HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

PENNSYLVANIA

State Snapshot

FY2025 Application / FY2023 Annual Report

November 2024

Title V Federal-State Partnership - Pennsylvania

The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY2025 Application / FY2023 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

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No Contact Information Provided

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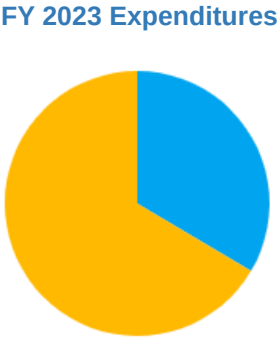
Funding by Source

Source	FY 2023 Expenditures
Federal Allocation	$24,940,352
State MCH Funds	$49,472,576
Local MCH Funds	$0
Other Funds	$0
Program Income	$0



Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$1,503,372	$9,816,594
Enabling Services	$11,153,180	$4,508,534
Public Health Services and Systems	$12,283,800	$35,147,448

FY 2023 Expenditures Federal

FY 2023 Expenditures Non-Federal

Percentage Served by Title V

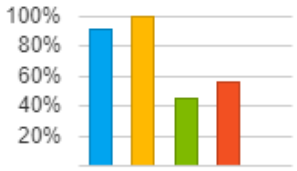
Population Served	Percentage Served	FY 2023 Expenditures
Pregnant Women	92.0%	$2,651,625
Infants < 1 Year	99.5%	$8,326,066
Children 1 through 21 Years	45.3%	$42,411,143
CSHCN (Subset of all infants and children)	56.3%	$12,802,211
Others *	0.4%	$5,735,428

*Others– Women and men, over age 21.

FY 2023 Expenditures

Total: $71,926,473

FY 2023 Percentage Served



The Title V legislation directs States to conduct a comprehensive, statewide maternal and child Health (MCH) needs assessment every five years. Based on the findings of the needs assessment, states select seven to ten priority needs for programmatic focus over the five-year reporting cycle. The State Priorities and Associated Measures Table below lists the national and state measures the state chose in addressing its identified priorities for the 2020 Needs Assessment reporting cycle. Beginning with the FY 2025 Application, all states are also reporting on two Universal National Performance Measures, Postpartum Visit and Medical Home.

State Priorities and Associated Measures

Priority Needs and Associated Measures	Reporting Domain(s)
Reduce or improve maternal morbidity and mortality, especially where there is inequity NPMs • Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV ○ ESM WWV.1: Percent of women or birthing individuals who successfully complete evidence-based or informed home visiting programs ○ ESM WWV.2: Percent of adolescents, women, and birthing individuals enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods ○ ESM WWV.3: Percent of women and birthing individuals served through the IMPLICIT ICC program that are screened for 4 behavioral risk factors during a minimum of one well-child visit ○ ESM WWV.4: Number of community-based doulas trained in communities served by the program ○ ESM WWV.5: Number of behavioral health providers trained in pregnancy intention assessment ○ ESM WWV.6: Percent of women and birthing individuals enrolled in home visiting, Centering Pregnancy and IMPLICIT that are referred for behavioral health services following a positive screening. ○ ESM WWV.7: Percent of women and birthing individuals who receive a maternal health assessment within 28 days of delivery through the 4th trimester pilot program ○ ESM WWV.8: Number of MMRC recommendations implemented annually ○ ESM WWV.9: Number of meetings held between DOH, DHS and MIECHV annually	Women/Maternal Health
Reduce rates of infant mortality (all causes), especially where there is inequity NPMs • A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF ○ ESM BF.1: Percent of Keystone 10 (K10) facilities that progressed by one or more steps each fiscal year ○ ESM BF.2: Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year ○ ESM BF.3: Convene five regional breastfeeding collaborative meetings twice per year.	Perinatal/Infant Health

Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM BF.4: Award 15 mini-grants to community partners to provide breastfeeding support each year. ● A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS ○ ESM SS.1: Number of CDR recommendations implemented annually (infant health) ○ ESM SS.2: Number of hospitals recruited to implement the model safe sleep program ○ ESM SS.3: Percentage of infants born whose parents were educated on safe sleep practices through the model program ○ ESM SS.4: Percentage of hospitals with maternity units implementing the model program ○ ESM SS.5: Number of targeted prevention initiatives or interventions implemented using Perinatal Periods of Risk (PPOR) data	
Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs NPMs ● Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV ○ ESM AWV.1: In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services ○ ESM AWV.2: Number of referrals provided to school and community-based resources (HRCs) ○ ESM AWV.3: Percent of visits that include counseling (HRCs) ○ ESM AWV.4: Number of community-based organization staff trained in the OBPP ○ ESM AWV.5: Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization ○ ESM AWV.6: The number of users who accessed the SafeTeens.org site ○ ESM AWV.7: The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line ○ ESM AWV.8: Number of substance use and brain injury professionals receiving brain injury and opioid training ○ ESM AWV.9: Number of CDR recommendations implemented (adolescent health) ○ ESM AWV.10: Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum ○ ESM AWV.11: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method ○ ESM AWV.12: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC metho	Child Health, Adolescent Health, Children with Special Health Care Needs

Priority Needs and Associated Measures	Reporting Domain(s)

• 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
  ○ ESM MH.1: Number of recommendations from CDR teams that are implemented (CSHCN)
  ○ ESM MH.2: Number of person-centered plans developed by BrainSTEPS teams
  ○ ESM MH.3: Number of families reporting satisfaction measures through surveys (Community to Home)
  ○ ESM MH.4: Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs
  ○ ESM MH.5: Fifty percent of children with asthma measured as "not well-controlled" at baseline will have "well-controlled" asthma after completing four visits (i.e., one month) in the Room2Breathe program
  ○ ESM MH.6: Number of meetings held annually between DOH and DHS (CSHCN)
  ○ ESM MH.7: Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic
  ○ ESM MH.8: Number of referrals to BrainSTEPS program
  ○ ESM MH.9: Number of calls received through the SKN Helpline
  ○ ESM MH.10: Number of community-based provider partnerships established by the Sickle Cell Community-Based programs
  ○ ESM MH.11: Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program
  ○ ESM MH.12: Number of youth age 14 and older enrolled in the Community to Home program who received a transition plan to transition to adult health care
  ○ ESM MH.13: Percentage of children without a provider referred to medical homes
  ○ ESM MH.14: Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems
  ○ ESM MH.15: Percent of families reporting through surveys that they were partners in decision making.
 	
SPMs
• SPM 5: Percent of children ages 6-17 who have one or more adult mentors	

Improve the percent of children and youth with special health care needs who receive care in a well-functioning system NPMs • 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 ○ ESM MH.1: Number of recommendations from CDR teams that are implemented (CSHCN)	Perinatal/Infant Health, Children with Special Health Care Needs

Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM MH.2: Number of person-centered plans developed by BrainSTEPS teams ○ ESM MH.3: Number of families reporting satisfaction measures through surveys (Community to Home) ○ ESM MH.4: Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs ○ ESM MH.5: Fifty percent of children with asthma measured as "not well-controlled" at baseline will have "well-controlled" asthma after completing four visits (i.e., one month) in the Room2Breathe program ○ ESM MH.6: Number of meetings held annually between DOH and DHS (CSHCN) ○ ESM MH.7: Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic ○ ESM MH.8: Number of referrals to BrainSTEPS program ○ ESM MH.9: Number of calls received through the SKN Helpline ○ ESM MH.10: Number of community-based provider partnerships established by the Sickle Cell Community-Based programs ○ ESM MH.11: Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program ○ ESM MH.12: Number of youth age 14 and older enrolled in the Community to Home program who received a transition plan to transition to adult health care ○ ESM MH.13: Percentage of children without a provider referred to medical homes ○ ESM MH.14: Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems ○ ESM MH.15: Percent of families reporting through surveys that they were partners in decision making. SPMs ● SPM 1: Percent of newborns with on time report out for out of range screens ● SPM 3: Increase the percent of hospitals making referrals to Early Intervention (EI) ● SPM 4: Percent of eligible infants with a Plan of Safe Care	
Reduce rates of child mortality and injury, especially where there is inequity NPMs ● Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child ○ ESM IH-Child.1: Number of recommendations from CDR teams that are implemented (child health) ○ ESM IH-Child.2: Number of ConcussionWise trainings to athletic personnel ○ ESM IH-Child.3: Number of comprehensive in-home child safety education visits.	Child Health, Adolescent Health

Priority Needs and Associated Measures	Reporting Domain(s)
○ ESM IH-Child.4: Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits. ○ ESM IH-Child.5: The number of child injury prevention and Child Death Review professionals who attend child injury prevention summits hosted by the Safe Kids Pennsylvania State Office and the Bureau of Family Health ○ ESM IH-Child.6: Percent of Pennsylvania counties within the Safe Kids affiliate network ● Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV ○ ESM AWV.1: In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services ○ ESM AWV.2: Number of referrals provided to school and community-based resources (HRCs) ○ ESM AWV.3: Percent of visits that include counseling (HRCs) ○ ESM AWV.4: Number of community-based organization staff trained in the OBPP ○ ESM AWV.5: Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization ○ ESM AWV.6: The number of users who accessed the SafeTeens.org site ○ ESM AWV.7: The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line ○ ESM AWV.8: Number of substance use and brain injury professionals receiving brain injury and opioid training ○ ESM AWV.9: Number of CDR recommendations implemented (adolescent health) ○ ESM AWV.10: Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum ○ ESM AWV.11: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method ○ ESM AWV.12: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC metho	
Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development SPMs ● SPM 2: Increase the number of programs or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	Perinatal/Infant Health, Cross-Cutting/Systems Building
Support and effect system change by promoting policies, programs and actions that advance health equity, address social determinants of health and deconstruct systems of institutionalized oppression NPMs	Adolescent Health, Cross-Cutting/Systems Building

Priority Needs and Associated Measures	Reporting Domain(s)

• Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
  ○ ESM AWV.1: In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services
  ○ ESM AWV.2: Number of referrals provided to school and community-based resources (HRCs)
  ○ ESM AWV.3: Percent of visits that include counseling (HRCs)
  ○ ESM AWV.4: Number of community-based organization staff trained in the OBPP
  ○ ESM AWV.5: Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization
  ○ ESM AWV.6: The number of users who accessed the SafeTeens.org site
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  ○ ESM AWV.9: Number of CDR recommendations implemented (adolescent health)
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  ○ ESM AWV.11: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method
  ○ ESM AWV.12: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC metho
 	
SPMs
• SPM 6: Rate of mortality disparity between Black and white infants
• SPM 7: Rate of mortality disparity between black and white children, ages 1-4
• SPM 8: Rate of maternal mortality disparity between Black and white persons	

Executive Summary

Program Overview

The Bureau of Family Health (BFH) as the Pennsylvania (Pa.) Title V administrator serves an estimated 2.6 million individuals of the maternal and child health (MCH) population annually, using over $76 million of Title V, state match, and other federal funding to support programming, state-level program management, and public health systems. In partnership with over 45 grantee and partner groups, the BFH applies a life course approach across the Title V population domains. An intentional effort to apply a health equity mindset to improve the health and well-being of the most underserved and expand the scope of work of Title V in Pa. to include an examination of a range of social determinants of health (SDOH) –most importantly those systems and policies reinforcing discrimination and increasing the allostatic load of populations marginalized by institutional systems of oppression and power – is foundational.

The BFH continues its workforce development efforts to strengthen staff's ability to use data to make evidence-based decisions in program planning, implementation, and evaluation. Title V program staff seek out training and professional growth opportunities complementing these efforts. In 2020, BFH developed a biweekly resource email consisting of a variety of live and recorded webinars, articles, and tools to aid in establishing common understanding of concepts, such as health equity and SDOH, amongst staff. Health equity remains a key and guiding priority for BFH. Consequently, the BFH brings the discussion of health disparities and equity to the forefront internally through workforce development efforts and mandated training for BFH staff and, externally, through the integration of health equity language into grant agreements and participation in learning collaboratives, task forces, and book clubs. The BFH has begun and will continue to provide technical assistance and guidance to grantees on the development of localized health disparities plans and the use of evidence-based practices for populations at greatest risk for poor health outcomes.

The BFH continues to implement components of a family engagement workplan, which involves increasing awareness, guidance, and assistance on developing and implementing strategies that meaningfully engage the populations being served in the design, conduct, and evaluation of MCH programs, policies, and systems.

In addition, the BFH recognizes the importance of engaging and partnering with community-based organizations led by and serving communities of color to co-create anti-racist strategies to dismantle systemic inequities impacting birth outcomes. Accordingly, the BFH has been and will continue to work collaboratively through various initiatives to prevent preterm birth while protecting positive birth outcomes and perinatal health in communities of color. The BFH plans to apply lessons learned from these efforts in the development of future programming.

As part of its systems-building work, the BFH has implemented processes to maintain a continuous cycle of feedback through interim needs assessment surveys, focus groups, and client satisfaction initiatives. Through this work, the BFH aims to ensure all MCH voices, including those most underserved, are heard. These processes were further actualized through the Five-Year Needs and Capacity Assessment completed in 2019 and the most recent Interim Needs Assessment Update in 2023.

The BFH was committed to performing a comprehensive and transparent needs assessment that engaged partners at each phase and identified the most pressing MCH health needs. Areas of need among the MCH health populations became evident following analysis of state and national data and through conversation with families and providers across the state. Among women and birthing people in Pa., access and receipt of timely prenatal care remains a challenge, rates of maternal morbidity and mortality are rising, and women and birthing people are increasingly in need of services and support for perinatal depression and substance use. Perinatal health in Pa. is continually impacted by infant mortality and preterm births. Other ongoing needs among infants include breastfeeding support and timely report out to a physician after an abnormal newborn screen. Among children and adolescents, bullying and injury remain risk factors associated with adverse health outcomes and supports are needed to promote reproductive, developmental, and mental health. The health of children with special healthcare needs (CSHCN) could be improved through increased access to a well-functioning system of care, including transition services. CSHCN are also disproportionately impacted by bullying and need support to achieve positive developmental and mental health outcomes. Both data and the lived experiences of service recipients confirm that racial and ethnic minoritized communities in Pa. continue to experience adverse health outcomes at a higher rate, as do lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) persons and CSHCN. As such, an overarching focus on advancing health equity remains an important mission of the BFH.

Based on these data and the input of service recipients, providers, and partners, the BFH adopted the following seven priorities to guide the 2021-2025 state action plan: 1) Reduce or improve maternal morbidity and mortality, especially where there is inequity; 2) Reduce rates of infant mortality (all causes), especially where there is inequity; 3) Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs; 4) Improve the percent of children and youth with special health care needs who receive care in a well-functioning system; 5) Reduce rates of child mortality and injury, especially where there is inequity; 6) Strengthen Title V staff's capacity for data-driven and evidence-based decision-making and program development; and 7) Support and effect change at the organizational and system level by supporting and promoting policies, programs and actions that advance health equity, address the social, environmental and economic determinants of health and deconstruct institutionalized systems of oppression.

The BFH recognizes the importance of evaluating performance and adapting to meet the ever-changing needs of the MCH populations in Pa. The strategies, objectives achieved, and lessons learned from the 2015-2020 action plan inform the work of this cycle. Given that the scope of direct services is limited by program capacity and funding, the BFH sees an opportunity to enhance existing strategies and develop system-level strategies to address maternal health. Ongoing work to ensure that women, birthing individuals, and mothers in Pa. have the support and services they need before, during, and after pregnancy includes home visiting, group prenatal care through Centering Pregnancy, and implementation of innovative preconception and interconception care

models. In addition to increasing access and use of services that are protective and may decrease the likelihood of maternal morbidity and mortality, the BFH supports Title V strategies including implementing community-based maternal care models such as a doula program and a fourth trimester pilot program aimed at improving care in the postpartum period. The BFH will use Maternal Mortality Review Committee (MMRC) recommendations to inform Title V programming and collaborate with other state and local agencies to ensure that funds are being leveraged to deliver non-duplicative services. These efforts aim to drive improvement in the Well-Woman Visit National Performance Measure around increasing women's access to and use of preventive medical services.

Among infants, the BFH seeks to enhance existing strategies to serve high-risk populations with gap-filling direct and enabling services and to expand systems-level work. Strategies related to promoting breastfeeding awareness and reducing sleep--related sudden unexpected infant death will continue to be implemented to prevent infant mortality and promote positive health outcomes among newborns. As the BFH continues its work to support the system of care for infants, it will also carry on with efforts to promote newborn screening of all infants and seek new collaborations to ensure that gaps in services are being identified and met by Title V to the extent possible. Newborn screening efforts aim to drive improvement in a state performance measure (SPM) around timeliness of report-out to a physician after receipt of an abnormal result. Strategies to address infant mortality include support and referral for infants with neonatal abstinence syndrome, efforts to build the capacity of Child Death Review (CDR) teams to review premature infant deaths, and use of CDR recommendations to inform future programming.

Among children, in addition to enhancing the existing capacity of CDR teams, the BFH aims to address behavioral, mental, and developmental health needs among children and to develop systems-level strategies addressing trauma. Updated programming around maintaining a home free of hazards will continue to drive improvement in the child injury and mortality rates. Title V will also continue to support CDR and efforts aimed to reduce head injury and concussion among youth. Over the course of the funding cycle, the BFH will seek to use CDR recommendations to inform future programming and develop system-level strategies to complement and enhance existing programming on child injury prevention and trauma. These efforts aim to drive improvement in the Injury Hospitalization NPM around reducing the rate of hospitalization for non-fatal injury among children.

For the CSHCN domain, the BFH will continue to administer direct and enabling programming aimed at providing children with well-coordinated, family-centered care. Gap-filling home visiting services for CSHCN will continue as will strategies supporting students with return to school settings following an acquired brain injury. Other Title V-supported strategies related to the provision of screening and specialty care to children with conditions such as sickle cell anemia and autism spectrum disorder will also continue. Other strategies, such as efforts associated with improving access to a medical home, have been adapted over the course of the funding cycle and new strategies related to improving access to transition services have been developed. Moving forward, CSHCN programming may also be informed by CDR recommendations, especially those related to reducing and addressing experiences with trauma. Additional strategies designed to strengthen the public health services and systems which support a well-functioning system of care are being identified over the course of the funding cycle. These efforts aim to drive improvement in the NPM around increasing the percent of CSHCN who have accessible, family-centered, continuous, comprehensive, and coordinated care, ideally in a medical home.

Among adolescents, the BFH sees an opportunity to enhance existing gap-filling direct and enabling services and to develop a system-level strategy addressing mental and behavioral health. Existing strategies which help youth establish protective factors associated with positive mental, behavioral, and developmental health outcomes will continue, including bullying prevention and mentoring programming. Title V funds continue to support services for LGBTQ youth, as well as reproductive health services and programming aimed to promote healthy relationships for youth in Pa. A youth advisory committee will also provide a mechanism to gather youth input on relevant issues and better ensure strategies developed are reflective and respectful of the communities being served. These strategies serve to advance the mental, behavioral, and developmental health priority, the priority aiming to address child mortality, a SPM which aims to assess the percentage of youth in Pa. who have a mentor, and the NPM around increasing youth access to and use of preventive medical care.

For the cross-cutting domain, the BFH continues to prioritize efforts to build staff capacity to analyze and use data from sources such as the Pregnancy Risk Assessment Monitoring System (PRAMS) and the National Survey of Children's Health (NSCH) and efforts are made to ensure that data from the CDR and the MMRC are reviewed and utilized to inform program design, planning, and implementation. These efforts connect to priority 6 and aim to drive improvement in tracking the extent to which policies and programs are modified as a result of data use and review of available evidence. Additionally, a strategy connecting to priority 7 aims to continue to build knowledge and understanding of health equity in the BFH. This strategy, and others developed over the course of the funding cycle, aims to drive improvement in the new SPM which will track the marked disparities between Black and white persons for key MCH indicators – mortality rates among infants, children, and mothers.

The BFH intends to achieve its objectives, maintain infrastructure, and support public health services and systems through partnerships. BFH works with local Title V agencies and selects partners throughout the state to provide public health, enabling, or direct services to the MCH population. BFH uses population and public health data to identify areas or populations for interventions, and then selects qualified grantees. For all grant agreements, BFH staff develop objectives, work statements, and budgets, and provide oversight and monitoring of grantee progress toward the stated goals. The BFH also coordinates efforts and collaborates with other Bureaus within the Department of Health (DOH) as well as with agencies at the local, state, and federal level. Given that many other organizations share the mission of advancing the health of MCH populations in Pa., remaining abreast of the work of these other entities remains essential. Convening of regular cross-agency meetings has been incorporated into the action plan and these intra- and interagency relationships, and the corresponding work, have been and will continue to be formalized through the creation of memoranda of understanding.

Given the breadth of the BFH's work to support the MCH system of care in Pa. and the ebb and flow of other funding sources, the BFH continually evaluates how Title V funds can be leveraged and combined with other state and federal funds to make the most positive impact on population health outcomes. As programming, other activities, and agencies receive Title V funds, the BFH will

continually ensure that work is represented on its action plan with corresponding performance measures for accountability and to ensure that dollars are spent as intended to advance specific MCH outcomes.

While spotlight issues rightly shape the agenda of the DOH, the BFH must continue to lead the work of Title V to look and listen for those bearing an unequitable burden of disease, injury, or mortality as their needs do not dissipate in the face of emergent issues. The inherent flexibility of the Title V funding allows the BFH to adapt to emerging issues and DOH priorities while maintaining the ability to address and innovate around ongoing MCH population needs over the long-term. This approach gives the populations most marginalized by institutional systems of oppression and power the best chance at achieving a higher quality of life through improved health and well-being.

How Federal Title V Funds Complement State-Supported MCH Efforts

The Bureau of Family Health (BFH) expends federal and state Title V funds to support maternal and child health (MCH) populations in accordance with Title V and other federal and state guidelines with the goal of protecting and promoting the health and well-being of women, birthing people, children, and families. In Federal Fiscal Year 2023 (FFY23), $24,940,352 federal Title V dollars were expended, $10,788,713 on preventive and primary care for children, $8,749,513 on children with special health care needs (CSHCN), and $2,486,455 on administrative costs. Pennsylvania (Pa.) bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations; $49,472,576 state funds were expended in FFY23. Additionally, the BFH expended $6,774,882 in other federal funds implementing MCH programming. Total state and federal Title V expenditures for FFY23 were $74,412,928. In Pa., state match funds primarily support services for infants, children, and CSHCN. As such, federal Title V funds are used to augment the systems of care for those populations while also providing support for pregnant women, birthing people, mothers, and the MCH workforce. Over time, Pa. has increased its capacity to serve a greater proportion of the MCH population by shifting reimbursable direct service expenditures to the appropriate payors and utilizing federal and non-federal Title V funds for population health programs, such as school health services and newborn screening.

MCH Success Story

Since 2018, the BFH has administered an Autism Diagnostic Clinic (ADC) through partnership with Easterseals Eastern Pennsylvania (ESEP), in collaboration with Children's Hospital of Philadelphia (CHOP) and Saint Christopher's Hospital for Children (St. Christopher's), using telehealth technology, the first of its kind in Pennsylvania (Pa.). Access to evaluations for autism spectrum disorder (ASD) is limited throughout Pa. In a traditional model, a child may not be identified for diagnostic testing until school age. After identifying the need for testing, families often encounter wait times from 12 to 18 months for a diagnosis, time critical to the child's development. Once diagnosed, a family may wait up to a year for supportive services to begin. These delays may impact the child's development. The use of telehealth in the ADC expedites the diagnostic process and facilitates the initiation of appropriate treatments. The ADC evaluates children aged 18 months to three years at risk for autism. Children are referred by Early Intervention (EI), where they have been screened using the Modified Checklist for Autism in Toddlers. The assessment is conducted in the child's home by a specially trained occupational therapist while videoconferencing with a Developmental Pediatrician and a Certified Nurse Practitioner from CHOP or St. Christopher's. Following the evaluation, the family receives the results, treatment recommendations, information, and referrals from the team of occupational therapist, service coordinator from EI, Developmental Pediatrician and Certified Nurse Practitioner. The ADC then facilitates referrals to service providers within the family's community. While waiting for formal services to begin, the family is provided with parent coaching sessions which include therapeutic principals and caregiver-peer support. This allows families to begin working with their child therapeutically as they wait for services, as well as providing a basis for the parents to assess delivery and effectiveness when services begin.

Participation in the ADC has increased each year. Since implementation, a total of 499 children have been evaluated, with 439 or 88% receiving a diagnosis of autism. All who received a diagnosis of ASD and their families received supportive services and referrals to additional services. The ADC has expanded from one to six counties since implementation and contracts bilingual clinicians, reaching people who have been historically underserved.

The BFH and ESEP applied to AMCHP to have the ADC reviewed for inclusion in the Innovation Hub. The ADC received the Cutting-Edge designation in 2021. AMCHP invited ESEP to present the ADC at the 2021 AMCHP Conference. ADC progressed to Emerging practice in 2022. In 2022-2023, the Drexel University Institute on Autism (Drexel) conducted a formal evaluation of the ADC and developed a replication plan. Drexel reviewed data, interviewed ESEP staff and families who participated in the ADC, and compared the program to literature for related programming. The evaluation, completed in 2023, confirmed the ADC was effectively lowering the age of identification by as much as three years, reducing wait times (by six months to a year), increasing access, and showing signs of improving long-term outcomes, though a more longitudinal study would need to be done. Drexel completed the replication guide and the BFH is moving to expand the program by July 2025. ESEP has also shared the ADC's results with Easterseals National and will be presenting the ADC model at the Easterseals 2024 Annual National Conference.

Maternal and Child Health Bureau (MCHB) Discretionary Investments - Pennsylvania

The largest funding component (approximately 85%) of the MCH Block Grant is awarded to state health agencies based on a legislative formula. The remaining two funding components support discretionary and competitive project grants, which complement state efforts to improve the health of mothers, infants, children, including children with special needs, and their families. In addition, MCHB supports a range of other discretionary grants to help ensure that quality health care is available to the MCH population nationwide.

Provided below is a link to a web page that lists the MCHB discretionary grant programs that are located in this state/jurisdiction for Fiscal Year 2023.

List of MCHB Discretionary Grants

Please note: If you would like to view a list of more recently awarded MCHB discretionary investments, please refer to the Find Grants page that displays all HRSA awarded grants where you may filter by Maternal and Child Health.