Utah State Action Plan Table 2026 Application/2024 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					
New mothers receive needed healthcare, mental healthcare, and other needed supports to thrive during and after the postpartum period.	A) By 2030, increase the percent of Utah women who attended a postpartum checkup within 12 weeks after giving birth from 92.2% (PRAMS, 2023) to 94.6%. B) By 2030, increase the percent of Utah women who attended a postpartum checkup and received recommended care components from 77.6% (PRAMS, 2023) to 85.3%.	Organize and develop a Utah postpartum visit coalition comprised of experts and stakeholders in the state with expertise related to postpartum visits and the associated care components. Hold at least 2 meetings with the coalition to discuss the status of postpartum visits and care components in the state and what can be done to improve rates. Create and publish a strategic plan on recommendations from the coalition to inform future strategies.	ESM PPV.1 - Develop and publish a strategic plan based on findings from a postpartum visit coalition	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
New mothers receive needed healthcare, mental healthcare, and other needed supports to thrive during and after the postpartum period.	By 2030, increase the percent of Utah women who were screened for depression or anxiety following a recent live birth from 87.7% (PRAMS, 2023) to 93.5%.	Conduct a community-informed assessment to understand the experiences, perceptions, and needs of perinatal individuals related to postpartum mental health. The Maternal Mental Health Program Specialist will complete a training on the intersection of perinatal and infant mental health to support integration of infant mental health concepts into program activities. Improve coordination and referral processes between local health departments and local mental health authorities. Manage the contract with Comunidad Materna to provide maternal mental health services and support for families. Review and enhance maternal mental health screening practices within local health departments to promote consistency and follow-up.	ESM MHS.1 - Develop and implement a community-based data collection project to assess perinatal mental health opinions, experiences, and knowledge.	NPM - Postpartum Mental Health Screening	**Linked NOMs:** Maternal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Child Injury Hospitalization Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					

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Infants and families have the institutional and community support they need to reduce the risk of infant injury and mortality during the first year after birth.	A) By 2030, increase the percent of Utah infants placed to sleep on their backs from 79.0% (PRAMS, 2023) to 83.1%. B) By 2030, increase the percent of Utah infants placed to sleep on a separate approved sleep surface from 25.9% (PRAMS, 2023) to 30.5%. C) By 2030, increase the percent of Utah infants room-sharing with an adult from 75.8% (PRAMS, 2023) to 80.3%. D) By 2030, increase the percent of Utah infants placed to sleep without soft objects or loose bedding from 70.5% (PRAMS, 2023) to 75.2%.	Convene a coalition to guide development of training and educational materials on safe sleep. Create advanced training for healthcare providers and clinic staff who interact with and give parents safety information with tailored approaches for families at high risk. Train stakeholders throughout the state on the 'whys' of infant safe sleep recommendations and how to have a conversation with families about sleep planning.	ESM SS.1 - The number of safe sleep tailored materials developed and tested by a safe sleep coalition, that are ready for use by providers.	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Child Health					
All children and families thrive, have access to, and use developmentally appropriate services and consistent and family-centered healthcare.	By 2030, increase the percent of Utah children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the previous year from 38.1% (NSCH, 2022-2023) to 49.8%.	The ECU program manager will promote ASQ screenings to partners, stakeholders, and program users to increase the number of programs screening through the statewide system. The ECU program manager will offer regular technical assistance to programs screening through the DHHS online account, encouraging them to screen early and often in their contact with families. The ECU program manager will coordinate with other enterprise account holders to promote screening and participation in the statewide system. The ECU program manager will provide trainings to users of the statewide ASQ online system about the importance of referrals. The ECU program manager will track data from DHHS enterprise account	ESM DS.1 - Number of screenings entered into the statewide coordinated developmental screening systems annually. ESM DS.2 - Percent of developmental screenings for children under 3 with suspected delays who are referred to Baby Watch Part C Early Intervention services	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status

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		and reach out to programs with high rates of screenings with "concern" scores to ensure proper referrals occur, and DHHS programs will track referrals to early intervention services.	for assessment. ***Inactive -*** *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* ***Inactive -*** *ESM DS.4 - The number of ASQ Online screenings completed through the statewide coordinated ASQ screening system annually.* ***Inactive -*** *ESM DS.5 - The number of new programs enrolled in the DHHS ASQ Online Enterprise Account annually*		
All children and families thrive, have access to, and use developmentally appropriate services and consistent and family-centered healthcare.	A) By 2030, increase the percent of children without special health care needs who have a medical home from 55.5% (NSCH 2022-2023) to 60.0%.	The Office of Early Childhood (OEC) will conduct up to 10 focus groups to assess barriers to establishing a medical home for Utah families. OEC will create and publish a strategic plan based on feedback received from focus groups to inform future medical home initiative design and implementation. OEC will conduct 12 care coordination trainings at clinics throughout Utah to improve care coordination skills and raise awareness of community and state resources available. The Utah Children's Care Coordination Network (UCCCN) will continue to recruit membership statewide particularly in rural, frontier, and tribal communities to increase medical home capacity for the CSHCN population.	ESM MH.1 - Number of early childhood and healthcare professionals who attend a care coordination training. ESM MH.2 - Percent of members of Utah Children's Care Coordination Network (UCCCN) who report an increase in knowledge and skills contributing to a comprehensive	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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		The Office of CSHCN will educate medical and service providers through UCCCN on the importance of a medical home and utilize UCCN and post-training survey data to determine how participating practices are increasing medical home capacity. To ensure continuity and unity of efforts across domains, the medical home activities will be coordinated between the Office of Early Childhood, the Office of Children with Special Health Care Needs, the Office of Maternal and Child Health (Adolescent Health Program), and community partners and stakeholders.	medical home for CSHCN and their families. ***Inactive -*** *ESM MH.3 - 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.4 - Increase UCCCN membership to include rural, frontier, and tribal communities through active, open, and targeted recruitment.*		
All children have access to needed preventive oral healthcare.	By 2030, increase the percent of Utah children, ages 1 through 17, who had a preventive dental visit in the past year from 84.7% (NSCH 2022-2023) to 88.1%.	The Oral Health Educator (OHE) will provide training on the “12 Oral Health Messages” to home visiting staff. Provide an updated dental resource guide of safety-net dental clinics to state-funded Home Visiting sites statewide. The OHE will work with the DHHS Home Visiting program staff to develop a post-training survey to measure the knowledge and skills home visitors gained from preventive oral health trainings. The State Dental Director (SDD) and Oral Health Program (OHP) staff will work with the Utah Dental Association and Utah Dental Hygienist Association to encourage participation in programs for at risk children in Utah The OHE will continue to work with all dental hygiene schools on advisory committees and provide toolkits and presentations on public health dentistry	ESM PDV-Child.1 - Percent of state funded home visiting staff trained on preventive oral health strategies and dental referrals through the DHHS Oral Health Program's "12 Oral Health Messages" training. ***Inactive -*** *ESM PDV-Child.2 - Percent of Medicaid children who had a preventive dental visit*	NPM - Preventive Dental Visit - Child	**Linked NOMs:** Tooth decay or cavities Children's Health Status CSHCN Systems of Care

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		for schools. The OHE will continue to create opportunities for dental hygiene students to provide oral health education and resources at community events. The OHE will develop modules, toolkits, and trainings on oral health education and prevention strategies for elementary and middle schools. In addition, the OHE will provide these materials to dental hygiene schools and provide training to dental hygiene students who want to implement these modules. The OHP will increase oral health knowledge and interprofessional collaboration by providing educational materials and dental technical assistance to the current and future non-dental medical workforce. The OHP will create a report of the Basic School Screening survey. After the report is finalized the OHP will disseminate to stakeholders including school administrators, school nurses, and local health departments. The OHE will work with the DHHS Utah School Nurse consultant to create an oral health professional training for all school registered nurses in Utah. The training will include information on the American Academy of Pediatrics Oral Health Risk Assessment, trauma, and nutrition. Once this is finalized, they will collaborate to disseminate the training. The SDD and OHP staff will continue to develop the State Oral Health Improvement Plan and Report. The team will then publish the report and work to implement the plan over the next 5 years.			
Adolescent Health					
Adolescents have healthy adult role models both inside and outside of their homes they can trust and talk to	By 2030, increase the percent of Utah adolescents, ages 12 through 18, who have one or more adults outside the home who they can relay on for advice or guidance from 94.9% (NSCH, 2022-2023) to 96.9%.	Collaborate with internal and external partners to utilize existing advisory groups for youth focus groups and engage at least 50-100 rural and urban youth in qualitative data collection. Develop adult mentor training materials and resources for LHDs and other partners. Provide in person and virtual training and technical assistance to LHDs to	ESM ADM.1 - Percent of local health departments who complete an adult mentor action plan.	NPM - Adult Mentor	**Linked NOMs:** Adolescent Depression/Anxiety Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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as they prepare for adulthood.		support the development of an adult mentor action plan for each LHD. Explore various evidence-based program models and potential audiences for Year 2 activities and begin to build a sustainable, cost-effective structure for providing training and resources to supportive adults.			
Children with Special Health Care Needs					
All children and youth with special health care needs have access to a well-coordinated medical home and a community support structure that prepares them for a smooth transition to adult living.	By 2030, increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult healthcare from 17.6% (NSCH, 2022-2023) to 26.5%.	The Office of CSHCN will contract with the Utah Parent Center to administer Transition University. The Office of CSHCN will actively promote Transition University through Title V programs, public health networks, clinical partners, school-based programs, and community organizations. Specific attention will be directed toward rural populations to ensure access to transition supports. The Utah Parent Center will develop a six-month follow-up survey to assess Transition University participants' practical application of skills learned. The Office of CSHCN will incorporate into internal care coordination protocols to introduce and refer eligible families to Transition University beginning at age 12. The Utah Children's Care Coordination Network (UCCCN) monthly sessions and listserv will be utilized to encourage all care coordinators to make referrals to Transition University. 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. The Transition Specialist within the Office of CSHCN will continue to work with pediatric-serving primary care and specialty practices to facilitate their implementation of transition to adult healthcare policies and practices. The Transition Specialist will continue to work with adult-serving primary care and specialty practices to recruit providers who deliver comprehensive care to young adults with special health care needs. Their practice	ESM TAHC.1 - The number of participants (youth with special health care needs and their caregivers) trained on youth transition through Transition University administered by the Utah Parent Center. ***Inactive -*** *ESM TAHC.2 - Percent of adolescents and youth with special health care needs ages 12-18 who receive a transition plan.* ***Inactive -*** *ESM TAHC.3 - Percent of providers trained in transition who created a transition policy for the adolescents and youth in their practice.*	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care

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		information may be included in the adult-serving provider public on-line searchable database to be developed. The Office of CSHCN will continue to actively participate in committees, workgroups, and coalitions across the state with a focus on transition to adulthood so that the transition to adult healthcare is always a consideration in discussion, planning, and policy development and implementation.			
All children and youth with special health care needs have access to a well-coordinated medical home and a community support structure that prepares them for a smooth transition to adult living.	By 2030, increase the percent of children with special health care needs who have a medical home from 52.6% (NSCH, 2022-2023) to 61.0%.	The Office of Early Childhood (OEC) will conduct up to 10 focus groups to assess barriers to establishing a medical home for Utah families. OEC will create and publish a strategic plan based on feedback received from focus groups to inform future medical home initiative design and implementation. OEC will conduct 12 care coordination trainings at clinics throughout Utah to improve care coordination skills and raise awareness of community and state resources available. The Utah Children's Care Coordination Network (UCCCN) will continue to recruit membership statewide particularly in rural, frontier, and tribal communities to increase medical home capacity for the CSHCN population. The Office of CSHCN will educate medical and service providers through UCCCN on the importance of a medical home and utilize UCCN and post-training survey data to determine how participating practices are increasing medical home capacity. To ensure continuity and unity of efforts across domains, the medical home activities will be coordinated between the Office of Early Childhood, the Office of Children with Special Health Care Needs, the Office of Maternal and Child Health (Adolescent Health Program), and community partners and stakeholders.	ESM MH.1 - Number of early childhood and healthcare professionals who attend a care coordination training. ESM MH.2 - Percent of members of Utah Children's Care Coordination Network (UCCCN) who report an increase in knowledge and skills contributing to a comprehensive medical home for CSHCN and their families. ***Inactive -*** *ESM MH.3 - 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.4 - Increase UCCCN membership to include*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			rural, frontier, and tribal communities through active, open, and targeted recruitment.		
Cross-Cutting/Systems Building					
Families have healthy environments and access to basic needs through strengthened Title V capacity in addressing non-medical factors affecting the health of Utah families.	By 2030, making meaningful and collaborative relationships with DHHS internal and external partners that address issues such as housing instability, homelessness, and food insecurity in MCH populations. Success will be measured by the Levels of Collaboration scale with a score of 30.	Conduct a quantitative data analysis using appropriate data sources such as the National Survey of Children's Health (NSCH) and Homeless Management Information System (HMIS) to illustrate how non-medical factors influence the health and well-being of families in Utah. Maintain a live archive of data sources that can be used to monitor trends in these non-medical factors. Share the findings of the quantitative analysis with community members and providers and gather their feedback on the findings. Develop a final comprehensive report that includes community recommendations to address non-medical factors that influence the health and well-being of families in Utah. Begin work in 2026 to identify potential external partners (committees, workgroups, and CBOs) and cultivate more collaborative relationships to address non-medical factors influencing health in Utah.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Building capacity to address non-medical factors influencing health in Utah.	