/CSHCN efforts across the state. One of the challenges is distributing limited state and federal dollars among populations with the greatest need. Needs assessments, surveys, data collection and reports are the best way to identify Title V population needs. The budget outlines where Block Grant dollars are distributed. A comprehensive five year needs assessment was conducted in 2020. MCH/CSHCN used this information to reassess and select NPMs, SPMs, ESMs for the 2021-2025. The MCH/CSHCN Bureaus continue to evaluate the effectiveness of funded programs and work with the Division Finance Office to redirect budgets accordingly. Block Grant funds are distributed as follows:

Bureau of Maternal and Child Health:

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

Bureau of Children with Special Health Care Needs:

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

Bureau of Health Promotion:

- Violence and Injury Prevention
- Healthy Living through Environment, Policy, and Improved Clinical Care Program
- Baby Your Baby

And Utah's 13 Local Health Departments

III.A.3. MCH Success Story

Lowest loss to follow-up/documentation in Utah EHDI History

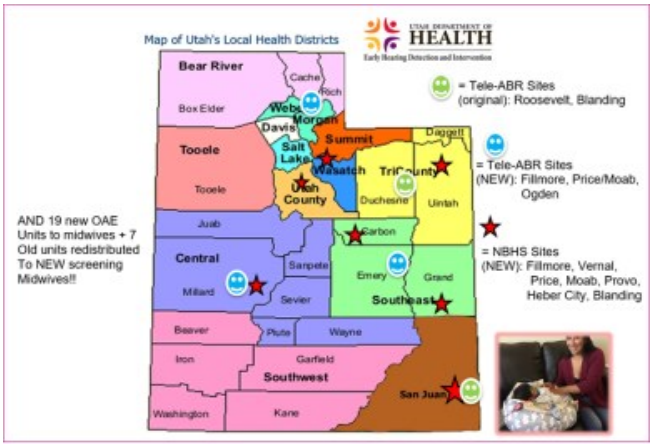
The Utah Early Hearing Detection & Intervention (EHDI) Program submitted 2019 data for the national CDC Hearing Screening and Follow-up Survey, it showed the lowest lost to follow-up in Utah history. From 2010 to 2019, the lost to follow up rate fell from 53.9% to 1.4%.

Several factors have contributed to this improvement; having a dedicated Follow-Up Coordinator, increased education and outreach to families and stakeholders, access to data systems, and dedication to program evaluation and quality improvement.

EHDI partnering with local health departments (LHD) to provide community hearing screening and expansion of tele-audiology services

Utah EHDI increased their partnership with LHDs to better serve their communities' unmet audiological needs. Otoacoustic emission hearing screening units were placed at seven rural LHDs across Utah. LHDs will provide newborn hearing screening for infants born out of hospital, those who were missed before discharge or who failed in the hospital and need an outpatient re-screening. The LHDs are able to share the equipment with other local programs.

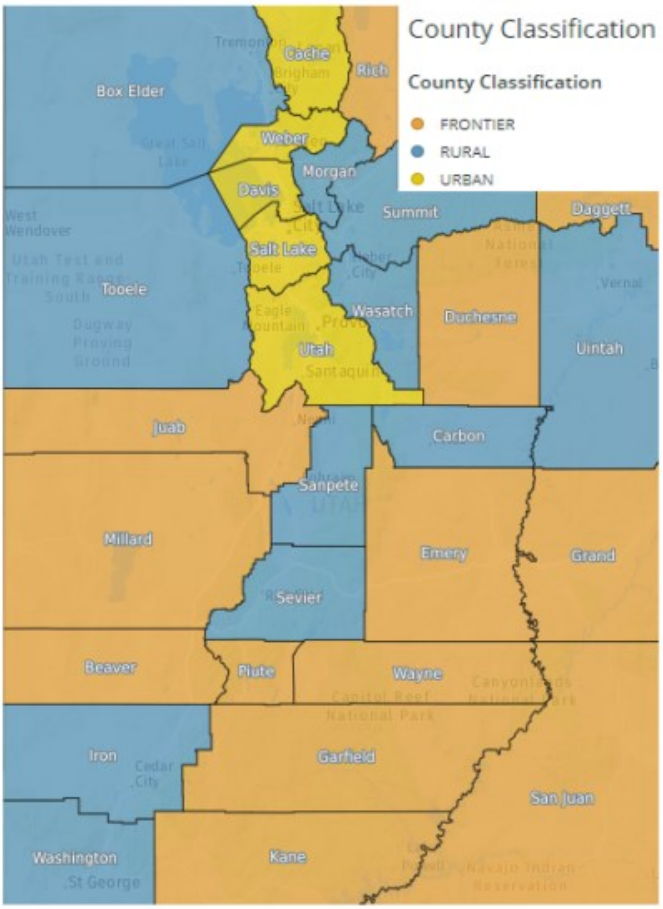
To expand Utah EHDI's provision of tele-audiology services, equipment was procured to create new spoke sites in the Southeast and Central LHDs, as well as in the underserved urban area of Weber County. This expansion will improve 3-month diagnostic EHDI milestone attainment for families whose geographical location or economic circumstances create barriers for completing this necessary testing.



III.B. Overview of the State

Population Demographics

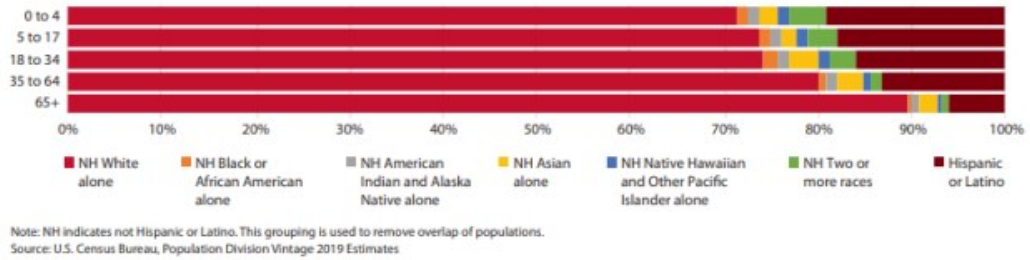
Utah is geographically the thirteenth largest state and is a largely rural and frontier state. Thirty-six percent of the State's population resides in a single county, Salt Lake County, which comprises one percent of the State's land mass. Utah has 5 urban, 11 rural, and 13 frontier counties. Utah's 2020 average population density is 38.5 persons per square mile, compared to 93.8 persons per square mile nationally. Sixty-seven percent of Utah's lands are under federal ownership, with 22% privately owned, 7% by the State and 4% by Utah's tribes.



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

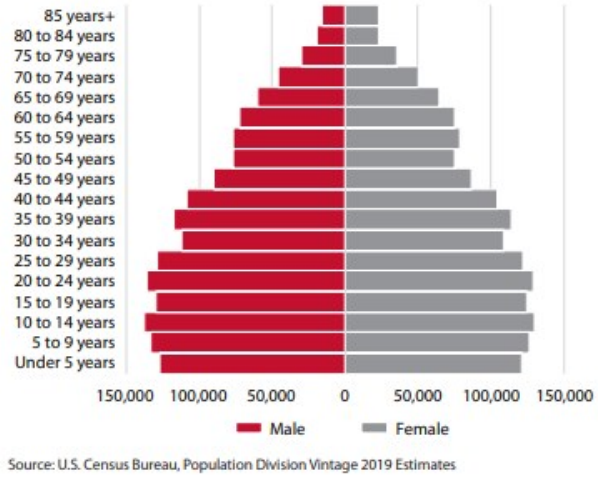
According to the report "Diversity in Utah, Race, Ethnicity and Sex", Utah ranks as the 34th most racially/ethnically diverse state in the nation with 22.3% of the population being of non-White race or Hispanic ethnicity. Utah's younger population is more diverse than older age groups.

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



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

Utah Population by Age and Sex



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

The latest information on religious affiliation in Utah comes from a 2014 survey by the Pew Foundation. The Pew Foundation reports that 55% of Utahns are members of the Church of Jesus Christ of Latter Day Saints and Utah is the world headquarters of the church. Eighteen percent are of other Christian faiths (Protestant, Catholic, Jehovah's Witness), four percent are of non-Christian faiths (Jewish, Muslim, Buddhist, Hindu), 22% are unaffiliated (agnostic or atheist) and 1% are undecided. Religious entities are invited to advisory committees and their input is sought out and valued.

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

Utah has resettled over 15,000 refugees since 1995 and ranks 24th in refugee arrivals. Recent data shows that the number of refugee arrivals in Utah declined from a high in 2016 of 1,555 to 550 in 2018, but increased to 585 in 2019. Of those arrivals in 2019, 51.2% were female. Most refugees in Utah arrive from the Democratic Republic of the Congo, Somalia, Iraq, and Burma.

In 2019, life expectancy at birth was 78.5 years for males and 82.0 years for females in Utah. The median age of Utah's population is 31.2 years, versus 38.5 in the U.S., making Utah the youngest state in the nation. The 2015-2019 American Community Survey (ACS) estimates note that 41.1% of Utah's population is under the age of 25, compared with 32.1% nationwide.

Utah's Births

Until 2017, Utah had claimed the highest general fertility rate in the nation. Utah's 2019 general fertility rate currently

ranks 4th highest in the nation, behind Alaska, North Dakota and South Dakota. Utah's fertility rate was 66.7 live births per 1,000 women in 2019 compared to 58.3 nationally. Utah continues to have the highest birth rate in the U.S. (14.6 Utah vs.11.4 U.S.). Utah's birth numbers declined for the fifth consecutive year with 46,832 live births to Utah residents in 2019.

Maternal Race/Ethnicity	Number of Births	Percent of Births
American Indian/Alaskan Native	390	0.8
Asian	1,083	2.3
Black/African American	732	1.6
Hispanic/Latina	8,061	17.2
Native Hawaiian/Pacific Islander	410	0.9
Two or more races	247	0.5
White, Non-Hispanic	33,640	71.8
Unknown	2,269	4.9

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

Maternal Race/Ethnicity	Preterm Birth*	Low Birthweight*	Cesarean Section*	Infant Mortality**	Adolescent Births*
American Indian/ Alaskan Native	11.5%	4.6%	28.2%	2.2/1,000	30.0/1,000
Asian	10.3%	9.3%	28.2%	5.4/1,000	4.7/1,000
Black/African American	13.0%	13.1%	30.1%	5.4/1,000	21.4/1,000
Hispanic/Latina	10.4%	8.5%	25.7%	6.0/1,000	28.4/1,000
Native Hawaiian/ Pacific Islander	14.2%	10.0%	31.2%	11.6/1,000	11.2/1,000
Two or more races	13.8%	6.1%	20.6%	***	2.8/1,000
White, Non-Hispanic	9.3%	6.7%	21.8%	4.5/1,000	7.7/1,000
Unknown	10.9%	7.5%	24.3%	20.8/1,000	
Statewide	9.7%	7.2%	23.0%	5.3/1,000	12.0/1,000
*2019 Vital Records data, ** 2016-2019 linked birth-death data, ***Data suppressed due to small numbers					

Utah's Economy

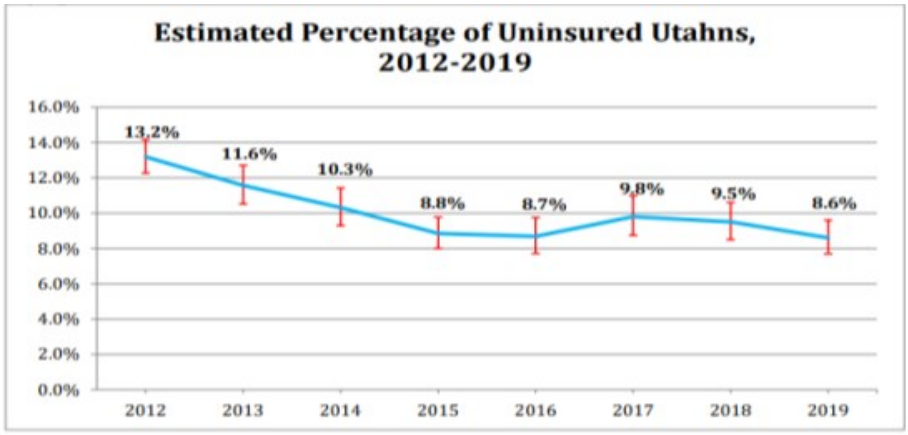
The Bureau of Labor Statistics notes that the 2019 unemployment rate in Utah was 2.6 compared to 3.7 for the nation. The 2015-2019 ACS estimates for median household income put Utah's $71,621 above the U.S. at $62,843. However, Utah's households are also large, resulting in a significantly lower per capita income ($31,771 vs. $35,672). There is also large variation in median income when broken out by race and ethnicity:

Race/Ethnicity	Median Income (2015-2019 American Community Survey)
American Indian/Alaskan Native	$45,957
Asian	$73,139
Black/African American	$41,752
Hispanic	$53,547
Pacific Islander/Native Hawaiian	$66,391
White Non-Hispanic	$75,227

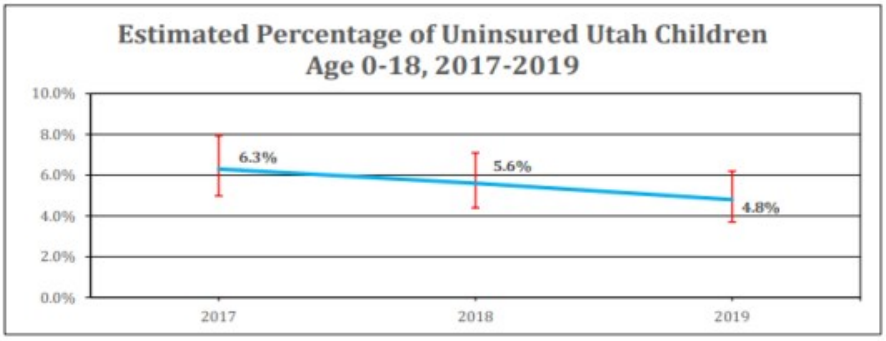
According to the 2015-2019 ACS 5-Year estimates, the percentage of individuals with incomes below the federal poverty level is 9.8% in Utah vs. 13.4% in the U.S. Poverty rates also range widely, depending on the county of residence. Poverty rates in 2019 were lowest in Morgan County (4.0%) and highest in San Juan County (21.9%), with a statewide mean of 8.8%. The 2018-2019 National Survey of Children's Health finds that 11.1% of families had a household income below 100% FPL, compared to 19.4% nationally.

Health Insurance

In 2019, data from the Behavioral Risk Factor Surveillance System (BRFSS) estimated that 8.6% of Utahns were uninsured.



Uninsured rates for Utah children ages 0-18 decreased as well during this time.



Rates of uninsured vary by race/ethnicity:

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

Utah BRFSS data from 2019 estimates that 4.8% of children below 18 years were without health insurance. The 2019 National Survey of Children's Health has higher estimates of no insurance among this group, at 7.8%.

Education

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

Household and Family

Utah has the largest household size in the country at 3.1 persons per household compared to 2.6 nationally. Utah's average family size is also larger than the U.S. (3.6 vs 3.2). The percent of Utah family households with one or more persons under the age of 18 is higher at 40.8% vs. 31.0% nationally.

Children and Adolescents

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

	Utah %	U.S. %
Race/Ethnicity		
Hispanic	18.0	25.6
White Non-Hispanic	72.1	50.2
Black Non-Hispanic	0.9*	13.3
Asian Non-Hispanic	1.5*	4.5
Other Non-Hispanic	7.4	6.3
Primary language spoken in home		
English	94.5	86.3
Non-English	5.5*	13.7
Highest Education in Household		
Less than High School	4.6*	9.2
High School	13.4	18.9
Some College	20.3	21.8
College Graduate	61.7	50.1
Family Structure		
Two parent, currently married	79.7	65.0
Two parent, not currently married	4.8*	8.8
Single parent	12.0	20.5
Grandparent household	1.4	3.8
Other family type	2.0*	1.9
Not insured at time of NCHS survey	7.8	6.7
Current insurance not adequate	30.0	27.9
2 or more adverse childhood events	17.6	18.7

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

The 2019 Youth Risk Behavior Survey illustrates differences between Utah high school youth and those in the nation: Utah youth were significantly more likely to report that they carried a weapon in the past 30 days (21.5% vs. 13.2%) and were more likely to report having carried a weapon onto school property (6.9% vs. 2.8%). Utah youth were significantly more likely to report having experienced sexual violence (14.3% vs. 10.8%). Utah youth were less likely than their U.S. peers to report any form of tobacco or alcohol use, but were just as likely to report illicit drug use.

The Schools Workgroup in the Bureau of Health Promotion at UDOH recently published a report detailing the findings from the latest YRBS conducted in 2019 (https://choosehealth.utah.gov/documents/pdfs/yrbs_2019.pdf). This report highlights important data on student health, safety, and lifestyle factors such as physical activity and nutrition, tobacco use, violence and injury prevention, and asthma. Key findings of the report:

- One in three students reported eating breakfast every day (30.9%)
- More than 1 of every 5 students seriously considered attempting suicide (22.3%)
- Nearly 1 in 5 Utah high school students were bullied on school property in the past 12 months (18.4%)
- More than 1 in 10 students reported using tobacco products including e-cigarettes or vape in the past 30 days (11.1% of males; 10.4% of females)
- 8.7% of Utah high school students have a current asthma diagnosis

The County Health Ranking and Roadmaps report reveals that the percentage of children who are eligible for free or reduced price lunch varies from 13% in Morgan County (north) to 100% in San Juan County (south).

Children with Special Health Care Needs (CSHCN)

Data from the 2019 National Survey of Children's Health (NSCH) found 18.4% of Utah children have one or more functional difficulties and 15.6% of Utah children have special health care needs. Utah's percentage of children with special health care needs ranks third lowest in the nation.

The Utah Registry of Autism and Developmental Disabilities (URADD), identifies Autism Spectrum Disorder using a community medical diagnosis and/or autism special education eligibility to indicate a prevalence estimate of 2% for individuals aged 0 to 16 years old. Of interest is the 4 years old population, prevalence is 1.2% which demonstrates Utah is diagnosing late. This year, the Autism Systems Development Program (ASDP) developed marketing and educational materials to encourage earlier diagnosis and worked with Help Me Grow Utah and early intervention programs to implement the M-CHAT and STAT screeners. The 2018 CDC Autism rates for URADD/UT-ADDM are embargoed until publication.

The 2019 National Survey of Children's Health data provides important information on Utah's CSHCN population and their parents:

	Utah %	U.S. %
Race/Ethnicity**		
Hispanic	18.0	25.6
White Non-Hispanic	72.1	50.2
Black Non-Hispanic	0.9*	13.3
Other Non-Hispanic	9.0	10.9
Household Income		
0-99% FPL	6.7*	22.7
100-199% FPL	27.9*	21.2
200-399% FPL	40.4*	26.8
400% or greater FPL	25.1	29.3
One or More Current or Lifelong Health Conditions	91.0	91.8
Current insurance not adequate	37.9	34.9
Consistent health insurance coverage in past 12 months	94.6*	93.6
Child has coordinated, ongoing, comprehensive care in a medical home	56.5*	42.4
Problems paying for child's medical or health care bills in past 12 months	22.2*	18.2
Family member cut back hours, stopped working, or both due to child's health	15.8*	19.2

**Interpret with caution - estimate may be unreliable due to small sample size*
*** Sample size too small to include Asian race category*

Attention Deficit Hyperactivity Disorder (ADHD) Prevalence Estimates

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

In Utah, we have been able to develop a prevalence estimate of ADHD through the Utah Registry of Autism and Developmental Disabilities (URADD). Identification of ADHD was based on a community medical ADHD diagnosis

(ICD-9: 314.00, 314.01 and ICD-10: F90.0, F90.1, F90.2, F90.8, F90.9).

Percent of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) in Utah (2020)		
Birth Year	Count	Percentage
2012 (8-year-olds)	768 of 50,605	1.5%
2011 (9-year-olds)	1,131 of 51,995	2.2%
2010 (10-year-olds)	1,499 of 52,913	2.8%
2008 (12-year-olds)	771 of 54,086	1.4%
2007 (13-year-olds)	1,086 of 54,402	2%
2006 (14-year-olds)	1,687 of 53,503	3.2%
2005 (15-year-olds)	1,932 of 53,158	3.6%
Data Source: The Utah Registry of Autism and Developmental Disabilities and the UDOH Public Health Indicator Based Information System (IBIS)		

Utah Title V Capacity

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

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

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

In 2019-2020, MCH/CSHCN staff, in partnership with the University Of Utah Division Of Public Health, conducted a comprehensive statewide needs assessment to determine the priority focus for the upcoming five years. A copy of the full Needs Assessment Report can be found here.

Using results from a detailed review of Utah data and the statewide Needs Assessment, Domain Leaders met and identified priority areas, associated National and State Performance measures (NPM/SPM) and Evidence Based Strategy Measures (ESM). Designated MCH/CSHCN program staff are assigned responsibility for one or more National/State Performance measures. Additional goals and objectives are developed by each program as issues arise. Regular meetings are held to evaluate, re-assess and change strategies and/or amend program plans as needed. The Block Grant annual report and application process provides an opportunity for each program to review its accomplishments and to amend plans as needed based on its achievement of the assigned measures. For a more comprehensive description of Title V programs, please see Appendix A.

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

The Utah Department of Health (UDOH) conducts a Utah Healthcare Safety Net bi-annual meeting. The meeting involves more than 50 stakeholders vested in MCH/CSHCN. They provide insight into legislative issues affecting healthcare, community resources, facilitate networking, and collaborate with State advocates and organizations throughout the State.

Utah's Strengths and Challenges

Strengths

Utah's Title V programs have many attributes which contribute to enhancing communities' health and wellness statewide. Utah has strong collaboration efforts with stakeholders and values and incorporates the advice of our peers to develop, implement, and evaluate programs for women, children, and families. The State was prepared when the COVID-19 pandemic hit, as it had already been pilot testing telework and telehealth services. This past year, all employees worked from the home environment and continued working on expanding telehealth capacity to address teleservice needs, protections and requirements for MCH/CSHCN populations. Utah found success by being able to continue our MCH/CSHCN work with stakeholders, the public and populations we serve by being available and present for virtual meetings and service provision. We also made ourselves available on a limited need basis for face-to-face meetings when safety procedure measures were put into effect. Lastly, a huge strength during the pandemic is the resilience of our employees. The MCH/CSHCN Bureau's leadership focused on personal/family health first which then allowed team members to continue to dedicate, contribute and be innovative with meaningful service provision.

Challenges

The geographic distribution of the State's population presents significant challenges for those delivering and accessing health care services, particularly in rural and frontier areas. Long travel distances and a shortage of nearby hospital facilities and providers, particularly specialists, mean many residents must travel hundreds of miles for care. Many may be reluctant, if not unwilling, to utilize certain services in their communities, such as family planning, mental health and telehealth, because of concern for confidentiality and anonymity, as well as cultural beliefs in seeking these services.

Face-to-face service provision during the pandemic continues to create challenges due to the variety of safety measures to be considered to reduce transmission of the virus and protect the service providers and population/families we serve. Telehealth technology also poses barriers with lack of technology lines, services and equipment in both rural and frontier areas, although we have made efforts to reduce these barriers during the pandemic. This past year Utah applied for and were granted Telehealth Cares Act funding. We created a lending library for Chrome Books and hot spots in addition to distributing audiology equipment throughout the State at the local health departments to provide virtual audiology services.

The pandemic for the CSHCN population has caused significant adaptions in everyday routines due to school closures, online learning, virtual health, lack of therapy and in-home services and financial hardships. Additionally, the pandemic has raised stress and anxiety in both parents and children, tension in relationships, fear of a CSHCN or family member contracting the virus and finding ways to manage caregiving. Finding the "new normal" has been challenging as schools and daycares have closed or have had limited capacity, limits of access to health care delivery and developing new strategies for service and work processes are continuing effort areas for improvement.

Creating a “new” normal service delivery system. Allowing the past to be the past and being open and creative in developing new modern strategies for service and work processes.

Major changes and reorganization of the UDOH and DFHP happened in 2020 and have continued into 2021. The DFHP Division moved from the Highland building to the main UDOH Cannon building. The majority of employees transitioned from in person working to virtual service provision as a result of COVID-19 and following the Governor's mission to have 80% of State employees work from home.

The variety of reorganizational changes has increased the turnover of employees and has created challenges with workloads, timeliness of rehiring, orienting and stabilizing new employees. The biggest challenge to our overall system is the leadership and structural changes that occurred throughout the fiscal year. This creates stress, strain and extra work beyond the normal position related duties on employees and the system. In addition, during the 2021 legislative session, it was determined to combine the Utah Department of Health and the Department of Human Services within the state to form a Department of Health and Human Services (DHHS), and reassess programs and their placement. This may bring challenges which the MCH/CSHCN Title V programs have to navigate.

Many changes also occurred at the Local Health Department (LHD) level during the past year, in part due to COVID-19. Eight of thirteen local health departments had transitions in leadership. Six of the eight who left employment retired, and two changed health departments. Two of the new LHD Health Officers are women. These are significant changes that will impact public health in the state for many years to come.

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

The last challenge we will discuss is with the priority of addressing the COVID-19 pandemic. The UDOH has been the statewide lead on the COVID-19 pandemic and employees across all sections of the department participated in areas of pandemic safety, education, in- person testing, setting up vaccination clinics, research and media information presentations. Our executive leadership have worked tireless hours to address community, legislative, safety needs while acknowledging the efforts of the entire UDOH team. The UDOH Public Information Office was stretched to capacity addressing COVID-19 in the state, and had limited time for other requests.

Addressing the Needs of a Diverse Population

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

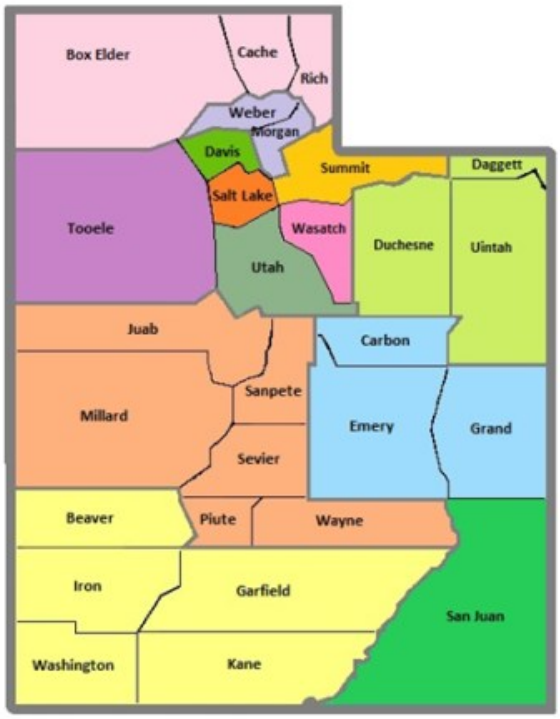
UDOH works with the Office of American Indian/Alaska Natives (AI/AN) Health Affairs. This office facilitates meetings with the Utah Indian Health Advisory Board (UIHAB). The purpose of this Board is to reaffirm the unique legal status of Tribal governments through the formal 'government to government'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

Public Health System

MCH/CSHCN services, including those for children and youth with special health care needs, are provided in various

settings, including medical homes/private providers, local health departments, community health centers that serve the homeless and migrant workers, and a number of free clinics.

Utah's public health system comprises the UDOH and 13 Local Health Departments (LHD). The Utah Department of Health and three LHDs are accredited by the Public Health Accreditation Board. Approximately half of the LHDs are multi-county districts covering large geographic areas. Many include both rural and frontier areas within their service region.



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

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

Systems of Care

The UDOH has created a safety net group of community providers who meet regularly to share their resources,

coordinate services, and identify ongoing community needs. Community Health Centers (CHCs) throughout the state and the Wasatch Homeless Clinic in Salt Lake City provide primary care to underinsured and uninsured MCH populations. Utah has thirteen CHCs who operate 56 clinics throughout the state. The Association for Utah Community Health, the state's primary care association, works to promote the development of new or expansion of existing community health centers in Utah.

The UDOH provides primary care through the Health Clinic of Utah (HCU), which is located in Salt Lake and plays a key role for the UDOH and Utah's Safety Net of providers. The medical clinic is staffed with a multidisciplinary team. The clinic provides high quality medical care at the lowest cost to clients. HCU accepts most forms of insurance including; Medicaid, the Children's Health Insurance Program (CHIP), Primary Care Network (PCN), and Medicare. Among the patients seen in the clinic in FY2019, 36.7% had Medicaid and 17.3% were uninsured. In addition to regular clinical services, the HCU provides immunizations and health screenings for newly resettled refugees and provides medical screenings for children in protective service care in multiple counties. Over the years, the HCU has reduced services. Since last year, the HCU went from three locations to one.

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

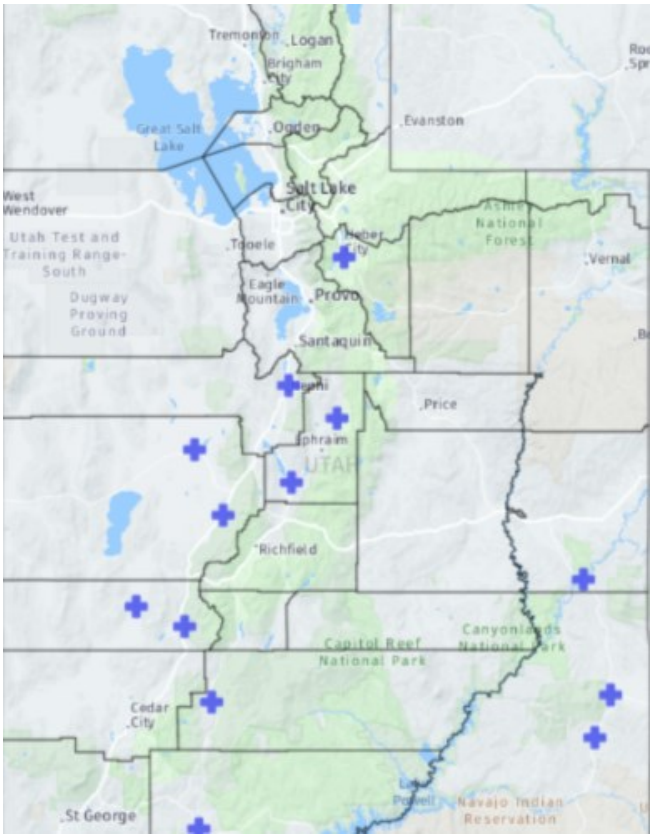
In 2019, staff with the Utah Department of Health Office of Health Disparities (OHD) conducted a qualitative study to evaluate one of its programs and to better understand challenges faced by Utah urban underserved communities in establishing a primary care provider. Thirty-five people from the neighborhood of Glendale (SLC) and the city of South Salt Lake participated in six focus groups. Represented were American-born, first-generation immigrants, refugees, single mothers, single grandparents, married couples, individuals experiencing homelessness, diverse races/ethnicities, etc. In this process, it was learned that access to health care is just one aspect of the multifaceted issue of inequity. These systematic barriers and problems must be addressed in order to improve the health of our communities.

Key takeaways from the study are as follows:
1. Cost is the main barrier: Most participants live paycheck to paycheck and do not have access to disposable income. Access to health care is perceived as a commodity not as a priority.
2. Understanding a complicated system: Participants linked the term primary care provider (PCP) with having health insurance. Although participants were fulfilling their primary care needs at free clinics, they did not perceive them to be their PCP.
3. Trust: There was a lack of trust in the health care system in general; many lacked trust in the care they receive at free clinics.
4. Stress: Financial concerns, challenging family situations, and rearing children under stressful circumstances take precedence and do not leave space or time for thinking about health.

Hospital Systems in Utah

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

Utah has 13 Critical Access Hospitals throughout the state:



Telehealth Capacity

Telehealth capacity is expanding in Utah. The 2020 America's Health Rankings Report notes that Utah has the highest percentage of households with high-speed internet, with a rate of 92.9%. To reduce barriers to early diagnosis, Utah Early Hearing Detection Intervention (EHDI) purchased auditory brainstem response equipment to provide tele-audiology services for rural communities. This equipment was placed in Blanding and Richfield, Utah. In 2019-2020, EHDI expanded the rural tele-audiology service. Utah has a small number of infant-pediatric audiologists, all of whom reside on the Wasatch Front or in the St. George area. Oftentimes, these babies become lost-to-follow-up due to lack of access to specialists, travel costs, inability to take time off from work, costs of testing, etc. In June 2020, the EHDI Program purchased 32 Otoacoustic Emission (OAE) equipment for local health departments and midwives who needed equipment. They are setting up education sessions for use of the new equipment. This will ensure providers can offer this service statewide and EHDI data remains updated and timely follow up can occur.

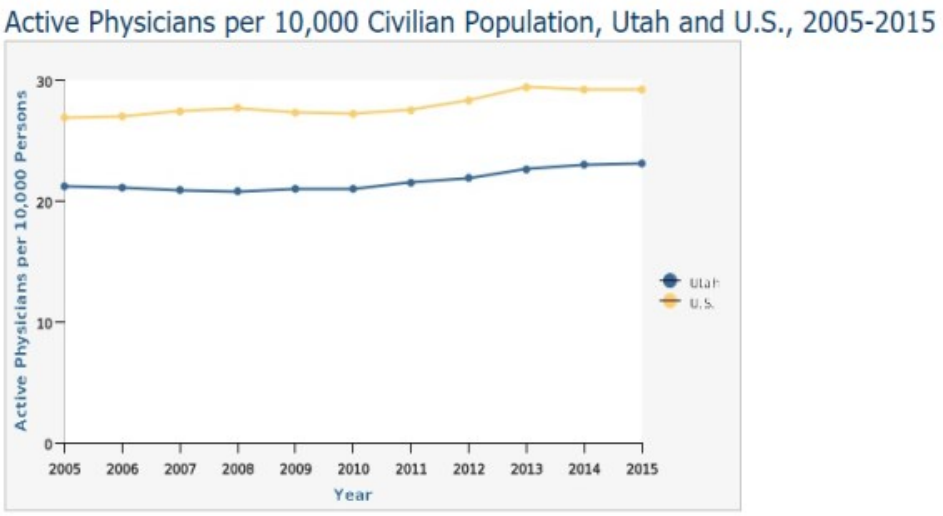
Tele-audiology services are hosted at the CSHCN Bureau with two pediatric audiologists on staff and a nurse at the remote site. During the pandemic, audiologists worked from their homes to provide the services. The nurse provides direct face-to-face contact with the family and child. The nurse connects the electrodes to the baby and stays with the family throughout evaluation testing, while the audiologist remotely accesses the computer to run the testing. The testing is considered diagnostic and if a child is identified as deaf or hard of hearing, the CSHCN Bureau helps the family with the next steps in the EHDI process, including referrals to early intervention, parent-to-parent support, and referrals to medical providers.

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

Starting in July 2019, the DFHP was requested by the Governor to support his initiative to implement and pilot teleworking. The Division over the past year transitioned many programs to telework. Some direct care service programs had not transitioned due to privacy and security concerns with patient care. Then in March 2020, when Utah started to experience the COVID-19 pandemic, telehealth became a quick methodology to implement. Due to previous experience with teleworking, both the MCH/CSHCN Bureaus were able to convert to a telehealth platform to provide continuity of care throughout Utah. National standards and changes allowed Utah to implement face-to-face services via telehealth. Within two weeks of the pandemic shut-down, the transition to telehealth was in place, all while ensuring guidelines were written to direct our services to occur in a safe, private and confidential manner. Virtual services cannot replace a face-to-face connection and services but we have found keeping communications open, providing online support and services have been invaluable during this time of crisis. We project this immediate transition has provided an opportunity for the future in offering virtual services when the individuals we serve do not have access or the ability to have a visit in person.

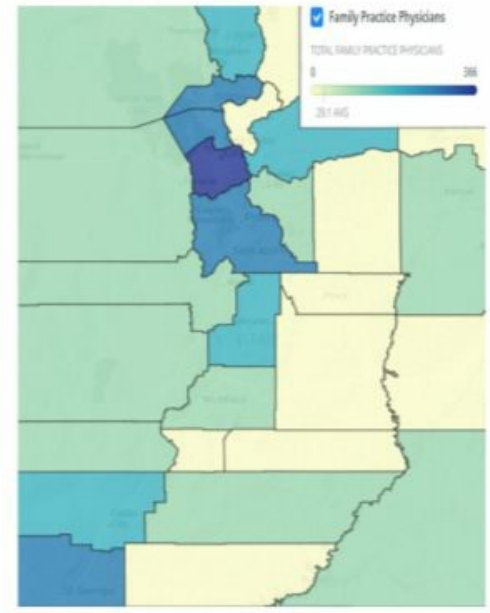
Clinical Workforce Availability

The 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. The Utah Office of Primary Care & Rural Health reports that the number of active physicians per 10,000 civilian population in Utah is lower than in the U.S. (23.1 vs 29.2, 2015 data).

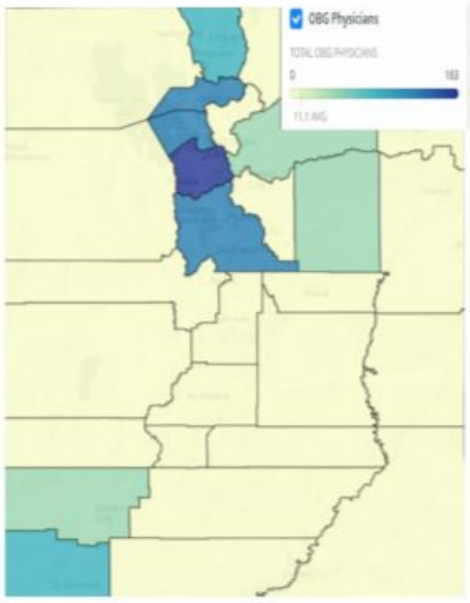


In 2017, the latest data available, the primary care physician to civilian ratio varied from a low of 1.7 in Tooele County to a high of 13.3 in Grand County. The Office of Primary and Rural Health at the UDOH noted that the distribution of healthcare providers is disproportionate to where the population resides in the state. In Utah, 21% of the population lives in rural areas, but only 11% of primary care providers, 9% of mental health providers, and 16% of dental providers work there.

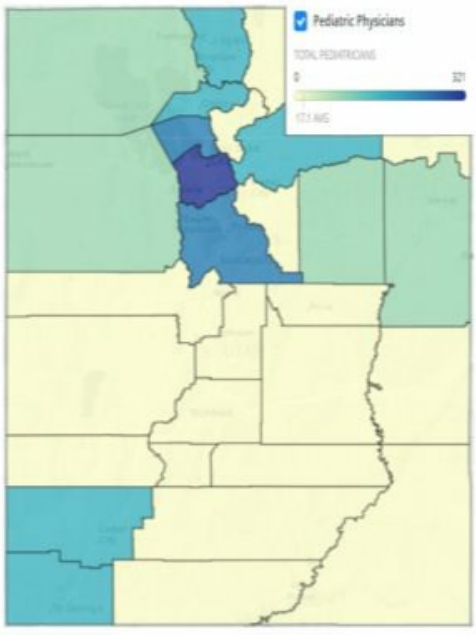
Primary Care: Family Physicians



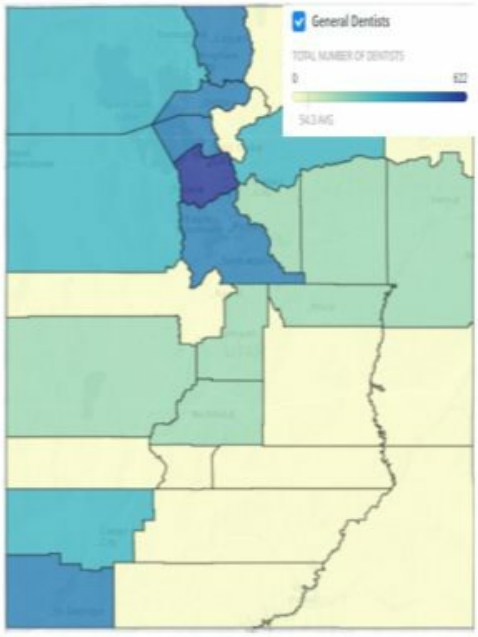
Primary Care: Obstetrics/Gynecology



Primary Care: Pediatricians



Primary Care: Dentists



For the past four years, the Integrated Services Program (ISP) has contracted with four LHDs within the State. These four LHDs provide care coordination and clinical coordination for direct care services to the CSHCN population residing within their counties. This model creates a regional “hub” or main point of contact for local families of CSHCN through which they may be referred to for support, specialists, and services that may benefit their child. Over 72% of the referrals for either care coordination, direct clinical services, or both were related to autism spectrum disorder. The CSHCN specialty and subspecialty pediatric providers are mostly located along the Wasatch Front, including the state's tertiary pediatric care centers, which are the University of Utah, Primary Children's Hospital and Shriners Hospital for Children. There is one comprehensive women and children’s health center located in the southern part of the state, serving a five-county rural area. The location of most pediatric specialists and

subspecialists in the most populous areas of the state present a problem for provider access for special needs children in rural Utah. Several counties have no pediatricians or sub-specialists, meaning families must drive long distances to access care for their children. In most cases, there is limited additional itinerant coverage from the private sector for these large geographic areas. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers.

Families continue to face formidable barriers in accessing services and coordinating care for their children with special health care needs. Access to pediatric specialists and subspecialists is adequate if you live along the Wasatch Front (although long waiting lists exist to see practitioners), but for those living in rural/frontier areas of the state, families must drive long distances to access the same services. The pandemic has adapted this service provision in that the ISP has not traveled to provide face-to-face service provision for over the past year, but adapted and utilized telehealth to meet families with their children for assessments, follow up and prescribing when practitioners are not available. The program has found this modality has allowed the ISP providers to be more flexible on appointment times and they have met in the evenings with families after the work day. Additionally, it has cut travel time and costs allowing for more service time.

Utah's Public Behavioral Health System

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

Utah Medicaid

Utah's Medicaid program is administered through the UDOH. The Medicaid program provides vital support to MCH/CSHCN populations throughout the State. Utah Medicaid contracts with managed care entities to provide medical services to Medicaid members. Utah Medicaid has two types of managed care entities that are relevant: Accountable Care Organizations (ACO) and Utah Medicaid Integrated Care (UMIC). Members enrolled through Adult Expansion living in Davis, Salt Lake, Utah, Washington, or Weber counties must choose a UMIC plan. Non-expansion members living in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties must choose an ACO. Members that live in other counties have the option to choose an ACO or the Fee for Service Network.

Each ACO or UMIC plan is responsible for covering all medically necessary services for their enrolled Medicaid members. Medicaid pays a monthly fee for each Medicaid member enrolled in an ACO or UMIC plan. Each ACO or UMIC plan is allowed to offer more benefits and potentially fewer restrictions than Utah's State Plan benefits, however they are not allowed to provide less benefits. The ACO or UMIC plan must specify services which require prior authorization and the conditions for authorization.

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

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

On December 23, 2019, the Centers for Medicare and Medicaid Services (CMS) authorized the Utah Department of Health to implement full Medicaid expansion, as authorized under the Affordable Care Act, for the State of Utah. More than 90,000 Utah adults have enrolled under the expansion program as of June 2021. Adults ages 19-64 are now eligible with household incomes up to 138% of the FPL. Enrollment in Medicaid continues year round and is not limited to an annual enrollment period.

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

Overview/Conclusion

The directors of Title V/MCH and CSHCN work with employees at the state and local levels as well as with strategic partners to implement programs and services of the Title V Block Grants three federally defined populations. The Title V/MCH and CSHCN Directors and staff use data, needs assessments, capacity surveys and historical experience to make determinations for program capacity, development and funding with the goals to improve access and services throughout Utah.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

MCH/CSHCN Ongoing Needs Assessment Activities

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

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

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

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

4. Programs within the MCH/CSHCN Bureaus collaborate to identify data gaps and to develop and conduct ongoing assessments to collect this data. Specific examples include developing questions related to well-woman care to propose for addition to the Behavioral Risk Factor Surveillance System (BRFSS) survey and developing the "Mom's Opinions on Mental Health" survey to gather information on mental health screening, treatment access and barriers, and knowledge of symptoms. Staff participate in several advisory committees, and propose adding new questions to fill identified data gaps. Advisory committees include the Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Monitoring Survey (PRAMS), Student Health and Risk Prevention (SHARP), and Vital Statistics.

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

Each year, the Center for Health Data and Informatics (CHDI) schedules a meeting with representatives from the UDOH. Participants are asked to bring ideas for potential HSU articles. The SSDI Project Director/MCH Epidemiologist represents the MCH/CSHCN Bureaus. Prior to the meeting, she requests that all MCH/CSHCN staff submit potential topics, which are presented for review 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 2020 related to MCH/CSHCN populations:

- Early Hearing Detection & Intervention (EHDI) Ten Years of Data. January 2020.
- Vaping and the Increased Risk for Youth Nicotine Addiction. February 2020.
- Children's Hearing Aid Program (CHAP). March 2020.
- Dental visits to Emergency Departments. March 2020.
- Maternal Mental Health Screening through WIC Services. March 2020.
- Child Blood Lead Status Update. June 2020.
- Maternal and Child Health State Priorities, 2021–2025. July 2020.
- Tobacco Smoking Around the Time of Pregnancy. August 2020.
- Abortion and Effective Contraceptive Use in Utah. September 2020.

- Infant Mortality in Utah. September 2020.
- Attention Deficit Hyperactivity Disorder (ADHD) Prevalence Estimates in Utah. October 2020.
- COVID-19 and the Return to Schools. October 2020.
- Infant Safe Sleep Recommendations. November 2020.

6. The UDOH produces reports to evaluate and educate on Title V populations and issues. This last year, due to the pandemic and staff turnover, only one report was finalized and published. Other reports have been drafted and are pending finalization. The MIHP published the report “Maternal Mental Health in Utah, 2017-2019” which was presented in a press conference and findings were highlighted in statewide media outlets.

7. Title V staff meet with community partners to identify emerging issues. The Utah Children’s Care Coordination Network, funded through Title V, convenes monthly as an educational and needs-based forum for care coordinators, commercial and public insurance providers, practice managers, and providers to discuss issues surrounding pediatric care coordination. Participants identify gaps in services for children with special health care needs then work together to problem solve and find solutions that include supports, specialists, and organizations that meet family needs. Guest speakers are invited to teach participants about special education, IEP/504, diagnosis-specific topics, legislative changes, Medicaid and CHIP, and other issues affecting care coordination. Based on the needs assessment, the CSHCN Bureau changed the format of outreach, accountability and goal setting. This past year has been a baseline year in which we have set up the new structure so future years will hopefully show how the changes positively affect our statewide service provision in reaching families' needs. The Integrated Services Program (ISP) holds weekly meetings with stakeholders who serve the CSHCN population and discuss collaborative ways to market services, refer to each other, unify quality assurance and satisfaction measures and lastly select a unified curriculum and process to educate the public on who access our services for both medical home and transition.

Concerning Changes in Utah’s MCH/CSHCN Populations

During the pandemic many issues arose and deficiencies were identified in the system. Lack of access to healthcare, food/hygiene/first aid resources, employment, housing and available resources, stable/reliable internet connections, language/cultural barriers, mistrust due to mistreatment, disparities and inequities have occurred. Gaps have been identified in the surveillance, data and effective communication systems throughout the State.

In the beginning and throughout the pandemic foster children and their families have been sick with COVID-19. The Christmas Box House, a facility which houses children who cannot be placed also caught the virus. With short staffing and quarantine, the children were limited in their activities and interactions. In the beginning of the pandemic, the CSHCN Bureau purchased 12 iPads and 18 headsets for the foster children in custody to utilize for education and school assignments, free time entertainment, and telehealth, as DCFS did not have funding to support these efforts. Additionally, this past year the Fostering Healthy Children Program (FHC) took the initiative to create an identification, monitoring and follow-through tracking system to assist the children, youth and families who contracted the COVID-19 virus.

The full impact of COVID-19 on MCH/CSHCN populations is yet to be determined. Preliminary birth data shows that the number of births in 2020 is down from 2019. We anticipate that the proportion of the population who attended preventive health visits during 2020 will be lower than in previous years. We also anticipate that with children isolated at home and not attending school, child abuse and adverse childhood experiences may go undetected. Additionally, the Utah Registry of Autism and Developmental Disabilities (URADD), which tracks the prevalence rates for Autism Spectrum Disorder and other Developmental Disabilities, has begun collecting data from 2020. This will allow CSHCN to look at the fallout of COVID-19 on the ability of families to obtain a diagnosis for their child or adolescent. Title V leadership will continue efforts to address these issues and work with stakeholders to improve the statewide system.

In January 2021, a new PRAMS report on maternal mental health was published. The report noted that the frequency of people reporting anxiety before pregnancy significantly increased from 12.8% in 2012 to 27.8% in 2019 and the frequency of reported postpartum depressive symptoms significantly increased from 11.2 % in 2012 to 15.0% in 2019. As the prevalence of perinatal mental health conditions is increasing in Utah, timely access to mental health resources is vital for parents and providers. This new data supports the need for continued focus on perinatal mood and anxiety disorders.

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

The COVID-19 pandemic impacted the systems of care in the State of Utah, including those for Title V populations. These impacts were especially felt among Utah's Local Health Departments (LHDs).

The COVID-19 pandemic of 2020 (and ongoing) arrived with force and completely overwhelmed public health especially at the LHD level. LHDs began preparation several months prior to the arrival of COVID-19 in Utah. Plans were reviewed, revised and re-implemented. Staff were retrained, educated and prepared for this upcoming situation. However, the impact of COVID-19 exceeded LHD capacity and consumed programs. LHD's had a responsibility to protect their residents to the best of their ability and priority was focused on this endeavor. It was an "all hands on deck" situation and every single person at each LHD was deployed to assist in this pandemic. Staff only recently have been able to start moving staff back to their original roles and programs. Staff have experienced extreme stress and trauma in the past year and long-term effects of COVID-19 on our public health workforce are a concern, including burnout and retention.

Clearly, some services had to continue (i.e. WIC, food/water sanitation, other disease investigations) and several modifications were implemented to safely provide these services. One area that was greatly impacted was Maternal Child Health (MCH). The COVID-19 pandemic needed nursing services for health assessments, testing and vaccinations and most, if not all, MCH nurses were pulled away. These nurses were some of the key individuals who were recruited early in the pandemic and continue to be utilized as the vaccination clinics and outbreaks continue. Additional staff were hired to help, but the workload remained at a high level, requiring internal staff to continue their support and MCH programs to be put on hold.

MCH services were put on the back burner as LHDs worked to address pressing issues such as rent, work, and personal health. As time allowed, outreach efforts were done to check up on clients via virtual/telephone methods. LHD's started doing more telehealth services and moved away from in-person visits to keep things going. Challenges noted in this process include not having enough private spaces in their worksites to allow all staff to work while protecting client confidentiality. As such, staff had to share private work spaces and alternate use of these areas. Additionally, internet access in some parts of the state is not equitable.

It is hard to move to a "recovery" phase of the pandemic when LHD's are still significantly dealing with an acute situation. Progress is being made with new COVID-19 funding coming to LHDs to support these efforts. There is a small light at the end of the tunnel. LHD's recognize the importance of getting these services back out to the Title V population and are prioritizing staffing to help get back to normal.

As LHD's pick up where they left off in the MCH realm, they are preparing for new and difficult situations that have impacted this population as a result of the pandemic (i.e. mental health issues, lack of preventative care, developmental delays). It is more important now than ever that MCH programs ramp back up to help serve this important and fragile population.

In October 2020, the CSHCN Bureau was awarded the AMCHP Telehealth Cares Act funding. This provided an opportunity to think outside of the box for ways the CSHCN population is reached, both during the pandemic and moving forward when in-person services are not an option. Processes and procedures have been developed to ensure sanitized equipment is available for delivery or pick-up, pre-visit, and return or pick up of loaned equipment.

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

Care coordinators and F2F HIC are educating and practicing with families on how to connect with telehealth providers and, as needed, are physically available to the family during their initial visit. The lending libraries are located at various agencies throughout the State of Utah, which include trained professionals with backgrounds in medicine, nursing, social work, care coordination, family peer support, audiology, physical and occupational therapies, and speech/language pathology. The lending library has been marketed through the hospital systems, Utah Parent Center/F2F HIC, Help Me Grow Utah, state and local health departments, and local primary care providers. In the past three years, the EHDI state audiologists have completed 60 diagnostic Auditory Brain Response (ABR) tests via telehealth (in the rural areas of Blanding and Roosevelt, Utah), which has allowed for timely diagnosis and intervention for infants. Utah is the only state currently providing this public health service.

Although these services have greatly helped families living in these two regions, other rural areas would also benefit from our teleaudiology program. This funding opportunity has expanded our reach by adding three more tele-audiology sites - two rural and one urban site in an underserved, low income, Latino community. This grant has funded the necessary audiology diagnostic testing and video-conferencing equipment (i.e., ABR, otoacoustic emissions).

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

A positive benefit of the AMCHP Telehealth CARES funding was both to create a virtual technology lending library and the ability for the Utah Parent Center to be able to utilize the equipment for scheduling and tracking vaccination appointments. The CSHCN Bureau Director coordinated with the Utah Parent Center and CSHCN families to coordinate them receiving the SARS-CoV-2 vaccination and being educated on the benefits, side effects, down time and needs for child care support after receiving the shot.

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

The Utah CSHCN Team applied for the P4 Challenge and our proposal included patient record review to determine which children are outside recommended well-child visit parameters; access to real-time patient-specific immunization and other public health data; referral to supportive care coordination with local care coordinators; and use of portable telehealth technology such as Chromebooks and Wi-Fi hotspots. All components of the intervention may not be well-suited to all patients in all locations, so discretion would be used on a case-by- case basis to tailor the most effective solution to serve the local population. Unfortunately, the funding was now awarded, but CSHCN will encourage the practices and clinics targeted for this intervention to enroll in the Child Health Advanced Records Management (CHARM) system. CHARM links several health care databases, primarily within the Utah Department of Health, to create a consolidated electronic health record for every child in Utah. Enrolled providers log into the CHARM Web Interface to allow access to newborn screening results, status of early intervention enrollment, and immunization histories.

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

The CSHCN Bureau programs strive to coordinate care for the children, adolescents and families served throughout the State. The ISP contracts with four Local Health Departments in rural Utah to provide Care Coordination in those communities. The Bureau has internal communication methods to encourage care coordination and transition for the populations served using an electronic record called CaduRx which allows sharing of patient records in one system to ensure clear communication and follow-through methods to reduce loss to follow-up.

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

Breadth of the State's Title V Partnership and Collaborations

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

The unexpected impact of COVID-19 allowed for broader statewide collaborations. With moving all meetings to an online forum, programs have seen an increase in partner participation in meetings. This has been especially noticed with our partners in rural areas of the state who can participate without a long drive.

The Early Childhood Utah Program has seen an increase in engagement from partners due to the online format for meetings. This has increased collaboration occurring within state and partner programs. ECU has seen a decline in use of the Ages and Stages Questionnaire (ASQ) Developmental Screener because children were not attending programs they usually would. However, there was an uptick in the Social Emotional Screener. As partners have become more comfortable with online platforms, ASQ use is increasing again.

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

Changes in Organizational Structure and Leadership

The Utah Department of Health (UDOH) is one of many state agencies in the structure of Utah's Government. During the 2021 legislative session, House Bill 365 was passed to combine the UDOH with the Department of Human Services in 2022. The Bureaus of Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) are housed in the Division of Family Health and Preparedness (DFHP), one of four Divisions in the UDOH. MCH/CSHCN are the lead agencies responsible for the administration of Title V activities.

This past year brought change in Utah State leadership throughout the system including a new Governor, Spencer James Cox, and new cabinet members. At the Department of Health level, Richard Saunders was appointed the Executive Director of the Department, along with Heather Borski, and Michelle Hoffman, MD as deputies. The Division of Family Health & Preparedness (DFHP), had a variety of leadership retirements. On March 1, 2021, Sarah Woolsey, MD was appointed as the new Director of DFHP. The organizational charts submitted with this application include UDOH, DFHP, MCH and CSHCN.

Sarah Woolsey, MD, is board-certified in family medicine and previously served as medical director with Comagine Health, Utah's quality improvement activities and regional health collaborative. She has contributed to the Utah Partnership for Value, a multi-stakeholder group that values health care delivery and patient engagement in Utah. Dr. Woolsey has been actively engaged in the advancement of community quality metrics through the Utah State Health Data Committee's Transparency Advisory Group and is a member of the state's Health Data Committee. She has worked in primary care for 20 years with underserved populations in Salt Lake City as a full-spectrum family doctor. The MCH/CSHCN Bureaus are excited to have Dr. Woolsey as a new leader who brings positive energy, engagement and new insights on how to improve the health and welfare of the women, children and families served throughout Utah.

The Bureau of Maternal and Child Health is headed by Bureau Director, Lynne Nilson and the Children with Special Health Care Needs is headed by Bureau Director, Noël Taxin. Significant staffing/structure changes happened during the past year:

Maternal and Child Health Bureau:

The MCH Epidemiology manager retired in May 2021 after a 30 year career, 21 of these years were with the Bureau of Maternal and Child Health. The SSDI grant coordinator left in October 2020 and the position was filled in May

2021. The Family and Youth Outreach (FYO) program manager left in May 2021 (Adolescent/Child, Oral Health, Pregnancy Risk Line/Mother to Baby, Utah Early Childhood Utah, Safe Haven). The vacant Epidemiology Program Manager position will be filled in October. Due to a variety of reasons that will be addressed later in this application the MCH Bureau Director decided not to replace the FYO Program Manager and all the functions of this program were split among other MCH Managers and the Bureau Director. See attached MCH Org chart for details of this change.

Bureau of Children with Special Health Care Needs:

The CSHCN Bureau hired two new epidemiologists to replace employees who left employment to support the programs. A number of nurses in the foster care system retired but we were able to replace those positions with new members to join the team. Lastly, with the ever changing structure changes to the system (i.e. minimal clinical services and closing our clinic), moving locations and reducing our space significantly. We have had to look at certain positions, reduce them and or redesign the job descriptions. Overall this year we have maintained the CSHCN staffing and continued service provision with quality.

Bureau of Health Promotion:

The Bureau Director position changed this year as well. The former BHP Bureau Director became a UDOH Division Director. And the Violence and Injury Prevention (VIPP) Program Manager was promoted to be the new BHP Bureau Director. An internal staff person was promoted to be the VIPP Program Manager.

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

III.C.2.a. Process Description

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

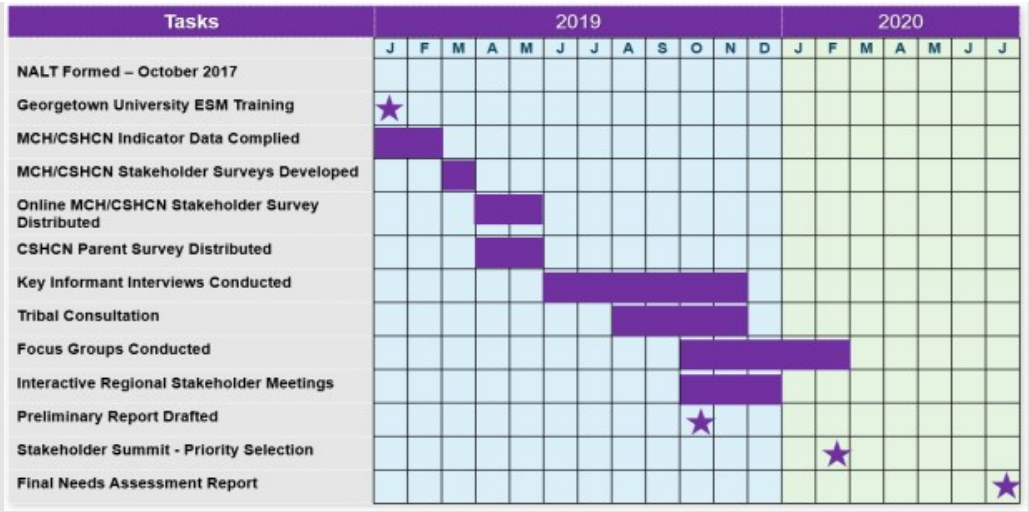
Needs Assessment Planning Process - As part of the Title V 2020 Maternal and Child Health (MCH) Needs Assessment, a Needs Assessment Leadership Team (NALT) was established to oversee the development and implementation of the 2020 MCH Need Assessment (NA) activities. The NALT consisted of the Maternal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

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

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

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

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



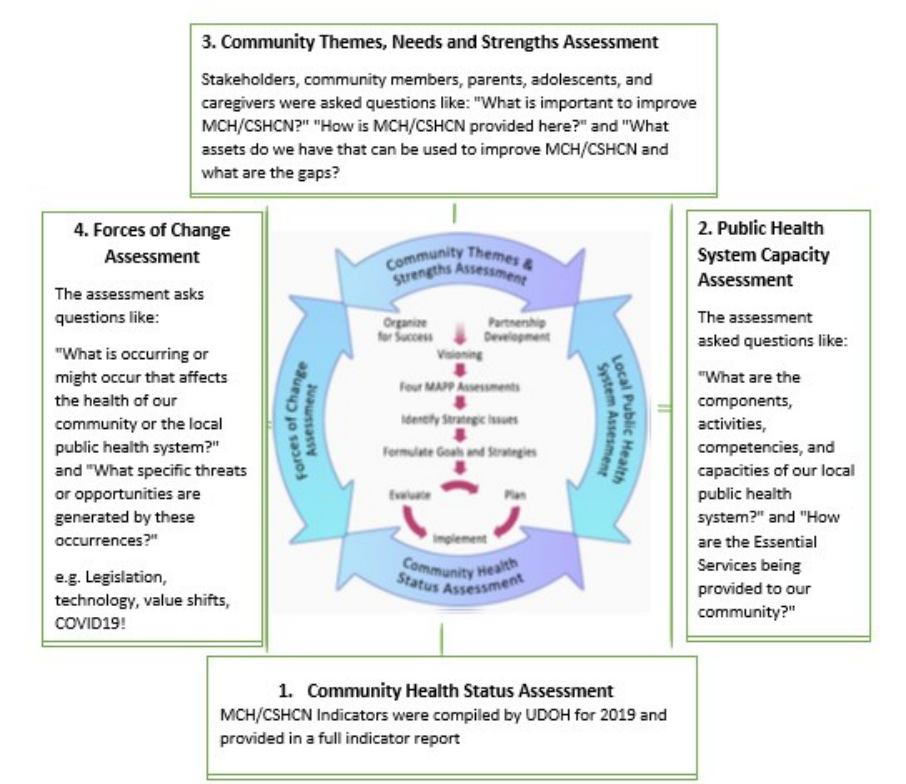
Participation by method, is presented in Table 1.

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

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

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

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



III.C.2.b. Findings

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

Results

1. **Community Health Status Assessment**

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

Health Insurance

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

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

Access to Care

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

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

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

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

Mental Health

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

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

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

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

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

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

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

Substance Use

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

Percent of adolescents who reported being offered, sold, or given an illegal drug on school property = 25.9%
Percent of adolescents who reported that they have never drank alcohol = **69.6%**
Percent of adolescents who reported that they have ever used marijuana = **16.6%**

Immunizations

Percent of children who have completed the combined 7-vaccine series = **67.9%**
Percent of female adolescents who have received at least one dose of the HPV vaccine = **63.1%**

Nutrition and Physical Activity

Percent of infants who were exclusively breastfed through 3 months = **55.5%**
Percent of children who are physically active at least 60 minutes per day, ages 6 – 11 = **21.9%**

Reproductive/Sexual health

Adolescent female Chlamydia rate, ages 15 - 19, per 100,000 = **1651**
Teen birth rate, ages 18 - 19, per 1,000 female population = **30.0**

2. Public Health System Capacity Assessment

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

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

Specifically:

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

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

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

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

recruitment strategies to increase diversity of staff who serve the community.

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

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

Top Concerns -

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

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

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

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

Access to Care/Health Insurance – Access to care related to affordability, including affordable health insurance, was a key issue for women, infants, and CSHCN domains. It was not noted as a priority for children and adolescents but was a particular concern of parents with CSHCN. There is strong support among stakeholders for ‘universal’ type of insurance coverage. However, they think they are the only ones. “This is Utah” is a sentiment used implying that this [universal/equitable] health coverage will never happen. There is hesitancy to voice their true feelings on this matter.
Specific recommendations for addressing access to care include:

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

Access to Care/Due to limited care – A variety of types of care were described as very limited and sometimes non-existent. This was the top concern for the CSHCN domain, where specialty medical care is extremely limited, especially in rural areas, and developmental screening is not comprehensive. Mental health and behavioral health services were described as very limited and as a system that is not nearly robust enough to meet the needs. Other

programs and services that are wanted and needed, but limited in scope include family planning, sexual health education for youth, quality and affordable childcare and afterschool care, school nursing, dental care, and training for parents/parenting skills. Specific recommendations for public health funding include:

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

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

Priority Issues and Service Needs of MCH/CSHCN Participants

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

Results of Online Surveys: Top 10 Ranked Issues by Domain

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

Maternal Health Domain – Top 10 Ranked Issues (n = 1025)[a]	
Rank[b]	
1	Depression, anxiety, or other mental health issues
2	Access to health care
3	Not having health insurance
4	Access to family planning services
5	Domestic violence/partner abuse
6	Parenting knowledge
7	Drug use: illicit use during pregnancy or postpartum
8	Not getting immunizations
9	Environmental exposures (such as air pollution, pesticides, other metals/chemicals)[c]
10	Prenatal care[c]

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

Infant/Perinatal Health - A total of 638 people answered questions about infant health in the online survey. The majority were women (85.9%), 87.1% were white, 9.7% Hispanic/Latino, and 1.6% Asian American/Asian, American Indian, Native American, or Alaskan Native, and 0.6% were Black or African American. The sample suggests that non-white participants were underrepresented when compared to the overall population. Rankings did not vary much by age group. The majority of participants reported their primary role as a clinician or public health professional, 66%, while 34% identified as a parent or community member. Priority rankings were similar in these groups with the exception of neonatal abstinence/withdrawal made the list for health professionals, but not community member/parents. The majority of respondents, 84.6%, were urban dwellers compared to 15.4% rural. The top 10 issues for this domain are:

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

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

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

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

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

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

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

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

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

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

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

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

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

COVID-19 Pandemic - The most notable force of change is the COVID-19 pandemic, which emerged in the latter part of this assessment in Spring of 2020. While consequences of this disruptive force are not fully understood, there are some emerging concerns and opportunities to consider:
• With people isolating at home, fewer women and children may be accessing well-child, prenatal visits, dental, and other preventive healthcare.
• With children isolated at home, not attending school, child abuse and ACEs may go undetected.
The economic downturn caused by the pandemic will put pressure on public health programs, we anticipate a larger proportion of the population will become eligible for programs like Medicaid, Baby your Baby, Early Intervention, WIC, and others.
• Multiple programs in MCH and CSHCN have experienced budget reductions and more are likely in coming months in reaction COVID-19 related economic crisis. These cuts are driven by a desire of Utah lawmakers to prioritize balancing the budget, which negatively impacts health and social services.
• With people at home including providers, CSHCN clinics services and home visits have been put on hold, only allowing for telehealth. Not providing in person visits limits the ability for screening, assessments, diagnosing and comprehensive care.
• Telehealth is becoming more accessible and reimbursable, meaning more specialty care and mental health care may be available. This is a timely opportunity, especially for rural areas.

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

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

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

address social determinants of health.

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

In addition to MCH/CSHCN focused SPM and NPMs, UDOH should work with partners to:

1. Address social determinants of health and intergenerational poverty.
2. Improve access to healthcare and affordable health insurance.
3. Better fund Children with Special Healthcare Needs and leverage new telehealth efforts.
4. Address family violence, abuse, neglect and increase affordable childcare, and
5. Work across sectors to expand needed mental health services.

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

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

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

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

The Division of Family Health and Preparedness (DFHP) is headed by Director Paul R. Patrick. The Bureau of Maternal and Child Health is headed by Bureau Director, Lynne Nilson and the Children with Special Health Care Needs is headed by Bureau Director, Noël Taxin.

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

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

The MCH and CSHCN Bureaus collaborate with other state agencies, key partners and private organizations on a regular basis to address ways to improve the health of women, infants and children in the state.

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

Program. The MCH Bureau also contracts with and oversees 13 local health department contracts for services to mothers, children and adolescents.

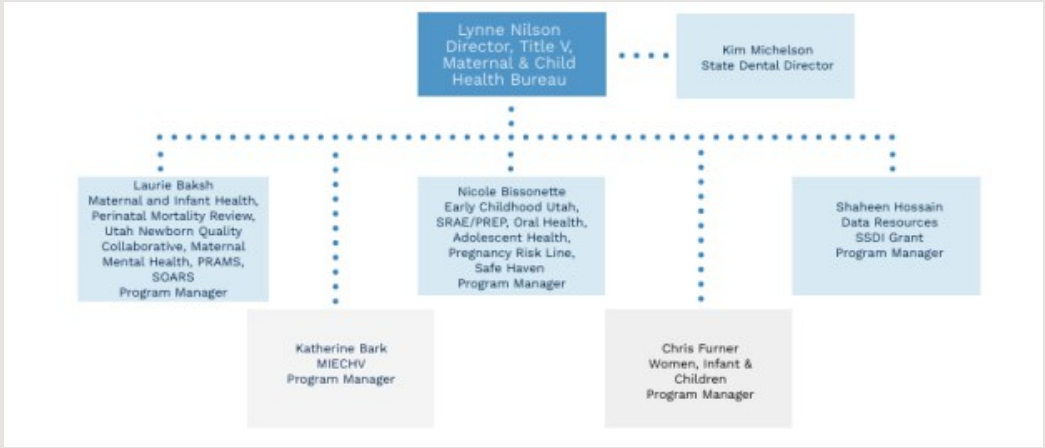
The CSHCN Bureau oversees fifteen programs that focus on improving the statewide system of care for CSHCN and their families: Autism Systems Development Program; Baby Watch Early Intervention Program; Child Health Advanced Records Management (CHARM); Critical Congenital Heart Defect Screening; Children's Hearing Aid Program (CHAP); Cytomegalovirus Public Education and Testing (CMV); Early Hearing Detection and Intervention (EHDI); Fostering Healthy Children Program; Integrated Services Program (ISP); Kurt Oscarson Children's Organ Transplant Fund; Organ Donations; Utah Birth Defects Network (including Zika Surveillance Intervention and Referral Program); Utah Family Voices and Weber Early Intervention Program. The CSHCN Bureau improves the quality of life for families and children with special health care needs by monitoring occurrence, early screening, education, care coordination, transition and intervention to reach optimal health.

The CSHCN Bureau programs strive to coordinate care for the children and families served throughout the State. The ISP contracts with four LHD's to provide Care Coordination in those communities throughout the State. The Bureau has internal communication methods to encourage care coordination and transition for the populations served using an electronic record called CaduRx which allows sharing of patient records in one system to ensure clear communication and follow through methods to reduce loss to follow up. Additionally, other platforms such as: Hi-Track, monthly meetings, data sharing agreements, CHARM and shared resources to create a system which flows smoothly for Bureau employees are utilized. The Bureau also has external partnerships with other State agencies which are working toward reducing redundancies, creating data sharing agreements, utilizing CHARM, quarterly meetings and working towards utilizing the cHIE electronic record in sharing records in a one stop shared resource.

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

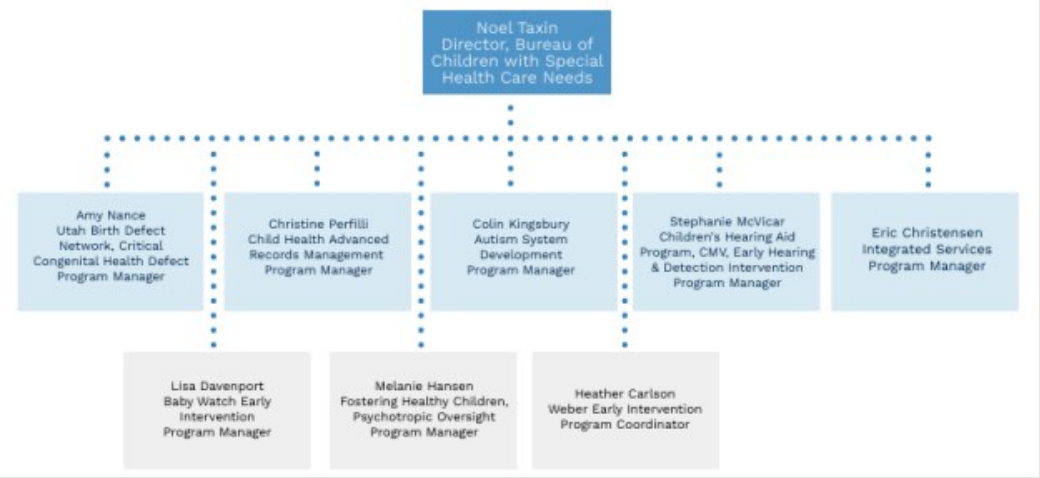
MCH/CSHCN managers lead the work of planning, implementation, evaluation, and data analysis capacity. The graphics below show the names and titles of the Bureau's/Programs in MCH/CSHCN and the Bureau of Health Promotion who address MCH/CSHCN issues. A blue box indicates if a program is funded (full or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

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

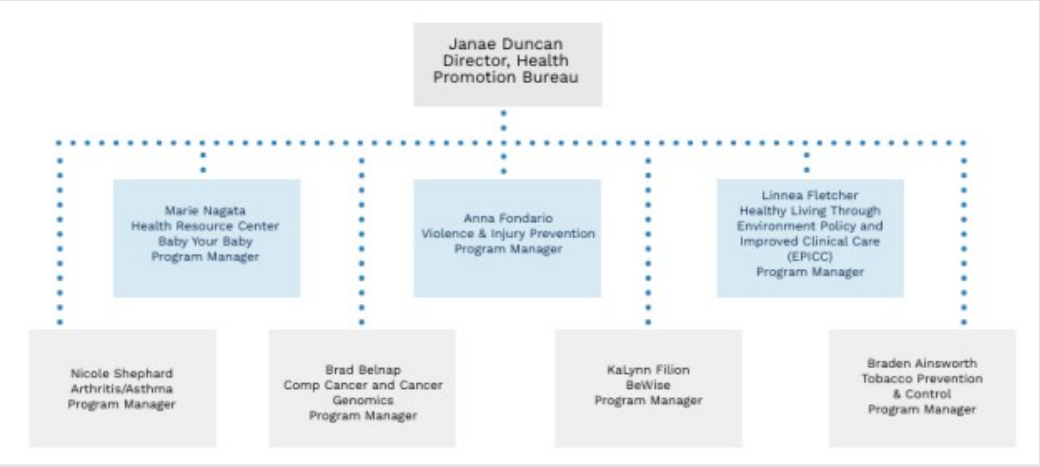


Bureau of CSHCN - The CSHCN Bureau oversees fifteen programs that focus on improving the statewide system of care

for CSHCN and their families: Autism Systems Development Program; Baby Watch Early Intervention Program; Child Health Advanced Records Management (CHARM); Critical Congenital Heart Defect Screening; Children's Hearing Aid Program (CHAP); Cytomegalovirus Public Education and Testing (CMV); Early Hearing Detection and Intervention (EHDI); Fostering Healthy Children Program; Integrated Services Program (ISP); Kurt Oscarson Children's Organ Transplant Fund; Organ Donations; Utah Birth Defects Network (including Zika Surveillance Intervention and Referral Program); Utah Family Voices and Weber Early Intervention Program. The CSHCN Bureau improves the quality of life for families and children with special health care needs by monitoring occurrence, early screening, education, care coordination, transition and intervention to reach optimal health.



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



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

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

LHD to determine staffing for Title V activities.

Additional Workforce Capacity (not funded by Title V) - Both the MCH and CSHCN Bureaus have a productive relationship with the Office of Vital Records and Statistics (OVRS). Staff from OVRS provide timely data to many staff within Title V programs. In addition to data, staff from Vital Records are asked to participate in many MCH/CSHCN advisory groups. Staff in OVRS have been very open to adapting the birth certificate to provide Title V programs the data they need. In return, MCH/CSHCN staff participate in statewide training of birth and death certificate clerks and offer quality improvement suggestions to OVRS staff when data issues are identified.

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

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

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

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

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

MCH/CSHCN have established partnerships that help expand the work of reaching women, infants, children (including CSHCN), and families. Federal and non-federal funds are leveraged to deliver programs and services in the state. MCH/CSHCN staff maintain working relationships with Title V and non-Title V Programs to create a statewide system of collaboration.

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

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

Programs funded by HRSA Maternal and Child Health Bureau:

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

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

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

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

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

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

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

The UDOH has a positive relationship with Community Health Centers (CHC), the Primary Care Association and the Association for Utah Community Health (AUCH). The Oral Health Program works with AUCH to provide technical assistance to their dental clinics and encourage the addition of dental clinics in other community health centers.

Effective partnerships with Utah’s hospital systems have been formed through the Utah Women and Newborns Quality Collaborative (UWNQC). Through UWNQC, participating hospitals regularly work on improving the care for Title V populations, an example of which is implementing the Opioid Use Disorder, hemorrhage, and hypertension safety bundles.

Additionally, the Critical Congenital Heart Defects and Early Hearing Detection & Intervention Programs work with hospitals and mid- wives to improve screening rates for all newborns in the state by providing education and follow up.

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

The Violence and Injury Prevention Program (VIPP) has developed a close working relationship with DSAMH as well. Program staff co-chair the Utah Suicide Prevention Coalition with DSAMH and work together on all suicide prevention efforts following the jointly developed activities of the Utah Suicide Prevention Plan. DSAMH staff serve on the Utah Child Fatality Review Committee and Domestic Violence Fatality Review Committee. VIPP also works with them on all prescription drug overdoses activities, such as coordinating the Use Only As Directed campaign. VIPP provides extensive data to DSAMH for use in their program planning and advises on legislative issues concerning suicide and prescription drugs, etc.

The Division has developed a strong collaborative working relationship with the Division of Child and Family Services (DCFS) and Child Protective Services (CPS) in a number of efforts, including providing services for children in foster care through a contract with the CSHCN Fostering Healthy Children Program (FHC). FHC is an exceptional program that ensures these children and youth receive needed medical, dental and mental health services.

UDOH Division representatives sit on the DCFS Child Abuse and Neglect Council, and an interagency group, Utah Prevention, to address substance use and other issues among youth. Division representatives are part of an interagency group to address youth transition issues.
Additionally, legislation passed in 2020 allows for better coordination of services with women identified as using substances during pregnancy. Staff in the MIECHV and MIHP programs have been working with DCFS on this project.

The Baby Watch/Early Intervention (BWEI) Program has a number of collaborative relationships. They worked with DCFS to develop policy and procedures for CAPTA requirements for referral of children with substantiated abuse and neglect to BWEI. Children who show potential problems are referred to BWEI. Local BWEI agencies partner with local DCFS personnel to train on the developmental screening tool and design referral procedures for children suspected of a developmental delay.

The Baby Watch Early Intervention program has an Interagency Coordinating Council (ICC) which is an independent advisory board appointed by the governor and required by federal regulation to include parents, EI providers, agencies, and representatives from the community. The purpose of the ICC is to provide meaningful direction, assistance, and support to the lead agency.

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

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

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

As a conclusion to the Needs Assessment process, a statewide in-person (with virtual capacity) summit was held on February 28, 2020. At this meeting, findings from the needs assessment, including previous stakeholder meetings, were presented. The NALT domain leaders presented their recommendations about the selection of state and national

performance measures for the next five-year cycle of the Title V grant. The audience was polled using PollEverywhere to share their input about the recommendations. Participants then broke into interest areas and further developed and presented recommendations.

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


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

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,349,076	$6,899,911	$7,374,954	$6,160,252
State Funds	$16,946,700	$16,235,243	$18,296,900	$15,490,482
Local Funds	$1,794,900	$1,188,395	$2,429,500	$0
Other Funds	$30,114,400	$11,081,603	$12,442,100	$15,200,399
Program Funds	$4,948,100	$4,798,663	$5,173,800	$947,208
SubTotal	$61,153,176	$40,203,815	$45,717,254	$37,798,341
Other Federal Funds	$59,382,100	$56,954,456	$57,415,800	$44,894,510
Total	$120,535,276	$97,158,271	$103,133,054	$82,692,851

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

	2022	
	Budgeted	Expended
Federal Allocation	$6,598,690	
State Funds	$16,182,050	
Local Funds	$4,100,000	
Other Funds	$15,214,000	
Program Funds	$1,044,900	
SubTotal	$43,139,640	
Other Federal Funds	$53,211,500	
Total	$96,351,140	

III.D.1. Expenditures

UTAH 2020 EXPENDITURES - FINANCIAL NARRATIVE

Overview

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

Expenditures (FY 2020 Annual Report Year)

Utah's Title V state match (as reflected on Form 2, line 3, "State MCH Funds" in Annual Report Expended) exceeds federal match and Maintenance of Effort requirements. State match is composed of state general funds, including funds for Early Intervention, Home Visiting, Newborn Safe Haven, Maternal Mental Health, and Children with Special Health Care Needs. Fluctuations in actual State Funds expended can occur each year based on one-time funding as match and maintenance of effort requirements for other federal funds or transfers being received. Form 2, line 5, "Other Funds" in the Annual Report Expended represents WIC rebates, and other revenue from other State Agencies (Department of Workforce Services, Department of Human Services), as well as revenue agreements with private nonprofits. Program Income (Form 2, line 6) includes fee revenue such as Pregnancy Risk Line collections, Baby Watch parent fees, CSHCN insurance billings, and Newborn Screening Kit Fees.

Form 2, "Other Federal Funds," shows Utah's MCH work was also supported by a variety of other federal funds in FY 2019 including: Women, Infants and Children (WIC); State Systems Development Initiative; Pregnancy Risk Assessment Monitoring System, Early Intervention, Early Childhood Utah Developmental Screening, and Home Visitation Funds.

Utah tracks expenditures to comply with the Title V 30/30/10 legislative requirements. That is, a minimum of 30% of total funding must be expended for CSHCN; a minimum of 30% of total funding must be expended for preventive and primary care for children; and a maximum of 10% of total funding can be expended for Title V administration.

In FY 2020, 34.8% of Title V expenditures were CSHCN; 50.2% of expenditures were for preventive and primary care and 8.7% of expenditures were for Title V administrative costs.

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

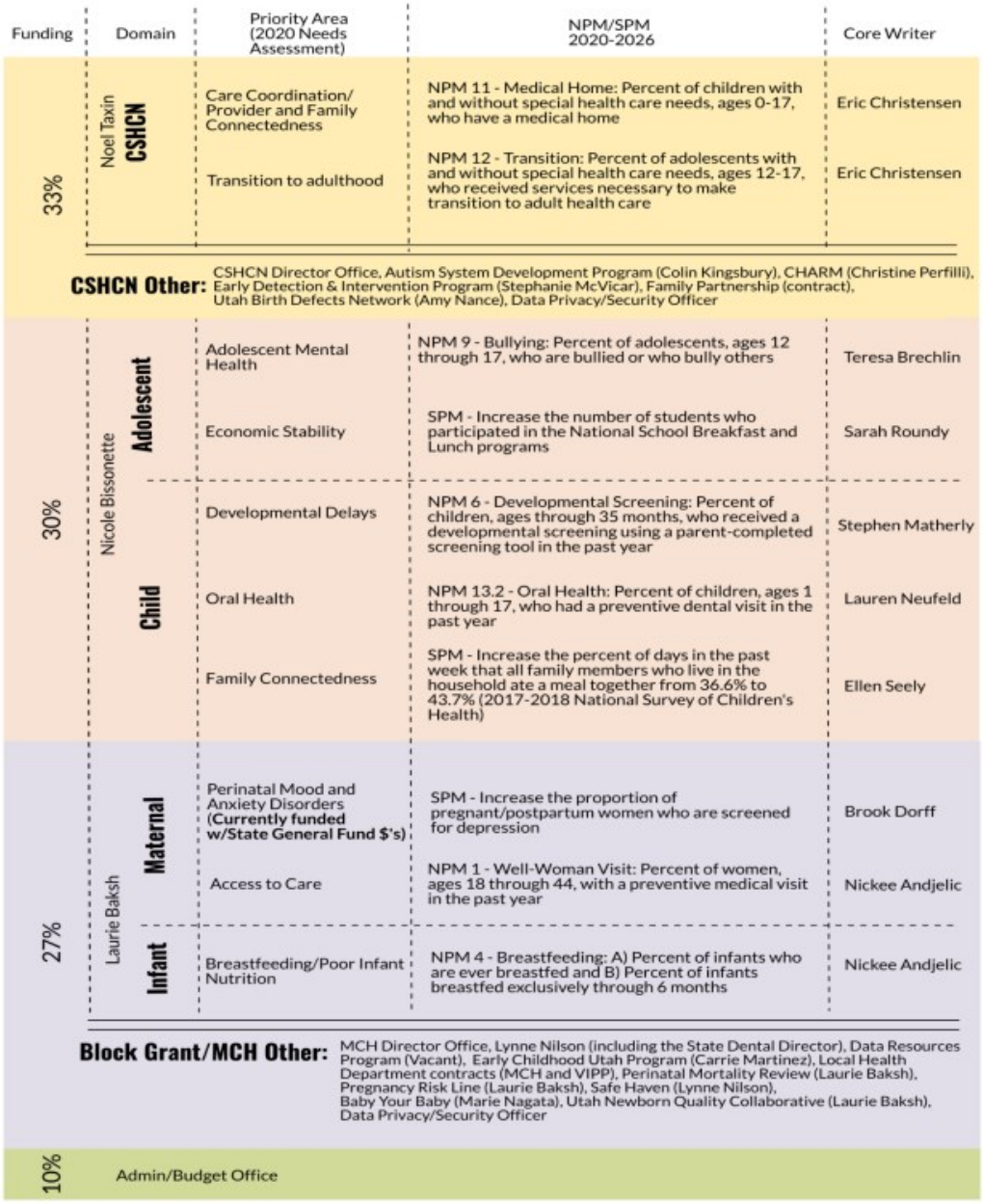
III.D.2. Budget

UTAH BUDGET (FY 2022 Application Year)

Together with state general funds and other federal funds, the Title V MCH block grant is used to address Utah's MCH priority needs, improve performance related to targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. Utah's Title V Leadership Team meets on a regular basis to discuss all aspects of Title V, including the budget and how federal and non-federal funds are being used to address the state's MCH needs. The table below illustrates projected Title V funding allocations for FY 2022:

Program	Proposed Budget 10/01/2021 - 09/30/2022
BUREAU OF MATERNAL AND CHILD HEALTH	
MCH Admin	$398,000.00
Maternal and Infant Health (Maternal and Infant Health, Utah Women's Quality Collaborative, Perinatal Review)	$375,500.00
Family Youth Outreach (Pregnancy Risk Line, Oral Health, Newborn Safe Haven)	$556,900.00
Data Resources	$300,000.00
BUREAU OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS	
Bureau of Children with Special Health Care Needs (Admin, Early Hearing Detection, Birth Defects, CHARM)	$757,500.00
CSHCN Integrated Services	$1,234,200.00
DISEASE CONTROL AND PREVENTION	
Baby Your Baby	$200,000.00
BHP Physical Activity	$99,500.00
Violence & Injury (VIPP)	$450,980.00
Community Injury (VIPP) - LHD Contracts	$387,710.00
FINANCIAL, LOCAL, OTHER	
Financial Resources	$150,000.00
LHD Contracts	$1,188,400.00
Child Development	$50,000.00
Utah Indian Health Advisory Board One Time	$0.00
Health Disparities Federal MCH 2 Year Project	$0.00
Indirect Cost	$450,000.00
	$6,598,690

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



Utah's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2022, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted. For FY 2021, 50.6% of the total Title V budget is designated for preventive and primary care for children; 34.1% is designated for Children with Special Health Care Needs; and 9.5% is designated for administrative costs. Title V leadership will hold budget discussions throughout the fiscal year to ensure that the budget and spending are on track, and to address any new or unplanned MCH needs.

Utah meets the required Title V state match which is a $3 match in non-federal funds for every $4 of federal Title V funds. Utah exceeds the required match. Budgeting of match is found in Utah's "State MCH Funds" (Form 2, line 3) and is composed of state general funds including: Division of Family Health and Preparedness Director's Office, Newborn Safe Haven, Informed Consent and Abortion Module, Home Visiting, Maternal Mental Health, Children with Special Health Care Needs, Birth Defects, Early Hearing Detection, and Early Childhood Utah. Along with other federal funds, these state MCH dollars are a critical component of Utah's MCH infrastructure. Form 2, line 5, "Other Funds" reflects funds including transfer funds from other state agencies, and WIC Formula Rebates "Program Income" (Form 2, line 6) includes Teratology collections and donations, Baby Watch Early Intervention Family Fees and other CSHCN fee revenue. Other federal funds anticipated in FY 2022 are indicated in Form 2, line 9, and are

similar to funds noted in the Expenditures section.

Challenges
As has been the case for a few years now, Utah continues to face challenges related to the Title V budget. The current working MCH budget has been reduced from over $7 million dollars annually to approximately $6.59 million, while the amount received from HRSA is just over $6.1 million, annually. Funding allocations continue to change to ensure we are spending within the level of our annual federal award, as well as prioritizing the outcomes from the Needs Assessment that was conducted in FY 2021. The most recent changes to bridge the gap between ongoing obligations and the grant award include:

- Securing outside grant funding for MCH/CSHCN Projects
- Lease savings from closure of the Children with Special Health Care Needs Building and the Division of Family Health and Preparedness Highland Drive Building. All MCH/CSHCN programs now reside at the Cannon Health Building, with cost savings as a result of reduced space needs from a statewide shift to teleworking.
- Reduction of Pregnancy Risk Line Contract with the University of Utah.

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

III.E. Five-Year State Action Plan

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

State: Utah

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The Division of Family Health and Preparedness (DFHP) in the Utah Department of Health (UDOH) has four Bureaus; the Bureau of Health Facility Licensure (including Child Care Licensing), the Bureau of Emergency Preparedness, the Bureau of Maternal and Child Health (MCH) and the Bureau of Children with Special Health Care Needs (CSHCN).

Utah Title V oversight is maintained by the Title V/MCH Bureau Director and the CSHCN Bureau Director. Both Directors and their staff serve as conveners, collaborators and partners in addressing MCH/CSHCN issues.

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

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

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

There have been many changes in Utah over the past 3-5 years that have significantly impacted on service delivery and Title V roles and responsibilities. The transformation of the Block Grant, internal UDOH changes, and moving programs between Bureaus has impacted our ability to do business as usual. This allows us the opportunity to "think outside the box" and create a "new normal" for prioritization and provision of services and programs. The changes at times create instability, delay long-term growth and measurement of successes.

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

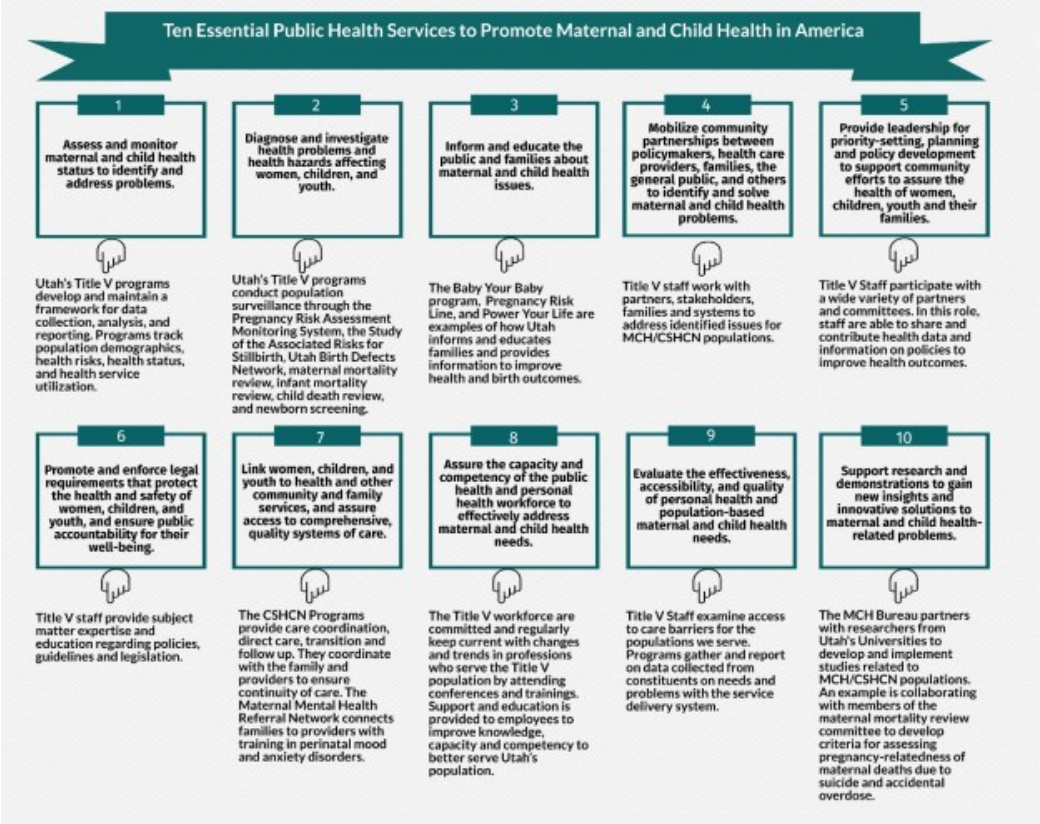
Utah's Local Health Departments (LHDs) were actively involved in the 2020 Needs Assessment process and their activities are aligned with the NPM/SPM's selected for the upcoming 5-year period. The Title V/MCH Director meets with the Nursing Directors bi-monthly to provide updates and to assess their progress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

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

Title V Framework

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

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



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

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

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

- Children's Hearing Aid Advisory Committee
- CSHCN Advisory Committee
- Cytomegalovirus Working Group

- Early Childhood Utah Council (Subcommittees include - Promoting Health and Access to Medical Homes, Early Care and Education, Social Emotional and Mental Health, Parent Engagement Support and Education, and lastly, Date Research and Policy)
- Fetal Alcohol Spectrum Disorder Collaborative Committee
- Kurt Oscarson Children's Organ Transplant Fund Board
- Medical Home Stakeholder Group
- Pediatric Audiology Working Group
- Perinatal Mortality Review (infant and maternal mortality)
- Transition to Adult Stakeholder Group and Sub-Committees
- Utah Women and Newborns Quality Collaborative
- Newborn Hearing Screening Advisory Committee
- National Birth Defect Prevention Network Parent Advisory Group (PAG)
- Utah Autism Initiative Committee
- Utah Registry for Autism and Developmental Disabilities (URADD) Committee
- Well Women Coalition

Utah aligns its CSHCN services with the AMCHP's National Consensus Standard for Systems of Care for CYSHCN. Utah supports a coordinated care model which is inclusive of the family. This past year has brought about positive changes in reducing silos throughout Utah. The CSHCN Bureau was able to virtually bring together over 30 stakeholders to look at reducing silos in order to better serve as a team versus independently. The Integrated Services Program holds weekly meetings in which these partners come together to work on medical home, transition and care coordination efforts in order to reduce the burdens of the system's diversity on families. Additionally, utilizing virtual technology has reduced travel, coordination of scheduling and allowed for different service providers to be on calls with families. Utah uses evidence-based approaches and values data in supporting initiatives to ensure a solid and robust foundation.

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

The newly elected 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. This document, in part, is driving the Utah decision to merge the Department of Health (DOH) and the Department of Human Services (DHS).

One of the 2020 legislative changes is to merge the DOH and DHS effective July 2022.
The vision for the new department is: "*The Department of Health and Human Services will advocate for, support, and serve all individuals and communities in Utah. We will ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. We will achieve this through effective policy and a seamless system of services and programs."*

MCH and CSHCN directors and managers are participating in specific "Merger Committees" as plans for combining the DOH and DHS Departments progresses. Participation in this process ensures that services and considerations for MCH/CSHCN populations are addressed.

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

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

The Utah Department of Health (UDOH) senior level managers lead the work of planning, implementation, evaluation, data analysis, and recruitment/retention of qualified program staff. MCH has approximately 54 full-time employees; 23 paid with Block Grant (BG) dollars for a total of 14 FTE. CSHCN has approximately 95 employees; 26 paid with BG dollars for a total of 11 FTE. The Bureau of Health Promotion has approximately 15 employees paid with BG dollars for a total of 5 FTE. UDOH staff are experienced and well-seasoned professionals. In addition, both MCH/CSHCN collaborate with staff at the Local Health Department level who work to improve the health of MCH/CSHCN populations.

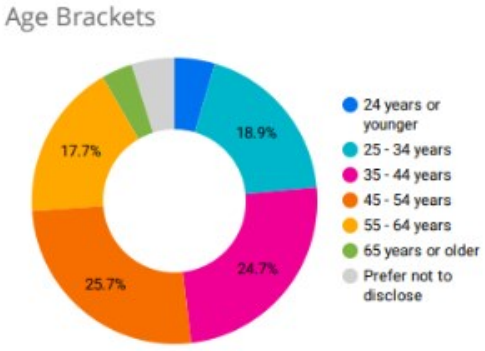
MCH/CSHCN maintains a staffing pattern which includes long-term employees, nearly half of whom have served at least ten years. Employee retention is accomplished through mentoring, administrative support, and professional development opportunities. Employment with the Utah State Government supports a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

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

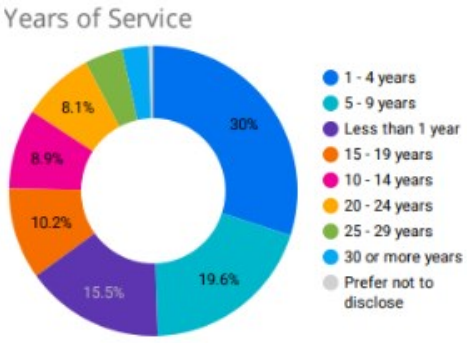
Utah Governor Spencer Cox is dedicated to redesigning how the State of Utah approaches traditional government administration including teleworking policies. The Governor's Office of Planning and Budget launched the "A New Workplace" initiative that aims to update management philosophy. State Employee recruitment, retention, efficiency, effectiveness and productivity is crucial to a desirable workplace where staff want to work and stay.

In 2021 the State of Utah Employee Survey (UES) was administered by the Governor's Office of Management and Budget. Results from the Utah Department of Health are noted below:

UES responses indicate that 43.4% are in the 45-64 age categories:

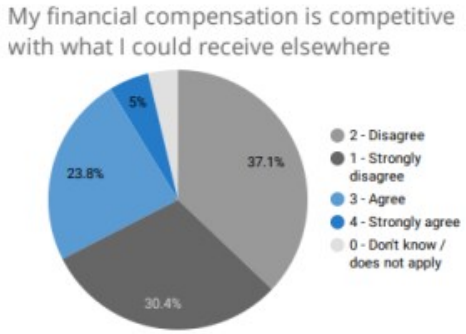


Sixty-five percent of the UDOH respondents have worked for the Department for less than ten years.

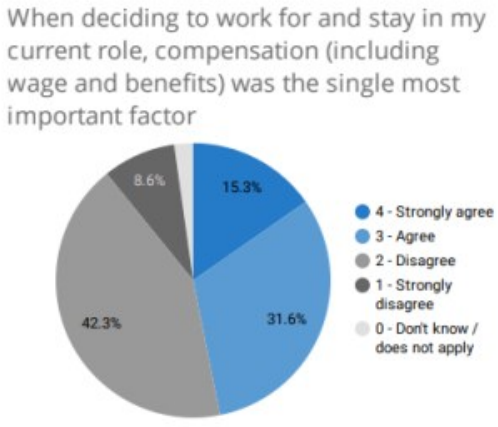


Job satisfaction is high among UDOH employees. Over 92% of staff either strongly agreed or agreed that they enjoy their job. When asked if their job gave them a sense of meaning, 92.5% of respondents agreed or strongly agreed.

Retention and recruitment of qualified staff is of utmost importance. UES responses note that the majority of respondents feel that their salaries are not competitive with what they would receive elsewhere.



However, UES respondents also noted that salary was not the single most important factor for deciding to stay in their positions.



In September 2018, the State of Utah began a teleworking pilot with four Departments. The pilot was successful in demonstrating that teleworking was feasible and it was expanded. An initial goal was set for 30% of eligible employees working for state agencies to work remotely. Goals were set related to air quality improvement, building efficiency, increasing access to jobs in rural Utah, and increasing retention of employees. In December of 2020, an implementation and assessment report was published showing that 135 employees had been retained or recruited

under this new structure. In June 2021, the Governor's Office of Planning and Budget released the "State of Utah Remote Work Guide" to assist agencies with best practices for remote working to enhance employee satisfaction and productivity. Currently, 75% of UDOH staff report working remotely three or more days per week.

MCH/CSHCN programs are committed to a learning environment in which employees develop professionally. Employees are encouraged to create and maintain individual development plans as a part of their annual performance review process. All professional staff are required or encouraged to attend at least one professional conference or training each year. In the past year, due to COVID-19 travel restrictions, many professional development opportunities have been available in virtual platforms. This has allowed many staff to participate in conferences they would not normally be able to attend due to travel costs.

All Bureaus working on Title V activities encourage or provide regular educational sessions and empower the Program Managers to understand systems change and ways to move forward to ensure the mission to serve women, infants, children with special health care needs, children and families continues. The Bureaus also provide continual education for self-improvement along with skill development in order to be more efficient and work collaboratively while maintaining a positive culture and climate. In 2020, the Department of Human Resource Management began offering their "Off the Shelf" learning sessions that are bi-monthly web-based sessions on topics that have included managing workplace stress, cultivating trust, employee engagement, and purposeful change navigation and many others. Additionally, the State of Utah has a statewide wellness council who encourages each Department and Division to participate. Every month employees receive an invitation to participate in health and wellness activities to improve their wellbeing.

The Integrated Services Program (ISP), Local Health Departments and Utah Parent Center (UPC) hold weekly training, problem solving, and program evaluation meetings with in-house program staff and the care coordinators contracted through four local health departments and UPC. ISP, LHD, UPC staff attend the Utah Children's Care Coordination Network (UCCCN) meeting. This multi-organizational group pairs care coordinators, nurses, practice managers, and clinical providers in a multi-disciplinary environment to learn about supports, services, and specialists around the state; share care coordination tips and best practices; and pursue group collective knowledge for solving concerns on challenging patient and family situations. UCCCN coordinates tele-learning technology which provides a virtual "face to face" environment in which all parties learn and share information. ISP clinical staff (APRN and psychologist) participate in weekly ongoing autism spectrum disorder training from specialists at the University of Utah through Project ECHO, a distance learning technology. Starting March 2020, the ISP program integrated a hybrid model in which both virtual and in person services were offered utilizing technology to serve the children with special health care needs and their families to protect the community from the COVID-19 pandemic.

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

Starting 2019-present URLEND project year. The CSHCN Bureau participated in a Foster Care initiative in evaluating transition planning for youth to adulthood. This project was structured through the University of Utah, South Main Clinic in Salt Lake City who is a main provider for services to children and youth in Utah's Foster Care System and primary care services to women, men and children during all stages of life. South Main also has an

obstetrics/gynecology clinic and a Teen Mother and Child Program to help promote health during pregnancy. The URLEND project research will assist in supporting the new five-year goals for CSHCN under the NPM of Transition. This collaborative ensures the foster care youth are receiving the support needed to transition to adulthood. In Appendix C you will find a 2020-2021 paper on the work and outcomes, “Transition Planning for Youth with Neurodevelopmental Disabilities Aging Out of Foster Care, Phase Two.”

Workforce development and coordination with Local Health Departments is key to maintaining a strong MCH Workforce. Each of the 13 Local Health Departments is required to report on professional development activities conducted during the year as part of their contractual obligation to the MCH Bureau. 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 trainings suggested came from MCH Navigator, AMCHP’s Training and Leadership Development programs, Advancing Health Transformation (from MCH Navigator) and others.

The UDOH Maternal and Infant Health Program, the Wyoming Department of Health and the Alliance for Innovation in Maternal Health (AIM), have collaborated to offer interested hospitals to provide access for staff to the eLearning course, “Breaking Through Implicit Bias in Maternal Healthcare.” The online course responds to the most recent data and national calls to action, by providing research-based education in Implicit Bias for patient-facing staff in the maternal healthcare environment. This involves clinicians taking the course and participating in facilitated debrief sessions with their co-workers. Co-developed by Quality Interactions and March of Dimes, the accredited one-hour course module covers: disparities in data in maternal healthcare, the cognitive basis for implicit bias and its evidence in the healthcare sector, how structural racism rooted in our country’s history is still affecting health outcomes for women of color, and an actionable set of strategies to use with patients to improve interactions. Fully narrated, this course offers chaptered learning with interactive exercises, real case scenarios, and end-of-lesson knowledge checks. Provider feedback is also collected to measure the impact of this initiative.

When the COVID-19 pandemic hit Utah the UDOH and its Bureaus/Programs adapted to the workforce needs, work environment and efficiencies immediately by all employees moving to teleworking. Teleworking was implemented to ensure the safety of our employees and MCH/CSHCN customers served throughout the State. Transitioning to telework and telehealth services has been challenging but customer surveys indicate the platform has mostly worked to keep them connected to services. Each Bureau Director meets weekly with Program Managers as a team and then individually to ensure Programs are functioning as efficiently as possible and with leadership support. Weekly connection with Bureau Directors, Program Managers and staff was highly important during 2020 and continues into 2021 as the dynamic of the pandemic changes and “return to work” policies are implemented. Informal input asking employees satisfaction with the telework and telehealth platform and feedback suggests workforce satisfaction and productivity have been positively impacted.

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

The CSHCN Bureau values family partnerships and the relationships are woven within the structure of the Bureau functions. The following information is to outline some activities and collaborations both the CSHCN and MCH Bureaus participate in and encourage support of family partnerships and collaborations with stakeholders.

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

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

The CSHCN Bureau has built capacity in family partnerships by including families and stakeholders in the CSHCN Mission and Strategic Plan. The Bureau has a CSHCN Advisory Committee which is composed of family members and individuals with special health care needs. This committee advises the Bureau on the family/parent perspective regarding issues, needs, and services, influences the direction of policies, contributes to program improvement, and ensures a voice for families and individuals with special health care needs to improve the system of care. The CSHCN Bureau conducts surveys with parents and engages in community discussions to identify needs within the community. The CSHCN Bureau incorporates its family partners in providing support within Bureau services and participating in advisory committees. The CSHCN Bureau Director is an active member of both the state-mandated Coordinating Council for People with Disabilities and Utah Developmental Disabilities Council. Both of these committees' purposes include alignment and coordination of professionals, agencies and families to better serve the disability populations.

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

During the pandemic the CSHCN Bureau collaborated with the Utah Parent Center to find families in need of education related to COVID-19 and vaccination locations. The CSHCN Bureau found resources throughout the State to assist families with the process and the Utah Parent Center was able to host a vaccine site for the families we serve. Additionally, the Bureau met regularly to discuss collaboratively meeting families' needs virtually to ensure continuity of care for the children, youth and families during the pandemic.

CSHCN Strategic Plan

Strategic Goal	Goal Detail	How It Will Be Accomplished

Family, Professional and Stakeholder Partnerships	Families, professionals and stakeholders will partner in decision making at all levels	To accomplish this, CSHCN staff work to ensure family and customer satisfaction, collaborate with families, professionals and stakeholders to strengthen relationships and receive input on services and increase partnerships with families and key stakeholders
Access to Services	Provide Services and Supports.	Services will be accessible and organized in a manner which supports family-centered care. Staff work in this area to increase public awareness of CSHCN Bureau Programs, improve the CSHCN Bureau website to effectively guide and assist the public, inform the public on key CSHCN health issues, efforts and successes, screen children appropriately and follow up in a timely manner, educate and support CSHCN families on private and public insurance options, educate families and partners on systems of care for children to receive services in a well-functioning, timely and organized manner and utilize and link health data to improve health outcomes
Medical Home, Care Coordination and Life Transition	Align families with a medical home, coordination of care, and transition education	The CSHCN Bureau will promote family-centered, coordinated, ongoing comprehensive care within a medical home. Staff work on this area to increase communication, resources and awareness of service options within a medical home, coordinate care to assist families in navigating the healthcare system, focus on high risk populations, provide children and youth with special health care needs the opportunity to receive the services necessary to make transition to all aspects of life, and encourage awareness and education for health care, education, leisure, work, housing and independence
Cultural and Program Competence	Promote Environments of Cultural and Program Competence	Children with Special Health Care Needs and their families will receive culturally and linguistically appropriate services (CLAS). Work in this area includes providing CLAS services which consider race, ethnicity, religion, and language, developing and

Staff Development and Quality Assurance		utilizing performance measures and objectives specific to each program mission, and ensuring programs align with the UDOH Strategic Plan and budget guidelines
	Promote a positive working environment that supports individual and team development	Each employee will be valued and have the opportunity to develop and contribute to quality outcomes by providing CSHCN Bureau employee orientation with clear expectations, job description, and performance evaluations, offering frequent praise and feedback to employees, providing annual Bureau trainings, and monthly program improvement discussions, implementing quality control measures and training to increase accuracy and timeliness in data input into CSHCN Bureau databases and cultivating an environment of Continuous Quality Improvement (CQI)

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

The Autism Systems Development Program has a long-standing collaborative committee, the Utah Autism Initiative, which meets quarterly and is composed of 25 stakeholders, including families. The committee works to review and improve the system of care, integrate systems and participate and influence the direction of policies and legislation affecting individuals with autism.

The Integrated Services Program (ISP) partners with 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 UFV staff to empower parents, caregivers, and patients to make informed decisions about the care and development of children and youth with special health care needs. Working in tandem, ISP and UFV staff have coordinated efforts with Juvenile Justice; Workforce Services (TANF, Supplemental Food, Medicaid, childcare eligibility determination); the foster care system; medical specialty and primary care; early and elementary education; local housing authorities; and US Citizenship and Immigration Services to ensure families access and apply for services for which they may be eligible.

ISP and four of the local health departments provide clinical services and care coordination in rural Utah, and, on a limited basis, along the Wasatch Front, working directly with families to assess and triage needs. Since March 2020, the ISP has integrated telehealth as a platform to support and connect families to services. Families referred into the

system by providers or self-referral, undergo a rigorous intake process to determine family needs and priorities including education, self-sufficiency, transportation, housing, Medicaid/insurance coverage, and direct medical services and are then referred to and scheduled with these services. Care Coordinators provide follow-up and encouragement and help families navigate personal and system barriers impeding them from obtaining support from within the community organizations and services around the state.

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

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

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

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

Lastly, the CSHCN Bureau connects with the Utah Help Me Grow 211 resource. We collaborate in finding children who need services, assessing and referring those families to needed providers and services.

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

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

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

III.E.2.b.iii. MCH Data Capacity

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

MCH epidemiology is the backbone to driving Utah's Title V work. The knowledge and support from all our epidemiologists is highly valued. Each program in Title V either has an internal epidemiologist or is supported by the Data Resources Program (DRP) that has well trained, experienced and collaborative team members.

In the Bureau of Maternal and Child Health (MCH) there are 5 FTE epidemiologists who provide data capacity and support to the MCH Bureau. The DRP houses the Epi Manager, and two Epidemiologists. The Epi Manager (vacant), funded by Title V, supervises the activities of the Data Resources Program and is the lead epidemiologist for the Title V Block Grant. The DRP team provides analytic support, grant management, website development and support, research and surveillance and the Web Enabled Systematic Tracking Tool (WESTT) system. WESTT is the online portal that houses the information from the Utah Block Grant core writers to compile data, report outcomes for the past year and write plans for the upcoming grant year. WESTT allows for the output of sections for placement into the Block Grant as well as the system outputs the Public Comment for dissemination.

For close to 22 years the Data Resource Program (DRP) was managed by Shaheen Hossain, PhD, who brought a wealth of knowledge and experience to Utah's management of data and development of most effective methods to collect data to compare and evaluate our Title V needs. Shaheen retired in May 2021 and a recruitment to fill the position is in process.

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

The DRP also houses the State Systems Development Initiative (SSDI) Epidemiologist and is funded through that grant. Jade Hill is the new SSDI Grant Coordinator/Epidemiologist and along with other staff in the Data Resources Program supports Title V efforts by collecting and compiling data needed for all Block Grant forms, providing data and analytic support for Utah's 2020 selection and development of NPMs/SPMs and related ESM and the 2020 MCH needs assessment, assisting with the preparation of annual applications and reports. Additionally, the SSDI Grant Coordinator/ Epi supports the data needs for UWNQC (AIM) QI projects. Finally, the SSDI assists with the expansion of the web-based application (WESTT) to better align with the updated MCH Block Grant guidance (FY19 - FY21) in order to coordinate the yearly submission of the Title V MCH Block Grant Application and Annual Report. In 2019, budget cuts resulted in the elimination of one epidemiologist position in the Data Resources Program.

The Maternal and Infant Health Program houses two epidemiology staff who focus on PRAMS and maternal mortality review. Nicole Stone is epidemiologist/data manager for the Utah PRAMS (Pregnancy Risk Assessment Monitoring System) project and the Study of the Associated Risks of Stillbirth (SOARS). This position is funded through a CDC PRAMS grant, state funding, and the Title V Block Grant. The PRAMS epidemiologist supports Title V activities by providing data related to ESMs and NOMs. For example, in 2021, Ms. Stone analyzed data related to maternal mental health and authored a report on findings. The PRAMS survey is integral to assessing maternal and infant health and identifying emerging issues.

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

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

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

Urja Dave, an Epidemiologist with The Early Hearing Detection and Intervention Program and is funded through mixed funding including state newborn screening dollars, CDC and HRSA EHDI funding. Urja left the position in June and a recruitment to fill this position is underway.

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

At a minimum, all Epidemiologists in the MCH/CSHCN Bureaus have a bachelor's degree, most are masters level trained and one is near completion of a doctoral degree.

During this past year the MCH/CSHCN Directors collaborated with the staff to provide information to the Utah Department of Health (UDOH), Deputy State Epidemiologist for an assignment to the Council of State and Territorial Epidemiologists (CSTE) regarding the three Essential Public Health Services (EPHS) related specifically to MCH epidemiology.

They are:
EPHS #1 Assess and monitor population health status, factors that influence health, and community needs and assets.
EPHS #2 Investigate, diagnose, and address health problems and hazards affecting the population.
EPHS #9 Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.

The CSTE inquiry sought to outline and determine the department's epidemiological ability to lead activities, provide subject matter expertise, and apply for, receive, and manage resources to conduct key activities in certain program areas. It also determined the most pressing training needs, determined the number of FTEs in each program by funding source, and explored tactics for successfully recruiting and retaining epidemiologists.

The survey asked about Utah’s MCH Epidemiology most pressing training needs from a list of options. Utah responded that their top two were cultural competency and persuasive communication. When asked to identify our three best assets for recruiting and retaining epidemiologists, we reported job interests/fulfillment, opportunity for skills training, and flexible schedules.

In Utah, finding epidemiologists is difficult due to the lower pay comparisons with the private sector. Title V programs tend to recruit new graduates who are very motivated and desire to learn but after gathering job experience, they determine moving to higher paid positions suits their lifestyles more effectively. Among our Epi staff, competitive salary, opportunity for advancement, cultivating meaningful/fulfilling positions, and training opportunities were among the highest-ranking items in epidemiologist retention and job satisfaction.

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 Bureau of Maternal and Child Health. The mission of the DRP is to provide analytic resources and statistical expertise to MCH and CSHCN programs for assessing the health status of the maternal and child health populations, and for planning and evaluating services. SSDI funding allowed the DRP to hire a full time SSDI Grant Coordinator to manage project activities related to data collection and analysis, and provide additional analytic support to the MCH Bureau. Funding also allowed the DRP to assist with the Five Year MCH Needs Assessment, the submission of Annual MCH Block Grant (BG) Report and Application, and application of data analysis to program planning for Title V related projects.

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

An data sharing agreement (DSA) exists between the MCH Bureau and the Utah Office of Vital Records and Statistics (OVRS). As a result, all projects and programs within MCH are able to access and use identifiable Birth and Death certificate data, including fetal and infant deaths, without navigating through the approval process for each additional project. This agreement also allows MCH programs to share identifiable data with each other and allows DRP to assist in analyses without additional agreements.

Throughout 2020-2021, the SSDI Grant Coordinator, provided analytic support to the Utah Women and Newborns Quality Collaborative (UWNQC) subcommittees including conducting analysis on factors associated with intrapartum transfers to hospital for delivery from planned out-of-hospital (OOH) birth settings and linking birth records by the mother, enabling identification of mothers who had actually had a preterm birth, rather than solely relying on self-reporting to assess utilization of progesterone in women with a previous preterm birth.

The SSDI Grant Coordinator completed analysis of 2016-2018 birth data and wrote up findings in a report on OOH births in Utah. This report informs the work of the UWNQC OOH birth committee. The report describes the characteristics of women who deliver in both in- and out-of-hospital settings in Utah and provides information of transfers that occurred from OOH settings to hospitals for delivery. The report is still in process. SSDI will continue collaboration with UWNQC for the remainder of the SSDI grant cycle.

In 2019, Utah launched a new safety bundle focused on maternal opioid use disorder. This safety bundle will not only focus on improving outcomes for mothers, but also their babies both long and short-term. A new data sharing agreement was drafted for this project so that hospital discharge data for the infant would also be available to track outcomes for infants with neonatal abstinence syndrome. The DRP linked birth and hospital discharge data and provided a de-identified linked data set to be used in analyses. SSDI Grant Coordinator also provided the Inter Tribal Council of Arizona with severe maternal morbidity (SMM) data among American Indian women in Utah.

The SSDI Grant Coordinator submitted an abstract for the 2020 CityMatch Conference. The title of the poster was “Risk factors associated with intrapartum transfer to a hospital from an out-of-hospital birth setting in low-risk and nulliparous and multiparous women”. The SSDI Grant Coordinator also helped the Maternal and Infant Health Program (MIHP) with a maternal mental health survey in REDCap, however, it was decided to conduct the survey using Qualtrics.

The SSDI Grant Coordinator and DRP Epi worked with MIHP staff to complete a draft of a Very Low Birth Weight (VLBW) Report. As part of Utah Administrative Rule R433-1., Very Low Birth Weight (VLBW) Infant Reporting, hospitals are required to enter all admissions of VLBW infants (deliveries and transfers) into a REDCap database. This REDCap data was merged with hospital discharge data and birth certificates in order to determine a gold standard for VLBW reporting. Following this assessment, it was decided to sunset the rule.

The DRP program SSDI Coordinator resigned in October of 2020. The position has been vacant until April 2021 with the hiring of Jade Hill. Additionally in May of 2021 The Manager of DRP / SSDI Project Director retired. The MCH Bureau has recruited to fill the position.

Goal 2: Enhance and advance the utilization of linked MCH data information systems to support assessment of long-term health outcomes by conducting longitudinal research studies	
Objective 2.2: Conduct a data validation study to assess the quality of the new synthetic progesterone variable in the birth certificate by linking Vital Records data and comparing to the Utah All-Payer Claims Database (APCD)	
2018	**2019**
• Created data sharing agreements with hospitals to collect facility data on synthetic progesterone prescribing and treatment • Created a database in REDCap for data collection to share data on a quarterly basis • Trained hospital staff on using this REDCap database and provided ongoing technical assistance as necessary • Assessed the quality of the synthetic progesterone treatment reporting variable • Prepared a report on findings	• Began also receiving data of 17P use from the University of Utah in addition to Intermountain facilities • Report on 17P use published in Utah Health Status Update • Continue to share data of 17P on a quarterly basis with UWNQC • Collaborated on a return on investment publication for 17P use in Utah Medicaid births • Linked birth certificate records by the mother, dating back to the year 1999, enabling identification of mothers who had actually had a preterm birth, rather to solely relying on self-reporting by the mother.
Objective 2.3: Continue partnering with Medicaid to link Medicaid eligibility files with Birth Certificate Data and conduct a comprehensive assessment of health outcomes of women enrolled in Medicaid	
2018	**2019**
• Completed analyses to assess birth outcomes among women enrolled in Medicaid using Medicaid status from birth certificate data	• Completed analysis and drafting of a manuscript concerning progesterone use and the potential return on investment in Medicaid enrolled women who reporting having a previous preterm birth

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

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

2018

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

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

2018	2019	2020
• Provided analytic support to the UWNQC maternal subcommittee • Provided analytic support to the UWNQC out-of-hospital (OOH) birth subcommittee • Provided analytic support to the UWNQC board/steering committee • Supported Utah's Alliance for Innovation on Maternal Health (AIM) by providing data collection and analytical support	• Attended planning meetings for implementation of the new AIM opioid use disorder safety bundle • Developed letter for reporting to individual hospitals on their OOH transfers and related feedback from providers • Created pilot survey for the new maternal mental health UWNQC subcommittee	• Assisted with determination of data to be collected by hospitals with implementation of new safety bundle • Conduct a risk assessment analysis of intrapartum transfers to hospitals in women having an out-of-hospital birth and submitted an abstract • Update and distribute letter for reporting to individual hospitals on their OOH transfers and related feedback from providers

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

2018	2019	2020
• Linked provisional birth data obtained from Office of Vital Records and Statistics (OVRS) and data entered directly to REDCap database by participating hospitals	• Met with and began collaboration with the CDC on the LOCATe project • Wrote data sharing agreements to obtain hospital discharge data to provide to the CDC • Compare data from hospital discharge to REDCAp VLBW database to assess for data quality and determine a gold standard for future use	• Linked birth certificate data to hospital discharge data for the CDC's LOCATe project • Provided CDC with data for their LOCATe analysis on maternal and neonatal outcomes • Drafted a report on data collected in REDCap on VLBW births to distribute to participating hospitals

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

Data capacity in the UDOH is strong and is focused around the Center for Health Data and Informatics (CHDI), which serves as the central point for state health data from many sources. The CHDI includes the Offices of Vital Records and Statistics, Public Health Assessment, Health Care Statistics, and Public Health Informatics. The CHDI oversees the legislatively mandated Health Data Committee which is responsible for oversight and publication of hospital performance data on various measures, such as Cesarean deliveries. The CHDI provides access to large data sets for analysis by UDOH staff and works with programs to assist in data analysis as needed.

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

The Department of Health Master Person Index (DOHMPI) project uses a mix of probabilistic and deterministic record linking technologies to maintain an ongoing repository of high quality linked identity information that facilitates operational and analytic data needs analysis across multiple diverse public health databases in UDOH. The DOHMPI is designed to uniquely identify each individual in the state receiving healthcare or public health services to support healthcare and public health operations and research. Currently, the DOHMPI links information from birth certificates, death certificates, Medicaid eligibility records, and the All Payer Claims Database (APCD). Other source systems being added to the DOHMPI include Utah Statewide Immunization Information System (USIIS), Controlled Substance Database (CSD), Hospital Discharge (HD), and Emergency Medical Services (EMS).

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

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

The Health Informatics program hosts the UDOH Informatics Network. The UDOH Informatics Network exists to promote collaboration, information sharing, and best practices among informatics professionals across all divisions at the Utah Department of Health. The group holds monthly meetings, has regular brown bag presentations, and promotes collaborative work projects. As an offshoot of the UDOH Informatics Network, the DRP and the Health

Informatics Program are currently working together to facilitate the addition of maternal morbidity data to the Utah DOHMPI project.

The Maternal and Child Health (MCH) Bureau and the Bureau of Children with Special Health Care Needs (CSHCN) have strong working relationships with the four CHDI offices and many joint projects are conducted. Capacity for MCH/CSHCN data collection and analysis is expanded through the Data Resources Program (DRP). The DRP provides analytic resources and statistical expertise to MCH and CSHCN Bureau programs for assessing the health status of the MCH population, planning and evaluating services. The DRP is headed by the MCH Epidemiologist with two epidemiology staff and one programmer. The DRP assists staff with survey development, database development, data analysis, and report writing.

The Data Resources Program (DRP) currently handles data requests from the Maternal and Child Health (MCH) Bureau and the Children with Special Health Care Needs (CSHCN) Bureau, as well as from outside state agencies, local colleges, and universities. The DRP conducts surveys, including, but not limited to Oral Health Surveys, WIC Participant Satisfaction Surveys, Developmental Screening Surveys, and the Commodity Supplemental Food Programs Customer Satisfaction Survey. The DRP routinely links Vital Records Birth Certificate data and Medicaid Eligibility data for the annual Maternal and Child Health Block Grant. The DRP also links data sets to assist several programs, e.g. Hospital Discharge data with Vital Records Birth Certificate data; Vital Records Birth data with Infant Death linkage and Death data; Hospital Discharge data with the Birth Defects Network data; and Vital Records Data with the WIC data.

The DRP is responsible for coordination of Title V MCH Block Grant Application each year. The program developed a web-based application titled Web Enabled Systematic Tracking Tool (WESTT) to align better with MCHB TVIS. The use of WESTT has allowed the 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. By providing around-the-clock access, WESTT makes it more convenient for contributors to work on block grant assignments when it fits their schedules. Program staff members have welcomed the system and have reported satisfaction with the fact that the new system has reduced overall assignment completion time.

The DRP also formed a work group, the Data and Information Group (DIG), to bring together innovative ideas and data projects focused on the MCH/CSHCN populations. Opportunities for collaboration with other UDOH programs are achieved through this group. Staff from the MCH and CSHCN programs participate in the meetings, which provide a forum for establishing priorities, developing concepts for data studies, application of data analysis to program planning efforts, and so on. The meetings enable program staff to learn what the others are doing or would like to do, which leads to ideas for new projects or to contributions for other's projects.

MCH/CSHCN Data Systems

The Child Health Advanced Records Management (CHARM) provides public health data through an integrated, secure electronic system to health care providers to coordinate care, and improve efficiencies and health outcomes of the children and families they serve. The CHARM program and system were established in 2000 as a coordinated, Department-wide effort within UDOH to link identifiable child health data in real time among appropriate health care programs and state agencies. To date, CHARM has linked the databases from the Office of Vital Records (Birth and Death Certificates), the Utah Statewide Immunization Program (USIIS), the Early Hearing Detection and Intervention (EHDI) Program, the Newborn Bloodspot (Heel-stick) Screening Program, the Baby Watch/Early Intervention Program, and the Office of Recovery Services. CHARM is also a conduit for the CSHCN

Bureau to connect to the Utah-wide clinical Health Information Exchange (cHIE) system. The CHARM system also provides a web interface/portal for providers and programs which enables authorized users to obtain newborn screening results (hearing, heel-stick, heart) and immunization histories for children to facilitate more complete and timely health care services. It creates a consolidated electronic health record for children in Utah. This health record can be printed and given to parents/guardians to assist MCH/CSHCN populations (infants, children, teens, mothers, families) and programs with continuity of care and follow-up.

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

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS is an ongoing, state-specific, population-based survey designed to collect information on maternal experiences and behaviors prior to, during, and immediately following pregnancy among mothers who have recently given birth to a live infant. PRAMS data informs Title V programs by providing information on changes in maternal and child health indicators such as maternal mental health, unintended pregnancy, prenatal care, breastfeeding, insurance status, among many others. The PRAMS data also provides important context for many measures. PRAMS data is the source for several Title V National Outcome Measures.

The Study of the Associated Risks of Stillbirth (SOARS) is also a joint surveillance project between the CDC and Utah. SOARS is an ongoing, state-specific, population-based survey designed to collect information on maternal experiences and behaviors prior to, during, and immediately following pregnancy among mothers who have recently experienced a stillbirth. Stillbirth is defined as the in-utero death of a baby at 20 weeks of pregnancy or later. SOARS was initiated to help health officials learn more about why stillbirths occur. Understanding the potential causes of stillbirth can lead to recommendations, policies, and services to help prevent them. SOARS data will also help us learn what support women need after such a loss.

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

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

The Mother To Baby/Pregnancy Risk Line provides information about medications and other exposures during

pregnancy and breastfeeding. The Utah database collects information on all inquiries made to the program through calls, emails, text messages, and web chats from the public and medical providers. The program also conducts customer satisfaction surveys.

Key challenges

The MCH/CSHCN Bureaus continue to have ongoing challenges with funding for data systems improvement and staffing. Data systems are expensive to build and maintain and state dollars and grant opportunities are limited. Title V Bureaus are hopeful that the new merger between the Departments of Health and Human Services will provide more collaborative funding and/or consolidations of systems to allow for more data capacity.

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

In 2020, the COVID-19 pandemic occurred throughout the world and appeared in Utah in March. On March 18, 2020, Utah experienced a 5.7 magnitude earthquake. The epicenter of the quake was located in Magna, Utah, a suburb of Salt Lake City. Utah citizens lost power, heat, dwelling structures and much more. The earthquake on top of the pandemic created more anxiety, fear and other emotions. We then experienced over 500 aftershocks in total over a week-long period and then a second 4.2 quake on April 14. Then Mother Nature continued to show her strength and on September 8, 2020, Utah had a major windstorm with winds up to 100 mph that tore through towns and communities uprooting trees, electrical and water lines and homes. Nearly 200,000 homes lost electrical power, with nearly 50,000 of these losing power for a week. Additionally, as many parts of the country experienced a variety of riots and damage to structures, Utah also experienced protests and civil unrest. The Utah Department of Health (UDOH) was targeted by community members who disagreed with implementing COVID-19 safety measures. Specifically, the UDOH Highland building had windows broken by a pellet gun. Luckily, no staff were at work when this incident occurred, but staff had concerns for their safety. There were also protests at the UDOH and individual employees' homes.

The UDOH has emergency plans in place to address natural and man-made disasters. Each bureau and program have building and program emergency plans to ensure that during a disaster, business can continue as normal as possible. The Family Health and Preparedness (FHP) Division houses the Bureau of Emergency Medical Services and Preparedness (BEMSP) who is the lead agency for Utah’s Emergency Medical Services (EMS) system and public health and medical preparedness and response. The BEMSP was available and provided statewide support during the pandemic response, two earthquakes, aftershocks and the windstorms. To ensure constituent input, the BEMSP has three statutory committees, three subcommittees, and various task forces. BEMSP's mission is to promote an effective and resilient public health, trauma, and emergency health care system to respond to emergencies and disasters through professional development, preparedness, regulation, quality assurance, and partner coordination.

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

The current EOP addresses vulnerable populations defined as individuals in need of additional response assistance and may include those who have disabilities, live in institutionalized settings, are elderly, are children, are from diverse cultures, have limited English proficiency or are non-English speaking, or are transportation disadvantaged. 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 MCH/CSHCN.

For the current State EOP, MCH/CSHCN staff were not involved or consulted in the planning and development of the state EOP. Leadership of MCH, CSHCN and BEMSP are in communication to better address the needs of the MCH population in the Emergency Support Function 8 (health and medical) annex/addendum to the state emergency operations plan.

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

Title V leadership (MCH/CSHCN) is included in the Continuity of Operations Planning (COOP) for the Utah

Department of Health. 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 CSHCN Bureau has developed COOP and department plans for years to address being able to continue services during an emergency. We have individuals identified for the response as well as duties and data systems which will require immediate attention. All the newborn screening programs (blood, heart and hearing screenings) and direct care services are involved in this plan. The plans did work during the pandemic and we were able to provide continued services to the children, youth and families we serve. Additionally, we continued to educate providers on screening and maintain compliance with the timeframes of the screeners during the pandemic.

To date, Title V leadership has not been involved in the Incident Command System (ICS). The scope, scale, and nature of the response is determined by UDOH leadership and they activate various UDOH 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 ICS needs.

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

The BEMSP applied for the National Emergency Medical Services for Children (EMSC) Resources Centers Demonstration CA *U01MC37471.* After receiving the grant, the CSHCN Bureau Director was made aware of the opportunity. Contact was made to collaborate as UDOH has the CSHCN Bureau who serves the population statewide and has knowledge, data and services offerings to serve this population. This opened a door for an internal and community partnership to work together to improve the opportunity, access and health of a rural area of Utah.

Activities of their demonstration grant include completion of an environmental scan of telehealth capabilities and need and development and implementation of a strategic plan to address the needs of either CSHCN or behavioral health emergencies. Over the years it has been found that silos have increased for a variety of reasons including overload of responsibilities, but the pandemic has opened the door as agencies/partners are realizing that working together will further our collective missions. This is a positive example of that growth. Our current plan is for the demonstration group to perform their environmental scan, then meet to evaluate the data compared to the Title V CSHCN Needs Assessment data. We will include knowledge from the Bureau of telehealth sites, access and needs and determine a service plan and expansion of collaborations moving forward. Additionally, the BEMSP Director is considering incorporating the CSHCN Bureau team members in emergency outreach planning for the future, as to date, each entity had siloed approaches.

The Utah Legislature conducted COVID-19 impact studies during the past 18 months which illustrated that areas with

a high health improvement index score, a composite measure of social determinants of health, tend to be disproportionately impacted by disasters or crises. In order to be prepared for future crises, including pandemics and natural disasters, the reports recommended increasing capacity for the system to respond quickly with rental and utility assistance and affordable housing; food assistance; paid sick leave; and childcare subsidies. It was also determined that the ability to quickly recruit, train, and mobilize community health workers; staff at community-based organizations, and within emergency response programs is essential in providing services to an affected public as soon as possible. Recommendations also include improving cellular infrastructure to allow for increased internet access and increased availability of telehealth services, particularly in rural and frontier parts of the state, accompanied by expanded digital literacy training for those who are less comfortable with this technology. Additionally, language and cultural barriers and mistrust of the system in general may limit the impact of public health initiatives, and even more so in times of crisis. This information will be reviewed and emergency plans will be updated accordingly. Title V leadership will continue to work with stakeholders and internal emergency preparedness staff to improve outcomes.

Work on this section of the Title V Block Grant has renewed conversations between programs related to emergency preparedness. Moving forward, plans are in place for the MCH and CSHCN Bureaus to meet with staff in BEMSP to engage the Bureaus in sharing needs and resources and how MCH/CSHCN population considerations will be integrated into emergency preparedness plans.

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

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

MCH/CSHCN have established partnerships that help expand the work of reaching women, infants, children (including CSHCN), and families. Federal and non-federal funds are leveraged to deliver programs and services in the state. MCH/CSHCN staff maintain working relationships with Title V and non-Title V Programs to create a statewide system of collaboration.

The levels of cooperation with various partners can include networking, information sharing, collaboration, integration, formal contractual agreements, joint training or co-sponsorship of events. Most all of the programs/agencies participated in the 5-year needs assessment.

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

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

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

The CSHCN Bureau has found the pandemic to be an opportunity to reduce silos and increase partnerships to be more effective with service provision, working on medical home and transition to adulthood initiatives. The Bureau took the opportunity and initiated engaging with a variety of stakeholders (approximately thirty) and assessed the current system of care. Some of the partners include: University of Utah Medical and Intermountain systems who service the CSHCN populations; Utah Parent Center, Help Me Grow (United Way), Local Health Departments, Community Health Centers, Human Services, Division of Child & Family Services, Early Intervention and community providers. Since March 2020 these medical home and transition focused partnership groups (curriculum, referral, marketing and quality assurance/surveys groups) met weekly for nine months. In January, the committees transitioned to monthly meetings to develop new processes in which sharing resources and committing to educating the public and populations became the goal. All participating stakeholders are implementing processes in a uniform and consistent manner. We have created momentum and excitement as we have found we can provide more to our populations if we team together. We have access to more resources, knowledge, funding and creative ideas.

Staff in both MCH and CSHCN coordinate regularly with staff in the Division of Substance Abuse and Mental Health on issues related to mental health for women, children and families. Staff also work collaboratively to improve services for pregnant women who are using illicit substances in pregnancy.

In 2019 HB 47 codified the relationship between the Early Childhood Utah (ECU) Advisory Council and Governor's Early Childhood Commission. The ECU Advisory Council convenes 28 diverse voting members representing different subsets of the Early Childhood Committees. There are five subcommittees: Health and Access to Medical Home, Data and Research, Parent Engagement, Social, Emotional and Mental Health, and Early Care and Education. These subcommittees have additional membership and together represent over 85 people from various early childhood areas. The subgroups meet monthly and work to develop recommendations for the Governor's Commission. These relationships have opened opportunities to bring on new stakeholders who are vested in early childhood development and develop ways to improve the system of care. Three recommendations were brought to the Commission this past year and are in process: early childhood data, comprehensive developmental screening and a trained early childhood workforce.

The Oral Health Coalition continues to meet quarterly with partners and ensure oral health is a priority. The Coalition has been advocating for additional funding from the Governor's Office to expand State Oral Health Services.

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

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

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

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

Program Outreach and Enrollment

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

Some specific activities CSHCN performs for Medicaid enrollees includes:

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

The CSHCN Bureau collaboration includes regular meetings with Medicaid to discuss the variety of CSHCN issues, coverage, needs, and improvements to service and care. Historically, CSHCN has primarily coordinated and collaborated with Medicaid to ensure services and funding for Title V populations. Medicaid and MCH/CSHCN have opened communications to improve collaboration among all Title V programs for their relative populations.

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

The Integrated Services Program, Baby Watch Early Intervention, and Fostering Healthy Children all provide administrative case management services, assistance, monitoring, coordination, referrals, and community education for Medicaid enrollees.

The programs provide extensive outreach throughout the state through many health fairs, agency and transition fairs, virtual and in-person educational training, and one-on-one counseling sessions on obtaining services and how to be

an advocate for your child.

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

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

In July 2021, the Medically Complex Children's Waiver program, which serves children with disabilities and complex medical conditions, opened enrollment for an additional 75 children. Admittance to the additional 75 spaces will be prioritized to the highest medical complexity and critical needs of the family. A press release from the Department of Health was issued statewide to alert families of the opportunity. The CSHCN Bureau has supported Medicaid with outreach and promoted this opportunity with its stakeholders and families we serve. The Integrated Services Program has assisted families in enrolling.

Changes to the Utah Medicaid Program

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

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

Medicaid and Family Planning Services
In 2018, the Legislature passed House Bill 12, which directed Medicaid to unbundle immediate postpartum Long Acting Reversible Contraception (LARC) insertion and pay for the devices separately from the inpatient hospital stay. The legislation also required Medicaid to submit a waiver to CMS to expand family planning coverage to all women at or below 95% FPL, but due to full expansion being implemented, this waiver was not submitted. Utah Medicaid expanded medical coverage to adults at or below 95% FPL in April 2019.

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

Medicaid Expansion
On December 23, 2019, the Centers for Medicare and Medicaid Services (CMS) authorized the Utah Department of Health (UDOH) to implement a full Medicaid expansion in the state. The expansion extends Medicaid eligibility to Utah adults whose annual income is up to 138% of the federal poverty level ($17,608 for an individual or $36,156 for

a family of four). The federal government covers 90% of the costs for these services with the state covering the remaining 10%. CMS has not yet approved the other items in this waiver request. The state continues discussions with CMS on these remaining items.

Integrated plans

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

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

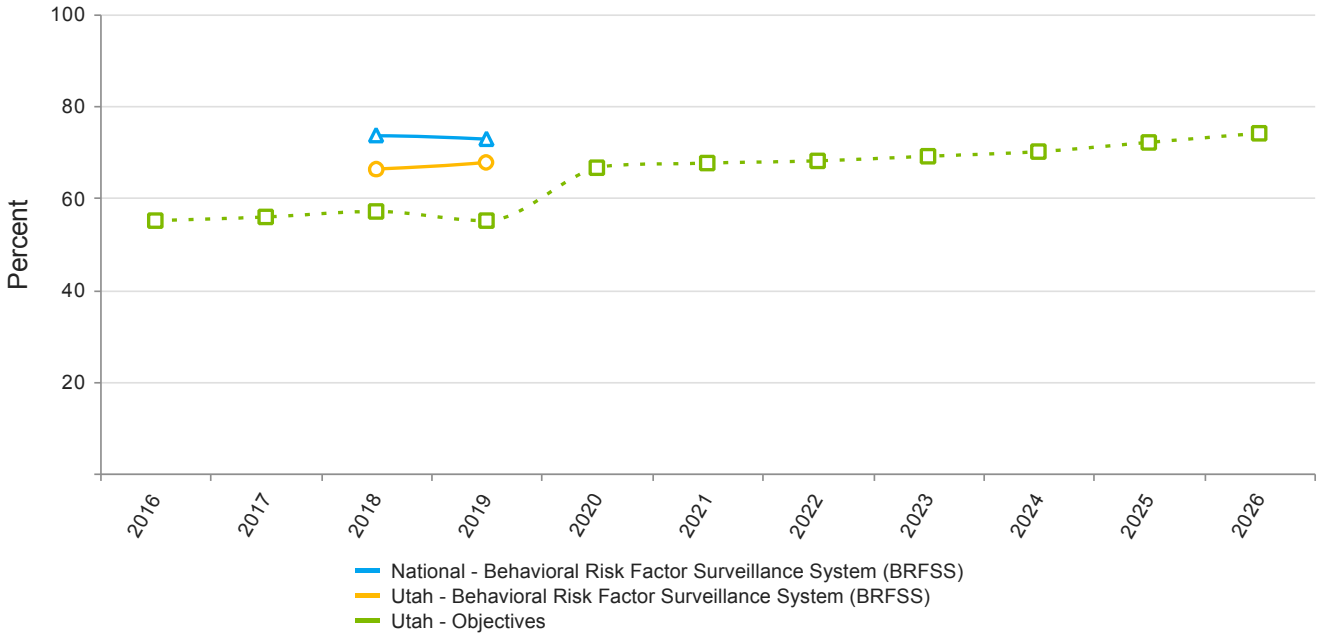
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	47.3	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	10.7	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.4 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.7 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	29.4 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.9	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.5	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.4	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	199.1	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2015	2.6 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	5.8	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	12.3 %	NPM 13.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.9 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.6 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	12.0	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	15.2 %	NPM 1

National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					66.5
Annual Indicator				66.1	67.6
Numerator				394,166	413,656
Denominator				595,993	612,087
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	67.5	68.0	69.0	70.0	72.0	74.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	300.0	350.0	400.0	450.0	500.0

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	14.0	16.0	18.0	20.0	22.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	1.0	1.0	1.0	1.0	1.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	56	60.8
Numerator	25,866	27,859
Denominator	46,186	45,807
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.8	66.8	69.8	72.8	75.8	78.8

State Action Plan Table

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

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - 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

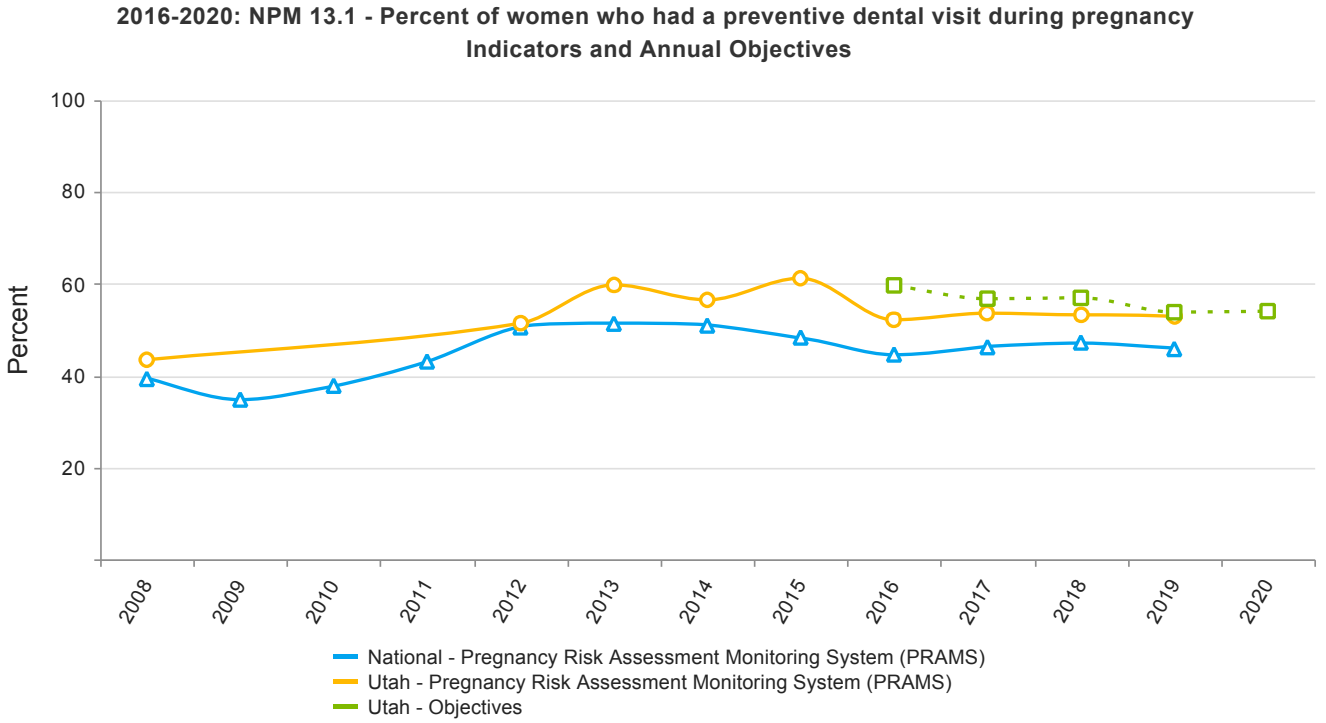
Objectives

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 59%.

Strategies

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

2016-2020: National Performance Measures



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	59.6	56.7	56.9	53.8	54
Annual Indicator	56.5	61.2	53.6	53.2	53.0
Numerator	27,701	29,790	25,341	24,250	24,201
Denominator	49,001	48,710	47,301	45,610	45,663
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2019

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

2016-2020: ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		45.3	37.1	25.2	25.4
Annual Indicator	45.1	36.9	25	25.9	25.9
Numerator	69	58	38	43	43
Denominator	153	157	152	166	166
Data Source	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report
Data Source Year	2015	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

MCH Block Grant FY22 Application & FY20 Report

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

Annual Report FY20:

This Performance Measure was achieved. The Performance Objective was 66.5% and the Annual Indicator was 67.6%.

As the BRFSS question related to this measure was changed, progress on this measure for the 2016-2020 time period cannot be reported.

Program Activities:

During FY20, the Maternal and Infant Health Program (MIHP) utilized the social media platforms Facebook and Instagram to share information on preventive health care visits. These messages were shared under the Power Your Life logo and branding. Over 35,000 people saw at least one post from either of the Power Your Life social media platforms. In addition to daily informational posts, Nickee Andjelic, the MIHP certified health education specialist, started a Facebook and Instagram video series called “Well Woman Wednesday’s.” These 5-7 minute video segments covered male/female preconception health, birth defects prevention, birth control methods, vaccinations before and during pregnancy, oral health during pregnancy, and mental health.

Ms. Andjelic also did an on-air television spot and podcast on a new Utah law that allows trained pharmacists to distribute self-administered hormonal birth control methods (pill, patch, ring) to women 18 and older under a physician standing order.

MIHP staff spent a considerable amount of time during FY20 at community health fairs and other events sharing information on routine preventive care, preconception health, contraception, pregnancy, and birth defect prevention. These health fairs also offered MIHP staff the opportunity to talk directly with community members, answer their direct questions, and provide additional resources as needed. As can be seen in the list below, MIHP staff were invited to health fairs across the state of Utah and reached a diverse population of men, women, and young adults.

- Junior League Care Fair. This once-a-year health fair allows underinsured, uninsured, and undocumented people the opportunity to receive routine preventative physical and oral health screenings at no to little cost. At this three-day event, educational materials and resources were provided to approximately 400 people.

- Hildale Health Fair. Being invited back to the health fair is a success for the MIHP program. Hildale is a small polygamist community on the Utah-Arizona border that has historically been wary of government assistance and outside education efforts. Three years ago, they began opening their town and welcoming state government assistance and educational efforts. MIHP was invited to have a booth at their annual health fair, where education was provided on routine preventive care, preconception health, contraception, pregnancy, and birth defects. A free three-month supply of prenatal vitamins was also offered to those that stopped by the booth. Approximately 150 people were reached at this event.

- Be Well Health Fair. The University of Utah hosts this annual health fair. Participants receive free health

screenings, cooking demonstrations, and educational resources from numerous community organizations. MIHP staff provided materials to an estimated 200 people.

- Urban Indian Health Fair. This health fair was held at the Urban Indian Center in Salt Lake City. It targeted the Native American population. MIHP staff provided materials to an estimated 50 people.

- University of Utah Block Party. This health fair was for University of Utah Students that live in married housing. MIHP staff provided resources to and answered questions from the nearly 150 people that attended.

- Pacific Islander Health Fair. Held yearly by the Pacific Islander Health Coalition. MIHP staff provided materials to an estimated 75 people.

- Utah Valley University (UVU) Student Health Fair. UVU Student Health Services sponsors this bi-annual health fair to provide students with information and resources to improve their health and wellness. MIHP staff attended both health fairs offered during FY 20, reaching a combined total of approximately 700 UVU students and faculty.

- Utah County Bridal Fair - This outside-the-box outreach event is one of the most rewarding for MIHP staff to do. The bridal fair offers the opportunity for the MIHP health educator to reach primarily young women prior to a point of significant life transition. Many of the people reached at this event have questions on birth control and what to expect at their first OB/Gyn visit. The MIHP health educator is knowledgeable in both of these areas and spends time with many young women who visit the booth to answer questions and offer resources. At this event, an estimated 250 people are provided with materials and education on routine preventive care, well-woman visits, birth control, pregnancy, and birth defects prevention.

MIHP staff also partnered with the Salt County Health Department to provide Power Your Life educational booklets through its home visiting program. These booklets are intended for women of reproductive age and are easy to read and understand. Education in these booklets includes evidence-based practices and facts on vitamins, nutrition, preventive care, family history, vaccinations, sleep, healthy relationships, the menstrual cycle, sexually transmitted diseases, mental health, tobacco, alcohol, and birth control methods. During FY20, home visiting staff gave 100 Power Your Life booklets to their home visiting clients. However, due to the COVID-19 pandemic, all home visiting programming was stopped for the safety of staff and clients.

Accomplishments / Successes:

A major success is the ongoing relationships the MIHP program has developed with community organizations. For example, lasting relationships with Utah Valley University and the University of Utah have provided us an opportunity to reach thousands of women with health messaging through yearly health fairs.

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

- Ongoing, mutually beneficial relationships with a local university, Utah Valley University, has allowed the Maternal and Infant Health Program (MIHP) to reach thousands of college-aged women with education and information about the importance of routine preventive care.

- A trusted resource at numerous community health fairs. Additionally, well-educated and approachable staff at these health fairs allows for education to happen on the spot.

- Strong community partnerships that allow us to distribute Power Your Life booklets to a wide network of women across the state.

Challenges / Gaps / Disparities Report:

Challenges:

Disparities in receipt of a preventive medical visit were noted by insurance status with a preventive visit reported by 71.9% of insured women and 44.6% of uninsured women.

The primary challenges faced by MIHP staff during FY20 was the COVID-19 pandemic. Due to federal, state and local ordinances, all large group gatherings, like health fairs, were canceled for the safety of all citizens. This led to MIHP staff being unable to attend as many health fairs as previous years thus resulting in lower numbers of people reached. We also anticipate a decrease in the percentage of women of reproductive age seeking routine preventive care in the next year due to the pandemic.

A secondary challenge of creating an evidence-based strategy for increasing our percentage of women receiving a well-woman visit is our inability to pinpoint the exact reasons 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.

Agency Capacity / Collaboration Report:

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

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

Another important partner, MotherToBaby Utah (MTB UT) provides information to women about exposures in the preconception period, during pregnancy, and during breastfeeding. In FY20, MTB UT answered questions from 360 women and their providers about exposures as they were planning for future pregnancies, 3,074 questions during pregnancy, and 2,325 questions before and during breastfeeding. MTB UT provides information about immunizations, chronic conditions, medications for conditions, taking prenatal vitamins, and other exposures that might affect the developing fetus to help women plan for their pregnancies.

Report of ESMs related to NPM-1

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

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

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

The COVID-19 pandemic closed down in-person learning and therefore on campus events were not feasible.

This ESM was discontinued in FY20.

Goal/Objective:

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

Significance of ESM 1.2:

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

A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions, such as diabetes, counseling to achieve a healthy weight, and smoking cessation, can be advanced within a well woman visit to promote women's health prior to, and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetricians and Gynecologists (ACOG) and was identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans, without cost-sharing.

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

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

Annual Report FY20:

The Performance Measure was not achieved. The Performance Objective was 54.0% and the Annual Indicator was 53.0%.

Program Activities:

In early February 2020, the Oral Health Educator (OHE) was able to provide oral health education, dental screenings, fluoride varnish and referrals to eight pregnant teens in the Salt Lake City Teen Success program. During the pandemic the Oral Health Specialist (OHS), along with an intern recorded a presentation by the National Center of Early Childhood Health and Wellness called Oral Health and Pregnancy. The OHE recorded the 12 Oral Health Messages staff training material. Videos were recorded in Spanish and English of these presentations and shared statewide with Early Head Start (EHS), Head Start (HS), Home Visiting, WIC and other early intervention programs. In addition, newly updated 12 oral health magnets, and modules were given to Home Visiting, EHS and HS sites to disseminate to families.

In May 2020, the OHE provided live virtual training with Utah County home visitors and Hello Baby and Early Intervention staff using the Smiles for Life! Preventive Strategies for Promoting Oral Health for Pregnant Women, Infants and Children. Thirteen staff members were in attendance and magnets and other educational materials were mailed to the site. Similarly, the OHE provided the same training and resources to Salt Lake County PAT and NFP staff. Sixteen were in attendance for this training and electronic materials were sent to both sites.

The OHP continues to partner with the Violence and Injury Protection Program to educate dentists and oral surgeons on Opioids for all populations, especially pregnant women and children. The OHP developed an opioid toolkit for dentists and oral surgeons in Utah. The OHP also partnered with the Utah Dental Association and the Association of Utah Community Health Programs. The OHS & OHE have shared information to dentists & oral surgeons statewide on Prescribing Opioids for Women of Reproductive Age: Information for Dentists. This was published by the National Maternal and Child Oral Health Resource Center. In April, 2020 the OHE shared portions of this toolkit specifically on pregnancy, adolescents and children considerations when prescribing opioids along with naloxone information to all of the Home Visiting Sites. The opioid toolkit has also been shared with the two dental schools and in six hygiene schools in Utah.

In the late spring of 2020, the OHS worked with two dental hygienists that spoke Nepali and Arabic and coordinated them to record a presentation on Oral Health and Pregnancy in their respective languages. The OHP's intern recorded this presentation in Spanish and English as well and it was shared with all Head Starts, WIC, Home Visiting programs in the state, and other early intervention programs.

On an ongoing basis, the OHP shares resources from the National Maternal Oral Health Resource Center on Oral Health and Pregnancy with WIC, HS/EHS, HV, Utah Fostering Healthy Children and other early intervention programs.

In the fall of 2019, the OHP screened and provided fluoride varnish to migrant farm workers. Two women were pregnant and resources were given in Spanish.

Accomplishments / Successes:

In the fall of 2019, the OHS worked with the State WIC and created an Oral Health Checklist for clients that was shared on their webpage and in-person. The OHS worked with the PRAMS Epidemiologist to gather data for the emergency department dental report. The report was released in fall 2019 and shared with stakeholders.

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

- The Oral Health Specialist & Oral Health Educator continues to present and coordinate four KUTV Baby Your Baby segments a year. Topics for these segments included Oral Health and Pregnancy, baby bottle use, the importance of primary teeth, limiting sugary snacks, and other oral health topics. These reached the general public throughout the State of Utah.

- The Oral Health Program continued using the "12 Oral Health Messages" created for pregnant mothers and children in collaborative efforts with WIC, Head Start, Fostering Healthy Children and Home Visiting programs.

- The Oral Health Program published and disseminated two Bi-Annual Oral Health Outreach Reports to stakeholders and other partners.

- The Oral Health Program continued to encourage and support efforts in the Utah Oral Health Coalition, the Utah Dental Association, and the Utah Dental Hygienists Association to increase the number of pregnant women who had preventive dental visits during pregnancy.

Challenges / Gaps / Disparities Report:

Clearly one of the biggest challenges of providing access to dental care has been the pandemic where all dental offices initially were shut down. These closures also affected both dental schools, all six dental hygiene schools and safety net dental clinics. Many safety net clinics did not have PPE or were very delayed in opening back up. Several of the safety net dental clinics also didn't offer preventive care, only exam and restorative care. This severely limited access to dental care. This was a nationwide problem. Several live online meetings were done to address this challenge. When the clinics finally opened, many families were very hesitant to go to the dentist let alone pregnant women and children.

Limited funding and staff is a challenge as we try to reach all of the state to address social justice and health inequities involving oral health. It is difficult to find programs to collaborate with that work solely with pregnant women, so efforts continue with groups who have a significant number of pregnant women. It is also a challenge in some rural areas to find a dentist who accepts Medicaid to refer pregnant women to for care. This is because all of the dentists in these areas who are Medicaid providers only see children. Language barriers are a problem for some pregnant women. Recent census data shows that about 120 languages are spoken in Utah, and about 14% do not speak English at home. Many of the women we work with have so many other challenges they are facing including lack of employment, a child with other medical issues, being a single parent, language barriers, transportation barriers, child care etc. This makes dental care a lower priority.

Agency Capacity / Collaboration Report:

The OHP continued to encourage, support, and partner in efforts with the Utah Oral Health Coalition, the Utah Dental Association, and the Utah Dental Hygienists Association to increase the number of pregnant women who had preventive dental visits during pregnancy. The OHP maintains strong relationships with all state dental and dental hygiene schools and connects staff from Home Visiting, WIC, Head Start and other programs to the schools and other low cost options. Efforts were made to help encourage any general dentists who have concerns about treating pregnant women, to see these women, and provide appropriate care during pregnancy. An example would be sharing the National Maternal Child Oral Health Resource on Pregnancy and Dental Care with these associations.

Report of ESMs related to NPM-13

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

Goal/Objective:

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

Significance of ESM 13.1:

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

ESM 13.1 Progress Report:

In the late spring of 2020, the OHS worked with two dental hygienists that spoke Nepali and Arabic and coordinated them to record a presentation on Oral Health and Pregnancy in their respective languages. This was done at the request of an organization that served many clients who spoke these languages. The OHP's intern also recorded this presentation in Spanish and English as well and it was shared with all Head Starts. Dental screenings and fluoride applications were not able to be done for this time period due to COVID-19.

The data for this ESM was not available because Head Start Programs were not required to submit reports for 2020 due to the COVID-19 pandemic.

Local Health Department Activities related to Oral Health:

One Local Health District worked on addressing dental health among pregnant/postpartum women in FY20. Below are highlights of successes and challenges related to their efforts:

Successes:

Many of those who are receiving Medicaid services do not realize that they have a dental benefit. This benefit is limited and only available while pregnant and up to two-month postpartum. Davis County Health Department (DCHD) set a goal to educate all prenatal/postnatal women about the importance of preventative dental care and the early treatment of dental issues during any prenatal/postnatal visits. The overarching goal was to get those who have dental needs into care before their benefit ends. To help ensure that women were following through with their

referrals, staff made follow-up calls to assess if the referral was completed and if not, help eliminate any barriers that may have been identified.

During the prenatal/postnatal visit, the MCH nurses would evaluate when the client had last seen a dentist. They would also assess to determine if the client was experiencing any dental issues (i.e. tooth pain, gum bleeding, and tooth loss). If an acute or preventative dental need was identified, the MCH nurse would help the client find a Medicaid dental provider and when possible, assist them in making an appointment. A reminder/recall was generated to call the client back two weeks post visit to see if they followed up with their dental referral. MCH staff would reach back out to those who were given referrals and assess the reasons why they didn't complete the follow-up. Barriers to completing the referral would be discussed and alternatives would be identified. The MCH staff would also remind them of the importance of dental care and how prevention is less costly and painful than treatment

Barriers:

COVID-19 greatly affected work in this area. Most of the programs provided by the health department were halted and response efforts moved towards the COVID-19 pandemic. All nurses who would normally be reaching out to our prenatal/postnatal clients were reassigned to COVID-19 response efforts. The pandemic remains in full force. DCHD has not been able to reinstate most of the MCH programs.

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

MotherToBaby Utah provided a specialized component of prenatal care by providing information about exposures in pregnancy and breastfeeding to help reduce untreated conditions, prevent exposures that increase risks for birth defects and developmental delays, prevent other adverse pregnancy outcomes, and increase breastfeeding rates.

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

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

Utah is a member state of the Alliance for Innovation on Maternal Health and partners with Wyoming to implement maternal safety bundles. Hospitals have been working in past years to implement the hemorrhage and hypertension safety bundles. In 2019, hospitals voted to begin work on implementation of the Obstetric Care for Women with Opioid Use Disorder safety bundle. Utah and Wyoming collaborated to close out work on the hypertension safety bundle and launch the implementation of the Obstetric Care for Women with Opioid Use Disorder safety bundle. The launch meeting was held on March 5-6, 2020. There were representatives from 27 Utah hospitals and six from Wyoming as well as representatives from AWHONN and the Colorado Perinatal Quality Collaborative. Attendees were given training on conducting simulation exercises on eclamptic seizure by the University of Utah. The launch of

the Opioid Use Disorder (OUD) bundle began with a presentation on implicit bias. Other session presentations included a nursing panel and a presentation from a patient with lived OUD experience. Monthly learning sessions on the Opioid Use Disorder bundle components were delivered via the Zoom platform.

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

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

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 is now reviewing maternal deaths for both states. Utah continued its collaboration with the CDC Foundation to contribute to enhanced surveillance and understanding of maternal overdose deaths.

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

MotherToBaby Utah provided information about exposures, including mood medications, in pregnancy and breastfeeding to help reduce untreated mood conditions, prevent exposures that increase risks for birth defects and developmental delays, prevent other adverse pregnancy outcomes, and increase breastfeeding rates. In FY 2020, MotherToBaby Utah provided information to 45 clients about postpartum depression and, assuming those pregnant and breastfeeding individuals started, continued, or restarted their prescribed medications, MotherToBaby Utah saved Utah over $1.4 million based on a study that indicated that untreated mood conditions cost each mother-infant pair $31,800 over the first five years of the child's life.

The Maternal and Infant Health Program supplied funding to 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 is offered in selected areas. For women who have a positive screen for perinatal depression, they are offered either support groups or individual mental health services via a telehealth platform.

Local Health Department Activities related to Postpartum Depression

Twelve of the thirteen Local Health Districts (LHD) worked on addressing postpartum depression in FY20. Below are highlights of successes and challenges related to their efforts:

Successes:

Women in these districts received education related to postpartum depression (PPD). Most districts offered screening for PPD using a validated screening tool. For those women who were identified to have PPD, were referred for follow up services. Utilization of mental health services was monitored for clients with positive screens who receive on-going intervention. Some LHDs ensured that mothers were meeting goals for treatment of postpartum depression.

The mechanism for providing this education and screenings was varied. One LHD, Davis County Health Department

(DCHS) visited women in conjunction with a Targeted Case Management (TCM) initial visit on newborns <4 months of age. Following completion of the infant TCM assessment, DCHD nurses would change focus and spend time on the new mom. A postpartum assessment would take place. As part of the assessment, all of these new moms were offered a postpartum depression screening (Edinburgh). Of the 732 new moms visited, 295 agreed to and had the Edinburgh postpartum screening performed. This accounted for 40% of the women evaluated. To assist the nurses in remembering to conduct the depression screening, the screening tool was placed in each of the infant referral packets.

Following the TCM visits, nurses would encourage post-partum moms to complete the depression screening while the nurse was there at the home. Upon completion of the screening tool (Edinburgh), nurses would score results immediately and anyone who scored ≥10 would be provided a mental health service referral. Nurses would follow-up on those that were given referrals (up to two follow up attempts) post screening - especially on those at high-risk.

Five of the LHDs participated in a telemental health project with the University of Utah College of Nursing. Staff from these districts participated in monthly partner calls of the U of U Maternal Mental Health Project. A tablet containing the Edinburgh screening tool was offered to pregnant/postpartum clients that came into the office. Several LHDs noted that during COVID-19, mothers' EPDS scores seemed higher. They found this an opportunity to offer more support to them.

Challenges:

The COVID-19 pandemic had a broad impact on work in this area. Many LHDs suspended many public health services so that work could be redirected towards COVID-19. WIC clinics were closed for a period of time. Nurses used WIC as a contact point to offer PPD screenings. WIC services resumed in virtual formats, but staff noted challenges with having women fill out the screener via a link sent to them. Staff felt that rates of refusal were higher than when women were attending in-person appointments. Fewer in-person appointments and home visits impacted progress in this area. MCH nurses would take on additional workloads and even do client visits later in the evening.

Other challenges to the work in this area noted by the LHDs:

- Getting clients to answer phone calls and keep appointments.
- Clients not scheduling appointments to follow up with their health care provider
- Some postpartum women refused the screening or would refuse the referrals. In order to address this, nurses would spend time with them, explaining what postpartum depression was and how important it is for women to be evaluated and to get them into care if they are at risk. Educational materials were left with the moms as well. The nurses would also attempt follow-up contact with the moms to see if they changed their mind and to again encourage that they follow-up with the referrals or at least communicate with their medical providers regarding their risk for postpartum depression.
- Several women reported difficulty connecting with telehealth services and some felt telehealth did not meet their needs. Home visitors continue to problem solve on a case by case basis.
- By not seeing clients in person, it is harder to gain rapport with them for them to allow referrals to the resources that they need.

MCH Block Grant FY22 Application & FY20 Annual Report

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 FY22:

During FY22, the Maternal and Infant Health Program (MIHP) and the Well Woman Coalition will continue to work to understand the knowledge, attitudes, and behaviors of women of reproductive age regarding the well-woman visit. This group will create a strategic plan that defines routine preventive care and describes the most common barriers to receiving that care. They will also recommend changes at the state, local, and systems levels to improve care and encourage all women to view preventive care as self-care. Furthermore, this coalition will work with MIHP to create an additional question to add to the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) that will ask a wider group of Utah citizens who identify as female why they did not seek routine preventive care in the last 12 months. Through these two efforts, we hope to create a sustainable program with targeted messaging that encourages and emboldens Utahns to receive routine preventive care.

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

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

Proposed Activities:

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

Priority Need: 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 FY22:

In addition to continuing all of the current activities in our program (ongoing training of providers, creating new collaborations, social media education, etc.), the Maternal and Infant Health Program (MIHP) will be finalizing and expanding some services to better serve the providers who will be implementing maternal mental health screening.

Finalizing the toolkit, which includes statewide screening and referral protocols, for the Utah Women and Newborns Quality Collaborative, will be a top priority. Once the toolkit is finalized, it will be piloted and implemented in several settings including an OB clinic, pediatric clinic, local health department, and possibly a Federally Qualified Health Center.

The MIHP maternal mental health specialist will seek to provide perinatal mental health training to at least one additional OB, midwife, psychotherapist, Pediatrician, TriCare provider, and look for people who speak Spanish as we are boosting our provider base on the maternal mental health referral network.

We are also hoping to expand use of online screening in local health departments through our contract with the University of Utah. This online screening tool is vital for rural and frontier health departments who don't 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 they take before arriving to their appointment.

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

Proposed Activities:

- Finalize provider toolkit for the Utah Women and Newborns Quality Collaborative and pilot the toolkit for improvements.
- Provide perinatal mental health training to at least one additional OB, midwife, psychotherapist, Pediatrician, TriCare provider (Veteran population), and Spanish language provider
- Expand use of online screening through the University of Utah to other rural districts.
- Continue to use social media platforms to encourage women to seek screening and care from providers.

Perinatal/Infant Health

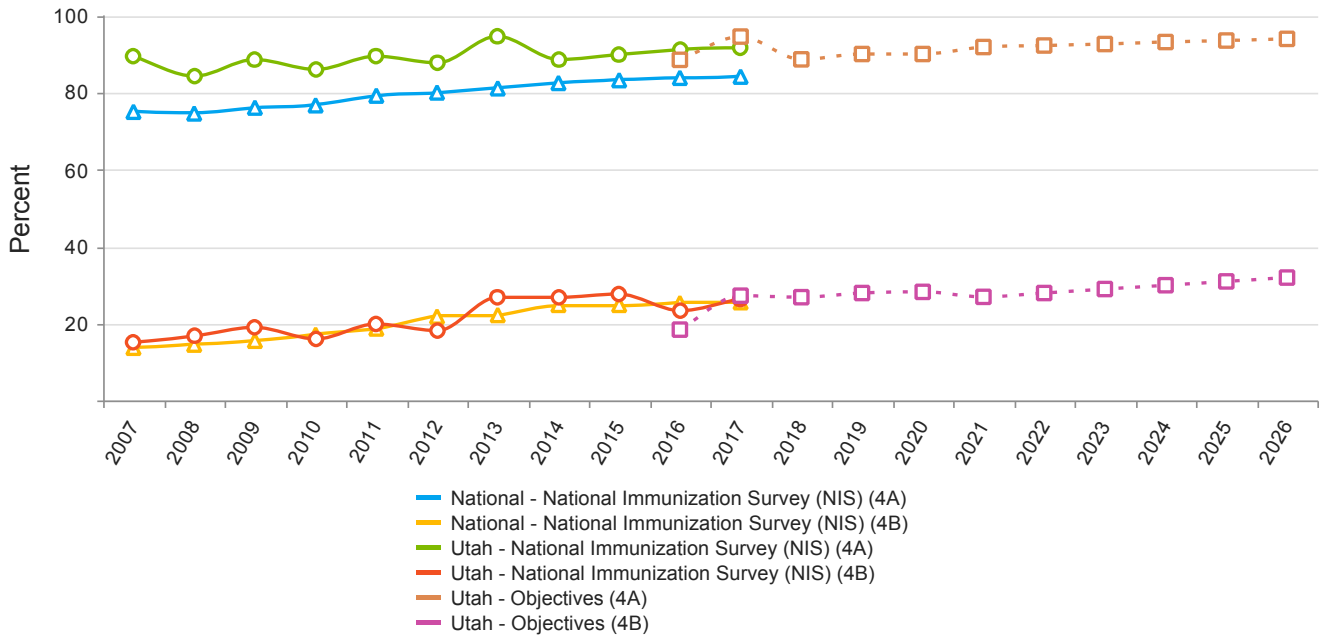
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.9	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.5	NPM 3 NPM 4
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.1	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.4	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	199.1	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	55.1	NPM 4

National Performance Measures

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

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	88.5	94.5	88.6	90	90
Annual Indicator	94.4	88.4	89.7	91.2	91.8
Numerator	43,550	43,382	43,073	45,052	39,458
Denominator	46,122	49,063	48,030	49,404	42,968
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	91.8	92.2	92.6	93.1	93.5	93.9

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	18.5	27.3	26.9	28	28.3
Annual Indicator	27.0	26.8	27.8	23.5	26.3
Numerator	11,890	12,259	12,643	11,415	10,658
Denominator	44,056	45,790	45,490	48,506	40,597
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.0	28.0	29.0	30.0	31.0	32.0

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
Annual Objective		
Annual Indicator	13.2	24.4
Numerator	6,225	11,435
Denominator	47,211	46,832
Data Source	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	30.0	33.0	36.0	40.0	43.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.9	6.6
Numerator	983	449
Denominator	7,093	6,831
Data Source	WIC Program Data	WIC Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.0	15.0	16.0	17.0	18.0	19.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	7
Numerator		
Denominator		
Data Source	EPICC Program Data	EPICC Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.0	40.0	40.0	40.0	40.0	40.0

State Action Plan Table

State Action Plan Table (Utah) - Perinatal/Infant Health - Entry 1	
Priority Need	
Breastfeeding/poor infant nutrition	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
A) By 2025, increase the percent of infants born in Utah who are ever breastfed from 89.7% (NIS, 2015) to 91.7%. B) By 2025, increase the percent of infants born in Utah who are exclusively breastfed through 6 months of age from 27.8% (NIS, 2015) to 31.5%.	
Strategies	
1. Implement the Stepping Up for Utah Babies program in delivering hospitals in Utah.	
2. Work with workplaces to create a written breastfeeding policy that complies with the federal lactation accommodation law.	
3. Increase access to, and use of, Utah WIC Breastfeeding Peer Counselor Program (BFPCP).	
ESMs	**Status**
ESM 4.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for Utah Babies program to become a “Breastfeeding Friendly Facility.”	Active
ESM 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.	Active
ESM 4.3 - Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

2016-2020: National Performance Measures

2016-2020: NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

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

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	92.8	91.7	90	90.4
Annual Indicator	92.7	91.6	89.1	90	90.6
Numerator	480	522	521	448	455
Denominator	518	570	585	498	502
Data Source	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

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

2016-2020: ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		100	100	100	100
Annual Indicator	100	100	100	100	0
Numerator	518	585	593	498	0
Denominator	518	585	593	498	502
Data Source	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		100	100	100	100
Annual Indicator	0	0	0	0	0
Numerator	0	0	0	0	0
Denominator	10	10	10	10	10
Data Source	Program Level Data	Program Level Data	Program Level Data	Program Level Data	Program Level data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: State Performance Measures

2016-2020: SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		9	9.4	9.4	9.4
Annual Indicator	9.3	9.6	9.4	9.4	9.7
Numerator	4,712	4,852	4,582	4,434	4,552
Denominator	50,776	50,486	48,578	47,211	46,832
Data Source	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

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

This Measure will not be continued.

Annual Report FY20:

Program Activities:

The Performance Measure was achieved. The Performance Objective was 90.4% and the annual indicator was 90.6%.

The Utah 2019 results are higher than the Healthy People 2020 target of 83.7%. From 2015-2019, the average for this indicator was 90%. This continues to be above the HP2020 baseline of 75% and above the target of 83.7%. According to a 2010 review of very low birth weight (VLBW) infants delivered in risk-appropriate settings, the percentage of VLBW infants born in a hospital with a level III or higher neonatal intensive care unit (NICU), changed only slightly between 2000 and 2007. (74.2% to 74.7% respectively). According to the National Performance Measure 3 Risk Appropriate Perinatal Care Evidence Review, "Five States reported greater than 90% of VLBW births were delivered at level III or higher hospitals, a goal that may not be achievable in all states."[1,2]

Utah has completed the CDC Levels of Care Assessment Tool (LOCATe). Utah contributed data to a multi-jurisdictional analysis to be conducted by the CDC. Facility groupings, by assessed levels of neonatal care, will be used to examine differences in neonatal and infant mortality between neonatal levels of care. Facility level characteristics reported on LOCATe, including volume of services, volume of high-risk deliveries, and specific availability of providers, will be assessed for relationships with neonatal mortality.

Accomplishments / Successes:

Utah has a rate of 1.07% of VLBW infants in 2019, with the national rate at 1.38%. The Utah rate was 29% lower than the national average. From 2015-2019, the average was 1.11%, which continues to be below the United States average. The VLBW HP2020 had a baseline of 1.5% and a U.S. Target of 1.4% and the VLBW in Utah has always remained below the HP2020 goal.

Utah successfully implemented the CDC LOCATe Assessment, providing the data to the CDC. This data will be combined with LOCATe data from other requesting jurisdictions, along with the birth and infant death cohort files for the corresponding years that LOCATe was implemented in each jurisdiction. The birth facility will be used as a key to link LOCATe data from each jurisdiction with the corresponding birth and infant death cohort files from that jurisdiction. The complex linking was completed by a data resource and is crucial to the multi-jurisdiction analysis.

A report was drafted on Very Low Birth Rates in Utah from 2014-2018. Some key findings included:

- The rate of VLBW births in Utah remained lower than the rate of VLBW births in the United States.
- VLBW infant birth rate was approximately 1,108 per 100,000 live births.
- The birth rate of VLBW infants (<1500 grams) did not display any significant changes during this time.
- There were no significant differences between VLBW birth rates across Local Health Districts.

- The VLBW birth rate among multiple births (9.53%) was significantly higher than the rate in singleton births (0.79%).

In 2015, a rule on VLBW reporting was implemented in Utah. This rule required hospitals to enter their VLBW data into a REDCap database. REDCap is a secure web application for building and managing online surveys and databases, which allows for robust data analysis and review. There has been decreased compliance with hospitals entering his information. Feedback was solicited from hospitals and they shared that the reporting requirements were difficult to implement for various reasons. These included having resources to compile and enter the data, the time that it was taking along with difficulties in pulling the data. Based on this feedback, the decision was made to sunset the rule.

Summary of successes and accomplishments on "Moving the Needle" in relation to NPM-3:

- The Data Resources Program completed the data linkages and de-identification needed for the CDC multi-jurisdictional analysis to explore maternal and neonatal risk-appropriate care from LOCATe data.

- Compiled a VLBW report with data from 2014-2018 that outlined various components of the VLBW birth rate in Utah, including how Utah compares to the United States, the rate among multiple births, the rate by maternal race/ethnicity, and mother's residence in Utah's Local Health Districts.

- The VLBW Reporting Rule was sunset due to feedback from hospitals on the burdensome requirements including the time that it takes to pull or enter the data and a lack of resources to compile the information.

Challenges / Gaps / Disparities Report:

Due to the continued success of this performance measure, it was determined that this will not be a state priority going forward. Between 2014-2018, the VLBW was higher in women who reported their ethnicity as Hispanic and in those who reported being non-Hispanic and non-white. The Utah Women and Newborns Quality Collaborative Maternal Committee began exploring a quality improvement project for the Latina Maternal population in FY21.

Agency Capacity / Collaboration Report:

Utah is one of the first states to provide LOCATe data to the CDC for the multi-jurisdiction exploration of maternal and neonatal risk-appropriate care. This is to evaluate practices and systems of risk-appropriate care to improve maternal, neonatal, and infant outcomes. Another key collaboration was listening to the feedback of hospitals to sunset a rule that was not working for them and had decreased compliance on hospitals entering the data. The hospitals were appreciative of the reduction in reporting requirements. The plan is to continue to use the results from the CDC LOCATe for discussions on how to improve health outcomes for women and infants.

Summary Progress Report of ESMs related to NPM-3:

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

Goal/Objective:

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

Significance of ESM 3.1:

Perinatal regionalization classifies hospitals at risk-appropriate levels in regards to care for both mothers and infants. This ensures that high-risk pregnancies and LBW, preterm or other at-risk infants have access to the most appropriate care. In Utah, hospitals self-designate their levels of care and because of this, there is no uniformity with Utah's leveling. In an attempt to assure level designations in our facilities, a database has been created that all Utah hospitals report the outcomes of every VLBW infant either delivered or transferred to their facility. This data will allow Utah to have a more informed conversation about the importance of Perinatal Regionalization through the eyes of some of our most ill and vulnerable infants.

ESM 3.1 Progress Summary

Maternal and Infant Program staff worked with Utah's delivering facilities to ensure that morbidity data on 100% of very low birthweight babies (VLBW) were entered into the REDCap system in compliance with rule 433-1. The implementation of the rule has made it possible to collect the data from all facilities and birth certificate data were used to verify reporting by the delivering facility. Three years of data were collected, but due to the burdens of reporting on hospitals, it was decided to sunset the rule that required this reporting.

ESM 3.2 Standardized guidelines: Percent of hospitals facilities providing support to build a consensus based model of Utah Standardized Level of Care.

Goal/Objective:

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

Significance of ESM 3.2:

A survey carried out by the Maternal and Child Health (MCH) Bureau several years ago provided objective criteria that indicates Utah currently has ten hospitals that self-designate as Level III neonatal intensive care units (NICU) while the survey data collected indicate that number is much smaller based on the published Guidelines. Currently, Utah regulations that designate Levels of Care for Perinatal Services are imprecise and there is no regular oversight of NICU services by the Department.
Through collaboration, the MCH Bureau has worked on developing Utah specific Guidelines for Neonatal Care based on the 7th edition of Guidelines for Perinatal Care; however, these guidelines have remained in draft form for the last few years. With the collection of Utah specific data on VLBW infants, creation of these guidelines will be able to be re-approached.

ESM Progress Summary:

This involves collaboration with the CDC Levels of Care Assessment Tool (LOCATe), which helps to create standardized levels of neonatal care. The Neonatal area of LOCATe is based on the most recent guidelines and policy statements issued by the American Academy of Pediatrics. Utah collaborated with the CDC to assist with collection and interpretation of the data. The results were compiled and reported back to each delivering facility and a report was given to the Utah Women and Newborns Quality Collaborative.

NPM-4.1: Percent of infants who are ever breastfed.

The Performance Measure was achieved. The Performance Objective was 90.0% and the Annual Indicator was 91.8%.

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

The Performance Measure was not achieved. The Performance Objective was 28.3% and the Annual Indicator was 26.3%.

Annual Report FY20:

Program Activities:

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

The Stepping Up for Utah Babies program is a free, Utah-centric program that works with birthing facilities to become certified as a "Breastfeeding Friendly Facility." The Stepping Up program utilizes quality improvement methods to assist participating birthing centers in implementing "The Ten Steps to Successful Breastfeeding" through an incremental approach – implementing two steps at a time, with the goal of implementing all 10 steps.

During FY20, the Stepping Up for Utah Babies program staff continued to offer on-going technical assistance to participating birthing facilities. Assistance included but was not limited to additional training for staff on requirements for step certification, sharing up-to-date research and resources, and providing feedback and answering implementation questions as they arise.

Stepping Up staff also continued their efforts to recruit additional birthing facilities to participate in the program. Outreach included directly contacting nursing/lactation staff to discuss the program and sharing information about breastfeeding/chestfeeding at community health fairs. We reached approximately 1,100 people with messages about general health, nutrition, pregnancy, breastfeeding/chestfeeding, women's health, maternal health, and infant health during those events. The community events were held prior to the COVID-19 pandemic.

The Utah WIC Program developed a statewide goal in FY19 to ensure that every pregnant and postpartum WIC participant receives at least one contact from the Utah WIC Peer Counseling Program. Breastfeeding peer counselor contacts are recorded in the WIC VISION computer system. Additional goals included that each local agency offers at least one training on breastfeeding to staff members; that lactation education courses for WIC staff, including breastfeeding peer counselors, be offered as funds allow; and that the Utah WIC Breastfeeding Peer Counseling Program continues to collaborate with the Utah Department of Health and community organizations.

In FY20, the Utah WIC program encouraged breastfeeding peer counselor contacts for prenatal and postpartum WIC participants in many ways. These included referring prenatal and postpartum WIC participants to the WIC breastfeeding peer-counseling program through the Nutrition Interview, Referrals, and Participant Care Plan screens in the Utah WIC VISION computer system; and through community program referrals by the Mother-To-Baby Utah (MTB UT) program. Furthermore, each local agency offered at least one training on breastfeeding, and many local

agencies asked their peer counselors to participate in the trainings through sharing new breastfeeding research with other staff members. Finally, a 45-hour Lactation Education course was offered to all WIC staff members, including peer counselors, in FY19.

Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC), in the Bureau of Health Promotion, successfully applied for funding from the Association of State and Territorial Health Officials (ASTHO) to help worksites improve or enhance their employee lactation accommodations. The award was received in January 2020. EPICC sent an RFA to worksites throughout the state inviting them to apply for funding using the ASTHO funds. Seventeen worksites were selected but work was not completed until FY21. EPICC's lactation specialist created a worksite training video and several podcasts on lactation accommodations in the workplace. EPICC continued its work with local health departments asking them to reach out to worksites and provide technical assistance on lactation accommodations (Note that this work slowed substantially due to the demands of COVID-19 work). The EPICC worksite specialist continued his work assessing the number of worksites that have lactation policies and/or meet the criteria for the federal lactation accommodations through several surveys that included the CDC Scorecard, the EPICC mini-scorecard, and the Utah Worksite Wellness Recognition Award assessment.

Accomplishments / Successes:

From the inception of the program in 2015 to the end of FY20, a total of 23 (52%) Utah birthing centers have been trained on the Stepping Up program and had successfully implemented a combined total of 117 steps. During FY20, we saw five birthing facilities complete all ten steps and become designated as a Breastfeeding Friendly Facility. These five Breastfeeding Friendly Facilities and the one Baby-Friendly facility accounted for 24.4% of births in Utah. This is significant because research has shown that families exposed to The Ten Steps to Successful Breastfeeding used by the Stepping Up for Utah Babies program have improved breastfeeding/chestfeeding rates.

Much of this success is due to the ongoing partnership and support from the Intermountain Healthcare System. They continue to encourage their member birthing facilities to continue working on the steps and certify as a Breastfeeding Friendly Facility.

During FY20, one hospital (Bear River Valley Hospital) was trained in the Stepping Up program. Bear River is located in Box Elder County and is considered a rural area of Utah. Also, during FY20, 30 new steps were implemented by the participating birthing facilities.

In FY20, 7% of pregnant and postpartum participants received at least one contact from a WIC breastfeeding peer counselor, which was less than the goal of 12% for FY20. Additionally, the number of employed peer counselors decreased from 36 in FY19 to 32. The decreased number of peer counselors and peer counselor contacts may have affected the Utah WIC breastfeeding prevalence rates. Utah WIC's ever breastfed prevalence rate was maintained at 88%, but all other breastfeeding prevalence rates, such as for breastfed at 6 months and 12 months, and exclusively breastfed at 3 months and 6 months decreased by 1 percentage point between FY19 and FY20.

Despite these challenges, there were several successes within the WIC Breastfeeding Peer Counseling Program. First, participants who were contacted by a breastfeeding peer counselor were often contacted at least 2 times, and sometimes 3 or more times prenatally and postpartum. This indicates that the participants who were contacted by peer counselors may have received improved quality of contacts. Additionally, breastfeeding peer counselors reported success while working from home and utilizing technology such as text messages, YouTube videos, and video calls to support participants in breastfeeding. Two local agencies successfully hosted virtual breastfeeding conferences in FY20 and reported having more participation than their past in-person conferences. Other local agencies worked with hospitals to provide outreach to their breastfeeding peer counseling programs, even though

they were unable to complete hospital visits during COVID-19.

Sending out the call for proposals increased awareness of worksites of the importance of providing accommodations for lactating women. It also provided a way for EPICC to reach worksites and provide resources and educational materials. It provided the opportunity to let staff at local health departments know about worksites in their jurisdictions that may be interested in technical assistance. Worksites that received funding were transformed by their improved lactation accommodations. The considerable number of applications received indicated the interest and need for technical and financial assistance for improving lactation accommodations among worksites.

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

- Stepping Up for Utah Babies program trained an additional hospital, oversaw the successful implementation of 33 steps, and designated 4 hospitals as a "Breastfeeding Friendly Facility."

- The Utah WIC Breastfeeding Peer Counseling Program contacted participants at least 2 times which led to an improved quality of contact. (December 31st, 1969 - December 31st, 1969)

- Two local WIC agencies hosted a virtual breastfeeding conference and had more participation than their past in-person conferences.

- EPICC received funding from the Association of State and Territorial Health Officials (ASTHO) that they released to worksites throughout the state. Seventeen funded worksites were provided technical assistance, resources, and education that improved their lactation accommodations.

Challenges / Gaps / Disparities Report:

An ongoing challenge to hospitals that have begun work on the Stepping Up for Utah Babies program is the amount of additional duties administrators, nurses, and educators must take on to accomplish the requirements set by the program. Furthermore, outreach to smaller and/or birthing facilities outside the two major health systems (Intermountain Healthcare and the University of Utah) has proven challenging. Communication attempts by Stepping Up for Utah Babies staff are often unreturned or directed to the incorrect person.

During FY20, the COVID-19 pandemic proved to be a significant disrupter of program activities. Birthing facilities were forced to react to the rapidly changing health directives and policies enacted by federal, state, local, and birthing facility officials. Quality improvement projects surrounding the implementation of the Stepping Up for Utah Babies program were halted in order for birthing facility staff to focus on protecting their patients from this novel virus. Additionally, due to social distancing requirements, restrictions on group gatherings and travel, and safeguarding birthing facility staff, and Stepping Up staff's overall safety, all training and in-person meetings were canceled.
The primary challenge in FY20 was the COVID-19 pandemic. The pandemic interrupted the operations of WIC clinics due to the policy changes required to ensure staff members' and participants' safety, such as not seeing participants in person. Additionally, many peer counseling staff members were asked to help with local agency COVID-19 tasks, which may have affected their time management for contacting prenatal and postpartum WIC participants. Furthermore, there were mixed messages about the safety of breastfeeding during the pandemic, which may have influenced WIC participants to choose not to breastfeed during this time. Finally, WIC agencies stated that because of the pandemic, they were unable to hire more peer counselors during FY20. Each of these challenges may have played a role in the decreased number of peer counselor contacts and the slight decline in the Utah WIC Breastfeeding Prevalence rates.

Many challenges occurred during 2020 due to the COVID-19 pandemic. Staff were redirected from their regular activities to COVID-19 work and were unable to give their time and energy to focus on breastfeeding. A webinar designed to help worksites understand lactation accommodations as well as an award program was delayed. Many businesses were also completely overwhelmed with contact tracing and staff shortages and were unresponsive to opportunities. We also had hoped for more responses to our women's survey. We anticipated having at least 40 women complete the survey about lactation accommodations in the workplace; however, many worksites were closed during the time the survey was conducted and we received only seven valid responses (despite the small number, the respondents provided insight into things that were important to them).

Emerging Issues:

Breastfeeding peer counselor recruitment and retention remains an ongoing concern within the Utah WIC Breastfeeding Peer Counseling Program. Additionally, despite improved collaboration with health care provider offices for the WIC Breastfeeding Peer Counseling program, some agencies have reported a lack of support from local hospitals who are not breastfeeding friendly and are unwilling to collaborate with WIC and promote breastfeeding.

The COVID-19 pandemic opened doors for more people to work at home on a more permanent basis and women with infants may be able to breastfeed at home in the future; therefore, work on lactation accommodations in the workplace may become less urgent than it has been in the past.

Agency Capacity / Collaboration Report:

The success of the Stepping Up for Utah Babies program would not be possible without our many partners. Our most important partners are the staff and administration that do the work to implement the Ten Steps to Successful Breastfeeding in their facilities. Their commitment and dedication to the program positively impact our breastfeeding rates. Second, partnerships with the Women, Infants, and Children (WIC) and the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) programs provide Stepping Up staff with expert advice and additional tools that can be shared with participating birthing facilities that assist in the implementation of 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. Intermountain Healthcare strongly encourages all of its member hospitals to participate in the Stepping Up for Utah Babies program, tracks their progress, and recognizes their achievements and certifications. The University of Utah is our only Baby-Friendly Facility in the state; however, they are supportive of the Stepping Up for Utah Babies program and have also received a designation of being a "Breastfeeding Friendly Facility."

The Utah WIC Program partners with several organizations. This includes MTB UT, local hospitals, local health care provider offices, local universities, La Leche League, Head Start, Community Health Clinics, Nurse Family Partnership programs, Parents as Teachers programs, Baby Your Baby, Early Intervention, Welcome Baby, the Mountain Mother's Milk Bank, and local doulas, local health educators, and local IBCLCs.

EPICC partnered with local health departments and shared names of worksites that applied but did not receive funding so that their staff could still follow up with them and offer assistance. In addition, EPICC established an internal workgroup comprised of EPICC staff who chaired or could speak on behalf of prominent statewide organizations (Utah Worksite Wellness Council, the Childhood Obesity Prevention Workgroup, and the Utah Association of Local Health Departments). EPICC contacted a private furniture sales industry to secure discounts on comfortable chairs for breastfeeding mothers for all worksites that applied, whether they were funded or not.

Summary Progress Report of ESMs related to NPM-4.1 and 4.2:

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

Goal/Objective:

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

Significance of ESM 4.1:

Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes, may have a lower risk of developing childhood obesity and asthma, and tend to have fewer dental cavities throughout life.

The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and postnatal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in postpartum hemorrhage and quicker return to a normal sized uterus over time. Mothers who breastfeed may be less likely to develop breast, uterine, and ovarian cancer, and have a reduced risk of developing osteoporosis.

ESM Progress Summary:

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

The Stepping Up for Utah Babies program is a free, Utah-centric program that works with birthing facilities to become certified as a "Breastfeeding Friendly Facility." The Stepping Up program utilizes quality improvement methods to assist participating birthing centers in implementing "The Ten Steps to Successful Breastfeeding" through an incremental approach – implementing two steps at a time with the goal of implementing all 10 steps.

From the inception of the program in 2015 to the end of FY20, a total of 20 (45%) Utah birthing centers have been trained on the program and had successfully implemented a combined total of 35 steps. Specifically, during FY20, Stepping Up program staff trained three new birthing facilities: Central Valley Medical Center (rural area), St. George Regional Hospital (the hospital is located in an urban city in a rural county), and Salt Lake Regional Medical Center (urban area) and oversaw the certification of 13 steps.
Moving forward, Stepping Up for Utah Babies program staff will continue recruiting birthing facilities to be trained and begin the work required to become a certified Breastfeeding Friendly Facility. Stepping Up staff remains committed to providing technical assistance and recognition to participating birthing facilities for those facilities already trained. Furthermore, Stepping Up staff plan to create increased educational opportunities by providing

short, on-demand training videos that will be available on the Stepping Up for Utah Babies website https://mihp.utah.gov/stepping-up-for-utah-babies. These training videos are currently being created and will be released at a later date.

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 is looking at other ways to reach these facilities. For example, surveys asking for more information about the implementation resources Stepping Up staff could provide that will help them succeed in becoming a recognized Breastfeeding Friendly Facility and looking for and working with community partners with pre-existing relationships with the birthing facilities.

The success of the Stepping Up for Utah Babies program would not be possible without our many partners. Our most important partners are the staff and administration that do the work to implement the Ten Steps to Successful Breastfeeding in their facilities. Their commitment and dedication to the program positively impact our breastfeeding/chestfeeding rates. Second, partnerships with the Women, Infants, and Children (WIC) and the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) programs provide Stepping Up staff with expert advice and additional tools that can be shared with participating birthing facilities that assist in the implementation of 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. Intermountain Healthcare strongly encourages all of its member hospitals to participate in the Stepping Up for Utah Babies program, tracks their progress, and recognizes their achievements and certifications. The University of Utah is our only Baby-Friendly Facility in the state; however, they are supportive of the Stepping Up for Utah Babies program and have also received a designation of being a “Breastfeeding Friendly Facility.

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

Goal/Objective:

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

Significance of ESM 4.2:

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

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

ESM 4.2 Progress Report:

During FY20, the EPICC program continued to reach out to, and collaborate with Utah worksites to create lactation policies that comply with federal and state laws. During FY20, eighty-three worksites completed either the CDC Worksite Health Scorecard, Healthy Worksite Award, or EPICC Mini-Scorecard. Of those, 61% of worksites currently have an existing breastfeeding policy in place that complies with federal standards. Sixteen worksites have created a new policy, formal communication, or revised and updated a policy for breastfeeding/lactation support for

employees and 84% of the worksites provide private space and provided paid or unpaid break time for expressing breast milk. EPICC staff and LHDs provided technical assistance and breastfeeding support materials to worksites that do not have policies or are not compliant with lactation accommodation law.

The 2020 survey of women who use lactation rooms and are affected by worksite policies was intended to be a one-time event but EPICC has obtained additional funds and is considering conducting another survey of women who use worksite accommodations.

In 2020, with funding from ASTHO, EPICC began the Workplace Lactation Accommodations Project, focusing on worksites with high concentrations of women earning $15.00 an hour or less. Funds were provided to 17 worksites to use on improving their lactation accommodations and ensuring that policies were in place. Women who used the improved accommodations were asked to take a survey to provide feedback about how they benefited from the changes along with challenges they faced. Because we asked employers to send the link to the women's worksite lactation accommodations survey to their employees, we have no knowledge of who received it and we cannot determine the exact number that it was sent to. Our results indicate that a minimum of 36 individuals received and at least initiated the survey. Filter questions were used to eliminate unqualified respondents. Respondents were disqualified if they were not female, if they had not had a baby within the past 18 months, if they were not currently using their employer's lactation accommodations. Responses were also not included if we could not confirm that respondents were 18 or over. We are using 36 as our denominator. Only seven surveys were determined to be complete and valid, yielding a response rate of 19.4% (7 of 36). Please note that the small sample is likely due to the low number of women who qualified to complete the survey as well as the impact that COVID-19 had on opportunities to work at home, therefore reducing the need for breastfeeding women to use their employers' accommodations.

Women who completed the survey reported challenges that included distance between women's workspace and the accommodations, distance to a bathroom or drinking fountain, the lack of extra chairs, sinks, or diaper-changing station, Also, the lactation room may not be "toddler friendly" for times that women need to have their older children with them. They appreciated having a specific place to pump and the educational materials on breastfeeding and postpartum depression in the lactation rooms. Women offered recommendations that included having accommodations closer to their workspace; providing comfortable chairs and refrigerators; ensuring that accommodations can support more than one woman at a time; and having paid breaks. This information can help employers target their lactation resources towards the things that are important to women who are breastfeeding. Note that the 17 worksites are not counted in the outcomes for this funding period as the work was not completed until October 2020.

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

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

Goal/Objective:

Increase the percentage of eligible pregnant and postpartum WIC participants who received at least one contact

from a WIC Breastfeeding Peer Counselor.

Significance of ESM 4.3:

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

ESM 4.3 Progress Report:

The Utah WIC Program is a breastfeeding support program that serves approximately 2% of Utah's population. The participants that Utah WIC serves includes approximately 9200 prenatal and postpartum women who receive education and support in reaching their breastfeeding goals. Research shows that peer counseling programs are effective in improving breastfeeding initiation and duration rates. Therefore, the Utah WIC Program's Breastfeeding Peer Counseling Program is helping the State of Utah meet its breastfeeding initiation and duration goals.

In FY20, the Utah WIC Program measured the number of referrals to its breastfeeding peer counseling program. While overall referrals from WIC staff members and community partners decreased, WIC's breastfeeding prevalence rates mostly stayed consistent with the previous years. Utah WIC collaborated with the MTB UT program, which provided concrete examples of referrals they had provided to the WIC breastfeeding peer counseling program and how these referrals benefitted participants. Additionally, in FY20, three local agency breastfeeding peer counseling programs were awarded national awards from USDA. Furthermore, local agencies were finding ways to expand their breastfeeding outreach through collaboration with health care providers and hospitals, community groups, creating community breastfeeding groups, and implementing evidence-based breastfeeding screening tools.

Since FY20, local agencies have continued to search for and implement innovative ways to improve breastfeeding outreach within the community. This includes furthering relationships with health care providers and hospitals, community organizations, health department and local agency organizations, and private practice health care professionals within their communities. Additionally, local agencies have hosted events, such as breastfeeding conferences and breastfeeding fairs to encourage community members and organizations to learn more about WIC and breastfeeding. During each fiscal year, WIC has obtained adequate funding to provide lactation continuing education courses to staff members, including peer counselors, to help them improve their breastfeeding promotion and support skills.

The primary challenge experienced by the Utah WIC Breastfeeding Peer Counseling Program is retention and recruitment of WIC breastfeeding peer counselors. Breastfeeding peer counselors sometimes have high turnover because of the hours, pay rate, or other personal needs, such as taking care of family or going back to school. Local agencies are working to find ways to promote improved recruitment and retention of breastfeeding peer counselors.

SPM-1: Percent of live births occurring before 37 completed weeks of gestation.

Annual Report FY20:

The Performance Measure was not achieved. The Performance Objective was 9.4% and the Annual Indicator was 9.7%.

Program Activities:

The Preterm Birth Rate was 9.7%. This rate is below the 2019 U.S. preterm birth rate of 10.2% and is a bit above the Healthy People 2020 goal of 9.4%.

The Reduce Preterm Birth Committee of the Utah Women and Newborns Quality Collaborative (UWNQC) did a data audit to compare birth certificate to hospital data. They reviewed 179 cases and found a 94% rate of offering 17 alpha-hydroxyprogesterone caproate (17P) to women with a previous preterm birth. Also, 80% of women who have a spontaneous preterm birth (PTB) did not have a history of PTB. The committee invited a 17-P patient to share her experience at a committee meeting including the process of receiving 17-P. A Cervical Length Project grant in rural areas of Utah was awarded. Family Planning Elevated at the University of Utah collaborated with ACOG to offer Preconception Care Awareness training in southern Utah. The committee members continued to share facility specific data at staff meetings, along with the resources developed to address Spontaneous Preterm Birth available at https://mihp.utah.gov/uwnqc/reduce-preterm-birth including the Preterm Birth Prevention Video Series, the Utah Screening and Progesterone treatment process and care protocol, What to Do to Prevent a Preterm Birth: 17P (Progesterone) Guide for Providers; 17P for Preventing Preterm Birth Fact Sheet (English and Spanish), What to Do After a Preterm Birth Guide for Families (English and Spanish). The resource also outlines how to implement changes and track improvement at hospitals.

COVID-19 resources were provided to clinicians. Family Planning Elevated provided Provider and Clinic Recommendations on contraceptive access during the pandemic.

Accomplishments / Successes:

In 2019, Vital Records staff presented to providers statewide on the importance of accurately reporting prior preterm births on the birth certificate. This included packets of information with UWNQC resources such as a 17P for Preventing Preterm Birth for Providers. Having the collaboration of Vital Records for our data collection and training providers has been a helpful resource. One of our contacts at Vital Records serves on one of our UWNQC committees which allows her to see our activities and understand why capturing the data is important.

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

Multiple births are a factor in the preterm birth rate. In 2019, 3.6% of total births were multiples (twins, triplets, quadruplets or higher), and this represented 23.1% of the total Preterm Births. The UWNQC committee has been focused on spontaneous singleton births.

Preterm Birth Risk factors included: Women who have had 3 or more previous live births (11.6%) PTB rate, age: 18-

19 year olds (12.97%), 35-39 year olds (11.47%) and 40-44 year olds (15.03%). Education is a preventive factor, with the more education that a woman has, the lower the PTB rate.

Although the Medicaid rate of Preterm Births hit 10.87%, the gap between mothers who were and were not enrolled in Medicaid reduced by 13% in 2019. Of the 12 Utah counties that had PTB rates over 10%, 10 of them are in rural or frontier counties. Rural or frontier counties account for 18% of all births and 19.24% of the PTB's. There are currently some telehealth programs in place that offer resources specific to rural residents.

Reviewing the rates of Preterm Birth by race and ethnicity, all races went up in comparison with 2018. The PTB rate for Hispanic/Latina did go down from 11.16% in 2018 to 10.42% in 2019. The highest rate for the past five years is among Native Hawaiian or Other Pacific Islanders (NHPI). Since 2012, The Utah Office of Health Disparities (OHD) in collaboration with public health and health care professionals and community partners has been working to address this issue, along with infant mortality. A final product of these efforts is the It Takes a Village: Giving our babies the best chance (ITAV) project. It Takes a Village raises awareness and educates NHPI families and community members about maternal and infant health in the context of Pacific Islander cultural beliefs and practices. ITAV is one of the outcomes of a birth outcomes disparities project that was originally rooted in the theoretical framework from the National Partnership for Action to End Health Disparities. The curriculum includes discussing topics such as birth spacing which can reduce the risk for Preterm Births.

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

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

- The Reduce Preterm Birth Committee of the Utah Women and Newborns Quality Collaborative (UWNQC) completed a data audit to compare the birth certificate to hospital data.

- Tracked 17P usage data via run charts for UWNQC hospitals. This data, along with Preterm Birth reduction resources, were provided to various hospitals statewide and at staff meetings.

- Family Planning Elevated at the University of Utah collaborated with ACOG to offer Preconception Care Awareness training in southern Utah.

Challenges / Gaps / Disparities Report:

An ongoing challenge is limited evidence-informed interventions to reduce preterm birth. With the U.S. Food and Drug Administration advisory committee recommending in October 2019 that the standard treatment to prevent women from having another preterm birth, Makena, be withdrawn from the market following a public hearing. That decision raised various concerns in the committee about prescribing 17-P and the SMFM and ACOG guidelines/statement were consulted. Due to COVID-19, meetings from March 2020-June 2020 were postponed. Based on the comprehensive Needs Assessment, Preterm Birth was determined to not be one of the MCH priorities for the next 5 years.

Agency Capacity / Collaboration Report:

Stakeholders from the key major health systems in Utah: Intermountain Healthcare, MountainStar (HCA), Steward

Health and the University of Utah work with the UWNQC board and committees. This collaboration helps us to educate providers, collect preterm birth data and implement statewide standard protocols and algorithms. Another partnership is with the University of Utah Family Planning Elevated team. They worked with ACOG to provide Preconception Care Awareness training for southern Utah clinicians. Government collaborations include working with Local Health Departments statewide and with hotlines such as the Utah Tobacco Quit Line, state resource center, Baby Your Baby and Mother-To-Baby. Social Media efforts include public education about how to be healthy prior to pregnancy on the Power Your Life website, along with offering various resources on the UWNQC for providers and the public. The collaboration with the Office of Vital Records is key in obtaining and analyzing 17P data utilization.

The collaboration between UWNQC and Family Planning Elevated at the University of Utah will continue as the House Bill 12 from the 2018 Legislative session provides a statewide, immediate Postpartum Long-Acting Reversible (LARC) Program. This includes offering a program that provides family planning services to low-income individuals, disseminating educational materials statewide, and training providers. The bill has provisions for family planning services within the state Medicaid program. It includes the Medicaid program reimbursing providers separately for the insertion of LARC immediately after childbirth, and providing family planning services to certain low-income individuals. Unintended pregnancy data will be tracked to determine if a reduction may help to move the needle in reducing preterm births.

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

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

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

National Outcome Measures (NOM):

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

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

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

MotherToBaby Utah provided information about exposures in pregnancy and breastfeeding to help prevent exposures that increase risks for birth defects, developmental delays, and fetal deaths.

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

The Study of the Associated Risks of Stillbirth (SOARS) is an ongoing, state-specific, population-based survey designed to collect information on maternal experiences and behaviors prior to, during, and immediately following

pregnancy among mothers who have recently experienced a stillbirth. SOARS was initiated in 2018 in an effort to find out why stillbirths occur and how to prevent future fetal deaths. Using methodology similar to the Pregnancy Risk Assessment Monitoring System (PRAMS), Utah women who recently experienced a fetal death are mailed a survey. Utah continued SOARS data collection in FY20.

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

MotherToBaby Utah provided information about exposures in pregnancy and breastfeeding to help prevent exposures that increase risks for birth defects, developmental delays, and fetal deaths.

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

MotherToBaby Utah provided information about alcohol exposure in pregnancy and breastfeeding to help prevent FASD which may include birth defects and developmental delays. MotherToBaby Utah is working with PRAMS to reinstate the question for alcohol use in the last 3 months of pregnancy.

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

MotherToBaby Utah provided information about exposures, including mood medications, in pregnancy and breastfeeding to help reduce untreated mood conditions, prevent exposures that increase risks for birth defects and developmental delays, prevent other adverse pregnancy outcomes, and increase breastfeeding rates. In FY 2020, MotherToBaby Utah provided information to 701 clients about mood conditions and, assuming those pregnant and breastfeeding individuals started, continued, or restarted their prescribed mood medications, MotherToBaby Utah saved Utah over $20 million based on a study that indicated that untreated mood conditions cost each mother-infant pair $31,800 over the first five years of the child’s life.

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 integrates data in real time from a variety of programs to present a consolidated record of newborn screening results such as newborn hearing, heel-stick (ranges are included) and critical congenital heart defect (CCHD) results. One way the CHARM system shares the integrated data is through its CHARM Web Portal (CWP). Authorized private and public health care providers continued to use the CWP to look up and view a child's health information/results from the above newborn screening tests to coordinate care, treatment, and follow-up in a timely manner. Providers were also able to access the Medical Home Portal through a link in the CWP to find diagnostic and treatment information for newborn disorders. In addition, CHARM continued to collaborate on the “Birth Certificate Alert Project” with the Early Hearing Detection and Intervention (EHDI) and Vital Records (VR) Programs. Through CHARM's data integration with EHDI and VR, when parents apply for a birth certificate for their child at the state or local health department, a hearing screening alert is generated by CHARM if the child did not pass a hearing screening test, was not screened, or needs to complete the process. When the birth certificate clerk sees the alert in the VR OLIVER system, he/she prints out a letter informing the parents or guardians that their child needs a hearing screening follow-up, and instructs them to contact the EHDI Program. The CHARM Program also prepares a report of these children for the EHDI Program in case the parent/guardian does not contact EHDI. From July 1, 2019 – June 30, 2020, there were 637 hearing alerts generated for children by CHARM and received in the OLIVER system; 319 (50.1%) 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.

Priority Need: Breastfeeding

NPM-4.1: *Percent of infants who are ever breastfed.*
NPM-4.2: *Percent of infants breastfed exclusively through 6 months.*

Annual Plan FY22:

During FY22, Stepping Up for Utah Babies staff will continue offering technical assistance to participating birthing facilities as they pursue their Breastfeeding Friendly Facility designation. During this program year, Stepping Up staff plans to re-evaluate outreach to non-participating facilities.

In the past, Stepping Up staff has relied on email and phone calls to reach out to birthing facilities to introduce and discuss the program. This has proven ineffective as many of these outreach attempts are left unreturned or directed to the incorrect person. Therefore, Stepping Up staff plan to change the strategy of trying to "sell" the program to birthing facilities and instead become a better partner and work with them to identify those resources that will assist them in becoming a certified Breastfeeding Friendly Facility. First, a comprehensive, up-to-date list of Nurse Managers, Lactation Educators, etc., contact information will be created by calling the birthing centers that are not already participating in the Stepping Up program. Next, a survey will be designed and sent to those identified as the decision-makers. This survey will introduce the Stepping Up program and ask birthing centers what resources they would like to see the Utah Department of Health offer that will make it easier for them to implement and complete all ten steps required to be certified as a Breastfeeding Friendly Facility. The survey will also ask why a birthing facility may not be interested in implementing the Stepping Up for Utah Babies program.

Stepping Up for Utah Babies staff also plan on creating training materials, 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 surrounding breastfeeding/breastfeeding. These materials will be able to be viewed or downloaded from our website, https://mihp.utah.gov/stepping-up-for-utah-babies.

Finally, Stepping Up for Utah Babies will continue working with the Women, Infants, and Children (WIC) and the Healthy Living through Environment, Policy, and Improved Clinical Care (EPICC) programs to educate the community through social and traditional media on the benefits of breastfeeding the Stepping Up for Utah Babies program. The Utah WIC Program will continue the following activities in FY22: maintaining a statewide goal to improve peer counseling contacts to prenatal and postpartum participants for all 13 local agencies, documenting peer counseling referrals and contacts by the peer counselor program in the Utah WIC VISION computer system, each local agency providing at least one training on breastfeeding, and providing continuing education lactation courses as WIC funds allow. The Utah WIC program will continue collaborating with the Utah Department of Health and community organizations.

A large number of worksites applied for funding through the Worksite Lactation Accommodations Project but only 17 could be funded. EPICC has secured additional funds (from 1807 SPAN) to continue the Project that began in 2020. EPICC will partner with MCH to re-examine and offer funding to some of the worksites. Through this opportunity, EPICC will identify and provide TA to at least 15 worksites that are not in compliance with the Federal Lactation Accommodation Law. Once worksites have made changes to their accommodations, EPICC will conduct site visits with each workplace to examine changes made.

EPICC had planned to work with the Utah Worksite Wellness Council to create a “breastfeeding accommodation award” as part of the recognition survey last year but this work was delayed due to the time and resource demands brought about by COVID-19. However, they hope to create this award in FY22. EPICC is still working on the federal and state laws and describes the importance of breastfeeding support in the workplace. This will be shared with worksites in Utah. EPICC will also maintain and update online worksite resources on legislation, policy, and lactation in the workplace. In addition they will conduct surveillance of breastfeeding policies using data from Qualtrics scorecards surveys and ECE reporting and enter policy information into the Bureau of Health Promotion Health Policy Tracking System. Finally, EPICC will continue to produce and publish podcasts that discuss the workplace accommodations required under the Federal Lactation Accommodation Law. EPICC staff and LHDs will continue to provide technical assistance and breastfeeding support materials to worksites that do not have policies and/or not yet compliant with lactation accommodation law.

During FY21, EPICC continued to reach out to Utah worksites to help them adopt lactation policies that comply with federal and state laws. To assess the results of the efforts made in FY21, four worksites answered the breastfeeding questions on the EPICC mini scorecard, thirty-eight completed the Healthy Worksite Award. Worksite Recognition Award and thirteen completed the CDC Worksite Health Scorecard (total=69). Of those, 35 (50.7%) had an existing breastfeeding policy in place that complied with federal standards. Seven of the 69 worksites (10.1%) created a new policy or formal communication or revised and updated a policy for breastfeeding/lactation support for employees during the twelve months of this funding period. Thirty-eight (55.1%) worksites provided space AND paid or unpaid break time for expressing breastmilk. In addition, EPICC contracted with local health departments to invite Early Childhood Education facilities to apply for a Teaching Obesity Prevention (TOP) Star endorsement. Having a formal breastfeeding policy is part of the endorsement process. Thirteen facilities were newly endorsed and therefore were required to have breastfeeding policies.

Proposed Activities:

- The Maternal and Infant Health Program (MIHP) will continue training hospitals and offering support for the Stepping Up for Utah Babies breastfeeding program.

- Utah WIC will continue working towards increasing referrals to the Peer Counseling Program for all 13 local agencies.

- EPICC will continue to work with new worksites on breastfeeding policy, accommodations, and leave times.

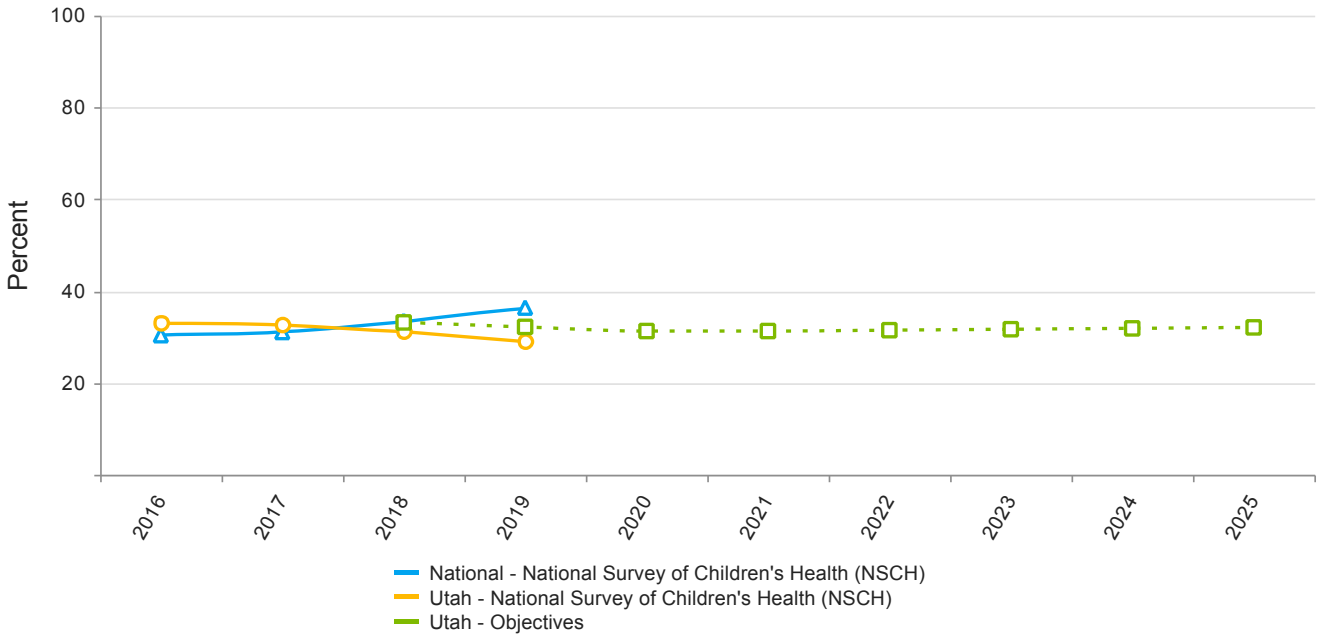
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	12.3 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.9 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.6 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33.2	32.2	31.3
Annual Indicator		33.1	32.6	31.1	29.1
Numerator		38,611	32,987	29,418	31,492
Denominator		116,514	101,171	94,514	108,310
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.3	31.5	31.7	31.9	32.1	32.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

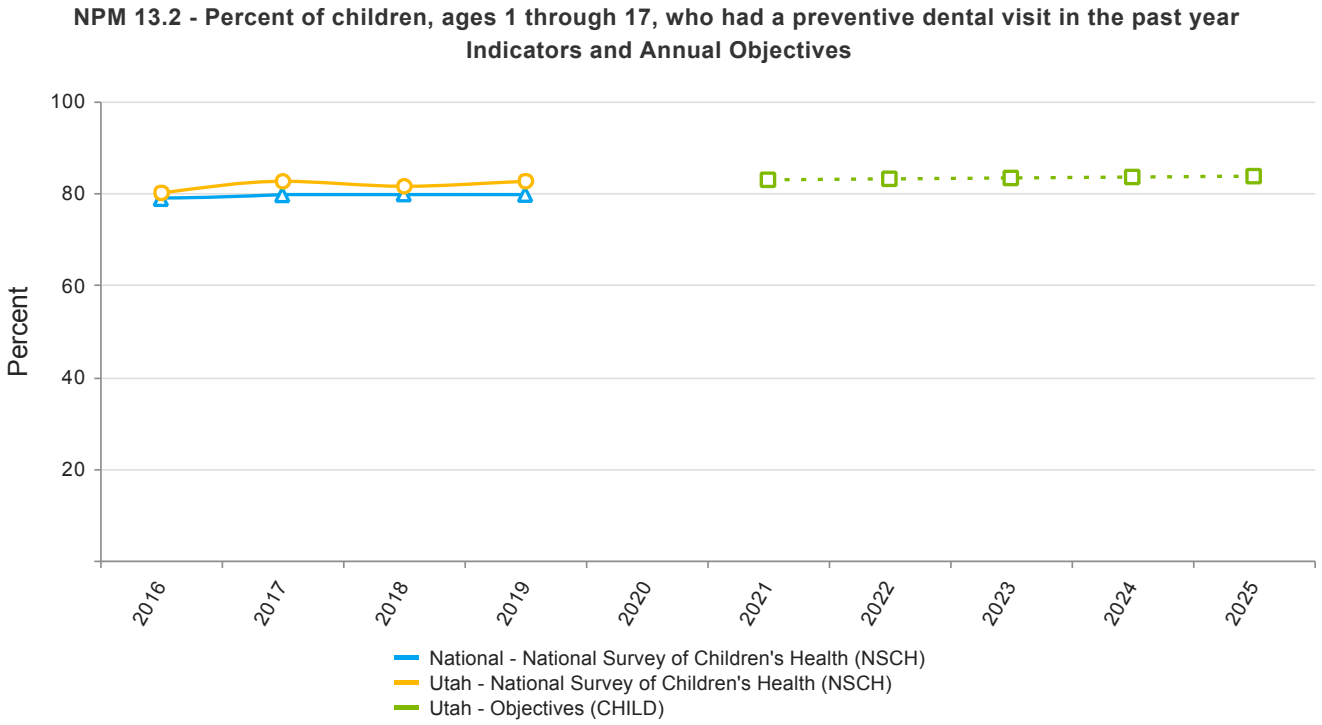
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	1.0	1.0	1.0	1.0	1.0

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7,988.0	8,387.0	8,806.0	9,246.0	9,709.0	10,195.0



NPM 13.2 - Child Health

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

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.8	83.0	83.2	83.4	83.6	83.8

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		53.6	51.5	54.4	55.7
Annual Indicator	53.4	51.3	54.2	55.5	51.9
Numerator	116,623	109,115	109,777	105,122	94,832
Denominator	218,295	212,848	202,518	189,242	182,597
Data Source	CMS 416	CMS 416	CMS 416	CMS-416	CMS-416
Data Source Year	FFY16	FFY17	FFY18	FFY19	FFY20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	52.1	52.3	52.5	52.7	52.9	53.1

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.8	79.5	80.2	80.9	81.7	82.4

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	38.0	41.0	44.0	47.0	50.0

State Action Plan Table

State Action Plan Table (Utah) - Child Health - Entry 1	
Priority Need	
Developmental delays	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By 2025, increase the percentage of children, ages 9 months through 35 months, who receive a parent-completed developmental health screen in the previous year from 31.1% (NSCH, 2017-18) to 32.3%.	
Strategies	
1. Increase the number of parent-completed developmental health screens received by children ages 9 months - 35 months by training additional Early Care & Education and Health programs in ASQ Online.	
2. Increase the number of parent-completed developmental health screens received by children ages 9 months - 35 months contributed to the UDOH ASQ Online Enterprise Account.	
ESMs	**Status**
ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program	Active
ESM 6.2 - The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

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

Priority Need

Oral health

NPM

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

Objectives

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

Strategies

1. The Oral Health Program (OHP) will Collaborate with Utah Medicaid with the goal to increase the percent of children who have preventive dental visits as well as dental treatment needed. The OHP will also collaborate with the Utah Oral Health Coalition, the Utah Dental Association, Head Start, the Office of Health Disparities, WIC, Fostering Healthy Children and the Utah Office of Home Visiting to reach these goals.

2. Collaborate & target high risk populations with Head Start, Early Intervention, Fostering Healthy Children, and WIC. The Utah Office of Home Visiting and the Office of Health Disparities, Smart Smiles (school based dental preventive program) to share resources and provide education and training to agency staff on the importance of dental care for children with the goal to increase the percent of children who have a preventive dental visit in the past year.

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

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

ESMs	Status
ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit	Active

NOMs

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

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

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

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

Priority Need

Family connectedness

SPM

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

Objectives

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

Strategies

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

MCH Block Grant FY22 Application & FY20 Report

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 FY20:

The Performance Measure was not achieved. The Performance Objective was 31.3 and the Annual Indicator was 29.1.

The FY 2020-25 Performance Objective to increase the percent of children, ages 9 through 35 months that receive a parent-completed developmental health screen from 31.1% (NSCH, 2017-18) to 32.3% has not been realized yet. According to Federally Available Data (2018-19, NSCH) 29.1% of children, ages 9 through 35 months, received a parent-completed screen in Utah.

Program Activities:

Utah articulated one objective for NPM #6 in 2020: 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 31.3%.

UDOH developed two related strategies:

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

A summary of the programmatic activities related to these two strategies is discussed below.

Train the Trainers

All of Utah's ASQ Online trainers were required to attend a Brookes Publishing "Train the Trainer" event to become a certified trainer. The Brookes training offers a specific curriculum for future trainees. ECU and HMGU enhanced the training curriculum information to include resource and referral information which was appropriate for providers to give to parents if a child scored in the moderate to below range on a screen. Another critical training addition was to educate all participants on the UDOH ASQ Online Enterprise account, assist interested programs with becoming enrolled and then provide TA on how to use the online account.

In early 2020 several ASQ Online trainings were offered in person. COVID-19 pushed all trainings to a virtual format. Virtual training may have increased the number of participants that were able to participate.

Increase ASQ Training

In partnership with the Utah Office of Child Care and United Way of Utah County's Help Me Grow (HMG) program, the UDOH revitalized its ASQ training protocols.

UDOH collaborated with HMG to develop monthly ASQ Online training for each of Utah's 13 Local Health Districts. The HMG ASQ training was published on the HMG website and available to any community providers to attend. This training was offered at no-cost to providers. In addition to the HMG training, the Early Childhood Utah Program Manager and the ECU Education Outreach Coordinator worked closely with the Local Health District (LHD) Nursing Directors to establish three tiered objectives.

Tier 1: ASQ Online Training and Promotion

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

Tier 2: ASQ Trained and Ready to Use ASQ

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

Tier 3: Advanced ASQ Use

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

In partnership with Utah's Office of Child Care, ECU's ASQ Online training is targeted to Licensed Child Care providers. This ASQ training is published on the ECU, the OCC and on the Child Care Resource and Referral Agency's (collectively known as Care About Childcare) websites; although word of mouth has become our most rewarding advertising method. Child Care providers earn Career Ladder incentives for participating in ECU's ASQ training. CC programs that incorporate ASQ Online screening in their procedures earn points on the Child Care Quality Rating and Improvement System. ASQ training is tracked on the OCC Professional Development Registry. The importance of routine developmental health screening with a parent-completed tool, such as the ASQ, is emphasized in Utah's Child Care and Development Block Grant State Plan.

It is important to note that anyone who contacts ECU or HMG can participate in either of these ASQ training opportunities. Another ASQ training highlight revolves around our sister program, the UDOH Office of Home Visiting (MIECHV). OHV contracts with HMG to provide ASQ training to new Home Visiting providers. Home Visitors, Place Based Community providers and LHDs are the primary participants in the HMG ASQ training.

Once ASQ Online training is complete, congratulation emails are distributed and participants are solicited to enroll in the UDOH ASQ Online Enterprise account. Once a program expresses interest, an easy to complete, one-page enrollment form is shared with the program's manager and their ASQ lead. Often programs that have used paper versions of ASQ or an ASQ Online Pro Account opt-in in order to take advantage of ECU support and research opportunities facilitated by our Early Childhood Integrated Data System.

After enrollment takes place much support and TA is provided to assist programs with implementing ASQ Online into their program/practice.

Expand ASQ Online opportunities to Medical and Mental Health providers

In addition to ECU's comprehensive work with Child Care providers and Local Health Departments, ECU is working closely with several pediatric providers. This collaboration is facilitated by Dr. Neal Davis, Sr. Medical Director, Pediatric Community-Based Care at Intermountain Healthcare. Dr. Davis and his team provided opportunities for ECU to present on the benefits of ASQ Online to a statewide network of pediatricians. Shortly after ECU's first presentation, Utah Valley Pediatrics enrolled in the UDOH ASQ Online Enterprise Account. Utah Valley Pediatrics operates 9 different clinics in one of Utah's most populated counties (Utah County) with Utah's highest birth rates. ECU is very excited about the screening potentials for young children this new relationship may bring to fruition.

Not only has Dr. Davis built a bridge between our program and community-based pediatricians he has also engaged Intermountain Healthcare's Hospital, Primary Children's Hospital and the University of Utah's Hospital Executive

Leadership in discussions regarding integrating SWYC (Survey of Well-being of Young Children) data with the UDOH Early Childhood Integrated Data System. These discussions are preliminary/exploratory in nature; however, the general concepts have been very well-received by this engaged group of medical leaders and may yield tremendous results.

Additional pediatric provider collaboration is facilitated by Summit and Wasatch County's Early Childhood Alliance. As a result of this community led collaboration ECU has successfully enrolled Wasatch Pediatrics in the UDOH ASQ Online Enterprise account. These pediatric providers serve many young children that reside in these booming communities. The Early Childhood Alliance is also connecting ECU to additional community-based medical providers, child care facilities and home visiting programs.

Wasatch Behavioral Health, Utah's public/Medicaid provider in Utah County and Wasatch County serves thousands of young children with social-emotional health needs. Recently, the ECU Education Coordinator enrolled this large program in the UDOH ASQ Online Enterprise Account. Onboarding this program will significantly increase the number of screens facilitated and received by our ASQ Online account.

Increase the number of ASQ Online screens received by children ages 9 months-35 months

Utah is making significant strides, on a systemic level, with increasing the number of screens received by all young children. In 2020, Utah's first Early Childhood Governor's Commission endorsed the ASQ-3 and ASQ SE: 2 as the state's early childhood developmental screening tool. Early childhood system, agency, program and community leaders are conducting assessments and co-creating blueprints to implement developmental screening, across all applicable agencies and programs, on a much broader and deeper scale than ever before. Ideas and pursuits include the potential development of a cross-agency/cross-program early childhood governance structure. A structure of this nature may help to better coordinate and increase developmental screening across Utah's largest family and child service agencies, namely the Utah Department of Health, the Utah Department of Human Services, the Utah State Board of Education and the Utah Department of Workforce Services.

Additional ideas and pursuits early childhood system leaders are taking is the migration of child level ASQ Online data to the state's immunization database. EC system leaders hope data enhancements of this nature may incentivize additional programs to participate along with improving care coordination and reducing duplication of effort.

ECU continued to work closely with the three HRSA/MCH funded Early Childhood Comprehensive Systems Grant Place Based Communities. Each of our PBC's hosted ASQ training within the last 12 months. Each PBC focused upon increasing the use of ASQ Online by engaging and educating partners on the tool, sharing resources and how to refer families with young children to the appropriate services. PBC partners include Help Me Grow Utah, Local Health Departments, Home Visiting, Early Intervention, Early Head Start, Head Start and Community Health and Pediatric providers. One of the overarching ambitions of the PBC's is to increase knowledge of the UDOH ASQ online program and how to effectively implement developmental screening into practice with the young children they serve. A common vision is shared; children with developmental delays should be identified early and receive the appropriate monitoring and/or interventions in order to improve their life trajectory.

The Ogden PBC has a close relationship with United Way of Northern Utah's Welcome Baby program. ECU, United Way and Welcome Baby worked together to enroll Welcome Baby into the UDOH ASQ Online Enterprise account and to train new employees in a newly created position; Home Visitation Coordinator. These AmeriCorps positions will provide a bridge between providers and families for completing ASQs and assist families with locating resources and information they may need. There are six AmeriCorps providers hired and trained in the ASQ. Early Childhood stakeholders look forward to assessing the impact AmeriCorps providers may have on the developmental

screening initiative.

Accomplishments / Successes:

In addition to the accomplishments described above, ECU re-enrolled 23 screening programs in 2019 and 11 programs in 2020. ECU added 11 new programs to the UDOH ASQ Online Account in 2019 and 10 new programs in 2020; along with 9 new enrollments so far in 2021. The UDOH ASQ Online Account received a record-breaking 15,382 screens (all ages/both tools) in 2019; which was a 123% increase since 2010. Due to COVID-19 related setbacks in 2020, the UDOH ASQ Online Account saw a decrease in the amount of overall screens, 11,039. However, we did see a slight increase in ASQ SE:2 screens from 2644 in 2019 to 3090 in 2020.

When we look at the results of ASQ-3 and ASQ SE:2 screens in a variety of ways, such as different age intervals, time-frames, geographies, first time or repeat screens and various care-types, we consistently find that around 23% of children are in the Monitoring Zone on the ASQ-3 and 14% on the ASQ SE:2; 19% are Below Cutoff on the ASQ-3 and 14% are Below Cutoff (converted) on the ASQ SE:2. The distribution for Below Cutoff scores across all five ASQ-3 domains are quite evenly distributed, between 19-23%. 57% of children score Below Cutoff in just one domain.

The ECU program continues to orchestrate the Early Childhood Utah Advisory Council. The advisory council is comprised of over 80 stakeholders from various communities and programs**.** The ECU Advisory Council provides recommendations from five subcommittees (Promoting Health and Access to Medical Homes; Early Care and Education; Data and Research; Social, Emotional and Mental Health; Parent Engagement, Support and Education) to the Governor's Commission on Early Childhood. Recommendations from the Promoting Health and Access to Medical Homes subcommittee to the Governor's Commission has helped to elevate support for statewide developmental screening.

The UDOH Early Childhood Integrated Data System (ECIDS) continues to flourish. Recent additions to ECIDS includes distinct child, service summary data, from MIECHV and state funded Home Visiting programs, from IDEA Part C Early Intervention (Baby Watch) and from two Early Head Start/Head Start grantees. UDOH ASQ Online data has been fully integrated with ECIDS, as a result, ASQ programmatic screening results and program crossover dashboard reports are ready to share with all of our enrolled screening programs. ECIDS recently added the ability to disaggregate ECIDS and ASQ reports by age, by gender, by race/ethnicity and by county (zip code is also available). ECIDS is in the process of integrating 'frequency/dosage' or 'engagement' data from the applicable participating programs. Data of this nature will be invaluable to return on investment and outcome/impact research. The UDOH Early Childhood Integrated Data Portal recently won a national award for making such progress.

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

- ASQ Online trainings in 2019: 0
- ASQ Online trainings in 2020: 23
- Total number of individuals trained in 2019: 0
- Total number of individuals trained in 2020: 141
- New programs enrolled in ASQ Online in 2019: 11
- New programs enrolled in ASQ Online in 2020: 10
- ASQ Online screens contributed to the UDOH Enterprise Account in 2019: 15,382
- ASQ Online screens contributed to the UDOH Enterprise Account in 2020: 11,039

Challenges / Gaps / Disparities Report:

The challenges our program faced with increasing the number of screens received by young children revolved around service delivery issues related to COVID-19. The programs that contribute screening data to the UDOH ASQ Online Account are direct service providers. Due to COVID-19, many direct service providers such as Home Visiting, Early Intervention, Head Start, Child Care and Pre-K suspended services for quite some time as they transitioned to virtual services, when possible. Some, but not all, providers are beginning to offer face/face services again. Due to this adjustment phase and competing priorities, the number of screens contributed to our account declined.

A positive side to COVID-19 related challenges is that many policy-makers and stakeholders are keenly aware of the developmental delay that may be rooted in children receiving abbreviated or no services. This awareness has led to an increased emphasis on the importance of developmental screening and care coordination. In the first 4 ½ months of 2021, UDOH has received over 4,000 screens from our screening partners; hopefully this is an indication of a sustained upward trend.

Emerging Issues

As per 2021 legislation, the Utah Department of Health and the Utah Department of Human Services are being consolidated into one agency. Additionally, Early Childhood programs hosted across multiple agencies are being assessed for the potentials of engaging in a streamlined governance structure. Agency consolidation and a merged Early Childhood Governance structure have potentials to increase developmental screening exponentially. These are quite complex ambitions that will take time to map out and execute effectively. Several steering and working committees, including an early childhood working committee, have been established to ensure an improved service delivery system, that better addresses social determinants of health, emerges from this systemic endeavor.

Agency Capacity / Collaboration Report:

The UDOH and soon the Utah Department of Health and Human Services have a tremendous capacity to coordinate an ever-increasing number of developmental screens for young children living throughout the state. Increasing developmental screens, improving care-coordination and improving the trajectory of children's lives by effectively addressing social determinants of health are critical objectives embraced by many leaders in Utah, including our new Governor and his Early Childhood State Team. Family voices are heard through the state's public meeting format, through our not-for-profit social service agencies and directly through working and subcommittees, such as the Early Childhood Utah Parent Engagement, Support and Education Subcommittee. As described above, ECU is designed to engage many community-based and state level leaders in the process of ongoing, meaningful and results orientated collaboration. Many of the state-level, systemic changes have evolved directly from this collaborative process. A shining example of effective Early Childhood collaboration has been the development of a co-created, comprehensive, professionally done, statewide birth-to-five statewide needs assessment and strategic plan. These documents have paved the way for many of the innovative Early Childhood structural changes that are currently in development. Both of these documents highlight the need for a synchronization of early childhood services, including developmental screening, care coordination and integrated data.

Summary Progress Report of ESMs related to NPM-6:

The following four ESMs (6.1 – 6.4) have been deactivated*.

ESM 6.1 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by

early care and education providers

ESM 6.2 - Early Childhood Utah (ECU) effort to increase ASQ screenings: Number of ASQ screenings conducted by early care and education providers

ESM 6.3 - Help Me Grow Utah (HMGU) ASQ screenings: Number of ASQ screenings conducted by Help Me Grow Utah (HMGU) staff

ESM 6.4 - Healthcare provider well-child checks: Number of ASQ online screenings done during well-child checks

*These measures were deactivated and replaced as the data were too difficult to extract from the database.

ESM 6.5: Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.

Goal/Objective:

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

Significance of ESM 6.5:

Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected or if there is cause of concern and further evaluation is necessary. This ESM is significant to increasing the number of developmental screens received by children ages 9 - 35 months. In order to increase the number of screens received by infants/toddlers we need to increase the number of Early Care & Education (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 - 35 month year old children.

ESM 6.5 Progress Report:

Trainings were held monthly as well as on request. Once trained, any provider or program was eligible to enroll in the ASQ Online Enterprise Account.

ESM 6.6: New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.

Goal/Objective:

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

Significance of ESM 6.6:

Early identification of developmental disorders is critical to the well-being of children and their families. Nationally, the 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 old children that receive parent-completed developmental health screening opportunities.

ESM 6.6 Progress Report:

Early Childhood Utah (ECU) held monthly ASQ trainings that were open statewide. The trainings were held at the Local Health Departments across the state. The trainings were open to anyone interested in taking the training, including: local health department staff, pediatric providers, child care providers and anyone else interested in using the developmental screening tool. In addition, due to COVID-19, a virtual webinar was made available on the Care About Child Care website and advertised with programs interested in the trainings. Additionally, Help Me Grow Utah, contracted through ECU, also moved their ASQ trainings to a virtual format.

Local Health Department Activities related to Developmental Screening

Utah's Local Health Districts (LHDs) worked on addressing developmental screening in FY20. Below are highlights of successes and challenges related to their efforts:

Successes:

LHDs worked to train their workforce on ASQ screening, the ASQ database, and M-CHAT screenings. LHDs worked to educate their community partners on the importance of promoting early screening and detection of children identified with developmental disabilities.

Screenings are conducted in a variety of settings. Staff discuss the developmental milestones at WIC appointments. Screens are discussed and completed during home visits for Targeted Case Management (TCM) and other home visits. During COVID-19, LHDs offered screenings through virtual visits and verbally walked the client through the ASQ form. Other LHDs work with Help Me Grow Utah to conduct screenings.

LHDs provide parents the results of the screen and follow-up activities to parents. Parents are educated on expected milestones and how to assess their child's current status. Educational materials on age-appropriate milestones are given to parents. When a LHD has a positive screen, parents are referred to Parents As Teachers, Early Intervention, or Head Start where applicable.

Challenges:

In several LHDs, developmental screenings were conducted during home visits. With COVID-19 limiting these, fewer screenings were able to be conducted. Also, LHD staff were diverted to COVID-19 response and other activities were put on hold during this time. One LHD noted that they struggled with ASQ's in the past, with the nurses reporting that it takes a lot of time to enter them into the online site. This LHD made arrangements with Help Me Grow to receive them by fax and enter them on their behalf. This has proved to be a great motivator to do the screenings.

Other challenges to conducting screenings include:

- Parent contact to provide education.
- Lack of follow through with nurse referrals. Where time permitted, follow-up contacts would be made to help identify barriers to parents seeking assistance from the referral services.
- Parents' belief that the screening takes a long time and they don't see the benefit. LHDs work to educate parents on the importance of the developmental screen.
- Parents do not have time to complete the screenings when there for other reasons (such as a WIC appointment). LHD staff utilize referrals to Help Me Grow to conduct the screenings when a parent has more time.
- Some parents need help completing the screenings which is hard to do virtually

- Parents have reported some increased difficulty accessing the early intervention programs they have been referred to during the pandemic. Home visitors continue to problem solve and advocate on a case by case basis.

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

Annual Report FY20:

The Performance Measure was achieved. The Performance Objective was 81.6% and the Annual Indicator was 82.6%

Program Activities:

The Oral Health Program (OHP) has several 'Baby Your Baby' and 'Check Your Health' segments on TV each year and talking points for local dentists and dental hygienists in leadership to give. Topics include: The importance of baby teeth, not sleeping with a baby bottle, limiting sugary snacks and our Oral Health Educator (OHE) gave a segment on E-cigarettes and oral health effects.

In collaboration with the UDOH Family Dental Plan Clinics (which closed in Oct 2020, due to COVID-19 legislative funding cuts), the OHP provided interns to give over 24 assembly presentations to elementary schools with the Seal A Smile program. Over 2,300 children were reached.

The OHP partnered with the Utah School Nurse Consultant to add a question to be used in the 2019-2020 school year's oral health assessment: Total number of students seen by the school nurse with a dental emergency? Great data was collected and shared with stakeholders in the OHP's Bi-annual report.

Fall of 2019, the Oral Health Specialist (OHS) and OHE presented at the San Juan Local Health Department to WIC, Early Interventions, and Home Visiting staff sharing the Smiles for Life Curriculum. The eight staff members in attendance covered a large rural region from Monument Valley to Blanding and San Juan. A large percentage of the families they serve live on the Navajo reservation.

The OHS worked with the Director of the Moab Regional Hospital, to coordinate and organize a rural oral health summit in Moab. The OHP spoke to 19 stakeholders at the first Moab Valley Oral Health Collaborative Summit in October 2019. The meeting was successful and several important points were discussed, including implementing community water fluoridation. Evidence-based research resources were shared after the meeting regarding community water fluoridation. The OHP also met with the local school nurse and other school-based leaders.

In fall of 2019, the OHP provided training to 14 dental students and 24 hygiene students and dental screenings & fluoride varnish to 107 Special Olympic athletes. In the fall of 2019 the OHE collaborated with the Tobacco Prevention and Control program to create educational resources specifically for dental providers on electronic cigarettes. The OHE spoke at a Utah Tobacco Control and Prevention conference on the oral manifestations of using electronic-cigarettes and encouraged the tobacco prevention specialist to engage dental professionals in tobacco cessation efforts among their patients. Over 30 tobacco control prevention specialists were in attendance. The educational materials produced were shared statewide with these tobacco cessation specialists. These same materials to the Utah Oral Health Coalition, dental schools and hygiene schools. Additional materials were created for health teachers and school nurses on the oral health effects of vaping and were shared statewide. The OHE also provided a check your health segment on KUTV on the oral health effects of using electronic cigarettes.

The Adolescent Oral Health Campaign (AOHC) is an intervention designed to educate middle school aged students about oral health care. In the 2019-2020 school year, 2,300 students were reached. The OHE managed OHP interns who implemented the program and gave presentations building program sustainability. To measure the effectiveness of the intervention, the students complete anonymous pre- and post-tests. These pre and post-test were administered electronically virtually eliminating data entry. This enabled the OHE to create one page fact sheets for

each school with school specific pre and post test data. All responses were compared and analyzed. Brochures with local safety net dental clinics are provided to all students and teachers physically and electronically.

In November of 2019 and in February of 2020 the OHE, OHS and OHP interns gave modified educational presentations to pre-K, Elementary, Middle and High School age students at the Utah School for the Deaf and the Blind at the Ogden, Salt Lake, and Orem campuses. A total of 139 students were reached over the course of several days. Everyone who participated received toothbrushes, toothpaste and floss.

In July of 2019, the OHE collaborated with Fortis dental hygiene student volunteers to provide educational activity booths at the Oquirrh Mountain fitness center, and a free lunch in the park program. Where students who utilize the free and reduced lunch program at school can get a free lunch during the summer. The OHE & OHS presented to 63 elementary aged children and three adults through this program. After the presentation, the children were split into four groups that rotated between stations on brushing, flossing, nutrition, and going to the dentist. This allowed all of the children to participate in hands-on activities and have one-on-one instruction.

In the fall of 2019, the OHP Intern provided an educational and resource booth at Midvale Middle School's back to school nights. Oral health education and local dental resources were provided to 400 families. An education and resource booth was also provided at Granite Park Junior High reaching an additional 100 families. Granite Park serves a diverse population of students from over 40 countries.

In February of 2020, the OHE and OHP Intern provided an educational booth at Grantsville Jr. High for an event with students from Grantsville, Tooele and Wendover. Dental resources, and donated toothpaste were handed out to each student who visited the dental booth. Reaching over 300 students.

The OHE along with OHP interns presented at the Annual Utah Early Childhood Conference in the spring of 2020 reaching over 10 early childhood caregivers and administrators. The OHS gave a presentation to Utah's Fostering Healthy Children nurses. The Smiles for Life presentation was given to 14+ nurses. Dental referral resources were also shared. In February 2020, the OHP gave oral health education, screenings, and fluoride varnish to 100+ refugees. Information on pregnancy, infant, and bottle guidance for babies was given.

During FY2020 the State Dental Director (SDD) attended the Utah Dental Association board meeting and the state dental licensing board meetings to represent the UDOH.
In April 2020, the SDD started working with the teledentistry Task Force, via Zoom, which was set up by the state board to help with suggestions for rules to be put in place as required by new state statutes regarding teledentistry. The group of dentists and dental hygienists made recommendations to the state board later in the year.

Accomplishments / Successes:

The OHS worked with individual Head Start & Early Head Start (HS/EHS) to help them get dental homes and address questions during shut down and pandemic. Because tooth brushing was halted in EHS/HS educational videos and materials were created and given to address these barriers and concerns.

During the pandemic, in spring of 2020, the OHP presented and shared virtually two presentations Empowering Parents and Oral Health and Pregnancy; (From the National Center of Early Childhood Health and Wellness presentations) to several Early Head Starts/HS in Utah and also had local dental hygienists that speak Nepali and Arabic share with vulnerable populations with Early Head Start. These were recorded in English, Spanish & these languages for refugees & other families with EHS/HS. These presentations were also shared with Home Visiting, WIC, and other early intervention programs. The Oral Health Specialist (OHS) and Oral Health Educator (OHE) tried

to think outside the box to create outreach to families during the pandemic.

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

- December 2019 the OHS published a report and is now in the process of publishing it professionally. The report is called "An Analysis of Utah's Emergency Department Non-traumatic Dental Visits 2007-2017". The OHS worked closely with the MCH epidemiologist on gathering information from the Office of Health Care Statistics. Utah Hospital Discharge Data was used. Additional years were gathered from 2007 -2017 (full 11 years) for all hospital emergency rooms state-wide to provide a more extensive look of visits over a longer period of time. This extensive report was released to the public December 2019 with a press release. The report and associated data was shared at the Oral Health Coalition and with many stakeholders in hopes to provide access to dental care for all ages.
- In the spring of 2020, oral health educational flyers were made for children with special health care needs; specifically, Down Syndrome, Feeding Tubes, Autism, and CMV.
- During the fall of 2019 the UDOH OHP saw 133 children at Ute Tribe Head Start, aged 3-5 years old. The OHS, OHE and 2 interns worked with the physician assistant students and faculty. Instruction and oversight was given for 40 PA students, providing oral health risk assessments and fluoride varnish.
- The OHP gave several presentations to multiple Parents as Teachers home visiting groups from fall of 2019 - spring of 2020. Reaching 30 staff members using the Smiles for Life national curriculum.
- In the spring and fall of 2020, with nationwide dental offices being closed, the Early Head Start and Head Start programs have been really struggling to meet their 90 day requirements for dental visits. The OHS, who is also the Dental Hygiene Liaison for Head Start in Utah, met with safety net clinics, dental schools, hygiene schools and others to see how they can help meet the requirement for 90 day visits upon enrollment. A few partnerships were formed, teledentistry was discussed and is slowly being implemented.
- Through the Adolescent Oral Health Campaign 2019- 2020 school year over 2,300 middle school students were reached. An additional 139 students at the Utah School for the Deaf and the Blind received an educational intervention and dental resources. Information on local dental safety net clinics is made available to all students, teachers and administrators. Through the OHP's other school based interventions an additional 500 families and 366 students were reached.

Challenges / Gaps / Disparities Report:

Challenges:

One of the biggest challenges of providing access to dental care has been the pandemic where all dental offices initially were shut down. Many safety net clinics did not have the PPE or were very delayed in opening back up. Several of the safety net dental clinics also didn't offer preventive care, only exam and restorative care. This was a nationwide problem. The OHS worked with both dental schools and hygiene schools to see if screenings or other care could be provided. Several live online meetings were done to address this challenge. When the clinics finally opened many families were very hesitant to go to the dentist let alone take their child.

Another challenge has been that nationwide there is a shortage of dental fluoride mouth rinse for school-based programs. Many schools almost overnight ended fluoride swish programs at their schools because there is none available to order. The OHS met with half a dozen school nurses over Zoom to discuss implementing fluoride varnish

programs in schools. She also connected them to a best practice program that is very robust and shared consent, policy, referral etc. information with the school RN's.
Because of the COVID-19 pandemic and funding concerns the oral health survey of Utah's school children which was planned for the 2020-21 school year was cancelled. During FY20 planning was underway and IRB approval had been obtained, so it was unfortunate to need to cancel the survey. The survey had been done every five years.

Emerging Issues:

Emerging issues include changes in PPE and protocols needed to treat patients. This increased level of PPE adds patient time and cost to dental providers. Aerosolizing procedures in dentistry are common and many modifications have been and are being made to limit the amount of aerosols produced. Providers have found that preventive products such as Glass Ionomer sealants, Silver Diamine Fluoride (SDF) need to be utilized more as they do not produce aerosols. SDF is not currently covered by Utah Medicaid but is currently under review.

Agency Capacity / Collaboration Report:

One of the OHP's greatest strengths is working with many strong partners and associated collaborations. The OHP continues it's now 10 years collaborating with the University of Utah Physician Assistance Program. Oral health risk assessments are taught along with fluoride varnish and the two programs go together to provide services to the Ute Tribe Head Start, Migrant Head Start (MHS) and Migrant Farm workers (parents of the MHS). Each year approximately 300 kids receive well child visits, oral screenings and fluoride varnish. In summary, the OHP partners with Head Starts, Office of Home Visiting, Fostering Healthy Children, WIC, and other early intervention programs to share educational resources, as well as, help these populations find dental homes.

Summary Progress Report of ESMs related to NPM-13.2

ESM #13.2.1: The percent of Medicaid children ages 1 - 18 who had a preventive dental visit.

Goal/Objective:

Increase the percent of Medicaid children ages 1 - 18 who had a preventive dental visit.

Significance of ESM:

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

This ESM is expected to increase the number of Medicaid children ages 1 through 18 years who had a 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 than those of higher economic status. It is important to concentrate on this population in Utah to improve this measure.

ESM Progress Summary:

In FY20, the State Dental Director (SDD) position was only 0.25 FTE, nevertheless efforts were made to help improve benefits for children receiving Utah Medicaid dental services. In September 2019, the SDD supported dentists who presented to the Utah Medicaid Medical Care Advisory Committee the advantages of including Silver Diamine Fluoride (SDF) as a dental benefit. The committee recommended that Utah Medicaid have the policy committee review the possibility of adding this service as a benefit for those with dental coverage. During FY20, the SDD also worked with Utah Medicaid to improve getting information to medical providers on getting reimbursement for application of fluoride varnish on young children as well as improving prior approvals for children to receive treatment in a hospital setting with general anesthesia.

Local Health Department Activities related to Children's Oral Health:

Efforts at the LHDs included:

- Teaching children how to properly brush and floss their teeth and have them demonstrate on tooth model
- Provide children with dental hygiene supplies
- Provide dental education handouts and low-cost dental resources as needed
- Provide training to RNs on how to apply fluoride varnish
- Establish a school fluoride varnish program at one LHD
- Working with school nurses to make referrals to LHD dental services

SPM-3: The rate (per 100,000) of injury deaths among children aged 1–19.

Annual Report FY20:

The Performance Measure was achieved. The Performance Objective was 14.4/100,000 and the Annual Indicator was 14.5/100,000.

Program Activities:

VIPP partners with 13 LHDs to establish injury prevention priorities, strengthen local injury prevention program capacity, develop community-based injury prevention projects, and implement evidence-based programs. The current VIPP Strategic Plan addresses priority areas across the MCH service areas and include: child maltreatment, infant sleep, school-related injuries, motor vehicle crashes, suicides, teen dating violence, prescription drug overdoses, sexual assault and family violence, traumatic brain injuries and youth sports concussion. MCH funding enables local health departments to maintain a basic level of violence and injury prevention programmatic efforts by supporting a portion of an FTE for an injury prevention coordinator across all 13 local health departments.

MCH funding also supports 8 local health departments to serve as the lead agency and coordinator of local Safe Kids coalitions. Funding was allocated based on the approved funding formula for local health departments. All 13 local health departments were required to conduct activities and implement evidence-based programs in the areas of child passenger safety, teen driver safety, and suicide prevention, and distribute child injury messages through traditional and social media platforms. The majority of these funds are used to implement evidence-based programs or promising practices for teen driving, child passenger safety, Safe Kids focus areas for unintentional injuries (water safety, sports safety, school related-injuries, etc.), teen suicide prevention, traumatic brain injury and youth sports concussions, firearm safety, suffocation, etc. Much of the partnerships and implementation of these activities are done by Safe Kids Utah and the local Safe Kids coalitions throughout the state.

Since the year 2007, VIPP, the Utah Department of Transportation Zero Fatalities Program, and Utah Teen Driving Task Force have worked closely with parents and families who have lost a teenager in a motor vehicle crash to tell their stories in a memoriam book, in addition to prevention messages. This culminates in a Teen Memoriam lunch with current and previous families who are provided information about grief support and available services. Grief counselors present on the stages of grief and families are provided an opportunity to share their story. This event creates an informal space for the families to connect and receive support. The families become a support network for each other and have expressed their appreciation and comfort in being able to share their story with others. The goal of the effort is to personally meet with the participating families, provide grief resources, and help support their prevention messages. We held the event in October 2019 to share stories of families who lost a child in a motor vehicle crash in 2018. Additionally, we work closely with the media contractor to evaluate the parent seminars in Utah high schools and the parent night programs as part of the driver's education curriculum to bring awareness and educate parents and students on deadly driving behaviors and Utah Graduate Driver's Licensing laws.

VIPP identifies school injuries through the Student Injury Reporting System (SIRS). The SIRS is an online database that helps to identify where, when, how, and why students get hurt at school. The SIRS database identifies reportable school injuries as an injury that caused the loss of at least one-half day of school and/or warranted medical attention and treatment from a school nurse, physician, or other health care provider. VIPP has provided this database as a free resource for schools to house their injury data. An online system (https://sir.health.utah.gov/) contains data starting on September 1, 2011. Users of the SIRS include Risk Managers at each of Utah's 41 school districts, school staff (such as principals, secretaries, coaches) at more than 800 Utah public schools. (90% of Utah schools participate in the SIR.) Data collected includes school district and number, date and time of injury, sex, aid that was given to the student, contributing factors of the injury, and activity during which the injury occurred. While the SIRS

holds a large amount of data regarding student injuries at school, data users and school districts had no way to easily explore, analyze, or display their data to better understand what it means. To increase availability of the data, the VIPP and the Office of Public Health Assessment launched a queryable system on the Indicator Based Information System for Public Health (IBIS) for school districts to use to look at their own student injury data since 2012. School district data is queryable at the school level, and users can also look at variables such as: grade, student sex, injury type, contributing factors, period, surface type, activity, number of days absent and actions taken. Additionally, the system allows school districts to populate graphs for better data use. The VIPP developed a user-friendly guidance on how to run various data queries using IBIS. The VIPP hopes this new data query system allows school districts to better use and understand their student injury data, ultimately making better, data-informed decisions on how to keep Utah students safe.

VIPP's media specialist created social media content, scheduled the content on a regular basis and disseminated content to local health departments for use in promoting the prevention of child injury, teen driving safety, teen dating violence prevention, teen suicide prevention, Safe Kids coalition activities, bullying prevention, summer safety, injury prevention laws (e.g., GDL and concussion), and drowning prevention. VIPP social media posts are reaching over 80,000 each month with more than 1,000 monthly engagements and an estimated reach through LHD efforts to promote child injury prevention messages continues to exceed 150,000 people. VIPP manages a teen dating violence prevention Facebook page; the Use Only as Directed website and Facebook page, and contributes to the Suicide Prevention website and Facebook page.

Since 1992, the Child Fatality Review Committee (CFRC) has been charged with the review of the circumstances and causes of all childhood deaths in Utah. The purpose of the CFRC is to develop a better understanding of child deaths in order to reduce the number of these tragedies. The goals of the CFRC are to: 1) Identify and describe risk factors by studying and reporting trends and patterns of child deaths in Utah, 2) Maximize resources through interagency collaboration to identify and describe the delivery of services by the involved systems (medical, human services, and law enforcement) to high-risk children, and make policy recommendations to improve the service systems to better meet the needs of families involved with these systems, 3) Promote effective prevention strategies to reduce the number of child deaths, and 4) Refer issues and propose strategies to appropriate organizations and agencies to promote education and prevention.

The CFRC meets once a month to review deaths of all Utah Children (ages 0-18) who died within the three months prior, as well as any more recent suspicious cases. The cases reviewed by the CFRC include any death that falls under OME jurisdiction. These include homicides, suicides, suspicious or undetermined deaths, as well as any sudden and unexpected deaths. This death review process provides a detailed understanding of how and why child deaths occur in Utah. CFRC data is entered into a national database. Recommendations are compiled after each review and shared with key stakeholders to implement for systems change.

Accomplishments / Successes:

Males have had a consistently higher child injury death rate compared to females and children ages 15 to 19 years have had consistently higher child injury death rates compared to ages 1 to 14 years of age.

Unfortunately, youth suicide in Utah continues to be a public health problem. Funding is provided to all 13 local health departments to implement suicide prevention efforts and VIPP feels confident that the rate of suicide deaths will start to decrease over time. In addition, VIPP has a full time suicide prevention coordinator that has provided technical assistance to the LHDs and is assisting with resource coordination with school districts. An emphasis on suicide prevention efforts have been placed on VIPPs priorities and VIPP has become involved in participating more

broadly in state and local efforts for suicide prevention. As part of this effort, the VIPP developed a community postvention toolkit to provide guidance to LHDs and their local communities on writing a postvention response plan.

Starting in 2018, the Utah Department of Health Violence and Injury Prevention Program (VIPP) began to develop a process for updating the Utah Violence and Injury Prevention, Strategic Plan. The plan focuses on prevention efforts, surveillance, and partners to collaborate through a shared risk and protective factors lens. We have developed a strategic plan focusing on this shared lens and have engaged LHDs in this effort. Upstream prevention priorities have been identified. They are: 1) Improve the socioeconomic conditions for Utahns disproportionately affected by poverty, through implementation of evidence-based strategies, 2) Promote individual, family, and community connectedness to decrease isolation and loneliness among Utahns, 3) Encourage social norms shown to promote safety and health among Utahns, 4) Enhance the Physical Environment to Improve Safe and Healthy Living, and 5) Improve access to and utilization of healthcare, including behavioral healthcare. As a result of this work, VIPP has been able to engage non-traditional partners, has been instrumental in informing state level work on shared risk and protective factors, has implemented primary prevention trainings to local communities in Utah, has presented on national webinars, and has had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state.

Summary of successes and accomplishments on "Moving the Needle" in relation to SPM-3:

- VIPP finalized a strategic framework and plan to address shared risk and protective factors. Upstream prevention priorities have been identified. They are: 1) Improve the socioeconomic conditions for Utahns disproportionately affected by poverty, through implementation of evidence-based strategies, 2) Promote individual, family, and community connectedness to decrease isolation and loneliness among Utahns, 3) Encourage social norms shown to promote safety and health among Utahns, 4) Enhance the Physical Environment to Improve Safe and Healthy Living, and 5) Improve access to and utilization of healthcare, including behavioral healthcare. As a result of this work, VIPP has been able to engage non-traditional partners, has been instrumental in informing state level work on shared risk and protective factors, has implemented primary prevention trainings to local communities in Utah, has presented on national webinars, and has had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state.
- VIPP provided funding to 13 local health departments to implement activities addressing shared risk and protective factors. LHD's were given a menu of evidence-based strategies to choose from. We anticipate expanding this effort going forward.
- Since August 2019, VIPP has been working with funds from the Overdose Data to Action (OD2A) Grant, a CDC funded effort, working to lower the numbers of opioid overdose deaths in the country, and in this instance, Utah. Substance misuse and abuse is a risk factor for child injury and deaths. The OD2A Grant distributed funds across the thirteen local health departments in Utah to raise awareness against substance misuse and abuse and provide help for those who need it. The OD2A Grant helps to provide protective factors where they are needed, to compensate for the risk factors of substance misuse and abuse.

Challenges / Gaps / Disparities Report:

Challenges:

VIPP provides funding to 13 local health departments to conduct local prevention activities. However, the pandemic has severely limited the time LHD staff have to work on activities as they were pulled from regular duties to help with the virus response and vaccination efforts.

VIPP completed a child fatality report and the report is going through approval. This has taken longer to get approved because staff have been working on COVID-19 response since last year.

Due to the pandemic the Utah Teen Driving Task Force has been discontinued for the past year. The annual teen memorial program was not held and the Teen memorial booklet was not produced. 2019 and 2020 cases will be combined for the booklet this coming year.

The VIPP Facebook page has almost 5,000 followers and receives almost 4,000 page views per day. COVID-19 has resulted in less traditional media campaigns over the past year.

The child fatality review team had to be halted during the beginning of the pandemic until the proper approvals to review cases virtually was approved. Regular reviews started again in July but we are behind and have been trying to catch up on cases.

Emerging issues

COVID-19 has shone a light on the health disparities that exist within Utah. VIPP is engaged in capacity building to address these disparities through a health equity and trauma-informed lens.

Agency Capacity / Collaboration Report:

VIPP partnered with multiple agencies and entities to address the child injury performance measure. VIPP continues to contract with all 13 local health departments to implement evidence-based injury and violence prevention programs to reduce risk factors and promote protective factors associated with injury and violence. Local health departments were also contracted to collaborate with local entities to enhance injury and violence efforts in their health district. Collaborations included Safe Kids coalitions, law enforcement agencies, hospital systems, parent-teacher associations, school districts, firearm retailers, fire departments, EMS, and others. Staff at the local and state level are supported to maintain certifications in various disciplines that may impact moving the needle for child injury mortality. These disciplines include maintaining certifications as child passenger safety technicians, QPR instructors, SafeTALK instructors, Mental Health First Aid instructors, and other injury-related trainings.

National experts conducted a technical assessment of VIPP's injury infrastructure, policy, and programs in the summer of 2018 through the Safe States Alliance State Technical Assessment Team (STAT) program. The STAT assesses injury and violence prevention within the state health agency, focusing on specific roles, relationships, and performance of the designated injury and violence prevention program. The goal is to support the development, implementation and evaluation of injury and violence prevention efforts at the state health department level by conducting an on-site, point-in-time assessment of the injury and violence prevention program, and providing recommendations for improvement. VIPP Is also in the process of adapting critical training on primary prevention and bystander intervention for digital dissemination.

Other activities in the Child Health domain that contribute to improvement in the National Outcome Measures

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

National Outcome Measures (NOM):

NOM 13: Percent of children meeting the criteria developed for school readiness

The CHARM system continued to integrate data between the Early Hearing Detection and Intervention (EHDI) and Baby Watch Early Intervention (BWEI) Programs. This linkage enables the EHDI program to know that a child with hearing loss has been referred to early intervention by six months of age for follow-up care. Receiving timely treatment and intervention for children that are Deaf and Hard of Hearing maximizes their developmental and communication potential so they can be ready for school entry. Likewise, the BWEI program receives hearing screening results in its BTOTS system through CHARM from the EHDI program. This has enabled the BWEI staff to know if a child has received a hearing screening, or still needs one, thereby providing timelier follow-up care and comprehensive service/treatment plans for a child. In addition, when a child transitions from part C to part B, the health information provided through CHARM continues to be documented in the child's record when the child moves from infant/toddler services to preschool, which provides continuity of care.

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

The CHARM system links immunization histories of children, ages 0-18, from the Utah Statewide Immunization Information System (USIIS) and provides it electronically to the Baby Watch/Early Intervention Program, the Early Hearing Detection and Intervention Program, the Fostering Health Children Program, the WIC Program, Newborn Screening Heel-stick Program, and private provider clinics. These programs that have obtained immunization information through the CHARM system have continued to identify children in need of immunizations, and follow-up with parents to get their child vaccinated and up-to-date. In addition, health care providers that use USIIS can access and view newborn hearing screening and Critical Congenital Heart Defect (CCHD) through CHARM links that query this information.

MCH Block Grant FY22 Application & FY20 Report

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 FY22:

#1: Assist Local Health Departments (LHDs) with reaching their tiered ASQ goals: The Early Childhood Utah Program (ECU) will continue to provide support to the LHDs on their work towards tiered goals. Support will include ongoing ASQ Online training, promoting developmental health resources and materials for integrating ASQ Online use into regular programing practices. ECU will provide ASQ Online Enterprise Account enrollment and technical support to all LHDs as needed and will attend the LHD quarterly Nursing Director's meetings to track updates on progress towards tiered goals and to provide additional support and training. ECU will seek additional opportunities to provide resources and information on ASQ when they are appropriate and become available, e.g. webinar training and new materials. Additionally, ECU will encourage LHDs/Nursing Directors to participate in the ECU Advisory Council to help meet the tiered goals listed below.

Tier 1: ASQ Online Training and Promotion

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

Tier 2: ASQ Trained and Ready to Use ASQ

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

Tier 3: Advanced ASQ Use

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

#2: Expand ASQ Online enrollment opportunities to medical providers: ECU will continue outreach to community health clinics and pediatric providers in all areas of the state in order to garner interest in utilizing the UDOH ASQ Online screening tools in their practice. Outreach includes training on ASQ Online, Enterprise Account enrollment, support, information and ongoing TA. Currently we recruit providers from quarterly ECU meetings and through ongoing collaborations with community leaders and programs.

#3: Early Childhood Systems Work: ECU will continue to serve as staff to the Early Childhood Utah Advisory Council in order to coordinate statewide early childhood activities with multi-sector engagement. The ECU Advisory Council provides recommendations from five subcommittees (Promoting Health and Access to Medical Homes; Early Care and Education; Data and Research; Social, Emotional and Mental Health; Parent Engagement, Support and Education) to the Governor's Commission on Early Childhood.

#4: Early Childhood Integrated Data Portal: Early Childhood Utah will continue to develop and enhance data

relationships and data tools that are imperative to Early Childhood Systems work. Our Early Childhood Integrated Data System will unveil the ability to filter our under-six service summary and ASQ reports by county, age, gender and race/ethnicity. Additionally, ECIDS will release Program Engagement reports that speak to the level of which a family/child attended or engaged in services. This data can be used by programs such as Home Visiting, Early Head Start/Head Start, IDEA Part C and WIC to assess the dosage of services that families/children receive. This will also be critical data to share with the state's P-20 longitudinal data system in order to accurately assess the effectiveness of interventions offered and received.

Priority Need: Dental Care

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

Annual Plan FY22:

In FY22, the Oral Health Program (OHP) plans to continue to collaborate with Medicaid to increase the number of children who receive preventive dental visits and receive needed dental treatments. The State Dental Director (SDD) will continue to work with the dental group with Utah Medicaid.

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

In February 2021, the SDD presented at a statewide UDA Leadership Conference to explain what is required for dentists to become providers to treat all of the patients in all of the various Utah Medicaid programs or arrangements. There are actually five applications for providers. First is the application as a Utah Medicaid provider, which is also required for the other four. Then there are two applications for the each of the two managed care plans and one application for CHIP dental. Finally, there is an application to be a University of Utah School of Dentistry Network Provider to treat some of the patient types that must get treatment through them.

The OHP Oral Health Educator (OHE) with OHP interns will continue to provide oral health education and dental referrals to middle and high school students in select schools within Canyons, Granite, Weber, and Tooele School Districts and at the Utah School for the Deaf and the Blind. The OHE and future interns will also be available for virtual presentations in other districts. This program was run completely virtually in the 2020 - 2021 school year due to the pandemic. The OHE will continue to collaborate with local dental hygiene programs to provide education resource booths at back to school nights in middle schools. The Oral Health Specialist (OHS), OHE, and SDD will continue to work with and promote teledentistry to increase access to care for school-based programs.

The OHP will continue inter-professional collaborations and outreach to vulnerable populations with the University of Utah's PA Program. The OHS and OHE will provide training to PA students on the AAP's Oral Health Risk Assessment and applying fluoride varnish. The OHP and PA program will screen migrant farm children through the migrant HeadStart programs and parents through the migrant farm workers screening days.

Proposed Activities:

- The OHS, OHE and SDD will continue to work with and promote teledentistry to increase access to care for school based programs.

- The OHP will continue to provide oral health articles bi-annually for the American Academy of Pediatrics Utah Chapter newsletter as well as bi-annual newsletters for the WIC "Wire and Flash".

- The OHP will continue to use the "12 Oral Health Messages" modules and magnets to share with WIC's, Head Start, Fostering Healthy Children, Home Visiting etc. Maternal & Infant oral health messages are included in this.

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

- The OHE in collaboration with OHP Interns will continue to provide middle school students with the adolescent oral health campaign educational intervention and local dental resources. This will be available in person and virtually.

- The OHP will continue inter-professional collaborations and outreach to vulnerable populations with the University of Utah's PA Program.

- The OHE will work with the State Nurse Collaborator to create an oral health toolkit for all school RN's in Utah. Including information on (AAP) Oral Health Risk Assessment, trauma, nutrition and educational posters.

Priority Need: 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 FY22:

Family meals has been a priority for the EPICC program since 2014, when the current governor was asked to sign a declaration creating Healthy Family Meals Month in Utah in September. In the declaration it states "we encourage families to make time to eat and socialize together around the dinner table at least once a week, enjoying one another's company, strengthening relationships, and eating nutritious foods. EPICC develops messaging each September to promote on various social media platforms to encourage families to engage in this health promoting behavior. Children who are engaged with their parents through supportive activities such as frequent family meals, are more likely to limit the use of harmful or illegal substances; achieve greater success in school; develop a high self-esteem, experience fewer mental and behavioral issues, including fewer serious thoughts of suicide; have lower obesity rates; cultivate improved communication skills; build stronger ties with their families and develop healthier eating and lifestyle habits.

The Family and Youth Outreach Program is implementing a curriculum called Teen Speak with Utah parents of youth with IEP's through funding from Utah State University's Center for Persons with Disabilities. The goal of the program is to foster positive adult-youth communication and strengthen relationships, ultimately empowering young people to make healthy decisions. This program supports the family meal time objective by promoting time spent together and improving communication between parents and their children.

Family Youth and Outreach Program:

From July 1, 2021 - June 30, 2022, implement *Teen Speak* with at least 240 parents/guardians of students with disabilities, referred by organizations that reach parents/guardians through in-person and/or web-based platforms.

Activities include:

- Contact and promote the *Teen Speak* program to at least three new parent-serving organizations (other than UT Foster Care)
- Implement at least 24 *Teen Speak* workshops (either virtual, in-person, or hybrid) to parents throughout Utah (averaging two workshops per month) with up to 10 people per session
- Provide access to online Teen Speak modules for participants to complete before live training. Online modules will be made available by the developer in Fall 2021
- Maintain partnership with UT Foster Care and recruit for *Teen Speak* participants by publishing one article per quarter in the Foster Roster newsletter and advertising monthly on social media
- Hold at least one training-of-facilitators (TOF) with up to 10 participants in the *Teen Speak* curriculum
- Distribute incentives to program participants (communication cards & $25 gift cards for parents, $50 gift cards for TOF participants)

- Facilitators will ensure *Teen Speak* evaluation tool from the developer is completed by participants. Data will be compiled and processed into reportable information.

EPICC:

During the school year 2021-2022 the EPICC program will work with the State Board of Education, local health departments and local education agencies to promote and offer summer meal programs. Each organization will work with school sites that offer summer meals programs and promote the importance of healthy family meals. Family meals provide an opportunity for family members to come together, strengthen ties and build better relationships. Additional activities include:

- Ask Governor Cox to proclaim September 2021 as Healthy Family Meals Month. (Proclamation attached below)

- Create and publish podcasts regarding Healthy Family Meals Month, and how to cook healthy family meals.

- Create and post family meals Facebook posts during Family meals month in 2021 and throughout the year.

Governor's Proclamation

"Whereas, family meals have long constituted a substantial pillar of family life in America;

Whereas, interaction between family members during meals has many positive effects on the social, emotional, and physical well-being of families and individuals, particularly youth;

Whereas, children who are engaged with their parents through supportive activities, such as frequent family meals, are more likely to limit the use of harmful or illegal substances; achieve greater success in school; develop a high self-esteem; experience fewer mental and behavioral issues, including fewer serious thoughts of suicide; have lower obesity rates; cultivate improved communication skills; build stronger ties with their families; and develop healthier eating and lifestyle habits; and

Whereas, we encourage families to make time to eat and socialize together around the dinner table at least once a week, enjoying one another's company, strengthening relationships, and eating nutritious foods;

Now, therefore, I, Spencer J. Cox, Governor of the State of Utah, do hereby declare September 2021 as Healthy Family Meals Month in Utah"

Priority Need: Economic Stability

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

Annual Plan FY22:

Local health departments (LHDs) will provide support and technical support to Local Education Agencies (LEAs) to strengthen local wellness policies in conjunction with the Child Nutrition Program (CNP) administrative reviews.

The Healthy Living through Environment, Policy and Improved Clinical Care (EPICC) will continue to foster and build strong relationships between the Utah Department of Health and the State Board of Education (USBE), Child Nutrition Program (CNP). S. Roundy will develop a plan with the CNP to identify ways to increase meal participation.

EPICC has plans to work with WIC, DWS and other state agencies to streamline and identify processes for families who qualify for free and reduced lunch easier.

EPICC will work with Action for Healthy Kids to create messaging strategies to educate families about school meals.

EPICC will work with LEAs to determine success and barriers around school meal participation.

Proposed Activities:

- Continue to support LEA to strengthen local wellness policies during their tri-annual administrative review. LHDs will provide an assessment tool, participate on wellness committees, and provide guidance to ensure that all components of the wellness policy are included.

- Partner with the State Board of Education to ensure that schools who participate in the National School Lunch Program also participate in the National School Breakfast Program. LHDs will work with LEAs and schools to implement innovative service models to increase participation.

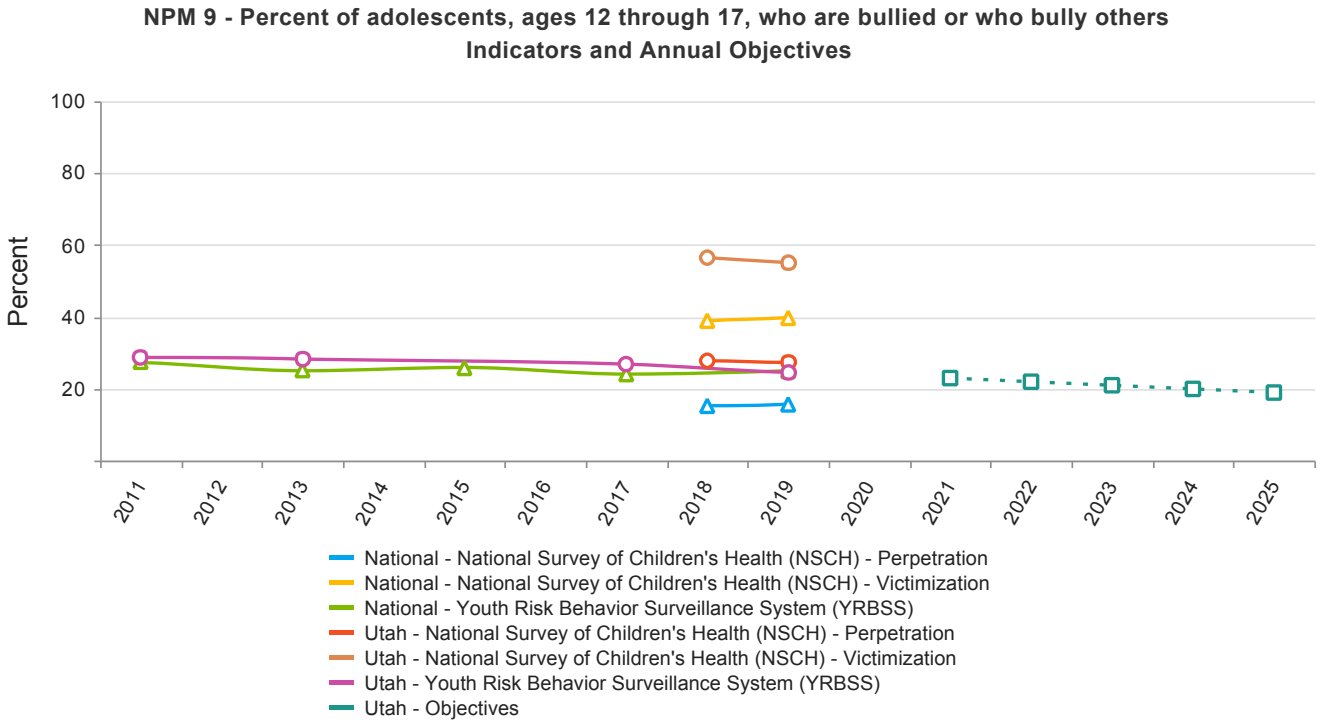
- Promote farm to school initiatives such as harvest of the season with food service directors. Provide support and connections to local growers to meal services staff. Work with food service directors to increase participation in school meals with marketing tools.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	12.3 %	NPM 13.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	34.7	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	22.7	NPM 9
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.9 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.6 %	NPM 8.2 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	9.6 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	8.5 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	9.8 %	NPM 8.2

National Performance Measures



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

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

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	23.0	22.0	21.0	20.0	19.0	18.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	350.0	400.0	450.0	500.0	550.0	600.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	21	21
Numerator	41,142	41,142
Denominator	195,912	195,912
Data Source	Estimates for percent of students physically activ	YRBS
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	23.0	25.0	25.0	27.0	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
Annual Objective		
Annual Indicator	400	430
Numerator		
Denominator		
Data Source	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	76.0	78.0	79.0	81.0	83.0	85.0

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	300.0	350.0	400.0	450.0	500.0	550.0

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.8	79.5	80.2	80.9	81.7	82.4

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	38.0	41.0	44.0	47.0	50.0

State Action Plan Table

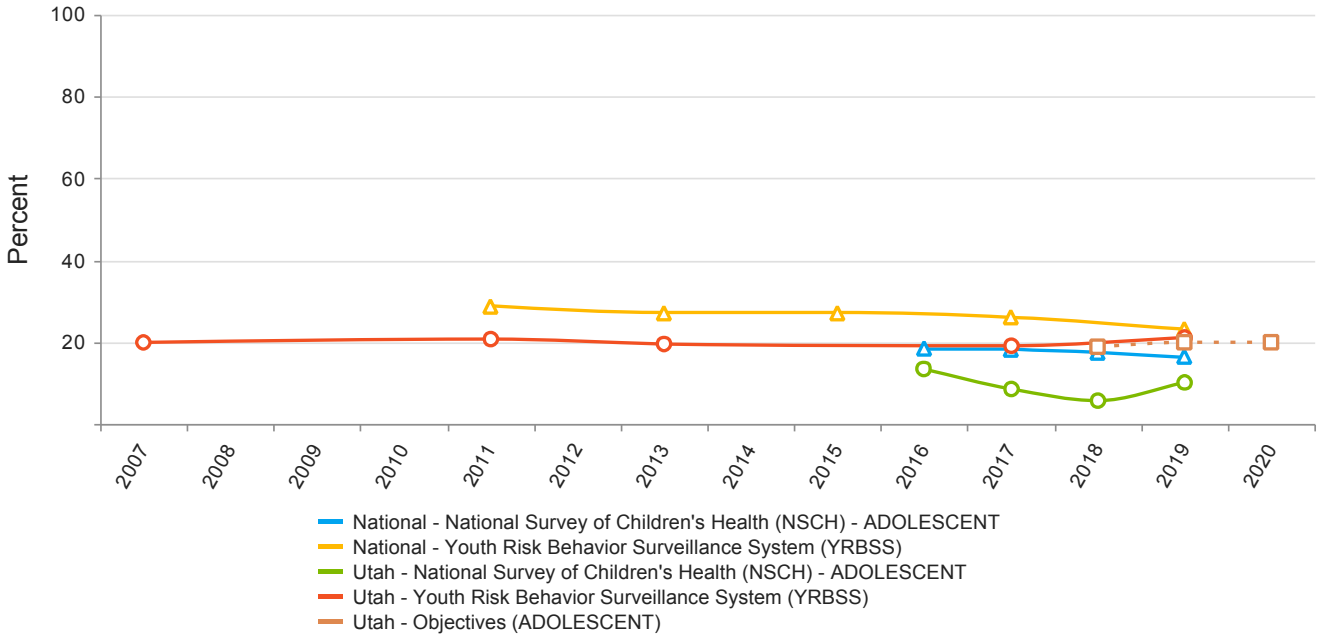
State Action Plan Table (Utah) - Adolescent Health - Entry 1	
Priority Need	
Adolescent mental health	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
By 2025, decrease the percentage of adolescents (10-18 years of age) who report being bullied at school in the past 12 months from 27.9% (YRBSS 2017) to 23%.	
Strategies	
1. Work with schools and parents to increase training for students, parents and staff on protective factors such as physical activity and communication.	
ESMs	**Status**
ESM 9.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).	Active
ESM 9.2 - The number of adolescents who receive bystander training (Upstanding)	Active
ESM 9.3 - Percent of adolescents who are physically active at least 60 minutes per day.	Active
ESM 9.4 - The number of youth participating in the Wyman Teen Outreach Program (TOP)	Active
ESM 9.5 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit	Active
ESM 9.6 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)	Active
NOMs	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (Utah) - Adolescent Health - Entry 2
Priority Need
Economic stability
SPM
SPM 3 - Percent of students enrolled in the free or reduced price lunch program
Objectives
By 2025, increase the number of students who participate in the National School Breakfast and Lunch Programs from 47.0% (Utah State Board of Education Child Nutrition Program Database) to 62.0%.
Strategies
1. Increase the number of school food authorities that use innovative service models to make breakfast and lunch more convenient and appealing to students.
2. Work with Local Education Agencies (LEA) to strengthen Local Wellness Polices that promote student wellness, prevent and reduce childhood obesity, and provide assurance that school meal nutrition guidelines meet the minimum federal school meal standards.
3. Work with Local Health Departments to educate and reach out to the families who have not automatically qualified or filled out an application to receive free or reduced price benefits for breakfast and/or lunch.
4. Support the Utah State Board of Education Child Nutrition Program by advancing the quality of school meal programs.
5. Educate LEAs about professional development opportunities to ensure that school nutrition program personnel have the knowledge and skills to manage and operate the National School Breakfast and Lunch Programs correctly and successfully.

2016-2020: National Performance Measures

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	19.9	19.9	18.9	20	20
Annual Indicator	19.7	19.7	19.1	19.1	21.0
Numerator	29,466	29,466	30,959	30,959	35,424
Denominator	149,852	149,852	162,207	162,207	168,525
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2013	2013	2017	2017	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			18.9	20	20
Annual Indicator		13.6	8.7	5.7	10.1
Numerator		37,056	25,092	17,632	31,489
Denominator		272,391	287,812	311,115	313,326
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

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

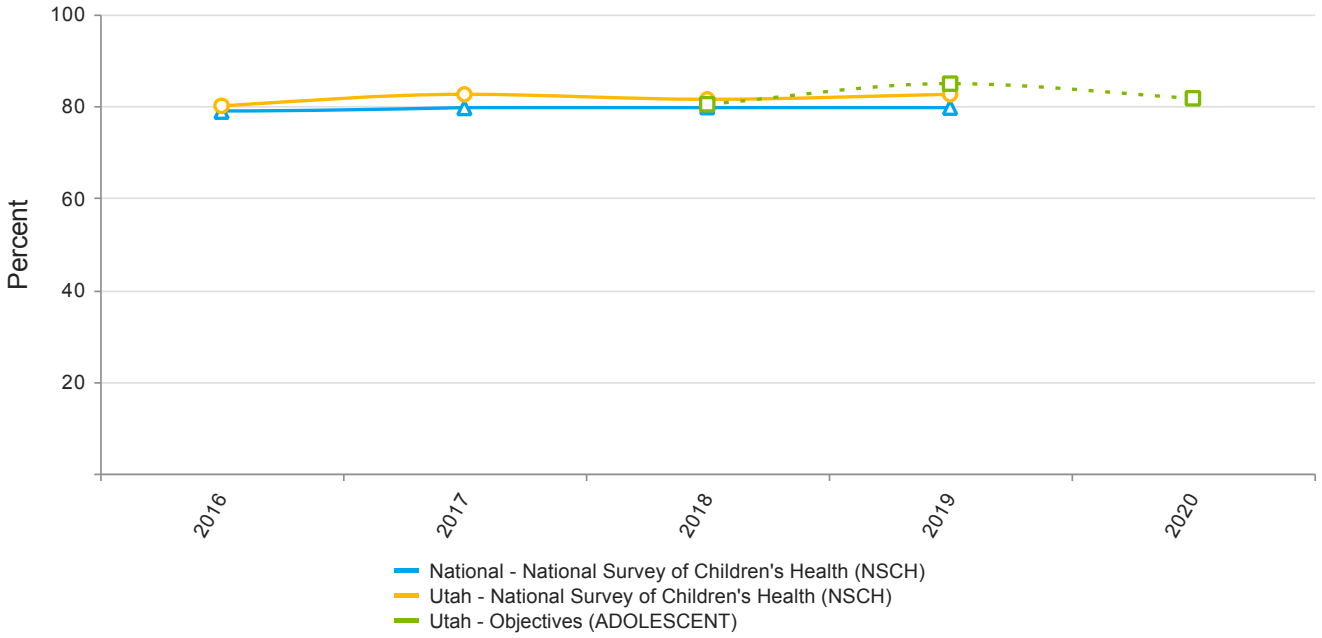
2016-2020: ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		10	25	25	50
Annual Indicator	7.1	25	25	25	25
Numerator		1	1	1	1
Denominator		4	4	4	4
Data Source	School Health Profiles	UDOH Policy Database	UDOH Policy Database	UDOH Policy Database	UDOH Policy Database
Data Source Year	2016	2017	2017	2017	2017
Provisional or Final ?	Provisional	Final	Final	Final	Final

2016-2020: ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4	35	36	37
Annual Indicator	6	34	31	34	0
Numerator					
Denominator					
Data Source	EPICC Training Database	EPICC Training Database	EPICC Training Database	EPICC Training Database	EPICC Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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



2016-2020: NPM 13.2 - Adolescent Health

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

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

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

None

2016-2020: State Performance Measures

2016-2020: SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		14.7	15.1	14.9	14.5
Annual Indicator	15.1	15.8	15.7	15	14.4
Numerator	144	152	152	147	141
Denominator	950,511	960,913	967,283	977,706	980,045
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		21	16.7	21.5	20.5
Annual Indicator	21	17.2	21.5	21.3	25.2
Numerator	49	41	52	53	64
Denominator	233,809	238,378	242,153	248,985	253,847
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

NPM-8: Percent of adolescents in grades 9-12 who report being physically active at least 60 minutes per day in the past week.

Annual Report FY20:

The Performance Measure was achieved during FY20. The Performance Objective was 20.0 and the Annual Indicator was 21.0.

Program Activities:

During FY20, the National SHAPE America Convention was supposed to be held in Salt Lake City in April of 2020. The Utah Department of Health and SHAPE Utah partnered to provide resources, support and technical assistance to the National SHAPE America. SHAPE America did not happen because of COVID-19. This convention would have brought up to 5,000 people from across the county to Salt Lake City. The SHAPE Utah team worked hard to create a team to oversee marketing, breakout equipment, attendance and volunteers. It was our responsibility to reach out to school administrators, health and PE teachers, elementary classroom teachers, and public health professionals. Many of the Local Health Departments (LHDs) worked with their school districts and provided scholarships to a few individuals to attend the once in a lifetime opportunity to attend the convention. We partnered with Weber State University, University of Utah, BYU, Utah Valley University, and Utah State University to gather student volunteers to help with breakout sessions, registration and special events. Because of the magnitude of the convention there were no other conferences and/or professional development opportunities.

Healthy Bodies, Healthy Minds conference was held on June 11, 2019 for elementary classroom teachers. There were 180 individuals who attended this conference. A total 20 breakout sessions were offered that provided a wide variety of games-based activities that demonstrated the long-term benefits of play and laid the foundation for creating a safe, inclusive, and respectful environment for students. Participants left the conference with ready-to-use group management tools, as well as an understanding of how to select and leverage games that support the physical, social, and emotional development of students.

Accomplishments / Successes:

The partnership between the SHAPE Utah, the Utah State Board of Education (USBE) and the Utah Department of Health (UDOH) has been the strongest that it has ever been. Between the three organizations, the work around physical activity and health has aligned within overarching messages around the state. Policies and environmental changes have been a collaborative effort.

The USBE developed a model health and wellness policy for Local Education Agencies to follow when creating new policies. The model policy outlines the best approach to ensuring environments and opportunities for all students to practice lifelong healthy habits that promote physical, mental, and social health. There were about 4 internal employees and Utah Department of Health employees who created language for the model policy. This group of individuals have worked on refining the model policy and created an evaluation tool for Local Education Authorities (LEAs) to use as a resource. The model policy will go before the school board in May of 2021.

Summary of successes and accomplishments on “Moving the Needle” in relation to NPM-8:

- Strengthen the relationship between the Utah Department of Health, Utah State Board of Education and SHAPE Utah and continue to enhance and create policy and environmental changes within the school system.

- Continued to partner with Utah Department of Transportation to provide support, resources, and technical assistance to the Safe Routes to School program that aims to increase the number of students that walk and bike to school.

- Created a State Board of Education Health and Wellness Policy for Local Education Agencies to follow.

Challenges / Gaps / Disparities Report:

The COVID-19 pandemic was the main challenge during this fiscal year.

Agency Capacity / Collaboration Report:

The Utah Department of Health and LHDs worked with LEAs and parent lead groups to encourage leaders to work with families to be active at home. LHDs provided school newsletters, activity calendars, physical activity equipment, etc.

Report of ESMs related to NPM-8:

ESM 8.1 Increase the number of the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake--that have a written policy recommending Comprehensive School Physical Activity Program (CSPAP) for all traditional public K-12 schools.

Goal/Objective:

Increase the number of the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake--that have a written policy recommending CSPAP for all traditional public K-12 schools.

Significance of ESM:

CSPAP is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally-recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime.

ESM 8.1 Progress Summary:

We found that providing a CSPAP training during a professional development day was successful. Teachers are already committed or mandated to attend so we did not have to worry about coordinating a substitute. Having district buy-in to CSPAP also helped provide leverage to the topic during the professional development learning session. We will continue to promote components of CSPAP during the statewide Secondary Health and PE Conference, elementary Healthy Bodies, Healthy Minds Conference and promoting the CDC e-learning opportunities.

No other school district adopted the language to incorporate CSPAP into their policies. Salt Lake, Granite, and Canyons all have sections of CSPAP but do not have the comprehensiveness or all of the components of a

dedicated policy that focus on getting kids active for 60 minutes a day.

ESM 8.2 Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the CSPAP.

Goal/Objective:

Increase the number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the CSPAP.

Significance of ESM:

Professional development is designed to actively engage learners. Teachers who attend professional development about physical activity and who incorporate movement during the school day will increase student opportunity to be active for 60 minutes a day.

Notes & Comments:

The numbers include the 41 school districts. Any individual within the district that attended a UDOH CSPAP training, secondary PE training or elementary Healthy Bodies Healthy Minds conference is included in the number. This does not reflect charter schools.

ESM 8.2 Progress Summary:

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

SPM-4: The rate (per 100,000) of suicide deaths among youths aged 15–19.

Annual Report FY20:

This Performance Measure was not achieved. The Performance Objective was 20.5/100,000 and the Annual Indicator was 25.2/100,000.

Program Activities:

The Violence and Injury Prevention Program (VIPP) worked with partners to develop suicide fact sheets as well as a report on COVID-19 and mental health in Utah. VIPP's suicide prevention coordinator continues to represent VIPP on the Utah Suicide Prevention Coalition and provides training on Question Persuade Refer (QPR) and Mental Health First Aid.

Updated youth suicide fact sheets are produced regularly. In addition, an overall suicide in Utah fact sheet is produced every year. The 2018 version can be accessed here: http://www.health.utah.gov/vipp/pdf/Suicide/SuicideInUtah2018.pdf. This fact sheet included information by age showing the rates of suicide deaths for ages 10-17 and 18-24 by age and sex. And it also contained circumstance data to better understand circumstances around suicide and had information on warning signs, risk factors, protective factors, prevention tips, and resources. The 2020 report was delayed due to COVID-19 but has now been completed and is going through UDOH approval.

VIPP works with the Suicide Prevention Coalition to distribute firearm locks and firearm safety brochures to families of teens through LHDs. Reporting on the numbers distributed by the LHDs has been delayed due to COVID-19.

VIPP continues to review all youth suicides in Child Fatality Review and develops recommendation and prevention strategies. The CFRC resumed meeting monthly in July of 2020.

Accomplishments / Successes:

Unfortunately, youth suicide in Utah continues to be a public health problem. Funding is provided to all 13 LHDs to implement suicide prevention efforts and VIPP feels confident the rate of suicide deaths will start to decrease over time. In addition, VIPP has a full time suicide prevention coordinator that has provided technical assistance to the LHDs and is assisting with resource coordination with school districts. An emphasis on suicide prevention efforts have been placed on VIPPs priorities and VIPP has become involved in participating more broadly in state and local efforts for suicide prevention. As part of this effort, the VIPP developed a community postvention toolkit to provide guidance to LHDs and their local communities on writing a postvention response plan. “Postvention” refers to activities that help individuals and communities cope with the emotional distress resulting from suicide.

Starting in 2018, the Utah Department of Health Violence and Injury Prevention Program (VIPP) began to develop a process for updating the Utah Violence and Injury Prevention, Strategic Plan. The plan focuses on prevention efforts, surveillance, and partners to collaborate through a shared risk and protective factors lens. We have developed a strategic plan focusing on this shared lens and have engaged LHDs in this effort. Upstream prevention priorities have been identified. They are: 1) Improve the socioeconomic conditions for Utahns, disproportionately affected by poverty, through implementation of evidence-based strategies, 2) Promote individual, family, and community connectedness to decrease isolation and loneliness among Utahns, 3) Encourage social norms shown to promote safety and health among Utahns, 4) Enhance the Physical Environment to Improve Safe and Healthy Living, and 5)

Improve access to and utilization of healthcare, including behavioral healthcare. As a result of this work, VIPP has been able to engage non-traditional partners, has been instrumental in informing state level work on shared risk and protective factors, has implemented primary prevention trainings to local communities in Utah, has presented on national webinars, and has had several abstracts accepted to present on this topic and provide technical assistance and guidance on this approach to reducing child injury deaths in the state. Staff continue to participate on the SafeUT Commission. The SafeUT App, which is a new statewide resource that youth can download on their phones to chat with a crisis counselor 24/7 or put in an anonymous tip if they are worried about a friend. This App is receiving thousands of tips/chats from Utah youth and is available throughout Utah.

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

- VIPP finalized a postvention toolkit for LHDs.
- VIPP actively participated on Utah's SafeUT commission. The SafeUT Crisis Chat and Tip Line is a statewide service that provides real-time crisis intervention to youth through live chat and a confidential tip program.
- VIPP has developed a strategic plan to address the risk and protective factors of suicide.
- VIPP continues to provide funding to all 13 LHDs to conduct youth suicide prevention activities.
- VIPP was instrumental in adding sexual orientation questions to the YRBSS and SHARP survey.

Challenges / Gaps / Disparities Report:

Challenges:

COVID-19 has limited the capacity of LHDs and VIPP to conduct youth suicide prevention activities. Most schools were relegated to remote learning which limited the opportunities to interface with students who may be struggling with their mental health.

Emerging Issues:

Over the last few years, suicide by firearm in youth has been increasing. The year 2018 saw the highest rate recorded for firearm suicide deaths (13.25 deaths per 100,000 youth ages 15-19). Efforts to promote means restriction and firearm safety among adults who own firearms is of paramount importance, in addition to promoting protective factors such as connectedness among youth. In addition, technology as a risk factor for suicide needs to be explored.

Agency Capacity / Collaboration Report:

Suicide prevention is a cross-program effort involving injury prevention, substance abuse, mental health, and other health professionals. VIPP partnered with multiple agencies and entities to address the suicide prevention among adolescents performance measure. VIPP contracted with all 13 LHDs to implement evidence-based suicide prevention programs and activities to reduce risk factors and promote protective factors associated with suicide. LHDs participate on their local suicide prevention coalitions as well as the Utah Suicide Prevention Coalition to coordinate efforts, share successes, and implement best practices. VIPP co-chairs this statewide coalition with the

suicide prevention coordinator with the Department of Substance Abuse and Mental Health. The four state suicide prevention coordinators, from the Division of Substance Abuse and Mental Health, the Utah State Board of Education, the Utah Chapter of the National Alliance on Mental Illness, and VIPP work together very closely to plan and implement state efforts to prevent suicide and suicidal behaviors as well as leverage resources.

Finally, Utah is changing its prevention approach to center around increasing protective factors and reducing the risk factors that most impact violence and injury related outcomes at all levels of the socio-economic model.

Priority Need: Mental Health

NPM-9.0: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

Annual Plan FY22:

The plan in FY22 is to build and broaden Upstanding with Utah schools. Working with Utah Board of Education (UBOE) to design better approaches to reach and disseminate bystander intervention around the state to k-12 students and educators.

We are now in process of developing a virtual and pre-recorded bystander training so in the future training plans and goals will have less barriers and disruptions. This plan has the added advantage of reach, as many people and organizations in Utah that are rural, or frontier can still access training when it is convenient for them and their communities.

Proposed Activities

- Partner with UBOE to offer more trainings and opportunities to Utah School for Bystander training.
- Develop a virtual and pre-recorded bystander training so in the future training plans and goals will have less barriers and disruptions.
- Develop a better system to capture bystander intervention programs that use Upstanding or other bystander intervention approaches.

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

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

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

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

Children with Special Health Care Needs

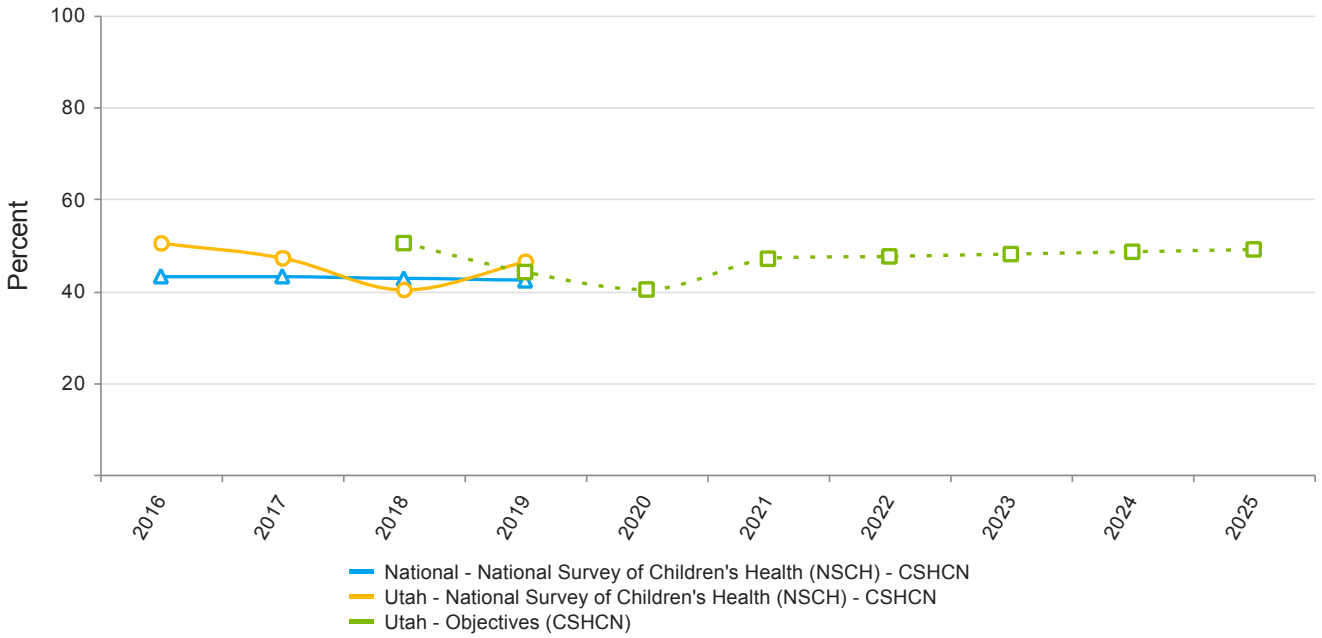
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	15.9 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	46.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.6 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.9 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			50.4	44.1	40.3
Annual Indicator		50.4	47.2	40.2	46.4
Numerator		75,090	68,219	59,263	69,395
Denominator		148,990	144,415	147,327	149,671
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	47.0	47.5	48.0	48.5	49.0	49.5

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Pre- and Post-training survey	Pre- and Post-training survey
Data Source Year	2020	2021
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

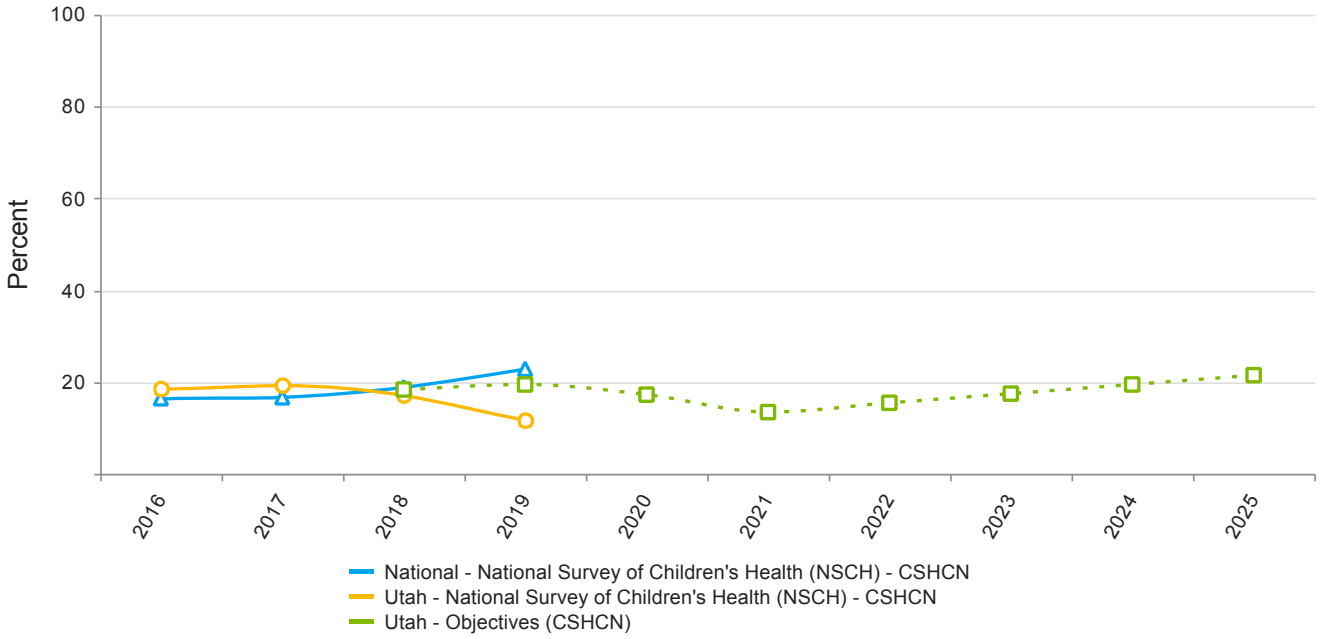
ESM 11.2 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	94
Numerator		614
Denominator		653
Data Source	CSHCN EMR or comprehensive database	CSHCN Electronic Medical Record
Data Source Year	2020	SFY 2021
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	94.5	95.0	95.5	96.0	96.5	97.0

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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			18.4	19.5	17.3
Annual Indicator		18.4	19.3	17.1	11.5
Numerator		11,791	12,760	13,378	8,906
Denominator		64,109	66,028	78,194	77,434
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	13.5	15.5	17.5	19.5	21.5	23.5

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	62.4
Numerator		552
Denominator		884
Data Source	Stakeholder work group survey	ISP electronic medical record, Utah Parent Center
Data Source Year	2020	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	65.0	68.0	71.0	74.0	77.0

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
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Stakeholder work group survey for transition	Stakeholder work group survey for transition
Data Source Year	2020	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

State Action Plan Table

State Action Plan Table (Utah) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Family and provider connectedness/Care coordination	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2025, increase the percent of children with special health care needs who receive care within a medical home from 40.4% (NSCH, 2017-18) to 42.5%.	
Strategies	
1. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah.	
2. CSHCN Bureau 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 evaluate and select a database to track care coordination efforts.	
5. Workgroup collaborates and determines collection methods to scan State on providers who utilize or desire to utilize telehealth, and assess best practices, barriers, and capacity.	
6. Workgroup reviews and utilizes Baby Watch Early Intervention Program tele-intervention cost study data to assess the benefits and challenges with utilizing virtual platforms for services.	
7. Workgroup encourages providers to incorporate the seven components of a medical home after being trained through online learning modules or other educational media.	
ESMs	Status
ESM 11.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.	Active
ESM 11.2 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.	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 21.5%.

Strategies

1. CSHCN Bureau to create a stakeholder workgroup to organize and unify existing educational materials and market the importance of transition to adulthood.

2. Determine best practices for educating the public, including medical and behavioral health providers, on the importance of transition to adulthood through a variety of traditional and on-line marketing, informational, and educational modules.

3. Workgroup to evaluate and select database to collect statewide data on transition efforts.

4. Survey families of transition-age youth who have been trained on the unified transition curriculum to assess skill development and progress toward reaching transition goals.

ESMs	Status
ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.	Active
ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.	Active
ESM 12.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.	Active

NOMs

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

MCH Block Grant FY22 Application & FY20 Report

NPM-11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Annual Report FY20:

The Performance Measure was achieved. The Performance Objective was 40.3% and the Annual Indicator from the 2018-19 National Survey of Children's Health (combined data sets) was 46.4%.

Program Activities:

In FY20 the Integrated Services Program (ISP) sponsored articles written by CSHCN and MCH Bureaus staff in the Growing Times newsletter, a publication of the Utah Chapter of the American Academy of Pediatrics to educate providers and families on topics related to the Medical Home. Articles included components of a medical home; community resources; practice improvements; and partnership opportunities. The Utah CSHCN and MCH Bureaus utilized social media such as Facebook and Twitter to send educational messages to families and providers about the importance of participating in a medical home. The ISP partially provided funding for the Medical Home Portal (Utah's shared resource) and collaborated with their staff and family representatives to review content and resources contained on that website. ISP also provided funding for the Utah Children's Care Coordination Network (UCCCN) which serves as a training, education, communication, and problem-solving forum for pediatric care coordinators across the state. The entire ISP team, including care coordinators from four local health districts, actively participated in the UCCCN monthly meetings and the ISP manager meets monthly to plan the educational agenda for upcoming meetings. The CSHCN Bureau collaborated with the University of Utah, Department of Pediatrics including the University Developmental Assessment Center (UDAC), and Utah Family Voices to encourage and promote care coordination within the medical home model. The CSHCN and MCH Bureaus continued to collaborate with Early Childhood Utah; the Office of Home Visiting; The Early Childhood Comprehensive Systems grant; the Family to Family Health information Center; the Utah Oral Health Coalition; and the Utah Parent Center.

Accomplishments / Successes:

The CSHCN Bureau continued to collaborate with community partners to promote components of the Medical Home, with an emphasis on care coordination. The Integrated Services Program worked closely with four local health departments and funded a care coordinator in these rural health districts. These local health department staff were supported by the ISP team, and vice versa, as all parties collaborated to provide care and clinical coordination for the families of CSHCN across the state. The care coordinators reside and work locally; hence they know their community resources, local contacts, decision makers, social influencers, and the children and families they are charged to serve. This helps to build relationships of trust, confidence, and competence with both families served, and local service partners. The Utah Children's Care Coordination Network was funded through support from the Block Grant and included (ten monthly meetings and one educational learning session. The strength of the UCCCN is that it unites care coordination peers and service professionals by promoting networking, peer connections, resource sharing, troubleshooting, and problem solving which ultimately benefits the children and families being served through pediatric, family practice, and other service providers across the state. ISP partially funds the Utah Medical Home Portal (Utah's shared resource) to ensure resources, services, medical conditions, and best practices are vetted and published for families of children with special health care needs and the providers who serve them. Ongoing funding continued for Utah Family Voices to partially cover their efforts to provide family to

family support and specific help for families of children diagnosed with Autism Spectrum Disorder. The ISP team participated in multiple agency and transition fairs across the state through which they promoted the Medical Home concept and provided resource and referral, including the Medical Home Portal, for families desiring care coordination. The ISP team, including the local health department care coordinators, served over 653 unique CSHCN families and patients; with 2630 care coordination-related patient encounters; and 406 clinical encounters across the state.

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

- ISP team supported the Medical Home by providing care coordination to 653 unique Utah families through more than 2600 patient encounters. (July 1st, 2019 - June 30th, 2020)

- The Utah Children's Care Coordination Network (UCCN) provided 11 monthly meetings and one learning session to enhance care coordination skills, networking, resource sharing, and case coordination with care coordinators from practices across the State. (July 1st, 2019 - June 30th, 2020)

- CSHCN Bureau renewed the contract to fund enhancements to the Medical Home Portal including adding content, adding and expanding local services listings, enhancing family ability to create and save lists of resources, and adding partners. More than 34,000 Utah users accessed the Portal. (July 1st, 2019 - June 30th, 2020)

Challenges / Gaps / Disparities Report:

Challenges:

The term "medical home" continues to be a foreign concept for many families of children with special health care needs. The same concept often feels unattainable to providers who operate on a tight financial margin coupled with limited staff and time that is even more limited. Given that there is little financial incentive for a provider to invest in full medical home implementation, those who do pursue this challenge often do so for altruistic reasons. Local help exists to support the medical home such as (1) care coordination through the four rural health departments and Integrated Services Program staff, (2) the Medical Home Portal, which serves as an online support for the provider who may not have a large CSHCN population, and (3) the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) which partners with pediatric offices to promote evidence-based best practices, such as establishing a medical home. However, many pediatricians are unaware of these resources, and therefore, do not participate.

Marketing to those offices can be difficult, as time, human resources, technology, and capital are limited. Finding the time to listen to or read marketing materials is difficult at best. National Survey of Children's Health data reflects lack of knowledge on the part of parents as to the very definition of a medical home. Often, they fail to fully comprehend the components of the medical home, and when surveyed, underrepresented the medical home of their primary care provider's office. Finally, with no universal way to share data and information between the multidisciplinary providers who care for the same patient, because of disparate EMRs and databases, even loosely defined medical home at a care coordination level is difficult, and renders the "shared plan of care" practically impossible.

Emerging Issues:

The emergence of COVID-19 early in 2020 greatly impacted the ability to provide services in the established usual and customary manner. Rural care coordinators were pulled away from normal CSHCN tasks for which they are

contracted with CSHCN, and moved to surveillance, containment, and contact tracing activities. In-state travel restrictions were imposed, rendering it impossible to hold rural traveling clinics. The ISP team was compelled to move the traditional face-to-face patient/family encounter to telehealth and tele-evaluation. The program psychologist was unable to administer diagnostic evaluations as she now had to learn how to convert standardized testing protocols to a telehealth environment. The psychologist participated in multiple training modules with several services providers at the University of Utah, Vanderbilt University, Brigham Young University, and other on-line learning modules. Commercial insurance and Medicaid made allowances for non-traditional telehealth encounters, however, ensuring providers were meeting new criteria for documentation and billing took a lot of research, coordination, and subsequent internal policy change within the Utah Department of Health, the Division of Family Health and Preparedness, and ultimately, the Integrated Services Program.

Agency Capacity / Collaboration Report:

The CSHCN and MCH Bureaus consistently seek to partner with other organizations such as those focused on physical or behavioral/mental health, social services, support and referral, and parent-led and peer to peer organizations. The Bureaus have enjoyed successful and cooperative collaborations with many local health departments, including the four that partner with the Integrated Services program. Many of these organizations, including the local health department, work together on committees to improve the system of services and better serve families of children with special health care needs. The Medical Home Portal includes developmental and social support information written and drafted by parents of children with special health care needs. Both the Utah Parent Center and Utah Family Voices (F2F HIC) partner with parents to provide peer to peer support and develop curricula that supports both the Medical Home and transition. The MCH Bureau and CSHCN provide financial support for these organizations. The MCH Bureau houses both Early Childhood Utah and the Home Visiting Programs, both of which affiliate and collaborate with many of the same players. The Integrated Services Program (ISP) manager 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 5; and also serves on the board of the Utah Public Health Association.

Summary Progress Report of ESMs related to NPM-11:

ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource.

Goal/Objective:

Increase the percentage of families connected to community resources.

Significance of ESM 11.3:

The goal is that CSHCN receive coordinated care and can easily access community-based services. Services are available, but families may be unaware of the services, or unaware of how to access the services.

ESM 11.3 Progress Report:

This ESM was established in support of the Utah Enhanced System for CYSHCN (UESC) HRSA D-70 grant. When

the grant ended, August 31, 2017, CSHCN contracts with many of the contributing partners also ended. As such, CSHCN no longer had access to the survey instrument, nor the data from those partners. Given that scenario, CSHCN continues to report the data from the final year of the grant.

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 FY20:

The Performance Measure was not achieved. The Performance Objective was 17.3% and the Annual Indicator from the 2018-19 (combined data set) National Survey of Children's health was 11.5%.

Program Activities:

The CSHCN Bureau continues to provide funding for the Utah Parent Center in support of the ongoing development and dissemination of training materials targeted at transition-age youth, with the Integrated Services Program manager actively working with a multi-agency curriculum development team to create Transition University: a three-part interactive webinar series. The Integrated Services Program (ISP) staff attended several local and regional school district agency and transition fairs to promote coordination services and obtain referrals from families in need of assistance for their youth of transition age, until many were canceled during the spring of 2020. Families of youth with special health care needs who were referred to ISP were provided with care coordination which included tools and processes outlined in the Six Core Elements of Health Care Transition 2.0; and were educated on Supplemental Security Income, Medicaid, ACA insurance provisions, and, a list of adult providers who may be able to help facilitate the transition process. Statewide, families were encouraged to use the Medical Home Portal (Utah's shared resource) for additional support, documents, and resources, and links targeting transition-age youth. ISP continues to fund the Utah Care Coordination Network (UCCCN) to further educate care coordinators around the state on topics related to general pediatrics, community resources, and transition services available. In FY20 the ISP sponsored articles written by MCH Bureau staff in the Growing Times newsletter, a publication of the Utah Chapter of the American Academy of Pediatrics to educate providers and families on topics related to the Medical Home including transition.

Accomplishments / Successes:

The CSHCN Bureau continued to work with partner organizations that serve youth and young adults in transition. These include the Employment Partnership (Utah Office of Rehabilitation); Child Mental Health (Utah Department of Human Services); the Utah Children's Care Coordination Network, Medical Home Portal, University South Main Clinic (University of Utah Department of Pediatrics); the Utah Parent Center; Utah Family Voices; the Utah State Board of Education; the Coordinating Council for Persons with Disabilities; and Intermountain Health Care. Collectively, these groups worked together on several committees that target activities and preparation for transition-age youth. The Medical Home Portal provides a great deal of information for families seeking to understand and navigate the world of transition. The ISP team made direct contact with several families at the school district(s) agency and transition fairs and were able to guide several families through some steps of transition. The Utah Parent Center provided ongoing workshops for interested families; and the staff of Utah Family Voices, several of whom have children of transition age, helped families navigate issues surrounding medical transition. The Utah Parent Center formed a workgroup to establish a live by video and subsequent streaming curriculum, entitled Transition University, targeting youth and young adults, and addresses all areas of transition from vocational training, independent living, education, and moving to adult medicine. The ISP Team worked with over 100 families of youth and young adults with special health care needs, from age 12-21, to address issues related to transition to adult health care.

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

- Utah's CSHCN Bureau collaborated with multiple medical, vocational, educational, and behavioral health organizations to address transition-related issues across the state.

- The Medical Home Portal / Shared Resource has been well utilized both in Utah and in other states and provided information that is needed by both families and providers, including resource directories, for families and providers regarding transition to adulthood services and activities.

- The Integrated Services Program, including care coordinators at four local health departments, helped guide over 100 families of youth in transition through information dissemination, referral, and follow-up.

Challenges / Gaps / Disparities Report:

Challenges:

While vocational transition planning through the educational system remained relatively robust, transition to adult health care continued to be challenging. The secondary education system, vocational rehabilitation, and other social services agencies coordinate post-secondary training, education, and employment plans well for youth with special health care needs, however, in that collaborative effort, the transition to adult medical care is often lacking. Limited funding, staff time, and technological limitations have been constantly a challenge for educating families on the preparation needed to successfully navigate transition. ISP care coordinators rely heavily on referral from community service organizations and medical providers, including pediatric and family practice offices, to find families who may be in need of transition assistance and coordination. Typically, though, referrals are made to the care coordinators for very young children and pre-adolescents, not youth of transition age. COVID-19 related challenges included the cancellation of several transition/agency fairs typically held live by local school districts; and inability to meet live with families, youth, and young adults who would benefit from face to face transition planning.

Emerging Issues:

On a positive note, there was an increased interest, across the state, to focus on transition to adult medicine. Key partners leading the charge include the Bureau of Children with Special Health Care Needs, Intermountain Health Care, Utah Parent Center, and the University of Utah Hospitals and Clinics. IHC partnered with Dr. Patience White from the national Got Transition organization to provide consultation and expertise in creating a statewide unified medical transition system.

Agency Capacity / Collaboration Report:

Collaborative partners, not limited to the Employment Partnership, Interagency Outreach Training Initiative, and Coordinating Council for Persons with Disabilities, provided outreach, tools, and training to health care providers and families and supported transition services such as support for employment. The partners included the Utah Parent Center, Utah Family Voices, Medicaid, Social Security Administration, Utah State University Center for Persons with Disabilities, Division of Services for People with Disabilities, Utah State Office of Education, Vocational Rehabilitation, Work Ability Utah, and the Utah Developmental Disability Council. The Utah Children's Care Coordination Network and Medical Home Portal provided training and support for care coordinators and family partners from a variety of private provider offices and healthcare organizations in the state. The Utah Parent Center provided several workshops for parents and youth in transition including topics of guardianship, medical transition, employment, and education, and established the Transition University workgroup, a multi-agency team, to formulate

a transition to adulthood curriculum. ISP worked with several of the local school districts to provide information to families in transition at transition and agency fairs sponsored by the districts prior to March 2020 and COVID-19 group gathering restrictions.

Summary Progress Report of ESMs related to NPM-12

ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood.

Goal/Objective:

Increase percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood.

Significance of ESM 12.2:

A written transition plan may help families of children with special health care needs to consider the health and other needs, and determine actions to help the youth transition to adulthood. The Utah Enhanced Services for CSHCN (UESC) Family Survey attempts to determine if families have access to a written transition plan, one of the components of the Six Core Elements of Health Care Transition 2.0.

ESM 12.2 Progress Report:

The data reported on previous years for this ESM was derived from responses to a survey developed by the Utah Enhanced System for CYSHCN (UESC). When the grant ended on August 31, 2017, our contracts with many of the contributing partners also ended. As such, we no longer had access to the survey instrument, nor the data from those partners. The data for this reporting year was calculated by chart review of all youth older than 15 in the ISP electronic medical record to ascertain whether a transition plan was created with the youth and/or the youth's family. The anticipated performance objective of 77% was exceeded as 81% of youth had a transition care plan in place documented in the EMR.

ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource.

Goal/Objective:

Increase the percentage of families connected to community resources.

Significance of ESM 12.3:

The goal is that CSHCN receive coordinated care, and can easily access community-based services. Services are available, but families may be unaware of the services, or unaware of how to access the services.

ESM 12.3 Progress Report:

The data reported on previous years for this ESM was derived from responses to a survey developed by the Utah Enhanced System for CYSHCN (UESC). When the grant ended on August 31, 2017, our contracts with many of the contributing partners also ended. As such, we no longer had access to the survey instrument, nor the data from those

partners. The data for this reporting year was calculated by chart review of all youth older than 15 in the ISP electronic medical record to ascertain whether a transition plan was created with the youth and/or the youth's family. The anticipated performance objective of 77% was exceeded as 81% of youth had a transition care plan in place documented in the EMR.

SPM-02: Rural Clinics: ***Percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.***

SPM-02 was discontinued in FY19.

Other activities in the Children With Special Health Care Needs domain that contribute to improvement in the National Outcome Measures:

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

National Outcome Measures (NOM)

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

The mission of the Child Health Advanced Records Management (CHARM) is to provide public health data through an integrated, secure electronic system to health care providers to coordinate care, and improve efficiencies and health outcomes of the children and families they serve. The program began in 2000, and is a coordinated, Department-wide effort within the Utah Department of Health (UDOH) that creates an electronic health record for children in Utah. The child health record can be printed and given to parents/guardians to assist CSHCN/MCH populations (infants, children, teens, mothers, families) and programs with continuity of care and follow-up. CHARM allows real-time access and data sharing among appropriate health care programs and partners. It supports the coordination of services the child has received by sharing accurate and real time data (newborn screening test results, immunizations, and services received) with programs and medical home providers that serve MCH and CSHCN populations statewide and in the rural areas of the state. The CHARM system in the CSHCN Bureau has demonstrated (though a survey of clinics) that it reduces duplicate tests and expedites appropriate referrals, services, and follow-up. Because a child's health information is readily available through CHARM, the medical home knows what tests have or haven't been done, and subsequently, reduces health care costs. It also eliminates referring families for services they don't need which saves parents time. During the past grant year, the CHARM program increased the percentage of healthcare providers utilizing the CHARM Web Portal (CWP) for treatment and care coordination purposes by 3.4% with the addition of new pediatric, ENT, and public health program users.

Also, during the grant year, the CHARM Program initiated a CMS HiTech Health Information Technology (HIT) 90/10 Medicaid funding proposal to hire a full time FTE to on-board Medicaid providers to use the CWP. The proposal was approved which will significantly increase the percentage of healthcare providers that utilize the CWP and have access to newborn hearing screening, heel-stick, and critical congenital heart defect result, as well as immunization histories. As stated in NOM 13, the CHARM Program also integrates with the Early Hearing Detection and Intervention (EHDI) and Baby Watch/Early Intervention (BW/EI) Programs to provide hearing screening results to health care providers to ensure that a child with special health care needs receives appropriate follow-up services with EI and the child's medical home. CHARM continued to assist these efforts to support special health care needs children, parents, and providers. In addition, CHARM provides immunization information and hearing screening results to the Baby Watch/Early Intervention (BW/EI) Program via a CHARM tab in their BTOTS system. EI providers in urban and rural areas of the state can click on the tab to get this information on a child they are already looking up

in their BTOTS system. The BW/EI program also shares limited IFSP information (enrollment and referral date, and EI advisor name) with the EHDI Program through CHARM. EI Providers get consent from parents to share this information with the EHDI program during in-take. The sharing of the BW/EI information continued to help the EHDI program follow-up on children they have referred to BW/EI to make sure these kids are receiving services, and timely treatment that they need, to maximize their developmental and communication potential.

CHARM's primary population in its core database consists of children aged 0-18 years of age that are born in Utah and also migrate into the state. CHARM is then able to match children between other program's system databases and find and track health information on the primary CSHCN and MCH population program served. Since CHARM's data contains both birth data of children born in Utah and in-migration, population estimates have been used as the denominator for CHARM's reach. The percentage of the population 0-18 that CHARM reaches per year based on population estimates is 99.8% for 2019 and 2020. CHARM continues to reach 8000+ health care providers in programs and clinics that have access to or use CHARM to find health information on children to coordinate care, treatment and follow-up.

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

The CHARM Program was approached by the Health Subcommittee of the Governor's Early Childhood Utah (ECU) Commission in March 2020 to present an overview of the CHARM Program and how the CHARM system integrates data. The Health Subcommittee was in search of a system that could integrate developmental screening data such as the Ages and Stages Screening Questionnaire (ASQ-3 and ASQ SE) results/scores. After the presentation there was much interest in using the CHARM system for this effort. Additional meetings were established by the ECU Health Subcommittee with the CHARM Program to explore using the CHARM system to share developmental screening results statewide with early care, development, education, and health providers, as well as clinicians. Sharing the ASQ results will help providers accurately identify young children who need further evaluation and determine if they are eligible for early intervention services. The CHARM Program will continue to work on this effort to support the integration and sharing of developmental screenings to meet the health needs of children/families.

MCH Block Grant FY22 Application & FY20 Report

Priority Need: Family and Provider Connectedness/Care Coordination

NPM-11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Annual Plan FY22:

The Bureau of Children with Special Health Care Needs (CSHCN) will provide funding support to internal and external partners to increase care coordination efforts throughout Utah. CSHCN will do the following: continue to meet with the Medical Home Stakeholder Workgroup to (1) organize and unite existing education materials to market to providers and families on importance of medical home; (2) continually research best practices to educate the public on the importance of the medical home; (3) continue to evaluate and 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 who have been trained to continue to incorporate the seven components of medical home; (6) market to and educate pediatric providers on care coordination support available to them through the Integrated Services Program to enhance their Medical Home.

Proposed Activities:

- Educate pediatric medical and services providers on the importance of establishing some or all components of the medical home.
- Work with families to understand the importance of receiving care within a medical home; ISP staff will help connect families who do not have a primary care provider with local pediatricians and family practice providers.
- Conduct an inventory of pediatric providers across the state who participate in and provide telehealth and tele evaluation services.
- Provide internet and cellular technology to families with limited access through ISP's Technology Lending Library.

Priority Need: Transition

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 FY22:

CSHCN will continue to meet with established and concurrently functioning transition to adult medicine sub-committees charged with: curriculum development and evaluation; marketing to providers, families, and youth; quality improvement and patient satisfaction; and referral and follow-up for transition supportive services, adult medical care, and care planning. Activities include ongoing revision and refinement of Utah-specific transition curriculum, based upon the National Got Transition curriculum; marketing the curriculum and supportive services to providers, families, and youth/young adults including brief videos, social media, and website offerings; coordinating data collection efforts for medical transition among the various partners and stakeholders; surveying families of transition age youth to assess progress and for quality improvement; surveying providers about their readiness and experience providing transition planning services; and providing ongoing training and support for practices wishing to implement transition support services. CSHCN will continue to fund a portion of the Medical Home Portal and the Utah Children's Care Coordination network in support of transition education and resource dissemination. CSHCN will continue to fund parent partners at Utah Family Voices, and the ongoing development of transition curriculum and educational modules at the Utah Parent Center. ISP will partner with local school districts to provide information and planning on transition for parents and youth with special health care needs at district-sponsored transition/agency fairs. ISP will continue to work with families to ease the transition between pediatric health and adult health. ISP will promote and coordinate transition activities with the care coordinators based at the four local health departments.

Proposed Activities:

- CSHCN will continue to convene monthly transition to adult medicine sub-committees that work on curriculum, marketing, quality improvement and patient/family experience, and referral and follow-up for resources and transition planning.

- CSHCN will work with stakeholders to coordinate 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.

- The Integrated Services Program will promote transition activities in-house and with care coordinators at the four local health departments to work with families, youth, and young adults so they may feel prepared to transition to adult medicine.

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

A. Public Input Process

Public input has always been a valued part of the annual MCH Block Grant application process. This year, the Data Resources Program (DRP) within the Bureau of Maternal and Child Health used the following mechanisms to collect input from both general public and key stakeholders for the FY22 Application and FY20 Annual Report:

1. Email Invitation to Key Stakeholders

An email invitation from the MCH Bureau and the CSHCN Bureau, requesting input and feedback, was sent to an extensive list of stakeholders and included parents, consumers, health care providers, and members of academia, community-based advocacy organizations, community health clinics, local health departments, and various government agencies. The list contained the email contacts of over 400 individuals. We also requested our partner agencies to forward the email with the web link to other contacts who may be interested. DRP worked with the UDOH Informatics Program to solicit feedback from Utah's healthcare providers. An email was sent to professionals who are licensed by the Department of Professional Licensing (DOPL). The list of professionals included Pediatricians, OB/GYN's, Family Medicine, General Practice, Psychiatrists, Psychologists, Clinical Therapists, Physicians Assistants, RN's, LPN's, APRN's, Certified Midwives, Direct Entry Midwives, Social Workers, and Marriage and Family Therapists.

2. Website Posting/Web Application

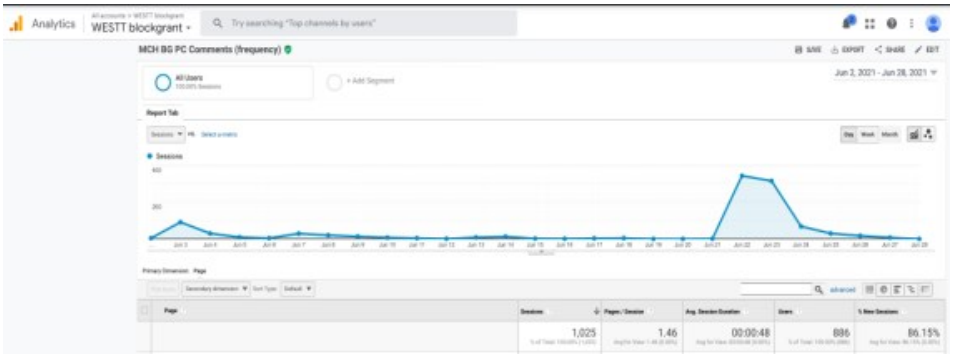
A public announcement was posted on Utah's MCH Block Grant site (http://www.health.utah.gov/westt/mchblock.php), notifying the public about the Public Comment Period. The announcement noted that the Division of Family Health and Preparedness is responsible for administration of the MCH Block Grant received by the State of Utah under the provisions of Title V of the federal Social Security Act. Under this capacity, the Division is required to submit an application annually to the U.S. Department of Health and Human Services. The public notice announced that the proposed program activities related to the annual national and state performance measures (NPMs/SPMs) for the Fiscal Year 2022 MCH Block Grant Application and Report were available for public review and comment. The website link directed the user to the FY2022 Annual Goals/Objectives webpage. The webpage outlined the proposed activities by the six health domains targeting the three mandatory MCH populations (pregnant women and infants; children and youth; and children and youth with special health care needs).

It was stated on the website the State selected 11 measures (eight NPMs and three SPMs) for targeted state focus over the next five years based on the findings of the 2020 MCH Needs Assessment and this should not be considered a comprehensive list of all MCH Bureau activities planned during this period. The following is a screen shot of the public comment social media link:

Online comments were accepted from 6/2/2021 – 6/27/2021. We received valuable feedback on needs and emerging issues as well as reaffirmation of the importance of program activities. This year we received 129 comments.

More than half of the responses (62.0%) referred to the women and maternal health domain (access to care/well-woman visits and perinatal mood and anxiety disorders/mental health). The next highest percentage of comments (17.1%) related to the perinatal and infant health domain (breastfeeding). Almost sixteen percent (15.5%) of comments were for the children with special health care needs (medical home and transition) and the remaining 5.4% were focused on child health and adolescent health (developmental screening, family connectedness / family meals, bullying, dental care, economic stability / free and reduced lunch).

The *Google Analytics* report showed there were 1025 sessions, and 886 users who logged-on to the Title V public comment website at least once or more. Sessions lasted, on average, 48 seconds.



3. Newsletter

To increase public awareness about MCH program activities, we additionally requested several MCH programs to add the public comment announcements in their on-line newsletter or web sites.

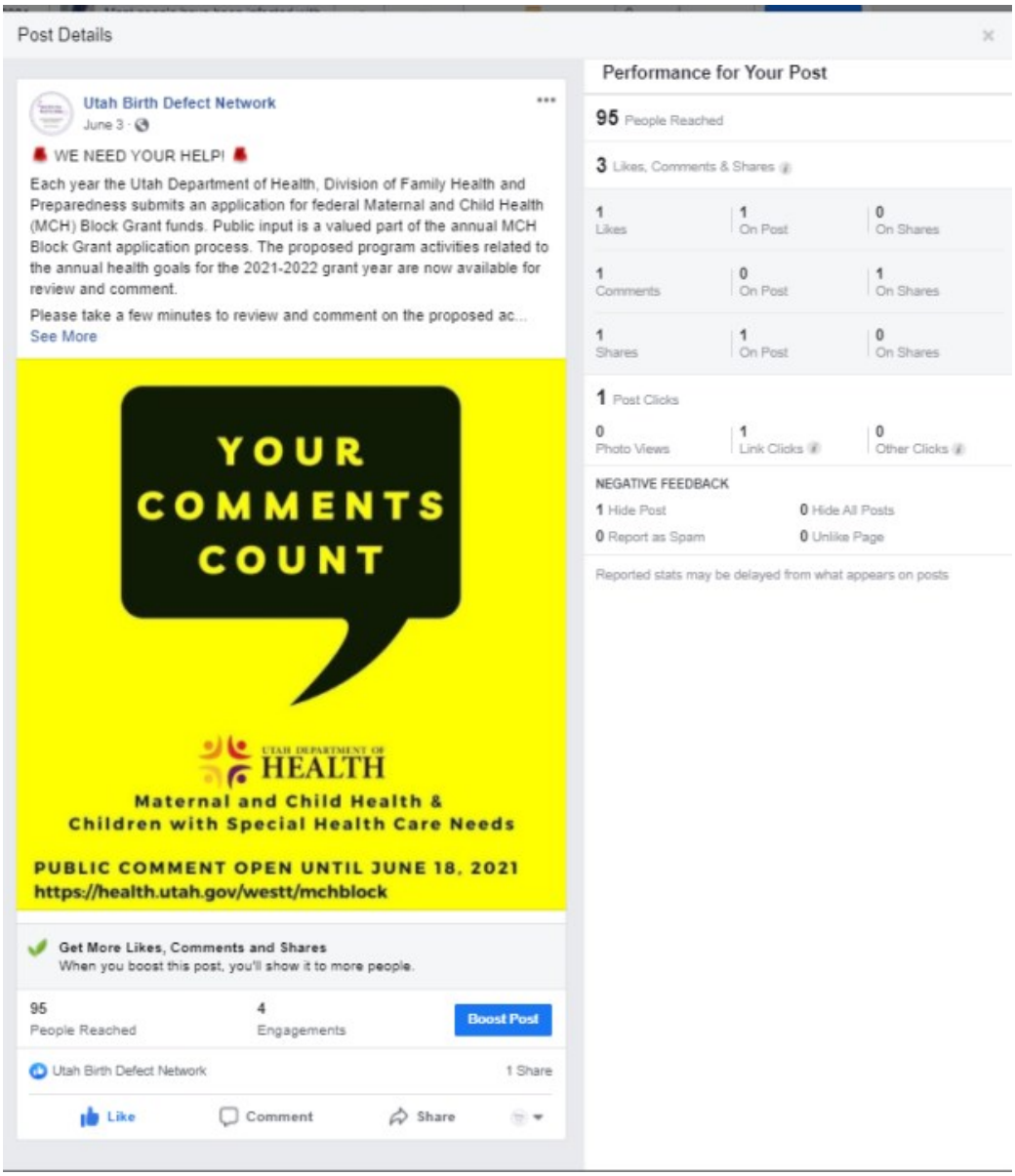
4. Social Media

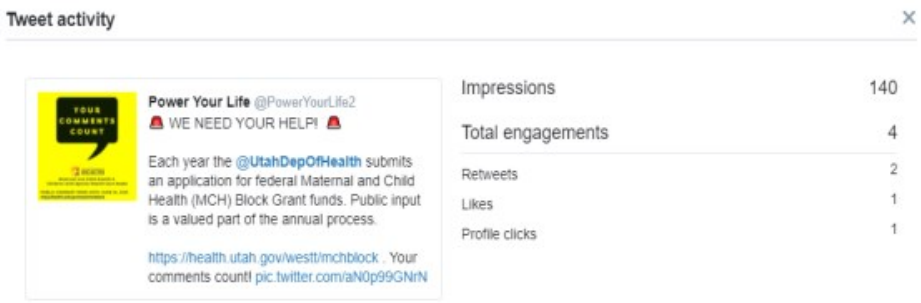
The UDOH MCH and CSHCN Bureaus sought public feedback through social media. We used the UDOH Facebook page, the MCH Maternal and Infant Health program's Facebook and Instagram accounts, and Facebook and Instagram for the CSHCN program and Utah Parent Center to boost circulation for our public input request. The request sought to solicit feedback from various stakeholders and community members on

the goals and objectives of this year's MCH Block Grant. Working with the UDOH Public Information Office (PIO), we created one Facebook ad, which was circulated extensively using Facebook posts. This ad was used to elicit feedback during the public comment period.
The ad ran on the Facebook and Instagram pages of Power Your Life and the Maternal Mental Health, and the Maternal and Child Health website, ultimately directing the public to the Block Grant public comment site. In future years, the Utah MCH Bureau will work to identify and promote these higher-impact images through social media, including Facebook, Pinterest, Instagram, and Twitter across many programs.

The UDOH PIO was also contacted to put the announcement on the UDOH main public website, the UDOH intranet page Healthnet, as well as to send a mass email to all UDOH employees. This was placed on the Utah Birth Defects Network Social Media account and reached 95 people and generated several comments.

The Utah Birth Defect Network Twitter account generated 140 impressions.





5. Other Outreach Methods

Additionally, UDOH staff and other agency partners were informed about the 2022 Block Grant Application and public comment process during regular bureau meetings and trainings.

Block Grant “core writer” trainings were offered on an individual basis this year for all UDOH staff who are responsible for working and reporting on activities related to Utah’s NPMs/ESMs/SPMs. Block Grant core writers were reminded about the public comment process and how their Annual Plans needed to be structured (objective, strategy, proposed program activities) to facilitate communication of the plans to the general public during the public comment period.

B. Changes in Annual Plan based on Public Feedback

A Public Comment Summary Report was prepared in June 2021 based on all public comments received. The report was shared with the lead/core program staff responsible for reporting on specific National and State Performance Measures and requested that they consider this feedback for incorporation in the final 2022 Annual Plans that would be submitted into TVIS. Applicable changes were made by the core writers and incorporated into the current application.

C. MCH Bureau Block Grant Information Compilation Process (Internal Customers)

Web Application WESTT

Information related to all performance measures (NPMs/SPMs/ESMs) were collected using an online system, called the Web Enabled Systematic Tracking Tool (WESTT). This system was developed by DRP to align better with federal MCH Transformation 3.0 and to make the coordination and collection of required information from various public health programs more efficient. The public comments were collected by WESTT and then extracted by Domains for the core writers.

III.G. Technical Assistance

Utah's Title V agency currently has not identified any technical assistance (TA) needs for the FY2022 MCH Block Grant Application. As we identify any needs, we will seek TA.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V_Medicaid_IAA_MOA_FINAL.pdf

V. Supporting Documents

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 - Combined_Organizational_Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Utah

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,598,690	
A. Preventive and Primary Care for Children	$ 3,343,498	(50.6%)
B. Children with Special Health Care Needs	$ 2,254,407	(34.1%)
C. Title V Administrative Costs	$ 621,900	(9.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,219,805	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 16,182,050	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 4,100,000	
5. OTHER FUNDS (Item 18e of SF-424)	$ 15,214,000	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,044,900	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 36,540,950	
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	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 53,211,500	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 96,351,140	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 153,700
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 345,500
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 387,300
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 671,300
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 251,500
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 40,856,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 420,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 2,942,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 232,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 186,700
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 6,523,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 140,900

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,979,388		$ 6,130,707	
A. Preventive and Primary Care for Children	$ 3,542,502	(50.8%)	$ 3,082,954	(50.2%)
B. Children with Special Health Care Needs	$ 2,176,855	(31.2%)	$ 2,137,701	(34.8%)
C. Title V Administrative Costs	$ 600,000	(8.6%)	$ 527,375	(8.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,319,357		$ 5,748,030	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,851,188		$ 15,954,017	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,050,094		$ 4,081,498	
5. OTHER FUNDS (Item 18e of SF-424)	$ 10,833,700		$ 15,143,381	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 5,233,600		$ 999,760	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 27,968,582		$ 36,178,656	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,897,700				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 34,947,970		$ 42,309,363	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 56,396,200		$ 48,064,134	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 91,344,170		$ 90,373,497	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 463,200	$ 341,864
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 751,000	$ 543,270
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 192,300	$ 153,790
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 237,400	$ 212,258
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 420,200	$ 389,064
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 142,500	$ 141,967
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,034,200	$ 2,529,047
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 94,741
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 42,951,500	$ 37,517,364
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 6,641,100	$ 5,618,179
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 239,800	$ 285,200
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 223,000	$ 237,390

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Includes award for 10/1/2021-9/30/2023 with an anticipated expenditure in first year and anticipated federal amount remaining in budget period 10/1/2020-9/30/2022 to be spent in second year.	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Amount includes all or portions of the following state general funds: Division of Family Health and Preparedness Director's Office and Financial Administrative Services, Newborn Safe Haven, Informed Consent, Pregnancy Risk Assessment Monitoring, Pregnancy Riskline, Maternal Mental Health, Children with Special Health Care Needs Administration, Children's Hearing Aid Program, Baby Watch Early Intervention and Office of Home Visiting. Increase in budgeted amount for FY 2022 compared to FY 2021 is due to increased funding from $1.6m in additional appropriations to the Baby Watch Early Intervention Program.	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Local MCH funds reported annually by Local Health Departments. LHDs did not report local MCH funds last year.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Other Funds include revenue agreements from private non-profit agencies. Prior to last fiscal year, this type of funding had been reported as program income.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**

	Field Note: Program income includes revenue received from Baby Watch Early Intervention family fees, CSHCN insurance billing, kit fee revenue and Pregnancy Risk Line collections.	
6.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2019 grant. Actual expended only includes amount expended from FFY 2020 grant award.	
7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2019 grant. Actual expended only includes amount expended from FFY 2020 grant award.	
8.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2019 grant. Actual expended only includes amount expended from FFY 2020 grant award.	
9.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Budgeted amount included estimated unexpended funds from year two of FFY 2019 grant. Actual expended only includes amount expended from FFY 2020 grant award.	
10.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Increases to state funding since FFY 2020 budget include increase to Baby Watch Early Intervention general fund appropriations, Newborn Safe Haven and Informed Consent. New appropriations of general fund including Maternal Mental Health and Office of Home Visiting.	

11.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Department of Health financial staff and Title V director have been working with Local Health Departments to clarify financial reporting requirements on MCH funds. Fiscal reporting is now more consistent between LHDs and in alignment with MCH reporting requirements.	
12.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Increase in FFY 2020 budget vs. actuals is a result of updating MCH reporting categories. Revenue agreements with outside agencies were previously reported as Program Income and are now being reported as Other Funds.	
13.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Decrease in FFY 2020 budget vs. actuals is a result of updating MCH reporting categories. Revenue agreements with outside agencies were previously reported as Program Income and are now being reported as Other Funds.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Utah

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 655,740	$ 630,285
2. Infants < 1 year	$ 562,934	$ 527,420
3. Children 1 through 21 Years	$ 2,327,189	$ 2,097,546
4. CSHCN	$ 2,254,407	$ 2,137,701
5. All Others	$ 176,520	$ 210,380
Federal Total of Individuals Served	$ 5,976,790	$ 5,603,332

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 3,724,946	$ 3,827,864
2. Infants < 1 year	$ 3,403,291	$ 3,512,897
3. Children 1 through 21 Years	$ 8,805,763	$ 8,900,425
4. CSHCN	$ 16,182,200	$ 15,403,869
5. All Others	$ 324,850	$ 452,103
Non-Federal Total of Individuals Served	$ 32,441,050	$ 32,097,158
Federal State MCH Block Grant Partnership Total	$ 38,417,840	$ 37,700,490

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: 1. Infants included in Form 2 under Preventative and Primary Care. 2. Utah continues to make budget reductions and modifications as existing MCH Block Grant obligations are currently $500,000 in excess of the annual award. To date, reductions have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, along with Utah Women Newborn Quality Collaborative activities. In FFY 2021, the Pregnancy Risk Line (Mother 2 Baby) Program budget was reduced by $110,000 in contractual costs with the University of Utah.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Included in Form 2 under Preventative and Primary Care.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Utah continues to make budget reductions and modifications as existing MCH Block Grant obligations are currently $500,000 in excess of the annual award. To date, reductions have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, along with Utah Women Newborn Quality Collaborative activities. In FFY 2021, the Pregnancy Risk Line (Mother 2 Baby) Program budget was reduced by $110,000 in contractual costs with the University of Utah.	
4.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Third party revenue agreements received for Early Childhood Utah activities, specifically relating to resource, referral and Utah ECIDS previously reported under All Others have now been adjusted and are being reported in budget and actuals under Children 1-21.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**

	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Included in Form 2 under Preventative and Primary Care.	
6.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Included in Form 2 under Preventative and Primary Care.	
7.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Utah continues to make budget reductions and modifications as existing MCH Block Grant obligations are currently $500,000 in excess of the annual award. To date, reductions have resulted in Maternal and Infant Health and Family and Youth Outreach program staff being reassigned to new funding sources and activities, along with Utah Women Newborn Quality Collaborative activities. In FFY 2021, the Pregnancy Risk Line (Mother 2 Baby) Program budget was reduced by $110,000 in contractual costs with the University of Utah.	
8.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Third party revenue agreements received for Early Childhood Utah activities specifically relating to resource, referral and Utah ECIDS Development previously reported under All Others, have been adjusted and are now being reported in Children 1-21.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Utah

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 1,873,778	$ 1,607,779
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 299,115	$ 302,103
B. Preventive and Primary Care Services for Children	$ 282,799	$ 285,622
C. Services for CSHCN	$ 1,291,864	$ 1,020,054
2. Enabling Services	$ 3,273,706	$ 3,154,545
3. Public Health Services and Systems	$ 1,451,206	$ 1,368,383
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		$ 1,607,779
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		$ 1,607,779
Federal Total	$ 6,598,690	$ 6,130,707

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 404,600	$ 239,258
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	$ 404,600	$ 239,258
2. Enabling Services	$ 30,877,500	$ 30,308,196
3. Public Health Services and Systems	$ 1,158,850	$ 1,549,704
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		$ 239,258
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		$ 239,258
Non-Federal Total	$ 32,440,950	$ 32,097,158

Form Notes for Form 3b:

Enabling Services - Enabling services are non-clinical services (i.e. not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Block Grant funds are utilized to funds these services. Enabling services for Utah include, but are not limited to the following program expenditures: Bureau of Health Promotion Physical Activity, Violence and Injury Prevention, Community Injury, Baby Your Baby Information and Referral Resource, Family and Youth Outreach including Pregnancy Risk Line, Early Hearing Detection, Birth Defects Network and other CSHCN care coordination and case management activities.

Public Health Services and Systems - Public Health Services and Systems are activities and infrastructure to carry out the core public health functions of assessment, assurance and policy development, along with the 10 essential public health services. Public Health Services and Systems for Utah include: Early Childhood Utah development, Utah Health Indian Advisory, Health Disparities, Local Health Department coordination, Utah Women's Quality Collaborative and Perinatal Mortality Review.

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Utah

Total Births by Occurrence: 48,035 **Data Source Year: 2019**

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	46,784 (97.4%)	728	86	86 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
CCHD	46,557 (96.9%)	107	5	5 (100.0%)
Newborn Hearing Screening Tests	47,682 (99.3%)	705	93	93 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Diet Monitoring (0-18)	1,340	80	80	80
Diet Monitoring (Pregnant Women)	1,340	7	7	7

4. Long-Term Follow-Up

Long-term follow-up is not part of the Utah Newborn Screening Program. Once a confirmed diagnosis is made, the infant is referred to the appropriate specialist for long-term care and treatment.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

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 2020

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	8,301	31.3	0.0	48.8	6.7	13.2
2. Infants < 1 Year of Age	11,561	58.5	0.0	30.4	3.0	8.1
3. Children 1 through 21 Years of Age	32,939	35.9	0.4	45.8	7.5	10.4
3a. Children with Special Health Care Needs 0 through 21 years of age^	11,256	28.6	0.0	64.4	7.0	0.0
4. Others	2,662	14.7	0.0	62.8	20.7	1.8
Total	55,463					

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	46,826	Yes	46,826	94.3	44,157	8,301
2. Infants < 1 Year of Age	48,023	Yes	48,023	100.0	48,023	11,561
3. Children 1 through 21 Years of Age	1,078,275	Yes	1,078,275	22.3	240,455	32,939
3a. Children with Special Health Care Needs 0 through 21 years of age^	182,548	Yes	182,548	84.9	154,983	11,256
4. Others	2,079,117	Yes	2,079,117	0.4	8,316	2,662

^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:	**2020**
	Field Note: Pregnant women number derived from the following sources: - Pregnancy Risk Line Health education (Pregnant Women through 60 days postpartum/breastfeeding), Infants less than 1 are not counted (not duplicated) since the health education is provided to the women/mothers and not the infant. Phone, email, in-person, etc. individual contacts/education episodes (n=2,366) - 1-800 Call Non-Eligibility Calls (Pregnant Women, Others), FY20 phone calls to Immunizations, CHIP (n=3,040) - Maternal and Child Health Service Report (n=2,895) Source of coverage came from FAD and the Maternal and Child Health Service Report	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Infant's number derived from the following sources: - Hearing Screening by the Utah Early Hearing Detection and Intervention Team (n=64) - Pregnancy Risk Line calls regarding breastfeeding infants under age 1 (n=1,809) - Ages and Stages Screenings (n=2,884) - Maternal and Child Health Service Report Service Report (n=6,804) substantial reduction from last year due to COVID-19. Source of coverage came from FAD and the Maternal and Child Health Service Report	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Children 1 through 21 years numbers derived from the following sources: - 1-800 Call Non-Eligibility Calls (CHIP, Immunizations) (n=3,268) - Health education (Children 1-21) (n= 223) - Maternal and Child Health Service Report (n=9,997) - Ages and Stages Questionnaire Screenings (n=8,130) - Oral Health Program Direct oral health screenings (n=65) Substantial reduction due to COVID-19 - Numbers from 3a (n=11,256) Source of coverage came from FAD and the Maternal and Child Health Service Report	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
- CSHCN Case Management (Utah Family Voices), Un-duplicated counts of intakes (n=1,141)
- CSHCN Translation, Follow up notes, Cytomegalovirus, records, Family Support (n=8,727)
- CSHCN Autism Referral, Scheduling, monitoring, referral, coordination (n=38)
- CSHCN Autism Explanation of benefits, referral and assistance (n=42)
- Oral Health Program CSHCN direct oral health screenings (n=107)
- CSHCN Transition planning (n=552)
- Rural Pediatric Orthopedics (U of U/PCMC) (n=405)
- Case Management/care coordination (ISP) (n=244)

Source of coverage came from FAD, the Maternal and Child Health Service Report, Rural Pediatric Orthopedics, and Case Management/Care Coordination Integrated Services Program

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
"Others" number derived from the following sources:
- Pregnancy Risk Line Health education (men/partners/relatives, women 22+ not pregnant yet or more than 60 days postpartum, professionals), phone, email, in-person, etc. individual contacts/education episodes (n=1,812)
- Pregnancy Risk Line Safe haven calls (n=21)
- MCH Service Report (n=780)
- Oral Health Program fluoride varnish applications (n=49)

Services were impacted significantly by COVID-19.
Source of coverage came from FAD and the Maternal and Child Health Service Report.

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2020**

Field Note:
Primary Source of Coverage determined by Local Health Department MCH Service Report, Federally Available Data, and the Integrated Services Program.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
In addition to numbers served from form 5a:
- Maternal and Infant Health Program Safety bundle hospital (n=35,837)

44,138/46,826 = 94.3% served

0.942595994 is the actual calculated percentage. TVIS would not save this number, consequently we gained 19 in the TVIS calculated number based on rounded percentage.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
In addition to numbers served from form 5a:
- Critical Congenital Heart Disease screening - Children screened in hospitals (n=46,557)
- Maternal and Infant Health Program Births in participating Stepping Up hospitals (n=35,034)
- Hearing screening, number of infants screened (n=50,578)

48,023/48,023 = 100% served

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
In addition to numbers served from form 5a:
- Physical Activity, Percent of adolescents who were physically active 60 minutes, 7 days per week (n=41,142)
- Oral Health Program Group Education Adolescents (n=10,294)
- PREP/Abstinence Education, Number of children enrolled in programs (n=1,511)
- Numbers from CSHCN (n=154,962)

240,848/1,078,275 = 22.3% served

22.3364169623 is the actual calculated percentage. TVIS would not save this number, consequently we gained 39 in the TVIS calculated number based on rounded percentage.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
In addition to numbers served from form 5a:
- Medical Home Portal, users (n=103,283) New and revised tracking system and website overhaul caused an increase in traffic counting
- CSHCN Utah Early Hearing Detection and Intervention Committee, individuals participating (n=195)
- CSHCN Hearing/Speech Training, Coordinated training for screening and referral (n=1,423)
- CSHCN Autism Downloads, ABA resource and Evaluation Provider downloads (n=37,893)
- Utah Birth Defects Network Surveillance cases (n=763)
- Oral Health Program Education (n=149)

154,962/182,548 = 84.9% served

84.88835813 is the actual calculated percentage. TVIS would not save this number, consequently we gained 21 in the TVIS calculated number based on rounded percentage.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
In addition to numbers served from form 5a:
- Utah Birth Defects Network Community Education, Events, # reached, # of vitamins distributed (n=3,972)
- Oral Health Program Outreach Education (n=2,248)
- Home visiting clients receiving preconception health information (n=200)
Most of our outreach has been significantly impacted by COVID-19

9,082/2,079,117 = 0.44 % served

0.436820054 is the actual calculated percentage. TVIS would not save this number, consequently we lost 766 in the TVIS calculated number based on rounded percentage.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Utah

Annual Report Year 2020

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	47,580	34,284	770	8,123	423	1,226	750	0	2,004
Title V Served	46,230	33,326	723	7,912	391	1,193	746	0	1,939
Eligible for Title XIX	11,857	6,609	387	3,540	251	223	345	0	502
2. Total Infants in State	48,035	34,629	779	8,187	424	1,235	756	0	2,025
Title V Served	46,655	33,647	732	7,973	392	1,201	752	0	1,958
Eligible for Title XIX	11,486	6,381	372	3,456	230	221	342	0	484

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data. Total Deliveries 2019	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data. Resident Deliveries 2019	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data. Medicaid Status based on Self-Reported Enrollment to the Medicaid Program, among Resident Deliveries 2019	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data. Occurrent Births 2019	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data. Resident Births 2019	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Office of Vital Records and Statistics, Utah Birth Certificate Data. Medicaid Status based on Self-Reported Enrollment to the Medicaid Program, among Total Resident Births 2019	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Utah

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 826-9662	(800) 826-9662
2. State MCH Toll-Free "Hotline" Name	Baby Your Baby	Baby Your Baby
3. Name of Contact Person for State MCH "Hotline"	Marie Nagata	Marie Nagata
4. Contact Person's Telephone Number	(801) 538-6519	(801) 538-6519
5. Number of Calls Received on the State MCH "Hotline"		3,040

B. Other Appropriate Methods	2022 Application Year	2020 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"		9,751
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		5,508
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		35,000

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Utah

1. Title V Maternal and Child Health (MCH) Director	
Name	Lynne Nilson
Title	Title V/Director, Bureau of Maternal and Child Health
Address 1	288 N 1460 W
Address 2	PO Box 142002
City/State/Zip	Salt Lake City / UT / 84116
Telephone	(801) 694-3143
Extension	
Email	lpnilson@utah.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Noel Taxin
Title	Title V/Children with Special Health Care Needs Bureau Director
Address 1	288 N 1460 W
Address 2	PO Box 144610
City/State/Zip	Salt Lake City / UT / 84116
Telephone	(801) 273-2956
Extension	
Email	ntaxin@utah.gov

3. State Family or Youth Leader (Optional)	
Name	Joey Hanna
Title	Utah Parent Center Executive Director
Address 1	230 W 200 S #1101
Address 2	
City/State/Zip	Salt Lake City / UT / 84101
Telephone	(801) 272-1051
Extension	
Email	joey@utahparentcenter.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Utah

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Perinatal mood and anxiety disorders	New
2.	Women's access to care	New
3.	Breastfeeding/poor infant nutrition	Continued
4.	Developmental delays	Continued
5.	Adolescent mental health	Continued
6.	Family connectedness	New
7.	Economic stability	New
8.	Family and provider connectedness/Care coordination	Revised
9.	Transition to adulthood	New
10.	Oral health	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 4

Field Note:
Priority need from 2015-2020 was "Developmental Screening". Continued.

Field Name:

Priority Need 5

Field Note:
2015-2020 priority need was "Suicide, mental health issues, and access to mental health services"

Field Name:

Priority Need 8

Field Note:
Based on the results of the 2020 Utah Statewide Needs Assessment

Form 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 Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 4

Field Note:
Priority need from 2015-2020 was "Developmental Screening". Continued.

Field Name:

Priority Need 5

Field Note:
2015-2020 priority need was "Suicide, mental health issues, and access to mental health services"

Field Name:

Priority Need 8

Field Note:
Based on the results of the 2020 Utah Statewide Needs Assessment

Form 10
National Outcome Measures (NOMs)

State: Utah

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

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
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
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
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
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**
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
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
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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**
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
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
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
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
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**
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
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
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
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
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
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
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
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
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
2018_2019	92.6 %	1.1 %	854,376	922,657
2017_2018	91.7 %	1.3 %	842,930	918,989
2016_2017	92.3 %	1.0 %	841,932	912,027
2016	92.7 %	1.0 %	839,113	905,467

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	8.5 %	0.2 %	1,560	18,455
2016	7.9 %	0.2 %	1,709	21,599
2014	8.2 %	0.2 %	1,870	22,919
2012	8.7 %	0.2 %	2,234	25,640
2010	12.5 %	0.2 %	3,264	26,045
2008	13.2 %	0.2 %	2,710	20,592

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.8 %	0.9 %	15,980	162,482
2017	9.6 %	0.8 %	15,119	157,588
2013	6.4 %	0.9 %	9,582	148,869
2011	8.6 %	0.8 %	12,711	147,981
2009	6.3 %	0.9 %	9,374	148,628
2007	8.6 %	1.8 %	11,888	138,875
2005	5.5 %	0.9 %	7,700	140,637

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	9.6 %	1.8 %	39,442	410,447
2017_2018	8.7 %	1.5 %	35,757	412,538
2016_2017	8.7 %	1.6 %	32,848	377,409
2016	9.5 %	1.9 %	31,613	334,315

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.7 %	0.5 %	71,681	929,592
2018	6.9 %	0.5 %	64,299	931,248
2017	6.7 %	0.5 %	61,508	924,827
2016	5.3 %	0.5 %	48,721	921,098
2015	7.6 %	0.4 %	69,298	911,752
2014	9.2 %	0.6 %	82,818	905,149
2013	9.0 %	0.6 %	80,465	897,411
2012	9.3 %	0.5 %	82,538	885,518
2011	11.1 %	0.7 %	97,541	881,364
2010	11.0 %	0.7 %	96,001	871,851
2009	10.2 %	0.6 %	88,555	867,275

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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**
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
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
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
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
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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					66.5
Annual Indicator				66.1	67.6
Numerator				394,166	413,656
Denominator				595,993	612,087
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	67.5	68.0	69.0	70.0	72.0	74.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	88.5	94.5	88.6	90	90
Annual Indicator	94.4	88.4	89.7	91.2	91.8
Numerator	43,550	43,382	43,073	45,052	39,458
Denominator	46,122	49,063	48,030	49,404	42,968
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	91.8	92.2	92.6	93.1	93.5	93.9

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	18.5	27.3	26.9	28	28.3
Annual Indicator	27.0	26.8	27.8	23.5	26.3
Numerator	11,890	12,259	12,643	11,415	10,658
Denominator	44,056	45,790	45,490	48,506	40,597
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.0	28.0	29.0	30.0	31.0	32.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			33.2	32.2	31.3
Annual Indicator		33.1	32.6	31.1	29.1
Numerator		38,611	32,987	29,418	31,492
Denominator		116,514	101,171	94,514	108,310
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.3	31.5	31.7	31.9	32.1	32.3

Field Level Notes for Form 10 NPMs:

None

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

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

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

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	22.0	21.0	20.0	19.0	18.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			50.4	44.1	40.3
Annual Indicator		50.4	47.2	40.2	46.4
Numerator		75,090	68,219	59,263	69,395
Denominator		148,990	144,415	147,327	149,671
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	47.0	47.5	48.0	48.5	49.0	49.5

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			18.4	19.5	17.3
Annual Indicator		18.4	19.3	17.1	11.5
Numerator		11,791	12,760	13,378	8,906
Denominator		64,109	66,028	78,194	77,434
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	13.5	15.5	17.5	19.5	21.5	23.5

Field Level Notes for Form 10 NPMs:

None

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

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

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.8	83.0	83.2	83.4	83.6	83.8

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Utah

2016-2020: NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

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

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	90	92.8	91.7	90	90.4
Annual Indicator	92.7	91.6	89.1	90	90.6
Numerator	480	522	521	448	455
Denominator	518	570	585	498	502
Data Source	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data	IBIS, Utah Birth Certificate Data
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	19.9	19.9	18.9	20	20
Annual Indicator	19.7	19.7	19.1	19.1	21.0
Numerator	29,466	29,466	30,959	30,959	35,424
Denominator	149,852	149,852	162,207	162,207	168,525
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2013	2013	2017	2017	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			18.9	20	20
Annual Indicator		13.6	8.7	5.7	10.1
Numerator		37,056	25,092	17,632	31,489
Denominator		272,391	287,812	311,115	313,326
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	59.6	56.7	56.9	53.8	54
Annual Indicator	56.5	61.2	53.6	53.2	53.0
Numerator	27,701	29,790	25,341	24,250	24,201
Denominator	49,001	48,710	47,301	45,610	45,663
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Adolescent Health

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

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Utah

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	56	60.8
Numerator	25,866	27,859
Denominator	46,186	45,807
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.8	66.8	69.8	72.8	75.8	78.8

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	76.7	78.1
Numerator	692,413	712,908
Denominator	903,273	912,249
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.8	79.5	80.2	80.9	81.7	82.4

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	38.0	41.0	44.0	47.0	50.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		9	9.4	9.4	9.4
Annual Indicator	9.3	9.6	9.4	9.4	9.7
Numerator	4,712	4,852	4,582	4,434	4,552
Denominator	50,776	50,486	48,578	47,211	46,832
Data Source	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS	Utah Birth Certificate Data, OVRS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 2 - CSHCN Rural Clinical Services: The percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		3.3	1	2	3
Annual Indicator	1.9	0.8	1.6	0	0
Numerator	550	272	533	0	0
Denominator	28,704	35,870	34,275	35,988	35,988
Data Source	CSHCN/UDAC Billing Data	CSHCN/UDAC Billing Data (2017) and Pop Est (2016)	ISP Utilization Data	ISP Utilization Data	ISP Utilization Data
Data Source Year	2015	2016-17	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: A decision has been made to discontinue this measure. State will make an effort to select an appropriate replacement.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Denominator data is based on population estimates. Source: IBIS 2017.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019 population counts used as Census data for 2020 not yet available This measure was discontinued.	

2016-2020: SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		14.7	15.1	14.9	14.5
Annual Indicator	15.1	15.8	15.7	15	14.4
Numerator	144	152	152	147	141
Denominator	950,511	960,913	967,283	977,706	980,045
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates	Utah Death Certificate Database and Pop estimates
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		21	16.7	21.5	20.5
Annual Indicator	21	17.2	21.5	21.3	25.2
Numerator	49	41	52	53	64
Denominator	233,809	238,378	242,153	248,985	253,847
Data Source	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS	Utah Death Certificate Database, OVRS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Utah

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	300.0	350.0	400.0	450.0	500.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	14.0	16.0	18.0	20.0	22.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	1.0	1.0	1.0	1.0	1.0

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
Annual Objective		
Annual Indicator	13.2	24.4
Numerator	6,225	11,435
Denominator	47,211	46,832
Data Source	Vital Records Birth Certificate Data	Vital Records Birth Certificate Data
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	30.0	33.0	36.0	40.0	43.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.9	6.6
Numerator	983	449
Denominator	7,093	6,831
Data Source	WIC Program Data	WIC Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.0	15.0	16.0	17.0	18.0	19.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	7
Numerator		
Denominator		
Data Source	EPICC Program Data	EPICC Program Data
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7.0	40.0	40.0	40.0	40.0	40.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Currently our capacity is offering one live training per month. We are operating at current capacity. We offer recorded sessions as well as live monthly trainings.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Our projections are revised due to funding changes that impacted our ability to fund a contractor to do ASQ trainings.	

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	7,988.0	8,387.0	8,806.0	9,246.0	9,709.0	10,195.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The data source has been changed from "The Brooks Publishing UDOH ASQ Online Enterprise" from an in-house database, "UDOH Early Childhood Integrated Database 2020".

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	350.0	400.0	450.0	500.0	550.0	600.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	21	21
Numerator	41,142	41,142
Denominator	195,912	195,912
Data Source	Estimates for percent of students physically activ	YRBS
Data Source Year	2019	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	23.0	25.0	25.0	27.0	27.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	400	430
Numerator		
Denominator		
Data Source	PREP and SRAE Reports Wyman Connect	PREP and SRAE Reports Wyman Connect
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

Field Level Notes for Form 10 ESMs:

None

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	76.0	78.0	79.0	81.0	83.0	85.0

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
Annual Objective		
Annual Indicator	100	340
Numerator		
Denominator		
Data Source	Program Data	Program Data
Data Source Year	2020	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	300.0	350.0	400.0	450.0	500.0	550.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Pre- and Post-training survey	Pre- and Post-training survey
Data Source Year	2020	2021
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is a new ESM based off of the Utah MCH And CSHCN Needs Assessments conducted in 2019-2020. A baseline will be established in FY2021, and subsequently projected performance objectives will be calculated for FY 2022-25.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Year one was intended to establish a baseline, develop curriculum, marketing strategies, referral processes, follow-up, and QI/satisfaction survey methods. It would be premature to reach out to families prior to ensuring stable program offerings. A baseline will be established in Year Two.	

ESM 11.2 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	94
Numerator		614
Denominator		653
Data Source	CSHCN EMR or comprehensive database	CSHCN Electronic Medical Record
Data Source Year	2020	SFY 2021
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	94.5	95.0	95.5	96.0	96.5	97.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.

ESM 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.

Measure Status:	Active

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.	
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.	

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
Annual Objective		
Annual Indicator	0	62.4
Numerator		552
Denominator		884
Data Source	Stakeholder work group survey	ISP electronic medical record, Utah Parent Center
Data Source Year	2020	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	63.0	65.0	68.0	71.0	74.0	77.0

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
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Stakeholder work group survey for transition	Stakeholder work group survey for transition
Data Source Year	2020	2020
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Year one will establish a baseline. Years 2-5 annual projected performance increase will be established once baseline is calculated at the end of year one.	
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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		53.6	51.5	54.4	55.7
Annual Indicator	53.4	51.3	54.2	55.5	51.9
Numerator	116,623	109,115	109,777	105,122	94,832
Denominator	218,295	212,848	202,518	189,242	182,597
Data Source	CMS 416	CMS 416	CMS 416	CMS-416	CMS-416
Data Source Year	FFY16	FFY17	FFY18	FFY19	FFY20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	52.1	52.3	52.5	52.7	52.9	53.1

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: CMS-416 Report for Utah, Numerator = line 12b 'Total' Medicaid children ages 1 - 18 years who had a preventive dental visit; Denominator = line 1b 'Total' Medicaid children ages 1 - 18 years eligible for 90 days or more	
2.	**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
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1	1	2	2
Annual Indicator	1	1	1	1	0
Numerator					
Denominator					
Data Source	Program Level Data	Program Level Data	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2015	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		100	100	100	100
Annual Indicator	100	100	100	100	0
Numerator	518	585	593	498	0
Denominator	518	585	593	498	502
Data Source	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database	REDCap VLBW Infant Morbidity Database
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
This measure was made inactive in 2019.

2016-2020: ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		100	100	100	100
Annual Indicator	0	0	0	0	0
Numerator	0	0	0	0	0
Denominator	10	10	10	10	10
Data Source	Program Level Data	Program Level Data	Program Level Data	Program Level Data	Program Level data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Awaiting VLBW morbidity data analysis to convene consensus group.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This measure was made inactive in 2019	

2016-2020: ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based 10 Steps to Breastfeeding Success

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		22	28	25	27
Annual Indicator	14	18	23	25	25
Numerator					
Denominator					
Data Source	Program Level Data	Program Level Data	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			178	126	138
Annual Indicator	26	89	114	67	17
Numerator					
Denominator					
Data Source	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey	Healthy Utah Worksite Assessment Survey
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		9,400	10,800	9,700	9,800
Annual Indicator	9,335	10,771	9,700	9,026	8,998
Numerator					
Denominator					
Data Source	Utah WIC Program Computer Report	Utah WIC Program Computer Report	Utah WIC Program Computer Report	Utah WIC Program Computer Report	Utah WIC Program Computer Report
Data Source Year	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
BFPC
State FY 2016 Data; 7/1/2015 – 6/30/2016
Participation: Grand Total—56,538
9,335/56,538==16.51%
Referral Summary to Breastfeeding Program:
9,335 Total Number of Referrals

2016-2020: ESM 6.5 - Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			45
Annual Indicator			72.6
Numerator			45
Denominator			62
Data Source			UDOH ASQ Online Enterprise Account
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			198
Annual Indicator			62
Numerator			
Denominator			
Data Source			UDOH ASQ Online Enterprise Account
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The ASQ online account database was reviewed and chronically inactive accounts were disabled in 2019.

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

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		10	25	25	50
Annual Indicator	7.1	25	25	25	25
Numerator		1	1	1	1
Denominator		4	4	4	4
Data Source	School Health Profiles	UDOH Policy Database	UDOH Policy Database	UDOH Policy Database	UDOH Policy Database
Data Source Year	2016	2017	2017	2017	2017
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4	35	36	37
Annual Indicator	6	34	31	34	0
Numerator					
Denominator					
Data Source	EPICC Training Database	EPICC Training Database	EPICC Training Database	EPICC Training Database	EPICC Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to the COVID-19 pandemic, all trainings for this reporting cycle were cancelled.

2016-2020: ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		69	67	68	68
Annual Indicator	68.8	67.3	68.1	68.1	68.1
Numerator	99	115	286	286	286
Denominator	144	171	420	420	420
Data Source	Program Level Data	Program Data, Integrated Services Program	Program Data, Integrated Services Program	Program Data, Integrated Services Program	Program Data, Integrated Services Program
Data Source Year	FFY17	FY2017	FY2018	FY2018	FY2018
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
UESC (D-70) grant ended August 31, 2018. Data for this ESM was not collected after that expiration date.

2016-2020: ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		23.5	20	76.5	77
Annual Indicator	23.5	23.5	76.2	76.2	81.5
Numerator	16	16	16	16	66
Denominator	68	68	21	21	81
Data Source	Program Level Data	Program Level Data	Program Level Data	Program Level Data	Program Level Data
Data Source Year	2016	2016	2018	2018	FY20
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		69	67	68	68
Annual Indicator	68.8	67.3	68.1	68.1	68.1
Numerator	99	115	286	286	286
Denominator	144	171	420	420	420
Data Source	Program Level Data, UESC Family Survey	Integrated Services Program Data	Integrated Services Program Data	Integrated Services Program Data	Integrated Services Program Data
Data Source Year	FFY17	FY2017	2018	2018	2018
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
UESC (D-70) grant ended August 31, 2018. Data for this ESM was not collected after that expiration date.

2016-2020: ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		45.3	37.1	25.2	25.4
Annual Indicator	45.1	36.9	25	25.9	25.9
Numerator	69	58	38	43	43
Denominator	153	157	152	166	166
Data Source	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report	Utah Office of Head Start, Program Report
Data Source Year	2015	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data for this ESM was not available as Head Start Programs were not required to submit reports for 2020 due to the COVID-19 pandemic.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Utah

SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker asked if they were feeling down or depressed during prenatal and postpartum care
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of women who self-report if a healthcare provider asked them if they were feeling down or depressed both during prenatal and postpartum care from 56% to 59% (2019 PRAMS data)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of women who self-report that a healthcare provider asked them if they were feeling down or depressed both during prenatal and postpartum care.</td></tr>
<tr><td>Denominator:</td><td>Number of resident women who delivered a live birth in Utah.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Similar to MICH-D01: Increase the proportion of women who are screened for postpartum depression at their postpartum checkup. No 2030 target has been established to date.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Utah PRAMS data.</td></tr>
<tr><td>Significance:</td><td>Postpartum depression is the most underdiagnosed and most common complication of pregnancy. Nationally, one in five women experience a perinatal mood and anxiety disorder. When a mother's mental health complications goes undiagnosed, there are serious implications on her birth (preterm birth, low birth weight, miscarriage), development of their baby postpartum (sleep, growth, behavioral issues, mother-infant bonding), and on the mother herself (low breastmilk supply, marital problems, substance use issues, low compliance in following medical advice and missing routine care for herself and baby). Additionally, the two leading causes of death in Utah for perinatal moms from 2015-2016 were accidental drug overdose and suicide, with 75% of the women who died during those same years having had a previous mental health issue. Screening has been recommended by The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). ACOG notes that "screening alone can have clinical benefits," and it is a way to connect mothers who are suffering to appropriate behavioral health resources, medication, and normalize an issue that is often not talked about due to heavy stigma and shame.</td></tr>
</table>

SPM 2 - Percent of family members who live in the household that ate a meal together 4 or more days per week.
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the percent of family members who live in the household that ate a meal together 4 or more days per week from 76.7% to 81.7% (2017-2018 National Survey of Children's Health)
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Children whose family eats meals together 4 or more days out of the week **Denominator:** Children age 0-17 years
Healthy People 2030 Objective:	There is no corresponding Healthy People 2030 measure.
Data Sources and Data Issues:	National Survey of Children's Health
Significance:	When people feel connected with their communities, they may feel more inclined to participate in actions that help the community. As an upstream factor, it impacts multiple levels of social ecology. Connectedness encompasses both family connection and support, as well as community violence. It is a shared protective factor. Family meals are a way to increase connectedness in families. This connectedness is a protective factor for youth and onset of risky behaviors. Connectedness is a protective factor for reducing suicide.

SPM 3 - Percent of students enrolled in the free or reduced price lunch program
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the number of students who participate in the National School Lunch Program
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of eligible students who participate in the National School Lunch Program **Denominator:** The total number of students enrolled in schools
Healthy People 2030 Objective:	Related to AH-04: Increase the proportion of students participating in the School Breakfast Program.
Data Sources and Data Issues:	Utah State Board of Education Child Nutrition Program Database
Significance:	Students who participate in the school meal programs consume more milk, fruits, and vegetables during meal times and have better intake of certain nutrients, such as calcium and fiber, than nonparticipants. Additionally, eating breakfast at school is associated with better attendance rates, fewer missed school days, and better test scores. School lunch is a proxy for economic stability.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Preterm Births: The percent of live births occurring before 37 completed weeks of gestation
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce the percent of live births occurring before 37 completed weeks of gestation</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 preterm births (less than 37 completed weeks of gestation)</td></tr>
<tr><td>Denominator:</td><td>Total number of live births</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>MICH Objective 9.1: Reduce total preterm births to 11.4%</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Utah Birth Certificate Database, Office of Vital Records and Statistics, Utah Department of Health</td></tr>
<tr><td>Significance:</td><td>Preterm birth is a leading cause of infant mortality. Babies born preterm have increased risks for long-term morbidities and often require intensive care after birth. Health care costs and length of hospital stay are also higher for premature infants.</td></tr>
</table>

2016-2020: SPM 2 - CSHCN Rural Clinical Services: The percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of children with special health care needs in the rural areas of the state who receive direct clinical services contractually from the University Developmental Assessment Center (UDAC)</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 CSHCN children in the rural areas of the state who received direct clinical services contractually from the University Developmental Assessment Center</td></tr>
<tr><td>Denominator:</td><td>Total number of CSHCN children in the rural areas of the state</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CSHCN billing data and NSCH data for total percent of CSHCN</td></tr>
<tr><td>Significance:</td><td>CSHCN in rural areas may be more likely to have unmet health care needs due to transportation difficulties or because care is not available in the area. Additionally, there may be greater time and financial burdens associated with the necessity of obtaining care at provider sites located further from home.</td></tr>
</table>

2016-2020: SPM 3 - Child Injury Deaths: The rate of injury-related deaths among children and adolescents ages 1 to 19 (per 100,000)
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	To reduce the rate of injury-related deaths among children and adolescents ages 1 to 19
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of injury-related deaths among children and adolescents ages 1 to 19 **Denominator:** Total number of children and adolescents ages 1 to 19
Data Sources and Data Issues:	Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health; National Center for Health Statistics (NCHS) / U.S. Census Bureau
Significance:	Each year, an average of 450 Utah children die in Utah. Approximately one-third of these deaths are due to injury. Injuries are mostly preventable, yet they continue to be a leading cause of death for children and adolescents in Utah.

2016-2020: SPM 4 - Adolescent Suicide: The rate of suicide death among youth ages 15 to 19 (per 100,000)
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To reduce the rate of suicide death among youth ages 15 to 19
Definition:	<table><tr><td>**Unit Type:**</td><td>Rate</td></tr><tr><td>**Unit Number:**</td><td>100,000</td></tr><tr><td>**Numerator:**</td><td>Number of suicide deaths among youth ages 15 to 19</td></tr><tr><td>**Denominator:**</td><td>Total number of youths ages 15 to 19</td></tr></table>
Healthy People 2020 Objective:	MHMD-1 Reduce the suicide rate -- MHMD-2 Reduce suicide attempts by adolescents -- IVP-30 Decrease firearm related death -- IVP-43 -- Surveillance of violent death -- ECBP-2 Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity
Data Sources and Data Issues:	Office of Vital Records and Statistics, Center for Health Data and Informatics, Utah Department of Health - IBIS Injury Mortality Module
Significance:	Utah has witnessed a steady increase in the rate of suicide fatalities among this age group over the past 10 years. In 2013, suicide surpassed unintentional injuries to become the leading cause of death among youth ages 10-19 in Utah. On average, 37 youths in Utah die from suicide and 942 are injured in a suicide attempt each year.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Utah

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Utah

ESM 1.1 - The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Count of women enrolled in Salt Lake County Home Visiting who receive education on the well-woman visit. **Denominator:**
Data Sources and Data Issues:	Salt Lake County Home Visiting Program Data
Significance:	A trusted professional, like a home visitor is an effective messenger on the importance of a well-woman visit. Educating and encouraging home visiting clients to schedule and attend a well-woman exam can help them maintain a healthy lifestyle and minimize health risks.

ESM 1.2 - Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of community partners and organizations engaged in a coalition to create a well-woman visit strategic plan for the State of Utah **Denominator:**
Data Sources and Data Issues:	Maternal and Infant Health Program data
Significance:	Public health issues are best addressed by developing and sustaining partnerships between community organizations, medical experts, and government. Programs that develop and sustain these partnerships provide opportunities to improve the health of women during their lifespan.

ESM 1.3 - Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.
Definition:	**Unit Type:** Count **Unit Number:** 9 **Numerator:** Number of questions on survey **Denominator:**
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System
Significance:	Success of public health messaging must include input from the population it is trying to reach. Using the Utah Behavioral Risk Factor Surveillance Survey (BRFSS), program staff will be able to ask a diverse group of women on the facilitators and barriers to receiving a well-woman visit. With this information it is possible to create programming that will resonante with our target population, thus increasing the percentage of women who receive care.

ESM 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 4.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of eligible pregnant and postpartum WIC participants who receive at least one contact from a WIC Breastfeeding Peer Counselor **Denominator:** The number of eligible pregnant and postpartum WIC participants
Data Sources and Data Issues:	WIC Program Data
Significance:	Breastfeeding is the normative standard for infant feeding and nutrition and can result in improved infant and maternal health outcomes. Mothers who receive help and support when they need it are more likely to reach their breastfeeding goals and meet their infant's complete nutritional needs. A mother's ability to begin and continue breastfeeding can be influenced by a host of community factors, and programs like WICs breastfeeding peer counselors can provide important coaching to enable and sustain breastfeeding efforts in WIC clients. Peer counseling interventions greatly improve breastfeeding initiation, duration, and exclusivity.

ESM 4.3 - Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of surveys received from women who utilize lactation policies and/or lactation rooms at the workplace
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of surveys received **Denominator:**
Data Sources and Data Issues:	EPICC Program Data
Significance:	The U.S. Surgeon General calls for employers to have high-quality employee lactation support programs and policies that work towards reducing breastfeeding barriers for working mothers. The effectiveness of these policies in supporting the needs of breastfeeding mothers is currently unknown in Utah. By getting their input, we can encourage workplaces to update current policies that meet the needs of lactating workers so they can reach their personal breastfeeding goals.

ESM 6.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Conduct at least 12 ASQ trainings per year
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of trainings **Denominator:**
Data Sources and Data Issues:	Training enrollment and attendance records kept by Early Childhood Utah program staff
Significance:	Developmental screening is a critical element of well-child care and an important opportunity to engage families in the process of developmental health promotion. The screening process is used to determine if development skills are progressing as expected or if there is cause of concern and further evaluation is necessary. This ESM is significant to increasing the number of developmental screens received by children ages 9 months - 35 months. In order to increase the number of screens received by infants/toddlers we need to increase the number of Early Care & Education (ECE) and Health programs that offer developmental screening services to families with young children. ECE and Health programs cannot provide ASQ online services without first being trained in ASQ online. If UDOH can sponsor an increased number of ASQ online training opportunities, additional ECE and Health providers will enroll in the UDOH ASQ online account and hopefully, actively participate. Ideally, increased ASQ online training opportunities will lead to an increase in the number of developmental health screening opportunities for 9 month - 35 month year old children.

ESM 6.2 - The number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of ASQ screens contributed to the UDOH ASQ Online Enterprise Account by participating partners and enrolled programs.
Definition:	**Unit Type:** Count **Unit Number:** 99,999 **Numerator:** Number of ASQ screens in UDOH ASQ Online Enterprise Account **Denominator:**
Data Sources and Data Issues:	UDOH ASQ Online Enterprise Account
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. Nationally, the percentage of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine-month visit. This measure is significant because only by monitoring and increasing the number of programs participating and the number of screens contributed to our ASQ online Enterprise account will we be able to increase the percentage of 9 month - 35 month year old children that receive parent-completed developmental health screening opportunities.

ESM 9.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Implement the Teen Speak training with 500 Utah parents in 5 years.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak). **Denominator:**
Data Sources and Data Issues:	Program records, attendance records. Information from the developer on those that complete the on-line pre-work
Significance:	Teen Speak is a communications program (total 8 hours: including self-study and in-person presentation) that provides parents a menu of strategies they can use to improve communication with their youth

ESM 9.2 - The number of adolescents who receive bystander training (Upstanding)
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the number of adolescents who have received the Upstanding curriculum.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** The number of adolescents who receive the Upstanding training **Denominator:**
Data Sources and Data Issues:	Program records
Significance:	Bullying is the unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. Passive bystanders provide the audience a bully craves and the silent acceptance that allows bullies to continue their hurtful behavior. A bystander to bullying is anyone who witnesses bullying either in person or in digital forms like social media, websites, text messages, gaming, and apps. When bullying occurs, bystanders are present 80 percent of the time. A bystander has the potential to make a positive difference in a bullying situation, particularly for the youth who is being bullied. Studies show, when youth who are bullied are defended and supported by their peers, they are less anxious and depressed. The Upstanding Program teaches children simple strategies for standing up to bullying that effectively removes, rather than provides, more peer attention.

ESM 9.3 - Percent of adolescents who are physically active at least 60 minutes per day.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the number of students who are active for at least 60 minutes a day through a variety of options throughout the school day.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** TBD **Denominator:** TBD
Data Sources and Data Issues:	Program records, Utah Youth Risk Behavior Surveillance System, Utah State Office of Education
Significance:	Physical activity has brain health benefits for school-aged children, including improved cognition (e.g., academic performance, memory) and reduced symptoms of depression. Regular physical activity in childhood and adolescence can also be important for promoting lifelong health and well-being and preventing risk factors for various health conditions like heart disease, obesity, and type 2 diabetes.

ESM 9.4 - The number of youth participating in the Wyman Teen Outreach Program (TOP)
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the opportunities for 400 youth to build positive connections with others through the Wyman Teen Outreach Program.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of youth participating in the Teen Outreach Program **Denominator:**
Data Sources and Data Issues:	PREP & SRAE Reports/Wyman Connect
Significance:	The Wyman Teen Outreach Program (TOP) increases teens' ability to build positive connections with others through weekly peer group meetings and community service learning.

ESM 9.5 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the percent of Utahns who qualify and file for the Earned Income Tax Credit from 75% to 83%.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Utahns who filed for the EITC **Denominator:** # of Utahns who qualify for the EITC
Data Sources and Data Issues:	Internal Revenue Service, Utah Tax Help, Program Records
Significance:	Bullying is associated with a number of community-level risks, such as concentrated poverty, residential instability, and density of alcohol outlets. Reducing exposure to these community-level risks can potentially yield population-level impacts on youth violence outcomes. Prevention approaches to reduce these risks include changing, enacting, or enforcing laws, city ordinances and local regulations, and policies to improve household financial security, safe and affordable housing, and the social and economic sustainability of neighborhoods. Public-private partnerships and community-driven needs and services are important elements of these approaches. Strengthening household financial security through tax credits, such as the Earned Income Tax Credit (EITC), can help families increase their income while incentivizing work or offsetting the costs of child-rearing and help create home environments that promote healthy development. The evidence suggests that the EITC can lift families out of poverty. Simulations show that a Child Tax Credit of a $1000 allowance per child, paid to each household regardless of income or tax status, would reduce child poverty in the United States from 26.3% to 23.2%; a $2000 allowance per child would reduce child poverty to 20.4%; a $3000 allowance per child would reduce child poverty to 17.6%; and a $4000 allowance per child would reduce child poverty to 14.8%.

ESM 9.6 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR)
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of Utahns who have been trained in Question, Persuade, Refer (QPR)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>999</td></tr>
<tr><td>Numerator:</td><td>The number of Utahns who have been trained in Question, Persuade, Refer (QPR)</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program Records</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 11.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of families of CSHCN who report a change in knowledge on the importance of the medical home.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families surveyed post-Medical Home training who report a positive change in knowledge. **Denominator:** Number of families who complete both the pre- and post test for Medical Home training.
Data Sources and Data Issues:	Pre- and Post-training survey
Significance:	Parents who understand the importance of the medical home may encourage their providers to incorporate the seven components of the medical home.

ESM 11.2 - Percent of children with special health care needs population served by the Bureau who have documented care coordination follow up as part of a medical home model of care.
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 12.1 - Percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of children with special health care needs who report the transition plans assisted them (report a change in knowledge, skills or behavior) in transitioning to adulthood.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth and adolescents with an active transition plan who report positive outcomes on stakeholder work group survey.</td></tr>
<tr><td>Denominator:</td><td>Number of youth and adolescents surveyed.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Stakeholder work group survey.</td></tr>
<tr><td>Significance:</td><td>Having a transition plan is critical for services to be seamlessly transferred to adult-serving providers. There is strong, recent evidence as summarized by the literature in Jones et al. (2017) and Lemke et al. (2018) that speak to the importance of sharing the plan with youth and families and for having a transition policy within a practice:

Jones, M. R., Robbins, B. W., Augustine, M., Doyle, J., Mack-Fogg, J., Jones, H., & White, P. H. (2017). Transfer from pediatric to adult endocrinology. Endocrine Practice, 23(7), 822–830. https://doi.org/10.4158/EP171753.OR.

Lemke, M., Kappel, R., McCarter, R., D’Angelo, L., & Tuchman, L. K. (2018). Perceptions of health care transition care coordination in patients with chronic illness. Pediatrics, 141(5). https://doi.org/10.1542/peds.2017-3168.</td></tr>
</table>

ESM 12.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Survey of youth with special health care needs who have an active transition plan. **Denominator:** All youth with special health care needs surveyed.
Data Sources and Data Issues:	Stakeholder work group survey of transition-age youth.
Significance:	Having a transition plan is critical for services to be seamlessly transferred to adult-serving providers. There is strong, recent evidence as summarized by the literature in Jones et al. (2017) and Lemke et al. (2018) that speak to the importance of sharing the plan with youth and families and for having a transition policy within a practice.

ESM 12.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Survey of providers trained who indicate they have an active transition policy in place.</td></tr>
<tr><td>Denominator:</td><td>All providers trained in transition.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Stakeholder work group survey for transition trained providers.</td></tr>
<tr><td>Significance:</td><td>Jones, M. R., Robbins, B. W., Augustine, M., Doyle, J., Mack-Fogg, J., Jones, H., & White, P. H. (2017). Transfer from pediatric to adult endocrinology. Endocrine Practice, 23(7), 822–830. https://doi.org/10.4158/EP171753.OR.

Lemke, M., Kappel, R., McCarter, R., D’Angelo, L., & Tuchman, L. K. (2018). Perceptions of health care transition care coordination in patients with chronic illness. Pediatrics, 141(5). https://doi.org/10.1542/peds.2017-3168.</td></tr>
</table>

ESM 13.2.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the percent of Medicaid children ages 1 - 18 who had a preventive dental visit
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Medicaid children aged 1-18 who had a preventive dental visit</td></tr><tr><td>**Denominator:**</td><td>Number of Medicaid children aged 1-18 eligible for Medicaid for 90 days or more</td></tr></table>
Data Sources and Data Issues:	CMS-416 Report for Utah, Numerator = line 12b 'Total' Medicaid children ages 1 - 18 years who had a preventive dental visit; Denominator = line 1b 'Total' Medicaid children ages 1 - 18 years eligible for 90 days or more.
Significance:	The Medicaid population is a group that has higher dental needs than those of higher economic status. They are part of the population in Utah that is important to concentrate on in improving this measure.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Peer preconception health: Number of institutions of higher learning partnered with to implement a peer preconception health program.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of institutions of higher learning partnered with MIHP.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>99</td></tr>
<tr><td>Numerator:</td><td>Number of institutions of higher learning</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MIHP Program Level data</td></tr>
<tr><td>Significance:</td><td>The Title V Maternal and Child Health Services Block Grant to States Program guidance defines the significance of this goal as follows:

A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.</td></tr>
</table>

2016-2020: ESM 3.1 - VLBW REDCap Data: Percent of reporting by hospital facilities where VLBW infants were delivered
2016-2020: NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	100% of VLBW infants reported to Utah Department of Health database.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of VLBW infants entered into VLBW Database **Denominator:** Total number of VLBW infants born in Utah
Data Sources and Data Issues:	Program Specific Data from VLBW Infant Morbidity REDCap Database
Significance:	Perinatal regionalization classifies hospitals at risk-appropriate levels in regards to care for both mothers and infants. This ensures that high-risk pregnancies and LBW, preterm or other at-risk infants have access to the most appropriate care. In Utah, hospitals self-designate their levels of care and because of this, there is no uniformity with Utah's leveling. In an attempt to dig past the surface of a self-proclaimed level and see what is actually happening in our facilities, a database has been created that all Utah hospitals report the outcomes of every VLBW infant either delivered or transferred to their facility. This data will allow Utah to have a more informed conversation about the importance of Perinatal Regionalization through the eyes of some of our most ill and vulnerable infants.

2016-2020: ESM 3.3 - Standardized guidelines: Percent of Level III NICU facilities providing support to build a consensus-based model of Utah Standardized Level of Care
2016-2020: NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of hospitals facilities providing support to build a consensus-based model of Utah Standardized Level of Care to 100%</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>The number of level III NICU facilities providing support/consensus</td></tr>
<tr><td>Denominator:</td><td>The total number of level III hospital facilities in the State (UT)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program-specific data of agreement collected at meetings and/or email</td></tr>
<tr><td>Significance:</td><td>A survey carried out by the Maternal and Child Health (MCH) Bureau several years ago provided objective criteria that indicates Utah currently has ten hospitals that self-designate as level III neonatal intensive care units (NICU) while the survey data collected indicate that number is much smaller based on the published Guidelines. Currently, Utah regulations that designate Levels of Care for Perinatal Services are imprecise and there is no regular oversight of NICU services by the Department.
Through collaboration, the MCH Bureau has worked on developing Utah specific Guidelines for Neonatal Care based on the 7th edition of Guidelines for Perinatal Care; however, these guidelines have remained in draft form for the last few years. With the collection of Utah specific data on VLBW infants, creation of these guidelines will be able to be reapproached.</td></tr>
</table>

2016-2020: ESM 4.1 - Stepping Up for Utah Babies: Number of Utah hospitals, that deliver babies, that have implemented some of WHO's evidence based 10 Steps to Breastfeeding Success
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number steps being implemented in Utah delivering hospitals.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of steps implemented **Denominator:**
Data Sources and Data Issues:	Program level data
Significance:	Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

2016-2020: ESM 4.2 - Worksite lactation policy: Number of worksites that have created a lactation policy that complies with federal standards
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of worksites that create a lactation policy that complies with federal standards.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of worksites with a policy **Denominator:**
Data Sources and Data Issues:	Healthy Utah Worksite Assessment Survey
Significance:	For infants not breastfeeding, there is an associated increased risk of infant morbidity and mortality and significantly higher risk of many diseases including diabetes, obesity, leukemia, SIDS, NEC, etc. Duration rates are greatly affected by mothers returning to work to businesses that are not meeting the federal workplace accommodation law. Policies must be in place and implemented to provide an environment that is conducive to supporting breastfeeding women. Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child’s nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

2016-2020: ESM 4.3 - Breastfeeding Peer Counselor Program (BFPCP): Number of WIC-eligible clients that are referred to the Breastfeeding Peer Counselor Program
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of referrals to BFPCP by 1% in the next year.
Definition:	**Unit Type:** Count **Unit Number:** 99,999 **Numerator:** Number of referrals **Denominator:**
Data Sources and Data Issues:	Utah WIC Program Computer Reports *It was suggested that BF PC Contacts Summary Report could be modified to separate duplicated and unduplicated contacts. Clinic Services Referral Summary Report will provide numbers referred to Peer Counselor Program.
Significance:	Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

2016-2020: ESM 6.5 - Active participation of enrolled programs: Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of enrolled programs that actively participate in the UDOH ASQ online account by 10%.</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>The number of enrolled programs that contribute any screening data to the UDOH ASQ online account throughout the calendar year.</td></tr>
<tr><td>Denominator:</td><td>The number of programs that are enrolled in the UDOH ASQ online program.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>UDOH ASQ online account.</td></tr>
<tr><td>Significance:</td><td>By increasing the percentage of enrolled programs that actively participate in the UDOH ASQ online account, the UDOH will gain an improved ability to track and increase the number of age aligned developmental screens that children ages 9-35 months receive.</td></tr>
</table>

2016-2020: ESM 6.6 - New program enrollment: Increase the number of programs enrolled in the UDOH ASQ online account by 10%.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of programs enrolled in the UDOH ASQ online account by 10%.
Definition:	**Unit Type:** Count **Unit Number:** 999 **Numerator:** Number of programs enrolled in the UDOH ASQ online account. **Denominator:**
Data Sources and Data Issues:	UDOH ASQ online account.
Significance:	If additional programs are enrolled and actively participate in the UDOH ASQ online account; UDOH may increase the number of children ages 9-35 months receiving an age aligned developmental screening.

2016-2020: ESM 8.2.1 - Schools with CSPAP: Percent of schools within four targeted LEAs that have implemented CSPAP
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the percent of schools within four targeted local education agencies (LEAs)--Cache, Canyons, Granite, and Salt Lake--that have implemented CSPAP
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of schools within the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake--that have implemented CSPAP **Denominator:** Total number of schools within the four targeted LEAs--Cache, Canyons, Granite, and Salt Lake
Data Sources and Data Issues:	School Health Profiles
Significance:	A Comprehensive School Physical Activity Program (CSPAP) is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally-recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime.

2016-2020: ESM 8.2.2 - Professional Development for Local Education Agencies (LEAs): Number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the Comprehensive School Physical Activity Program (CSPAP)
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of LEAs receiving professional development and technical assistance to establish, implement, and evaluate the CSPAP</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>99</td></tr>
<tr><td>Numerator:</td><td>Number of local education agencies (LEAs) in the state that received professional development on CSPAP</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>EPICC training database</td></tr>
<tr><td>Significance:</td><td>Professional development is designed to actively engage learners. Teachers who attend professional development about physical activity and who incorporate movement during the school day will increase student opportunity to be active for 60 minutes a day.</td></tr>
</table>

2016-2020: ESM 11.3 - Linkage to community resources: Percent of families served who were connected to a needed resource
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of families connected to community resources by June 2017.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Families who were connected with a community resource **Denominator:** Families that allowed a follow-up contact (call, email, etc.) to determine if they were connected with a community resource
Data Sources and Data Issues:	Program data, Integrated Services Program, CSHCN. The CSHCN Integrated Services Program will collect data in FY2017 based on families referred by the shared resource (Medical Home Portal). The Integrated Services Program will attempt to follow up with families to determine if they were connected with a community service.
Significance:	The goal is that CSHCN receive coordinated care and can easily access community based services. Services are available but families may be unaware of the services or unaware of how to access the services.

2016-2020: ESM 12.2 - Written transition plan: Percent of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the percentage of CSHCN, at least 15 years old, with a written transition plan to promote transition to adulthood.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of respondents with a child over 15 years old who report having a written transition plan. **Denominator:** Number of respondents with a child over 15 years old who responded to the question about a written transition plan.
Data Sources and Data Issues:	Program level data, UESC Family Survey
Significance:	A written transition plan may help families of children and youth with special health care needs consider health and other needs and determine actions to help the youth transition to adulthood. The UESC Family Survey attempts to determine if families have access to a written transition plan, one of the components of the Six Core Elements of Health Care Transition 2.0.

2016-2020: ESM 12.3 - Linkage to community resources: Percent of families served who were connected to a needed resource
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of families connected to community resources by June 2017.</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>Families who were connected with a community resource</td></tr>
<tr><td>Denominator:</td><td>Families that allowed a follow-up contact (call, email, etc.) to determine if they were connected with a community resource</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program level data

The CSHCN Integrated Services Program will collect data in FY2017 based on families referred by the shared resource (Medical Home Portal). The Integrated Services Program will attempt to follow up with families to determine if they were connected with a community service.</td></tr>
<tr><td>Significance:</td><td>The goal is that CSHCN receive coordinated care and can easily access community based services. Services are available but families may be unaware of the services or unaware of how to access the services.</td></tr>
</table>

2016-2020: ESM 13.1.1 - Collaborate with EHS: Percent of pregnant women who had a dental exam and/or treatment during pregnancy
2016-2020: NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the percent of EHS pregnant women who had a dental exam and/or treatment during pregancy.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of EHS pregnant women who had a dental exam and/or treatment during the reporting year **Denominator:** EHS total enrollment of pregnant women
Data Sources and Data Issues:	Utah Office of Head Start - Program Information Report (PIR) Summary Report - 2015 - State Level, Numerator - line C.21, p. 17; Denominator = line A.14, p. 3
Significance:	Measures the number of pregnant women in the EHS program who had a dental exam and/or treatment during pregnancy.

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 2020

	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	Annually	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Data obtained through ongoing joint MCH and OVRS data agreement. Data is available in September for the data year ending in January,
Data Source Name:	**2) Vital Records Death**
	Field Note: Data obtained through ongoing joint MCH and OVRS data agreement. Data is available in September for the data year ending in January,
Data Source Name:	**3) Medicaid**
	Field Note: Data obtained through DRP and Medicaid Eligibility data sharing agreement.
Data Source Name:	**4) WIC**
	Field Note: Data obtained through a joint data sharing agreement through the DRP and the Utah WIC program.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: We currently do not have access to this data.
Data Source Name:	**7) Hospital Discharge**
	Field Note: This data is obtained annually with a data sharing agreement between DRP and the Office of Health Care Statistics and monthly through Utah Women's and Newborn Quality Collaborative and Office of Health Care Statistics.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: Data available annually through the MIHP and CDC.