Pennsylvania 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					
Reduce or improve maternal morbidity and mortality, especially where there is inequity	Increase the percent of women who successfully complete evidence-based or -informed home visiting programs by 2% each year Annually increase the percent of adolescents and women who talked with a health care professional about birth spacing or birth control methods by 1% Increase the percent of women enrolled in IMPLICIT ICC program screened for risk factors during well-child visits by 1.5% each year Increase the number of community-based doulas providing services in targeted neighborhoods Increase the number of behavioral health providers trained in pregnancy intention assessment Increase the percent of women enrolled in Title V home visiting, Centering Pregnancy, and IMPLICIT programs that are referred for services by 1% annually, following a positive	Increase the percent of women who successfully complete evidence-based or informed home visiting programs Increase the percent of adolescents and women enrolled in centering pregnancy programs who talk with a health care professional about birth spacing or birth control methods Implement care models that include preconception and interconception care Implement community-based, culturally relevant maternal care models Implement care models that include maternal behavioral health screenings and referral to services Implement care models that encourage women to receive care in the early postpartum period Use Maternal Mortality Review Committee (MMRC) recommendations to inform programming Initiate regular meetings and collaboration between DOH, DHS, and MIECHV	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	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

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	screening Increase the percent of women that receive early postpartum care through a 4th trimester pilot program, compared to the year 1 baseline data, by at least 3% annually, starting with reporting year 2022 Implement a minimum of 1 MMRC recommendation annually Convene quarterly meetings between agencies that provide services related to maternal health		ESM WWV.4 - Number of community-based doulas trained in communities served by the program ***Inactive -*** *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		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,

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			ESM WWV.8 - Number of MMRC recommendations implemented annually ESM WWV.9 - Number of meetings held between DOH, DHS and MIECHV annually		Formerly NOM 24) - PPD
	A Five-Year Objective has not yet been established.	Strategies for this NPM have not yet been established.	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					
Reduce rates of infant mortality (all causes), especially where there is inequity	Annually increase the percent of PA birthing facilities designated as a Keystone 10 facility each fiscal year Annually identify and develop collaborative opportunities between the Safe Sleep Program and the Breastfeeding Program Annually provide breastfeeding education, and community outreach to improve breastfeeding initiation and duration rates	Facilitate the adoption and implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within PA birthing facilities Collaborate with the Safe Sleep Program to promote and support breastfeeding within each program Collaborate with community-based organizations to increase breastfeeding initiation and duration rates statewide	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	NPM - 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	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 (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

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			five regional breastfeeding collaborative meetings twice per year. ESM BF.4 - Award 15 mini-grants to community partners to provide breastfeeding support each year.		
Reduce rates of infant mortality (all causes), especially where there is inequity	Annually increase the number of recommendations from CDR teams related to preventing infant death that are reviewed for feasibility and implemented each year Increase the number of birthing hospitals implementing the hospital-based model safe sleep program by 3% annually Increase the number of targeted prevention initiatives or interventions implemented utilizing PPOR data	Use Child Death Review data to inform infant programming Implement a hospital-based model safe sleep program Use data, as determined by the 6-step LG (PPOR) process, to implement prevention initiatives or interventions in the selected communities	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	NPM - 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	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 (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

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			ESM SS.5 - Number of targeted prevention initiatives or interventions implemented using Perinatal Periods of Risk (PPOR) data		
Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Increase the number of requested repeat filter papers obtained each year to expedite diagnosis and treatment Annually increase the percent of newborns receiving a DBS screening Perform a data comparison and match newborns who were reported as SUID to the CDR teams with newborns in the Pennsylvania Internet Case Management System (iCMS) to determine if any infant reported to have expired had abnormal DBS, CCHD, or NAS results or missed initial timely screening that may have contributed to demise	Review and analyze data from iCMS to identify submitters with requested repeat filter papers obtained; provide non-compliant submitters with technical assistance and information on best practices to improve their follow-up process Utilize the match with the Vital Records Registry to identify newborns with a dried blood spot (DBS) screening Work with the Child Death Review (CDR) program to determine possible opportunities to collaborate		SPM 1: Percent of newborns with on time report out for out of range screens	
Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Annually increase the number of reviews by local CDR teams of prematurity deaths that include identification of the underlying causes of death	Increase access to and use of Child Death Review data sources to enhance program planning, design and implementation			

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Child Health					
Reduce rates of child mortality and injury, especially where there is inequity	Annually increase the number of recommendations from CDR teams related to preventing child death that are reviewed for feasibility and implemented each year Annually increase the number of ConcussionWise trainings provided by the safety and youth sports program to athletic personnel by 2 per year	Use Child Death Review data to inform child safety programming Reduce head injury amongst participants in school and non-school related sports	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. 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	NPM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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			Kids Pennsylvania State Office and the Bureau of Family Health ESM IH-Child.6 - Percent of Pennsylvania counties within the Safe Kids affiliate network		
Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	Community Health Nurses will provide information about available medical homes to all families without a provider or insurance and that have children, ages 0-17 during visits to the SHC	Community Health Nurses will provide information about available medical homes to all families without a provider or insurance and that have children, ages 0-17 during visits to the SHC	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 ***Inactive -*** *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	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

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			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 ***Inactive -*** *ESM MH.9 - Number of calls received through the SKN Helpline* ESM MH.10 - Number of community-based provider partnerships established by the		

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			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 ***Inactive -*** *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		

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			(FQHC) health systems ESM MH.15 - Percent of families reporting through surveys that they were partners in decision making.		
	A Five-Year Objective has not yet been established.	Strategies for this NPM in this domain have not yet been established.	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 ***Inactive -*** *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	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

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			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 ***Inactive -*** *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		

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			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 ***Inactive -*** *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		

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			systems ESM MH.15 - Percent of families reporting through surveys that they were partners in decision making.		
Adolescent Health					
Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	Annually increase the number of youth ages 12-17 utilizing HRC services by 2% each year Annually increase the number of community-based organization staff trained in a bullying awareness prevention program by 5% each year Annually increase the number of users who access SafeTeens.org by 2% each year Annually increase the number of text messages received on the SafeTeens Answers! text line by 2% each year Increase the number of brain injury and Opioid trainings provided to substance use and brain injury rehabilitation programs by 1 per year	Improve the mental and behavioral health of youth while increasing access of care for youth through Health Resource Centers (HRCs) Improve interpersonal relationships among youth through staff training and implementation of the Olweus Bullying Prevention Program (OBPP) for Community Youth Organizations Increase the dissemination of information to youth through social media and other technology-based platforms Individuals working in the field of drug and alcohol or brain injury will have a greater understanding of the correlation between substance use and brain injury	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	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide 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

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			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		(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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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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		(Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	Annually increase the number of youth participating in evidence-based or evidence-informed mentoring programs by 50 participants each year Increase the percentage of LGBTQ-identified youth participating in an evidence-based or evidence-informed program who report increased positive coping strategies, specifically, support-seeking, problem-solving, distraction, and escape strategies by .02% over the course of the program	Increase protective factors and improve interpersonal relationships for youth through evidence-based or -informed mentoring programs Increase protective factors for LGBTQ-identified youth through evidence-based or evidence informed behavioral health programs		SPM 5: Percent of children ages 6-17 who have one or more adult mentors	
Reduce rates of child	Annually increase the number of recommendations from CDR	Implement Child Death Review (CDR) recommendations as they become available	ESM AWV.1 - In schools with a Health	NPM - Percent of adolescents, ages 12	NOM - Adolescent mortality rate ages 10 through 19, per 100,000

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mortality and injury, especially where there is inequity	teams related to preventing adolescent deaths that are reviewed for feasibility and implemented each year Annually increase young adult and adolescent males receiving trainings through the Coaching Boys into Men Curriculum by 4 per year	Young adult and adolescent males will increase their understanding of healthy relationships through evidence-based or -informed programs	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	through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	(Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide 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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th

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			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		percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

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			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		
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	Increase the percentage of clients who are provided a most effective or moderately effective contraceptive method by 3% by June 30, 2022	Increase the number of youth who are receiving sexual health services and education, including effective contraception methods	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	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide 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

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			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		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 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

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			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		NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Children with Special Health Care Needs					
Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	Annually increase the number of recommendations from CDR teams related to preventing CSHCN death that are reviewed for feasibility and implemented each year	Prevention recommendations from CDR teams, including recommendations related to addressing trauma will be regularly reviewed and implemented	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 ***Inactive -*** *ESM MH.3 - Number of families reporting satisfaction measures through surveys (Community to Home)*	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

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			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		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
			Inactive - *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 ***Inactive -*** *ESM MH.13 - Percentage of children without a*		

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			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.		
Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Annually increase the percentage of reported NAS cases receiving a referral to EI	Review and analyze neonatal abstinence syndrome (NAS) cases reported in iCMS to identify birth hospitals that are not making Early Intervention (EI) Referrals and provide technical assistance to improve referral rates		SPM 3: Increase the percent of hospitals making referrals to Early Intervention (EI)	
Improve the percent of children and youth with special health care needs who receive care in a well-functioning	Annually identify and develop collaborative opportunities to share data and trends in NAS reporting and follow-up.	Collaborate with the Office of Children, Youth, and Families (OCYF) to help support the enrollment into Plan of Safe Care.		SPM 4: Percent of eligible infants with a Plan of Safe Care	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
system					
Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Annually increase the number of person-centered plans developed with the BrainSTEPS teams by 5% each year Annually increase the number of families reporting through satisfaction surveys that they were partners in decision making through the Community to Home program by 5% Annually increase the number of collaborative agreements with medical providers through the Sickle Cell Community-Based program by 8 per year Annually increase the percentage of CSHCN receiving quality care through project-funded FQHC health systems. Increase the percent of families who successfully complete the Room2Breathe asthma home visiting program by 3% annually Convene quarterly meetings between agencies that provide services related to CSHCN Annually increase the number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic by 5 each year	Families are partners in decision making, and are satisfied with the services received CSHCN receive coordinated, ongoing, comprehensive care within the medical system Initiate regular meetings and collaboration between DOH and DHS CSHCN are screened early and continuously for special health care needs Community based services are organized so families can use them easily Youth with SHCN receive services to make appropriate transitions	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 ***Inactive -*** *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	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
	Conduct outreach and BrainSTEPS program promotion to increase referrals by 15 per year Annually increase the number of calls received through the SKN helpline by 25 calls Annually increase the number of partnerships engaging community-based providers established by the Sickle Cell Community-Based program by 8 per year Annually increase the number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program by 4 per year Of youth age 14 and older being served in Community to Home, 50% will have appropriate transition plans within 6 months of receiving services		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 ***Inactive -*** *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 -		

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			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 ***Inactive -*** *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.		

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Cross-Cutting/Systems Building					
Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Review BFH programs to evaluate existing data sources and provide supplemental data sources where available to at least 10% of programs per year Disseminate annual NSCH data to program staff after it is released on childhealthdata.org each year to support and develop MCH programming Annually produce and disseminate at least two PRAMS data analysis products Annually increase the number of reviews by local CDR teams that include identification of the underlying causes of death	Assess BFH programs to determine existing data and determine methods for sharing data with internal and external partners Increase staff access and use of National Survey for Children's Health data sources to enhance program planning, design and implementation To use PRAMS to conduct epidemiological surveillance of the maternal and child health population in PA Increase the number and quality of local CDR team reviews to enhance program planning, design and implementation		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	
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	Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff	Increase staff understanding of Health Equity principles		SPM 6: Rate of mortality disparity between Black and white infants	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
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	Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff	Increase staff understanding of Health Equity principles		SPM 7: Rate of mortality disparity between black and white children, ages 1-4	
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	Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff	Increase staff understanding of Health Equity principles		SPM 8: Rate of maternal mortality disparity between Black and white persons	