Utah State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Women's access to care	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 69.8%.	1. Staff will analyze data from the BRFSS to understand where women of reproductive age obtain their chosen method of birth control and publish a report detailing findings. 2. Staff will attend a variety of community events throughout the year to meet community members and educate them on preconception health and the importance of the well-woman visit. 3. Staff will review, revise, and update the Power Your Life website to educate the public about the annual well-woman visit.	***Inactive -*** *ESM WWV.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 WWV.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 WWV.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 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			Inactive - *ESM WWV.4 - Develop and offer an educational module to community health care workers as an online supplemental course* ESM WWV.5 - Develop and publish reports on findings from BRFSS data on Utahn's folic acid uptake and attitudes on the well-women visit.		NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					Formerly NOM 24) - PPD
Perinatal mood and anxiety disorders	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 69.5%.	1. Promote toolkit for the Utah Women and Newborns Quality Collaborative, translate the toolkit into Spanish, and assess the toolkit for improvements. 2. Train at least two more: OB, midwife, psychotherapist, Pediatrician, TriCare (Veteran population) on perinatal mental health, and look for providers who speak Spanish to include on the referral network. 3. Expand the use of online screening to other health departments. 4. Implement a project to address maternal mental health in Hispanic/Latino individuals. 5. Continue to use social media platforms to encourage women to seek screening and care from providers. 6. Train community health workers, doulas, and substance use peer support specialists in maternal mental health.		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	
Women's access to care	A) By 2025, increase the percentage of Utah women who attended a postpartum checkup within 12 weeks after giving birth from 91.0% (PRAMS, 2022) to 92.8%. B) By 2025, increase the percentage of Utah women who attended a postpartum check-up and received recommended care components from 84.7% (PRAMS, 2022) to 86.4%.	Analyze combined years of PRAMS data to explore disparities in who is getting a postpartum checkup and who is not to identify potential intervention strategies. Among those attending a postpartum checkup we will explore which components (mental health or contraception) are being discussed with lower frequency. We will explore by urban/rural residence, race and ethnicity, and other demographic factors.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Breastfeeding/poor infant nutrition	A) By 2025, increase the percent of infants born in Utah who are ever breastfed from 89.7% (NIS, 2015) to 89.4%. B) By 2025, increase the percent of infants born in Utah who are exclusively	1. Stepping Up for Utah Babies staff will work to bring the program into neonatal intensive care units to improve the breastfeeding initiation and continuation rates of the state's most vulnerable infants. 2. Stepping Up for Utah Babies staff and interns will create culturally relevant breastfeeding training materials to be added to the Stepping Up	ESM BF.1 - The proportion of live births that occur in facilities that have met all requirements set by the Stepping up for	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	breastfed through 6 months of age from 27.8% (NIS, 2015) to 31.1%.	for Utah Babies website for public use. 3. Utah's Women, Infants, and Children (WIC) program will continue work towards their goal to provide at least three breastfeeding peer counseling contacts to eligible WIC participants throughout the perinatal period. 4. The Healthy Environments Active Living (HEAL) program will use CDC funds to address racial and ethnic disparities in breastfeeding by increasing continuity of care for members of these under-resourced populations.	Utah Babies program to become a “Breastfeeding Friendly Facility.” ***Inactive -*** *ESM BF.2 - The percentage of eligible pregnant and postpartum WIC participants who received at least one contact from a WIC Breastfeeding Peer Counselor.* ESM BF.3 - The number of worksites that have federal lactation accommodations and breastfeeding strategies. ***Inactive -*** *ESM BF.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 BF.5 - The	through 6 months (Breastfeeding, Formerly NPM 4B) - BF	(Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			percentage of eligible pregnant and postpartum WIC participants who received at least three contacts from a WIC Breastfeeding Peer Counselor.		
Child Health					
Developmental delays	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 41.5%.	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. 4. Increase the number of programs and providers offering screenings and referrals, and promote the ASQ screening tools as universal screeners. 5. Support and promote the use of the Sparkler app, which encourages families to complete developmental screenings at regular intervals. 6. Promote the utilization of the ECIDS ASQ and advanced reports to inform the work done by early childhood programs.	***Inactive -*** *ESM DS.1 - Number of annual ASQ trainings offered by the Early Childhood Utah program* ***Inactive -*** *ESM DS.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 DS.3 - Number of pediatric, early health, early care, and early education providers that participate in the state's ASQ new provider training process annually	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			ESM DS.4 - The number of ASQ Online screenings completed through the statewide coordinated ASQ screening system annually. ESM DS.5 - The number of new programs enrolled in the DHHS ASQ Online Enterprise Account annually		
Oral health	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 84.9%.	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. Additionally, the State Dental Director, and Oral Health Educator, and Program Coordinator will provide support to both the Utah Dental Association and Utah Dental Hygienist Association boards of trustees in an advisory role. 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, develop and distribute oral health educational materials, and training to agency staff on the importance of dental care for children. The goal is to increase the percentage 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 will continue to create opportunities for dental hygiene students to attend community events such	ESM PDV-Child.1 - Collaborate with Medicaid. Percent of Medicaid children who had a preventive dental visit	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		as providing educational and resource booths at local elementary schools. 4. The OHEd along with the Dental Hygiene Liaison for Utah collaborates with the University of Utah's Physician Assistants Program for interprofessional development. 5. The OHP is planning and implementing the BSS of 3rd graders in FY24. Results will be analyzed, and a report will be created and disseminated publicly. 6. The SDD and OHP will develop and implement the State Oral Health Improvement Plan.			
Family and provider connectedness, Medical Home, and Care coordination	By 2025, increase the percent of children (ages 1 through 17) with and without special health care needs, ages 0 through 17, who have a medical home from 53.9% (NSCH, 2021-2022) to 54.5%.	The Early Childhood Utah Health and Medical Home subcommittee will develop strategies to increase insurance coverage among children ages 0-8. Increase UCCCN membership, inclusive of rural, frontier, and tribal communities through active, open, and targeted recruitment.	***Inactive -*** *ESM MH.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.* ESM MH.2 - Percent of children with special health care needs population served by the Office of CSHCN who have documented care coordination follow up as part of a medical home model of care. ***Inactive -*** *ESM MH.3 - Percentage of families who receive services from a practice participating in the Utah Children's Care Coordination*	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			Network (UCCCN) who report satisfaction with the components of the medical home. ESM MH.4 - Increase UCCCN membership, inclusive of rural, frontier, and tribal communities through active, open, and targeted recruitment.		
Adolescent Health					
Adolescent mental health	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 18.9%.	1. Improve access to and utilization of behavioral health care. VIPP will provide funding to local health departments to 1) work with local schools to implement suicide prevention programs such as Hope Squads, 2) provide training to school personnel on Question, Persuade or Refer (QPR) or Mental Health First Aid, or 3) refer families in need of behavioral health care for children to affordable options like sliding scale clinics. 2. VIPP will continue to work on improving economic stability through increasing awareness and uptake of the Earned Income Tax Credit and/or Child Tax Credit, especially to those who are disproportionately affected by poverty. 3. VIPP will provide funding to local health departments to work within their communities and with employers to promote the benefits of family friendly workplace policies such as flexible work schedules, remote work options, parental leave, childcare support, and other family-oriented benefits to ensure that parents can successfully manage their professional and family responsibilities. 4. Encourage social norms that promote safety and reduce the risk for bullying. VIPP will continue to offer Upstanding, a bystander intervention	***Inactive -*** *ESM BLY.1 - Number of parents with youth between 10-18 years of age that complete the communications course (Teen Speak).* ESM BLY.2 - The number of adolescents who receive bystander training (Upstanding) ESM BLY.3 - Percent of adolescents who are physically active at least 60 minutes per day. ESM BLY.4 - The number of youth	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		program. This program is intended to alter harmful norms around masculinity and to promote help-seeking behavior. 5. VIPP will promote educational and awareness initiatives that involve members of the firearm community in suicide prevention endeavors, including the secure storage of firearms during critical moments. VIPP will provide funding to local health departments to work on these activities at the community level. 6. The Adolescent Health Program will continue to offer the Teen Speak program for parents and Wyman's TOP program. 7. The HEAL program will work with schools to increase physical activity. 8. Enhance the physical and social environment to improve safety for children and adolescents. VIPP will continue to provide funding to local health departments to 1) build community support to improve the environment (i.e., creating safer physical environments with clean streets and safe, acceptable sidewalks); 2) work with community-based organizations and government agencies to create or improve harassment policies; 3) provide suicide prevention training for staff and promote school safety assessments; 4) support and promote community green spaces; 5) intervene at suicide hot spots by erecting barriers (e.g., bridge barriers, train barriers or signage); and/or 6) build support for creating safe spaces for youth within communities. 9. Promote individual, family, and community connectedness. VIPP has released a toolkit for promoting adolescent connectedness. VIPP will distribute the toolkit widely and will offer technical assistance to partners working on connectedness. VIPP will continue to provide funding to local health departments to 1) implement and support activities from VIPP's youth connectedness toolkits into the community, 2) build support for inclusion of safe school policies for all students regardless of race, sex, or identity, 3) develop, recruit, and reward youth participation in community coalitions, and 4) hold community events that promote community connectedness and family well-being.	participating in the Wyman Teen Outreach Program (TOP) ESM BLY.5 - Strengthen Household Economic Security through an uptick in Utah filings for the Earned Income Tax Credit ESM BLY.6 - Number of Utahns who have been trained in Question, Persuade, Refer (QPR) ESM BLY.7 - The number of parents who participate in the Families Talking Together intervention		
Economic stability	By 2025, increase the number of eligible students who participate	1. Increase the number of school food authorities that use innovative service models to make breakfast and lunch more convenient and		SPM 3: Percent of eligible students enrolled in the	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	in the National School Breakfast and Lunch Programs from 26.5% (Utah State Board of Education Child Nutrition Program Database) to 88.7%.	appealing to students, such as grab-n-go breakfast in the classroom and second chance breakfast. These ideas will be disseminated through professional learning days, statewide training, and school meetings that support school meals. 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. Increase the number of LEAs using the Wellness Policy in Action Tool (WPAT). 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. Create local education agency health and wellness teams and/or school health councils. These organizations will guide school meal services to enhance the program within schools.		free or reduced price lunch program	
Children with Special Health Care Needs					
Family and provider connectedness, Medical Home, and Care coordination	By 2025, increase the percent of children with special health care needs who have a medical home from 40.4% (NSCH, 2017-18) to 54.4%.	1. Provide funding support to internal and external partners to increase care coordination efforts throughout Utah. 2. Educate pediatric medical and service providers through the Utah Children's Care Coordination Network (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. 3. Promote hybrid telehealth/in-person service delivery model to meet the needs of the family.	***Inactive -*** *ESM MH.1 - Percent of families of CSHCN who report a change in knowledge on the importance of the medical home.* ESM MH.2 - Percent of children with special health care needs population served by the Office of	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		4. The Office of CSHCN will continue to fund external partners to enhance and expand work related to medical home. 5. UCCCN will survey the membership to ascertain training needs to enhance and expand the medical home and the applicability of that training to their organization. 6. The Office of CSHCN, the UCCCN Planning Committee, and the Medical Home Committee will advocate for a hybrid medical and behavioral health care model that includes live and virtual assessment and diagnostic visits to meet family needs. 7. UCCCN will work to increase UCCCN membership by 10% through active recruitment to other medical and social services providers across the state particularly in rural, frontier, and tribal areas.	CSHCN who have documented care coordination follow up as part of a medical home model of care. ***Inactive -*** *ESM MH.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.* ESM MH.4 - Increase UCCCN membership, inclusive of rural, frontier, and tribal communities through active, open, and targeted recruitment.		(Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Transition to adulthood	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 20.2%.	1. 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. 2. Ensure that youth of transition to adult healthcare age who receive services funded by Title V are offered care coordination and transition education. 3. ISP Transition Specialist to offer transition planning to target diagnosis groups within the Birth Defect Network registry.	***Inactive -*** *ESM TR.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*	NPM - 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 (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		4. ISP team to provide consultation, care coordination, and transition planning and support for homeless youth in Salt Lake City. 5. The Office of CSHCN will continue to convene a monthly interagency Transition to Adult Healthcare meeting to disseminate a unified transition curriculum, promote standardized messaging, and encourage and aid practices in adopting a formal transition policy. 6. The Office of CSHCN will fund a full-time transition specialist to facilitate transition activities with families served by care coordinators funded by Title V at the four contracted local health departments, ISP, and rural, frontier, and tribal families who may not have access to either care coordination or transition planning. 7. The Office of CSHCN Transition Specialist will begin outreach efforts to the pilot target population selected by the Utah Birth Defect Network through a fully executed data sharing agreement. 8. The Office of CSHCN will continue to investigate the best platform to create an adult provider database that families, pediatric providers, social service workers, and others may use to help facilitate the transfer of care from pediatrics to adult-serving providers.	*adulthood.* ESM TR.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan. ESM TR.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.		