Utah State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Women's access to care	1. Engage community partners to develop a well-woman visit strategic plan. 2. Improve understanding of barriers to receipt of routine preventive care. 3. Train community health workers through an online Maternal and Child Health module on basic preconception and well-woman and the necessary knowledge and skills to advocate for the populations they serve.	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%.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: The number of home visiting clients that receive education on the well-woman visit from Salt Lake County Home Visiting Program staff.* ***Inactive -*** *ESM 1.2: Number of community partners and organizations engaged in coalition to create a well-woman visit strategic plan for the state of Utah.* ***Inactive -*** *ESM 1.3: Add additional question(s) on the Utah Behavioral Risk Factor Surveillance Survey (BRFSS) to learn more on the facilitators and barriers to women receiving routine preventive care.* ESM 1.4: Develop and	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

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				offer an educational module to community health care workers as an online supplemental course	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
Perinatal mood and anxiety disorders	1. Increase the number and types of information and training materials for providers statewide. 2. Increase the number and types of providers trained statewide.	By 2025, increase the number of women who self-report if a healthcare provider asked them if they were feeling down or depressed both during prenatal and postpartum care from 56% (2019 PRAMS) to 68.3%.	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		
Perinatal/Infant Health					
Breastfeeding/poor infant nutrition	1. Implement the Stepping Up for Utah Babies program in delivering hospitals in Utah. 3. Increase access to, and use of, Utah WIC Breastfeeding Peer Counselor Program (BFPCP). 4. Support Local Health Departments in efforts to help worksites meet the requirements of the federal lactation accommodations law. Measured by the number of worksites that meet the requirements.	A) By 2025, increase the percent of infants born in Utah who are ever breastfed from 89.7% (NIS, 2015) to 94.0%. B) By 2025, increase the percent of infants born in Utah who are exclusively breastfed through 6 months of age from 27.8% (NIS, 2015) to 31.9%.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	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.” ***Inactive -*** *ESM 4.2:*	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

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				The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor. ESM 4.3: The number of worksites that have federal lactation accommodations and breastfeeding strategies. ***Inactive -*** *ESM 4.4: Survey women who utilize lactation policies and/or lactation rooms at the workplace to share their thoughts about lactation accommodations to determine barriers, supports, and breastfeeding acceptance* ESM 4.5: The percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer	

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				Counselor.	
Child Health					
Developmental delays	1. Increase the number of parent-completed developmental health screens received by children, ages 9 months - 35 months, by increasing the number of programs/providers that are trained to facilitate ASQ Online screenings. 2. Increase the number of parent-completed developmental health screens received by children ages 9 months - 35 months, by increasing the number of new programs enrolled in the DHHS ASQ Online Enterprise Account. 3. Increase the number of parent-completed developmental health screens received by children, ages 9 months - 35 months, submitted to the DHHS ASQ Online Enterprise Account.	By 2025, increase the percentage of children, ages 9 months through 35 months, who receive a parent-completed developmental health screen in the previous year from 31.1% (NSCH, 2017-18) to 45.2%.	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	***Inactive -*** *ESM 6.1: Number of annual ASQ trainings offered by the Early Childhood Utah program* ***Inactive -*** *ESM 6.2: The number of ASQ screens, for 0-3 year olds, contributed to the DHHS ASQ Online Enterprise Account by participating partners and enrolled programs.* ESM 6.3: Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually ESM 6.4: The number of ASQ screenings, for children 0-5, contributed to the DHHS ASQ Online Enterprise Account annually.	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

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				ESM 6.5: The number of new programs enrolled in the DHHS ASQ Online Enterprise Account Annually	
Oral health	1. The Oral Health Program (OHP) will collaborate with Utah Medicaid with the goal to increase the percentage of children who have preventive dental visits as well as dental treatment needed. The OHP will also collaborate with the Utah Oral Health Coalition, the Utah Dental Association, Utah Dental Hygienist Association, Head Start, the Office of Health Equity, WIC, and the Utah Office of Home Visiting to reach these goals. 2. Collaborate and work with high risk populations in Early Head Start, Head Start, Early Intervention, WIC, Office of Home Visiting, and school based prevention programs to share resources and provide education and training to agency staff on the importance of dental care for children. The goal is to increase the percent of children who have had a preventive dental visit in the past year by providing education and local dental resources. 3. The Oral Health Educator (OHEd) works closely with the professional advisory councils at many of the dental hygiene programs to encourage the professional development of dental hygiene students to create a public health minded workforce. The OHEd also presents at several of the dental hygiene schools to students on topics including loan repayment programs, social justice, health equity and cultural empathy. 4. The OHEd along with the Dental Hygiene Liaison for Utah collaborates with the University of Utah's Physician Assistants Program for interprofessional development.	By 2025, increase the percent of children (ages 1 through 17) who had a preventive dental visit in the past year from 81.4% (NSCH, 2017-2018) to 83.6%.	NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	ESM 13.2.1: Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit	NOM 14: Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 19: Percent of children, ages 0 through 17, in excellent or very good health
Family connectedness	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	By 2025, increase the percent of family members who live in the household that ate a meal together 4 or more days per week from 76.7% (2017-2018 National Survey of Children's Health) to	SPM 2: Percent of family members who live in the household that ate a meal together 4 or more days per week.		

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		84.0%			
Adolescent Health					
Adolescent mental health	1. Work with schools and parents to increase training for students, parents and staff on protective factors such as physical activity and communication.	By 2025, decrease the percentage of adolescents (10-18 years of age) who report being bullied at school in the past 12 months from 27.9% (YRBSS 2017) to 21.4%.	NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	***Inactive -*** *ESM 9.1: Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).* ESM 9.2: The number of adolescents who receive bystander training (Upstanding) ESM 9.3: Percent of adolescents who are physically active at least 60 minutes per day. ESM 9.4: The number of youth participating in the Wyman Teen Outreach Program (TOP) ESM 9.5: Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit ESM 9.6: Number of Utahns who have been trained in Question,	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

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				Persuade, Refer (QPR) ESM 9.7: The number of parents who participate in the Families Talking Together intervention	
Economic stability	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.	By 2025, increase the number of eligible students who participate in the National School Breakfast and Lunch Programs from 26.5% (Utah State Board of Education Child Nutrition Program Database) to 88.7%.	SPM 3: Percent of eligible students enrolled in the free or reduced price lunch program		
Children with Special Health Care Needs					
Family and provider connectedness, Medical Home, and Care coordination	1. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah. 2. CSHCN Office creates a stakeholder workgroup to organize and unify existing education materials to market the importance of medical home (primary care, dental, behavioral/mental health). 3. Work group determine best practices and educates the public on the	By 2025, increase the percent of children with special health care needs who receive care within a medical home from 40.4% (NSCH, 2017-18) to 57.5%.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	***Inactive -*** *ESM 11.1: Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.* ESM 11.2: Percent of	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

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	importance of medical home. 4. Work group evaluates and selects a database to track care coordination efforts. 5. Work group review and utilize Baby Watch Early Intervention Program tele-intervention cost study data to assess the benefits and challenges with utilizing virtual platforms for services. 6. Workgroup encourages providers to incorporate the seven components of a medical home after being trained through online learning modules or other educational media. 7. Work group collect data on pediatric Medicaid providers who utilize telehealth and survey those providers to assess capacity, barriers, and best practices. 8. Educate pediatric medical and service providers through the UCCCN and Project ECHO on the importance of the components of a medical home and utilize UCCCN and post-training survey data to determine how participating practices are increasing medical home capacity. 9. Promote hybrid telehealth/in-person service delivery model to meet the needs of the family. 10. ISP to track families served who do not have a medical home, are referred to a primary care provider and successfully establish care. 11. Survey families who receive care from UCCCN member practices to evaluate status of and satisfaction with medical home.			children with special health care needs population served by the Office of CSHCN who have documented care coordination follow up as part of a medical home model of care. ESM 11.3: Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination Network (UCCCN) who report satisfaction with the components of the medical home.	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
Transition to adulthood	1. CSHCN Office to create a stakeholder workgroup to organize and unify existing educational materials and market the importance of transition to adulthood. 2. Determine best practices for educating the public, including medical and behavioral health providers, on the importance of transition to adulthood through a variety of traditional and on-line marketing, informational, and educational modules.	By 2025, increase the percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care from 17.5% (NSCH, 2017-18) to 23.3%.	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	***Inactive -*** *ESM 12.1: Percentage of children with special health care needs who report the transition plans assisted them (report a change in*	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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	3. Survey families of transition-age youth who have been trained on the unified transition curriculum to assess skill development and progress toward reaching transition goals. 4. Ensure that youth of transition to adult healthcare age who receive services funded by Title V are offered care coordination and transition education. 5. ISP Transition Specialist to offer transition planning to target diagnosis groups within the Birth Defect Network registry. 6. ISP team to provide consultation, care coordination, and transition planning and support for homeless youth in Salt Lake City.			*knowledge, skills or behavior) in transitioning to adulthood.* ESM 12.2: Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan. ESM 12.3: Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.	