Pennsylvania 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					
Behavioral Health During Pregnancy and Postpartum	By 2030, improve the utilization of behavioral health resources by pregnant, postpartum, and parenting women by 1% annually By 2030, attend regular meetings (at least 75% of all meetings held per year) of the whole group and subgroups, sharing Pennsylvania's State Action Plan components related to Postpartum Visit with peers, and providing feedback and suggestions to other states' State Action Plans as appropriate	Increase the percentage of caregivers with a positive depression, intimate partner violence, or substance use screenings who receive services Actively participate in the Big 6 Peer Learning Initiative and its Postpartum Visit Subgroup	ESM PPV.1 - Percentage of pregnant and postpartum women participating in home visiting who receive behavioral health services after receiving a positive screening for depression, intimate partner violence, or substance use. ESM PPV.2 - Percent of regular peer learning meetings attended with active participation in presenting and/or responding to peer discussion	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
High Quality and Respectful Maternal Healthcare	By 2030, at least 90% of community-based doulas trained supported with Title V funding will have completed the Commonwealth's Certified Perinatal Doula certification process	Increase the percent of community-based doulas trained supported with Title V funding who achieve certification as Certified Perinatal Doulas	ESM DSR.1 - Percent of newly-trained community-based doulas supported with Title V funding who achieve certification as Certified Perinatal Doulas ESM DSR.2 -	NPM - Perinatal Care Discrimination	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Preterm-Related Mortality

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			Percent of eligible counties with at least one Perinatal Periods of Risk (PPOR) study completed or in progress		Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Optimal Health and Wellbeing for Infants	By 2030, at least 57.3% of children ages 0-5 will be living with a parent/caregiver who reports they are coping well with the day-to-day demands of raising children	Increase the percent of parents/caregivers of children ages 0-5 who are able to cope very well with the day-to-day demands of raising children with the provision of services, supports, and education to improve child safety	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percent of children ages 0-5 years old living with a parent/caregiver who is coping very well with the demands of raising children	
Preterm Birth and Preterm-Related Mortality	By 2030, at least 42% (8) of Pennsylvania's 19 eligible counties will have started and/or completed the Perinatal Periods of Risk (PPOR) process	Increase the percent of eligible counties with at least one Perinatal Periods of Risk (PPOR) study completed or in progress	ESM DSR.1 - Percent of newly-trained community-based doulas supported with Title V funding who achieve certification as Certified Perinatal Doulas ESM DSR.2 - Percent of eligible counties with at least one Perinatal Periods of Risk (PPOR) study completed or in progress	NPM - Perinatal Care Discrimination	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Preterm-Related Mortality Postpartum Depression Postpartum Anxiety
Child Health					
Early Childhood Development and Optimal Health	By 2030, at least 73% of children ages one to five enrolled in Parents as Teachers will receive age-appropriate developmental screenings	Increase parental knowledge of early childhood development and positive parenting practices through Parents as Teachers	ESM DS.1 - Percent of children, ages one to five years enrolled in Parents as Teachers, who receive	NPM - Developmental Screening	**Linked NOMs:** School Readiness Children's Health Status

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			age-appropriate developmental screenings		
Early Childhood Development and Optimal Health	By 2030, attend regular meetings (at least 75% of all meetings held per year) of the whole group and subgroups, sharing Pennsylvania's State Action Plan components related to Medical Home with peers, and providing feedback and suggestions to other states' State Action Plans as appropriate	Actively participate in the Big 6 Peer Learning Initiative and its Medical Home Subgroup	ESM MH.1 - Percent of regular peer learning meetings attended with active participation in presenting and/or responding to peer discussion ESM MH.2 - Percentage of counties providing diagnostic services and follow-up care coordination resources through the autism diagnostic clinic (ADC) program. ESM MH.3 - Percentage of CYSHCN living in rural Pennsylvania reporting they received care coordination services which support their health and wellness needs through surveys upon through Community to Home (C2H) program discharge. ESM MH.4 - Percentage of CSHCN receiving	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
			care coordination project services in federally qualified health centers (FQHCs). ESM MH.5 - Percentage of individuals with sickle cell disease (SCD) receiving care coordination through the Community Based Services and Supports (CBSS) program. ***Inactive -*** *ESM MH.6 - Number of recommendations from CDR teams that are implemented (CSHCN)* ***Inactive -*** *ESM MH.7 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs* ***Inactive -*** *ESM MH.8 - Number of person-centered plans developed by BrainSTEPS teams* ***Inactive -*** *ESM MH.9 - Number of medical provider collaborative agreements*		

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			established by the Sickle Cell Community-Based programs ***Inactive -*** *ESM MH.10 - 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* ***Inactive -*** *ESM MH.11 - Number of meetings held annually between DOH and DHS (CSHCN)* ***Inactive -*** *ESM MH.12 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic* ***Inactive -*** *ESM MH.13 - Number of referrals to BrainSTEPS program* ***Inactive -*** *ESM MH.14 - Number of youth with special health care needs receiving evidence-*		

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			based or -informed leadership development training through the Leadership Development and Training Program ***Inactive -*** *ESM MH.15 - 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.16 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems* ***Inactive -*** *ESM MH.17 - Percent of families reporting through surveys that they were partners in decision making.*		
Adolescent Health					
Adolescent Mental Health and Suicide Prevention	By 2030, at least 20% of youth who are screened or assessed by the Student Assistance Program (SAP) and identified as having a mental health need receive interim	Increase access to care for youth who need mental health services by providing interim mental health services and supports Increase youth knowledge of healthy relationships to decrease teen dating violence	ESM MHT.1 - Percent of youth screened or assessed and identified as having a mental health	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization

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	services and supports By 2030, increase the percentage of middle school youth who demonstrate growth in knowledge of teen dating violence and healthy relationships by 10%		need who receive non-clinical, interim mental health services and supports from a Student Assistance Program (SAP) liaison ESM MHT.2 - Percent of youth who received evidence-based education on healthy teen relationships, completed the pre- and post-survey, and showed an increase in knowledge of teen dating violence following program completion		Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Provider Access, Care Coordination, and Navigation for Children and Youth with Special Health Care Needs	By 2030, increase the percentage of counties providing diagnostic services and follow-up care coordination resources to 51% By 2030, increase the percentage of CYSHCN living in rural PA who receive care coordination services through the Community 2 Home (C2H) program which support their health and wellness needs by 20% By 2030, increase the percentage of CSHCN receiving care coordination services in federally	Improve access to autism spectrum disorder diagnostic services and follow-up care coordination resources through telehealth Improve care coordination to CYSHCN living in rural PA through the C2H program Improve care coordination for CYSHCN in FQHCs through implementation of evidence-based quality improvement practices Improve care coordination for individuals with SCD and their families across health care systems and community-based services	ESM MH.1 - Percent of regular peer learning meetings attended with active participation in presenting and/or responding to peer discussion ESM MH.2 - Percentage of counties providing diagnostic services and follow-up care coordination resources through the autism diagnostic	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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	qualified health centers (FQHCs) by 25% By 2030, increase the percentage of individuals with sickle cell disease (SCD) receiving care coordination services by 10%		clinic (ADC) program. ESM MH.3 - Percentage of CYSHCN living in rural Pennsylvania reporting they received care coordination services which support their health and wellness needs through surveys upon through Community to Home (C2H) program discharge. ESM MH.4 - Percentage of CSHCN receiving care coordination project services in federally qualified health centers (FQHCs). ESM MH.5 - Percentage of individuals with sickle cell disease (SCD) receiving care coordination through the Community Based Services and Supports (CBSS) program. ***Inactive -*** *ESM MH.6 - Number of recommendations from CDR teams that are*		

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			implemented (CSHCN) ***Inactive -*** *ESM MH.7 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs* ***Inactive -*** *ESM MH.8 - Number of person-centered plans developed by BrainSTEPS teams* ***Inactive -*** *ESM MH.9 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs* ***Inactive -*** *ESM MH.10 - 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* ***Inactive -*** *ESM MH.11 - Number of meetings held*		

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			annually between DOH and DHS (CSHCN) ***Inactive -*** *ESM MH.12 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic* ***Inactive -*** *ESM MH.13 - Number of referrals to BrainSTEPS program* ***Inactive -*** *ESM MH.14 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program* ***Inactive -*** *ESM MH.15 - 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.16 - Percentage of CSHCN receiving*		

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			quality care in participating Federally Qualified Health Center (FQHC) health systems ***Inactive -*** *ESM MH.17 - Percent of families reporting through surveys that they were partners in decision making.*		