Maternal and Child Health Services Title V Block Grant

Pennsylvania

FY 2022 Application/ FY 2020 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

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DEPARTMENT OF HEALTH

August 12, 2021

Christopher Dykton, MA
Acting Director
Division of State and Community Health
Maternal Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 18N33
Rockville, MD 20857

Dear Mr. Dykton:

This letter and Application for Federal Assistance Form 424 are formal notification that the Pennsylvania Department of Health wishes to continue administrative responsibility for the Title V Maternal and Child Health (MCH) Services Block Grant in Federal Fiscal Year 2022. As directed, Pennsylvania's 2020 Annual Report and 2022 Application have been submitted electronically via the Health Resources and Services Administration's Electronic Handbook (EHB).

I look forward to your final approval of our request. Please contact Morgan Williams-Fake, Title V MCH Block Grant Coordinator, at mwilliamsf@pa.gov with any questions.

Sincerely,

Tara Trego
Director
Bureau of Family Health

I certify that the financial information contained in this application is true and accurate to the best of my knowledge.

Lori Stubbs
Digitally signed by Lori Stubbs
Date: 2021.08.12 10:45:05 -04'00'

Lori Stubbs
Chief Financial Officer

Department of Health
7th Floor East | Health & Welfare Building | Harrisburg, PA 17120 | 717.346.3000 | F 717.772.0323 | www.health.pa.gov

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. 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 stakeholder groups, the BFH applies a life-course approach across the Title V population domains. An intentional effort is also being made to apply a lens of health equity to improve the health and well-being of the most vulnerable, 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 vulnerable populations.

The BFH continues its workforce development efforts aimed at strengthening staff ability to use data and 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 weekly 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. The BFH continues to bring the discussion of health disparities and equity to the forefront internally through workforce development efforts 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 develop technical assistance documents and guidance for grantees on the development of localized health disparities plans and the use of evidence-based practices for at-risk populations. In December 2018, the BFH formed a Health Equity Committee to drive this work.

The BFH continues to implement a family engagement workplan composed of four phases: Communication, System, Unification and Adaptation. The plan involves increasing awareness, guidance, and assistance on how to implement strategies that meaningfully engage the populations being served in the design, conduct and evaluation of MCH programs and systems. The BFH provided a Client and Family Engagement 101 virtual training to program staff in August of 2020.

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-racists strategies to dismantle systemic inequalities 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 of the most vulnerable, are heard. These processes were further actualized through the Five-Year Needs and Capacity Assessment completed in 2019 and the Interim Needs Assessment Update in 2021.

The BFH was committed to performing a comprehensive and transparent needs assessment that engaged stakeholders 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 in PA, access and receipt of timely prenatal care remains a challenge, rates of maternal morbidity and mortality are rising, and women 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 pre-term 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 also need support to achieve positive developmental and mental health outcomes. Both data and the lived experiences of service recipients confirm that racial and ethnic minority 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 stakeholders, 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 will inform the work of the next 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 and mothers in PA have the support and services they need before, during and after pregnancy will include home visiting, group prenatal care through Centering Pregnancy, behavioral health screening 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 will also begin supporting new 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 also begin using 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 National Performance Measure (NPM) 1 around increasing women's access to and use of preventive medical services.

Among infants, the BFH sees an opportunity to enhance existing strategies to continue 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 will aim to drive improvement in a newly developed state performance measure (SPM) around timeliness of report-out to a physician after receipt of an abnormal result. New strategies to address infant mortality will 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. When new strategies are created for infants with a positive newborn screening, they will be reported under the CSHCN domain, since the count of individuals served by Title V was updated to capture infants. These efforts aim to drive improvement in NPMs 4 and 5 around improving initiation and duration of breastfeeding and creating a safe infant sleep environment, respectively.

Among children, in addition to enhancing the existing capacity of CDR teams, the BFH sees an opportunity to address behavioral, mental, and developmental health needs among children and to develop systems-level strategies addressing trauma. Existing 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 new 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 NPM 7.1 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 including the Special Kids Network helpline and provision of screening and specialty care to children with conditions such as Sickle Cell Anemia, Autism Spectrum Disorder and CSHCN who require rehabilitation services will also continue. Other strategies, such as efforts associated with improving access to a medical home, will adapt over the course of the funding cycle and new strategies related to improving access to transition services will be developed. Moving forward, CSHCN programming will 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 will also be identified over the course of the funding cycle. These efforts aim to drive improvement in NPM 11 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 will also continue to support reproductive health services, programming aimed to promote healthy relationships and services for LGBTQ youth in PA. These strategies will serve to advance the mental, behavioral and developmental health priority, the priority aiming to address child mortality, a newly developed SPM which aims to assess the percentage of youth in PA who have a mentor and NPM 10 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 a new effort will be 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 a new SPM which will track the extent to which policies and programs are modified as a result of data use and review of available evidence. Additionally, a new 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 target 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 still having the ability to address and innovate around ongoing MCH population needs over the long-term. This approach gives the most vulnerable populations the best chance at achieving a higher quality of life through improved health and well-being.

III.A.2. 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, children, and families. In Federal Fiscal Year 2020 (FFY20), $23,928,946 federal Title V dollars were expended, $11,771,621 on preventive and primary care for children, $7,217,569 on children with special health care needs (CSHCN), and $2,392,894 on administrative costs. Pennsylvania (PA) bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations; $46,813,492 state funds were expended in FFY20. Additionally, the BFH expended $3,423,394 in other federal funds implementing MCH programming. Total state and federal Title V expenditures for FFY20 were $74,165,832. 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, 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.

III.A.3. MCH Success Story

The COVID-19 Pandemic impacted lives in many ways. Youth served through the Maternal and Child Health Services Block Grant (MCHSBG) were particularly impacted as schools switched to virtual learning and services through MCHSBG had to switch to formats not normally used for service provision.

The Health Resource Centers (HRC) Program, funded by MCHSBG, was one of the programs greatly impacted by the pandemic. HRCs are primarily housed in school settings, with some programs operating through community settings. Due to the switch to virtual learning in March 2020, and then the uncertainty of schools utilizing virtual learning, in-person, or a hybrid of in-person and virtual learning for the 2020-2021 school year, planning for service delivery became very difficult. Despite this difficulty, provider agencies continued to come up with creative ideas for serving youth.

HRCs situated in school settings had to convert to a community-based model due to the uncertainty of school situations and schools trying to reach youth for their normal educational needs and not necessarily putting much emphasis on “extracurricular” services provided in schools. HRCs operating in community settings were better equipped to make a quick switch to virtual service delivery than the HRCs operating in school-based sites. The provider agencies operating HRCs in schools had to work closely with school personnel to determine if and how virtual service delivery may occur during the school year, while attempting to discover new ways to engage youth.

Many of the strategies used by provider agencies included: using Facebook Live to hold educational sessions, used other virtual classroom platforms for educational sessions, holding virtual events to educate and provide outreach/recruitment activities, running paid ads on virtual platforms such as Instagram, and many other avenues to reach youth in their new spaces. Overall, the lesson learned was to stay connected as much as possible with not only the youth, but within the provider agency network as well. It was important for provider agencies to have frequent and consistent opportunities to meet with one another, albeit virtually, to learn from one another on how to meet the demands of this challenging time.

The community youth organization (CYO) Olweus Bullying Prevention Program (OBPP), funded by the MCHSBG, was also impacted by the pandemic. Though traditionally implemented in schools, Pennsylvania is piloting a CYO OBPP training and certification process in partnership with Clemson University, the sole provider for OBPP training and consultation in the United States. Thirteen individuals from eight CYOs received in-person training and were provisionally certified in the CYO OBPP in February 2020. These individuals were tasked with training organizational leadership teams and staff who interact with youth prior to program implementation by the summer of 2020. Due to the pandemic, many of the organizations experienced prolonged building closures and staff furloughs which delayed or prevented trainings and program implementation. Virtual training materials were created and distributed to assist the CYOs. Despite the obstacles, all eight CYOs were able to train their organizational leadership teams by the end of the 2020 calendar year.

III.B. Overview of the State

To understand maternal and child health (MCH) population needs in Pennsylvania (PA), it is necessary to learn the geographical, social, economic, and political traits of the Keystone State and its residents. PA is a vast, increasingly diverse state comprised of large rural areas and concentrated urban centers which are both evolving economically and socially. Located in the northeast, PA is the fifth most populous state, home to over 12.8 million people. In addition to its rural and urban divide, the state is physically divided in half by a large swath of rural forest created by the Appalachian Mountains.

PA is anchored by two urban counties, Allegheny in the west and Philadelphia in the east. Urban counties are those with a population density higher than the state population density, while rural counties have a lower density. Harrisburg, the capital and headquarters for the Department of Health (DOH), is situated in the southcentral part of the state. As of March 2020, PA's 19 large counties (counties where 75,000 or more are employed) accounted for 77% of total employment within the commonwealth. All but two of those counties are considered urban. In 2019, nearly 80% of the state gross domestic product was produced by urban counties. PA has the sixth largest economy in the nation but, as of February 2021, had a seasonally adjusted unemployment rate that was higher than the national average. In 2019, 27% of PA's population was low income (under 200% federal poverty level or FPL), and, in 2020, more than half of PA's Medicaid expansion population worked a job that did not offer health benefits.

The educational services, health care and social assistance, manufacturing, and retail trade sectors are major contributors to the economy. The industry with the greatest number of employees in PA in 2019 was educational services, health care, and social assistance, growing eight percent since 2010. Employment in agriculture, forestry, and fishing (which includes farming) increased from 2010-2019. Of PA 's 67 counties, 52 have at least 500 individuals employed in agriculture, forestry, and fishing.

The delivery of health care services is significantly impacted by the distinctive rural and urban characteristics across the state. While 48 of PA's 67 counties are considered rural, nearly three-quarters of PA's residents live in urban counties. The concentration has become even more pronounced since 2010, as most of the population growth in PA has occurred in urban counties. In 2018, there was one primary care provider in direct practice for every 1,075 residents in urban counties, as compared to one rural primary care physician for every 1,561 residents. Of the 16 counties without Federally Qualified Health Centers (FQHC), all but one are rural. As of 2020, of the estimated 510,983 residents living in a designated Primary Care Health Provider Shortage Area (HPSA), the majority lived in a rural county. The only non-rural areas designated as HPSA were in Allegheny, Beaver, York and Franklin counties. Small areas of several urban counties are considered medically underserved. As of 2017, approximately 17.6 percent of PA's population lived in an area designated as medically underserved. In 2019, there were 65 general acute care hospitals, with a total of 7,753 beds, in rural PA. Seven rural counties had no hospitals. On average, there were 2.28 hospital beds for every 1,000 rural residents compared to 2.74 hospital beds for every 1,000 urban residents.

In addition to a general lack of healthcare resources, rural areas have other challenges including an aging population, a growing young minority population with higher rates of poverty and unemployment, and a lack of resources or training to meet the language and cultural needs of the growing immigrant populations. On average, rural PA residents are older than urban PA residents. In 2019, nearly 20% of the rural population was 65 years old and older compared to 17% of the urban population. From 2010 to 2040, the number of senior citizens in rural PA is projected to increase by 54%.

Across the state in 2019, the 147 general acute care hospitals (including 15 Critical Access Hospitals [CAH]) with over 33,500 licensed beds handled over 1.41 million admissions. An additional 85 federal and specialty hospitals

handled over 160,000 admissions. There are nine children's hospitals in PA, six of which are in either Philadelphia or Pittsburgh. The other three are in Danville, Erie, and Hershey. Children who live in rural areas or in areas not near these hospitals may not have ready access.

Supplementing the hospitals are over 200 FQHC or rural health centers providing primary care services in 44 counties. FQHCs are an important resource for PA's vulnerable populations. In 2019, 87% of FQHC patients were at or below 200% FPL, 48% were on Medicaid, and 54% were members of a racial or ethnic minority.

CAH are rural hospitals that provide 24-hour emergency services with an average daily census of 25 patients or less. These hospitals serve as key providers in areas with sparse populations, geographic barriers to care, and significant health professional shortages to address populations who are generally older, sicker, and poorer. Besides anchoring a broad range of health and human services in their communities, many of these hospitals continue to be the top employers in their county and major contributors to local economies. Of concern is that in Fiscal Year (FY) 2019, five of the CAH (33%) reported negative operating margins. CAHs also operate on thinner margins in general. Four of the CAHs had positive operating margins of 2.3% or less. As of 2017, the average operating margin for CAHs in PA was 2.3%, compared with 5.2% at hospitals across the state.

Other important partners in the delivery of services within the MCH system of care are the County/Municipal Health Departments (CMHDs) and state health centers. The ten CMHDs are in urban areas and tailor services to the needs of their local communities. Primary and secondary preventive health services are emphasized and geared to improve the community's health through direct health services, education, and leadership. CMHDs are funded by Act 315, PA's Local Health Administration Law, with additional funding by state, federal, and local government going towards local office priorities. At a local level, CMHDs currently cover more than 41% of PA's population. In addition, several CMHDs have either applied for or achieved public health accreditation through the Public Health Accreditation Board (PHAB). As a result, those communities have access to higher-quality programming and services.

Counties without CMHDs have state health centers who provide and support public health programs throughout PA. To organize the state health centers, PA is split into six community health districts, each covering a geographic region of the state. Each health district in turn has a district office that helps coordinate activity throughout the district. Through the utilization of community health assessments and outreach, the centers focus on five core functions: communicable disease investigation and prevention, immunizations, public health education, human immunodeficiency syndrome/sexually transmitted disease services, and tuberculosis investigation and treatment.

Health insurance is a key factor for health care access. In 2019, 5.8% of the approximately 12.6 million civilian noninstitutionalized population in PA were uninsured. By gender, 6.5% of men were uninsured compared to five percent of women. Only 5.2% of whites were uninsured compared to 6.9% of blacks and 12.5% of Hispanics. More than 10% of 26 to 34-year-olds were uninsured, the largest proportion of any age group. As educational attainment increased, the percentage insured increased.

The Affordable Care Act (ACA) has brought some insurance relief with the introduction of the federal Marketplace. While the uninsured rate ranges from 2.9 to 11.3% across counties, the uninsured are primarily working families with an income below 400% of the FPL, unemployed or employed less than full-time, less than a high-school graduate and non-white. In 2020, over 331,000 residents selected a Marketplace plan, of which 84% received financial assistance. While the uninsured rate has fallen for all racial and ethnic groups because of the ACA, as of 2019, whites are still more likely to be insured than blacks.

A key component in the MCH system of care is Medicaid, administered in PA by the Department of Human Services

(DHS). Medicaid eligibility is determined by having a special condition or belonging to a particular group such as pregnant women, children, low-income adults, elderly adults, or disabled adults and meeting financial and citizenship requirements. Medicaid eligibility levels are highest in PA for children and pregnant women and both are higher than the median United States (U.S.) rate.

Medicaid also has special programs for specific medical conditions and waiver programs available for those who require assistance with activities of daily living or who meet functional requirements (such as those with AIDS, on home ventilators, or with autism). Although these waivers provide a wide array of services (such as home health aides, transportation, and case management), they are not an entitlement and there is no guaranteed entrance.

In addition to covering basic Medicaid services, states can choose to cover up to 30 optional benefits. PA covers 24, including prescription drugs, vision, dental, physical therapy, home health, and hospice care. PA's Medicaid expansion coverage includes the ACA's ten essential health benefits and expanded mental health and substance use treatment services. Children with special health care needs (CSHCN) are served by Special Needs Units (SNU) within Medicaid. SNU are housed within physical health Managed Care Organizations (MCO) and ensure CSHCN receive services and supports in a timely manner. SNU also assist CSHCN with access to services and information, coordinate between physical health and behavioral health and other systems, and staff a dedicated special needs hotline. Each physical health MCO has a full-time SNU coordinator. SNU staff also work in close collaboration with the SNU housed within DHS.

Individuals not eligible for Medicaid may qualify for Children's Health Insurance Program (CHIP), also a part of DHS. CHIP provides free or low-cost health insurance to uninsured children and teens up to age 19 in families with incomes over the Medicaid limit (133% FPL). As of April 2021, there were 161,645 children enrolled in CHIP. As of January 2021, CHIP and Medicaid combined provided health and long-term care coverage to more than 3.3 million in PA. Medicaid is also a major source of funding for safety-net hospitals and nursing homes, and most Medicaid spending in PA is for the elderly and people with disabilities. In State Fiscal Year (SFY) 2019, Medicaid accounted for 61% of all federal funds received by PA and 36% of the state general fund spending.

Following a national trend, PA is becoming more racially and ethnically diverse. From 2010 to 2019, the minority population increased from 36 to 40% nationally, and from 21 to 24% in PA. Minority residents make up more of the population in urban areas (29%) than in rural areas (9 percent). From 2010 to 2019, the population identifying as Hispanic increased in PA by 39%, and the population identifying as black increased by 11.8%. From 2000 to 2019, the rural population became more racially diverse, as the non-white or Hispanic rural population increased from 5 percent of the total population, to 9 percent. As of 2017, approximately one in three PA children are children of color. With the total minority population projected to double between 1990 and 2025, the responsibility and challenge of the Title V program is to understand their diverse backgrounds and how services and Title V programming can adapt to their needs.

With an increasingly diversifying population, it is important to consider how people of color experience PA's system of care, signified by key MCH indicators. In 2018, the infant mortality rate for whites was 4.8 per 1,000 live births. The rate for blacks was more than twice that, and for Hispanics, it was 52% higher. For blacks, the disparity has persisted since at least 1999, and for Hispanics, since 2012. Preterm births are a leading cause of infant death. In 2019, the percentage of preterm births for whites was 9.1 percent. Blacks had a percentage that was one and a half times that of whites (roughly 50% higher), and for Hispanics, the percentage was 15% higher than that of whites. The disparity for preterm births for Blacks has been roughly the same since 2003. From 2013 to 2017, the maternal mortality rate for whites was 9.1 per 100,000 births. The rate for black mothers was more than 2.5 times the rate for whites. In 2019, one percent of white mothers had no prenatal care; for black mothers, it was more than four times

that, a disparity that has not changed since 2011. For Asian mothers, the percentage was approximately twice that of whites, and more than three times that of whites for Hispanic mothers. Since 2003, the rate for Hispanic mothers has been at least twice that of whites for every year except one. A lack of prenatal care has been linked to poor birth outcomes, including low birth weight and infant mortality. In 2019, the teen pregnancy rate for whites was 3.2 per 1,000 females aged 15-17. Despite teen pregnancy rates for blacks having dropped over 67 percent from 2010-2019, rates are still more than three times that of whites. Like blacks, despite a decline in teen pregnancy rates from 2010 to 2019, the teen pregnancy rate for Hispanics was more than five times that of whites. That disparity has been roughly the same since 2010. With the projected increase in populations of color, if health disparities in these populations are not addressed, they have the potential to create a greater burden over time.

Overlapping the disparities are familial, educational and economic characteristics of the population that further define their interaction with the MCH system of care. In general, PA is growing older. In 2019, about one-quarter of Pennsylvanians were under the age of 20 and one-third were 55 and older. The percentage of population aged 65 and older was greater in PA (18.7%) than the US overall (16.5%). From 2010-2019, PA's population grew less than 1 percent, the number of young residents (under 18) decreased more than 5 percent, but the number of residents 65 and older increased more than 21%. In 2040, an estimated 25% of the total rural population will be 65 and older. At that time, there will be more senior citizens than children and youth in rural PA. Counties with large elderly populations could face the possibility of diverting resources from MCH populations towards their elderly residents.

Of the approximately 5 million households in the state in 2019, over 3.2 million of these households are defined as families, with an average size of 3.02 members. The U.S. Census Bureau categorizes families as: married-couple families, male householder (no wife present) and female householder (no husband present). While married families are most common, nearly 71% of non-married families are female-led. These households have slightly larger family sizes, are more likely to have members less than 18 years of age and are more likely to live in multi-unit structures. Over eight percent of all households in PA are single parent households with children under 18 and no spouse present. PA had a lower percentage of households with children (24%) than the national figure (26%). The population of children under age 18 is evenly distributed across age groups for each family type. Of the 2.62 million children in the state, approximately 1.7 million live in a married family. Over 221,000 children live in male-led families; and over 675,000 children live in female-led families, which are less likely to have an unmarried partner present.

The racial distribution greatly varies between types of households with children. While 81% of children in married families are identified as white, nearly 70% of children in male-led families and nearly 52% of children in female-led families identify as white. Over 59% of black adolescents and over 42% of Hispanics live in female-led families compared to only 18.4% of whites. Female-led families are more likely to have grandchildren in their households, and more likely to have a child with a disability in their household when compared to other households.

According to the 2018-19 National Survey of Children's Health, 20.8% of children in PA have special health care needs. Children and their families may encounter multiple barriers to perform daily life functions and often need services from multiple systems of care which can be challenging for families to navigate.

Median income varies by county from $39,700 to $100,214; for families with children, it is $80,661. However, there are stark differences in median income when considering family type. The median income for married families is $108,305, $47,220 for male-led families and $30,665 for female-led families. In addition, female-led families are slightly larger in size than male-led or two-parent families, but their median income is much lower. Women's income is also affected by the wage gap. In 2018, women in PA are earning 79 cents for every dollar a man makes, less than the national average of 82 cents. The wage gap is even greater if the woman is a minority.

In 2019, a smaller percentage of PA residents (12.4%) lived in poverty compared to the national rate (13.4%).

However, there are still large swaths of the population living in poverty, as 26% of PA's black residents and 28.1% of PA's Hispanic residents lived in poverty and families with black or Hispanic householders were more than three times as likely to be living in poverty than whites. Of the 1.37 million families with related children under 18, 14.3% were living below the poverty level during the previous year. Female-led families were more likely than any other to be living below the poverty level. For families with children under 18, female-led families were twice as likely to be living below the poverty level. The highest rates of poverty were for those families with a householder having less than a high school education. However, at all levels of educational attainment, the percentage of female-led families living below the poverty line was higher than other families, more than double in most cases.

Adolescents (15 to 19 years) are an important sub-population within the MCH population, numbering approximately 803,000 with more than 89% enrolled in school in 2019. School enrollment among adolescents is consistent by race and ethnicity, with black adolescents having the lowest enrollment at 87.3%.

Future earnings are related to a person's level of educational attainment. For the more than 9 million people aged 25 years and over in PA in 2019, 91% have a high school degree or higher, varying a bit by county, and more than 32% have a bachelor's degree or higher. For this same population, for whom poverty status is determined, the rate of poverty for those with less than a high school diploma is 25.1% and decreases with educational attainment. The median annual income for those aged 25 years and older is approximately $42,225 and ranges from $26,350 for those with less than a high school diploma or equivalency to $73,800 for graduate or professional degree holders. Of the approximately 1.16 million 18 to 24-year old's, 35.5% have graduated high school; 44.2% are enrolled in college or graduate school and 13.5% have a bachelor's degree or higher. Females in this age group are enrolled in college or graduate school at a higher rate than males.

According to a 2016 Williams Institute analysis of Census Bureau data, there are 22,340 same-sex couples in PA (sixth nationally) compared to 646,500 in the U.S. with almost 16% of these couples in PA raising children. Most same-sex couples in PA are women (56%) and 81% are white. The mean income for same-sex couples is higher than that of different-sex couples, $52,000 versus $46,000, and over half have a college education as compared to only 33% of different-sex couples. Ninety percent of same-sex couples have health insurance. In PA, three percent of people identify as Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) with 27% raising children; the U.S. numbers are four and 29%, respectively. As with same-sex couples, most of the LGBT population is white (72%). PA ranks 38th in percentage of LGBT individuals. Over a quarter (28%) of LGBT individuals have an income less than $24,000 as compared to non-LGBT individuals (21%). More non-LGBT (90%) individuals have health insurance than LGBT individuals (86%). The percentage of non-LGBT and LGBT individuals having a college education is nearly equal. As of 2018, 4.1% of PA is LGBT, compared to 4.5% nationally, and five percent of the PA workforce is LGBTQ. As of 2019, PA has 36,711 same sex households (980,276 nationally), 52.3% of whom are married.

LGBTQ residents face ongoing health inequities in terms of their absence in statewide surveillance systems, discrimination by healthcare providers, in the workplace, and in social situations. Over half of LGBTQ individuals have reported discrimination at some point based solely on sexual orientation, which remains legal in PA. There are few laws protecting LGBTQ families regarding insurance coverage, hospital visitation rights, and powers of attorney. Members of LGBTQ groups have health needs both regular and specific to their sexual and gender orientation that often go unmet. In response to a range of discriminatory laws being passed in other states, Governor Wolf signed executive orders in April 2016 stating, "no agency under the governor's jurisdiction shall discriminate on the basis of sexual orientation, gender expression, and identity, among other areas." These orders pertain to commonwealth employees, and the commonwealth grants and procurement process. Over 40 municipalities have passed separate ordinances to prohibit discrimination based on sexual orientation and gender identity.

The Secretary of Health's priorities combined with the State Health Improvement Plan (SHIP) and the DOH's Strategic Plan guide the agency and illuminate areas for Title V to implement work to improve the health of populations in PA. The 2015-2020 SHIP was developed in partnership with a broad representation of public health system stakeholders. The SHIP priorities are: 1) obesity, physical inactivity, and nutrition; 2) primary care and preventive services; and 3) mental health and substance abuse. Through the process of defining the SHIP priorities, five cross-cutting themes were also identified: health literacy, public health systems, health equity, social determinants of health, and integration of primary care and mental health. In 2018, the DOH prioritized the protection of access to health care in rural communities using a Rural Health Model, developed in coordination with the Centers for Medicaid and Medicare Services. As of January 2021, there were 18 hospitals participating in the model. The 2020-2021 annual SHIP work plan includes the current evidence-based strategies for each SHIP priority, the activities planned to implement the strategies, the target populations, collaborators, targets, and data sources.

The State Health Assessment (SHA), which reports on the health status of PA's population, factors that contribute to health issues, and resources that can be mobilized to address population health improvement, was recently updated. The Department released the 2020 SHA in January 2021.

The DOH 2020-23 Strategic Plan consists of the following five key strategies: 1) Maintain and enhance emergency services and public health preparedness; 2) Continually develop our talents to significantly advance public health in PA; 3) Promote public health with awareness, prevention and improvement of outcomes where the need is greatest; 4) Use data, measures, and technology to enable public health performance; and 5) Improve staff, customer, and partner experience with consistent, efficient, and effective services and work processes. These department strategies closely align with the work of Title V in PA and the Bureau of Family Health (BFH), as the Title V administrator, will continue to emphasize evidence-based and data driven decision-making within its programming while increasing the integration of quality improvement techniques throughout its work.

In March 2019, the DOH achieved national public health accreditation per notification from the Public Health Accreditation Board. Accreditation ensures that the DOH is meeting national evidence-based standards and providing PA residents with the best programs and services available. Accreditation can help the BFH improve collaborations between staff and stakeholders and further the Title V mission and programming through increased accountability, quality service delivery, and institutionalized processes, such as the use of evidence-based practices and integration of quality improvement techniques.

PA's MCH system of care is further augmented by state statutes mandating programs serving the MCH populations and requiring the resources of Title V in both staff and funding. The Newborn Child Testing Act (35 P.S. § 621, et. seq. and amended by Act 36 of 2008 and Act 133 of 2020) establishes a program providing for the screening tests of newborn children and follow-up services related to case management, referrals, confirmatory testing, assessment and diagnosis of newborn children with abnormal, inconclusive or unacceptable screening tests results. Act 133 of 2020 mandates submitters order testing for conditions which have been recommended for screening by the United States Department of Health and Human Services. These conditions include the disorders on the Mandatory Screening Panel and the Mandatory Follow-up Panel except for three disorders which were removed because of not being federally recommended for screening. Act 87 of 2008 mandates the Child Death Review (CDR) Program, which provides for statewide and county-based multidisciplinary CDR teams to conduct reviews of all deaths of children aged 21 and under. The Act also requires an annual report on the information, distribution and causes of child deaths in PA and reflects information collected during the CDR process from collaborative processes between the DOH and local CDR teams. The Pennsylvania Code (028 Pa. Code § 27.22 and 028 Pa. Code § 27.34) requires laboratories and providers to report blood lead test results to the DOH. Act 24 of 2018 establishes a Maternal Mortality Review Committee to conduct multidisciplinary reviews of maternal deaths and develop

recommendations for the prevention of future maternal deaths.

Impacting PA residents, the health care system and the broader landscape of the MCH system of care are several important, emerging issues. The 2019 novel coronavirus (COVID-19) pandemic has presented an unprecedented challenge to the world, to the U.S., and to PA and its public health system. COVID-19 prompted the federal declaration of a nationwide emergency and, in PA, the activation of a command center at the Pennsylvania Emergency Management Agency and a disaster declaration. PA continues to monitor COVID-19 cases and fatalities across the state and is actively engaged in supporting the public health and medical systems with the response. While COVID-19 cases continue to rise daily, as of June 2021, PA has over 1.14 million positive cases, more than 26,000 Pennsylvanians have died, and over five million Pennsylvanians are fully vaccinated. Effective May 31, COVID mitigation orders were lifted. Effective June 28, the order requiring universal face coverings was lifted statewide. However, DOH continues to urge Pennsylvanians to follow CDC guidance for wearing a mask where required by law, rule, and regulations, including healthcare, local business and workplace guidance and get vaccinated if eligible. While adults aged 65 and older as well as those who are immunocompromised or with underlying conditions are at highest risk of contracting the virus, the CDC also advises pregnant persons to take extra precautions. Many Pennsylvanians have reported delays and interruptions in their and their children's routine health care visits as a result of COVID-19. Title V-supported programs offer important safety-net services during times of crisis when the health care system may be overwhelmed by caring for emergent cases.

Like other states, the simultaneous epidemic of opioid use remains a priority of both the Governor's administration and the DOH. In 2019, PA's mortality rate from opioid deaths was higher than the national rate (25.1 versus 15.5 per 100,000), and more than double that of 2015 (11.2). According to the CDC, there were 4,377 drug-related overdose deaths in 2019, a 2.5 percent decrease from 2018. While there is a broad range of ages for these deaths, the typical decedent is male and between 25 and 34 years old. The distribution of overdose deaths by race in PA roughly corresponds to the state's racial makeup, and 70 percent of all overdose deaths in PA were male. An additional impact of opioid use that affects the MCH population is that of Neonatal Abstinence Syndrome (NAS). According to data from the PA Health Care Cost Containment Council, in 2019, there were 1,610 reported newborn hospital stays with NAS, a rate of 12.9 per 1,000 newborn hospital stays. This puts an additional burden on the health care system, as the mean length of hospital stay for newborns with NAS during that time was 15.9 days, nearly five times the average stay of 3.4 days for all other newborns. NAS-related stays added an estimated $15.2 million in hospital payments in FFY 2017-2018. Another impact of NAS is premature births - 16 percent of NAS births in PA in 2018 were premature, compared to 9 percent statewide.

Attempts to combat the drug problem are multi-faceted and range from improving prescribing practices to providing better and more widely available addiction treatment services. In January 2018, Governor Wolf declared the heroin and opioid epidemic a statewide disaster emergency, a first for a public health emergency. The declaration allowed for the creation of a command center that will track progress and enhance the coordination of health and public safety agencies, helping commonwealth agencies address the opioid epidemic. In May 2021, the Governor signed a fourteenth consecutive 90-day renewal of the declaration extending the designation of the opioid epidemic as a disaster emergency.

In addition to the aforementioned emerging issues, the DOH is assessing how to leverage growing support at the state level to name racism as a public health crisis and evaluate policies and practices to identify and eradicate systemic racism. The DOH Antiracism and Health Equity Task Force, established in 2021, has been tasked by the Secretary's office with developing a series of action steps and initiatives to further this work over the next 18 months. Title V-funded staff sit on the Antiracism and Health Equity Task Force and will look for opportunities to align the work of the Title V State Action Plan and BFH Health Equity Committee with Task Force initiatives. Additionally, PA's Title

V program will be participating in the Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention learning and practice cohort and intends to apply lessons learned to other Title V priority areas and share experiences with the DOH Antiracism and Health Equity Task Force. PA is also following the Black Maternal Health Momnibus Act of 2021 progress and, if passed, will seek opportunities to utilize the legislation to further antiracism and health equity work.

Finally, in May 2021, the Wolf administration released the Pennsylvania Climate Impacts Assessment 2021. In the corresponding press release, Governor Wolf stated, “On our current path, the Pennsylvania our children and grandchildren inherit will be very different from the one we grew up in and continue to enjoy today…We simply cannot afford to ignore the warning signs, and this report underscores the critical need to take action to reduce emissions and do our part to address climate change.” Pennsylvania Climate Impacts Assessment 2021 uses federal, state, and local data to show the trend of rising temperatures and increasing rainfall and project how it will continue into midcentury (2041-2070) and beyond, if greenhouse gas emissions are not reduced. The extent of impacts, from limited to catastrophic, is projected for numerous aspects of life in PA. Pennsylvanians living in communities that have been disinvested and are ripe for resource development, including maternal and child health populations, often face significant challenges that are exacerbated by climate change impacts. These challenges include living near industrial sites, living in older housing stock, often without air conditioning, and facing limited transportation options. Heat and extreme weather events caused by climate change can aggravate health conditions stemming from poor air quality and heat exposure. The Department of Environmental Protection’s Environmental Justice Office is calling on state and local leaders to work proactively and intentionally with communities and other partners to reduce the significant risks of climate change and cultivate resources, health supports, and other development in communities that disproportionately confront these critical climate issues.

PA is a state of contrasts presenting unique challenges to the delivery of services and resources across the MCH system of care. An aging but diverse population will gradually force a system adjustment to meet geographic, programmatic, and cultural needs. Swaths of poverty are inseparable from gender, education, race and ethnicity, with women led families bearing an unequal burden. Systems of care are equipped to meet urban needs but not rural needs. This, however, is not as dire as it seems. There is strength in the access to care provided by Medicaid and CHIP, the local work of the CMHD, and DOH development of strategic plans, initiatives, and programs to meet current and emerging challenges such as COVID-19, opioid addiction, racism, maternal mortality, and climate change. The PA Title V program will have to be nimble and adaptable to meet the changing landscape of MCH service needs in PA.

III.C. Needs Assessment

FY 2022 Application/FY 2020 Annual Report Update

I. Overview of Approach to Needs Assessment

In preparation for interim needs assessment from 2021 to 2025, the Bureau of Family Health (BFH) developed a plan and framework. Similar methods will be employed annually, and the cumulative results will serve as groundwork for the five-year needs and capacity assessment in 2025. When appropriate, annual results from ongoing assessment may be compiled and considered in aggregate in future years. Health equity remains the overarching framework of the BFH's needs assessment activities.

Ongoing needs assessment activities fall into three broad categories: 1) engagement of stakeholders to characterize maternal and child health (MCH) needs in the state, identify emerging issues, and inform development and implementation of strategies; 2) assessment of qualitative data collected through stakeholder engagement and available quantitative state data to further characterize the health status of the MCH populations and; 3) evaluation of the MCH system and the BFH's capacity as the Title V administrator. Activities completed to date are described by category in the sections below.

II. Needs Assessment Update

1. **Stakeholder Engagement and Primary Data Collection**

    1. **Public Input Survey:** A public input survey asking respondents to identify unmet MCH needs and provide recommendations on strategies that would advance the state's priorities for each Title V population domain was developed in 2020. The survey was launched for one month from April to May 2021 and 100 people from 16 counties responded (~30% of all 67 counties in the state) with most respondents from the populous Allegheny, Philadelphia, and Dauphin counties and surrounding areas. Of those who responded, 72 were service providers and 28 were service recipients or caregivers. The questions included in the survey were predominantly open-ended and qualitative analysis consisted of categorization of text responses and subsequent identification of key themes based on the frequency with which responses in each category were identified. Given that the results of the public input survey inform understanding of the MCH population's health status and unmet needs by domain, summary tables are incorporated into the corresponding sections, below.

    2. **Focus Groups:** Stakeholders and service recipients were also engaged through meetings and focus groups. Given the prevalence of MCH providers with additional duties associated with the COVID response, the BFH optimized previously planned meetings and virtual site visits in order to seek their input. The BFH facilitated discussion at a virtual site visit with 11 adolescent health providers participating in the Leadership Education in Adolescent Health (LEAH) fellowship in February 2021. Providers were asked about adolescent health needs, service gaps, telehealth, youth engagement, and the COVID-19 vaccine. In April 2021, the BFH facilitated another discussion with 26 providers participating in the Leadership Education in Neurodevelopment and Other Related Disabilities (LEND) fellowship. Providers were asked about the needs of children with special health care needs (CSHCN) and their families, service gaps, telehealth, and care decision-making. Finally, in April and May of 2021, the BFH organized two virtual focus groups with youth service recipients, engaging 17 adolescents across the state. Participants were asked about issues facing youth, assets and needs in their communities, health resources, and youth engagement.

        Data resulting from these sessions with providers and service recipients contribute to understanding of the health status of MCH populations and help to inform the direction of Title V activities. Key takeaways and themes of the discussions are incorporated into the following section on health status under the corresponding population domain(s) and in the emerging issues section.

2. **Assessment of Maternal and Child Health Status: Update**

    1. **Women/Maternal Health:** The existing Title V priority for the women/maternal health domain is reduce or improve maternal morbidity and mortality, especially where there is inequity. Available data suggest that the rate of maternal mortality in Pennsylvania (PA) may be rising (13.8 deaths per 100,000 live births during 2014-2018 compared to 14.8 deaths per 100,000 live births during 2015-2019 per the National Vital Statistics System) and the rate of maternal mortality remained nearly three times higher among black people as it is among white people in PA during 2015-2019. Similarly, state inpatient hospitalization data suggest that the rate of severe maternal morbidity has risen from 74.2 cases per 10,000 delivery hospitalizations in 2016 to 77.0 cases in 2018 and the rate of morbidity is two times

higher among black people as compared to white people. As such, continued focus on this priority and the persistent racial disparity is imperative.

This priority and its associated strategies are linked to NPM 1, the percentage of women in PA who have received a routine check-up or a preventive medical visit in the past year. This indicator remained around 75% in 2018 and 2019, but receipt of routine care remains least frequent among those who are uninsured (64.8% in 2019). Given the rise in unemployment associated with the COVID-19 pandemic and the potential for a corresponding increase in uninsured people, connecting birthing and pregnant people to safety net preventive physical and mental health care services remains an important strategy of the 2022 action plan.

Newly available state data suggest that changes should be noted for several related indicators. Birth certificate data suggest that the prevalence of pregnant people with gestational hypertension or diabetes may be increasing. Preliminary data suggest an increase from 6.2% of pregnant people with gestational hypertension in 2017 to 8.1% in 2020 and an increase from 5.8% of pregnant people with gestational diabetes in 2016 to 7.6% in 2020. Given the association between these conditions and adverse maternal and infant health outcomes, associated prevention strategies can be encompassed within the existing priority. Finally, Pregnancy Risk Assessment Monitoring System (PRAMS) data from 2016-2019 also suggest an increase in prevalence of self-reported depression during pregnancy from 12.5% of people reporting depression during pregnancy in 2016 to 18.2% reporting depression in 2019. Behavioral health and depression screening and referral are existing components of the Title V action plan and will remain important strategies in 2022. Results from the public input survey (see Table 1) further confirm that continued focus on mental health and access to care remain necessary to address unmet needs in communities and networks of care across the state.

Table 1: Summary of public input survey responses to question about unmet women/maternal health needs in Pennsylvania by respondent type, 2021

Top two most frequently cited unmet needs - Service recipients/caregivers	Responses - Examples
1. Support and services for mental health*	"Mental health resources are very limited. As a new mother none of my doctors addressed my concerns. I filled out a survey at my doctor's office about my struggles and no one discussed them with me"; "Mental health support for postpartum depression and dealing with the pandemic"
1. Accessible care before, during, and after pregnancy*	"There is no hospital for delivery. Must travel at least 45 minutes to have the baby or receive prenatal care"; "Appointments are needed in a timely manner"; "Access to home care"
Top two most frequently cited unmet needs - Providers	**Responses – Examples**
1. Access to health care services, including preventive care	"Specifically related to the pandemic I have seen reduced access to prenatal care, specifically during pregnancy and immediately postpartum, in the areas where I serve. Known disparities already exist and this has had the potential to only amplify those disparities"; "There is disparate access to the full options of care for pregnant and birthing people"
2. Mental health services	"One of the highest unmet needs that I have seen is timely and appropriate access to mental health services." "The most important but unmet health need of women, mother and pregnant women in my line of work is a collaboration between mental health needs and prenatal care. Many pregnant women struggle with some degree of mental health and most do not receive the care by a specified mental health provider to help manage and control conditions (or help them not to worsen postpartum)."

*NOTE: Among service recipients/caregivers, the two needs listed were cited with equal frequency.

2. **Infant/Perinatal Health:** The existing Title V priorities for the infant/perinatal health domain are reduce rates of infant mortality, especially where there is inequity and improve the percent of [infants] with special health care needs who receive care in a well-functioning system. The most recent available data suggest that the statewide infant mortality rate continues to decline (6.1 deaths per 1,000 births in 2015 to 5.9 deaths per 1,000 live births in 2019). However, the infant mortality rate is higher among infants born preterm and with a very low birthweight. This remains a concern as the percentage of infants born preterm or with a low birthweight was mostly unchanged in PA from 2009 to 2019. Additionally, the rate of infant mortality remains highest among black infants as compared to white infants. Death certificate data

indicate that the black-white gap in infant mortality has persisted from 2012 to 2018, remaining nearly three times higher among black infants as compared to white infants. A similar pattern is evident for preterm-related mortality, neonatal mortality, and postneonatal mortality. As such, addressing this racial disparity in infant mortality and reducing preterm birth remain an important focus of the state's Title V program.

This priority and associated strategies are linked to two NPMs; NPM 4 measures the percentage of infants breastfed and NPM 5A-5C focus on the percentage of infants experiencing safe sleep practices. Birth certificate data suggest a continued gradual increase in breastfeeding initiation, from 81.1% of infants ever breastfed in 2016 to 82% in 2019. PA PRAMS data also suggest that the percentage of infants breastfed for at least 24 weeks (6 months) may also be increasing (56.3% during 2012-2015 to 60.6% during 2016-2019). However, the prevalence of breastfeeding initiation and exclusive breastfeeding remains lower among black infants as compared to white infants. PA PRAMS data also suggest that continued breastfeeding remains less prevalent among young birthing people (≤19 years) and among people of lower socioeconomic status. Given the benefits of breastfeeding for birthing people and infants, and the association between breastfeeding and a potential reduction in postneonatal mortality and sudden unexpected infant death, strategies that aim to increase breastfeeding are encompassed within the existing priority that aims to reduce infant mortality.

Since 2016, there has been a statistically significant increase in the percentage of infants placed on a separate approved safe sleep surface (32.4% in 2016 to 39.8% in 2019). Similarly, the percentage of infants placed to sleep without soft objects or loose bedding has also significantly increased (46.1% in 2016 to 59.5% in 2019). However, differences still exist when evaluating safe sleep practices by maternal age; these practices are less common among birthing people under the age of 19. Additional work may be needed to advance the practice of placing infants on their back to sleep. While five-year estimates suggest an increase in the practice (80.5% during 2012-2015 to 82.3% during 2016-2019), annual estimates demonstrate fluctuation and no consistent pattern since 2015.

Many of the indicators of infant/perinatal health in PA remain unchanged and the quantitative data and public input survey responses (Table 2) suggest that the existing priorities are sufficiently broad to respond to the persistent unmet needs. While strategies such as safe sleep education, home visiting, and breastfeeding awareness are underway, additional strategies that aim to advance development of protective factors among parents/caregivers to prevent adverse infant health outcomes will continue to be considered.

Table 2: Summary of public input survey responses to question about unmet infant/perinatal health needs in Pennsylvania by respondent type, 2021

Top two most frequently cited unmet needs - Service recipients/caregivers	Responses - Examples
1. Parent/caregiver education and support	"I believe providing more information to mothers and families at the weekly/monthly doctor appointments is crucial. I feel that my doctor did not provide me with any information about what to expect when my child arrived"; Improved education of mothers and families about infant nutritional needs and developmental issues"; "Food, care, and education for the parents. How to classes, what if classes, red flag classes, how to dress your child for the weather and elements…"
2. Availability of safe and affordable childcare for infants	"Desperate need for quality and affordable infant care"; "Listings/rankings of safe daycares"
Top two most frequently cited unmet needs - Providers	**Responses – Examples**
1. Postpartum support and education for parents/caregivers	"Postpartum education and follow-up and home visiting in the postpartum"; "postpartum follow up. NOT just routine baby visits to a doctor, but individual visiting with the new mom and baby for the purposes of support, assessing problems early, and prevention of neglect, abuse, and morbidity"
2. Lactation and breastfeeding/chest-feeding support	"I feel the need centers on more breastfeeding support. Too many people give up and pediatrician offices do not provide this level of support. In many cases, by the time we get these families the parent has given up and is using formula"; "Continuous support and assessment of breastfeeding/chest-feeding babies"

3. **Child Health:** The existing Title V priority for the child health domain is to reduce the rates of child mortality and injury, especially where there is inequity. The rate of hospitalization for nonfatal injury among children ages 0 through 9 has decreased from 152 deaths per 100,000 in 2016 to 139.8 in 2018. The prevalence of nonfatal injury hospitalization is highest among children less than 1 and is nearly two times higher among black children ages 0 through 9 as compared to white children. The most recent available data suggest that the rate of mortality among children in PA between the ages of 1 and 9 continues to fluctuate – there was a slight increase from 15.1 deaths per 100,000 in 2017 to 16.4 deaths per 100,000 in 2019. Similar to the patterns apparent in hospitalization data, the child mortality rate is nearly two times higher among younger children, between the ages of 1 and 4, as compared to the rate among children ages 5 through 9 and is also nearly two times higher among black children as compared to white children. The BFH remains committed to identifying additional strategies linked to the existing priority that may drive improvement in child mortality and address the disparities by age and race that persist among children for both mortality and injury hospitalizations.

   Given newly available two-year estimates from the National Survey of Children's Health (NSCH), there are several changes to note for child health. Potential improvements include an increase in the percentage of children ages 9 through 35 months who received a developmental screening using a parent-completed tool (26.1% in 2016-2017 to 35.2 in 2018-2019) and a minor increase in the percentage of children ages 6 through 11 who are physically active at least 60 minutes per day (28.8% during 2016-2017 to 31.3% during 2018-2019).

   Conversely, 2018-2019 data suggest a decrease in the percentage of children reported to be in excellent or very good health and a potential increase in the percentage of children not receiving needed mental or behavioral health care. Additionally, a change in the NSCH question about bullying may have resulted in better characterization of bullying among children ages 6 to 11 in the state. The updated question asks parents/caregivers to consider all instances of bullying, even if it occurred only once or twice, in the past year. In the prior iteration of the survey question (2016-2017), only 17.2% of parents said it was "true" or "somewhat true" that their child was ever bullied, excluded, or picked on. While not directly comparable, the new question (2018-2019) suggests that ~59.1% of children ages 6 to 11 were bullied at least once in the past 12 months.

   Data from the public input survey (Table 3) reaffirm the continued importance of the existing priority around improving the mental, behavioral, and developmental health of children with and without special health care needs. While the BFH does not currently have any specific activities linked to this priority in the child domain of the action plan, identification of potential strategies will be ongoing in 2022.

   The second most frequently cited need by child health providers who responded to the public input survey was access to dental care (Table 3). While 2018-2019 data suggested an increase in the percentage of children in PA who had a preventive check-up, a dental visit, or a flu vaccination in the past 12 months, disruptions to routine care that resulted from COVID-19 may require additional efforts to maintain and increase access to care and vaccination among children moving forward. The BFH has taken steps to raise awareness of the importance of preventive services for children, such as by amplifying HRSA's "Well Child Wednesday" social media campaign among stakeholders, and will continue to coordinate with partners, such as the Bureau of Community Health Systems and the Bureau of Health Promotion and Risk Reduction, to boost Title V's capacity to support the provision of direct, safety net services for children.

Table 3: Summary of public input survey responses to question about unmet child health needs in Pennsylvania by respondent type, 2021

Top two most frequently cited unmet needs - Service recipients/caregivers	Responses - Examples
1. Support for children who experience neglect, abuse, or other adverse childhood experiences	"Stricter penalties for child abuse and neglect. More investigation into abuse and fraud of welfare and state support. Too many families "using" children to fraud government, harming children"; "Potential abuse or neglect at home"; "[support for] children who lost parent to the opioid crisis [or] criminal justice violence"
2. Mental and developmental health	"Learn how to socialize again"; "Social isolation lack of ability to get out"; "Social interaction with peers"; "Caregivers need to understand what they are looking for when they see behaviors"
Top two most frequently cited unmet needs - Providers	**Responses – Examples**
1. Mental health resources, services, and support	"To be in a safe environment that nurtures positive relationships and protects them from abusive treatment by peers"; "mental health needs related to changes in school environment and bullying"; "Mental health resources"
2. Access to dental care	"Lack of dental care"; "Early access and continued dental care"; "Sometimes all health needs are unmet due to the location of the closest child hospital. More accessibility would help meet these needs in a timely manner. This includes pediatric dentists."; "Only 20% of our children enrolled in Medicaid are seeing a dentist before age 3..."

4. **Adolescent Health:** The existing Title V priorities for the adolescent health domain are reduce rates of mortality and injury (especially where there is inequity), improve mental health, behavioral health, and developmental outcomes, and support and effect change at the organizational and system level by supporting policies, programs, and actions that advance health equity. While the adolescent mortality rate among youth ages 10 to 19 has continued to decline from 31.8 deaths per 100,000 in 2017 to 27.9 deaths per 100,000 in 2019, the mortality rate remains higher among youth aged 15 to 19 (44.1 deaths per 100,000) as compared to youth aged 10 to 14 (14.8 deaths per 100,000) and the mortality rate remains nearly two times higher among black adolescents as compared to white adolescents. The suicide rate among adolescents aged 15 to 19 has continued to rise in PA from 8.2 deaths per 100,000 during 2014-2016 to 9.3 deaths per 100,000 during 2017-2019. Five-year estimates from 2015-2019 suggest that suicide rates are higher among males (13.4) as compared to females (4.8) and that suicide rates appear higher among youth who reside farther from a metro area (large central metro 6.6; large fringe metro 8.8; small/medium metro 9.7; non-metro 13.3). Corresponding data from YRBS suggest an increased prevalence of high school aged youth who self-report depression (29.4% in 2017 to 34.5% in 2019) or suicidal ideation (15.1% in 2017 to 17.2% in 2019). Additionally, from 2015 to 2019 the prevalence of depression or suicidal ideation has remained nearly two times higher among youth who identify as gay, lesbian, or bisexual, as compared to heterosexual youth.

   New data allow for improved characterization of several indicators of the health status of adolescents in PA. Improvements include the continued, significant decline of nonfatal injury hospitalizations among youth ages 10 to 19 from 242.5 hospitalizations per 100,000 children in 2016 to 210.1 in 2018, and an increase in the percentage of adolescents that receive services supporting transition to adult health care from 16.3% during 2016-2017 to 20.3% during 2018-2019. The percentage of youth ages 12 to 17 who report experiencing bullying also significantly declined from 27.9% in 2017 to 23.5% in 2019, but the prevalence of bullying remains higher among youth who identify as gay, lesbian or bisexual (19.3%) as compared to heterosexual youth (8.8%). The percentage of adolescents who are active for at least 60 minutes per day decreased slightly from 19.8% in 2016-2017 to 17.3% in 2018-2019. Strategies that address bullying fall within the existing priority around mental and behavioral health. Given the relationship between mental and physical health, several existing strategies linked to the mental health priority aim to build protective factors among youth (i.e. access to a mentor) while also promoting physical activity.

   Given the adolescent mortality and mental health data and the persistent disparities, the aforementioned priorities and associated strategies that aim to promote development of protective factors among youth remain an essential component of the Title V action plan, especially for improving adolescent mental health. Adolescent health providers engaged during the LEAH site visit promoted youth programming that facilitates development of protective factors and skill-building, especially to promote mental health and the transition to adulthood. Responses from the public input survey (Table 4) further confirm the importance of mental health resources for adolescents, as well as the need for sexual and reproductive health services and education – the latter being another existing strategy encompassed within the health

equity priority.

Table 4: Summary of public input survey responses to question about unmet adolescent health needs in Pennsylvania by respondent type, 2021

Top two most frequently cited unmet needs - Service recipients/caregivers	Responses - Examples
1. Mental health	"Adolescent depression, anxiety, and suicide"; "increasing youth satisfaction with life"; "Good mental health services"; "there should be programs to help them with peer pressure"
2. Safe activities/opportunities to socialize	"They need to be with each other during this pandemic"; "There are no activities that are healthy in the community. There needs to be opportunities to socialize for kids that are safe"
Top two most frequently cited unmet needs - Providers	**Responses – Examples**
1. Mental health (including social and emotional health)	"Social and emotional learning, opportunities to be heard"; "bullying and mental health needs"; "access to health care, including mental health care"; "COVID has created tremendous pressure and stress on our adolescents, evidenced by rising rates of suicide. I really believe we need to focus some effort on helping adolescents cope with the stress they've experienced while home bound and unable to be out with friends in any normal fashion"
2. Sexual and reproductive health services and education	"More school-based sexual health resources"; "comprehensive sexual health education from 5-12 grades, need for sexual and reproductive health experts that they can trust and are easy to access"; "education on reproductive anatomy and resources to obtain healthcare"; "Receiving comprehensive sexual health education"

In addition to advancing each of the existing priorities, the BFH is in the process of exploring means of improving its engagement and inclusion of youth in strategy identification, development, and implementation. Adolescent health providers at the LEAH site visit shared examples of successful youth engagement via telehealth, real-time text surveys, intervention mapping, and inclusion of youth on advisory boards. Youth across focus groups agreed that one of the most important things that they learned from the session was that "some adults really do want to listen and hear youth," highlighting the importance of this effort and making youth voices heard.

5. **Health of CSHCN:** The existing priorities for the CSHCN domain are improve the mental health, behavioral health, and developmental outcomes of CSHCN and improve the percentage of CSHCN, including infants, who receive care in a well-functioning system. In PA, bullying is more frequently reported among CSHCN as compared to children who do not have a special health care need. As of 2018-2019 47.9% of CSHCN aged 12 to 17 experienced bullying in the past 12 months as compared to 32.7% of children without special health care needs. The prevalence of experiencing an adverse childhood experience also remains higher among CSHCN in PA as of 2018-2019 (25.3% among CSHCN; 19.4% among children without special health care needs). While the existing priority around mental health and developmental outcomes is sufficiently broad to address promoting protective factors that may help CSHCN address trauma or bullying, identification of strategies that link to this priority is still ongoing.

While there was an increase in the percentage of CSHCN who receive care in a well-functioning system in PA (from 16.5% during 2016-2017 to 21.6% during 2018-2019), given that less than a quarter of all CSHCN in the state receive such care, this remains an important priority that encompasses various factors at the system-level. As of 2018-2019, the percentage of CSHCN receiving care in a well-functioning system is lowest among CSHCN aged 12 to 17 (10.1%) as compared to CSHCN aged 6 to 11 (33.7%) or 0 to 5 (22.3%). Upon reviewing the well-functioning system's component parts, the areas where most improvement is needed are access to a medical home and transition services. While the percentage of CSHCN aged 12 to 17 receiving transition services increased from 15.8% during 2016-2017 to 26.7% during 2018-2019, the percentage of CSHCN aged 0 through 17 in PA with a medical home has significantly declined from 51.8% in 2016 to 44.5% during 2018-2019. While strategies aimed at improving transition services are currently being implemented, in 2022 the BFH will continue to consider how to improve access to medical homes. The need for additional system-level supports for families as they seek to access and coordinate care is further emphasized by the responses from the public input survey (Table 5).

Table 5: Summary of public input survey responses to question about unmet health needs among children with special health care needs in Pennsylvania by respondent type, 2021

Most frequently cited unmet need - Service recipients/caregivers	Responses - Examples
1. Access to care*	"Services are available in the city, which is too far and expensive. Bring the services to the people"; "Specialists mainly in the city, not convenient"
Top two most frequently cited unmet needs - Providers	**Responses – Examples**
1. Access to care	"Isolation due to school closures, lack of stability that community/school can provide and deferred care or services"; "COVID has restricted the ability of professionals to provide in-home and in-person services. Some professional services have successfully incorporated virtual services, but others are unable to effectively"; "Care closer to home"; "The availability of trained caregivers to provide shift care"; "Access to pediatric pain management, mental health, equipment…"
2. Care coordination	"getting them referred and enrolled in the network of services. Families that accept love the services"; "Lack of synergistic services; good services operating in relative silos"; "streamlined referral process to [Early Intervention]"

*NOTE: Among service recipients/caregivers, the need listed was the only one cited.

The newly available 2018-2019 data from NSCH also allow for improved characterization of several CSHCN indicators. The percentage of CSHCN ages 0 through 17 who are continuously and adequately insured increased from 64.6% during 2016-2017 to 72.1% during 2018-2019. Several other apparent improvements include a decrease in the percentage of CSHCN ages 10 through 17 who are obese (28.4% during 2016-2017 to 14.9% during 2018-2019) and a decrease in the percentage of CSHCN ages 1 through 17 who had decayed teeth or cavities in the past year (17.5% during 2016-2017 to 15.1% during 2018-2019). However, the prevalence of tooth decay/cavities remains higher among CSHCN (15.1%) as compared to children without special health care needs during 2018-2019 (8.6%). As access and receipt of preventive medical and dental care is a component of a well-functioning system, associated strategies that address access to dental care among CSHCN can be encompassed within the existing priority and capacity of the BFH and its partners.

Given that infants are now included in the definition of CSHCN, the BFH is in the process of evaluating its existing services for infants with special health care needs and identifying gaps. One potential change that should be noted for infants with special health care needs is the rate of infants born with neonatal abstinence syndrome (NAS) per 1,000 hospital births. PA Health Care Cost Containment Council (PHC4) data demonstrated a marked increase in NAS hospitalizations from 5.1 cases per 1,000 hospital births in 2008-2009 to a peak of 15.0 cases per 1,000 hospital births in 2016-2017. Data from 2018-2019 suggest that hospitalizations for NAS may be on the decline statewide (13.8 cases per 1,000 hospital births in 2018-2019). However, at the regional level, rates of NAS continue to vary markedly by county across the state. Strategies that support infants born with NAS are linked to the well-functioning system priority.

Responses from the public input survey (Table 5) suggest that as the BFH continues to support a well-functioning system of care for CSCHN, including infants, additional focus on referral processes and increased education and support for families of infants may be needed.

Table 6: Summary of public input survey responses to question about unmet health needs among infants with special health care needs in Pennsylvania by respondent type, 2021

Top two most frequently cited unmet needs - Service recipients/caregivers	Responses - Examples
1. Increased parent/caregiver education and awareness about available resources and services	"Early Intervention [EI] through the Department of Human Services is a wonderful resource that many mothers do not know about. I was not informed at the hospital that because my infant was in the NICU that he automatically qualified for EI services"; "Make sure the families have the red flags information. Make sure the families have the Watch Me Grow information so that they can monitor the child's milestones."
2. Access to specialty care	"Bring the treatments and assessments closer. Specialty care is too far and a huge expense for some families"; "Provide free transportation for mothers/infants to get to care."
Top two most frequently cited unmet needs - Providers	**Responses – Examples**
1. Training and support among providers and hospitals on successful referral of families to needed services	"Have more teams that are dedicated to following up on the referrals...referrals are made for services but somehow the ball gets dropped...person making the referral may not have time to follow up due to other responsibilities, time, care load, etc."; "Need a list of special healthcare need diagnoses codes to be utilized to improve screening for and referrals to services"; "Improvement of resource guides for the hospitals so they are aware of all the services and resources available, especially in rural areas of the state"
2. Increased education and support for families about available resources and services	"Case management programs"; "parents need inclusion in supportive services, such as support groups and postpartum home visits"; "I am not sure parents always understand how to enroll in programs such as early head start or early intervention"

3. Capacity Assessment

9. **Changes in Organizational Structure and Leadership:** Governor Tom Wolf appointed Alison Beam as Acting Secretary to the Department of Health and Dr. Denise A. Johnson as Acting Physician General following Dr. Rachel Levine's departure to serve as Assistant Secretary of Health at the U.S. Department of Health and Human Services in January 2021.The BFH's Director (Tara Trego), Division Directors (Erin McCarty, Stacey Gustin, and Cindy Dundas), Title V Block Grant Coordinator, and MCH Epidemiologist (Nhiem Luong) continue to lead the planning, evaluation, and data analysis required to administer the Title V program. The previously vacant director position of the Division of Child and Adult Health Services has been recently filled by Kathy Jo Stence.

   Two new positions were added to the Title V leadership team. A Public Health Program Manager position in the Division of Bureau Operations was filled by TaWonda Jones-Williams; this position supervises the Title V Block Grant Coordinator and provides oversight of the completion of the annual Title V report/application in addition to supporting the BFH's health equity, workforce development, and client and family engagement efforts. The BFH also created a new MCH Epidemiology Research Associate (ERA) position in 2020, which was filled by Caryn Decker. This position provides epidemiological support through collection, analysis, and interpretation of MCH data to inform public health program development, implementation, and evaluation. The position also supports ongoing needs assessment activities. After Caryn Decker departed the Title V Block Coordinator role to fill the MCH ERA position, the coordinator position was vacant, but has since been filled by Morgan Williams-Fake.

1. **Title V Program Capacity:** The capacity of the Title V program to serve the MCH populations in PA remains robust due to its continued implementation of strategies and programs that support essential public health services and systems. Changes in program capacity for each domain, including CSHCN, are described further in the state action plan narrative by domain for the application year.

   A component of program capacity is the tenure and experience of BFH staff supporting Title V. Approximately 43% of BFH staff have been in their current positions for less than three years. This suggests improved retention since the last workforce capacity survey which indicated that more than half of all staff had been in their position for less than three years. Among staff with a short tenure, half were program staff; most managers and directors (62%) have been in their positions for three years or more. Additionally, the percentage of BFH staff who report at least three years of public health experience has

increased from 70% in 2020 to 82% in 2021. Improved retention provides the program with continuity and a workforce that is increasingly experienced in public health is an asset. Additionally, the combination of seasoned management staff and new program staff remains a strength of the Title V program as it seeks to continually adapt to new perspectives and the ever-evolving MCH evidence base.

2. **Title V Program Partnerships, Collaboration, and Coordination**
   An updated table of partnerships (Table 7) is below.

Table 7: Title V Partnerships, Collaboration and Coordination

Other MCHB Investments	
State Systems Development Initiative (SSDI)	The BFH administers the HRSA-funded SSDI grant that complements the Title V MCH Block Grant program by improving the availability, timeliness, and quality of MCH data. The SSDI grant is used to build state MCH data capacity to support Title V programs in making data-driven decisions. Data will include sources from the Department of Health as well as stakeholders and partners. Utilization of these data is central to the BFH's capacity to assess the Title V program, implement and evaluate its programming and complete the annual Title V MCH Block Grant application.
Parent Education and Advocacy Leadership Center (PEAL)	PEAL is the Family-to-Family Health Information Center for PA. The BFH collaborates with PEAL to create leadership opportunities for children and youth with special health care needs.
Leadership Education in Neurodevelopmental Disabilities (LEND) Fellowship Program	The BFH partners with the Leadership Education in Neurodevelopmental Disabilities (LEND) program at Children's Hospital of Philadelphia (CHOP). LEND is a fellowship for professionals who are completing or recently completed an advanced degree in healthcare fields associated with maternal and child health, family members who care for children with neurodevelopmental or related conditions, or an individual who has experienced a disability or chronic condition in their own life, and who is looking to expand their knowledge and experience with leadership. The BFH and the LEND program maintain communication about projects related to maternal and child health, look for opportunities to collaborate, and the BFH's Family Delegate serves on the LEND Community Advisory Board. Through this partnership, the LEND program is able to make appropriate referrals to the BFH's programs.
Leadership Education in Adolescent Health (LEAH) Fellowship Program	The Leadership Education in Adolescent Health and Young Adult Health (LEAH) Fellowship Program at the Children's Hospital of Philadelphia (CHOP) prepares health professionals for leadership roles in public health and focuses on improving the health and well-being of adolescents and young adults. Enhancing the capacity of Title V programs to respond to current and emerging health needs of adolescents and young adults is a specific focus of the program. Department staff meet with the LEAH fellows and their leadership once a year to provide an overview of the Title V Maternal and MCH Block Grant, summarize current adolescent health programming, and discuss possible collaboration.
Drexel MCH Public Health Catalyst Program	The purpose of the Catalyst program at Drexel is to provide an increased focus on fundamental MCH content and competencies. The BFH recently developed a relationship with this program and is exploring opportunities to engage students.
Other Federal Investments	
School Re-Entry Program (BrainSTEPS)	The BFH represents the Department of Health as a lead and founding partner with the PA Department of Education for the BrainSTEPS (Strategies Teaching Educators, Parents and Students) Program. BrainSTEPS works to ensure that those who provide educational support to children with brain injury understand brain injury, its challenges, and the supports and interventions that help students achieve optimal educational success.
Traumatic Brian Injury (TBI) Implementation Grant	The BFH leads initiatives aimed at increasing awareness of brain injury. These activities include training to increase awareness of TBI and screening for TBI within the juvenile justice and older adult population. The BFH has also implemented a NeuroResource Facilitation Program to connect individuals with brain injury to appropriate resources. Through the federal TBI grant, the BFH serves as a mentor to other states in the areas of juvenile justice and return to learn programs.
Sudden Unexpected Infant Death (SUID) Registry and the Sudden Death in the Young (SDY) Registry	The BFH was awarded a cooperative agreement with the Centers for Disease Control and Prevention in 2018 for the SUID and SDY Registries. The SUID and the SDY registries fall within PA's Child Death Review Program. Unexplained, undetermined and sleep-related deaths of infants fall under the SUID registry. Sudden and unexplained deaths of children and youth from birth through age 21 fall under the SDY registry. The purpose of the registries is to understand the underlying causes of death in order to develop prevention recommendations. The work of SUID registry is supplemented with Title V monies and the work of the SDY registry is funded completely with Title V monies.
The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS)	PA PRAMS is an epidemiologic surveillance system managed within the BFH. The program collects unique state-specific, population-based data on maternal attitudes and experiences before, during and after pregnancy. Data are analyzed and shared to inform MCH program and policy development both within the Department of Health and by external partners and stakeholders.
Sexual Risk Avoidance Education (SRAE)	The BFH partners with Temple University Harrisburg to implement the Teen Outreach Program (TOP) at six sites across PA. TOP is an evidence-based, positive youth development program that promotes the healthy development of youth in grades 6-12. Temple University Harrisburg serves as the TOP replication partner and is responsible for fidelity monitoring, data collection and evaluation, training and technical assistance.
Personal Responsibility Education Program (PREP)	The BFH administers PREP, which provides evidence-based teen pregnancy prevention programs, education on healthy relationships, adolescent development, and healthy life skills. The BFH partners with Persad Center, Inc. to provide lesbian, gay, bi-sexual, transgender and questioning (LGTBQ) cultural competency services to PREP implementation sites. Services include an assessment of organizational LGBTQ cultural competency, LGBTQ 101 and advanced trainings for staff as well as ongoing technical assistance.

Childhood Lead Poisoning Prevention Program (CLPPP)	The BFH administers the CLPPP by partnering with six County/Municipal Health Departments to implement activities to reduce lead exposures and lead poisoning in children under the age of six. CLPPP aims to increase the number of children tested, enhance its ability to collect data, use data to determine where to target interventions, educate the public and professionals working on lead poisoning prevention, identify children who have been exposed to lead, and link those children to appropriate follow-up services.
Maternal & Child Environmental Health Collaborative Improvement and Innovation Network (MCEH CoIIN)	BFH staff participate in the Maternal & Child Environmental Health Collaborative Improvement and Innovation Network, which seeks to strengthen blood lead testing, surveillance, population-based interventions, and processes to identify lead exposed children and linkages to service.
Child Safety Learning Collaborative (CSLC)	Staff from the BFH are participating in CSLC. Through the CSLC, states and jurisdictions are working with one another to increase the adoption of evidence-based policies, programs, and practices at state and local levels. The collaboration aims to reduce injuries, violence, and deaths in children and adolescents ages 1-19 in supported topics such as Bullying Prevention and Sudden Unexpected Infant Death Prevention.
Lead Hazard Control Program (LHCP)	With funding from the Department of Housing and Urban Development (HUD), the BFH partners with local governments to administer the LHCP in targeted areas of PA. The program works to create lead-safe home environments for low-income families with children under age six. Additionally, the program aims to increase the capacity of the local government to attain HUD funding directly.
Lead Testing in Schools and Child Care Program Drinking Water Grant	Through the Environmental Protection Agency (EPA) Federal Water Infrastructure Improvements for the Nation (WIIN) Act, the Department of Health and BFH partner with the Department of Environmental Protection (DEP), the Department of Education (PDE), the Department of Human Services (DHS), and PENNVEST to implement the Lead Testing in Schools and Child Care Program Drinking Water Grant. This testing program seeks to use the EPA 3T testing model to test drinking water in approximately 3,000 schools and child care facilities for lead and provide remediation plans should elevated lead levels be found.
Other HRSA Programs	
Pennsylvania Association of Community Health Centers (PACHC)	The BFH provides Title V funding to PACHC to support systems improvement for CSHCN within HRSA-funded Federally Qualified Health Centers (FQHC) across the state.
Newborn Hearing Screening Program	The BFH provides universal newborn hearing screening and intervention through a HRSA grant. Children identified as deaf or hard of hearing are referred to the Tuscarora Intermediate Unit, through a grant agreement, to receive parent and deaf mentor services.
State and Local MCH Programs	
Child Death Review Teams (CDR)	The BFH is responsible for administering the CDR Program and works closely with key stakeholders including the PA State Coroner's Association, the Department of Human Services, the PA State Police, Bureau of Emergency Management Services, the PA District Attorney's Association, as well as medical examiners, pediatricians and neonatologists. The goal of CDR is to reduce the incidence of preventable child deaths by combining multi-agency and multi-disciplinary reviews of these deaths to identify risk and implementation and evaluation of targeted prevention efforts.
Philadelphia Special Needs Consortium (PSNC)	The BFH partners with the PSNC, operated through the Philadelphia Public Health Department, to provide programs and resources for CSHCN and their families.
Family Planning Councils	The BFH provides Title V funding to the four family planning councils: AccessMatters, Adagio Health, Family Health Council of Central PA, and Maternal and Family Health Services. The four councils are the designated Title X (National Family Planning Program) Grantees for the state of Pennsylvania. Funds are supplemental to Title X funds and are used to provide reproductive health services to youth 21 years of age or younger.
Maternal Mortality Review Committee	The through a grant provided by the CDC, the BFH works with the MMRC to develop and implement recommendations to reduce the maternal mortality rate in PA.
Perinatal Periods of Risk (PPOR)	Utilizing Title V funding, the BFH is partnering with Allegheny County Health Department, the Philadelphia Department of Public Health, and the Maternal and Child Health Consortium of Chester County to conduct Perinatal Periods of Risk (PPOR) assessments. PPOR is an analytic framework for studying racial disparities in fetal and infant mortality rates in urban communities; it helps communities determine the period(s) of risk with the most disparity in deaths, in order to appropriately focus community efforts. The goal of this partnership is to foster greater cooperation in improving MCH through more effective data use, strengthened data capacity, and greater shared understanding of complex infant mortality issues, and reduce disparities in infant mortality in the selected communities.

Other programs within the state Department of Health	
Bureau of Health Promotion Risk Reduction (BHPRR)	The BHPRR within the Department of Health administers the Violence and Injury Prevention Program and oversees the Injury and Violence Prevention Network (IVPN). It also houses the Division of Obesity, Physical Activity and Nutrition. The Title V grant pays for 85% of a position in the Bureau of Health Promotion and Risk Reduction. This partnership with HPRR furthers the BFH's maternal and child health work across several of our programs related to child safety and injury prevention, including: Representation on the TBI Advisory Board; inclusion of TBI awareness activities in HPRR programs; collaboration between Child Death Review and Safe Kids PA. Through this collaboration the BFH aims to develop a comprehensive and coordinated injury prevention effort with the IVPN. Additionally, the BFH partners with the Division of Obesity, Physical Activity and Nutrition to provide information and assistance regarding breastfeeding across PA.
PA Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	The BFH partners with WIC to jointly develop breastfeeding education materials and to ensure that community-based breastfeeding initiatives involve collaboration with local WIC agencies and populations. Additionally, electronic records are routinely shared between the PA PRAMS program and WIC to identify telephone numbers for sampled and surveyed mothers. This collaborative relationship serves to elevate the PA PRAMS survey response rate. Lastly, BFH partners with WIC to ensure PKU formula is provided for CSHCN through five years of age.
Bureau of Public Health Preparedness (BPHP)	The BFH's Family Advisor collaborates with the BPHP on emergency preparedness planning for CSHCN.
Office of Health Equity (OHE)	The BFH collaborates with OHE on initiatives related to health equity and ensures that cultural and linguistic competence standards are met across the Department of Health and within BFH programming. The BFH uses Title V to fund a position within OHE to support this work.
Bureau of Epidemiology	The BFH is funding an MCH epidemiologist and epidemiology research associate in cooperation with the Bureau of Epidemiology to provide data and trend analyses for all MCH programming within the BFH. The MCH epidemiology staff allocate time to PRAMS, Title V Needs and Capacity Assessment, and other MCH analyses. The MCH epidemiology staff are supported by a senior epidemiologist from the Bureau of Epidemiology.
The Pennsylvania Dept. of Health's Bureau of Health Statistics and Research (BHSR), Division of Vital Statistics	The BFH has an ongoing collaboration with BHSR. The BFH's Division of Newborn Screening and Genetics works with BHSR to ensure that all PA newborns with a birth certificate have newborn screenings performed. Additionally, BHSR pulls the monthly PRAMS batch files from the birth certificate records in accordance with the defined sampling frame and provides PRAMS staff with the annual final birth file which is needed by the CDC to weight the PRAMS data. Similarly, the Child Death Review process begins when the BHSR provides vital statistics information to the BFH on a monthly and a quarterly basis. The BFH compiles the data and securely disseminates it to the local CDR teams. Local teams use this information to initiate collaborative, multidisciplinary reviews.

Bureau of Communicable Diseases	The mission of the Bureau of Communicable Diseases is to reduce the incidence and prevalence of communicable diseases in PA. A component part of that work is to provide vaccines for specific diseases that affect infants, children, adolescents.
Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS)	PA-NEDSS is a statewide, web-based surveillance system that receives and stores reports for all diseases reportable to the Department of Health. Data stored within PA-NEDSS can be used to identify high-risk areas, analyze service gaps, and inform programmatic decisions. The ongoing maintenance of PA-NEDSS is a collaborative effort between the Bureau of Informatics and Information Technology (BIIT) and several programs within the Department including those in the BFH.
Bureau of Community Health Systems (BCHS)	The BCHS, through the six health districts, operates a network of state health centers and supports public health programs throughout the commonwealth. Health centers engage in community health assessment and quality assurance activities and provide other public health services, including community integration and outreach programs, to promote healthy behaviors.
Bureau of Informatics and Technology (BIIT), Division of Health Informatics	The BFH works with BIIT to access and utilize maternal and child health data and datasets.
William Penn Fellowship Program	The William Penn Fellowship is granted to talented, passionate individuals with a commitment to public service and a drive to help make PA a better place to live. The program provides aspiring professionals with the opportunity to serve and learn with the state's top executive leaders. To date, the BFH has worked with a William Penn Fellow placed in the Department of Health on MCH policy and other related projects in PA.
Other governmental agencies	
Lead Learning Network	The BFH participates in the Lead Learning Network which convenes agencies across PA to discuss funding, programming and strategies for reducing lead poisoning and exposure, testing all children for elevated blood lead levels and training more lead abatement certified professionals to remove the hazard of lead from PA's aging housing stock.
Department of Drug and Alcohol Programs (DDAP)	The BFH collaborates with DDAP on training opportunities through their Training Management Systems. Brain Injury and Opioid training programs created by BFH have been made available to Human Service Personnel and Substance Abuse Counselor Professionals on TMS.
Department of Education (PDE)	PDE is an important partner with the BFH for CSHCN programming. They are a resource and referral source for families with concerns related to Individual Education Plans (IEPs) and 504 Plans. In addition, BFH works closely with the PA Training and Technical Assistance Network (PaTTAN) operated through the PDE. PaTTAN coordinates the Transition State Leadership Team, as well as the Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW) groups on the topic of transition of YSHCN to adulthood. Additionally, BFH partners with PDE to develop school age TBI services such as the School Re-Entry program (BrainSTEPS). Additionally BFH partners with PDE to reach schools to support testing drinking water for lead.

Department of Labor & Industry	The BFH works with the Office of Vocational Rehabilitation (OVR) through Labor and Industry on the transition of CSHCN to adulthood.
Department of Human Services (DHS)	The BFH partners and collaborates with several different offices of DHS to meet the needs of families of CSHCN, including the Office of Medical Assistance Programs (OMAP), Office of Mental Health and Substance Abuse Services (OMHSAS), the Medical Assistance Transportation Program (MATP), and the Office of Child Development and Early Learning (OCDEL), which is an office operated jointly by the Departments of Education and Human Services. The Division of Newborn Screening and Genetics collaborates with the OCDEL to share data related to Early Intervention at Risk Tracking for newborns born with Neonatal Abstinence Syndrome. Additionally, callers to the Healthy Baby Helpline are often referred to the online COMPASS program where individuals can apply for medical assistance and other benefits. Further, the BFH collaborates with DHS on a childhood lead data match project and outreach to child care facilities to test drinking water for lead. On a quarterly basis, claims data for Medical Assistance (MA) children are matched against BFH data on children who were tested for lead poisoning. BFH staff also participate on the Fetal Alcohol Spectrum Disorder (FASD) Task Force to assist in the development of a comprehensive system of care for individuals born with a FASD. Additionally, MA pays for newborn screening costs associated with the filter paper blood specimen and PKU monitoring.
Department of Environmental Protection (DEP)	The BFH collaborates with DEP for drinking water expertise to support childhood lead poisoning prevention through the Lead Testing in Schools and Child Care Program Drinking Water Grant.
PENNVEST	The BFH collaborates with PENNVEST to support the distribution of funds and contract management of childhood lead poisoning prevention through the Lead Testing in Schools and Child Care Program Drinking Water Grant.
Pennsylvania Department of Transportation (PENNDOT)	A collaborative relationship between the BFH's Child Death Review (CDR) Program and PENNDOT serves to enhance child death review capacity. In securing traffic death information, the CDR program can provide local teams with critical information surrounding traffic fatalities.
Public health and health professional education programs and universities	
The Bloustein Center for Survey Research (BCSR) at Rutgers University	The BFH collaborates with the BCSR to administer Pennsylvania's Pregnancy Risk Assessment Monitoring System (PRAMS) survey implementation and data collection. The BFH is also partnering with BCSR to conduct a mixed-methods evaluation of the Pennsylvania Medical Home Initiative.
Trustees of the University of Pennsylvania	The BFH collaborates with the Trustees of the University of PA to provide interconception care to mothers between pregnancies to improve health outcomes for women, newborns and children. The BFH also collaborates with the Trustees to implement a hospital-based model safe sleep program throughout PA as well as a social marketing plan.

Clemson University	The BFH partners with the Clemson University Institute on Family and Neighborhood Life to train and certify community youth organizations to implement the Olweus Bullying Prevention Program.
The PA State University (PSU)	The BFH partners with PSU as a grantee implementing the Personal Responsibility Education Program (PREP) to youth. The program provides youth with information on abstinence, contraception, healthy relationships, adolescent development and life skills.
University of Pittsburgh	The BFH supports the University of Pittsburgh's collection of data through the Behavioral Risk Factor Surveillance System (BRFSS) for Pennsylvania.
Specialty Care Program	The BFH administers over 28 contracts with the major health systems in PA. The Specialty Care Program provides services to PA residents with sickle cell disease, spina bifida, hemophilia, cystic fibrosis, Cooley's anemia, and autism. The Specialty Care Program utilizes Title V and state funds to enhance care coordination, improve access to care, enhance individualized care planning, increase mental health screenings, and engage clients and families in program services. One of the Specialty Care Program grantees is Drexel University.
Family/Consumer Partnerships and Leadership Programs	
Traumatic Brain Injury Advisory Board (TBI)	The BFH supports the TBI Advisory Board which is comprised of an ethnically and culturally diverse group of individuals who have a commitment to serving those with brain injuries. Advisory Board members include individuals living with TBI, family members of individuals with TBI, representatives from several government agencies, and community-based organizations in TBI service provision and advocacy. The Board includes representation from the following entities: Rehabilitation and Community Providers Association, PA Training and Technical Assistance Network, PA Insurance Department, PA Department of Aging, Council on Brain Injury, Bureau of Emergency Medical Services, Office of Vocational Rehabilitation, PA Athletic Trainers' Society, Office of Long-term Living, Office of Mental Health & Substance Abuse Services, PA Department of Corrections, Centers for Independent Living, RESTART Your Life/RENEW Your Mind, Brain Injury Association of PA, Bureau of Health Promotion and Risk Reduction, Disability Rights PA, Developmental Disabilities Council, and Traumatic Brain Injury Model Systems.
The Pennsylvania Perinatal Partnership (PPP)	The PPP represents the collaborative efforts of PA's Healthy Start Projects and Maternal and Child Health Programs. There is an ongoing collaboration between PA PRAMS, administered by the BFH, and the PPP.
Eastern PA Special Needs Consortium (Association)	The BFH supports the Eastern PA Special Needs Consortium as a formal network for medical providers, social service providers, legal advocates, local and state health departments and parents of technology-assisted children to learn more about issues related to care of technology-assisted children.
PRAMS Committee	As part of participation in PRAMS, the BFH is required to have a PRAMS steering committee. The PRAMS Committee is currently composed of fourteen members including Department of Health staff and stakeholders representing a variety of maternal and child health programs and services.
Newborn Screening Technical Advisory Board/Newborn Hearing Screening Technical Advisory Committee	The BFH supports both the Technical Advisory Board and the Technical Advisory Committee to provide expertise, medical advice on medications, and guidance on program improvement. The Board deals with issues related to the metabolic portion of the Newborn Screening Program and the Committee deals with issues related to the hearing portion of the program.
Pritzker Children's Initiative	Bureau staff participate in the Pritzker Children's Initiative subgroup related to lead poisoning prevention. This group consists of participants from state and local government, managed care organizations, housing authorities, hospitals, health systems, home visiting and other social programs. The initiative aims to increase blood lead screening and referral rates, allocate state funding for remediation services and engage the public to eliminate lead poisoning in PA's children.

3. **Preparation for Five-Year Needs and Capacity Assessment**
   In an effort to further operationalize and publicize the results of the five-year needs and capacity assessment completed in 2020, the BFH developed a visual executive summary and fact sheets highlighting the strategies currently linked to the Title V priorities. The goal of these documents is to make the work of Title V more accessible, encourage public understanding of the program during the 2021-2025 funding cycle, and continue the engagement and momentum initiated by the five-year assessment. As described in the overview, ongoing needs assessment activities conducted in interim years will inform the five-year needs and capacity assessment in 2025.

4. **Capacity to Address Emerging Issues**
   Several emerging issues were identified through stakeholder engagement. Adolescent health providers identified adequate nutrition, food security, and access to accurate and thoughtful messaging about the COVID-19 vaccine as emerging issues among youth. The BFH will identify and evaluate opportunities to assess food security and incorporate resources and information related to nutrition within Title V programs where relevant and will explore opportunities to partner with the Bureau of Health Promotion and Risk Reduction which already houses youth programming addressing nutrition, diet, and exercise. The BFH also has the capacity to contribute to development of youth-appropriate messaging related to COVID-19 vaccines as opportunities arise and will be engaged in dissemination of resources to youth vendors, providers, and stakeholders once vaccines are available.

   When asked what the biggest issue is for youth, a common theme that emerged across focus group sessions with adolescents was the desire to feel safe and secure in their community. Youth expressed concern about gun violence, drugs, and living in an unsupportive community with a lack of safe spaces to gather or feel accepted. Lack of services and programs that promote youth mental health, especially among LGBTQ youth, was also cited. As the BFH builds its capacity to address system-level support for youth, it will continue to implement and promote strategies that aim to develop protective factors among youth to address stressors like trauma or isolation.

   LEND providers identified lack of mental health services for CSHCN, lack of coordinated care, and the continued importance of health literacy in all communications with families of CSHCN as persistent needs that have been exacerbated by the COVID pandemic. CSHCN providers also emphasized the importance

of recognizing that there are some families and some special health care needs that are not best served by telehealth. Given the existing priority around improving the mental and behavioral health of all children in PA, the BFH is building the capacity and identifying strategies to address this gap in the system of care. Similarly, care coordination, communication, and access to appropriate care are all needs that the BFH has the capacity to address within the well-functioning system priority.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Pennsylvania's 2020 Title V Five-Year Needs and Capacity Assessment was composed of several phases broadly described as preparation, assessment of the health status of maternal and child health (MCH) populations, prioritization and assessment of capacity. Preparation for the assessment included development of a work plan and timeline, assembly of a needs and capacity assessment steering committee and identification of the goals and guiding principle of the assessment. The goals identified were: 1) Identify urgent priority needs of the MCH population domains that can be feasibly addressed given the state Title V Program's capacity and workforce and; 2) Engage and collaborate with stakeholders to identify means of furthering the Bureau of Family Health's (BFH) mission to provide comprehensive, equitable and community-centered health services to the MCH populations. Health equity was the guiding principle of the 2020 assessment. As such, in addition to analyzing data and gathering information from stakeholders to characterize the health issues facing all MCH populations in Pennsylvania (PA), the assessment also aimed to identify specific population groups that are disproportionately affected by adverse health outcomes and to evaluate underlying social, economic and environmental determinants of health. During the preparation phase, the BFH presented on the plan at meetings with Title V stakeholders and service recipients to raise awareness of the assessment and encourage robust participation in web surveys, focus groups and the prioritization.

Figure 1: Outline of Prioritization Process

i.	Identification of values to guide selection of priorities
ii.	BFH identification and scoring of initial lists of potential priorities; Subsequent selection of four potential priorities for each population domain
iii.	In-service training of BFH staff to build capacity to facilitate working groups and take notes during regional stakeholder prioritization meetings
iv.	Regional prioritization meetings with stakeholders to request feedback on and ranking of potential priorities
v.	Additional efforts to collect feedback and ranking of potential priorities – distribution of ranking sheets at in-person events and via web survey
vi.	Analysis of stakeholder feedback; Solicitation of additional feedback from agency partners and BFH staff
vii.	Final selection of priorities

In order to assess the health status of maternal and child health populations in PA, staff members from the BFH were assigned a set of indicators and asked to gather data from the past five years in order to determine whether MCH outcomes had improved, declined or remained the same. Data were gathered for the following datasets: American Community Survey (2015-2017), CDC Wonder Detailed Mortality and Linked Infant Death/Birth Datasets (2012-2016), National Center for Fatality Review and Prevention – National Reporting System (2011-2015), National Immunization Survey (2014-2018), the National Survey for Children's Health (2016-2017), PA Youth Survey (2013, 2015 and 2017), PA Health Care Cost Containment Council (2008-2017), and the Youth Risk Behavior Survey (2009, 2015, 2017). Data from PA birth certificates and death certificates were summarized from the PA Department of Health's online data platform, Enterprise Data Dissemination Informatics Exchange (EDDIE) for 2012-2017 and data files were also procured for Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7 data (2012-2015), PRAMS Aggregate Site Data from 34 PRAMS sites (2012-2015), and the Behavioral Risk Factor Surveillance System (BRFSS) (2011-2017). Additionally, qualitative data on the health needs of families and communities across PA were collected from stakeholders via focus groups and a web survey. Results from the quantitative and qualitative data analyses were summarized into a series of data briefs highlighting both the strengths and needs of each population domain. The data briefs were then distributed to stakeholders in order to inform the prioritization phase of the assessment.

In consultation with a team from the Center of Excellence in MCH Education, Science and Practice Program at the Johns Hopkins Bloomberg School of Public Health, the BFH developed an iterative prioritization process that was designed to incorporate feedback from stakeholders. The process was informed by a literature review of needs assessment methods and the experiences of other states. An initial list of priorities was identified and scored by the needs and capacity assessment steering committee based on the needs identified through the analysis of quantitative and qualitative data. The potential priorities were then ranked by stakeholders at a series of regional prioritization meetings and through an online survey. Stakeholders invited to participate in prioritization included all current MCH vendors and partners, service providers, service recipients and their families as well as other organizations, persons, and groups with an interest or stake in maternal and child health in PA. These rankings were then used by the steering committee to inform final priority selection. An outline of the prioritization process is provided in Figure 1.

Finally, the BFH completed several activities to assess their capacity to carry out the mission of Title V and to direct work related to the newly proposed priorities. In addition to evaluating existing infrastructure and capacity, Title V staff were surveyed on strengths, training needs and competencies. The BFH also held an in-person meeting with the Department of Health and other agency partners at which the BFH sought feedback on the health needs that stakeholders had identified as the highest priorities, discussed organizational capacity and opportunities for collaboration.

To ensure that the assessment was comprehensive and that the process of developing state priorities and the action plan was directed by data and input from stakeholders, the ultimate direction of the assessment was informed by the results of each preceding phase. The BFH identified seven state priorities and, once finalized and approved by the Department of Health's leadership, the BFH developed its state action plan. While the BFH currently operates many existing programs and activities that address the new priorities, a component of action plan development was identifying gaps where new strategies could be developed. The development and implementation of new strategies will be informed by the data collected and

summarized over the course of the needs assessment. Additionally, health equity remains at the forefront of action planning and programming and activities will be implemented in areas and among populations where health disparities and inequity were most apparent.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

While the major health issues reflected in the state's priority needs are described below, the aforementioned data briefs provide a summary of all the health indicators evaluated for each Title V population domain. The data briefs are available online at the following link:
https://www.health.pa.gov/topics/Documents/Programs/Title%20V%20MCH%20Data%20Briefs.pdf.

Women/Maternal Health: Over the past five years, women in PA increasingly reported attending well-woman visits, discussing preconception health with medical providers, and taking a multivitamin containing folic acid prior to pregnancy. Additionally, the percentage of women who report smoking during pregnancy has decreased and women in PA also increasingly report attending postpartum care visits. The BFH has been successful in supporting women and mothers with gap-filling direct services by supporting home visiting for women who do not meet traditional eligibility criteria, providing interconception care programming and supporting Centering Pregnancy group prenatal care programs. Given that the scope of direct services is limited by program capacity and funding, the BFH sees an opportunity to develop system-level strategies addressing maternal health issues in PA.

Based on available data and feedback from stakeholders across the state, the BFH identified four key health issues affecting women and mothers in PA: 1) access to early and adequate prenatal care and preventive care; 2) increasing rates of maternal morbidity and mortality; 3) substance use and; 4) perinatal depression. The health issue ultimately reflected in the state's priority needs is maternal morbidity and mortality. Stakeholders consistently reported that they viewed this as a major issue for the state. Many referred to the stark racial disparity in maternal mortality ratios and expressed a desire for more solutions that might help to address it. While maternal mortality rates may be decreasing in PA, Black and African American women were almost three times as likely to die a pregnancy-related death than white women from 2011-2015 in PA. The rate of severe maternal morbidity per 10,000 delivery hospitalizations has also increased in PA from 85.8 women with severe morbidity per 10,000 delivery hospitalizations in 2010 to 114.8 in 2015. Maternal morbidity is also most apparent among minority women, especially among non-Hispanic black women. An associated challenge is improving protective factors during and after pregnancy, such as receipt of prenatal care. From 2015 to 2017, approximately 1.6% of women in PA did not have any prenatal care and 26.2% did not receive timely prenatal care starting in the first trimester and, again, Black and African American women were least likely to receive prenatal care as compared to women of another race or ethnicity.

While awareness of maternal mortality may be increasing, the severity of the issue is only becoming more apparent as data collection and reporting improve. PA's Maternal Mortality Review Committee (MMRC) was established in 2018 with the goal to systematically review all maternal deaths, identify root causes of these deaths and develop strategies to reduce preventable morbidity, mortality and racial disparities related to pregnancy in PA. Given its recent inception, recommendations from the MMRC have not yet been released. However, as reporting of maternal deaths continues and the quality of maternal mortality data in PA improves, there is an opportunity for the BFH to implement recommendations from the Maternal Mortality Review Committee as they become available and to develop new strategies, as needed, to address high-risk populations.

Infant/Perinatal Health: Over the past five years, the percentage of infants ever breastfeed has increased, infant mortality rates have decreased, and the percentage of infants placed to sleep on their backs has increased in PA. However, for each of these indicators there is still a significant disparity for Black and African American infants. As such, although some progress has been made, infant mortality and breastfeeding remain major health issues in PA. The BFH has successfully implemented gap-filling direct services for infants in the form of home-visiting for mothers and infants following birth and breastfeeding awareness/education programming. Additionally, Title V funds support an enabling safe sleep program aimed at reducing sleep-related infant death. This support is complemented by systems-level programming including the newborn screening and genetics program, child death review and breastfeeding support at the hospital level through Keystone 10. The BFH sees an opportunity to enhance existing strategies to continue to serve high-risk populations and to expand systems-level work.

Based on available data and feedback from stakeholders across the state, the BFH identified four key health issues affecting infants in PA: 1) pre-term birth; 2) infant mortality; 3) breastfeeding initiation and duration; and 4) timely reporting of results from newborn screens. The health issue ultimately reflected in the state's priority needs is decreasing the infant mortality rate.

While stakeholders felt that community members may not view infant mortality as a widespread concern unless they have been personally affected, they indicated that, among providers and public health professionals, infant mortality is an issue of high severity and importance. Stakeholders emphasized the stark disparity in mortality rates between White and Black or African American infants in PA. The infant mortality gap between Black and White infants in PA persists. Since 2012, the infant mortality rate in PA has decreased from 7.0 deaths per 1,000 live births to 6.1 infant deaths per 1,000 live births in

2016. However, the infant mortality rate for Black/African American infants in PA in 2016 is 14.6 deaths per 1,000 live births which is two times higher than the overall state rate, six times higher than the mortality rate for Asian/Pacific Islander infants (2.3) and three times higher than the rate for White infants (4.6). Many stakeholders also indicated that this priority is intertwined with pre-term birth and maternal well-being, suggesting that work on this priority may impact other areas of maternal and perinatal health.

Child Health: Over the past five years, children in PA are increasingly reported to attend child well visits and the rate of non-fatal injury hospitalizations has also decreased. Additionally, the percentage of children in PA who have had a preventive dental visit, have a parent-reported health status of “excellent” or “very good” and who reported experiencing bullying is below the national average. The BFH currently supports an enabling safe and healthy homes program aimed at reducing health risks and hazards in children’s homes, supports gap-filling direct services provided to children by County and Municipal Health Departments and supports the system-level Child Death Review (CDR) teams which operate statewide. In addition to enhancing the existing capacity of CDR teams, the BFH sees an opportunity to address behavioral, mental and developmental health needs among children and to develop systems-level strategies addressing childhood injury and trauma.

Based on available data and feedback from stakeholders across the state, the BFH identified four key health issues affecting child health in PA: 1) access to preventive visits and medical care; 2) child mortality and injury; 3) bullying and; 4) mental, behavioral and developmental health outcomes. The health issues ultimately reflected in the state’s priority needs are reducing child mortality and injury and improving mental, behavioral and developmental health outcomes. Data trends suggest that non-fatal injuries and related mortality rates are prevalent and a high severity issue, especially for youth and adolescents. In Pennsylvania, the leading causes of child and adolescent death include accidents, injuries and unintentional harm as well as suicide and intentional harm. Youth suicide rates have also consistently increased over the past several years. Stakeholders indicated that reducing child and youth mortality rates could be achieved, in part, by addressing mental and behavioral health. Additionally, in Pennsylvania, experiences with violence and hazards in the home contribute to the non-fatal injury hospitalization rate.

Health of Children with Special Health Care Needs (CSHCN): Given that there is minimal longitudinal data on CSHCN in PA, it is challenging to know to what extent improvement in health status has been made among this population over the past five years. Improving access and quality of data remains a challenge and an opportunity for the BFH for this domain. Based on available data and feedback from stakeholders across the state, the BFH identified four key health issues affecting the health of CSHCN in PA: 1) bullying; 2) access to and use of transition services to the adult health care system; 3) receipt of health care in a well-functioning system; and; 4) mental, behavioral and developmental health outcomes. The health issues ultimately reflected in the state’s priority needs are increasing CSHCN receiving care in a well-functioning system and improving mental, behavioral and developmental health outcomes.

Stakeholders reported that increasing CSHCN receiving care in a well-functioning system is viewed as a large concern by the community because there are not enough specialists and there is a lack of communication across systems. Similar sentiments emerged from the focus group discussions held with families, providers and children and youth with special health care needs. Many of the major themes that emerged from those discussions (i.e. doctor turnover, lack of continuity of care, transition services, caregiver respite) are related to a well-functioning system of care. A well-functioning system of care is imperative to optimizing the physical, mental, and behavioral health of PA’s CSHCN. Attempting to navigate a fragmented system can affect the health and well-being of both CSHCN and their families/caregivers. The BFH continues to administer programming aimed at providing children with a medical home and well-coordinated, family-centered care. Other components of a well-functioning system, including transition, may require the development of new system-level strategies. Additionally, CSHCN are more likely to have experienced ACES as compared to children without special health care needs. A new strategy aimed as supporting children, including CSHCN, with adverse experiences or experiences with trauma may need to be developed to address this.

Adolescent Health: Over the last several years, the teen pregnancy and birth rates have declined in PA, as has the rate of non-fatal injury hospitalizations. Based on available data and feedback from stakeholders across the state, the BFH identified four key health issues affecting adolescent health in PA: 1) morbidity and mortality; 2) bullying; 3) mental, behavioral and developmental health outcomes and; 4) teen pregnancy. The health issues ultimately reflected in the state’s priority needs are reducing rates of child mortality (including adolescents) and improving mental, behavioral and developmental health outcomes. The BFH currently supports gap-filling, direct teen pregnancy prevention and reproductive health services through the state’s Health Resource Centers and Family Planning Councils and provides direct behavioral health services to LGBTQ youth. Enabling programming developed to improve protective factors among youth and prevent bullying is also supported by Title V. The BFH sees an opportunity to enhance existing strategies and develop a system-level strategy addressing mental and behavioral health.

Stakeholders reported that increased support of mental health and behavioral health services among adolescents is warranted in PA and could lead to overall improvement in adolescent health and in the transition from adolescence to adulthood. In addition to increasing suicide rates among adolescents in PA, the percentage of adolescents reporting sadness/hopelessness has increased and adolescents are also increasingly reporting trying substances such as electronic cigarettes and experiencing bullying and interpersonal violence, with LGBTQ youth being most affected. Increased access to mental health services and positive youth development programming is merited to address these issues.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The mission and efforts of the Department of Health (DOH) are guided by the Commonwealth's leadership. Governor Tom Wolf was inaugurated as PA's 47th Governor on January 20, 2015 and was re-elected for a second term in 2018. The Governor's cabinet is comprised of the directors of various state agencies who are appointed by the Governor and confirmed by the Senate. All Cabinet members are responsible for advising the Governor on subjects related to their respective agencies. Dr. Rachel L. Levine was confirmed as Secretary of Health in March of 2018 and serves as a Cabinet member. Dr. Levine serves as the chief executive officer for the DOH and sets the policies, direction and mission. Dr. Levine also establishes strategic goals and objectives and advises the Governor on all medical and public health-related issues and policies. The mission of the PA DOH is to promote healthy behaviors, prevent injury and disease, and to assure the safe delivery of quality health care for all people in PA.

The DOH's Bureau of Family Health (BFH) is the State Title V Agency in PA and is responsible for administering programming and activities funded by the Title V Maternal and Child Health Services Block Grant. The BFH's Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO), Newborn Screening and Genetics (NSG) and Bureau Operations (DBO) administer and oversee programming and activities that aim to improve the health and well-being of PA's mothers, women, infants, children and youth, CSHCN and their families. The Department of Health and Bureau of Family Health organizational charts are included as supporting documents to the Title V annual application/report.

The BFH currently operates approximately 37 programs and activities using Title V funds. The BFH also administers other programs using federal grants and state funding. Collectively, these programs carry out the mission of Title V by establishing and supporting public health services and systems, enabling access to care and supporting the provision of gap-filling direct services. Table 1 provides a listing of all the Title V supported programs. The BFH continues to work toward strengthening the public health systems at the base of the pyramid in order to ensure that there is sufficient capacity and infrastructure for the essential maternal and child health services to be delivered statewide.

Table 1: Title V-Funded Programs and Activities	
Title V Program/Activity	**Function(s)**
Sudden Infant Death Syndrome Education and Prevention Program Act, Act 73 of 2010	The BFH distributes educational materials and an acknowledgement form regarding Sudden Unexpected Infant Death (SIDS) and Sudden Unexplained Infant Death Syndrome (SUID) to hospitals. This initiative is based on Act 73 of 2010.
Local Title V Programs	Ten county municipal health departments provide services aimed at improving maternal, infant and child health across PA. Health departments are in Allegheny County, Allentown, Bethlehem, Bucks County, Chester County, Erie County, Montgomery County, Philadelphia, Wilkes Barre and York City. Programs provided through the health departments include maternal and infant home visiting, breastfeeding education and support, safe sleep and other child safety education, preconception and interconception care, screening for behavioral health, depression, substance abuse and intimate partner violence, and smoking cessation.
Centering Pregnancy Programs	This group prenatal care model aims to reduce health disparities, promote healthy behaviors, provide peer support, improve pregnancy outcomes and reduce infant mortality. Additionally, as part of this program, Lancaster General Hospital offers a Centering Pregnancy group for women with Substance Use Disorder/Opioid Use Disorder.
IMPLICIT Interconception Care (ICC) Project	The ICC project identifies maternal behavioral risks during their child's well-child visits, up to 2 years of age in order to improve interconception care. During each well child visit the provider assesses four components of the woman's health: smoking status, depression, birth control and folic acid intake. Women are counseled and referred for services as needed. The initiative is focused on changing maternal behaviors to improve the health of women as well as improve birth outcomes in subsequent pregnancies. Beginning in 2020, the BFH will work with the Grantee to implement a 4th trimester model of care. The project will increase the number of women receiving maternal health care within 28 days from delivery in an effort to decrease rates of maternal mortality and morbidity in the early postpartum period.
Family Planning Services for Women with Opioid Use Disorder (OUD)	This project increases access to family planning care and improves detection of OUD among women and access to OUD treatment. This project builds the capacity of behavioral health professionals, through training and technical assistance, to assess women in OUD treatment programs for their pregnancy intentions and provides referrals to family planning clinics.
Reproductive Health Services	This program provides family planning services, including routine gynecological care, pregnancy testing, contraceptives, cervical cancer exam, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening service to clients up to age 21 who are considered to be sexually active.
SafeTeens	As part of this program, the Grantee maintains the SafeTeens.org website which provides PA adolescents with access to sexual and reproductive health care services and information. The Grantee also provides the SafeTeens Answers! program which allows teens to text a question about reproductive health or healthy relationships and receive a medically accurate answer within two hours.
Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Program	This program provides services to LGBTQ youth through Persad Center's Safe Spaces Project, which include suicide prevention training to youth, and engages in coalition building activities with organizations to help them become Safe Space certified. The Mazzoni Center provides a drop-in health center for youth to obtain a variety of health care and social services.
Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Behavioral Health Services	This is a new program that will start 10/1/2020 which will provide services to LGBTQ youth to promote mental health, substance use prevention, or suicide prevention services.
Health Resource Centers (HRC)	Reproductive health services are provided to high school students in Philadelphia, Delaware, Allegheny, Berks, Dauphin, Lackawanna, Lycoming, Fayette, Beaver, Venango and Lehigh counties through the Health Resource Center (HRC) Program. These counties were selected due to their high rates of teen pregnancy, sexually transmitted infections (STIs) and school dropouts. Services include counseling and education, information about reproductive health and relationships, STI screening and pregnancy testing, and referrals to school, community-based resources, and family planning network for free or low-cost reproductive health services.
Healthy Adolescents Promoted by Partnership for Youth (HAPPY)	Through this program, partnerships have been formed between schools, domestic violence prevention providers, and healthcare providers to conduct outreach and educational activities to prevent intimate partner violence between adolescents.
Healthy Eating Active Living (HEAL)	Through this program, the Grantee provides healthy eating and active living programming to LGBTQ youth. Youth are provided with weekly healthy food demonstrations, recreational activities, and healthy living group discussions.
Bullying Prevention	This program is a modification of the Olweus Bullying prevention Program by the developers at Clemson University. The aim of the program is to deliver the training program in community youth organizations. Eight community organizations were chosen by an RFA and began operating January 1, 2020. Staff from each organization received provisional certification in the Olweus Bullying Prevention Program in February 2020. Community youth organizations will begin programming in the late spring and summer of 2020.
Mentoring Program	Through this program, three grantees in Philadelphia county provide evidence-based mentoring to youth focused on increasing protective factors.
Safe and Healthy Homes Program	The Safe and Healthy Homes Program (SHHP) is a primary prevention program targeting childhood injuries using a holistic healthy homes approach. The SHHP conducts home assessments for low-income MCH populations to identify healthy and safety hazards. Evidence-informed education and interventions are provided to remedy hazards using a healthy homes approach. The SHHP provides additional resources to local resources to address health, education, and other needs that are beyond the scope of the program.
Infant Safe Sleep Initiative	The Infant Safe Sleep Initiative is intended to decrease infant deaths due to SUID. A hospital-based model program was developed and is being implemented for newborns to increase teaching and reinforcement of safe sleep practices. The supporting social marketing plan targets high risk and minority populations.
Safety in Youth Sports Act (Act 101 of 2011)	The law is intended to protect student athletes from head injuries. As coaches are often the first line of defense in recognizing a concussion in athletes, the law offers tips and guidelines for recognizing and managing these injuries. Key components include establishing standards for managing concussions, removal of an athlete that is suspected of suffering from a head injury, guidelines for returning an athlete to play once medical clearance is received and required training for coaches.
Shaken Baby Syndrome (SBS) Prevention and Awareness Program (Act 176 of 2002)	The BFH provides Shaken Baby Syndrome educational materials, free of charge, to the hospitals and birthing centers. Hospitals and birthing centers in PA are required to provide the educational materials to the parents or legal guardians as outlined in Act 2002-176.
Traumatic Brain Injury School Re-Entry	A statewide school re-entry program aimed at assisting schools with the re-entry issues of children and adolescents who have sustained a Traumatic Brain Injury (TBI). This program ensures that schools are educated on the issue of TBI so that children are accurately identified and receive the appropriate interventions to succeed.
Parent Education, Advocacy and Leadership	Through a partnership with the Parent Education, Advocacy, and Leadership Center (PEAL), PA's federally designated Family to Family Health Information grantee, services offered for Children and Youth with Special Health Care Needs (CSHCN) and their families include Parent Leadership Institutes, Youth Leadership Institutes, support to grandparents raising CSHCN, and a fatherhood conference.
Community to Home (C2H) - formerly Special Kids Network	Provides information and resources for Children and Youth with Special Health Care Needs (CSHCN) and their families. The new Community to Home program began implementation 10/1/19 and provides home-visiting under the Community Health worker model in six rural regions of PA. Services to families will begin in 2020. The Special Kids Network hotline continues to function as a toll-free helpline by providing information and resources to families and providers.
PA Medical Home Initiative (MHI)	Based on the Educating Physicians in their Communities (EPIC) model, the MHI is a statewide education and quality improvement program, using a medical home approach to primary care as the key to improving the care provided to children, youth, and young adults in Pa., including those with special health care needs. The MHI's Transition Program identifies adult PCPs with a medical home approach and transitions pediatric patients into adult primary care.

Title V Program/Activity	Function(s)
Sickle Cell Community-Based Programs	Community based organizations across the state provide services, education, and psychosocial services to patients. Services include outreach, case management, transition issues, community awareness and family support. The program also works with grantees to identify and address barriers to care within the client's community and connect clients with community supports and care coordination.
Sickle Cell Health Systems Programs	Select hospitals provide services to diagnosed patients and include diagnostic testing, transitional services, assessment, care, counseling, support, education and preventative therapeutic interventions. The program also works with grantees to identify and address barriers to care within the client's community and connect clients with community supports and care coordination.
Child Rehabilitation Program	Hospitals and one community-based organization provide comprehensive, multidisciplinary team care to clients with neuromuscular and orthopedic disorders. The program also works with grantees to identify and address barriers to care within the client's community and connect clients with community supports and care coordination.
Autism Diagnostic Clinic	Community based organizations provides early diagnosis of Autism Spectrum Disorder (ASD) and provides care coordination, support, as well as parent and family training in therapeutic care approaches. In 2018 the Easter Seals of Eastern PA initiated a telehealth model in collaboration with Children's Hospital of Philadelphia and the Berks County Early Intervention Unit to identify and diagnose ASD in pre-school aged children. Easter Seals also assisted families in identifying and applying for appropriate therapeutic services for children diagnosed with ASD. In 2019 Easter Seals began training parents in Applied Behavioral Analysis techniques to aid families while waiting for full therapeutic services to begin.
Spina Bifida Program	Select hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Spina Bifida. The program also works with grantees to identify and address barriers to care within the client's community and connect clients with community supports and care coordination.
Male Involvement Initiative (MII)	The Male Involvement Initiative program provides the Coaching Boys into Men curriculum to young male athletes using a coach-led model. The program addresses intimate partner violence by promoting violence prevention, greater gender equity and respectful and non-violent relationships with dating partners.
Opioid/Brain Injury Training Program	Through this program the grantee will develop and implement a curriculum on how opiosd misuse and brain injury affect one another. Training locations will be identified to serve professionals working in both the brain injury and substance misuse field on a statewide level.
Acquired Brain Injury Program (ABI)	The Acquired Brain Injury Program provides services to individuals 18 to 21 years old who have sustained an Acquired Brain Injury. Services include short term rehabilitation including cognitive therapy, assistive community integration and work skills training as well as case management services.
Breastfeeding Awareness and Support Program	The Keystone 10 initiative is a maternity-based breastfeeding support quality improvement initiative. Implementation has begun at 84 of the of state's 90 birthing facilities. In addition, the breastfeeding program has expanded to include community-based programs to improve county breastfeeding rates through community outreach and other services. All services are being provided in counties with a breastfeeding rate below the statewide average of 81%.
Newborn Screening and Follow-up Program	This program assures screening and follow-up for 10 mandated conditions and 27 "follow-up" conditions by ensuring that blood spot specimen collection occurs as required by law, point of care testing occurs and screening results are reported for follow up through diagnosis. Follow-up services are provided on all infants with abnormal results. Newborns are referred to the appropriate treatment center to receive proper medical evaluation, confirmatory testing, diagnosis and treatment. The program contracts with treatment centers to provide newborn screening evaluations and medical services. The program manages a statewide pharmacy metabolic formula distribution system that supplies formula to diagnosed Pennsylvanians up to the age of 22 months.
Newborn Hearing Screening and Follow-up Program	This program assures that all newborns are screened for hearing loss within the first 30 days of birth, are diagnosed within three months, and receive prescribed treatment or intervention services within six months of birth. Newborns receive an initial hearing screening while still in the hospital and infants who do not pass the initial screen receive follow-up re-screening at the hospital, often as an outpatient. The BFH performs follow-up and tracking of infants not passing their follow-up re-screening and infants identified as being at risk of delayed onset hearing loss receive continued monitoring as appropriate. The department also administers infant hearing screening educational outreach and training workshops for nurses, audiologists, physicians, early intervention staff, and other concerned professionals.
Child Death Review Program	Act 87 codified the Child Death Review (CDR) Program which is designed to promote the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. The CDR Program facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies. Local CDR teams review deaths of children 21 years old and younger. In 2018, DOH reconvened the State CDR Team which will function as a support to the local teams and address any statewide issues.
Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registries	The BFH tracks PA data for the CDC's National SUID and SDY Case Registries. These comprehensive data from the multidisciplinary child death review team meetings capture the circumstances surrounding SUID deaths in eleven counties and SDY deaths in Philadelphia including each case investigation. This information is used for the development of targeted SUID reduction and prevention activities.
Pregnancy and Risk Assessment Monitoring System (PRAMS)	PA PRAMS is an epidemiologic surveillance system managed within the BFH. The program collects unique state-specific, population-based data on maternal attitudes and experiences before, during and after pregnancy. Data are collected via mail and telephone survey by a contractor. BFH PRAMS staff analyze and disseminate data guided by programming priorities and individual requests. PA PRAMS operations are funded by the Title V Block Grant. For the 2020 birth year, Title V funds allocated to PRAMS were increased to support a larger sample size for participation in a Postpartum Assessment of Women Survey.
Neonatal Abstinence Syndrome (NAS) Follow-up Program	This program assures mandatory reporting of all PA NAS cases that meet Council of State and Territorial Epidemiologists confirmed or probable case definition in the Division of Newborn Screening and Genetics (DNSG) Internet Case Management System. The DNSG will ensure birth facilities are routinely connecting families with health and social services to promote optimal child development and family well-being.

III.C.2.b.ii.b. Agency Capacity

In order to maintain infrastructure to support essential public health services and systems at the state level, BFH works with local Title V agencies and selects additional community-based partners throughout the state to provide public health, enabling or direct services to the MCH population. BFH uses population and public health data to target geographical 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. Through workforce development, technical assistance, and system change initiatives, BFH ensures its staff and partners have the capacity, expertise and resources needed to design, implement and evaluate public health programming that is evidence-based, family and community-driven, shaped by an awareness of the social determinants of health and the principles of health equity, and sensitive to the unique needs of the populations served by the Bureau.

Capacity to Serve Women and Mothers: PA's Title V program provides a critical safety net for pregnant women and women of childbearing age. In partnership with providers at the local level, the Title V program works to meet the needs of women in the communities in which they reside. Women accessing Title V services are at higher risk for maternal morbidity and mortality due primarily to the impact of social determinants of health. The resources provided by Title V work to lower this risk at the individual, community, and state level by addressing social determinants, reducing racial disparities in health care, and increasing access to quality healthcare and health education throughout PA. The BFH collaborates with the 10 local health departments to provide home visiting services to women who do not fit the criteria for the traditional home visiting services, is working to expand Centering Pregnancy, and supports the Interconception Care (ICC) Project. Augmenting and supporting these collaborations is the Pregnancy Risk Assessment Monitoring System (PRAMS). See Table 1 for more information on PRAMS and each of the aforementioned programs.

Capacity to Serve Infants: Many of the services focused on perinatal/infant health are provided through collaborative work between the BFH and hospitals or midwifery practices. These services seek to promote infant health and well-being beginning at birth. The BFH's Newborn Screening and Follow-up Program (NSFP) performs follow-up services for dried blood spot, hearing, and critical congenital heart defects screenings. Other hospital-based activities include prevention efforts related to Shaken Baby Syndrome and breastfeeding promotion through the Keystone 10 initiative. The BFH also supports the development and ongoing implementation of an evidence-based, hospital-based model for safe sleep through staff and caregiver education. In addition to providing support to hospitals, the BFH also administers and supports programming at the community level. Supported programs include home visiting, the Breastfeeding Awareness and Support Program and the Neonatal Abstinence Syndrome (NAS) Follow-up Program. See Table 1 for more information on each of these programs. The BFH also operates the Healthy Baby hotline as a mechanism for pregnant and new mothers to access information and resources on insurance coverage, prenatal care and referrals to local healthcare providers.

Capacity to Serve Children: Child health programs provided by the BFH are community-based. An important component of the Title V program is to provide gap-filling direct services for uninsured children in PA. Title V nurses in the 10 local health departments staff clinics offered to children who are uninsured, underinsured or uninsurable and educate families on the importance of well child visits, development and nutrition. The BFH administers the Child Death Review (CDR) Program and also aims to improve the health and safety of families and homes in PA through the Safe and Healthy Homes Program and by working collaboratively with local partners to educate families on childhood lead poisoning prevention and lead hazards. For more information on each of these programs, see Table 1. Furthermore, the PA Department of Health tracks and monitors childhood lead activity through the PA National Electronic Disease Surveillance System (PA-NEDSS). PA-NEDSS is

a web-based application system that receives all lead reports on PA's children. The BFH utilizes available data through PA-NEDSS to identify possible high-risk areas, locate areas of under-testing and identify other potential service gaps.

Capacity to Serve Adolescents: The BFH aims to serve PA's adolescents through partnerships and initiatives, with a focus on youth in high-need areas. Title V and federal funds support teen pregnancy prevention, sexual health education, bullying prevention, mentoring and services for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth. Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE) funding supports programs to delay sexual activity, increase condom or contraceptive use and reduce pregnancy. Health Resource Centers (HRC) provide sexual health education, counseling and referrals to youth in schools or other easily accessible locations. The BFH also supports Title X clinics by supplementing services for youth 21 years of age and younger with Title V funding. Several BFH programs aim to increase protective factors and decrease risk factors among youth including an evidence-based mentoring program and the Bullying Prevention Program. The BFH prioritizes providing services to LGBTQ youth in PA, who experience a higher rate of health disparities than their heterosexual peers. For more information on each program, see Table 1.

Capacity to Serve Children with Special Health Care Needs*:* Due to the broad range of care and coordination needed to meet the needs of CSHCN, the BFH supports direct, support and referral services across the state. In the creation and implementation of programs, the BFH ensures that the National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs (CSHCN) are incorporated. The BFH addresses domains directly within the purview of Title V funding, such as Identification, Screening, and Referral; Access to Care; Medical Home; Community-Based Services and Supports; and Transition to Adulthood. Other domains are addressed through partnership with state and federal agencies, stakeholder agencies and other partners. Services provided to this population are targeted towards individuals and families most in need; therefore, the BFH serves those blind and disabled individuals under age 16 who receive Supplemental Security benefits from Title XVI to the extent that those services are not provided by Title XIX (Medical Assistance). Staff from the BFH collaborate with staff from the Department of Human Services Office of Medical Assistance Programs (OMAP) to avoid duplication of services and ensure that appropriate referrals and information are shared.

The BFH ensures that children and families of CSHCN are active, core partners in decision making. The services and supports provided to CSHCN and their families are implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner. The BFH offers support and advocacy programs such as Community to Home, Special Kids Network Helpline and Leadership and Development Training. The BFH also provides comprehensive, multi-disciplinary health related services to individuals with certain conditions. The Comprehensive Specialty Care Program provides care coordination and information and education provided by hospitals and community organizations. Through the BFH brain injury programs including Acquired Brain Injury Program, Traumatic Brain Injury (TBI) and Opioid, and BrainSTEPS, the BFH offers brain injury education, rehabilitation services and assistance with integrating back to a school environment following a brain injury. The BFH also partners with the Tuscarora Intermediate Unit to provide referral and follow-up services to infants who fail a hearing screening. BFH staff works with these partners to educate clinicians and parents on the importance of screening and early intervention for better hearing outcomes. Additionally, the BFH's memorandum of understanding with the Department of Aging (PDA) allows the BFH to use PDA's Pharmaceutical Assistance Contracts for the Elderly program's claims processing and administrative functions to provide metabolic formula for CSHCNs, including Spina Bifida, Cystic fibrosis, MSUD, and PKU. The MOU allows the BFH to expand the number of accessible pharmacies and consolidate claims processing through a single administrative agency.

The County/Municipal Health Departments provide services to CSHCN including home visiting for at risk families, referrals to Early Intervention, a Medical Home Community Team for CSHCN in Philadelphia, and the Philadelphia Special Needs Consortium, which includes family members, providers, and other professionals to strengthen the system of care. For more information on each of these programs, see Table 1.

III.C.2.b.ii.c. MCH Workforce Capacity

Table 2: Title V-Funded Staff Positions as of March 2020

Bureau/Office	*Number of Title V Funded Positions*	*Location*
Bureau of Family Health, Bureau Office	2	Harrisburg, PA
Bureau of Family Health, DBO	11	Harrisburg, PA
Bureau of Family Health, CAHS	13	Harrisburg, PA
Bureau of Family Health, CSDO	13	Harrisburg, PA
Bureau of Family Health, NSG	16	Harrisburg, PA
Bureau of Community Health Systems	1	Harrisburg, PA
Bureau of Epidemiology	1	Harrisburg, PA
Office of Legal Counsel	1	Harrisburg, PA
Office of Health Equity	1	Harrisburg, PA
Local Title V Staff	53	Statewide
Total	112	

The state's Title V program currently funds 59 full-time staff located in Harrisburg, PA and 53 local Title V staff who operate statewide through the County/Municipal Health Departments (Table 2). While most staff operate out of the BFH where the block grant is housed, other positions across the DOH which support the BFH or serve MCH populations are also supported by Title V. The BFH's Director, Division Directors, Title V Block Grant Coordinator and MCH Epidemiologist serve as the lead positions that contribute to planning, evaluation and data analysis:

- ***Director of the Bureau of Family Health****:* Tara Trego was appointed as the director of the Bureau of Family Health in December of 2018 and serves as the state's Title V MCH Director. Tara has worked for the BFH for over twelve years

and has 16 years of public health experience. She holds a master's degree in Health Education.

- ***Director of the Division of Child and Adult Health Services****:* Following the recent departure of former division director, Kelly Holland, this director position is currently vacant. Given the state employee hiring freeze in place due to the novel coronavirus (COVID-19), this position can only be filled if an exemption is approved. In the interim, the Bureau Director (Tara Trego) will oversee this division.
- ***Director of the Division of Bureau Operations*****:** Erin McCarty has been the director of this division since April of 2017. Erin holds a Master of Public Health degree and has over 13 years of public health experience. Erin is also the Title V CSHCN Director.
- ***Director of the Division of Newborn Screening and Genetics:*** Stacey Gustin was named as the Director of this division in February of 2020. Stacey has worked in the BFH for eight years and has 13 years of public health experience. She holds a B.S.N degree in Nursing.
- ***Director of the Division of Community Systems Development and Outreach*****:** Cindy Dundas has been the director of this division since November of 2016. Cindy has worked in the BFH for 18 years and has over 20 years of public health experience, in addition to ten years of experience in the mental health/intellectual disability field. She holds a bachelor's degree in psychology and is the parent of a CSHCN.
- ***Maternal and Child Health Epidemiologist*****:** Nhiem Luong was hired as the MCH epidemiologist for the BFH in October of 2018. As MCH epidemiologist, Nhiem conducts analysis on various MCH datasets and provides BFH staff with technical assistance and support related to accessing, analyzing and interpreting data and summarizing results. Nhiem holds a DrPH degree and has over twenty years of experience in medicine, public health and research.
- ***Title V Block Grant Coordinator*****:** Caryn Decker was named the Title V Block Grant Coordinator in May of 2020. Caryn holds a Master of Public Health degree and has over five years of public health experience. Caryn has worked in the BFH for nearly two years and also coordinated the 2020 Title V Five-Year Needs and Capacity Assessment.

To gauge the tenure of current Title V staff, BFH staff were surveyed on the amount of time that they have been in their current position as well as their public health experience. More than half of the BFH's current Title V workforce (53%) have been in their positions for less than three years. When broken out by job title, it is evident that most newer hires are program-level staff (public health program administrators and public health program assistant administrators). This suggests that there has been some turnover over the past three years. In contrast, most managers and directors (89%) have been in their position for three years or more, suggesting that there is considerable institutional knowledge of Title V at the management level. The combination of experienced management and new program staff who may bring a fresh perspective to their work is a strength of the BFH's Title V workforce. However, concentration of Title V knowledge and experience at the management level may suggest that continued training on the mechanics and framework of the MCHSBG at the program-staff level is warranted.

The BFH has two staff members who identify as parents of CSHCN and draws on the experiences and expertise of the consumers and family members who serve on the BFH's program advisory boards and committees.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

It is through partnership, collaboration and coordination with other entities that the BFH and the state's Title V program can meet the needs of the women, mothers, infants, children, CSHCN and adolescents in PA. The BFH has productive collaborations with other governmental agencies at the state and local level as well as with other programs within the Department of Health and successfully augments its Title V funding with state and federal dollars in order to support the MCH system of care in the state. The BFH will continue to work with other programs within the Department to identify new opportunities for collaboration and to avoid duplication of efforts. Over the next funding cycle, the BFH also sees an opportunity to further collaborate with the Department of Human Services in order to coordinate efforts related to home visiting, CSHCN and child health. Additionally, the BFH intends to continue to expand and strengthen its consumer/family partnerships.

Table 3: Title V Partnerships, Collaboration and Coordination	
Other MCHB Investments	
State Systems Development Initiative (SSDI)	The BFH administers the HRSA-funded SSDI grant that complements the Title V MCH Block Grant program by improving the availability, timeliness, and quality of MCH data. The SSDI grant is used to build state MCH data capacity to support Title V programs in making data-driven decisions. Data will include sources from DOH as well as stakeholders and partners. Utilization of these data is central to the BFH's capacity to assess the Title V program, implement and evaluate its programming and complete the annual Title V MCH Block Grant application.
Parent Education, Advocacy, and Leadership Center (PEAL)	PEAL is the Family-to-Family Health Information Center for PA. The Bureau of Family Health collaborates with PEAL to create leadership opportunities for children and youth with special health care needs.
Leadership Education in Neurodevelopmental Disabilities (LEND) Fellowship Program	The BFH partners with the Leadership Education in Neurodevelopmental Disabilities (LEND) program at Children's Hospital of Philadelphia (CHOP). LEND is a fellowship for professionals who are completing or recently completed an advanced degree in healthcare fields associated with maternal and child health, family members who care for children with neurodevelopmental or related conditions, or an individual who has experienced a disability or chronic condition in their own life, and who is looking to expand their knowledge and experience with leadership. The BFH and the LEND program maintain communication about projects related to maternal and child health, look for opportunities to collaborate, and the BFH's Family Delegate serves on the LEND Community Advisory Board. Through this partnership, the LEND program is able to make appropriate referrals to the BFH's programs.
Leadership Education in Adolescent Health (LEAH) Fellowship Program	The Leadership Education in Adolescent Health and Young Adult Health (LEAH) Fellowship Program at the Children's Hospital of Philadelphia (CHOP) prepares health professionals for leadership roles in public health and focuses on improving the health and well-being of adolescents and young adults. Enhancing the capacity of Title V programs to respond to current and emerging health needs of adolescents and young adults is a specific focus of the program. Department staff meet with the LEAH fellows and their leadership once a year to provide an overview of the Title V Maternal and MCH Block Grant, summarize current adolescent health programming, and discuss possible collaboration.
Drexel MCH Public Health Catalyst Program	The purpose of the Catalyst program at Drexel is to provide an increased focus on fundamental MCH content and competencies. The BFH recently developed a relationship with this program and is exploring opportunities to engage students.
Other Federal Investments	
School Re-Entry Program	The BFH represents the Department of Health as a lead and founding partner with the PA Department of Education for the BrainSTEPS (Strategies Teaching Educators, Parents and Students) Program. BrainSTEPS works to ensure that those who provide educational support to children with brain injury understand brain injury, its challenges, and the supports and interventions that help students achieve optimal educational success.
Traumatic Brian Injury (TBI) Implementation Grant	The BFH leads initiatives aimed at increasing awareness of brain injury. These activities include training to increase awareness of TBI and screening for TBI within the juvenile justice and older adult population. The BFH has also implemented a NeuroResource Facilitation Program to connect individuals with brain injury to appropriate resources. Through the federal TBI grant, the BFH serves as a mentor to other states in the areas of juvenile justice and return to learn programs.
Sudden Unexpected Infant Death (SUID) Registry and the Sudden Death in the Young (SDY) Registry	PA was awarded a cooperative agreement with the Centers for Disease Control and Prevention in 2018 for the SUID and SDY Registries. The SUID and the SDY registries fall within PA's Child Death Review Program. Unexplained, undetermined and sleep-related deaths of infants fall under the SUID registry. Sudden and unexplained deaths of children and youth from birth through age 21 fall under the SDY registry. The purpose of the registries is to understand the underlying causes of death in order to develop prevention recommendations. The work of SUID registry is supplemented with Title V monies and the work of the SDY registry is funded completely with Title V monies.
The PA Pregnancy Risk Assessment Monitoring System (PA PRAMS)	PA PRAMS is an epidemiologic surveillance system managed within the BFH. The program collects unique state-specific, population-based data on maternal attitudes and experiences before, during and after pregnancy. Data are analyzed and shared to inform MCH program and policy development both within the Department of Health and by external partners and stakeholders.
Sexual Risk Avoidance	The BFH partners with Temple University Harrisburg to implement the Teen Outreach Program (TOP) at six sites across PA. TOP is an evidence-based,
Personal Responsibility Education Program (PREP)	The BFH administers PREP, which provides evidence-based teen pregnancy prevention programs, education on healthy relationships, adolescent development, and healthy life skills. The BFH partners with Persad Center, Inc. to provide lesbian, gay, bi-sexual, transgender and questioning (LGTBQ) cultural competency services to PREP implementation sites. Services include an assessment of organizational LGBTQ cultural competency, LGBTQ 101 and advanced trainings for staff as well as ongoing technical assistance.
Childhood Lead Poisoning Prevention Program (CLPPP)	The BFH administers the CLPPP by partnering with six County/Municipal Health Departments to support activities to reduce lead exposures and lead poisoning in children under the age of six. CLPPP aims to increase the number of children tested, enhance its ability to collect data, use data to determine where to target interventions, educate the public and professionals working on lead poisoning prevention, identify children who have been exposed to lead, and link those children to appropriate follow-up services.
Maternal & Child Environmental Health Collaborative Improvement and Innovation Network (MCEH CoIIN)	BFH staff participate in the Maternal & Child Environmental Health Collaborative Improvement and Innovation Network, which seeks to strengthen blood lead testing, surveillance, population-based interventions, and processes to identity lead exposed children and linkages to service.
Child Safety Learning Collaborative (CSLC)	Staff from the BFH are participating in CSLC. Through the CSLC, states and jurisdictions are working with one another to increase the adoption of evidence-based policies, programs, and practices at state and local levels. The collaboration aims to reduce injuries, violence, and deaths in children and adolescents ages 1-19 in supported topics such as Bullying Prevention and Sudden Unexpected Infant Death Prevention.
Lead Hazard Control Program (LHCP)	With funding from the Department of Housing and Urban Development (HUD), the BFH partners with local governments to administer the LHCP in targeted areas of PA. The program works to create lead-safe home environments for low-income families with children under age six. Additionally, the program aims to increase the capacity of the local government to attain HUD funding directly.
Other HRSA Programs	
Newborn Hearing Screening Program	The BFH provides universal newborn hearing screening and intervention through a HRSA grant. Children identified as deaf or hard of hearing are referred to the Tuscarora Intermediate Unit, through a grant agreement, to receive parent and deaf mentor services.
State and Local MCH Programs	
Child Death Review Teams (CDR)	The BFH is responsible for administering the CDR Program and works closely with key stakeholders including the PA State Coroner's Association, the Department of Human Services, the PA State Police, Bureau of Emergency Management Services, the PA District Attorney's Association, as well as medical examiners, pediatricians and neonatologists. The goal of CDR is to reduce the incidence of preventable child deaths by combining multi-agency and multi-disciplinary reviews of these deaths to identify risk and implementation and evaluation of targeted prevention efforts.
Philadelphia Special Needs Consortium (PSNC)	The BFH partners with the PSNC, operated through the Philadelphia Public Health Department, to provide programs and resources for CSHCN and their families.
Family Planning Councils	The BFH provides Title V funding to the four family planning councils: AccessMatters, Adagio Health, Family Health Council of Central PA, and Maternal and Family Health Services. The four councils are the designated Title X (National Family Planning Program) Grantees for the state of PA. Funds are supplemental to Title X funds and are used to provide reproductive health services to youth 21 years of age or younger.
Other programs within the state Department of Health	
Bureau of Health Promotion Risk Reduction (BHPRR)	The BHPRR within the Department of Health administers the Violence and Injury Prevention Program and oversees the Injury and Violence Prevention Network (IVPN). It also houses the Division of Obesity, Physical Activity and Nutrition. The Title V grant pays for 85% of a position in the Bureau of Health Promotion and Risk Reduction. This partnership with HPRR furthers the BFH's maternal and child health work across several of our programs related to child safety and injury prevention, including: Representation on the TBI Advisory Board; inclusion of TBI awareness activities in HPRR programs; collaboration between Child Death Review and Safe Kids PA. Through this collaboration the Bureau of Family Health aims to develop a comprehensive and coordinated injury prevention effort with the IVPN. Additionally, the Bureau of Family Health partners with the Division of Obesity, Physical Activity and Nutrition to provide information and assistance regarding breastfeeding across PA.

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PA Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	The BFH partners with WIC to jointly develop breastfeeding education materials and to ensure that community-based breastfeeding initiatives involve collaboration with local WIC agencies and populations. Additionally, electronic records are routinely shared between the PA PRAMS program and WIC to identify telephone numbers for sampled and surveyed mothers. This collaborative relationship serves to elevate the PA PRAMS survey response rate. Lastly, BFH partners with WIC to ensure PKU formula is provided for CSHCN through five years of age.
Bureau of Public Health Preparedness (BPHP)	The BFH's Family Advisor collaborates with the BPHP on emergency preparedness planning for CSHCN.
Office of Health Equity (OHE)	The BFH collaborates with OHE on initiatives related to health equity and ensures that cultural and linguistic competence standards are met across the DOH and within BFH programming. The BFH uses Title V to fund a position within OHE to support this work.
Bureau of Epidemiology	The BFH is funding an MCH epidemiologist in cooperation with the Bureau of Epidemiology to provide data and trend analyses for all MCH programming within the BFH. The MCH epidemiologist allocates a large portion of their time to PRAMS and Title V Needs and Capacity Assessment analyses. The MCH epidemiologist is supported by a senior epidemiologist from the Bureau of Epidemiology.
The PA Dept. of Health's Bureau of Health Statistics and Research (BHSR), Division of Vital Statistics	The BFH has an ongoing collaboration with BHSR. The Division of Newborn Screening and Genetics works with BHSR to ensure that all PA newborns with a birth certificate have newborn screenings performed. Additionally, BHSR pulls the monthly PRAMS batch files from the birth certificate records in accordance with the defined sampling frame and provides PRAMS staff with the annual final birth file which is needed by the CDC to weight the PRAMS data. Similarly, the Child Death Review process begins when the BHSR provides vital statistics information to the BFH on a monthly and a quarterly basis. The BFH compiles the data and securely disseminates it to the local CDR teams. Local teams use this information to initiate collaborative, multidisciplinary reviews.
Bureau of Communicable Diseases	The mission of the Bureau of Communicable Diseases is to reduce the incidence and prevalence of communicable diseases in PA. A component part of that work is to provide vaccines for specific diseases that affect infants, children, adolescents.
PA National Electronic Disease Surveillance System (PA-NEDSS)	PA-NEDSS is a statewide, web-based surveillance system that receives and stores reports for all diseases reportable to the Department of Health. Data stored within PA-NEDSS can be used to identify high-risk areas, analyze service gaps, and inform programmatic decisions. The ongoing maintenance of PA-NEDSS is a collaborative effort between DOH's Bureau of Informatics and Information Technology (BIIT) and several programs within the Department including those in the BFH.
Bureau of Community Health Systems (BCHS)	The BCHS, through the six health districts, operates a network of state health centers and supports public health programs throughout the commonwealth. Health centers engage in community health assessment and quality assurance activities and provide other public health services, including community integration and outreach programs, to promote healthy behaviors.
Bureau of Informatics and Technology (BIIT), Division of Health Informatics	The BFH works with BIIT to access and utilize maternal and child health data and datasets.
William Penn Fellowship Program	The William Penn Fellowship is granted to talented, passionate individuals with a commitment to public service and a drive to help make PA a better place to live. The program provides aspiring professionals with the opportunity to serve and learn with the state's top executive leaders. To date, the BFH has worked with a William Penn Fellow placed in the Department of Health on MCH policy and other related projects in PA.
Other governmental agencies	
Lead Learning Network	The BFH participates in the Lead Learning Network which convenes agencies across PA to discuss funding, programming and strategies for reducing lead poisoning and exposure, testing all children for elevated blood lead levels and training more lead abatement certified professionals to remove the hazard of lead from PA's aging housing stock.
Department of Education (PDE)	PDE is an important partner with the BFH for CSHCN programming. They are a resource and referral source for families with concerns related to Individual Education Plans (IEPs) and 504 Plans. In addition, BFH works closely with the PA Training and Technical Assistance Network (PaTTAN) operated through the PDE. PaTTAN coordinates the Transition State Leadership Team, as well as the Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW) groups on the topic of transition of YSHCN to adulthood. Additionally, BFH partners with PDE to develop school age TBI services such as the School Re-Entry program.
Department of Labor & Industry	The BFH works with the Office of Vocational Rehabilitation (OVR) through Labor and Industry on the transition of CSHCN to adulthood.
Department of Human Services (DHS)	The BFH partners and collaborates with several offices to meet the needs of families of CSHCN, including the Office of Medical Assistance Programs (OMAP), Office of Mental Health and Substance Abuse Services (OMHSAS), the Medical Assistance Transportation Program (MATP), and the Office of Child Development and Early Learning (OCDEL), which is an office operated jointly by the Departments of Education and DHS. The Division of Newborn Screening and Genetics collaborates with the OCDEL to share data related to Early Intervention at Risk Tracking for newborns born with Neonatal Abstinence Syndrome. Additionally, callers to the Healthy Baby Helpline are often referred to the online COMPASS program where individuals can apply for medical assistance and other benefits. Further, the BFH collaborates with DHS on a childhood lead data match project. On a quarterly basis, claims data for Medical Assistance (MA) children are matched against BFH data on children who were tested for lead poisoning. BFH staff also participate on the Fetal Alcohol Spectrum Disorder (FASD) Task Force to assist in the development of a comprehensive system of care for individuals born with a FASD. Additionally, MA pays for newborn screening costs associated with the filter paper blood specimen and PKU monitoring.
PA Department of Transportation (PENNDOT)	A collaborative relationship between the DOH's Child Death Review (CDR) Program and PENNDOT serves to enhance child death review capacity. In securing traffic death information, the CDR program can provide local teams with critical information surrounding traffic fatalities.
Public health and health professional education programs and universities	
The Bloustein Center for Survey Research (BCSR) at Rutgers University	BFH collaborates with the BCSR to administer Pennsylvania's Pregnancy Risk Assessment Monitoring System (PRAMS) survey operations. The BFH is also partnering with BCSR to conduct a mixed-methods evaluation of the PA Medical Home Initiative.
Trustees of the University of PA	The BFH collaborates with the Trustees of the University of PA to provide interconception care to mothers between pregnancies to improve health outcomes for women, newborns and children. The Bureau of Family Health collaborates with the Trustees to implement a hospital-based model safe sleep program throughout PA as well as a social marketing plan.
Clemson University	The BFH partners with the Clemson University Institute on Family and Neighborhood Life to train and certify community youth organizations to implement the Olweus Bullying Prevention Program.
The PA State University (PSU)	The BFH partners with PSU as a grantee implementing the Personal Responsibility Education Program (PREP) to youth. The program provides youth with information on abstinence, contraception, healthy relationships, adolescent development and life skills.
University of Pittsburgh	The BFH supports the University of Pittsburgh's collection of data through the Behavioral Risk Factor Surveillance System (BRFSS) for Pennsylvania.
Specialty Care Program	The BFH administers over 35 contracts with the major health systems in PA. The Specialty Care Program provides services to PA residents with sickle cell disease, spina bifida, hemophilia, cystic fibrosis, Cooley's anemia, autism, and neuromuscular and orthopedic conditions. The Specialty Care Program utilizes Title V and state funds to enhance care coordination, improve access to care, enhance individualized care planning, increase mental health screenings, and engage clients and families in program services. One of the Specialty Care Program grantees is Drexel University.
Family/Consumer Partnerships and Leadership Programs	
Traumatic Brain Injury Advisory Board (TBI)	The BFH supports the TBI Advisory Board which is comprised of an ethnically and culturally diverse group of individuals who have a commitment to serving those with brain injuries. Advisory Board members include individuals living with TBI, family members of individuals with TBI, representatives from several government agencies, and community-based organizations in TBI service provision and advocacy.
The PA Perinatal Partnership (PPP)	The PPP represents the collaborative efforts of PA's Healthy Start Projects and Maternal and Child Health Programs. There is an ongoing collaboration between PA PRAMS, administered by the BFH, and the PPP.
Eastern PA Special Needs Consortium (Association)	The BFH supports the Eastern PA Special Needs Consortium as a formal network for medical providers, social service providers, legal advocates, local and state health departments and parents of technology-assisted children to learn more about issues related to care of technology-assisted children.
PRAMS Committee	As part of participation in PRAMS, the BFH is required to have a PRAMS steering committee. The PRAMS Committee is currently composed of fourteen members including Department of Health staff and stakeholders representing a variety of maternal and child health programs and services.
Newborn Screening Technical Advisory Board/Newborn Hearing Screening Technical Advisory Committee	The BFH supports both the Technical Advisory Board and the Technical Advisory Committee to provide expertise, medical advice on medications, and guidance on program improvement. The Board deals with issues related to the metabolic portion of the Newborn Screening Program and the Committee deals with issues related to the hearing portion of the program.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Table 4: Values Informing the Prioritization of MCH Needs in PA's 2020 Title V Five-Year Needs and Capacity Assessment

Theme	Value
Impact	Magnitude and trends of the problem
	Seriousness or severity of the problem
Changeability	Ability for impact
	Magnitude and longevity of potential benefit
Acceptability	Community and stakeholders view issue as a problem
	Interventions to address issue are acceptable to the community
	Problem aligns with federal and/or state goals and mission
Feasibility	Evidence-based or informed strategies are available
	Organizational capacity to address issue and implement solutions
Equity	Problem disparately impacts individuals based on race, ethnicity, sexual orientation, gender identity, geographic location, age, poverty status, disability/special health care need, or other aspects of social disadvantage
Measurability	Problem can be measured/tracked
Externalities	Potential for collaboration/partnerships
	Response to the problem fosters involvement of consumers/clients and their families
	Addressing the problem could improve other priority areas
	Possibility for unintended negative consequences

In order to develop the initial list of priorities, the BFH considered all of the National Outcome Measures (NOMs) and National Performance Measures (NPMs) put forward for Title V as well as the corresponding data that had been analyzed as part of the characterization of MCH population health status. Potential priorities were then scored by the needs and capacity assessment steering committee based on the list of pre-identified values (Table 3) and the BFH's data briefs, which summarized the state and national health data that had been analyzed and data from the focus groups and web survey related to social determinants of health in PA.

The resulting list of 21 priorities (four priorities per Title V population domain and one cross-cutting priority) was then ranked by stakeholders at a series of regional prioritization meetings, in-person events and via web survey and by BFH staff and agency partners at an agency meeting. Following the conclusion of the regional prioritization events and the agency meeting, the steering committee reviewed the priorities that were top ranked by stakeholders at each of the events. Given that stakeholders were asked to make their rankings considering the values identified at the start of the prioritization process, the data presented in the data briefs and the unique needs in their networks of care, the BFH felt the priorities stakeholders had ranked in first place for each population domain should be considered as top priorities for the 2020 Title V MCHSBG cycle. Once the BFH confirmed that there was existing capacity to address the new priorities or the ability to build capacity, the first-ranked priority for each population domain was considered one of the final priorities. Afterward, the BFH considered those priorities that were ranked in second place in each domain and completed the same exercise of considering the capacity of the BFH. Given that several of the second-place priorities had tied, considerations related to capacity played a larger role. Once priorities for each population domain were finalized, the cross-cutting priority was adopted and a seventh priority explicitly addressing health equity was added given the feedback received from stakeholders throughout the prioritization process about the importance of advancing health equity and addressing social determinants of health in PA.

Several priority areas that were not on the list that the BFH put forward for consideration and ranking were raised by stakeholders at the prioritization events held across the state. Many of the priorities that were proposed can be broadly characterized as addressing social determinants of health – from deconstructing institutional racism, addressing social isolation and ensuring housing is safe to improving food security and transportation options. Proposed priorities that address social determinants of health were proposed across all prioritization meetings and for all the Title V population domains. Another need that consistently emerged was improved oral health and access to oral health care in PA. This proposed priority was suggested by at least one stakeholder for all the Title V population domains. The need for improved access to and coordination of health care services was also frequently cited by stakeholders.

The proposed priorities related to specific determinants of health, such as food security, were not adopted. However, a priority that broadly addresses social determinants of health was developed. While the BFH does not have the bandwidth to address all the social, environmental and economic factors that influence health individually, the BFH does see a role for Title V in supporting efforts that advance health equity. Similarly, the need around improved access to care was noted but not adopted as a unique priority given that access to care and care coordination are components of many of the priorities included in the final list. Finally, the need around improving oral health and access to oral health services was not adopted as a Title V priority given that there is existing capacity, funding and programming addressing oral health within the Bureau of Health Promotion and Risk Reduction (BHPRR) in the Department. However, given the breadth of the final Title V priorities, the BFH is committed to considering the extent to which the frequently cited needs, including improving oral health, may be addressed through new collaborations and the development and implementation of strategies over the next five-year cycle.

The BFH developed and implemented a prioritization process that was transparent and deliberately committed to incorporating the input of stakeholders and the needs of their communities. As such, it was important to the BFH that the input and rankings received from stakeholders across PA directly informed the selection of the final priorities. The final set of seven priorities are responsive to the high priority needs identified over the course of the assessment. This resulted in the PA Title V Program identifying seven new priorities for the new five-year reporting cycle.

Each of the new priorities is connected to an NPM or State Performance Measure (SPM) with the goal that strategies and programmatic activities encompassed within each priority will drive improvement in national performance and outcome measures. The priority aiming to reduce or improve maternal morbidity and mortality is connected to NPM 1 on ensuring women receive a preventive medical visit. While access to health care is only one factor contributing to a woman's health, women with the highest rates of severe maternal morbidity and mortality are also among the women who are less likely to receive preventive care. Strategies implemented to address risk factors associated with maternal morbidity and mortality will encompass an emphasis on regular receipt of preventive care to address co-morbidities and other health issues before, during and after pregnancy. The priority aiming to reduce infant mortality is directly connected to NPM 4.1 and 4.2 on improving breastfeeding initiation and duration as well as NPM 5 on safe sleep practices. Given the known association between breastfeeding, infant health outcomes across the life-course and maternal health and connection with their infant in the postpartum, strategies associated with improving breastfeeding awareness and duration will be implemented to address the priority and, in turn, the NPM. Sleep position and environment are also modifiable risk factors. When safe sleep practices are promoted and implemented, they can reduce infant mortality that may result from sleep-related unexpected infant death. The priority aiming to improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs connects to NPM 10 on adolescent preventive medical visits. Strategies associated with improving mental, behavioral and developmental outcomes will include an emphasis on the importance of seeking care when navigating the physical, cognitive and social transitions that are characteristic of adolescence and improved access to care in alternative settings such as in schools and in community-based organizations, particularly those dedicated to serving historically marginalized people. The priority aiming to reduce rates of child mortality and injury is connected to NPM 7.1 on reducing rates of hospitalization for non-fatal injury. Given that the priority mirrors the NPM, associated strategies which aim to reduce child injury in PA will address the NPM as well. The priority aiming to connect CSHCN to a well-functioning system of care is connected to NPM 11 on Medical Home. Given the priority's focus on developing a system that integrates each of the components of a well-functioning system, including Medical Home, this priority should directly drive improvement in NPM 11.The priority aiming to strengthen Title V staff's capacity for data-driven and evidence-based decision-making and program development is connected to an SPM focused on increasing the number of programs or policies created or modified. This SPM aims to measure the extent to which data and evidence are utilized to direct and inform Title V work. Given Title V's framework of implementing strategies across MCH domains that are effective and have a strong evidence base – improvement made under this priority will serve to advance the identified SPM as well as the NPMs associated with the other priorities.

In addition to the relationship between the priorities and the NPMs described above, several of the priorities and their corresponding strategies link directly to an NOM. Given that there are many factors not represented in the NPMs which influence the NOMs, in these scenarios the BFH has developed SPMs. The BFH developed an SPM that mirrors NOM 12 (Percent of newborns receiving an on-time report out and follow-up by an appropriate physician), which is still under development nationally. While there is no national data source to date for the NOM, PA has programmatic data for this indicator which can be used to track progress and improvement at the state level. Similarly, the priority aiming to advance health equity and address social determinants of health is connected to an SPM which aims to reduce the gap in mortality rates between Black/African American and White infants, children and women. This SPM will serve the dual purpose of driving change in the mortality rates described in NOM 3 (maternal mortality), NOM 9.1 (infant mortality) and NOM 15 (child mortality) while also addressing the persistent state disparity in mortality rates by race. The BFH will continue to consider the addition of other SPMs as the action plan is further developed.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$23,491,258	$23,748,778	$23,480,555	$23,732,205
State Funds	$46,514,800	$46,295,838	$48,774,500	$45,232,580
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$70,006,058	$70,044,616	$72,255,055	$68,964,785
Other Federal Funds	$5,902,230	$6,230,399	$5,231,068	$5,267,011
Total	$75,908,288	$76,275,015	$77,486,123	$74,231,796

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$23,748,778	$23,928,946	$23,732,205	
State Funds	$48,640,500	$46,813,492	$47,572,500	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$72,389,278	$70,742,438	$71,304,705	
Other Federal Funds	$7,343,533	$3,423,394	$6,463,826	
Total	$79,732,811	$74,165,832	$77,768,531	

	2022	
	Budgeted	Expended
Federal Allocation	$23,928,946	
State Funds	$47,605,500	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$71,534,446	
Other Federal Funds	$7,917,414	
Total	$79,451,860	

III.D.1. Expenditures

The Pennsylvania Department of Health and the Bureau of Family Health (BFH) expend federal and state maternal and child health (MCH) funds 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, children, and families. Title V FFY 20 expenditures, both federal and non-federal, aligned with Pennsylvania's nine MCH priority needs identified during the 2015 Needs and Capacity Assessment process. Priority needs were addressed through the following strategies:

- **Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support -** Federal Title V funds were expended to implement evidence-based or evidence-informed home visiting programs, Centering Pregnancy programs, and innovative interconception care initiatives for women, utilize motivational interviewing techniques, expand the evidence-informed Health Resource Center (HRC) program, utilize Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) organizations to provide drop-in primary medical and support services for high-risk and LGBTQ youth, and make available office visits and counseling/health education to youth as part of a reproductive health visit at a family planning provider. Other federal funds were expended in partnership with federal Title V funds to implement the Personal Responsibility Education Program and Abstinence Education Grant Program with other federal funding used to pay for direct services and federal Title V funding used to support state-level program management and public health systems development.
- **Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants -** Federal Title V funds were expended to facilitate adoption of evidence-based strategies to support initiation and continuation of breastfeeding, provide and promote breastfeeding education, develop collaborations, and implement media campaigns.
- **Safe sleep practices are consistently implemented for all infants -** Federal Title V funds were expended to develop and implement a hospital-based model safe sleep program, implement a social marketing plan to increase awareness of safe sleep practices, and implement Sudden Unexpected Infant Death (SUID) prevention strategies, including safe sleep promotion, based upon the data reported in the SUID/Sudden Death in the Young (SDY) Case Registry. Other federal funds were used to support participation in the SUID/SDY Case Registry.
- **Appropriate health and health related services, screenings and information are available to the MCH Populations -** Federal Title V funds were expended to review and analyze data from the Newborn Screening (NBS) system to inform quality improvement activities to improve data collection and reporting and develop strategies to address identified weaknesses in NBS data collection and reporting, expand provider access to medical home concepts and tools, facilitate the involvement of youth and caregivers in aspects of medical homes, utilize evidence-based or informed strategies to provide service coordination, resources and information to families of children with special health care needs (CSHCN), develop collaborations between systems of care serving CSHCN, and support vendors to address health disparities by including health disparities language in all BFH grant agreements. Non-federal as well as other federal funds were also expended to improve the NBS data system and follow-up services, provide direct, enabling, and public health services to CSHCN through specialty care grants, and provide school health services to children with and without special health care needs.
- **MCH populations reside in a safe and healthy living environment -** Federal Title V funds were expended to provide comprehensive home assessments to identify potential home health and safety hazards as well as home safety interventions to address the leading causes of child injury and death. Other federal funds were expended to enhance childhood blood lead level surveillance and implement lead prevention activities.
- **Protective factors are established for adolescents and young adults prior to and during critical life**

stages - Federal Title V funds were expended to provide evidence-informed LGBTQ cultural competency training to BFH vendors who serve adolescents, identify evidence-based strategies to address bullying, implement an evidence-informed approach to train youth-serving organizations to become a safe space for LGBTQ youth, implement an evidence-based suicide prevention training for LGBTQ youth, address healthy relationships and intimate partner violence through the Healthy Adolescents Promoted by Partnerships for Youth (HAPPY) program, and utilize the Coaching Boys into Men curriculum to promote violence prevention. Federal Title V funds and other federal funds were expended to develop evidence-based or evidence-informed mentoring, counseling, and adult supervision programs for children ages 8 to 18 with and without special health care needs.

- **Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted -** Federal Title V funds were expended to promote the utilization of the evidence-based behavioral health screening tools and motivational interviewing as well as smoking cessation programs for pregnant and post-partum women.
- **MCH populations are able to obtain, process and understand basic health information needed to make health decisions -** Federal Title V funds were expended to review and evaluate available social media platforms for messaging of basic health information, explore the feasibility of using a text messaging or smart phone application outreach program to provide basic health information, and implement the BrainSTEPS program. Other federal funds were expended to provide direct and enabling services through the Traumatic Brain Injury program while federal Title V funds were used to support state-level program management of the Traumatic Brain Injury program and public health systems development.
- **Title V staff and grantees identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs -** Federal Title V funds were expended on staff who reviewed program activities and goals to determine programmatic needs, conducted analysis, interpreted results, developed actionable reports, developed program strategies based on actionable findings, and used PA Pregnancy Risk Assessment Monitoring System (PRAMS), Child Death Review (CDR) findings, and the Maternal Mortality Review Committee to inform, develop, modify and evaluate public health programs and policies in Pennsylvania. Other federal funds, supplemented with federal Title V funds, were expended to collect, analyze, and report PA PRAMS data as well as to improve the state's ability to identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs.

Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services) were completed in accordance with the guidance. All direct service expenditures reported on Form 3b reflect services that were not covered or reimbursed through another provider. These Title V funded direct services include pharmacy and physician/office charges for pregnant women, infants, children, and CSHCN. Title V is the payor of last resort for all direct services. The state match funded direct services include pharmacy, laboratory and physician/office charges for pregnant women, infants, and CSHCN.

Federal Title V, state and other federal funds were expended in FFY20 to support MCH programming throughout the state, improving the health of women, children, and families. The program outcomes discussed in the State Action Plan and other sections of the Application/Annual Report could not have been achieved without federal Title V funding.

In FFY20, $23,928,946 federal Title V dollars were expended, $11,771,621 (49.1% of the total Title V federal expenditures) on preventive and primary care for children, $7,217,569 (30.1% of the Total Title V federal expenditures) on CSHCN, and $2,392,894 (10% of the total Title V federal expenditures) on Title V administrative

costs. Pennsylvania bases maintenance of effort match funds on all non-federal funds that serve MCH populations. In FFY20, $46,813,492 state dollars targeting MCH populations were expended, surpassing the state's maintenance of effort amount from 1989, $20,065,575. Total state and federal Title V expenditures for FFY20 were $70,742,438. Additionally, the BFH expended $3,423,394 in other federal funds implementing MCH programming. State MCH grand total expended for FFY20 was $74,165,832. State funds that contributed to the maintenance of effort amount included state appropriations for school health services and MCH Services as well as appropriations for special conditions impacting MCH populations such as Sickle Cell, Cystic Fibrosis, Hemophilia, Cooley's Anemia, Tourette Syndrome, Services for Children with Special Needs, Epilepsy, and NBS. State funded expenditures supported direct, enabling, and public health services and systems targeting infants and children with and without special health care needs.

Expenditures of Title V funds were in compliance with the legislative requirement that a minimum of 30% of funds are allocated for the support of preventive and primary services for children, a minimum of 30% of funds are allocated for services for children with special health care needs, and a maximum of 10% of funds are allocated as administrative costs. There were no significant variations of more than 10% in the FFY20 Title V expenditure data reported on Form 2 as compared to the planned budget for FFY20, though less was expended in other federal grants due to delays in program implementation, grants ending, and decreased funding availability. However, there were significant variations of more than 10% in the FFY20 Title V expenditure data reported on Forms 3a and 3b. Several factors led to the significant variations. First, the Department of Health prioritized addressing maternal mortality in its strategic plan and, simultaneously, the Title V 2020 Needs and Capacity Assessment process resulted in a new Title V priority focused on reducing maternal mortality. As a result, new enabling and public health services and systems initiatives were begun and Title V expenditures in the pregnant women domain increased in 2020. Second, the number of births in 2020 was less than projected, causing a decrease in Title V and state match newborn screening related expenditures for infants. Third, the addition of program staff serving all Title V population domains, including postpartum people and families, as well as the addition of legislative additions targeting CSHCN and their families led to an increase in expenditures in the all others population domain for both Title V and the state match in 2020. Finally, conscious efforts to move MCH programming down the pyramid led to a significant variation in direct service expenditures for both federal Title V and state match funded programs. Additionally, state funded CSHCN programming originally budgeted as public health services and systems for 2020 was reclassified as enabling services after a review of program scope while a planned evaluation of CSHCN programming was cancelled because of disruptions in care caused by the COVID-19 pandemic. The result of these efforts led to a significant increase in enabling services expenditures for 2020.

Expenditures are monitored on a monthly basis to ensure compliance with legislative financial requirements. Federally and state funded Title V programs served an estimated 2.6 million individuals from the MCH population. Title V served 92% of pregnant women, 99% of infants, 55% of children, and 82% of CSHCN in FFY20. Over time, Pennsylvania 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 state Title V funds for population health programs, such as school health services and NBS.

III.D.2. Budget

Title V FFY 2022 budget estimates, both federal and non-federal, align with Pennsylvania's seven MCH priority needs resulting from the 2020 Needs and Capacity Assessment, as identified on Form 9. Priority needs will be addressed through the following strategies:

- **Reduce or improve maternal morbidity and mortality, especially where there is inequity -** Federal Title V funds are budgeted to implement evidence-based or -informed home visiting programs, Centering Pregnancy programs, community-based, culturally relevant maternal care models, and innovative interconception and early postpartum care initiatives for women as well as to promote maternal behavioral health screenings and referral to services. Federal Title V funding is budgeted to support state-level management of these programs as well as related public health services and systems activities, such as participating on the Maternal Mortality Review Committee and collaborating with the Pennsylvania Department of Human Services programs serving people who are pregnant or postpartum.
- **Reduce rates of infant mortality (all causes), especially where there is inequity -** Federal Title V funds are budgeted to facilitate adoption of evidence-based strategies to support initiation and continuation of breastfeeding. Federal Title V funds are also budgeted to implement a hospital-based model safe sleep program and SUID prevention strategies, including safe sleep promotion, based upon the data reported in the SUID/SDY Case Registry. Other federal funds are budgeted to support participation in the SUID/SDY Case Registry. Federal Title V funding is budgeted to support state-level management of these programs as well as related public health services and systems activities, such as CDR and collaborating with the Pennsylvania Department of Human Services programs serving infants and people caring for infants.
- **Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs -** Federal Title V funds are budgeted to expand the evidence-informed HRC program, increase protective factors for LGBTQ-identified youth through evidence-based or evidence-informed behavioral health programs, implement Olweus Bullying Prevention Program the community youth organizations, support youth mentoring, implement SafeTeens/SafeTeens Answers!, promote awareness of the correlation between substance use and brain injury, and implement CDR recommendations to address trauma. Federal Title V funds and other federal funds are budgeted to develop evidence-based or evidence-informed mentoring, counseling, and adult supervision programs for youth with and without special health care needs for children ages 8 to 18. Other federal funds are budgeted to provide services through the Personal Responsibility Education Program and Abstinence Education Grant Programs while federal Title V funding is budgeted to support state-level management of these programs as well as related public health systems development activities.
- **Improve the percent of children and youth with special health care needs who receive care in a well-functioning system -** Federal Title V funds are budgeted to review and analyze data from the Newborn Screening (NBS) system to inform quality improvement activities to improve data collection and reporting and develop strategies to address identified weaknesses in NBS data collection, reporting, and follow-up. Federal Title V funds are also used to ensure families are partners in decision making and are satisfied with the services received, CSHCN receive coordinated, ongoing, comprehensive care within the medical system, CSHCN are screened early and continuously for special health care needs, community-based services are organized so families can use them easily, and youth with special health care needs receive services to make appropriate transitions. Additionally, Federal Title V funds are used to review and analyze neonatal abstinence syndrome cases reported in the NBS case management system to identify birth hospitals that are not making Early Intervention Referrals and provide technical assistance to improve referral rates as well as to collaborate with the Office of Children, Youth, and Families to help support enrollment of impacted infants into Plans of Safe Care. State and other federal funds are also budgeted to improve the NBS case management

system, provide direct, enabling, and public health services to CSHCN through specialty care grants, provide school health services to children with and without special health care needs, and implement the service component of the Traumatic Brain Injury program while federal Title V funds are budgeted for state-level program management and related systems development activities, such as collaborating with the Department of Human Services programs serving CSHCN.

- **Reduce rates of child mortality and injury, especially where there is inequity -** Title V funds are budgeted to reduce sports-related head injuries, increase adolescent males understanding of health relationships through evidence-based or -informed programs, provide comprehensive home assessments to identify potential home health and safety hazards as well as home safety interventions to address the leading causes of child injury and death. Other federal funds are budgeted to enhance childhood blood lead level surveillance and implement lead poisoning prevention activities. Federal Title V funding is budgeted to support state-level management of these programs as well as related public health services and systems activities, such as CDR and collaborating with the Pennsylvania Department of Health's injury prevention program.
- **Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development -** Federal Title V funds are budgeted to review program activities and goals to determine programmatic needs, conduct analysis, interpret results, develop actionable reports, develop program strategies based on actionable findings, and use PA PRAMS, National Survey for Children's Health (NSCH), CDR, and the Maternal Mortality Review Committee findings to inform, develop, modify and evaluate public health programs and policies in Pennsylvania. Title V and other federal funds are budgeted to collect, analyze, and report PA PRAMS, SUID/SDY and NSCH data as well as to improve the state's ability to identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs. Federal Title V and other federal funds will be used to assess program performance related to targeted MCH outcomes so improvements can be made as needed.
- **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 -** Federal Title V funding is budgeted to support reproductive health and family planning for adolescents with the intent of addressing determinants influencing disparities in unintended teen pregnancy rates. Federal Title V funding is also budgeted to increase staff understanding of health equity principles and to support state-level management of these programs as well as related public health systems and MCH workforce development activities.

Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services) have been completed in accordance with the guidance. Pennsylvania is requesting a federal funding amount for FFY 2022 that is level with the FFY 2020 award.

Pennsylvania's proposed budget for FFY 2022 is in full compliance with the federally mandated threshold requirements. Of Pennsylvania's proposed federal grant award for 2022, $10,381,678 (43.4% of the total grant award) is designated for the support of preventive and primary services for children, and $7,744,494 (32.3% of total grant award) is designated for the support of services for children with special health care needs. Administrative costs are budgeted at $2,392,894, which is 10% of the grant award. Administrative Costs include all personnel and operating costs that are not directly or indirectly incurred for the provision of direct, enabling, or public health services and systems. Beginning in FFY 2018, Pennsylvania adjusted the reporting methodology for funding designated to preventive and primary care for children to reflect the population served, rather than the outcome of the service. In

previous years, services provided to pregnant women were included in the calculation because the goal of these services was to improve perinatal and infant health outcomes. Services provided to pregnant women are no longer designated as preventive and primary services for children.

Pennsylvania bases maintenance of effort match funds on all non-federal funds that serve MCH populations. Pennsylvania's maintenance of effort amount from 1989 is $20,065,575. State funds that contribute to the maintenance of effort amount include state appropriations for school health services and MCH services as well as appropriations for special conditions impacting MCH populations such as Sickle Cell, Cystic Fibrosis, Hemophilia, Cooley's Anemia, Tourette Syndrome, Services for Children with Special Needs, Epilepsy, and NBS. Total state funds contributed to MCH services in 2022 are $47,605,500. This exceeds the required $3 match in non-federal funds for every $4 of federal Title V Block Grant funds expended. The federal-state Title V Block Grant partnership subtotal for 2022 is $71,534,446. Federal Title V and state funds will be monitored on a monthly basis to ensure the match requirements are met for FFY 22.

The BFH is the recipient of several other federally funded projects that impact the MCH population, including: State Sexual Risk Avoidance Education Grant and Personal Responsibility Education Program from the Administration for Children and Families; PRAMS, SUID/SDY Case Registry, Preventing Maternal Deaths, and Childhood Lead Poisoning Prevention Program from the Centers for Disease Control and Prevention; State Systems Development Initiative, and Universal Newborn Hearing Screening and Intervention from HRSA; Traumatic Brain Injury from the Administration for Community Living; and Lead-based Paint Hazard Control from the Department of Housing and Urban Development. The total funding from all other federal projects for 2022 is $7,917,414. State MCH budget grand total for 2022 is $79,451,860.

Budgeted amounts outlined on Form 3b reflect Pennsylvania's intent to spend the majority of its anticipated FFY21 MCH funding from federal Title V, state, and other federal sources on enabling services and public health services and systems. The budgeted amounts for direct services reported on Form 3b are estimates of the cost of direct services not covered or reimbursed through another payor. These Title V funded direct services include pharmacy and physician/office charges for pregnant women, infants, children, and CSHCN. Title V is the payer of last resort for all direct services. The state funded direct services include pharmacy, laboratory and physician/office charges for infants and CSHCN. As evidenced by the variety of programming listed within the State Action Plan, Pennsylvania has allocated funding to directly and indirectly support the public health essential functions for the three legislatively defined populations, preventive and primary care services for all pregnant women, mothers, and infants up to age one, preventive and primary care services for children, and services for CSHCN. The allocation of funding for enabling services and public health services and systems outlined on Form 3b demonstrates Pennsylvania's continued commitment to expanding systems of care for both MCH and CSHCN populations.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Pennsylvania

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Within the structure of the Pennsylvania (PA) maternal and child health (MCH) system of care, the Bureau of Family Health (BFH) is uniquely positioned as the leader on MCH public health issues as the administrator of the Title V Maternal and Child Health Services Block Grant (MCHSBG). Full integration of evidence-based public health, driven by the transformation of the Title V MCHSBG, has made the BFH a leader within the PA Department of Health (DOH) on the use of evidence-based practices, data driven decision-making, continuous quality improvement, client and family engagement and satisfaction activities, workforce development, and integration of principles of health equity into public health programming. The BFH utilizes the Title V federal grant, other federal grants, and state funding to support program activities. The BFH is comprised of the following four divisions:

- Division of Child and Adult Health Services

  The Division of Child and Adult Health Services (CAHS) provides evidence-based programming to improve health outcomes and support women, mothers, infants, and children, including children with special health care needs (CSHCN). The CAHS implements strategies from the MCHSBG action plan to address maternal health before, during and after pregnancy, infant mortality, child safety and injury prevention, adolescent health and LBGTQ services. The CAHS also manages federal grants which provide teen pregnancy prevention, lead hazard control services, and support the prevention of childhood lead poisoning.

- Division of Community Systems Development and Outreach

  The Division of Community Systems Development and Outreach (CSDO) works in partnership with family, caregivers, and stakeholders to improve health outcomes for individuals and families through systems change. CSDO supports evidence-based programming for CSHCN, including the home visiting Community to Home program and the Specialty Care Program addressing spina bifida, cystic fibrosis, hemophilia, sickle cell, Cooley's Anemia, epilepsy, and orthopedic and neurological conditions. CSDO works to support and build family-centered systems by partnering with organizations such as the Parent Education, Advocacy and Leadership Center as well as Federally Qualified Health Centers and community-based organizations. Families are linked to needed resources through CSDO's Special Kids Network Helpline and CSDO houses the state's Traumatic Brain Injury (TBI) programs, which include those for acquired brain injury, concussion awareness, return to learn, and TBIs related to opioid use/misuse. CSDO also houses an adolescent health program promoting positive relationship behavior among young men, and an innovative program using telehealth to diagnose young children with Autism Spectrum Disorder.

- Division of Newborn Screening and Genetics

  The Division of Newborn Screening and Genetics (NSG) is responsible for ensuring all infants born in PA receive a dried blood spot screening, critical congenital heart defects screening and hearing screening. NSG staff provide follow-up services to ensure that each newborn receives the three newborn screens and any newborn with an abnormal screening result receives a referral for confirmatory testing and diagnosis. The Division also oversees grant agreements with metabolic, cystic fibrosis, hematology treatment centers, and the metabolic formula program and is responsible for the BFH's breastfeeding education, awareness, and support activities. In addition, NSG administers a neonatal abstinence program (NAS) which receives NAS case reports that will be submitted to the Opioid Command Center and will be used to implement a long-term follow-up program.

- Division of Bureau Operations

  The Division of Bureau Operations (DBO) provides support to BFH staff by managing the reporting requirements of the Title V MCHSBG and through leadership and technical support to the Bureau and grantees on client satisfaction, client engagement, data collection and analysis, cultural humility, health equity, and staff/workforce development. DBO also supports several surveillance programs including Child Death Review, Sudden Unexpected Infant Death/Sudden Death in the Young Case Registry, and the PA Pregnancy Risk Assessment Monitoring System (PA PRAMS). Other grant programs administered by DBO include the Technology Assisted Children's Home Program (TACHP), Tourette Syndrome Support program, and State Systems Development Initiative (SSDI).

These four divisions work with over 45 partners in the form of grantees, advisory boards, Medicaid bureaus, advisory and advocacy groups to execute programming across the six MCH population domains. The BFH serves as convener and a point of contact for MCH issues across the state as the representative of the Title V MCHSBG work. While key internal DOH partners, such as the Bureau of Women, Infants and Children (WIC) and the Bureau of Health Promotion and Risk Reduction address niche health issues within the MCH population such as nutrition, obesity, physical activity, oral health, and breast and cervical cancer screening, the BFH has the singular ability to address the public health issues facing the MCH population from a broad perspective across the life course. As such, the life-course theory is the guiding roadmap for the implementation of programs with the use of Title V, state, and other federal funds. Understanding the key risk and protective factors that influence a person's health across the lifespan enables the BFH to design, plan, and implement programming at multiple critical life stages simultaneously, thereby giving current and future generations the best chance at improved health.

Key to the application of life-course theory to MCH population health is an understanding of the services and systems that shape the health of the most vulnerable of the MCH population, particularly the role of Medicaid in the provision of direct service, especially for CSHCN. While the BFH does continue to support gap-filling direct services for vulnerable and uninsured populations, the BFH has been working toward shifting the role of Title V away from direct service provision to focus on the provision of enabling services and the maintenance and enhancement of public health services and systems through a combination of Title V, state, and other federal funding streams. Integral to the BFH's systems-level work is the implementation of the core public health functions of assessment, assurance, and policy development. The BFH is committed to ongoing assessment of the health status of the MCH populations in PA in order to identify and address emerging issues. In addition to continually evaluating the efficacy of Title V programming, the BFH is also working to assure a competent workforce that is capable of researching innovative, evidence-based strategies that may drive improvement in health outcomes. The BFH also plays a role in linking communities to needed information and resources so that they can drive change in policy and practice at the local level.

As such, while ensuring access to health insurance and high quality, appropriate, and culturally sensitive care remains an important facet of the work of Title V, the BFH is increasingly applying a lens of health equity to expand work to address the social determinants of health across the life-course which are linked to maternal and child health outcomes. The BFH has taken steps to implement evidence-based practices among populations at higher risk of adverse outcomes, such as those with low breastfeeding rates, high infant mortality rates, and among LGBTQ youth. In order to further those efforts and foster development of system-level strategies for each of the MCH population domains, the BFH's focus on health equity was intentionally woven into each of the new priorities driving the 2021-2025 action plan. Additionally, a concerted effort is being made to increase workforce development around addressing health disparities and health equity to increase the BFH's capacity to mitigate the impact of social, environmental, and economic determinants of health including the effects of discrimination and racism, sexism,

classism, and heterosexism.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Recruitment of qualified Title V staff is important to the Bureau of Family Health (BFH), as is staff retention. Retaining knowledgeable, dedicated program staff over the course of the five-year state action plan and across funding cycles makes delivery of Title V programming more consistent and effective. These efforts occur in alignment with the 10 Essential Public Health services and the MCH Leadership Competencies. The BFH is adapting its workforce development efforts towards a transformative approach to build a workforce that is able to respond to challenges at both the community and state-level, address the root causes of health inequities, and ensure that staff are continuously learning. The BFH encourages staff to participate in professional development opportunities as part of its retention efforts.

Each division within the BFH identifies such opportunities relevant to the topic area(s) in which program staff work. Additionally, Title V program staff often facilitate professional development workshops and offer technical assistance or other trainings to their grantees and local Title V staff in order to build capacity and support personnel across the state.

In 2021, the Division of Newborn Screening and Genetics (NSG) planned on providing a statewide training for audiologists. As a result of the COVID-19 pandemic, the training was postponed. The Infant Hearing Screening Advisory voted to host the training remotely and develop it into an online learning module that can be housed on TRAIN PA, Pennsylvania's gateway into the TRAIN Learning Network, in 2022. Throughout 2022, NSG will continue to provide staff with the opportunity to attend topical conferences, including the NewSTEPs New Disorders and Short-Term Follow-up Virtual Meeting, the Association of Public Health Laboratories Newborn Screening Symposium, and the North American Cystic Fibrosis Conference. In addition, the NSG will continue to participate in topical webinars hosted by various organizations related to dried blood spot, hearing, and critical congenital heart defects screening, in addition to breastfeeding and neonatal abstinence syndrome.

The Division of Child and Adult Health Services (CAHS) will offer training to grantees on long-acting reversible contraception (LARC), upon request. During the past year, there were no requests for LARC trainings, which may be a result of the COVID-19 pandemic. All field staff in the Safe and Healthy Homes Program (SHHP) completed at least one professional development course during 2020. This requirement will remain for SHHP staff through 2021. As a result of the pandemic, grantees completed more professional development courses than during pre-pandemic years. In an effort to ensure that the needs of all populations are being met through the services offered by the Department, all bullying prevention providers will be required to annually attend a one-day LGBTQ cultural competence training. Originally, these trainings were scheduled to start in 2019 but, due to scheduling conflicts, did not begin until 2020. The pandemic also impacted these trainings, which mostly took place virtually. LGBTQ cultural competency trainings will continue to be facilitated by Persad Center through 2022 and will provide opportunities to identify resources for LGBTQ youth, evaluate cultural competency of the organization, answer questions from staff, problem solve challenges, celebrate successes, and discuss unmet needs that have emerged through the delivery of services.

Despite the challenges of holding and attending workforce development activities during the COVID 19 pandemic, the Division of Community Systems Development and Outreach (CSDO) staff attended a wide range of trainings and events to maintain and increase their knowledge base. Staff who oversee the Traumatic Brain Injury Programs attended the National Association of State Head Injury Administrators conference, the Brain Injury Association of Pennsylvania's conference, and the Administration of Community

Living TBI Stakeholder meeting in 2020 and will attend them in 2021 and 2022. Attending these conferences will increase knowledge of brain injury and best practices in prevention and treatment. Staff assigned to the Specialty Care Programs (SCP) will attend trainings related to implementing systems level change and supporting cross-systems collaboration to enhance technical support to SCP grantees. CSDO staff attended events focused on improving the CSHCN system of care in 2020 and will continue these workforce development opportunities in 2021 and 2022. Events included the PA Community on Transition Conference, the Everyday Lives conference, the PA Community Alliance Summit, the Disability and Mental Health Conference, and the Special Needs Unit Training Day. Some of these events included presentations on CSDO's CSHCN programming. Staff will attend trainings related to programs that are new or are undergoing changes, including the Male Involvement Initiative. The Male Involvement Initiative training for youth and advocates, entitled "Make a Difference", was postponed from 2020 to 2021 and held virtually. Plans are underway for in-person training in 2022. Similarly, the Parent Education and Advocacy Leadership training for youth with special health care needs, entitled "Bring Your Voice: Share Your Vision", was held virtually in 2021 after having been planned to be in-person in 2020. This conference is also being planned for in-person in 2022. The CSDO staff will take part in training opportunities intended to improve their ability to identify systematic issues and develop programming to address the issues. Opportunities will be provided for BFH staff to attend trainings presented by CSDO grantees, which will provide information related to condition-specific populations, public health concerns experienced by each population, and best practices related to service provision.

The Division of Bureau Operations (DBO) has and will continue to support and provide training opportunities and technical assistance for BFH staff and grantees on a variety of topics as outlined in the narrative below. DBO staff may attend conferences, such as the 2021 Family Voices Virtual Family Engagement Convening annual family engagement conference and the Specialty Care Symposium. BFH staff will continue to explore external opportunities for enhancing knowledge and skills associated with family engagement strategies. DBO will continue to develop and lead workforce development activities throughout the BFH.

In addition to the division-specific professional development activities described above, several staff from each division typically have the opportunity to attend and/or present at the annual Association of Maternal and Child Health Programs (AMCHP) and American Public Health Association (APHA) Conferences in order to build new skills and expand their knowledge of best practices that can be incorporated into BFH programming.

In January 2021, the Department of Health formally adopted a duty statement around health equity that has been added to all employee's position descriptions. This statement holds staff responsible to "demonstrate awareness of the vulnerable populations the organization serves by identifying, providing, and advocating for resources, services, communication methods, and policies that would help those populations achieve health equity". The Office of Health Equity will be working with the Health and Human Services Delivery Center to offer health equity training to ensure a well-trained and prepared workforce is maintained.

The Department is also exploring new mechanisms for recruiting and retaining qualified public health staff. The Department is in the process of implementing a workforce development plan developed in 2017 for the 2017-2021 period. Given that the BFH must adhere to the Department's recruiting policies and procedures, innovations in recruitment and retention could be beneficial to the BFH and, by extension, to the state's Title V program. The BFH aligns its workforce development activities with the Department-level initiatives whenever feasible. The BFH's staffing structure is also dictated by the framework established by the Department. The Organizational Structure section of the Needs Assessment Summary (III.C.2.b.ii.a.) describes the staffing structure of the state's Title V program. The organizational charts for the BFH and the Department are also included with the Application as supporting documents.

As the BFH has adapted to the transformed Title V block grant structure and reporting requirements, it has become apparent that workforce development needs to move beyond program and discipline specific trainings for BFH staff and grantees. The BFH will continue to augment the trainings and development opportunities discussed above with bureau-wide trainings to enhance staff understanding of public health concepts, health equity, MCH Leadership Competencies and their application to programming, as well as to the community and systems they impact, and the root causes of health inequities.

Recognizing that client and family engagement activities are central to creating a system of care that is family-centered and responsive to the needs of maternal and child health (MCH) populations, throughout August 2020, DBO hosted one-hour Client Family Engagement 101 trainings for BFH staff. Concepts reviewed included: BFH Commitment and Purpose; Client and Family Engagement Goals; Title V Block Grant Guidance; BFH Client and Family Engagement Workplan; Client and Family Engagement and Health Equity; and SharePoint Resources. This training was held virtually, due to the COVID-19 pandemic.

Internal surveys of BFH staff conducted as part of the internal capacity assessment in 2020 and a smaller staff survey conducted in 2021 suggest that capacity building on decision making and program development based on data and evidence is still warranted and desired. Additionally, given the high percentage of new BFH staff at the programmatic level, continued training and opportunities for professional development in this area may benefit staff who have worked in public health but are new to Title V and public health programming.

Similarly, the BFH also intends to continue building capacity among grantees who administer Title V-funded programs across the state. While grantees indicated in the 2018 interim needs assessment that they had built capacity that would allow them to identify evidence-based practices, some indicated that additional technical assistance is needed for them to access data and effectively evaluate their programs.

DBO will continue to offer training to BFH staff and grantees to support program decision-making and implementation. Training topics may include public health problem solving concepts, data use, evidence-based practices, quality improvement, and program evaluation. Staff will also be encouraged to take advantage of web-based training, such as the “Harnessing the Power of Data” training from the Mid Atlantic Regional Public Health Training Center. In April 2020, DBO shared the “Harnessing the Power of Data” webinar, as well as the “Basic Concepts in Data Analysis” training from the Northwest Center for Public Health Practice with staff to increase their ability to work with and present data from the public health perspective.

In 2021, DBO staff provided training to staff and to grantees, entitled “Pennsylvania Title V MCH Block Grant Performance Measure Framework”, aimed to build the capacity of the MCH workforce to apply the Title V performance measure framework to programming. This training provided an overview of public health principles, Title V and the Performance Measure Framework, developing SMART (specific, measurable, attainable, relevant, and time-bound) goals, and disaggregating data. The BFH aims to integrate the collection of more evaluation measures into its grant agreements and, for everyone to understand the need and benefit of these changes to effectively serve the MCH population, must begin training staff and grantees around how to collect and analyze data, develop enhanced process and outcome measures, and use these tools to inform program decisions and improve program effectiveness. DBO is planning a Data and Data Disaggregation training for staff to take place in 2021.

Additionally, in February and April 2021, the BFH held informational meetings with the Leadership Education in Adolescent Health Children’s Hospital of Philadelphia (CHOP) fellows’ program and the joint Leadership Education in Neurodevelopmental Disabilities CHOP and Children’s Hospital of Pittsburgh (CHP) fellows’ program

respectively. These meetings served as an opportunity to share programs and initiatives that are taking place within the BFH and learn from the CHOP and CHP fellows' first-hand accounts of what is taking place with patients and the communities they live in and identify opportunities for further partnership and training.

Surveying BFH staff will occur at least annually to determine internal staff capacity and training needs around the aforementioned topics. Due to staff changes in 2020, a comprehensive internal staff capacity and training survey was not conducted; however, a survey is planned for fall 2021. A smaller survey was conducted to gather information to inform trainings for 2021 and existing workforce capacity efforts, including the weekly resource meal. Additionally, work continues on the creation of a resource library to compile literature and other supplemental resources to be used by BFH staff. This will potentially be made available to grantees as well.

In order to support retention and engage staff in capacity building during the COVID-19 pandemic under the work from home orders, BFH piloted a weekly resource email beginning in June 2020. The weekly resource email which included a combination of the following: live webinars and trainings, recorded webinars and trainings, articles, reports, tools, and upcoming national health observances that are relevant to public health, leadership building, health equity, behavioral health, and the maternal child health population. This resource email has become a staple within the Bureau as it strives to highlight upcoming events, recent reports, and tools for each population domain in its over 45 issues, as of April 2021. Anecdotally, staff have shared that there were beneficial trainings related to health equity, data disaggregation, and specific programs/population domains that have aided in furthering their understanding of a topic, program, or issue.

To learn more about the perceptions around the bureau's weekly resource email, staff were surveyed in May 2021 to determine if they have utilized any of the resources that are shared through the weekly resource email. Of the respondents, 86% (32 staff), shared that they have utilized resources that have been shared within the weekly resource email and 57% (21 staff) shared that they felt the resources were very beneficial or beneficial, while 27% (10 staff) responded neutral, and 16% (6 staff) responded somewhat beneficial to the same question. Given the challenges of the past year, it was important to understand if staff were able to continue building their capacity and increase their understanding or skills by participating in virtual or web-based workforce development activities. When asked, 95% of those who responded (35 staff) shared that they continued to build their capacity by participating in trainings and most shared they have participated in MCH trainings on various topics, including but not limited to adolescent health, CSYCHN, health and racial equity, implicit bias and microaggressions, the collection, utilization and analysis of data, and conferences or skills institutes while temporarily teleworking.

Another aspect of the BFH staff engagement includes regular staff meetings. Staff meetings are held quarterly to conduct workforce development activities, provide updates, and highlight work taking place in each of the divisions. In 2020, a few of the highlights included education on the historical origins of some health disparities with a focus on redlining, presentation about newborn screening, highlights from child health programs, releasing the new BFH Mission Statement, and quick tips for using SharePoint. Additionally, a quarterly newsletter was introduced in 2021 to share information as well as highlight new and ongoing initiatives within the Bureau.

As a result of the work in 2017 by the BFH 's two Master of Public Health interns, four introductory presentations were developed for BFH staff on public health concepts, data use, evidence-based practices and health marketing strategies. These trainings were recorded and made available to new staff. The BFH will continue to encourage staff to participate in appropriate web-based and in-person trainings (once it is safe to do so again amid COVID-19 protocols). Additional training needs continue to include public health competencies, health equity, and MCH Leadership Competencies, as previously mentioned. However, the following additional training needs (not inclusive of all the training needs) have been shared by staff for either themselves, or for their programs:

- Reproductive Justice and Long-Acting Reversible Contraceptives

- CYSHCN and Reproductive Health
- CYSHCN and Adolescent Health
- CYSCN and Bullying
- Brain Injury Education
- CYSHCN and the Medical Home
- LGBTQ Health Topics
- Trauma Informed Care
- Utilizing Critical Thinking Skills
- How to Navigate and How to Have Difficult Conversations
- Motivational Interviewing

Over the long term, the BFH also plans to create opportunities for grantees to engage in learning and sharing their expertise. Several grantees have conducted introductory presentations to BFH staff about their respective programming and this will continue over the next year. Training on implicit bias began in 2019 and was offered by a grantee to health, medical, and social service providers across Pennsylvania. This effort concluded in the fall of 2020. In addition to implicit bias, additional training is still needed to further explore this topic, as well as health and racial equity.

The BFH also plans to offer training to increase understanding of the social determinants that greatly influence the health of populations. As a result of the February 2019 BFH Workforce Development Survey, it was identified that most staff did not feel that they could describe the limitations/gaps of Title V programming or apply behavioral models in the design of interventions for MCH populations. Although the survey results suggest that staff felt most confident in their understanding of health disparities and social determinants of health as they relate to MCH, these areas were also identified by staff as their highest priority areas for ongoing training. Additionally, the BFH's Health Equity Committee (HEC) will continue to implement the workplan to reduce health disparities and promote health equity in the population served by Title V. To address these goals and guide the development of a BFH workplan, the BFH HEC applied for and was accepted into the 2019 Cohort of the National MCH Workforce Development Center. During the cohort experience, the HEC developed a draft of a three-year workplan. The two main goals outlined for the first year were to: 1) develop a training plan for internal staff on health disparities and health equity; and 2) develop an approach for internal staff to provide technical assistance to grantees developing plans to address health disparities. In July 2019, the HEC administered a survey to BFH staff to understand staff's knowledge about health equity to inform future health equity work within the bureau. The survey identified that increased knowledge and capacity building was needed for the following topics: education on the concepts of health equity (including the history of inequities) and evidence-based practice; education and communication on meaningful community engagement; and identifying better ways to communicate about health equity in reporting. Results of the survey were shared with BFH staff during an all-staff meeting. The HEC has worked to identify training resources related to the above topic areas and anticipated in-person staff trainings and training evaluation for the BFH staff to begin in 2020; however, as a result of the COVID-19, these efforts have been postponed. The resulting postponement offered an opportunity to research trainings that could be offered virtually. In addition, 2020 highlighted the need to analyze the committee's approach to racial equity. Careful consideration has been given to how best to approach the topics of racial equity and health equity as training topics in virtual settings. A series of introductory health equity virtual trainings will serve as pre-requisites to more advanced in-person trainings and are expected to be shared with staff in fall of 2021.

Considering these challenges, the BFH has taken advantage of opportunities to further staff's capacities around these complex and systemic issues. Diverse teams made up of members from across the Bureau participated in the National MCH Workforce Development Center and the Maternal Health Learning and Innovation Center Virtual Fall

Skills Institute “Operationalizing Your Title V Action Plan During Times of Uncertainty” and the Virtual Spring Skills Institute “Strengthening Skills for Health Equity”. The teams left the trainings with increased knowledge, skills, and action steps to strengthen the BFH programs. During the Spring Skills Institute, the BFH health equity journey was presented as part of the peer learning. Additionally, BFH staff presented on lessons learned standing up the HEC at the 2020 AMCHP conference.

A small team, which includes program managers and directors, the bureau director, and members of the HEC participated in the Pennsylvania Department of Health’s Office of Health Equity Anti-Racism Institute, alongside 200 other Commonwealth staff from various sister agencies. This workshop serves to promote the work of dismantling systemic racism by equipping participants with learning, tools, and a professional network to be effective change agents for antiracism on an interpersonal, institutional, and structural level. This team is currently exploring how the racial equity work will align with the health equity work and overall systems change efforts within the Bureau. It is important to ensure that the antiracism work does not end at the conclusion of this workshop and that it permeates throughout each individual action and program. Additionally, members of this team will be joining the Department’s Antiracism and Health Equity Task Force, which was initiated in May 2021.

In 2020, DBO released a request for applications (RFA) to solicit applications from institutions and organizations to be funded to develop and deliver online and in-person educational sessions. The overall goal of this funding was to improve the capacity around public health concepts and topics, including health equity and social determinants of health among Bureau staff, grantees, and partners. Applications for this funding announcement were due October 2020 with the intent to begin funding one applicant by January 1, 2021. However, during contract negotiations with the selected applicant, BFH staff identified additional workforce development needs, including a process to better facilitate the transfer of learning, that needed to be addressed in the work statement. As a result, the RFA was withdrawn to be revised to better reflect the capacity building needs of the Bureau and its partners. The updated RFA will include a deliverable to achieve a multi-layered learning agenda, which will facilitate learning that impacts systems change and addresses the updated 10 Essential Public Health Services. The Bureau plans to release the workforce development RFA to begin in 2022.

III.E.2.b.ii. Family Partnership

Family and Consumer Partnerships (FCPs) are essential components of improving the health status of maternal and child health (MCH) populations over the life course. The Bureau of Family Health (BFH) recognizes the value of FCPs, has established multiple means of incorporating families and consumers into the Title V decision-making process, and is committed to expanding meaningful community partnerships grounded in health equity principles. Promoting equity in policies, regulations and standards based on family engagement practices helps to strengthen the public health care system while decreasing health care disparities. The aim is to continuously support, offer, and engage in opportunities that establish partnerships with families, assuring they are key partners in BFH's program development and policy-making decisions. Prioritizing effective and meaningful engagement practices with stakeholders promotes dialogue and strategic planning efforts to create positive outcomes. Active client/family engagement strategies and practices will assist with the measurement of quality assurance within a service, program, or intervention and will promote improved health outcomes across the population domains.

The BFH is in the process of implementing a client and family engagement framework composed of four phases: Communication, System, Unification, and Adaptation. The engagement framework involves strategies that will increase awareness and provide guidance in the implementation of engagement practices meaningful to MCH populations. The Communication phase involves the process of disseminating information, identifying trainings, creating awareness, and publicizing the BFH initiative to expand client/family engagement strategies while addressing health equity practices within the BFH. The System phase involves exchanging information with stakeholders and identifying meaningful strategies of client/family engagement within BFH. This phase will foster new engagement opportunities while supporting and encouraging existing engagement practices. The Unification phase will cover BFH supporting stakeholders in identifying a process of continued communication and evolution. The Adaptation phase will consist of an active collaborative dialogue and activities with stakeholders. The BFH is currently engaged in the System phase of the framework.

The COVID-19 pandemic caused changes and modifications in the implementation of the client and family engagement framework plan to eliminate in-person activities. However, BFH adapted and developed and delivered its first virtual training focusing on increasing staff knowledge about client and family engagement. The training covered Title V guidance fundamentals in family partnership, the BFH client and family engagement initiative as well as the family partnership continuum, and BFH's goals for expanding engagement. The training also covered the intersection of cultural/linguistic competence, health equity and family engagement. The mandatory training was offered to all BFH staff. A survey was provided to participants using principles from the Family Engagement in Systems Assessment and Family Engagement in Systems Toolkit developed and released by Family Voices in 2019/2020. The survey assessed knowledge of client and family engagement practices. The survey garnered a 52% response rate from participants. The survey revealed staff were able to positively understand their role in family engagement at a rate of 88%. Participants were able to identify the levels of engagement across the health care system at a rate of 52%.

The survey served as a tool to collect baseline data on meaningful engagement fundamentals. The data will provide an opportunity to continuously monitor, measure, and improve engagement standards during the implementation of the four-phase framework. BFH looks to improve previously collected rates by 10% by 2022. The survey identified staff were aware of BFH family engagement technical assistance online resource at a rate of 28%. The aim is to increase staff awareness by 30% while also measuring for utilization. BFH will continue workforce development by offering training and educational opportunities in family engagement grounded in health equity principles to staff and partners to ensure quality assurance.

The BFH envisions a grantee support mentorship program where grantees will be able to connect with each other. The BFH encourages program outreach and awareness to our family and consumer partners to create dialogue and planning sessions to enhance and evolve existing partnerships. BFH will encourage all grantees to collect data on family engagement practices and grantees will also be able to seek assistance from BFH program officers to

capture data related to family engagement. In the future, the BFH will expand partnerships with external partners and will collaborate with family organizations to increase family participation in advisory roles and on committees at the system level. BFH continues to look for innovative outreach opportunities to expand external partnerships and will continue to identify new relationships with family-led organizations.

Engagement with consumers and their families was also an integral component of interim needs assessment activities. The BFH incorporated multiple opportunities for engagement of stakeholders across the MCH population domains by requesting input from Title V service recipients and providers about their experiences with the care system and factors influencing their health through a web survey and virtual focus groups in order to inform the assessment of MCH health status and identify strategies to address Title V priorities. Several possible options that the BFH is considering for improving family and consumer participation in future assessments include coordinating with providers to offer transportation to in-person events, exploring childcare options, better advertising of incentives such as meals and consideration of additional monetary incentives for participation. Another possibility under consideration is continuing to hold virtual meetings so that families or service recipients who are unable to attend in person can still participate.

The BFH convenes several advisory boards and committees which include consumers and family members. For example, the Traumatic Brain Injury (TBI) Advisory Board includes a requirement that at least fifty percent of board members must be an individual with a brain injury. Although positions on the board are not compensated, the BFH provides for transportation, lodging and subsistence. There are currently six individuals with a TBI and three family members on the TBI Advisory Board. The Infant Hearing Screening Advisory Committee has one parent representative who is a volunteer. The Newborn Screening and Follow-up Technical Advisory Board has one parent representative who is a volunteer.

The State Interagency Coordinating Council for Early Intervention (SICC) on which the BFH participates has three family members of individuals with disabilities who serve as SICC board members. A staff member from the BFH is the DOH representative on the Pennsylvania Developmental Disabilities Council which includes six family members of individuals with disabilities and seven individuals with disabilities.

Within some programming, family members have roles beyond serving on a committee. The Parent Education and Advocacy Leadership (PEAL) Center is the federally designated family to family information center in Pennsylvania. PEAL receives funding through Title V to conduct youth leadership institutes to provide youth the ability to network with other youth and improve their self-advocacy skills. PEAL also provides trainings to grandparents who are raising grandchildren with special health care needs and links them with resources. PEAL employs family members to educate individuals and their families on resources for children and youth with special health care needs. The BFH's Community to Home Program partners with the Health Promotion Council to conduct home visiting services for CYSHCN and their family members. The Health Promotion Council employs two family members of individuals with a disability.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

The Bureau of Family Health (BFH) recognizes the need for improved availability, timeliness, and quality of MCH data, as utilization of these data is central to the BFH's capacity to report on its Title V MCHSBG program assessment, planning, implementation, and evaluation efforts. The BFH has expanded its MCH Epidemiology workforce to support the Bureau; is using SSDI to further support the Pregnancy Risk Assessment Monitoring System (PRAMS) and program evaluation activities; and is working to expand staff's capacity for data collection and analysis regarding programming.

The current MCH epidemiology workforce funded by and supporting the Title V program includes a full-time PhD level Epidemiologist, responsible for managing and analyzing MCH data, and a full-time master's level Epidemiology Research Associate (ERA) who analyzes MCH data, assesses and tracks MCH indicators at the state and national level, facilitates access to internal and external datasets, and supports BFH staff in building the capacity to use and interpret data to inform programming. Both Epidemiology staff are housed within the BFH and dually report to the MCH Director in the BFH and a senior supervisory epidemiologist in the Bureau of Epidemiology. This arrangement allows for ongoing, daily collaboration between epidemiology and program staffs, strengthens the relationship between the two Bureaus, and ensures the epidemiologist and ERA can access the training, guidance, and resources offered by leadership in the Bureau of Epidemiology. Accordingly, the MCH Epidemiology staff's knowledge and experience can be leveraged to support and evaluate Title V programs. The BFH also supports, through other federal funding, ERAs dedicated to childhood lead poisoning surveillance and maternal mortality, respectively. As the BFH continues to expand its access to MCH data sources these Epidemiology staff are critical to providing support to staff through data linkages and analysis. In 2020-2021 the BFH established the objective to build the infrastructure and capacity necessary to make ongoing needs assessment an innate, year-round process. Previously, staff capacity was not always sufficient to support year-round needs assessment activities. Now, internal epidemiology staff can provide daily support to staff for data-related needs as well as the support needed to coordinate interim and five-year needs and capacity assessment activities. The DOH also employs a statistician dedicated to MCH activities who provides support to the BFH.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The State Systems Development Initiative (SSDI) grant complements the Title V MCHSBG program by improving the availability, timeliness, and quality of MCH data. This project enables the BFH to enhance its data capacity by increasing access to and building capabilities for data collection, analysis, systems, and linked information systems. The work defined and supported through SSDI contributes to Title V MCHSBG data collection through the support of SSDI funds and in-kind contributions.

For the grant project year beginning in December 2019, the BFH has focused on the following activities:

1. Build and expand state MCH data capacity to support the Title V MCH Services Block Grant program activities and contribute to data-driven decision making by supporting Title V interim needs assessment efforts and PRAMS data collection. PA PRAMS is an epidemiologic surveillance system managed within the BFH. The program collects unique state-specific, population-based data on maternal attitudes and experiences before, during and after pregnancy. Data is analyzed and shared to inform MCH program and policy development both within the DOH and by outside partners and stakeholders. PRAMS data are used by the BFH and other MCH stakeholders to develop programs and policies to improve pregnancy and birth outcomes.

   SSDI Funds support PRAMS through an increased sample size. PRAMS was able to increase the sample size from 1,693 to 1,788. Larger sample sizes help ensure that the data gathered is generalizable to state's population of birthing people.

   The BFH Epidemiological staff provide support and analysis of the PRAMS data. SSDI and Title V funds supplement the PRAMS CDC grant, allowing BFH to increase PA's PRAMS sample size and take on additional temporary supplement modules. In 2020, PA PRAMS participated in a six-month supplement module for COVID-19. For 2021, PA PRAMS added the COVID-19 vaccine supplement and intends to participate in the Social Determinants of Health Supplement planned for 2021. Both supplements are planned to be in the field for 12-month timeframes. These supplements are funded in part with SSDI dollars and will allow for timely analysis of data on these topic areas.

   Data collected through PA PRAMS will be shared through reports and briefs on the Department's website and provided directly to MCH stakeholders. Findings from this project can be used by internal and external stakeholders to address maternal and infant morbidity and mortality; inform needs assessment activities; strengthen staff's capacity for data driven and evidence-based data for program decision making; and support policies and programs that advance health equity.

   Training resources or technical assistance (TA) documents are potential products to be developed. These documents will be part of the training and resource infrastructure to benefit new staff and expand current staff skills around identifying sources of data, conducting basic data analysis, using data to inform program development and evaluation, and developing process and impact measures.

   Through the completion of project activities and dissemination of findings, the BFH will be closer to its goal of developing, enhancing, and expanding state MCH data capacity for its needs assessment and performance measure reporting in the Title V MCHSBG.

2. Advance the development of and utilization of linked information systems between key MCH datasets by linking the BFH's iCMS with the vital records system.

   The Division of Newborn Screening and Genetics (DNSG) Director will continue to oversee the maintenance of the linkage of the newborn screening case management system, iCMS, with vital records data, completed through a collaboration of PA DOH's Bureau of Health Statistics and Registries and a contractor, Natus.

3. Support program evaluation activities around the NPMs that contribute to building the evidence base for the Title V MCHSBG through internal capacity building to evaluate programs.

   SSDI will continue to support Title V program assessment, monitoring and reporting on an annual basis to ensure project activities have been implemented as intended. This support is provided through focus groups and surveys to gauge client and customer satisfaction regarding programs throughout the Bureau as well as to assess program effectiveness.

   Priority 6 of the new Title V MCHSBG State Action Plan, "Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development" embodies the BFH's commitment to ensuring all Title V work, programming and activities are data-driven, evidence-based and, aligned with this SSDI goal. Priority 6 is a continuation of the data-focused workforce development priority included in PA's former State Action Plan ("Title V staff and grantees identify, collect and use relevant data to inform

decision-making and evaluate population and programmatic needs"). Internal surveys of BFH staff conducted as part of the internal capacity assessment in 2020 and a smaller staff survey conducted in 2021 suggest capacity building on decision making and program development is still needed. As the BFH moves to increase data availability, training for staff to increase the overall data capacity by increasing awareness and knowledge of types of datasets available and how to utilize the data to identify trends, make inferences, and develop or modify program will be key to informing programs.

In March 2021, BFH held a bureau-wide training on the Title V performance measure framework, developing SMART (specific, measurable, attainable, relevant, time-bound) measures, and the importance of disaggregating data. BFH plans to hold additional trainings and TA sessions on specific datasets, using data to inform program development and evaluation, and refining program process and outcome measures. Staff will also participate in the National PRAMS Conference, in conjunction with the CityMatCH Maternal and Child Health Leadership Conference and apply lessons learned to the trainings and TA developed by BFH.

Several process measures have been defined for each SSDI goal to measure progress on objectives and activities. While COVID has hindered BFH's ability to physically interact with vendors and program recipients, BFH is resuming virtual focus groups and surveys, a vital part of program design and evaluation.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Lessons learned from the 2020 five-year needs and capacity assessment have informed, and will continue to inform, focus group planning, conduct, and data collection activities over the course of the 2021-2025 cycle. During the five-year needs and capacity assessment, the BFH facilitated at least one focus group for each Title V population domain, and with service recipients and providers, respectively. Providers were more likely to engage in other phases of the assessment (i.e., respond to web surveys and participate in in-person events), while service recipient and family engagement and input was more challenging to obtain. Focus groups were determined to be one of the best opportunities to seek and receive direct stakeholder input. As a result, focus group opportunities with service recipients will continue to be prioritized.

To help support data sharing BFH is using Title V funds to sponsor a state-wide oversample for the National Survey of Children's Health (NSCH), which will provide data for the 2022 calendar year. This oversample will provide Pennsylvania with increased NSCH data which is expected to enable staff to analyze results for sub-populations of interest, including children with special health care needs. Additionally, BFH staff will be provided training annually on availability and access of NSCH data as well as how to use the dataset to inform programming and policy decisions.

The BFH also supports PA's State Health Assessment (SHA)/State Health Improvement Plan (SHIP) by participating in various committees and providing data for the MCH section of the SHIP. Data has been provided from PRAMS and other MCH data sources in the past and this partnership will continue for new iterations of the SHIP/SHA.

The BFH is also creating a streamlined process for data and training/TA requests. The standardization of the process with specific questions and prompt follow-up will expedite data requests while enabling BFH to track the types of requests it receives. This process will support BFH in following up with requests to determine if program or policy changes were made as a result of the data/TA requests. Together with the training described in the SSDI section above, this initiative will create a long-term solution to building capacity while using data to improve public outreach, strengthen service to stakeholders, and build effective data-sharing partnerships.

BFH, which manages Child Death Review (CDR) and the Sudden Unexpected Infant Death (SUID) Case Registry in Pennsylvania, will continue to provide a variety of trainings and TA to local CDR teams throughout the year to improve data quality and use. Currently, DBO provides one statewide resource meeting occurring in Harrisburg (virtually during the COVID-19 Pandemic). TA is and will continue to be provided to local CDR teams as requested. Technical assistance includes aiding teams in building/restructuring new teams; strengthening current teams; data collection, analysis, and utilization; identifying partners for collaboration; crafting recommendations; and developing prevention efforts.

MCH Data Access and Linkages

As referenced on Form 12, data access and linkages can be defined in two general groups: data where BFH has direct ownership and data owned by a second party. Data which BFH directly controls includes: Newborn Bloodspot screening (NBS), Newborn Hearing Screening (NHS); Neonatal Abstinence Syndrome (NAS) Case Reporting; PRAMS; National Center for Fatality Review and Prevention Cases Reporting System for CDR; and the Maternal Mortality Review (MMR) Program data. These datasets are readily accessible to staff within BFH allowing data to be queried and analyzed as needed. Data such as PRAMS or NBS are naturally linked with birth data from vital records. Additional linkages can be made at the BFH level for analysis as needed on a case-by-case basis.

The second type of data, datasets not owned by BFH, include vital records for birth and death; Medicaid; Women, Infants and Children (WIC); and Hospital Discharge Data. Data owned by another party can be made available to BFH staff via data request if approved.

The BFH receives subsets and/or limited access to vital records birth files for specific operations related to PRAMS, CDR, SUID/SDY registries, MMR, and newborn screening but internal requests for direct access to the electronic data source or to an analytic file that could be used to inform other Title V programs or needs assessment activities have been denied or are outstanding. Accordingly, analysis of and linkage between vital records and other MCH datasets is either limited or not possible. Vital records data is readily available for the PRAMS and CDR programs to support the projects. These processes have been in place for some time and continue to be updated monthly. New data requests for individual-level or raw data must be submitted to the PA DOH's Bureau of Health Statistics and Registries and may take up to 12 months before the data is made available. A subset of aggregated birth and death records is released publicly each year via PA's Enterprise Data Dissemination Informatics Exchange and is available for Title V use.

The BFH receives de-identified aggregate data from the Office of Medicaid Programs on Title XIX eligible deliveries and infants by race and ethnicity for Title V reporting on Form 6 on an annual basis and has received aggregate data on active Medicaid members that have a specific condition or special health care need to inform CSHCN programming upon request.

Inpatient hospital discharge data from the Pennsylvania Health Care Cost Containment Council (PHC4) can be linked to vital records and other data sources solely by special request and linkage must be performed by PHC4 staff.

The BFH currently does not currently receive any WIC data. This data could be made available by request, although this has not been explored, but potential linkages are not clear.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

In order to alleviate suffering and aid citizens whose personal resources are exceeded by the effects of a disaster or emergency, government at all levels must provide public and private resources to cope with any emergency. To employ those resources in an organized, effective manner requires a consistent approach, well-defined and practiced procedures, and organizational structures. The Pennsylvania Emergency Management Agency (PEMA) is responsible for preparing and maintaining PA's written Commonwealth Emergency Operations Plan (CEOP) and other required contingency plans to provide for Commonwealth and local disaster emergency management responsibilities. The CEOP is reviewed and updated every two years, or sooner if required. The CEOP outlines procedures and organizational structures and assigns responsibilities to accomplish the mission of helping the citizens of Pennsylvania. It is an operational, not an administrative plan. The responsibilities and coordination structures outlined in the CEOP align as closely as possible with day-to-day responsibilities, but their accomplishment during a disaster emergency must be coordinated. For the CEOP to work, the tasks and procedures outlined in the plan must be practiced and exercised.

At the federal level, the National Response Framework (NRF) aligns federal coordination structures, capabilities, and resources into a unified, all-discipline, and all-hazards approach to incident response and the National Incident Management System (NIMS). The CEOP aligns with the NRF and incorporate the principles of NIMS. The continual refinement of plans and procedures and the mandated use of NIMS will accommodate situational changes and promote preparedness for all kinds of emergency situations.

The CEOP is designed to assist state-level leaders and emergency management personnel in handling all phases of emergency management during a human-caused or natural disaster. All-hazards emergency management acknowledges that most disasters and emergencies are best managed as a cycle consisting of five phases: prevention, preparedness, response, recovery, and mitigation. The CEOP concentrates primarily on the response and recovery phases of that cycle, while mitigation, prevention, and preparedness responsibilities are included in an Appendix. All-hazards emergency management also acknowledges that there are common emergency functional responses. To address these commonalities, the plan contains fifteen functional annexes, each addressing an Emergency Support Function (ESF). The basic plan and the ESF annexes provide all-hazards emergency operations policies and guidance to state agencies. The CEOP assigns responsibility for the accomplishment of the ESFs to appropriate agencies of state government.

The CEOP is organized into three sections. The first is the Basic Plan, which prescribes general principles and responsibilities. The second is a set of fifteen ESF Annexes, which provide for the accomplishment of specific functions. The third is a set of Appendices, which provide amplifying information for users of the plan. The guidance contained in the CEOP is intentionally general in nature. Each department or agency mentioned in the plan has developed implementing instructions to ensure accomplishment of those responsibilities assigned in the plan. In those cases where the assigned responsibilities require a plan of their own, a separate, stand-alone plan was developed. The Table of Contents of the CEOP refers to these as "related plans" and divides them into two groups: incident (hazard)-specific plans and support plans (such as Volunteer Management). While the PEMA will coordinate and track the currency of related plans, the agency that is responsible for writing and maintaining the plan is listed.

This CEOP outlines the organization of emergency response assets at all levels of government in Pennsylvania, and the approach that will be used to respond to disasters and emergencies of all types. It further prescribes procedures and coordination structures for state-level response, which includes field forces and support by state agencies to local and county responders. This plan delegates responsibilities to the various state agencies and prescribes coordination structures that will ensure optimum efficiency in the application of limited state assets. The ultimate objective of all emergency response is to minimize the negative consequences of any disaster or emergency

situation in the state. This is best accomplished by orchestrating state activities during prevention, preparedness, response, recovery, and mitigation from disasters and emergencies. Each department or agency developed internal operating procedures or implementing instructions to ensure that responsibilities assigned in the CEOP are executed.

Each of Pennsylvania's 67 counties is required, in accordance with the provisions of the Commonwealth of Pennsylvania Emergency Management Services Code or Title 35, Pa. C.S.A. Section 7503 (1), to prepare, maintain, and keep current an emergency operations plan for the prevention and minimization of injury and damage caused by disaster, prompt, and effective response to disaster and disaster emergency relief and recovery in consonance with the CEOP.

The CEOP does not specifically consider the needs of the MCH population, which includes at-risk and medically vulnerable women, infants, and children. Instead, the agencies responsible for serving the MCH and other vulnerable populations are encouraged to consider the needs to the populations in their plans. Title V program staff were not involved in the planning and development of the CEOP, nor is Title V leadership included in the Incident Management Structure. However, Title V leadership is included in the DOH management structure and is consulted when emergencies impact MCH populations. Additionally, Title V staff are asked to review frequently asked questions documents, factsheets, and other pertinent disaster/emergency response communications related to MCH populations before they are published. When appropriate, Title V leadership may be called upon to participate in emergency preparedness planning and training exercises when warranted.

Furthermore, the Bureau of Family Health (BFH), as Pennsylvania's Title V program, has a Continuity of Operations Plan (COOP) used to ensure BFH can maintain operations during an emergency or disaster. The COOP is a web-based system allowing each Bureau within the Pennsylvania Department of Health (DOH) to develop their own plan, which in turn is a part of the Commonwealth's COOP overseen by PEMA. Title V program staff are not directly involved in the overarching planning and development of the Commonwealth COOP; however, BFH has direct control over its own COOP and Title V program staff are involved in identifying essential functions as well as identifying how to maintain essential functions during an emergency. As part of the DOH Executive staff, the Title V Director is involved in DOH COOP planning. The BFH COOP is reviewed every three months and updated as necessary.

The BFH COOP plan specifically addresses all programming within the BFH, including programming for at risk and medically vulnerable women, infants, and children. Where programs are funded locally via Title V, staff work closely with vendors to ensure they also have a COOP and can continue to serve at-risk and medically vulnerable populations during an emergency.

Overall, there were no gaps identified during the Title V needs assessment related to emergency planning. The COVID-19 pandemic did force Title V staff and programs to function in a new way. Historically the BFH COOP was based primarily on having an alternative location for staff to physically be present. The pandemic and subsequent quarantine forced staff to work out of their homes and found little to no loss of operations and in some ways modernized practices. This adds another tool to the BFH COOP which was not previously considered a widespread option. Additionally, many of the community-based Title V programs were able to continue to provide some level of service virtually throughout the COVID-19 pandemic, though service numbers were impacted. Due to the nature of the pandemic, PA, like many other states, saw disruptions to prevention and primary care for maternal and child health populations. In future, more consideration may be given to public messaging about the importance of continuing routine care during extended emergencies and addressing concerns about safety when seeking care. The COVID-19 pandemic did reveal the need for better collection of demographic information with surveillance data and, subsequently, DOH has worked with submitters to improve the collection and reporting of demographic information and thereby improve DOH's ability to assess and address disparities.

All Commonwealth staff are provided annual training on emergency preparedness. In order to test effectiveness, drills are provided by PEMA periodically to ensure that the CEOP and COOPs are maintained, updated, and functional. PEMA also provides periodic trainings and updates to the emergency preparedness coordinators in each department. These trainings are attended by the emergency preparedness coordinator for the Bureau of Family Health.

Title V continues to look for opportunities to participate in the development of emergency preparedness and response training, communication plans, and tools/strategies to enhance statewide preparedness for MCH populations. The Title V program oversees many of the statewide MCH public health programs in PA, such as newborn screening, Title V home visiting, Child Death Review, and Maternal Mortality Review, and includes these programs in its preparedness planning. Additionally, Title V leadership coordinates plans with other public health programs within DOH, such as WIC, as appropriate and utilizes regularly scheduled meetings with agency partners to identify additional opportunities for coordination. The Title V program will continue to seek opportunities to strengthen statewide preparedness planning to address potential short- and long-term impacts of disasters and emerging threats on the MCH population.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Pennsylvania's Title V program and the Bureau of Family Health (BFH) aim to ensure access to quality health care and needed services for maternal and child health (MCH) populations across the state.

While the BFH continues to strive to increase investments in enabling services and public health systems and to monitor programming to assure that direct services are funded only as a last resort, changes in the Affordable Care Act (ACA) and the allocation of federal funds have made it necessary for Title V to provide additional financial support for some gap-filling, direct services over the course of this funding cycle. Following the introduction of the ACA and related Medicaid expansion, health insurance coverage in Pennsylvania (PA) improved. In 2017, only 5.5% of the nearly 12.6 million noninstitutionalized civilians in PA were uninsured. However, as of July 2019, the percentage of the now 12.6 million non-institutionalized civilians in PA who lack health insurance has increased to 5.8%. Similarly, while enrollment in Marketplace plans in PA increased from 2014 to 2016 due to the ACA, the number of residents selecting a Marketplace plan has declined since then with 365,000 enrolled in 2019 and only approximately 331,000 people enrolled in 2020.

Given that many Pennsylvanians still lack health insurance or have inadequate coverage, the BFH partners with local agencies and multidisciplinary clinics on the provision of direct services for vulnerable and uninsured MCH populations using Title V and state funds.

Local Title V staff at the County and Municipal Health Departments (CMHDs) provide direct services for children and pregnant women who are uninsured, underinsured, or uninsurable. Services include early pregnancy testing to encourage early entry into prenatal care or home visiting programs and depression screenings to all prenatal and postpartum women receiving services. Referrals are provided as needed to improve the health of women and their families.

Additionally, several of the CMHDs offer health clinics where basic services such as well visits, immunization and referral services are provided to individuals who have no insurance due to a gap in coverage between providers or insurances or for individuals who are uninsurable. Title V funds also provide safety net pharmaceutical services for patients with medical confirmation of cystic fibrosis, spina bifida, maple syrup urine disease (MSUD) and phenylketonuria (PKU). To be eligible for services, patients must meet all of the following criteria: U.S. citizenship, PA residency, and lack of monetary resources or health insurance. Depending on income, some families may be required to contribute to the cost of their prescriptions. If the eligible individual has prescription coverage, it must be used first.

While adolescents may be insured under their parents' health plans, many avoid needed healthcare due to concern about their parents' reactions if they obtain sexual or reproductive health services. To overcome this barrier, the BFH works with the state's four family planning councils to provide reproductive health services to youth 21 and younger. Services provided include routine gynecological care, pregnancy testing, contraceptives, cervical cancer screening tests, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.

Additionally, Title V supports the provision of reproductive health services to high school students through Health Resource Centers (HRC). Reproductive health services include counseling and education, information about reproductive health and relationships, decision making and sexuality, sexually transmitted infection screening and pregnancy testing, and referrals to school and community-based resources and family planning network for free or low-cost sexual and reproductive health care. The grantee, AccessMatters, operates HRCs in thirteen Philadelphia

area schools, as well as twenty-five additional sites in ten counties across the Commonwealth with high rates of teen pregnancy, STIs, and school dropouts.

A second grantee, the Mazzoni Center provides a drop-in clinic for LGBTQ youth in Philadelphia. The center provides primary medical care, support services including case management, HIV and sexually transmitted disease testing and screening, and health education regardless of insurance status.

Finally, the Specialty Care Program (SCP) aims to support child rehabilitation services, and populations with Cooley's Anemia, Cystic Fibrosis, Hemophilia, Sickle Cell, or Spina Bifida, using a combination of state and federal funds. The SCP is focused on patient centered care through a multidisciplinary team clinic model and its goal is to improve patient health outcomes by providing comprehensive care and reducing barriers that prevent adherence to treatment plans, such as gaps in insurance or lack of access to transportation.

The BFH will continue to provide safety net services for uninsured populations who are unable to access the services they need through traditional payment mechanisms and remains prepared to change course and support the provision of additional direct services as needed in order to ensure that the MCH population is able to access quality health care.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

In addition to the gap-filling services supported by Title V, a key component in the MCH system of care and the primary insurance provider for many of the vulnerable populations in PA is Medicaid, housed with the PA Department of Human Services (DHS). The BFH is currently collaborating with Medicaid in several areas. The BFH has standing bi-monthly meetings with representatives from the Office of Medical Assistance Programs (OMAP) and other DHS staff in order to discuss issues particular to the system of care serving children with special health care needs. Additionally, the Division of Newborn Screening and Genetics (NSG) also collaborates with the Office of Child Development and Early Learning (OCDEL) to share data related to Early Intervention at Risk Tracking for newborns born with Neonatal Abstinence Syndrome (NAS) and for infants with failed hearing screening. DHS' OCDEL also houses the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). Given that MIECHV also serves MCH populations, the BFH coordinated with OCDEL on needs assessment activities in 2020 and is exploring other areas for collaboration.

Such coordination and collaboration with DHS and Medicaid remain essential to advance the common goal of working to improve the health of MCH populations. In 2019, DHS announced its expansion of home visiting services for some individuals covered by Medicaid in PA. In collaboration with the physical health Medicaid managed care organizations (MCOs), all first-time mothers and at-risk mothers covered by Medicaid will be eligible for at least two home visits with implementation effective July of 2020. Additionally, children receiving shift care covered by Medicaid will be eligible for at least one home visit with implementation effective July of 2020. Part of this effort was the development of a pediatric shift care nursing home health task force which aimed to develop recommendations and best practices to inform the new home visiting requirement for children with special health care needs. BFH staff participated in the task force's workshops in order to learn about the initiative and identify opportunities to align Title V programming with the new work. Given that the BFH supports Title V home visiting programs for mothers and children with special health care needs, remaining abreast of such changes is crucially important to avoid duplication of efforts and leverage both Title V and Medical Assistance programming to ensure that gaps in services are continually identified and met. As part of that effort, the BFH has initiated quarterly meetings with DHS to discuss issues related to maternal health, infant health, and early childhood, including home visiting services.

To further solidify the coordination and collaboration with Medicaid, the BFH has an updated Memorandum of Understanding (MOU) between the two agencies. The goal of the MOU is to clearly define areas of collaboration to eliminate duplication of services while providing for opportunities to share resources and information regarding the work of both agencies. Each agency would like to determine how to most effectively use available resources to fill gaps in services and improve the provision of quality services across the MCH system of care. Avenues for data sharing, particularly around performance measurement, remain key areas where future collaboration is desired.

III.E.2.c State Action Plan Narrative by Domain

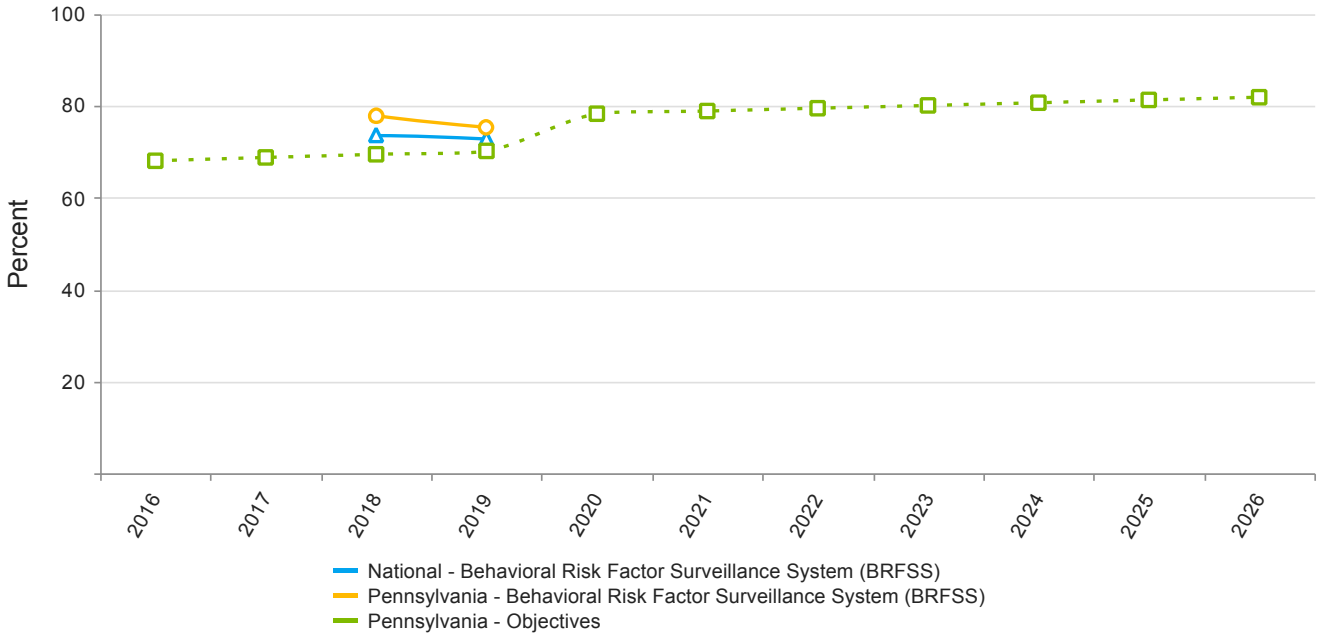
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	77.0	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	14.8	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.4 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.9 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	24.3 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	6.3	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.9	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	4.2	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.7	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	232.9	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	92.1	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	7.0 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	14.2	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	88.8 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	13.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	11.6 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					78.2
Annual Indicator				77.6	75.2
Numerator				1,651,482	1,609,089
Denominator				2,128,688	2,140,534
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	68	68.7	69.4	70.1	78.2
Annual Indicator	66.5	66.4	65.3	77.6	
Numerator					
Denominator					
Data Source	NIS	NIS	NIS	NIS	
Data Source Year	2015	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.8	79.4	80.0	80.6	81.2	81.8

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women who successfully complete evidence-based or informed home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.5	25.0	25.5	26.0	26.0

ESM 1.2 - Percent of adolescents and women enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.0	85.9	86.8	87.7	88.6	89.5

ESM 1.3 - Percent of mothers served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one well-child visit

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.4	83.6	84.8	86.1	87.3

ESM 1.4 - Number of community-based doulas trained in communities served by the program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	4.0	4.0	4.0	4.0	4.0

ESM 1.5 - Number of behavioral health providers trained in pregnancy intention assessment

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	0.0	0.0	0.0

ESM 1.6 - Percent of women enrolled in home visiting, Centering Pregnancy and IMPLICIT who are referred for behavioral health services following a positive screening

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	80.8	81.6	82.4	83.2	84.4

ESM 1.7 - Percent of women who receive a maternal health assessment within 28 days of delivery through the 4th trimester pilot program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

ESM 1.8 - Number of MMRC recommendations implemented annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 1.9 - Number of meetings held between DOH, DHS and MIECHV annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

State Action Plan Table

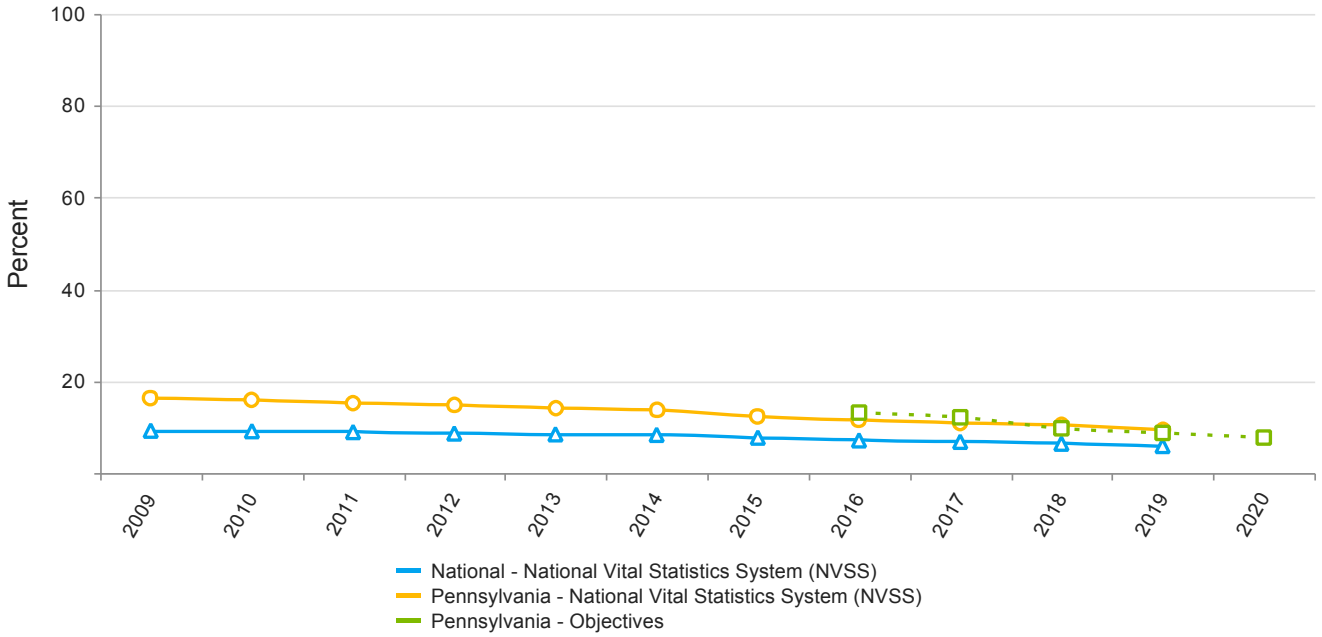
State Action Plan Table (Pennsylvania) - Women/Maternal Health - Entry 1
Priority Need
Reduce or improve maternal morbidity and mortality, especially where there is inequity
NPM
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Objectives
Increase the percent 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 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
Strategies
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

ESMs	Status
ESM 1.1 - Percent of women who successfully complete evidence-based or informed home visiting programs	Active
ESM 1.2 - Percent of adolescents and women enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods	Active
ESM 1.3 - Percent of mothers served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one well-child visit	Active
ESM 1.4 - Number of community-based doulas trained in communities served by the program	Active
ESM 1.5 - Number of behavioral health providers trained in pregnancy intention assessment	Active
ESM 1.6 - Percent of women enrolled in home visiting, Centering Pregnancy and IMPLICIT who are referred for behavioral health services following a positive screening	Active
ESM 1.7 - Percent of women who receive a maternal health assessment within 28 days of delivery through the 4th trimester pilot program	Active
ESM 1.8 - Number of MMRC recommendations implemented annually	Active
ESM 1.9 - Number of meetings held between DOH, DHS and MIECHV annually	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

2016-2020: National Performance Measures

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	13.2	12.2	9.8	8.8	7.8
Annual Indicator	12.5	11.5	11.1	10.4	9.5
Numerator	17,295	15,875	15,026	13,874	12,446
Denominator	138,426	137,557	135,851	133,690	131,653
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1,000	1,400	1,500	1,550
Annual Indicator	0	1,304	1,005	1,322	1,001
Numerator					
Denominator					
Data Source	n/a	n/a	n/a	n/a - see field note	n/a - see field note
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 14.1.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV)

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		75	80	85	90
Annual Indicator	0	89	76.5	73.2	70.5
Numerator			1,326	1,236	818
Denominator			1,734	1,689	1,161
Data Source	n/a	Grantee Reports	Grantee Reports	Grantee reports	Grantee reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 14.1.3 - Percent of women who report smoking after confirmation of pregnancy

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		30	28	26	25
Annual Indicator	20	20	6.1	6.2	6.5
Numerator			105	105	76
Denominator			1,734	1,689	1,161
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		20	30	40	40
Annual Indicator	30	30	30	30	20
Numerator			3	3	2
Denominator			10	10	10
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Women/Maternal Health - Annual Report

For reporting year 2020, the Bureau of Family Health (BFH) conducted activities in the Women/Maternal Health domain through Title V funding only and did not have additional federal or state funding to support these services. Taking into consideration the overall population needs and current partners, the BFH has developed strategies that do not duplicate other funding sources, and that fill gaps not addressed by the existing system of care and current partners.

In 2019, there were over six million women living in Pennsylvania (PA). The racial composition of this population is 81% white, 12% black/African American, four percent Asian/Pacific Islander and two percent multi-race. Eight percent of women living in PA identify as Latinx. Several factors contribute to poor maternal and infant outcomes and particularly disparate outcomes for black/African American birthing people and babies. These factors include systemic racism, substandard housing, unsafe neighborhoods, stress, mental health issues, tobacco, and other substance use as well as intimate partner violence (IPV). Mental health, substance use (including substance use during pregnancy) and IPV have particularly negative consequences on a family. Between three and nine percent of birthing people experience IPV during pregnancy, which has been shown to increase the incidence of depression and substance use. Additionally, research has shown that birthing people abused during pregnancy are twice as likely to miss prenatal care appointments or initiate prenatal care later than recommended, supporting an association between insufficient prenatal care and adverse birth outcomes, including preterm delivery and low birth weight. Nationally, about five percent of pregnant people use illicit substances and one in ten birthing people experience symptoms of postpartum depression.

The COVID-19 pandemic has resulted in a host of additional challenges for birthing people in PA. Preliminary data suggests that birthing people – particularly individuals of color – have experienced disproportionately higher rates of mental health concerns and substance use disorders, while simultaneously facing reduced access to supports for IPV and behavioral health needs in comparison to pre-pandemic life. While comprehensive evidence is not yet available to conclude that the rate of IPV has increased during COVID-19, the pandemic has exacerbated traditional IPV risk factors. In addition, reports from maternal health advocates have indicated that pregnant individuals have experienced reduced access to doula care and family supports before, during, and after childbirth, due to hospital policies related to COVID-19 as well as the difficulty of providing in-person care while ensuring the health and wellbeing of all parties. Finally, birthing people with children have faced challenges due to school closures, hybrid in-person/virtual school schedules, lack of childcare, job insecurity and other economic factors. Although most of these issues – behavioral health concerns, access to timely and quality supports, childcare, and employment and economic security – have historically been an issue for at-risk populations, including pregnant and postpartum people, the increased prevalence of these concerns over the course of the pandemic, coupled with reduced access to services and supports, may have serious long-term consequences. For example, pregnant and postpartum people may be more likely to engage in unhealthy behaviors, such as increased drug or alcohol use, to cope with the stress of the pandemic; this uptick may be reflected in maternal and infant health outcomes over the coming months and years. The Department of Health (DOH) has attempted to address some of these concerns by establishing a Pregnant Women/Young Children subgroup of its interdepartmental COVID-19 Health Equity Response Team, and by direct communications with hospital systems and other maternal healthcare providers regarding the importance of ensuring doula access for pregnant and laboring people during the pandemic.

Another increasingly challenging issue is that of maternal mortality and morbidity. Maternal mortality and morbidity are on the rise in the United States, with black/African American birthing people being most at risk for poor maternal health outcomes. The disparity between black/African American birthing people and white birthing people is unsettling, with black/African American birthing people three times more likely than white birthing people to die from pregnancy-related causes. Past and present experiences with racial discrimination shape black/African American

patients' interactions with their medical providers, and racism, stereotypes, implicit bias, and mistrust continue to interfere with care.

Despite pervasive racial disparities in maternal deaths, public attention has only recently focused on this issue as a public health crisis. Information and education regarding the incidence, causes and prevention recommendations regarding racial disparities among maternal deaths must be shared with health providers and the public to reduce the risk factors associated with these deaths. The Maternal Mortality Review Committee (MMRC), a requirement of the Maternal Mortality Review Act, will serve as the formal process to investigate the causes of death in this population and develop prevention strategies. The MMRC is made up of committee members from across the commonwealth in various specialties as laid out in the legislation, enacted in 2018. The committee includes obstetricians, maternal fetal medicine specialists, a certified nurse-midwife, an addictions medicine specialist, specialized gynecologic psychiatrists, social workers, coroners, an emergency medicine physician, and community voices such as home visiting programs. This expanse of knowledge and expertise will provide medical and clinical guidance, as well as a focus on social determinants of health, as the committee works to aid in eliminating racial bias and health inequity in the state. In 2019, the MMRC began reviewing maternal deaths from 2018. However, due to the complexity of the cases, staffing challenges, and the fact that all pregnancy-associated deaths in the commonwealth are included, regardless of cause, as well as challenges with COVID-19, all cases have not yet been reviewed. Due to reorganization within the DOH the MMRC will be changing leadership and be relocated to the BFH. Program staff are hopeful that this move will allow for positive changes that will help PA resolve the backlog of cases, and determine recommendations based on the present-day health system and the challenges currently facing birthing people in society.

In 2018, the rate of maternal mortality in the United States was 17.4 deaths per 100,000 births. In PA in 2018, the maternal mortality rate was 14 pregnancy-related deaths per 100,000 live births, based on data from the National Center for Health Statistics. While the PA rate is lower than the 2018 national rate there is much room for improvement, particularly within the disparities associated with maternal mortality. Vital statistics data for all pregnancy-associated deaths (deaths occurring within one year of a pregnancy) indicated that Black/African American birthing people accounted for 23% of deaths in PA from 2013 to 2018, while only accounting for 14% of births during this period. Of the deaths with payment information for the birth, 53% of the births were paid by Medicaid, while only 32% of all births during this period were paid for by Medicaid. Further, nearly half of the deaths from 2013 to 2018 occurred among birthing people who did not receive adequate prenatal care. All these factors together show a stark racial divide. Additionally, accidental poisoning, which includes drug-related overdose deaths, accounted for 30% of deaths from 2013 to 2018; it was also the leading cause of death among both black/African American and white birthing people in PA from 2013 to 2018.

The preconception and interconception periods are times when having access to a trusted health care practitioner is valuable, and that present opportunities for important conversations to occur. Data analyzed through Pregnancy Risk Assessment Monitoring System (PRAMS) surveys suggest that when birthing people have a health care practitioner talk to them about health issues, there is recognition and value in those conversations as preventative measures or interventions. Pregnancy and the postpartum period present a window of opportunity for home visitors, obstetricians, pediatricians and other providers to assess and take steps to improve both the physical and mental health of birthing people and families, if the providers are able to connect with and gain the trust of the birthing people they are serving.

Unhealthy birth outcomes, such as low birth weight and preterm birth, are influenced by many factors both before and during pregnancy. Preconception care allows birthing people to talk to their provider about steps to take to promote a healthy pregnancy before conception or implement strategies to delay pregnancy. It also opens the door for early entry into prenatal care. Prenatal care continues to be a crucial method in identifying health issues throughout pregnancy, allowing for early intervention and healthier birth outcomes. Additionally, pregnancy intention is

associated with several health outcomes. Studies indicate that unintended pregnancies are associated with a plethora of adverse physical health, psychological, economic, and social outcomes which impact birthing people, their families and society. The BFH focuses on preconception and interconception care and uses programming to provide tools and resources to the birthing people and families served by Title V. By implementing interconception and preconception care initiatives, the BFH intends to positively influence birth outcomes.

In 2019, 74.2% of all birthing people in PA received prenatal care in the first trimester. Of those who received prenatal care in the first trimester, 77.9% of birthing people were white, 64.2% of birthing people were black/African American, and 65.4% of birthing people were Latinx. Racial disparities are evident and continue to persist with 1.1% of white birthing people, five percent of black/African American birthing people and 3.7% of Latinx birthing people receiving no prenatal care. The BFH consistently ensures that services provided by Title V address the prevalence of disparities among specific at-risk populations that experience social and economic disadvantages related to race, ethnicity, sexual orientation, disability, mental health, immigration status or geographic location. These populations are often faced with discrimination and generally have poorer health outcomes. The BFH is working to address racial disparities by requiring that all grantees who serve Title V populations annually develop and implement a plan to identify, address and eliminate health disparities in their communities. Health disparities plans across grantees vary significantly and are dependent on the population being served. Several of the County Municipal Health Departments (CMHDs) have focused their plans around providing culturally appropriate materials and adequate interpreter services to better serve the diverse populations in their communities. Many CMHDs serve refugee populations and are dedicated to finding the best way to provide culturally relevant services to participants.

Home visiting programs have achieved positive outcomes in reducing the incidence of low birthweight babies and repeat pregnancies. These programs have also resulted in improved child development and increased immunization rates. Beginning in July of 2020, the Department of Human Services (DHS) expanded home visiting services for all first-time mothers and at-risk mothers covered by Medicaid. These services will be provided in collaboration with the physical health Medicaid managed care organizations (MCOs) and numerous CMHDs are in negotiations with MCOs to provide these services. The MCOs refer the expectant or parenting mother to an evidence-based or evidence-informed maternal home visiting program who will complete the assessment and determine the needs of the family. Further, the parent can elect to be enrolled in the program even if it's her third or fourth child. DHS is still working to evaluate the first year of this program. BFH staff will continue to work with DHS to collaborate and ensure services are not duplicated between agencies. In PA, the Office of Child Development and Early Learning (OCDEL) is the lead agency for the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). Many of the home visiting models offered through MIECHV have specific requirements beyond poverty level and need, such as prenatal enrollment and first pregnancy, unlike the flexible enrollment requirements of the CMHDs. Many of the CMHDs have MIECHV home visiting programs administered out of the same office, which allows for collaboration and referral. In 2019, the BFH made it a requirement that the CMHDs collect five outcome measures also collected by the MIECHV Program. This initiative was implemented to have a better grasp on the effectiveness of the CMHDs home visiting programs as compared to the MIECHV Program. The outcomes for the initial six month collection period reported by the CMHDs were as follows: 9.7% of infants were born preterm following program enrollment; 76.7% of primary caregivers enrolled in home visiting were screened for depression; caregivers were asked if they had concerns with their child's development, behavior, and learning at 93% of home visits; 69.4% of caregivers were screened for IPV; and 94.9% of caregivers with positive screens for IPV received referral information. Once data has been collected for an entire year, BFH staff will compare to the MIECHV outcomes. The CMHDs will continue to collect the five outcome measures, reporting them on a yearly basis.

Priority: Adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support

NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objective 1: Annually increase the percent of adolescents/women who talked with a health care professional after delivery about birth spacing or birth control methods

Objective 2: Annually increase the percent of adolescents/women who are engaged in family planning after delivery

ESM: Number of women served through evidence-based or -informed home visiting

ESM: Number of families served through Centering Pregnancy Program

ESM: Percent of adolescents/women engaged in family planning after delivery

ESM: Percent of adolescents/women who talked with a health care professional about birth spacing/birth control methods

The BFH continued its partnership with the CMHDs to provide local services to residents in their communities. The ten CMHDs are in Allegheny County, Allentown City, Bethlehem City, Bucks County, Chester County, Erie County, Montgomery County, Philadelphia County, Wilkes-Barre City and York City. Each of these locations is affected by poverty, racial and health disparities and greatly benefit from the maternal and child health (MCH) services provided. The CMHDs have been longstanding partners for numerous reasons, one of which is direct access to Title V eligible participants at the local level. The CMHDs serve this population in many different capacities and it is beneficial to the CMHDs as well as to the families to provide services across a wide range of physical health, mental health, and social services to improve and enrich the lives of families.

Various evidence-informed programs and best practices have been implemented to improve health outcomes and to reduce health disparities among at-risk and underserved populations served by the CMHDs. The CMHDs provide preconception and interconception care, home visiting, and smoking cessation programs, among others, to improve the health of families. In 2020, 1,161 pregnant and birthing people were served through CMHDs home visiting programs, below the annual goal of 1,800. As of a result of COVID-19, the number of pregnant and birthing people enrolled in and served by home visiting programs decreased due to discontinuation of in-person visits in response to stay-at-home orders, adjustment to connecting virtually, and CMHDs emergency response to the pandemic. In addition, particularly early in the pandemic, many CMHDs nurses were called upon to work on COVID-19 programming within their county or municipality, reducing the number of staff available to carry out Title V program activities. Program numbers typically fluctuate annually due to the number of families enrolled, nurse capacity and other factors. Home visitors have regular contact with families, which facilitates comprehensive, family-centered care. This care puts home visitors in an ideal position to identify and address physical, mental, or emotional challenges pregnant and birthing people may be experiencing, as well as issues within the home, such as IPV, substance use, and social or financial problems.

Each of the 10 CMHDs home-visiting programs serve prenatal and postpartum birthing people and their infants. Evidence-based or evidence-informed programming and curriculums, such as Parents as Teachers and Partners for a Healthy Baby, provide primary and preventative maternal and infant health services and education on a variety of health topics, such as substance use, healthy homes, safe sleep, fetal development, healthy nutrition for pregnancy, immunizations, birth control and family planning, parenting techniques, and breastfeeding.

Despite continued efforts to educate birthing people about the health benefits of services for themselves and their babies, barriers to delivering services remain. Challenges presented include birthing people refusing services, excessive missed appointments, staff turnover, and language barriers. Several of the CMHDs were unable to fill vacant home visiting-related positions because of COVID-19 hiring freezes enacted by counties and municipalities. Additionally, high-risk families that face multiple challenges related to young age, single parenting, lack of parenting education, lack of family support, social and emotional issues, intellectual disabilities, and substance use were most likely to leave home visiting programs early or discontinue services. The CMHDs continually work to identify and address these issues among their patients.

In 2019, the Philadelphia Department of Public Health (PDPH) developed the Doula Support Program (DSP). The DSP focuses on low-income prenatal and postpartum people with a history of a substance use disorder (SUD), including opioid use disorder (OUD). The program utilizes a community-based doula model to offer support to enrolled individuals up until one year postpartum. Due to a rise in cases of infants born with neonatal abstinence syndrome (NAS), PDPH saw a need to design this program to specifically serve pregnant people with substance use issues. The program, which began in 2020, falls under the 2021-2025 State Action Plan strategy to implement community-based, culturally relevant maternal care models and will be described in more detail in the Application section. Due to COVID-19, in person visits with doulas had to be changed to virtual connections with program participants and the program was only able to serve four people in the first year. Of these participants, 25% identified as black/African American, 50% identified as Latinx and 25% identified as Native American or other. 100% of program participants were covered by Medicaid. To foster a sense of community among program participants, the DSP started a virtual bi-monthly parent group to offer support and facilitate connections among program participants.

Numerous CMHDs utilize the One Key Question® initiative developed by the Oregon Foundation for Reproductive Health. One Key Question® is a pregnancy intention screening tool used to decrease unintended pregnancies and improve the health of wanted pregnancies. It was designed to proactively address some of the root causes of poor birth outcomes and disparities in maternal and infant health and is used to open a dialogue with patients to identify pregnancy intention within the next year. As nearly half of all pregnancies are unintended, this initiative allows the CMHDs to educate and develop a reproductive life plan with the individuals they serve. The initiative helps individuals to choose when they are ready to begin or expand their families.

Additionally, reproductive health planning helps individuals obtain optimal health before pregnancy, leading to healthier birth outcomes. However, limited research suggests that changing the wording of the question may increase its effectiveness. Asking the question, “Can I help you with any reproductive health services today, such as birth control or planning for a healthy pregnancy?” reflects patients’ preference for being offered services without needing to identify or specify their reproductive life plan or pregnancy intentions. BFH staff will explore and discuss this option with CMHDs that utilize the One Key Question® initiative. The One Key Question® initiative helps the BFH meet its objectives around family planning and birth control. In 2020, 148 individuals were screened by the CMHDs using the One Key Question® and engaged in conversations with their provider about pregnancy intention and birth control.

The BFH continued its partnership with two hospitals, Lancaster General Hospital (LGH) in Lancaster City and Albert Einstein Medical Center (AEHN) in Philadelphia County, to provide Centering Pregnancy Programs (CPP). AEHN CPP Grant ended in June 2020. LGH and AEHN both struggle with high rates of low birth weight babies and racial disparities in infant health outcomes. In Lancaster City from 2017-2019, 9.2% of infants were born with a low birth weight; for the same period, 11.1% of babies born in Philadelphia County had a low birth weight. Both rates are higher than the overall percentage for that period in PA of 8.4%. Among Lancaster City and Philadelphia’s black/African American populations, 13.1% and 14.7% of babies, respectively, were born with a low birth weight.

PA's overall rate in that period was 14.1%. The CPPs in these areas aim to improve birth outcomes as well as improve the knowledge base of the participants related to pregnancy and parenting.

LGH also administers a group specifically for pregnant people with substance use disorder (SUD). Sessions are facilitated by a Licensed Social Worker who is certified in addictions counseling. The group follows the traditional CPP model of prenatal care but incorporates education specifically related to SUD and pregnancy, such as how to calm an infant going through withdrawal, stress management, and what to expect if your infant must stay in the Neonatal Intensive Care Unit. In 2020, 30 pregnant people enrolled in the SUD CPP group Challenges to participation included fear of stigma and Children and Youth services involvement, transportation issues, and scheduling conflicts with counseling and medication dosing appointments. However, despite challenges, the program continues to be successful with 100% of participants reporting satisfaction with their care. Due to isolation because of COVID-19, the SUD CPP group had an increase in referrals, with staff making more frequent contact with participants to provide additional support surrounding anxiety and higher likelihood to relapse. Combined, these programs served 248 families with a continued emphasis on improving birth outcomes and reducing disparities among at-risk populations in Lancaster City and Philadelphia County. Of those served, 47% were white, and 38.7% were black/African American, with 26.8% of participants identifying as Latinx. Program outcomes were positive. LGH saw higher than expected rates for full-term births with 92.5% of their participants delivering at full term.

Breastfeeding rates were also positively affected by the CPPs, with 86% of participants breastfeeding at birth versus 76% of birthing people prior to the implementation of the CPPs. CPP participants were screened for depression and referrals were made to mental health professionals as necessary. The CPPs had high patient satisfaction rates, with LGH reporting that 100% of birthing people that completed the program were satisfied with the experience. Additionally, a Request for Application (RFA) was posted in May 2020 for current CPP to expand their established programs in more focused areas or populations depending on the communities they serve. Potential expansion areas for the RFA included, but were not limited to, better serving disparate populations or birthing people with SUD, and increasing access to health care services such as transportation, mental health counseling, or dental care. The two awarded applicants were AEHN, who will focus on behavioral health screenings and referrals, and WellSpan York, who will serve their Spanish-speaking population by offering culturally and linguistically relevant group prenatal care. The BFH did not meet its goal of serving 350 families through CPP; however, the BFH anticipates that when the new grantees have fully implemented their expanded CPP, the goal will be met in the coming years.

The CMHDs and CPPs submitted data related to family planning and birth spacing. Currently, 82.6% of birthing people of child-bearing age, including adolescents, being served through these programs are engaged in family planning after delivery, not meeting the goal of 84%. However, 88% of birthing people talked with a healthcare professional about birth spacing/birth control methods exceeded its goal of 84% for this objective. Delaying pregnancy allows birthing people in PA the opportunity to choose when they are ready to begin or expand their families. It also affords them the opportunity to improve their own health and habits prior to becoming pregnant.

The BFH continued its partnership with the Alliance of Pennsylvania Councils, Inc. (Alliance) in an initiative to reduce the rate of unplanned pregnancies in birthing people with opioid use disorder (OUD). The unintended pregnancy rate for birthing people with OUD is 86% compared to the national average of 45%. Unfortunately, due to the rise of unintended pregnancies in birthing people with OUD, the number of infants affected has increased. According to the DOH's Neonatal Abstinence Syndrome: 2018 Report: a total of 2,140 PA infants were diagnosed with opioid related NAS after birth. The Alliance is currently comprised of three family planning councils, each serving a region within PA. A fourth council, located in Western PA, has since ceased its participation in the Alliance and this initiative. Due to the diversity in the population of PA, each region was tasked with developing a pilot program to serve specific needs in the region. Projects include training behavioral health providers to assess pregnancy intention and

contraceptive needs, facilitating access to family planning services for people in treatment facilities, conducting screenings in schools to identify youth in need of services, and educating communities about addiction. As a result of this initiative, in 2020, 783 birthing women with OUD received services and 36 behavioral health providers were trained in the ability to assess for pregnancy intention. In addition, 1,358 men with a substance use disorder (SUD) received limited scope contraceptive care and sexual and reproductive health education from the Alliance to improve men's preconception health and reduce rates of unintended pregnancy. Due to the COVID-19 pandemic, the Alliance experienced challenges in providing in-person services, counseling, education, and training throughout 2020, resulting in lower numbers served than initially anticipated. Although efforts are being made to engage populations of color through this initiative, across the state, the majority of clients served by this program are white (75.1%); however, the percentage of white clients ranges between the pilot projects, from a minimum of 39.1% to a maximum of 82%. Overall, the program population is slightly less majority-white than the state of PA (75.1% compared to 81.6%). The program also serves slightly more Latinx clients than the state population (8.9% compared to 7.8%). If, after the current initiative ends, the BFH selects to replicate elements of the pilot projects in future partnerships, a focus on serving communities of color will be key. By providing integrated sexual and reproductive health services for people with, or at-risk for, SUD, the BFH hopes to reduce the incidence of unintended pregnancy and improve birth outcomes for birthing people with OUD and their babies.

Through Title V funds, the BFH partnered with the Shadyside Hospital Foundation to continue implementation of the IMPLICIT Interconception Care (ICC) Program, wherein maternal screenings are conducted at well-child visits (WCVs). This interconception care project works within scheduled child well visits to check on the health of birthing people. Each visit addresses four behavioral risk factors to assess birthing people's health: (1) smoking status, (2) depression, (3) contraception use, and (4) multivitamin with folic acid use. Birthing people are counseled and referred for services as necessary. This initiative is focused on increasing the number of birthing people who see their medical providers in the interconception period as well as changing maternal behaviors to improve overall health and birth outcomes in subsequent pregnancies. Working with this population is an opportunity to address mother's health, as many birthing people do not follow through on postpartum visits. Instead, they are focused on the health needs of their child and likely to take their children to WCVs. In the first five years of this program, 9,103 birthing people were screened for ICC behavioral risk factors at twelve sites across PA, with a 78.8% screening rate across all sites. Of those served, 54.2% were white, and 30.6% were black/African American, with 20.7% identifying as Latinx and 75.3% as non-Latinx, demonstrating that this initiative is effectively reaching those at higher risk of poor birth outcomes. Upon initiation of this program, the IMPLICIT Network began following a cohort of 1,184 mother/baby dyads born in 2016 to measure maternal behavior change following intervention. Of this cohort, mothers attended 4,555 of the babies' 5,189 WCVs. During the first five years of the program, 31.1% of this cohort screened positive for tobacco use, 26.6% screened positive for depression, 48.8% screened positive for lack of contraception use, and 76% screened positive for lack of multivitamin with folic acid use. Maternal behavioral change following intervention was reported at 39.2% for tobacco use, 49.6% for depression, 56.1% for contraception use and 52.3% for multivitamin with folic acid use. In 2020, the BFH worked with the grantee to develop a plan for a 4th trimester model of care. In the coming year, the program will work with the University of Pennsylvania to continue to expand the IMPLICIT Network, increase utilization of the ICC Program, and implement the newly-developed 4th trimester model of care to decrease rates of maternal mortality in the early postpartum period.

Priority: Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted

Objective 1: Annually increase the number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health

ESM: Number of Title V funded women who are screened for behavioral health

The BFH understands the strong connection between physical health and behavioral health and has worked to ensure that birthing people are screened for behavioral health issues during home visits. Early in this grant cycle, the BFH made it a requirement for all Title V funded CMHDs home visiting programs to utilize the Institute for Health and Recovery's 5Ps (5Ps) screening tool, an evidence-informed screening tool. By assessing behavioral health issues during the perinatal period, the BFH aims to identify and address potentially risky behaviors or circumstances to improve pregnancy outcomes, as well as improve health for children and families in the same household. The 5Ps is a quick, non-threatening conversational tool that assesses risk for alcohol dependency, substance misuse, interpersonal violence, and depression based on five domains (Parents, Peers, Partner, Pregnancy, and Past). The tool guides health professionals to make referrals or recommendations based on responses. The tool asks questions about drug or alcohol use by parents or peers to open the conversation about substance use. Birthing people, especially during pregnancy, may be hesitant to talk about their own substance use but are often willing to share about the habits of their parents or peers. In 2020, the BFH made the decision to no longer require the use of the 5Ps tool. The BFH is asking the CMHDs to utilize evidence-based tools for screening and the 5Ps tool is not considered an evidence-based tool it lacks published, peer-reviewed research studies a. To remain consistent, BFH staff have allowed the CMHDs to discontinue use of the 5Ps if it was not working for their organization. As of 2021, seven CMHDs continue to use the 5Ps screening tool.

For agencies or staff who wish to continue using the 5Ps tool, the BFH provides online training and resources to assist them in identifying appropriate referral sources for further assessment and treatment as needed. The BFH has chosen to measure the number of birthing people receiving Title V home visiting services who are screened for behavioral health, in order to expand the number of opportunities for support and referral for birthing people who need behavioral health services. CMHDs home visiting programs also utilize Motivational Interviewing (MI) to elicit behavioral changes that can help to improve the health of PA's families. MI is a goal-oriented, client-centered counseling style for eliciting behavioral change by helping individuals understand the need for change. Home visitors have the unique advantage of being trusted enough to spend time with pregnant and birthing people and their families in the home. By integrating proven tools into the work that is done in the home, the BFH anticipates an improvement in the number of pregnant and birthing people who are screened for behavioral health issues and the likelihood that they will receive needed follow-up services. In 2020, 1,001 or 86% of pregnant and birthing people enrolled in the CMHDs home visiting programs were screened for behavioral health issues not meeting the goal of 1,550. While the goal of 1,550 participants was not met, the percentage of pregnant and birthing people enrolled in the program that are screened for behavioral health issues continues to increase. Reasons pregnant and birthing people may not be screened include refusal or early withdrawal from the program.

The IMPLICIT Interconception Care (ICC) Program, mentioned earlier in this report, includes maternal depression screenings at well-child visits (WCVs). Birthing people are counseled and referred for services as necessary. This initiative is focused on increasing the number of birthing people who see their medical providers in the interconception period and changing maternal behaviors to improve overall health and birth outcomes in subsequent pregnancies. In 2020, 2,895 birthing people received a depression screening, of the 522 positive screenings, intervention was documented at 396.

Through a technical assistance grant from the Center for Law and Social Policy, BFH staff collaborated with the PA DHS' Office of Mental Health and Substance Abuse Services and other agencies on a maternal depression initiative, Moving on Maternal Depression (MOMD). The formal grant has concluded but work continues in partnership with the Jewish Healthcare Foundation. The initiative aims to improve prenatal and postpartum depression screening and follow-up services as well as reduce racial and ethnic disparities associated with perinatal depression screening and follow-up rates. To accomplish this, the Pennsylvania Perinatal Quality Collaborative (PA PQC) will recruit, train, and coach 10 birthing hospitals and their affiliated outpatient perinatal

offices, birth centers, and pediatric offices to adopt tactics, protocols, toolkits, and resources and implement depression screening and follow-up services. All the PA PQC MOMD provider sites will track prenatal and postpartum depression screening and follow-up rates by race and ethnicity.

Pennsylvania, through the Pennsylvania Partnership for Children, was awarded the Pritzker Children's Initiative Prenatal-to-Age-Three Implementation grant. The overall goal of the project is to increase the number of children and families receiving high-quality services by 25% by 2023, and by 50% by 2025. BFH staff sit on the Maternal Health Subgroup, which is focusing on extending Medicaid access to postpartum services, ideally for 12 months; advancing behavioral health screenings for prenatal and postpartum people; ensuring that those with a positive screen receive needed services; and advancing reimbursement for doulas in the Medicaid program.

Objective 2: Annually increase the percentage of women with a home visitor who have a conversation about intimate partner violence (IPV)

ESM: Percent of women who talk with a home visitor about IPV

The 5Ps include a question about feeling unsafe in one's relationship. The Title V home visiting programs have adapted their curricula or models to include the use of the 5Ps and provide appropriate follow-up recommendations and referrals. Additionally, several of the CMHDs have selected evidence-based screening tools in lieu of using the 5Ps to screen for IPV. These tools include the Hurt, Insult, Threaten, and Scream (HITS) and the Humiliation, Afraid, Rape, Kick (HARK) screenings. In 2020, 818 out of 1,161 or 70.4% of pregnant and birthing people enrolled in Title V home visiting programs talked to a home visitor about IPV; this is lower than the goal of 90%. Enrolled pregnant and birthing people may not have spoken to a home visitor about IPV if they were newly enrolled or if they lacked a private location in which to have this conversation.

NPM 14: A) Percent of women who smoke during pregnancy

Objective 1: Annually decrease the percentage of women who report smoking during pregnancy

ESM: Percent of women who report smoking after confirmation of pregnancy

ESM: Percent of grantees who implement evidence-informed tobacco free programs

The BFH has opportunities to impact pregnant and birthing people through home visiting programs. Utilizing MI, home visitors may be able to address tobacco use in the prenatal and postpartum periods.

Two of the CMHDs offer evidenced-based or evidence-informed smoking cessation programs aimed at pregnant and postpartum people, not meeting the 2020 goal of 4. The programs being offered are Baby & Me - Tobacco Free (BMTF) and Smoking Cessation & Reduction in Pregnancy Treatment. In 2020, 6.5% of birthing people participating in a CMHD home visiting program reported smoking after confirmation of pregnancy.

The BMTF smoking cessation program has received the National Association of City and County Health Officials' Model Practice Award. The program addresses the high prevalence of tobacco use by birthing people during pregnancy. It provides counseling, support, and resources to pregnant people and their partners to help them quit smoking and maintain smoking cessation. The program is successful in helping birthing people quit and abstain from smoking, resulting in improved birth outcomes and long-term positive outcomes for birthing people, children, and their families. In 2020, although no new enrollment sites were added, 30 individuals completed recertification. Garnering interest from local obstetrics practices and local Women, Infants, and Children program offices continues

to be a challenge; however, efforts continue with these organizations. Despite challenges, 22 birthing people were enrolled in the program in 2020. The Department of Health's Tobacco Prevention and Control Program, funded in part through tobacco settlement funding, has continued to operate the PA Free Quitline using a specialized protocol for pregnant and postpartum people.

Women/Maternal Health - Application Year

I. Overview of Approach to Women/Maternal Health Domain

The health and well-being of pregnant and birthing people, infants, and children determine the health of the next generation. The effects of maternal mortality and morbidity are devastating for families, communities, and society. Further complicating circumstances are the racial disparities surrounding maternal mortality and morbidity. Black/African American birthing people are significantly more likely than white birthing people to die or suffer from pregnancy complications. The Bureau of Family Health (BFH) offers programming around, and is committed to reducing, this disparity to achieve health equity among all birthing people for a healthier Pennsylvania (PA).

The BFH identified program areas that address the new BFH priority on reducing maternal morbidity and mortality. In addition to existing work, the BFH is incorporating additional programming around community-based maternal care models, such as doula services, and models of care that promote male involvement and father engagement into its action plan. BFH staff are also exploring what medical services home visitors can provide to pregnant and birthing people in the prenatal and early postpartum periods, in hopes of reducing maternal morbidity and mortality in PA.

II. Other Federal Funding and State-Funded Activities/Future Efforts

The BFH conducts activities in the Women/Maternal Health domain primarily through Title V funding and does not have additional state funding to support these services. Other federal funds from the Centers for Disease Control and Prevention (CDC) are used to support the Maternal Mortality Review Committee (MMRC). Taking into consideration the overall population needs and current partners, the BFH has developed strategies that do not duplicate those of other funding sources outside of the BFH, and that fill gaps that are not addressed by the existing system of care and current partners. Through this effort, staff identified initiatives aimed at improving maternal health outcomes, including the: Title V MCHSBG, MMRC, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM), Pregnancy Risk Associated Monitoring System (PRAMS), and COVID-19 Health Equity Response Team sponsored by the Department of Health (DOH); Moving on Maternal Depression (MOMD), Value-Based Payment Model/Maternity Care Bundle, Plans of Safe Care, and Opioid Use Disorder Centers of Excellence sponsored by the Department of Human Services (DHS); Pregnant Women and Women with Children Inpatient Non-Hospital Programs and Pregnant Support Services Grant sponsored by the Department of Drug and Alcohol Programs (DDAP); Pennsylvania Perinatal Quality Collaborative (PQC) and Doula Services Workgroup sponsored by the Jewish Healthcare Foundation; and Pritzker Children's Initiative sponsored by the Pennsylvania Partnerships for Children (PPC). To better streamline the Commonwealth's diverse maternal health initiatives, the BFH participates in both intra-agency collaboration with internally-administered programs such as PRAMS and ERASE MM and inter-agency coordination with Departments that have overlapping programmatic and/or population needs such as the DHS and DDAP.

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III. Priorities

Priority: Reduce or improve maternal morbidity and mortality, especially where there is inequity

NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Strategy: Increase the percent of women who successfully complete evidence-based or informed home visiting programs

Objective: Increase the percent of women who successfully complete an evidence-based or informed home visiting program by 2% each year

ESM: Percent of women who successfully complete evidence-based or informed home visiting programs

Home visiting can have positive effects on pregnant and birthing people, infants, children, and children with special health care needs (CSHCN) as well as on the family. Home visiting programs support families by providing health check-ups, screenings, referrals, parenting advice, and guidance in navigating other programs and services in the community. Additionally, home visiting programs monitor progress on children's developmental milestones and help parents to provide a safe and supportive environment for their children to grow. This support and education aim to improve the overall health and well-being of the families served, improve birth outcomes, and increase birth spacing.

The County Municipal Health Departments (CMHDs) offer home visiting services to pregnant and birthing people, infants, children and CSHCN. CMHDs home visiting programs have the flexibility to utilize the program that best fits the population being served. Due to PA's diverse population, what works in one location may not be appropriate or practical in another. Evidence-based models such as Nurse Family Partnership, Parents as Teachers and Healthy Families America are used in some areas. Other areas utilize evidence-informed curriculums such as Partners for a Healthy Baby or Bright Futures. All provide both clinical and social services to the families they support. The flexibility inherent in these home visiting programs facilitate participation from those who may not otherwise be eligible for alternate home visiting programs. CMHDs home visiting programs deliver necessary services to birthing people who have had repeat pregnancies or delayed enrollment in a home visiting program. Ideally, home visitors connect with birthing people in the prenatal period; however, not all birthing people seek assistance during this time. Many CMHDs home visiting programs allow birthing people to obtain services up to a year after the birth of their child. All these factors enable home visitors to develop a relationship with and begin supporting the family exactly where they are, to assist in acquiring needed services and improving the overall health and wellbeing of PA families.

The CMHDs home visiting programs work to support birthing people in the prenatal and postpartum period who may not be eligible for traditional home visiting programming. The BFH is choosing to measure the percent of pregnant and birthing people who complete home visiting programs to assess the impact on families served. By increasing the percentage of pregnant and birthing people who successfully complete these home visiting programs, the BFH aims to help birthing people address risk factors that may be associated with severe morbidity and mortality, such as co-morbidities and receipt of care in the postpartum period. Additionally, an important component of home visiting programs is connecting the people to needed services including preventive care. While access to health care is only one factor contributing to a pregnant or postpartum person's health, birthing people with the highest rates of severe maternal morbidity and mortality are historically less likely to receive preventive care. As such, this strategy aligns with the new priority and may drive improvement in the National Performance Measure (NPM). In the coming year, the BFH will continue to partner with the CMHDs to provide home visiting services to the Title V population.

Strategy: 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

Objective: Annually increase the percent of adolescents and women who talked with a health care professional about birth spacing or birth control methods by 1%

ESM: Percent of adolescents and women enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods

Centering Pregnancy is a patient-centered model of group prenatal care. The curriculum offers the flexibility and time to engage in conversations around important health topics dependent on the needs of the group; this can lead to a greater engagement in one's pregnancy and overall health, as well as to a positive learning environment. Quantitative studies have shown that birthing people who receive prenatal care through the Centering Pregnancy Program (CPP)

model have a reduced number of low birthweight babies, a reduced number of preterm births, a higher number of prenatal visits, and increased breastfeeding rates, compared to traditional prenatal care. The CPP curriculum covers birth control and birth spacing at numerous points throughout the pregnancy and postpartum periods to encourage birthing people to actively participate in interconception care. Studies have shown that group prenatal care can positively influence birthing people's health outcomes after pregnancy and improve the utilization rate of preventive health services such as family planning. Additionally, evidence suggests that group prenatal care supports successful outcomes in pregnant people with substance use disorders (SUD), as it does for other vulnerable groups.

The BFH will continue its partnership with Lancaster General Hospital (LGH) to provide CPP in the next year. Additionally, the BFH will continue to assess the pilot program created specifically for pregnant people with SUD. This group follows the original CPP model with the addition of education focused on pain management without opioids, soothing techniques for babies diagnosed with neonatal abstinence syndrome (NAS), and other topics specific to this population. The opioid crisis has caused an immediate need for this group, as the number of infants born exposed to substances continues to grow both across the nation and in PA. Incidence of NAS in the U,S. has been increasing substantially since 2004, from 1.5 per 1,000 live births in 2004 to 6.5 per 1,000 live births in 2014. According to the PA DOH's *Neonatal Abstinence Syndrome: 2018 Annual Report*, among infants born in PA on or after January 10, 2018, through December 31, 2018, a total of 2,140 cases of NAS have been reported; 67 of these NAS cases were of infants born at Lancaster County hospitals and birthing facilities, and 61 were of Lancaster County residents. SUD also negatively impact maternal health, putting pregnant people at risk for interpersonal violence (IPV) and other unsafe situations, failure to obtain prenatal care, as well as apprehensiveness to seek help for SUD due to a fear of custody issues or legal consequences.

In May 2020, the BFH announced a Request for Application (RFA) for existing CPP to provide additional services through the CPP model. Two applicants were awarded through this RFA. Beginning in 2021, Albert Einstein Healthcare Network (AEHN) and WellSpan York will expand their already existing CPP to better accommodate the needs of the communities they serve. AEHN will focus on providing behavioral health screenings, initial counseling, and making warm handoffs to behavioral health services as needed. WellSpan York will help meet the needs of their community by providing a culturally and linguistically competent CPP to Spanish-speaking birthing people in the county they serve.

Pregnant and birthing people enrolled in CPP have pre-established relationships with their providers that foster trust in the medical system and encourage future visits with healthcare professionals. These relationships help to increase both the number of birthing people that seek care between pregnancies and the percent of birthing people that talk to a healthcare professional about birth control and birth spacing. Therefore, the BFH has chosen to document and track the number of birthing people who speak with a health care professional about birth spacing and birth control methods. This strategy may help to reduce maternal health risks and complications associated with unintended pregnancies and short birth spacing, thereby aiming to reduce the incidence of maternal mortality and morbidity.

Strategy: Implement care models that include preconception and interconception care

Objective: Increase the percent of women enrolled in IMPLICIT ICC program screened for risk factors during well-child visits by 1.5% each year

ESM: Percent of mothers served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one well-child visit

Poor maternal health contributes to excess rates of preterm birth and infant mortality.

When birthing people are provided with preconception interventions, or interconception care (ICC), they are more likely to enter pregnancy in optimal health. ICC is designed to identify and potentially modify risks to improve future birth outcomes and is recommended by the CDC and the Health Resources and Services Administration (HRSA). Although some adverse outcomes of pregnancy cannot be prevented, optimizing a birthing person's health before and between pregnancies can reduce the risks of poor birth outcomes for both birthing person and infant. As birthing people that receive interconception care tend to have healthier pregnancies and lower-risk births, this strategy may help lower rates of maternal morbidity and mortality among birthing people that receive this care.

Since there is no widely accepted model for delivering ICC, the Interventions to Minimize Preterm and Low Birthweight Infants using Continuous Improvement Techniques (IMPLICIT) Network developed and implemented an innovative, inter-professional, evidence-based approach to ICC. The BFH is working with the University of Pennsylvania and the IMPLICIT Network on implementing the IMPLICIT ICC program throughout PA. The ICC program works to change maternal behaviors and improve birth outcomes by screening birthing people for four behavioral risk factors at well-child visits: smoking status, depression, contraception, and multivitamin with folic acid use. At least 1,500 birthing people are being screened during well-child visits each year as part of this initiative. In addition, a cohort of 700 people who gave birth in 2020 are being followed for three years to evaluate the effectiveness of the ICC model of care. To date, maternal behavioral change after intervention for each of the four behavioral risk factors has been identified and continues to be tracked. Through continued implementation of this innovative model, the BFH seeks to show that the IMPLICIT ICC model of care can effectively identify modifiable maternal risks and show maternal behavior change that may lead to improved birth outcomes.

Strategy: Implement community-based, culturally relevant maternal care models

Objective: Increase the number of community-based doulas providing services in targeted neighborhoods

ESM: Number of community-based doulas trained in communities served by the program

Doulas are trained to provide non-clinical emotional, physical, and informational support for people before, during, and after labor and birth. Doulas can facilitate positive communication between the birthing person and their care providers by helping people articulate their questions, preferences, and values. Benefits to continuous labor support include a significant reduction in cesarean deliveries, shorter labors, reduced use of medication, lowered risk of birth trauma, improved birth outcomes, higher rates of breastfeeding initiation, and reduced risk of postpartum depression. Because these benefits are particularly important for those most at risk of poor outcomes, doula support has the potential to reduce health disparities and improve health equity. Unfortunately, doula care is often out of reach for high-risk pregnant people due to financial constraints and the limited availability of doulas in low-income communities.

To address this need, the BFH is working to increase the number of community-based doulas that are being trained in communities at high risk for maternal and infant morbidity and mortality. By connecting more high-risk pregnant people to doula support, the BFH aims to improve health outcomes for birthing people and their babies.

Community-based doula programs include services tailored to the specific needs of the community they serve at no or very low cost. In addition to birthing support, community-based doulas usually offer prenatal and postpartum home visits, childbirth and breastfeeding education, and referrals for needed health or social services. Most community-based doulas are members of the community they serve, sharing the same background, culture, and/or language with their clients, and conduct their work with an understanding of intergenerational trauma, implicit bias, and maternal health disparities. Community-based doulas lead with the understanding that choice, access and informed,

shared decision-making in pregnancy, childbirth, and reproductive care are central to improving outcomes. In addition, community-based doula programs are the only home visiting program models in the U.S. in which a home visitor is present at the birth.

The Philadelphia Department of Public Health (PDPH) has developed a Doula Support Program (DSP) aimed toward birthing people with SUD. The program utilizes trained doulas and provides additional trainings to support the SUD population. Training topics include: trauma-informed care and doula support; how to support birthing people with SUD or opioid use disorder (OUD) throughout pregnancy, birth, and in the postpartum period; mandated reporting, and how to navigate the DHS system and make referrals; NAS education; and harm and stigma reduction for birthing people with SUD/OUD.

In addition to the PDPH DSP, the BFH plans to issue an RFA for PA communities with high rates of racial disparities in preterm birth and infant mortality, and that want to establish a community-based doula program using the HealthConnect One (HC One) model. HC One collaborates with community health agencies to establish effective doula programs, and supports the program development process with training, technical support, and ongoing mentorship. This initiative will enable pregnant individuals that are high risk for poor birth outcomes to access culturally relevant care during pregnancy, labor, and the postpartum period. It will also increase the number of individuals from these communities that are trained and employed as community-based doulas, resulting in a positive economic impact for these individuals. The RFA will fund up to two three-year grants using Title V funds for this community-based doula initiative, with an anticipated start date of July 1, 2022.

Strategy: Implement community-based, culturally relevant maternal care models

Objective: Increase the number of behavioral health providers trained in pregnancy intention assessment

ESM: Number of behavioral health providers trained in pregnancy intention assessment

Unhealthy birth outcomes, such as low birth weight and preterm birth, are influenced by many factors, including pregnancy intention. Studies indicate that unintended pregnancies are associated with adverse physical and mental health, economic and social outcomes; these impact birthing people, their families and society. The unintended pregnancy rate for birthing people with OUD, is 86%, compared to the national unintended pregnancy rate of 45%. Unfortunately, due to the rise of unintended pregnancies in birthing people with OUD, the number of infants diagnosed with opioid-related neonatal abstinence syndrome after birth has also increased.

To address this need, behavioral health providers are being trained to assess pregnancy intention and contraceptive needs so that they may facilitate access to family planning services for birthing people in SUD treatment facilities. The BFH has formed partnerships with the Alliance of Pennsylvania Councils (Alliance) to address unintended pregnancy rates among individuals with OUD. Each of the three councils within the Alliance has implemented a pilot project to build linkages between family planning agencies and SUD treatment centers, leveraging the partnerships and experience to find the right fit for the communities served. In the next year, the Alliance will focus their efforts on continued implementation of their individual regional programs and develop recommendations based on best practices for replication of services. As BFH funding for the pilot projects will cease on June 30, 2022, the lessons learned from this initiative will help inform future work around reducing the incidence of unintended pregnancy and improve birth outcomes for birthing people with SUD and their babies.

Strategy: Implement care models that include maternal behavioral health screenings and referral to services

Objective: Increase the percent of women enrolled in Title V home visiting, Centering Pregnancy, and IMPLICIT programs that are referred for behavioral health services by one percent annually, following a positive screening

ESM: Percent of women enrolled in home visiting, Centering Pregnancy and IMPLICIT programs that are referred for behavioral health services following a positive screening

Screening is an important tool to maximize the services provided to families. When used in the prenatal period, screening tools can identify the need for additional services and improve birth outcomes for both birthing person and infant. When used in the postpartum period, screening tools provide home visitors with the opportunity to assess birthing people's behavioral health status and provide referrals, as necessary, to improve health in the critical interconception period. They also present an opportunity to introduce, or to continue, a discussion about birth spacing and birth control methods. The BFH continues its work with the CMHDs to ensure screening among pregnant and postpartum people for risk factors related to behavioral health.

Many of the CMHDs utilize the Institute for Health and Recovery's Integrated 5Ps Screening Tool (5Ps) to screen pregnant, birthing, and postpartum people during home visits. Online trainings on the use of the 5Ps tool are available if training is needed. This screening tool assists with the identification of pregnant, birthing, and postpartum people in need of support and referral for mental health services, SUD assessment and IPV counseling.

Depression is a common complication during pregnancy and in the postpartum period, affecting nearly one in seven birthing people, and has negative consequences for both birthing people and infants when untreated. In the prenatal period, maternal depression has been associated with preterm birth, low birth weight and fetal growth restriction. In the postpartum period, maternal depression may result in issues with breastfeeding, difficulties in relationships or increased substance use. Screening for depression in both the prenatal and postpartum periods is necessary to identify birthing people in need of services and to improve the health of birthing people and their families. Some evidence suggests that although screening without follow-up care can have benefits, referral and treatment offer the most benefit. Moving forward, the CMHDs will be required to utilize a validated screening tool to assess individuals for depression. The CMHDs will track the number of behavioral health services referrals made because of the positive screens.

With BFH and Title V support, the University of Pennsylvania and the IMPLICIT Network continues to implement the IMPLICIT ICC model of care throughout PA. The ICC program screens birthing people for depression and three other behavioral risk factors at well-child visits. Positive screens are addressed through brief intervention or referrals to treatment. The IMPLICIT ICC model of care has been shown to effectively identify modifiable maternal risks and show maternal behavior change that may lead to improved health outcomes. Over the next year, the IMPLICIT Network will continue to increase ICC screening rates across PA, maintain or increase intervention rates for positive screens, and expand the IMPLICIT ICC model of care throughout the state.

Changing the picture of IPV necessitates recognizing all its characteristics and focusing on changing attitudes, particularly among key population groups that experience higher rates of such violence. The BFH program assesses pregnant and birthing people for indicators of IPV and provides vulnerable individuals with resources to reduce the risk of being harmed in their relationships. Home visitors are in an ideal position to address IPV and begin a conversation with their clients. A simple conversation could save or improve the life and health of a birthing person or child by removing the stigma associated with violent relationships. Home visitors will continue to talk with clients about IPV and the impact it can have on a family if left unaddressed. Public health strategies that promote healthy behaviors in relationships are important in stopping the cycle of IPV. Moving forward, the CMHDs will be required to utilize a validated screening tool to assess clients for IPV.

The BFH is working to increase the percent of birthing people enrolled in Title V programs that are screened and referred for services, to ensure continuity of care and the best outcomes for birthing people and their families.

Strategy: Implement care models that encourage women to receive care in the early postpartum period

Objective: 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 three percent annually, starting with reporting year 2022

ESM: Percent of women who receive a maternal health assessment within 28 days of delivery through the 4th trimester pilot program

The “fourth trimester” generally refers to the first 28 days postpartum. During this time, birthing people experience significant biological, psychological, and social changes that may not be sufficiently addressed by the mainstream maternal health framework, which does not provide routine care for birthing people until six weeks postpartum. Concerns regarding maternal mental health, contraception and birth spacing, physical recovery from childbirth, substance use, and other issues often go unrecognized in these early weeks. As a result, physical and behavioral health problems may go untreated and exacerbate one another, increasing the risks of maternal morbidity and mortality, particularly among birthing people who are low-income, black/African American, or who have chronic medical conditions. To improve the health of all birthing people and reduce health disparities, health providers and systems are increasingly seeking to provide routine maternal health care during the fourth trimester.

In 2019, the IMPLICIT Network began designing a new initiative to address maternal morbidity and mortality in the postpartum period. This project, called “4th Trimester,” is based on 2018 recommendations from the American College of Obstetricians and Gynecologists to address maternity care needs in the weeks and months following childbirth. Improved fourth trimester care was also recognized as a high priority area by the National Institute of Child Health and Human Development in its strategic planning for 2020.

The IMPLICIT 4th Trimester initiative will allow providers to identify high-risk birthing people, develop tailored care recommendations for families and increase the number of birthing people receiving maternal health care within 28 days of delivery. Through this initiative, biomedical and psychosocial risk factors associated with maternal morbidity and mortality, such as cardiovascular health, mental health, substance use, and trauma, will be identified and addressed. Participating sites will provide counseling, interventions, or referrals for birthing people that screen positive for one or more of the risk factor areas, within 28 days of delivery. Through this initiative, the BFH seeks to decrease rates of maternal morbidity and mortality in the early postpartum period. As such, this strategy aims to directly address the priority need and, if successful, could drive improvement for the NOMs on maternal morbidity and mortality. A minimum of 500 birthing people annually is expected to be served by this project after the new 4th Trimester care model is implemented. Of these individuals, a cohort of 250 people that give birth from 2021-2022 will be followed for a minimum of two years, to evaluate the effectiveness of the 4th Trimester model of care.

Strategy: Use Maternal Mortality Review Committee (MMRC) recommendations to inform programming

Objective: Implement a minimum of 1 MMRC recommendation annually

ESM: Number of MMRC recommendations implemented

During this grant cycle, the BFH will continue to participate on the Maternal Mortality Review Committee (MMRC), reviewing maternal death cases and assisting in developing and implementing recommendations regarding the

prevention of maternal deaths in PA. The MMRC is made up of a diverse group of professionals to take into consideration each aspect of a birthing person's life and death, with a focus on social determinants of health, when possible. The MMRC continues to review cases; once a full year of cases has been reviewed, the MMRC will recommend action steps to reduce PA's maternal mortality rate. BFH will aim to implement a minimum of one of these recommendations annually.

Strategy: Initiate regular meetings and collaboration between DOH, DHS, and MIECHV

Objective: Convene quarterly meetings between agencies that provide services related to maternal health

ESM: Number of meetings held between the DOH, DHS and MIECHV annually

Effective collaboration and coordination are important to create a high-quality system of support for birthing people and families in PA. Collaboration can increase service utilization through effective referral processes. Further, agencies that communicate with one another and share information can provide their service recipients with consistent messaging. As a result, families may be less overwhelmed by information and less frequently faced with competing demands by multiple agencies. Consistent messaging may also increase utilization of services due to destigmatizing the receipt of those services. Additionally, collaboration across sectors, agencies and programs ensures better-coordinated services and facilitates the creation of shared care plans, identification of individuals and families for targeted outreach, and development of cross-sector plans for improving health outcomes. Cross-collaboration also provides public health programs and professionals with an opportunity to address critical social determinants of health, including education, environment, lifestyle, and socioeconomic factors, thereby providing more holistic services to PA residents. As mentioned in the report narrative, the PA Medicaid Program has expanded home visiting services for first-time and at-risk birthing people. With this expansion, it is beneficial to Title V programming to stay up to date on changes to ensure BFH continues to fill gaps not met by existing programming.

In the next year, the BFH will organize quarterly meetings with the DOH, DHS, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program to promote collaboration and better serve PA residents.

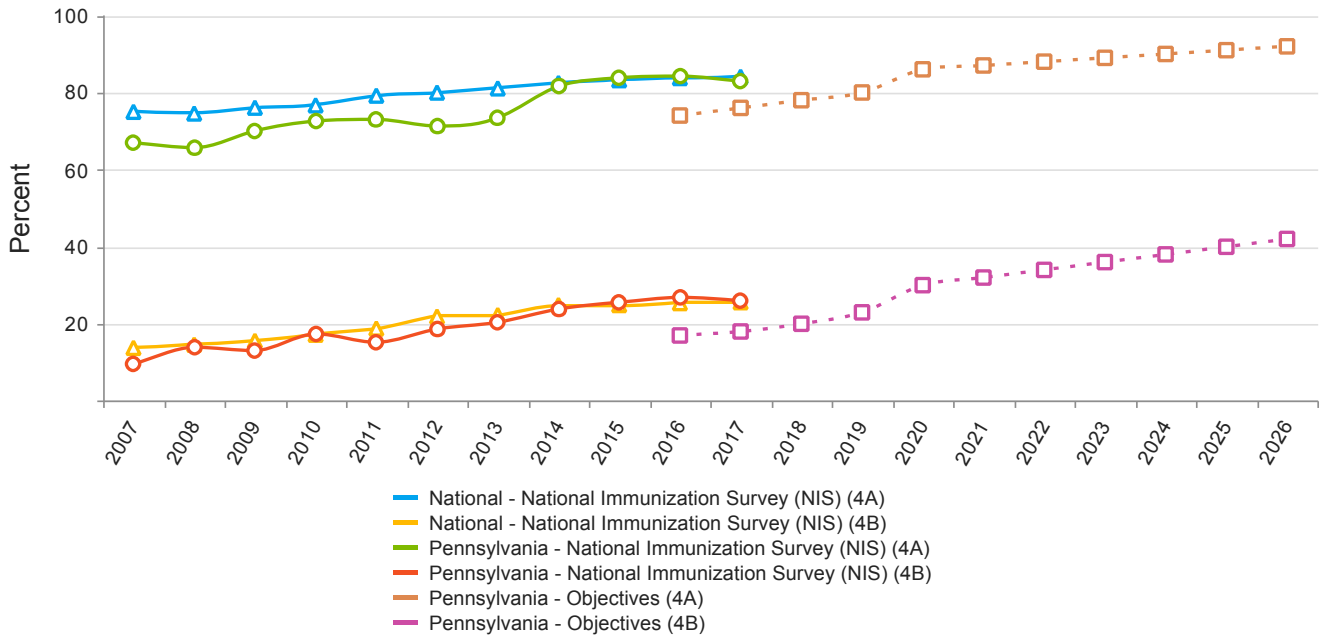
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.9	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.7	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	92.1	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	74	76	78	80	86
Annual Indicator	73.3	81.8	83.8	84.2	82.9
Numerator	99,273	108,050	111,838	113,497	105,668
Denominator	135,367	132,020	133,410	134,782	127,530
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	88.0	89.0	90.0	91.0	92.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	17	18	20	23	30
Annual Indicator	20.5	23.7	25.6	26.9	25.9
Numerator	27,408	30,174	32,912	35,760	32,327
Denominator	133,488	127,300	128,398	132,966	124,942
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	34.0	36.0	38.0	40.0	42.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of Keystone 10 facilities that progressed by one or more steps each fiscal year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	60.0	60.0	60.0	60.0	60.0

ESM 4.2 - Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

ESM 4.3 - Convene five regional breastfeeding collaborative meetings twice per year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	10.0	10.0	10.0

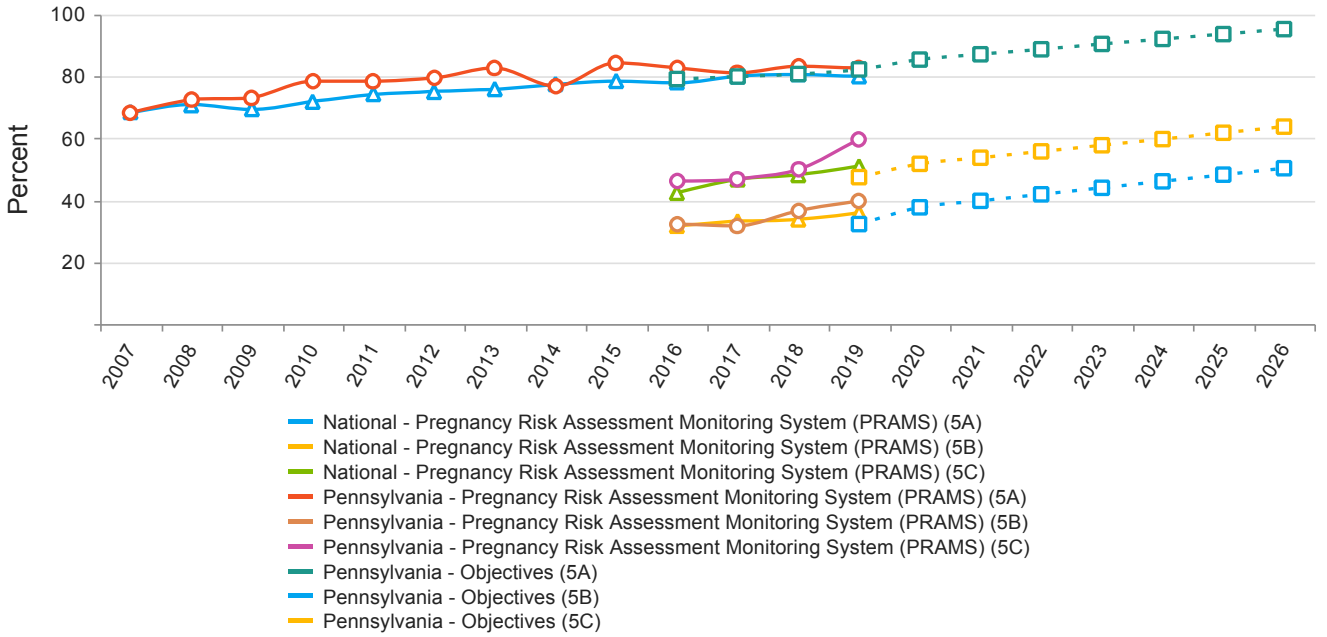
ESM 4.4 - Award 15 mini-grants to community partners to provide breastfeeding support.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	15.0	15.0	15.0	15.0	15.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79	79.8	80.6	82.1	85.3
Annual Indicator	76.7	84.0	81.2	83.1	82.4
Numerator	101,695	110,308	103,722	104,542	101,724
Denominator	132,585	131,259	127,773	125,760	123,405
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	79	79.8	80.6	82.1	85.3
Annual Indicator	76.7	84	81.2	83.1	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Data Source Year	2014	2015	2017	2018	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	87.0	88.6	90.3	91.9	93.5	95.1

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		32.3	37.7
Annual Indicator	31.5	36.6	39.8
Numerator	38,141	44,262	46,940
Denominator	121,226	120,893	118,085
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			32.3	37.7
Annual Indicator	32.4	31.5		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2012-2015	2016-2017		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	39.8	41.9	44.0	46.1	48.2	50.3

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		47.4	51.7
Annual Indicator	46.9	50.1	59.5
Numerator	56,601	60,875	70,513
Denominator	120,631	121,402	118,424
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			47.4	51.7
Annual Indicator	46.1	46.9		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2012-2015	2016-2017		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	53.7	55.7	57.7	59.7	61.7	63.7

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of CDR recommendations implemented annually (infant health)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 5.2 - Number of hospitals recruited to implement the model safe sleep program

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2	3	3	0
Annual Indicator	2	6	6	6	0
Numerator					
Denominator					
Data Source	quarterly reports from the Infant Safe Sleep Initi	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports - Infant Safe Sleep Initiative	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

ESM 5.3 - Percentage of infants born whose parents were educated on safe sleep practices through the model program

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	8	9	18
Annual Indicator	0	3	8.6	17.4	0
Numerator			11,639	23,337	
Denominator			135,498	134,091	
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports - Infant Safe Sleep Initiative	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.0	0.0	0.0	0.0	0.0	0.0

ESM 5.4 - Percentage of hospitals with maternity units implementing the model program

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	2	4	8
Annual Indicator	0	2	1.9	8.9	0
Numerator			2	9	
Denominator			107	101	
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports - Infant Safe Sleep Initiative	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	0.0	0.0	0.0	0.0	0.0

ESM 5.5 - Number of targeted prevention initiatives or interventions implemented using PPOR data

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0

State Performance Measures

SPM 1 - Percent of newborns with on time report out for out of range screens

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.5	71.0	71.5	72.0	72.5	73.0

State Action Plan Table

State Action Plan Table (Pennsylvania) - Perinatal/Infant Health - Entry 1	
Priority Need	
Reduce rates of infant mortality (all causes), especially where there is inequity	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
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	
Strategies	
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	
ESMs	**Status**
ESM 4.1 - Percent of Keystone 10 facilities that progressed by one or more steps each fiscal year	Active
ESM 4.2 - Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year	Active
ESM 4.3 - Convene five regional breastfeeding collaborative meetings twice per year.	Active
ESM 4.4 - Award 15 mini-grants to community partners to provide breastfeeding support.	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Pennsylvania) - Perinatal/Infant Health - Entry 2

Priority Need

Reduce rates of infant mortality (all causes), especially where there is inequity

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

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

Strategies

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

ESMs	Status
ESM 5.1 - Number of CDR recommendations implemented annually (infant health)	Active
ESM 5.2 - Number of hospitals recruited to implement the model safe sleep program	Active
ESM 5.3 - Percentage of infants born whose parents were educated on safe sleep practices through the model program	Active
ESM 5.4 - Percentage of hospitals with maternity units implementing the model program	Active
ESM 5.5 - Number of targeted prevention initiatives or interventions implemented using PPOR data	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Pennsylvania) - Perinatal/Infant Health - Entry 3

Priority Need

Improve the percent of children and youth with special health care needs who receive care in a well-functioning system

SPM

SPM 1 - Percent of newborns with on time report out for out of range screens

Objectives

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

Strategies

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

State Action Plan Table (Pennsylvania) - Perinatal/Infant Health - Entry 4

Priority Need

Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development

Objectives

Annually increase the number of reviews by local CDR teams of prematurity deaths that include identification of the underlying causes of death

Strategies

Increase access to and use of Child Death Review data sources to enhance program planning, design and implementation

Perinatal/Infant Health - Annual Report

The Bureau of Family Health (BFH) provides services to the perinatal/infant domain through a combination of Title V, other federal, and state funding as described below. Within the BFH, programs serving this population domain are split between the Division of Newborn Screening and Genetics (DNSG) and the Division of Child and Adult Health Services (DCAHS). Title V funds the breastfeeding awareness and support program, the safe sleep program, newborn screening program staff, and the newborn screening data system. Additionally, the BFH continues to supply educational materials including a training video, pamphlets and a commitment statement to hospitals and birthing centers in accordance with Pennsylvania (PA) Law 2002-176 on Shaken Baby Syndrome. State funds are utilized for the agreement with the contracted newborn screening lab, which includes payment for the disorders on the mandatory screening panel, grant agreements with the treatment centers, and a phenylketonuria formula program. In addition, in 2020, the DNSG received Health Resources and Services Administration (HRSA) funding for activities related to newborn hearing screening.

There are three laws that have established the newborn screening program in PA: Newborn Child Testing Act, Newborn Child Pulse Oximetry Screening Act, and Infant Hearing, Assessment, Reporting, and Referral Act. These laws have provided for the creation of the Newborn Screening Follow-up Technical Advisory Board and the Infant Hearing Screening Advisory Committee. These committees provide recommendations, guidance, and support to the newborn screening program.

In PA, there are 88 birthing hospitals/free standing birthing centers and 106 midwives performing deliveries. In 2020, based on newborn screening data, there were 134,173 infants born in PA, with 96.7% of births occurring in hospitals and free-standing birth centers, and 3.3% of births occurring in other settings (e.g. clinic/doctor's office, home birth). Occurrent birth data from PA in 2020 is not yet available. Newborn screening encompasses three types of screenings: dried blood spot, hearing, and critical congenital heart defects (CCHD). In 2020, the DNSG's contracted laboratory, PerkinElmer Genetics, performed 133,910 initial dried blood spot screenings. The number of infants receiving a hearing screening in 2020 was slightly less at 132,350. In addition, 133,458 newborns received a CCHD screening. The DNSG entered into a data share agreement with the Vital Records Registry to identify newborns with a birth certificate without the completion of the various newborn screenings. In 2020, 263 newborns were identified without a dried blood spot screening. The Community Health Nurses within the DNSG provided case management services for newborns identified without screening results.

The infant mortality rate for PA dropped to 5.9 per 1,000 live births in 2018. The rate for black infants decreased (12.6) but is still two times the goal of 6.0 for Healthy People 2020. The rate for black infants was higher than the rate for Latinx infants (7.3), which also did not meet the Healthy People 2020 goal, and nearly triple the rate for white infants (4.8). In 2018, 9.5% of PA babies were born prematurely, which surpasses the Healthy People 2020 goal of 11.4%. The percentage of low birth weight babies was 8.3 which does not meet the Healthy People 2020 goal of 7.8. Health disparities persist again when stratifying the rate by race and ethnicity: black/African American (13.9), Latinx (9.0), white (7.0). Only the rate for white babies surpasses the Healthy People 2020 goal of 7.8%.

Nearly half of the 2018 deaths (most recent year complete data is available) reviewed by local Child Death Review (CDR) teams were deaths among infants. There were 482 total infant deaths reviewed, representing 46.1% of all cases reviewed. Prematurity remains the leading cause of death for infants. Of the total 482 infants' deaths reviewed, 227 (47.1%) were due to prematurity. An examination of PA's reviewed infant deaths for 2018 revealed that 87 (9.8%) of the 888 infant deaths were Sudden Unexpected Infant Death (SUID) related cases. The causes of death for the SUID-related cases include pending, unknown/undetermined, unintentional asphyxia, and Sudden Infant Death Syndrome (SIDS). Centers for Disease Control and Prevention (CDC) WONDER data for PA shows that black/African American infants die of SUID at more than twice the rate of white infants. In 2020, for most local CDR teams, review meetings were curtailed due to COVID-19 mitigation efforts and to team members' roles being resourced to COVID-19 related work. Only the Philadelphia team was able to continue to review and enter data without interruption. Teams have resumed regular meeting schedules. Teams were offered assistance in hosting

virtual review meetings. BFH hosted virtual review meetings for two teams.

In 2020, the BFH participated in Cohort 2 of the Child Safety Learning Collaborative (CSLC). The CSLC provided the BFH with the opportunity to learn about and apply quality improvement methodologies to infant and safe sleep programming to prevent SUID-related deaths. The BFH benefited from the small group size to regularly and meaningfully engage with other states and quality improvement experts. As new quality improvement processes related to SUID-related deaths are learned through participation in the CSLC, the BFH will identify opportunities for implementation.

Using Title V funds, the Montgomery County Health Department (MCHD) completed a Perinatal Periods of Risk (PPOR) study in 2020. Results of the study indicated disparities among black/African American women and their infants compared to white infants, with the greatest disparity being the death rate for very low birthweight black/African American infants. In 2021, MCHD is focusing on the development and implementation of a strategic plan aimed at lowering disparities and improving birth outcomes for black/African American infants. The plan is a collaboration of the MCHD and community stakeholders to ensure that the community is an equal partner and voice in developing action steps to reduce disparities. The strategic plan will focus on the following areas: education, improving the patient – provider relationship, enhanced care for pregnant and parenting people, mental health counseling and social support, and improving referral systems.

In addition to MCHD's PPOR initiative, the BFH issued an RFA for PA communities to conduct a PPOR study and develop and implement a community action plan based on the results of the study. Three applications were selected to receive grant funding starting January 1, 2021: Maternal and Child Health Consortium of Chester County, Allegheny County Health Department, and the Philadelphia Department of Public Health. Each grantee is required to complete the six-stage PPOR process; create a detailed community action plan for perinatal health; and implement at least three targeted, evidence-based, or evidence-informed prevention initiatives or interventions to address specific drivers of feto-infant mortality.

Priority: Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants

NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objective 1: Increase the proportion of PA birthing facilities that provide recommended care for breastfeeding mothers and their babies

ESM: Percent of facilities designated as a Keystone 10 facility each fiscal year

Modeled after the World Health Organization's Ten Steps to Baby Friendly Hospitals Initiative, as well as similar initiatives in other states, the PA Breastfeeding Awareness and Support Program (program) has implemented its Keystone 10 Initiative (K10) in birthing facilities statewide. The program provides funding to the PA Chapter of the American Academy of Pediatrics (PA AAP) to administer the K10 Initiative. This voluntary initiative focuses on the adoption and implementation of the ten evidence-based steps to successful breastfeeding. The K10 Initiative began in March 2015 with 69 participating birthing facilities engaged in a three to five-year initiative to implement the ten steps to successful breastfeeding. In 2020, 86 of PA's 90 birthing facilities were engaged in the K10 Initiative. The program's goal was for 27% of K10 facilities to be designated as completing the K10 Initiative by the end of 2020. This goal was met, as 27 facilities, or 31% of K10 birthing facilities, have completed all ten K10 steps.

According to a national study, the effect of maternity-care practices on breastfeeding plays a major role in breastfeeding rates. Mothers in the U. S. are 13 times more likely to stop breastfeeding before six weeks if they delivered in a hospital not participating in the K10 Initiative in comparison to mothers who delivered at a facility

where at least six of the ten steps were followed. After the completion of the sixth year of the initiative, 22 hospitals have implemented six or more steps and 27 hospitals have completed all ten steps of the K10 Initiative.

Facilities participating in the K10 Initiative have been grouped into five regions. Each region has an in-person biennial collaborative. The 2020 collaborative meetings focused on an overview of the K10 and First Food programs, as well as pre-natal education (K10 step 3) and referrals to breastfeeding support groups (K10 step 10). Overall, the collaborative meetings provided an opportunity for hospitals and organizations within the community to familiarize themselves with the resources available to refer mothers, babies and families in their communities, ultimately building a warm referral network and increasing access to breastfeeding support resources. A web-based project management tool, Base Camp, is utilized to allow the regional collaboratives to share information, best practices, and pose discussion questions. In addition to the collaboratives, the program provided a 15-hour breastfeeding management course to staff members of facilities participating in the K10 Initiative.

In June 2020, the K10 webinar “How OB Providers Can Enable Women to Achieve Their Breastfeeding Goals” was offered to all K10 facilities. The main objective was to understand why obstetrician-gynecologists and other obstetric providers are an important part of the support and management of breastfeeding;108 attendees participated and 48 received continuing education credits.

The most common K10 barriers recognized are the lack of administrative support for staff implementing K10 and the length of time required to approve and implement the evidence-based steps. Multiple efforts have been implemented to overcome these barriers. Each facility has a designated champion who is aware of the importance of breastfeeding to both maternal and infant health. These champions are the driving force of each facility’s momentum. K10 regional facilitators are available to provide on-site technical assistance to facilities reporting lack of administrative support. In addition, there are currently 27 K10 designated facilities available to offer guidance to the other K10 facilities. The COVID-19 pandemic and mitigation efforts were an additional barrier in 2020 as all technical support, collaborative meetings and trainings could no longer take place in person. Fortunately, K10 staff was able to quickly switch to hosting such efforts in a virtual format so that K10 participants could safely attend events and access resources and trainings.

Objective 2: Starting with reporting year 2017, annually increase number of counties with a breastfeeding rate at or above the 2016 statewide average of 81%

ESM: Percent of counties with breastfeeding rates at or above the 2016 statewide average of 81% each fiscal year

The program aims to increase the percent of counties with breastfeeding rates at or above the 2016 statewide average of 81% each fiscal year. The 2020 goal required 57% of counties to have a breastfeeding rate of 81% or higher. This goal was not met, as the number of counties with a breastfeeding rate at or above the statewide average decreased from 45% to 40%. While the number of counties meeting the statewide average did not meet the goal, the overall statewide breastfeeding rate maintained at 82%.

In state fiscal years 2018-2020, the program conducted a pilot project where community-based organizations in counties with a breastfeeding rate below the statewide average received mini-grants to provide breastfeeding education and outreach to help raise breastfeeding rates. In the first year of the project, five community-based organizations were selected and approved to receive mini-grants. In the second year of the project, 10 community-based organizations were selected and approved to receive mini-grant funds to increase county breastfeeding rates and provided services through the second half of 2019 and the first half of 2020.

In 2020, the program provided mini-grant funds to ten community-based organizations to provide breastfeeding education and support in areas with a low black/African American breastfeeding rate through an initiative with AccessMatters. Funds were used to provide one or more of the following services: education on the benefits of breastfeeding for black/African-American mothers and their family members, support for black/African-American mothers who choose to breastfeed, the creation of peer support networks for black/African-American breastfeeding mothers, and/or, faith-based health promotion and education on breastfeeding in black/African-American communities. Funds were provided to ten partners in Fall 2019, and services were provided in the first half of 2020, which were extended into the latter half of 2020 as the organizations figured out how to provide their services in a COVID-19 safe manner. Additionally, in the second half of 2020, five more community-based organizations were selected and approved to provide services into 2021.

Objective 3: Annually identify and develop a minimum of one collaborative opportunity with programs serving MCH populations

ESM: Number of new collaborations developed (between breastfeeding programs and other programs)

In November of 2020, the program issued an RFA to community partners through the First Food initiative. Applications were reviewed from community-based groups and organizations that support, or desire to support, breastfeeding and maternal child health. Funding was awarded to projects designed to impact and improve rates of breastfeeding at the local and county level through community outreach. Twenty-five applications were received and 15 were approved in December of 2020 from all regions of the state, with the goal of working with underserved populations. These mini-grant projects will begin in early 2021.

Fifteen projects were approved to begin in early 2021. These projects include a partnership with UPMC Cole to provide breastfeeding education and support for infants and mothers in rural areas, a partnership with La Leche League to provide breastfeeding support and resources for low income women in Chester County and a partnership with Pettaway Pursuit Foundation to provide women with consultations with Certified Lactation Counselors.

Objective 4: Annually implement a minimum of one media opportunity promoting breastfeeding as the infant feeding norm for the state

ESM: Number of new media opportunities implemented promoting breastfeeding per fiscal year

In 2020, PA AAP began distributing their quarterly newsletter in digital format. The newsletter is now emailed directly to K10 facilities and community partners and available on PA AAP's breastfeeding website. PA AAP also recorded the virtual collaborative meetings, and currently hosts them on Vimeo. The recorded collaborative meetings can be accessed by K10 participants and other community partners, who now have ongoing access to presentations and educational resources free of charge. Additionally, PA AAP established a Facebook page to keep community partners up to date with educational resources and events through the K10 and First Food programs.

Priority: Safe sleep practices are consistently implemented for all infants

NPM 5: (A) Percent of infants placed to sleep on their backs (B) Percent of infants placed to sleep on separate approved sleep surface (C) Percent of infants placed to sleep without soft objects or loose bedding

Objective 1: Beginning in the second year of the grant cycle, annually decrease the rate of mothers who report sleeping with their baby in the first year of life

Objective 2: Annually decrease the percent of infants who are strangled or suffocated due to unsafe sleep environment

ESM: Number of hospitals recruited to implement the model safe sleep program

ESM: Percentage of infants born whose parents were educated on safe sleep practices through the model program

ESM: Percentage of hospitals with maternity units implementing the model program

ESM: Number of social marketing messages disseminated

Sleep position and environment are modifiable factors for infants and can have a direct result in reducing infant mortality. A multitude of challenges must be overcome to change the collective knowledge and practice to achieve safe sleep practices for all infants at all sleeps. Current and accurate guidance on risk reduction methods is crucial to address changes in the science over time and cultural norms that have been practiced for generations.

A study showing increased adherence to safe sleep practices in the hospital setting when a bundled intervention was implemented at room orientation rather than hospital discharge prompted the BFH to support development of such a model program. The development and implementation of a hospital-based model safe sleep program is supported with a social marketing approach targeting Philadelphia.

The grant with the Trustees of the University of Pennsylvania continued successfully for the infant safe sleep initiative during 2020. The grantee was fully engaged in recruitment and implementation this year and efforts extended well beyond the southeastern corner of the state. All components of the hospital-based model safe sleep program, including training modules, patient education materials, implementation forms and guides, and evaluation instruments are available online at www.pasafesleep.org. After implementing the hospital-based model safe sleep program, the grantee has been able to strengthen the evidence base used to develop the program. The dedication to supporting the model with ongoing data adds to the strength and validity of the model resulting in greater interest in the model from birthing hospitals throughout the state.

In 2020, despite the pandemic and mitigation policies, the safe sleep work generally continued without significant adverse impacts. For the spread and implementation of the hospital-based model program, the most notable impact was a halt to travel directly affecting in-person recruitment and training. The grantee was able to pivot and transition to a virtual platform with minimal challenges. Participating hospitals reported shorter length of stays and less caregivers receiving the safe sleep education due to limitations on hospitals visitors. Nursing staff were able to ensure safe sleep messages were clearly, concisely, and consistently shared and reinforced even for short stays.

By the end of 2020, the hospital-based model safe sleep program was fully implemented in 14 of the 90 birthing hospitals (15%) which exceeded the ESM goal of eight percent of birthing hospitals with implementation. Over 31,000 infants or 24% of the births in 2020 had parents who received safe sleep education through the model program exceeding the 18% ESM goal.

It is important to note that since the ESMs were developed, both the number of birthing hospitals and annual births

have declined. While these declines impact the ESMs, even using the higher number of birthing hospitals and annual births from 2018, this programming is exceeding the ESMs. There is no doubt that the high-quality program development by the grantee and ongoing support of participating hospitals has been instrumental in the hospital participation, despite declines in birthing hospitals and annual births.

The ESM goal for the number of hospitals with maternity units recruited to implement the model safe sleep program in the next year was zero for 2020 due to the end of the current grant period on June 30, 2021. While commitment to execute a new grant agreement to continue the programming without pause was approved in late 2020 there was not sufficient time for the grantee to formally recruit hospitals. During 2020, the grantee had many requests from hospitals seeking to implement the hospital-based model program.

To support the messaging provided in the hospital setting, the grantee implemented a social marketing campaign using social media posting and advertisements, public transit advertisements, and email blasts. The social media advertisements engaged the target demographic populations and drove traffic to the PA Safe Sleep website. The simple and consistent messaging supporting safe sleep practices now reaches families in both the hospital and community settings. Previous implementation of the social marketing plan demonstrated that there was greater impact with quality and placement of messages rather than quantity of messages. As such the ESM targets were reduced for future period and more focused to target individuals who identify as infant caregivers. The previously adjusted target ESM of 86 social marketing messages disseminated was achieved and exceeded in 2020 with 93 messages disseminated. While this approach is a departure from the initial strategy it is expected to have better results on the individual behaviors and practices around safe sleep.

An ongoing plan to determine the future of the social marketing plan was not completed in 2020 as anticipated. While the BFH does not want to abandon messaging in support of safe sleep practices, the ability to do so in a manner supported by evidence statewide is not within capacity moving forward. Focusing on programming with a strong evidence-base will result in clear and known outcomes to improve infant mortality.

Priority: Appropriate health and health related services, screenings and information are available to the MCH Population

SPM: Percent of newborn screening dried blood spot (DBS) filter papers received at the contracted lab within 48 hours after collection

Objective 1: By 2020, increase the annual percentage of DBS samples with a transit time to the contracted lab of less than 48 hours by five percent each year to expedite diagnosis and treatment

The DNSG has continued to implement efforts to improve the timeliness of DBS newborn screening. With a baseline of 39.7% of DBS samples collected in 2014 received by the laboratory within 48 hours of collection, the DNSG has shown steady progress in improving the SPM. In 2020, 56% of samples were received at the laboratory within 48 hours of collection, which fell short of the 2020 goal of 64%.

Specimen delivery was impacted by the COVID-19 pandemic throughout 2020. More parents are now choosing to deliver their babies through midwives and home births to avoid hospital stays. Out-of-hospital births typically have longer collection to receipt time at the lab than hospital births. Mothers and their babies are also being discharged from the hospital early, which affects the timing of specimen collection and creates a need for babies to return to the hospital for their DBS. Additionally, courier services such as UPS and FedEx, as well as the USPS have experienced delays in shipping due to disruptions stemming from the pandemic. These delays are causing specimen shipments to take longer than the usual 24-hour overnight shipping requirement.

The DNSG continues to provide quarterly reports to all hospitals, which include the average collection to receipt time and benchmarks the hospital against the state average. The reports are sent to the DBS coordinator, nursery

manager and neonatal intensive care unit (NICU) manager for each birthing hospital. PerkinElmer Genetics, the contracted screening laboratory, provides birthing hospitals monthly reports which include the hospital's average collection to receipt, the state average collection to receipt, and the hospital's percentage of unacceptable DBS samples. Any hospital with a collection to receipt timeframe greater than 52 hours receives technical assistance from DNSG staff. The DNSG has received positive feedback and has seen increased hospital efforts due to the sharing of timeliness data. Due to COVID-19 pandemic restrictions, technical assistance with a focus on timeliness, which has historically included site visits to low-performing hospitals, was provided virtually in 2020.

The learning module funded by NewSTEPs 360 and completed by the University of Pittsburgh via an inter-governmental agreement with the DNSG in 2019, and focuses on newborn screening timeliness, was posted on the TrainPA website in 2020.

The DNSG continues to release newborn screening quarterly newsletters. Newsletters provide submitters (hospitals, birthing centers, and midwives) with program updates and DBS timeliness improvement methods. Additionally, individual calls with DBS coordinators, nursery managers, NICU managers and midwives to discuss barriers, educational needs and program updates were held as needed.

A barrier to timely specimen transit remains the out-of-hospital submitters. Most of these submitters do not utilize UPS and often batch shipments to save on costs. Both the DNSG and PerkinElmer Genetics continue to promote the use of UPS shipping and provide technical assistance on the importance of timely screening results.

Objective 2: By 2020, implement a system where all newborns born in Pennsylvania are screened for all conditions listed on the Recommended Uniform Screening Panel (RUSP)

In PA, there is a two-panel system for newborn screening consisting of a mandatory screening panel and an optional follow-up panel. In 2020, newborns were screened for 10 mandatory conditions and the submitters elected which of the 27 other conditions on the mandatory follow-up panel were screened for. The list of disorders on the mandatory screening panel and mandatory follow-up panel align with the RUSP.

Some submitters, mainly midwives, elected to only screen for the disorders listed on the mandatory screening panel. The DNSG pays for the screening of the mandatory conditions utilizing state funds and the submitters are required to pay for the screening of the disorders on the optional follow-up panel if they elect to screen for those conditions. Due to the out of pocket expense, most midwives elected not to screen for optional follow-up disorders.

In 2020, there were 88 hospitals/birthing centers and 106 midwives performing deliveries in PA. Fifty-two midwives, accounting for 1,277 births, elected to only screen for the mandatory conditions; six hospitals/birth centers and 18 midwives elected to screen for all disorders on the RUSP, except for Severe Combined Immunodeficiency (SCID), which accounted for 4,970 births; and the remaining 82 hospitals and 32 midwives screened for all conditions listed on the RUSP, accounting for 127,663 births. The percentage of hospitals and birth centers screening for all conditions listed on the RUSP increased from 92% in 2019 to 94% in 2020. This increase can be attributed to the technical assistance provided to each hospital and birth center electing not to include SCID on their screening panel. In conjunction with the screening laboratory sending notification letters to submitters, the quality assurance nurse provided verbal education to management staff at each facility regarding the importance of screening for SCID. The SCID Newborn Screening and Follow-up Technical Advisory Board subcommittee has been working with the Clinic for Special Needs and midwife community to continue to increase the number of newborn screening submitters screening for SCID. This collaboration resulted in 30% of out-of-hospital births screened for SCID.

Senate Bill 983 was introduced by Representative DiSanto in 2019 and approved on November 25, 2020. Senate Bill 983 encompasses Act 133, amending the Newborn Child Testing Act of September 9, 1965 (P.L. 497, No.251). Act 133 goes into effect on May 24, 2021 and mandates screening and follow-up for the same 34 disorders for all PA newborns. The original mandatory screen of ten disorders will be funded by the PA Department of Health, through state funds, while the supplemental panel consisting of 24 disorders will be paid for by the submitter.

I. Overview of Approach to Infant/Perinatal Health Domain

In order to promote positive infant health outcomes and well-being across the life course, the new priorities for this domain will guide work addressing infant mortality and the provision of a well-functioning system of care for children with special health care needs (CSHCN), beginning at birth with newborn screening. As screenings are performed shortly after birth to detect potentially fatal or disabling conditions, newborn screening is an important component of a well-functioning system for all newborns, and especially those identified with an out-of-range result. Such early detection allows treatment to begin immediately which reduces, or even eliminates, the effects of the condition.

II. Other Federal Funding and State-Funded Activities/Future Efforts

Future Title V-supported efforts will also aim to address the disparities in breastfeeding initiation and duration rates across the state. In 2020, the Breastfeeding Awareness and Support Program awarded grant funding to promote breastfeeding education, community outreach and improve breastfeeding initiation and duration rates in PA. Education and support services will be provided into and through the 2022 calendar year. Services provided may include but are not limited to: providing regional collaboratives for birthing facilities (hospitals, birthing facilities, midwives and other providers) and community partners; providing breastfeeding education for populations with lower initiation and duration breastfeeding rates; distributing grants focused on improving initiation and duration breastfeeding rates in areas of need based on demographics; and providing program evaluation for all deliverables included in the grant. The program will also partner with the Pregnancy Risk Assessment Monitoring System (PRAMS) program, housed in the Division of Bureau Operations (DBO), to evaluate data on breastfeeding duration. Annual breastfeeding initiation and duration rates will be used to assess progress.

In addition to the aforementioned efforts, the Shaken Baby Syndrome (SBS) Program, an injury prevention program provided by the BFH and in accordance with PA Law 2002-176, is exploring the extent to which program expansion is needed. The program's goal is to reduce the incidence of abusive head trauma by assisting hospitals in fulfilling the statutory requirement of providing SBS education to parents before discharge from the hospital after the birth of a baby. The BFH will continue to supply educational materials to the hospitals and birthing centers and provide direction as needed on program requirements and adherence while also conducting research on the future direction of the program.

III. Priorities

Priority: Reduce rates of infant mortality (all causes), especially where there is inequity

NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Strategy: Facilitate the adoption and implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within PA birthing facilities

Objective: Annually increase the percent of PA birthing facilities designated as a Keystone 10 facility each fiscal year

ESM: Percent of Keystone 10 facilities that progressed by one or more steps each fiscal year

Improving breastfeeding initiation and duration rates is necessary to reduce infant mortality, as breastfeeding has been found to decrease the risk of hospitalization in the first year of life, the development of chronic health conditions, and the occurrence of Sudden Unexpected Infant Death (SUID) by at least 50%. Mothers in the United States are 13 times more likely to stop breastfeeding before six weeks after birth if they deliver in a hospital not participating in a

10-step breastfeeding initiative in comparison to mothers who delivered at a facility where at least six of the ten steps were followed. Therefore, the BFH's Breastfeeding Awareness and Support Program (program) will continue funding the PA Chapter of the American Academy of Pediatrics (PA AAP) to administer the Keystone 10 (K10) initiative through June 30, 2023. The program will work with the PA AAP to improve promotion of the K10 initiative and encourage participants to complete K10 steps. Education will be given to participants on the positive outcomes breastfeeding has on mothers and their babies, and how completing K10 steps leads to better breastfeeding rates. The program and PA AAP will continue to provide technical assistance and approve applications for K10 step completion. By continuing the partnership with PA AAP, the program is ensuring K10 continues as a free and viable option to facilities who may not pursue the Baby-Friendly initiative.

The most common barriers noted from K10 facilities are the lack of administrative support for staff implementing K10 and the length of time required to approve and implement the quality improvements. To combat this, the regionally based learning collaborative model will continue to be utilized to facilitate group discussion with focus on specific steps and barriers to success. The collaborative meetings will provide consistent education to all facilities, as well as give facilities an opportunity to share best practices and procedures with other facilities.

Strategy: Collaborate with the Safe Sleep Program to promote and support breastfeeding within each program

Objective: Annually identify and develop collaborative opportunities between the Safe Sleep Program and the Breastfeeding Program

ESM: Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year

The BFH houses both the Division of Newborn Screening and Genetics (DNSG) and Division of Child and Adult Health Services (DCAHS). The PA Breastfeeding Awareness and Support Program is administered by the DNSG, while the Safe Sleep Program is administered by DCAHS. These programs work closely with one another, as they serve the same population and collaborate with the same community partners. Increased breastfeeding, in combination with safe sleep practices, may serve to reduce the infant mortality and morbidity rate. By providing cross education on breastfeeding and safe sleep, mothers who originally chose not to breastfeed will receive education on breastfeeding and health outcomes that they otherwise may not receive. The programs will meet four times a year to discuss possible collaboration such as joint promotion and education, outreach and media and marketing efforts. By combining resources and efforts, these programs will serve a larger population statewide.

Strategy: Collaborate with community-based organizations to increase breastfeeding initiation and duration rates statewide

Objective: Annually provide breastfeeding education, and community outreach to improve breastfeeding initiation and duration rates

ESM: Convene five regional breastfeeding collaborative meetings twice per year each year

ESM: Award 15 mini-grants to community partners to provide breastfeeding support each year

In 2020, the program constructed a RFA allowing organizations to compete for grant funding to administer a program to increase breastfeeding support and awareness statewide. PA AAP was awarded the grant funding in the summer of 2020 and the program officially started in October of 2020. In 2022, PA AAP will collaborate with community based organizations and partners by hosting regional collaborative meetings for birthing facilities and community partners, providing breastfeeding education for populations with lower initiation and duration breastfeeding rates, and distributing mini-grants focused on improving initiation and duration breastfeeding rates in areas of need based on target population demographics.

PA AAP will conduct 10 regional collaborative meetings each year. These bi-annual collaboratives will educate and support birthing facilities and community partners on breastfeeding best practices and policies as well as the Keystone 10 Initiative. They will also serve as an avenue for professionals to network and brainstorm with peers to share knowledge and promote collaboration. Regions include the Southwest, Southcentral, Southeast, Northwest, and Northcentral/Northeast. By hosting the collaborative meetings regionally, each region's needs and barriers can be focused on specifically. PA AAP will also provide at least three breastfeeding educational opportunities to community partners each year. These opportunities will include breastfeeding literature, statewide outreach events and webinars as well as public library story kits that will engage and empower community partners utilizing libraries

as meeting spaces to promote and support breastfeeding in their communities. Educational resources will be developed and distributed statewide and focus on increasing breastfeeding initiation and duration rates. Lastly, PA AAP will award mini-grants to community partners to provide breastfeeding support and education based on demographic need. Mini-grants will be awarded to 15 community partners based on application. All applications will be reviewed and scored by a grant review team, which will include representatives from the program. The selected mini-grants will have representation from each region in PA and will focus on increasing breastfeeding initiation and duration rates.

NPM 5: (A) Percent of infants placed to sleep on their backs (B) Percent of infants placed to sleep on separate approved sleep surface (C) Percent of infants placed to sleep without soft objects or loose bedding

Infant mortality can result from a variety of different circumstances, many of which seem beyond the control of practitioners, but sleeping safety is truly a viable area of intervention. As such, the BFH recognizes the importance of providing education and outreach to increase safe sleep practices across the commonwealth to improve outcomes related to infant mortality.

The BFH plans to continue to collaborate with the Child Safety Learning Collaborative (CSLC) to gather ideas, learn strategies, and receive feedback to improve Safe Sleep programs and implement processes that will allow the BFH to reduce fatal and serious injuries among infants. The BFH plans on using data to expand on existing efforts that have been effective and identify evidence-based or evidence-informed strategies for preventing injuries related to safe sleep. These efforts include maintaining and expanding collaborations through the Safe Sleep Initiative and the ongoing PA CDR program work to unify investigative responses to infant death and develop consistent messaging about safe sleep practices and the prevention of death and injury. The CSLC will help shape and support the BFH programs in decreasing the incidence of infant death due to unsafe sleep practices. CDR's SUID registry provides data to inform message delivery ensuring that information reaches the audience most in need.

Strategy: Implement a hospital-based model safe sleep program

Objective: Increase the number of birthing hospitals implementing the hospital-based model safe sleep program by three percent annually

ESM: Number of hospitals recruited to implement the model safe sleep program

ESM: Percentage of infants born whose parents were educated on safe sleep practices through the model program

ESM: Percentage of hospitals with maternity units implementing the model program

The BFH will continue to support an infant safe sleep grant to develop and implement a hospital-based model program with a supporting social marketing approach through 2024 with The Trustees of the University of Pennsylvania. The hospital-based model program will continue to be implemented in hospitals with maternity units and moves the education regarding safe sleep practices from hospital discharge to room orientation. There are proven improvements resulting from this approach as there is more time for observation, correction, and reinforcement of safe sleep practices during the hospital stay. SUID is one of the leading causes of infant death after the first month of life. SUID-related deaths are rarely observed and frequently sleep related, suggesting that safe sleep practices can have measurable impacts on infant mortality.

During state fiscal year 2021-2022, the hospital-based model-program will be implemented in at least six hospitals throughout the state. The number of hospitals and the associated annual births will keep the BFH on track to achieve the targeted ESMs for the number of hospitals recruited to implement the hospital-based model program, percentage of infants born whose parents were educated on safe sleep practices, and the percentage of hospitals with maternity units implementing the program. Many of the large birthing hospitals have already fully implemented or are in the process of implementing the hospital-based model program, and with implementation moving to smaller hospitals the percentage of infants born whose parents were educated on safe sleep practices will increase, but at a slower pace from the prior years.

Due to demand from hospitals that serve infants but do not have a post-partum unit, the hospital-based model program will be available for implementation in such hospitals. This will help educate staff in these hospitals and support safe sleep practices in the inpatient setting during the first year of life.

The BFH was not able to find an evidence-based means to continue the social marketing plan beyond June 30, 2021. The BFH will continue to seek a means to support educating the larger community on safe sleep practices and SUID risk reduction practices.

Strategy: Use Child Death Review data to inform infant programming

Objective: **Annually increase the number of recommendations from CDR teams related to preventing infant death that are reviewed for feasibility and implemented each year**

ESM: Number of CDR recommendations implemented (infant health)

One tool being utilized to address infant mortality rates and the persistent racial disparities is data from the local Child Death Review (CDR) teams. Each team makes recommendations for deaths determined to be preventable and reports those recommendations to the BFH. The State CDR Team implemented a new prevention recommendation framework in 2021. The framework process consists of three steps: assessment; development; and evaluation. Assessment includes review of data (CDR data and other relevant data), current prevention strategies occurring in PA and other jurisdictions and best practices.

Using the information learned during the assessment phase, the State CDR Team brainstorms prevention strategies. The strategies are assessed for effectiveness and feasibility. Selected strategies are made actionable. The team determines to which entities the white papers would be targeted. Targeted entities would have the capability to implement/lead prevention strategies or already be involved in developing/implementing similar prevention strategies. The State CDR Team defines success in sharing of the white papers and how success is measured. This information is the basis for the evaluation which will occur on a yearly basis. The State CDR Team annually will develop a minimum of one white paper
The actionable recommendations concerning deaths related to preterm births in the white papers as well as recommendations from local teams are shared within the BFH and with other department bureaus as appropriate. The BFH reviews known partner agency programming to see if recommendations can be made to them.

Strategy: Use data, as determined by the 6-step Perinatal Periods of Risk (PPOR) process, to implement prevention initiatives or interventions in the selected communities

Objective: Increase the use of relevant data to inform decision-making, evaluate population and programmatic needs at the community level.

ESM: Number of targeted prevention initiatives or interventions implemented utilizing PPOR data.

Racial disparity in birth outcomes continues to play a defining role in the maternal-child health landscape in Pennsylvania. From 2016-2018, 13.3% of black/African American infants in Pennsylvania were born preterm, compared to 8.6% of infants born to white women; 14% of black/African American infants had a low birth weight,

compared to only seven percent of white infants. Preterm birth and low birth weight are two primary causes of infant mortality; PA's infant mortality rate (IMR) for black/African American infants reflect the racial disparity evident in these other markers. In 2018, PA's IMR for black/African American infants was 12.6 per 1,000 live births, compared to the white IMR of 4.8 infant deaths per 1,000 live births. To address these persistent racial disparities in infant mortality, regions can utilize local data to identify the greatest areas of risk and opportunity and implement programming based on that knowledge. A valuable tool being used to identify disparities in fetal and infant mortality is the Perinatal Periods of Risk (PPOR) Study. PPOR is an analytic framework for studying racial disparities in fetal and infant mortality rates in urban communities with at least 60 fetal-infant deaths over a five-year period. PPOR is based on core principles of full community engagement and equity and follows a six-stage, community-based planning process. Using vital records, fetal and infant deaths are categorized into four periods of risk, based on birthweight and age at death and that correspond to specific factors associated with birth outcomes. PPOR determines the period(s) of risk with the most disparity in deaths to focus community efforts. MCH programs can use PPOR to integrate health assessments, initiate planning, identify gaps, target more in-depth inquiry, and suggest clear interventions for addressing fetal and infant mortality. In addition, PPOR fosters greater cooperation in improving MCH through more effective data use, strengthened data capacity, and greater shared understanding of complex infant mortality issues.

Service recipient engagement through focus groups and key informant interviews is a key component of the PPOR framework. Several initial focus groups with pregnant or recently pregnant people took place in 2020-2021. Given that focus group sessions associated with those projects are ongoing, results and input relevant to maternal and infant/perinatal Title V work will be described in the 2021 report year needs assessment update.

In the coming year, BFH will continue to partner with the Maternal and Child Health Consortium of Chester County, Allegheny County Health Department, and the Philadelphia Department of Public Health to complete PPOR studies, to identify and address specific drivers of feto-infant mortality at the local level. Each community is required to develop a community action plan for perinatal health, based on the results of their PPOR study. The community action plans developed must include at least three targeted, evidence-based, or evidence-informed prevention interventions or initiatives that address racial disparities in feto-infant mortality. The three communities are expected to implement their action plans, evaluate the results, and expand initiatives or interventions by December 31, 2023.

Priority: Improve the percent of children and youth with special health care needs who receive care in a well-functioning system

SPM: Percent of newborns with on-time report out for out of range screens

From infancy, the Newborn Screening and Follow-up Program (NSFP) serves the general population of all newborns born in PA to identify children who have special health care needs. This allows the newborn and their family access to specialty care services that can reduce long-term consequences and complications of diseases identified from the newborn screening panel. The national Newborn Screening Technical assistance and Evaluation Program (NewSTEPs) is a key stakeholder in the national Consensus Framework for Improving Systems of Care for CSHCN.

Newborn screening fits into critical data and quality measures for CSCHN under domain one, identification, screening, assessment, and referral. The system of care set in place by the NSFP ensures that newborns with an identified out-of-range result receive state legislation mandated follow-up.

Strategy: 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

Objective: Increase the number of requested repeat filter papers obtained each year to expedite diagnosis and treatment

ESM: Percent of newborns with a requested repeat filter paper obtained

The DNSG has identified the lack of repeat filter papers requested, despite the request for a repeat, as a concern. In 2020, data indicates that 98.5% (7816/7936) of the requested repeat filter papers were collected. Ensuring that all newborns who require a repeat newborn screen receive this screen is important, and the associated ESM will measure success in the newborn screening system for infants and CSHCN. A breakdown in the system occurs when a repeat is not obtained, because the repeat screen will determine if a referral to a specialty care treatment center is necessary. Depending on the condition, a missed repeat screen could lead to symptoms of increasing severity, including physical disability, severe cognitive impairment, or death.

The BFH also developed an SPM that mirrors national outcome measure (NOM) 12, which is still under development. The SPM, percent of newborns receiving an on-time report out for an abnormal result is also indirectly linked to the newly established ESM, because without a repeat filter paper, there is no on-time report out or physician follow-up. Often, a treatment center reports a diagnosis to the program that was not captured by newborn screening. While there is no national data source to date for the NOM, the DNSG plans to continue developing and collecting programmatic data related to this indicator, which can be used to track progress and improvement at the state level.

The BFH's Community Health Nurses will primarily be invested in advancing improvement as they are responsible for providing case management services after the notification of a requested repeat filter paper. The nurses will reach out to the submitter and/or the primary care provider and the family to notify them that a repeat filter paper is requested. In 2020, a new process was implemented providing the parents with a letter and a disorder fact sheet via mail which includes next steps after an abnormal screening result. This process will continue.

The Nursing Services Consultant will monitor a report which identifies requested repeats not obtained. In addition, this nurse will review every case closed without a requested repeat to ensure appropriate case management of the Community Health Nurse. Awareness of the lack of compliance is the first step in engaging birth facilities to help more readily bring families back in for a repeat collection.

Strategy: Utilize the match with the Vital Records Registry to identify newborns with a dried blood spot (DBS) screening

Objective: Annually increase the percent of newborns receiving a DBS screening

ESM: Percent of newborns born in Pennsylvania receiving a DBS screening

Increasing the percent of newborns receiving a dried blood spot (DBS) screening is in accordance with the U.S. Department of Health and Human Services "National Survey of Children with Special Healthcare Needs Chartbook's" six core systems outcome framework. Newborn screening ensures core system number four is met, that all children are screened early for special health care needs, in this case treatable genetic diseases.

The ESM identifies newborns born in the state of PA to ensure they receive an initial newborn screening. Some newborn screening results indicate the newborn needs to be referred to a specialty care treatment center for diagnostic testing and treatment, if necessary. Without this DBS screening, children are not referred for diagnostic testing until they are symptomatic. By that time, the newborn is often late in getting the care they need to reduce long-term complications and consequences may include death if treatment is delayed.

The DNSG will continue the data share agreement with the Vital Records Registry to identify newborns with a birth certificate without the completion of the various newborn screenings, which includes DBS screening. In 2020,263 newborns out of 134,173 did not have a newborn screening documented in the internet case management system (iCMS). The DNSG Community Health Nurses will provide case management services which include contacting the families and birth facility to notify both parties of the missed DBS screening. In addition, technical assistance will be provided by the DNSG's Nursing Services Consultant which will include education to birth facilities to inform them of the importance of timely screening and screening verification.

Strategy: Work with the Child Death Review (CDR) program to determine possible opportunities to collaborate

Objective: Perform a data comparison and match newborns who were reported as SUID to the CDR with newborns in the Pennsylvania Internet Case Management System (iCMS) to determine if any infant reported to have expired had abnormal Dried Blood Spot (DBS), Critical Congenital Heart Defect (CCHD), or Neonatal Abstinence Syndrome (NAS) results or may have missed timely screening that may have contributed to demise.

ESM: Meet with Child Death Review program for collaboration between programs four times per year

The DNSG and DBO initially entered into a data sharing agreement to begin analyzing data submitted to the CDR and CCHD data submitted to the DNSG to see if any correlations existed that could lead to programmatic changes that may prevent future infant deaths.

The agreement between divisions involves a quarterly data match of SUID cases reported to the CDR to infant cases in iCMS. The two divisions began analyzing 2019 SUID cases to see if any of the infants who died did not receive a timely CCHD screen by the birth hospital or in the home birth setting. Should it be discovered that the infant did not receive a timely CCHD screening, the Community Health Nurses will contact the birth facility to review the mandatory screening guidelines and, in the case of home births, ensure the midwife has the equipment and training necessary to perform future CCHD screenings. CDR cases that were also found to have a confirmed CCHD will be further reviewed to see if the mother had completed recommended prenatal visits where a prenatal ultrasound would likely have been completed and may have led to the CCHD being diagnosed prenatally. Additionally, the divisions will complete a review of the 2020 matched cases to see if other correlations can be made that may lead to policy changes and potentially improved infant outcomes.

The DNSG and DBO were able to complete a data match of 65 infants reported as SUID cases in 2019 with CCHD screening results reported in iCMS. Sixty-four infants received timely CCHD screening and passed, and one was not appropriate for screening due to birth weight less than 1500 grams. Although the divisions were unable to correlate missed or lack of timely CCHD screens as a potential contributing factor to SUID in the first year of data analysis, the programs plan on completing a full additional year of analysis.

In addition to completing a SUID to CCHD quarterly data match, the programs also plan on matching 2020 DBS results and NAS cases to SUID cases. The DBS match will allow the program to ensure infants did in fact receive timely screening and all conditions screened for were within normal screening limits. The DNSG community health nurses and consultants will contact birthing facilities and home birth midwives to review mandatory screening guidelines and timelines should it be discovered an infant had a delay in screening completion. The program will also analyze the data to see if any SUID reported case was associated with a DBS screening parent refusal. Parents in the state of PA have the right to refuse dried blood spot screening if the screening conflicts with their religious beliefs or practices. The BFH will conduct technical assistance with the birth hospital, birth center, or home birth midwife knowing that the parent education they provide can be influential in the parent's decision on whether to proceed with

future DBS screening. 2020 SUID cases will be matched to 2020 NAS cases to see if any correlation may exist between substance affected infants and their families and confirmed SUID cases.

Priority: Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development

SPM: Increase the number of program or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year

Strategy: Increase access and use of Child Death Review (CDR) data sources to enhance program planning, design, and implementation

Objective: Annually increase the number of reviews by local CDR teams of prematurity deaths that include identification of the underlying causes of death

ESM: Increased percent of prematurity cases reviewed by local CDR teams that include identification of the underlying causes of death by five percent each year

ESM: Number of annual trainings to local CDR teams on guidelines of identifying the underlying causes of prematurity deaths

Act 87 of 2008 requires that all counties in PA either establish a local public health CDR team or collaborate with other counties to operate on a regional basis. The teams are comprised of local professionals including coroners, law enforcement, physicians, mental health providers, substance misuse treatment providers, public health, and child welfare services. The local CDR teams should review all deaths of children and youth age 21 years and younger. Teams make prevention recommendations based on the information gathered at the reviews.

Historically, infants comprise the largest age group of deaths. Of the 482 infant deaths in 2018 (most recent data available) reviewed by local CDR teams, 227 (47.1%) infant deaths were related to prematurity. This is consistent with previous years' CDR data. In 89.0% of the infant prematurity deaths reviewed; local CDR teams determined the child's death was not preventable. This is also consistent with previous years' CDR data. Without data identifying the underlying causes of premature births, prematurity deaths of infants will continue to be categorized as unpreventable and data-supported prevention recommendations will not be made by local CDR teams.

That data regarding the underlying causes of infant prematurity deaths could also be used by BFH to inform policies and programs. The underlying causes of prematurity are often related to the social determinants of health. Social determinants include the social and environmental factors in which people are born, grow, live, work and age. Social determinants of health impact one's health in utero. Lack of prenatal healthcare is an associated risk factor for premature births. Increasing access to prenatal healthcare may be associated with decreased risk of premature birth. For local CDR teams to develop appropriate prevention recommendations for infant deaths due to prematurity, the underlying causes of death must be identified.

To strengthen local CDR teams' ability to identify the underlying causes of infant deaths due to prematurity, the BFH will develop guidelines to assist local CDR teams in their reviews of these cases. Annually, the BFH will provide training on the guidelines to local CDR teams. Training can be delivered to local teams' members virtually or face-to-face through the Annual Resource Building Summit. In addition, the BFH will assist local CDR teams to replicate the

successes that a few teams have had with establishing subgroups to review infant deaths due to prematurity. Using specialized subgroups to review complex types of death can result in substantive recommendations and are a best practice. The subgroups reviewing infant deaths from prematurity include individuals with expertise in prenatal, perinatal, and maternal health. Prevention efforts from these subgroups have included:

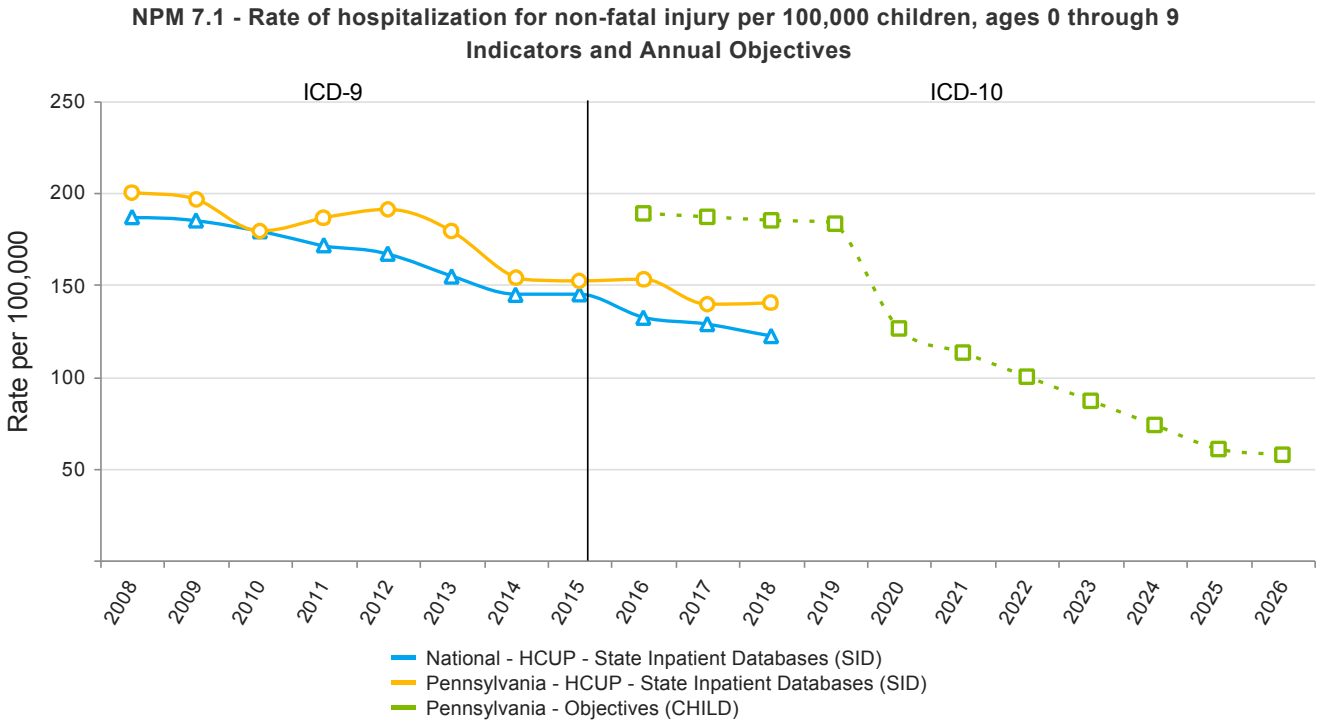
- Increased recognition by providers of the role of obesity on prenatal outcomes.
- Increased referrals by prenatal care providers to the local health department's nurse home visiting programs.
- Implemented monthly case conferences held with prenatal care providers from prenatal clinics and local health department's nurse home visitors to coordinate care for high risk cases and to address social determinants of health.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	16.4	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	27.9	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	7.1	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	9.3	NPM 7.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	21.6 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.1 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	88.8 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.0 %	NPM 11

National Performance Measures



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	188.7	186.8	184.9	183.1	126.2
Annual Indicator	175.4	152.0	152.5	139.4	139.8
Numerator	2,553	1,654	2,201	2,004	1,997
Denominator	1,455,450	1,088,130	1,443,388	1,437,802	1,428,611
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	113.1	100.0	86.9	73.8	60.7	57.6

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Number of recommendations from CDR teams that are implemented (child health)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 7.1.2 - Number of ConcussionWise trainings to athletic personnel

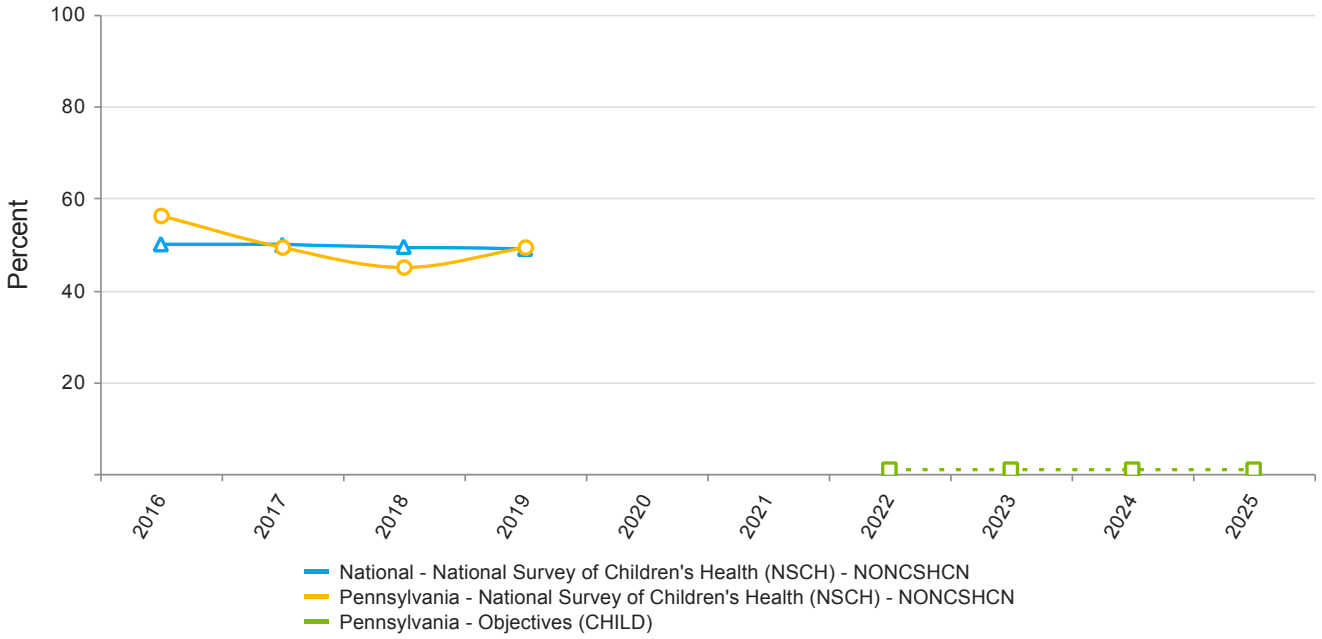
Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Child Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2020
Annual Objective	
Annual Indicator	49.3
Numerator	1,027,215
Denominator	2,085,050
Data Source	NSCH-NONCSHCN
Data Source Year	2018_2019

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	1.0	1.0	1.0	1.0	1.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	3.0	4.0	5.0	6.0	7.0

ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	475.0	498.0	523.0	549.0	576.0	604.0

ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	55.0	58.0	61.0	64.0

ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	8.0	8.0	8.0	8.0

ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	43.0	46.0	46.0	49.0	50.0

ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	500.0	515.0	530.0	545.0	560.0	575.0

ESM 11.9 - Number of calls received through the SKN Helpline

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	800.0	825.0	850.0	875.0	900.0	925.0

ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	8.0	8.0	8.0	8.0

ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	44.0	48.0	52.0	56.0	60.0

ESM 11.12 - 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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	19.0	23.0	27.0	31.0	35.0

ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0

State Action Plan Table

State Action Plan Table (Pennsylvania) - Child Health - Entry 1	
Priority Need	
Reduce rates of child mortality and injury, especially where there is inequity	
NPM	
NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	
Objectives	
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	
Strategies	
Use Child Death Review data to inform child safety programming	
Reduce head injury amongst participants in school and non-school related sports	
ESMs	**Status**
ESM 7.1.1 - Number of recommendations from CDR teams that are implemented (child health)	Active
ESM 7.1.2 - Number of ConcussionWise trainings to athletic personnel	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

State Action Plan Table (Pennsylvania) - Child Health - Entry 2

Priority Need

Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

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

Strategies

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

ESMs	Status
ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)	Active
ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams	Active
ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)	Active
ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs	Active
ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program	Active
ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)	Active
ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic	Active
ESM 11.8 - Number of referrals to BrainSTEPS program	Active
ESM 11.9 - Number of calls received through the SKN Helpline	Active
ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs	Active
ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program	Active
ESM 11.12 - 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	Active
ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes	Active
ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Child Health - Annual Report

Current work in the Bureau of Family Health (BFH) addresses child health and injury prevention through a variety of programs. The Child Death Review (CDR) program promotes the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children up to the age of 21 years. All 67 Pennsylvania (PA) counties are represented on 63 local CDR teams. The CDR program through the BFH facilitates the review process, provides training and technical assistance to local teams, and ensures data quality. The CDR program is supported through a combination of Title V and other federal funds, with other federal funds being used to fund staff time and Title V funds being used to fund training and technical assistance efforts as well as prevention activities.

There were 1,923 deaths of children 21 years of age and under in 2018 (most recent CDR data available). Of the total deaths, 1,063 (55.3%) were reviewed. The PA rate of death for all children 21 years of age and younger (53.0 per 100,000 population) is nearly equal to the national rate of 53.1 per 100,000 population. Nearly half (45.3%) of all deaths reviewed were infant deaths. Children 18 through 21 years of age accounted for 28.3% of child deaths reviewed. Combined, these two age groups represent 73.7% of all child deaths reviewed in PA in 2018 (most recent complete data available).

In PA, the rate of death for black/African American children decreased from 98.4 per 100,000 population in 2017 to 88.5 per 100,000 population in 2018. Nationally, for the same period, the rate decreased for black/African American children from 91.4 per 100,000 to 88.6 per 100,000. Despite the decreases, black/African American children die at a rate nearly twice that of white children. The PA rate of death for white children was 46.5 per 100,000 population in 2018 compared to 49.1 per 100,000 population in 2017. In 2018, the national rate for white children was 47.0 per 100,000 population, and, in 2017, the rate was 48.9 per 100,000 population. The rate of death for Asian or Pacific Islander children residing in PA increased from 34.0 per 100,000 population in 2017 to 37.4 per 100,000 population in 2018. The national rate for Asian or Pacific Islander children decreased in 2017 from 35.0 per 100,000 population to 33.5 per 100,000 population.

Of the 121 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent cause of death was motor vehicle accidents identified in 15 cases (12.4%). In the 159 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was assault, weapon, or person's body part over multiple manner of death categories to include homicides, suicides, and accidents, identified in 45 cases (28.3%). The 301 reviews conducted on deaths of youth aged 18 through 21 years revealed the most frequently occurring cause of death was assault, weapon, or person's body part over multiple manner of death categories to include homicides, suicides, and accidents, identified in 116 cases (38.5%).

The purpose of the reviews conducted by local CDR teams is to gather and examine data regarding the circumstances surrounding child deaths. The examination of that data is used to promote prevention initiatives that reduce the incidence of child fatalities. Development and implementation of prevention measures vary according to the community and the findings of the local CDR Team. Prevention activities are led by the local CDR teams, local CDR team members or through collaborations with other local entities, including, but not limited to, coroners, local health departments, hospitals, law enforcement, home visitation programs, children's advocacy centers, and schools. Some of the prevention measures that have been implemented focus on motor vehicle safety, suicide prevention, safe sleep, prematurity, and farm safety.

The past year has brought several challenges. For most local CDR teams, review meetings were curtailed due to COVID-19 mitigation efforts and to team members' roles being resourced to COVID-19 related work. Only the Philadelphia team was able to continue to review and enter data without interruption. Teams have resumed regular

meeting schedules. Teams were offered assistance in hosting virtual review meetings. BFH hosted virtual review meetings for two teams. Plans for a virtual Annual Resource Building Summit for local CDR teams had to be postponed. Information on various available webinars were shared with local CDR teams. The topics included the new Sudden Unexpected Infant Death Investigation Reporting Form, the new version of the case reporting system and data collection. The State Team continued to meet virtually and reviewed data from the 2020 Annual Child Death Review Report in addition to receiving regular updates on SUID/SDY data.

The BFH also aims to prevent childhood injury through concussion prevention and management training and protocols in youth sports. The goal of the Safety in Youth Sports Program (SYSP) is to educate and train personnel involved in youth sports, both school-based and club-based, regarding general traumatic brain injury (TBI) knowledge, concussion prevention, concussion identification, and concussion management. Target personnel included medical providers, school and club coaches, school nurses, parents, athletes, and students. In 2020, this program faced significant barriers due to COVID-19 related school closures and cancellations of athletic activities. Despite these challenges, the program was able to adapt trainings to be delivered virtually and ten (10) trainings were conducted with diverse audiences reaching 879 individuals. Twenty-three (23) individuals took training to obtain their certifications as ConcussionWise Instructors. Because of the decrease in trainings, the program shifted focus to program promotion and raising public awareness regarding concussions and safe Return to Play. The BFH conducts these activities through a grant with the Pennsylvania Athletic Trainers Society.

Lead poisoning is a preventable environmental health hazard and, if not addressed, affects families regardless of race, ethnicity, or socioeconomic status. Nationally, among states with older housing stock, lead-based paint is a significant source of lead exposure in young children. According to the 2019 American Community Survey estimate, PA ranks fifth in the nation for the percentage of housing units identified as having been built before 1950, when lead was most prevalent. In PA lead exposure and lead poisoning disproportionally affect minority children and low-income families. Of the children poisoned, black/African American and Hispanic children are disproportionately represented because, due to inequities caused by systemic racism, they are more likely to be economically disadvantaged. The number of black/African American children poisoned is over 2.5 times higher than the share of black/African American children in the population and the number of Hispanic children poisoned is 1.2 times higher than the share of Hispanic children in the population. Further, the share of white children poisoned is nearly 2 times lower than the share of white children in the population. In 2020, lead abatement or remediation efforts were continued through the federally funded Lead Hazard Control Program (LHCP), which provided funding to local partners to contract with certified lead professionals. The grant, through the Department of Housing and Urban Development (HUD), ran from December 2016 through November 2020. The department worked with partners in targeted high-risk areas across the Commonwealth to identify and remove lead hazards in housing units occupied by low income families with children six years of age and under. The goal of the LHCP is to protect PA's children from the long-term effects of lead poisoning as well as evaluate the overall living conditions within the home to obtain healthier outcomes for PA families.

The LHCP held a total of 383 events in 2020 educating the public about lead exposure and lead poisoning as well as the LHCP and its benefits to families and the community. Throughout the duration of the grant, 268 units were evaluated for LHCP services. Of those evaluated, 125 homes were remediated making them lead safe.

The Department was awarded a new grant from HUD effective September 15, 2020 through March 14, 2024. The total funding amount is $2.9 million with $2.5 million for lead hazard remediation and $400,000 for other healthy homes related services. The Department anticipates making 165 units lead safe with these funds and improving the health and lives of those families and their community.

Furthermore, efforts to reduce lead exposure and lead poisoning in children continued through the Childhood Lead

Poisoning Prevention Program (CLPPP). Utilizing funds received from the Centers for Disease Control and Prevention for a three-year grant (September 2017 through September 2020), the CLPPP partnered with local health departments to implement strategies and activities aimed to strengthen blood lead testing, population-based interventions, and linkages of lead-exposed children to recommended services. Additionally, the CLPPP was awarded funds for a fourth year (September 2020 through September 2021) to continue with the implementation of lead poisoning prevention activities. The BFH continues to operate a toll-free Lead Information Line to provide information and resources on prevention, screening, abatement, and regulatory issues on lead for the citizens of PA.

Bureau staff participate in the Pritzker Children's Initiative subgroup related to lead poisoning prevention. This group consists of participants from state and local government, managed care organizations, housing authorities, hospitals, health systems, home visiting, and other social programs. The initiative aims to increase blood lead screening and referral rates, allocate state funding for remediation services, and engage the public to eliminate lead poisoning in PA's children. Bureau staff also participated in the Maternal & Child Environmental Health Collaborative Improvement and Innovation Network (MCEH CoIIN), a quality improvement initiative which aims to improve the rates of children tested for lead and receiving appropriate follow-up services. While the MCEH CoIIN ended in 2020, the BFH continued to utilize knowledge gained through participation in the CoIIN to assist with quality improvement and collaboration efforts.

Additionally, using Title V funding, the BFH supports a variety of child health focused programs implemented by the ten County Municipal Health Departments (CMHDs). Allegheny County Health Department utilizes the Healthy Families America (HFA) Program to educate parents and families on the importance of well child visits, child development, safety, and nutrition. For 2020 the HFA program enrolled and served over 50 families. The Philadelphia Department of Public Health (PDPH) offers a clinic specifically designed for youth aimed towards improving their health and increasing their knowledge about health-related issues. Staff assess psychological and reproductive needs and offer referrals to clinical, social, and behavioral health services as well as engaging teens in reproductive life planning. In 2020, PDPH served 101 youth through this program. Various school-based programs targeting children's self-esteem, positive body image, and goal setting have also been implemented by the CMHD.

Priority: MCH populations reside in a safe and healthy living environment

NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9

Objective 1: For each year of the grant cycle, the BFH will increase the number of households that receive a home assessment or intervention

ESM: Number of comprehensive home assessments completed

ESM: Number of health and safety hazards identified through comprehensive home assessments

ESM: Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments

One component of child health programming is focused on improving the health and safety of the home environment for the maternal and child health (MCH) populations through the implementation of a holistic home assessment and intervention program which does not fall within typical health or home rehabilitation programming. These home assessments not only identify both safety and environmental hazards in the home but also provide the residents with interventions to decrease or eliminate the hazard. While the living environment is more than the home, that is the

area on which BFH can have an immediate impact. The prevention of injuries through decreased hospitalization for non-fatal injuries is being used to measure these primary prevention methods with improved physical and mental health for the entire family as another expected outcome.
During 2020, the Safe and Healthy Homes Program (SHHP), funded with Title V money, continued as the BFH's second iteration of healthy homes programming that targets regions across the state with the highest injury rates. The SHHP incorporates the American Academy of Pediatrics guidance and interventions to reduce the risks of injuries, and it continues to provide limited housing rehabilitation and education to address safe and healthy home issues. Falls, poisoning, and hot objects are the leading causes of injuries resulting in hospitalizations in PA, especially in the MCH population. Interventions aimed at reducing these hazards to prevent injuries are supported by research that ranges from proven to promising and is offered to families who participate in the SHHP.

The global pandemic had a strong impact on the ability of the SHHP grantees to implement the in-home programming. At the end of March, mitigation orders resulted in a full stop on programming. As different areas of the state opened, there was variation in how each grantee's organization operated to ensure safe operating procedures. More impactful than grantee operations were concern from potential participants about having non-household individuals come into their homes. At the end of the year, all grantees were able to restart in-home programming with many potential participants still hesitant to have in-home services.

One modification to the SHHP service model was to allow grantees to provide primary prevention education and home assessment over the phone. The grantee was able to have the participating family travel inside the home to describe conditions and answer questions to identify hazards. While not having grantee eyes and expertise in the participants' home did not yield the same level of identification of hazards and resulting interventions, it allowed for a continuation of program services despite mitigation closures.

As described below, the SHHP fell short on all the projected evidence-based strategy measures (ESMs) in 2020. Despite not achieving its ESM targets, the SHHP filled a void in services not provided by traditional medical providers or by housing programs. Most notably, all the SHHP grantees engaged staff members in professional development on both soft skills and safety awareness and injury prevention. The ESM data reported includes a combination of in-home assessments completed by grantee staff and the over the phone assessments completed with the participants.

In 2020, 700 comprehensive home assessments were targeted and SHHP grantees completed 336 assessments. While not meeting the target of 5,600 health and safety hazards identified through comprehensive home assessments, the SHHP identified 2,059 hazards. The target was based on identifying eight health and safety hazards per home. In 2020, on average, there were only six identified per home. Not meeting this target is not of great concern as it indicates that the residents were living in homes that were healthier and safer than anticipated. There was a difference in the number of hazards identified during in-home assessments as compared to those identified during the phone assessments at seven hazards and four hazards respectively. Unfortunately, the hypothesis that participants would not fully identify hazards was realized; however, greater involvement in the process resulted in more robust questions and discussion. The SHHP seeks to provide education and prevention, rather than complete response to hazards. The numbers as well as the reports from grantees show they are getting into homes before hazards are large problems. While not meeting the target of performing 3,500 health and safety interventions, the SHHP performed 1,770 interventions. Despite not meeting the overall target ESM, the rate of health and safety interventions in 2020 was five per home assessment, which meets the target of five per home assessment. Combining the results of this ESM and the prior ESM, SHHP was able to address more of the identified hazards per home than originally anticipated.

Previously, SHHP grantees reported an increase in the need for interpretation and translation services. In 2020,

SHHP grantees began reporting on services provided in languages other than English. Not all families who speak a language other than English request translation and/or interpretation services. Eight percent of families who received SHHP services required translation and/or interpretation of program materials. These 28 families received services in Spanish, Arabic, Swahili, Karen, and Dari from a mix of multi-lingual staff, over the phone interpretation, in-person interpretation, and translation of written materials. Paid services cost approximately $350 per family with translation accounting for approximately 75% of those costs. SHHP grantees report higher satisfaction with in-person interpretation as much of the terminology does not make for simple over the phone translation during the in-home assessment.

The BFH continues to serve as a statewide resource on healthy homes providing information and referrals to appropriate organizations.

Child Health - Application Year

I. Overview of Approach to Child Health Domain

While the priorities for the child health domain have changed, existing strategies aiming to reduce childhood injury and death will continue. Over the course of the funding cycle, new strategies will be developed to complement existing efforts on childhood injury and mortality prevention and additional strategies will be identified which address the new child health priority aiming to promote developmental, behavioral, and mental health outcomes among children in Pennsylvania (PA).

II. Other Federal Funding and State-Funded Activities/Future Efforts

While the action plan does not address lead activities and programming, Bureau of Family Health (BFH) staff participate in a variety of activities that support this important component of child health prevention and intervention. Lead exposure remains a concern for children with the major causes of elevated blood lead levels among U.S. children being lead-based paint and lead dust. Houses built before 1978 are likely to contain some lead paint which becomes a problem when it deteriorates or is destabilized during renovations which release lead dust. In 2022, the BFH will continue to explore and apply for additional funding to continue the mission of reducing injury and lead poisoning among the most vulnerable children in PA. Utilizing funding through the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Housing and Urban Development, the BFH, in partnership with local county and municipal health departments as well as other local governments and community organizations to implement primary and secondary prevention strategies to ensure blood lead testing and reporting, enhance blood lead surveillance, improve linkages to recommended services, and develop policies for targeted, population-based interventions with a focus on community-based approaches for lead hazard elimination for children and families in PA.

The BFH will utilize Title V funds in partnership with the Bureau of Health Promotion and Risk Reduction's (BHPRR) Preventive Health and Health Services (PHHS) Block Grant to provide financial support for the Safe Kids PA statewide coalition and County Municipal Health Departments (CMHDs) for Safe and Healthy Communities. In 2019-20, more than 240 coalitions and partner agencies engaged in numerous safety community events, professional trainings, public policy, and media contacts to prevent unintentional childhood injury and death. The BHPRR continued to support the Safe Kids PA coalition but changed vendors from the Central Susquehanna Intermediate Unit 16 to the American Trauma Society of PA in 2021. In addition, the BHPRR continues to leverage funds from the PHHS Block Grant, as wells as funds available through a partnership with the PA Department of Transportation, for nine CMHDs' Safe and Healthy Communities program strategies to prevent childhood injuries:

- Implement local health policies and/or sustainable environmental changes to reduce the prevalence of unintentional injuries.
- Implement evidence-based motor vehicle injury prevention activities focusing on reducing motor vehicle related injuries and deaths.
- Implement policy, systems, or environmental changes supported by evidence-based educational and outreach activities to reduce the prevalence of Adverse Childhood Experiences.
- Implement policy, systems, or environmental changes supported by evidence-based educational and outreach activities to decrease suicide within the community.

Children in PA are also increasingly experiencing trauma and adverse childhood experiences (ACES) early in life. As of 2018-19, 20.6% of children in PA had experienced at least one ACE and ACES were most commonly reported among racial and ethnic minority children and among CSHCN. In 2019, Governor Wolf established the Office of Advocacy and Reform (OAR), which was tasked with the protection of vulnerable populations in PA,

including children. Since then, the OAR launched a think tank to develop a plan to make PA a trauma-informed state. PA was also recently selected as one of four states that will participate in the National Governor Association's Robert Wood Johnson Foundation "Improving Well-being and Success of Children and Families - Adverse Childhood Experiences Learning Collaborative" initiative. Through these efforts, PA aims to develop best practices for addressing ACES and a plan that will aid state and local agencies as they work to use trauma-informed principles to guide decisions. BFH will continue to look for opportunities to leverage the work of the OAR to develop strategies to promote developmental, behavioral, and mental health outcomes among children.

As a result of the 2020 Needs and Capacity Assessment, the BFH identified a new priority which aims to reduce rates of child mortality and injury, especially where there is inequity. The BFH reviewed PA injury death, injury hospitalization, and injury emergency department data to identify the types of injuries as well as age, geographic, and racial and ethnic disparities that injuring and killing young children. The types of injuries that children ages 0-9 experience are preventable for the most part as the largest numbers fall into the unintentional category. As children age, the number of injuries that lead to death and hospitalization decrease and the most common types of injuries shift. Black/African American and Hispanic children were more likely to have an injury result in hospitalization than white children. Injury rates varied widely between counties with no clear causes.

Child injuries decrease when caregivers have positive well-being and low stress. Providing child safety information as part of larger parental supports, such as home visiting, positions the information to be better received, accepted, and implemented. Specific to unintentional injuries, education of caregivers shows increased use of safety equipment and safety practices. Most of the research on this type of education is associated with home visiting programs in the first two years of life. Home safety education provided one-to-one as face-to-face also showed increases in safety practices. These practices were enhanced when free, low-cost, or discounted safety equipment was provided as well as when education is delivered in the home.

By continuing to address factors contributing to injuries and death during early childhood in the home environment, the BFH anticipates a reduction in the child mortality rate and the rate of hospitalization for non-fatal injuries.

The BFH is in the process of the procurement process for the Prevent Injuries in Children (PIC) program to begin in 2021. This primary prevention program combines in-home education and interventions to increase child safety practices including the use of child safety equipment.

PIC will be provided in association with other home visiting programs as an additional and separate component that provides education as well as interventions to families. PIC providers will be required to complete motivational interviewing training to better engage with families as well as training on child injury hazards, prevention, and appropriate interventions. Low-cost interventions will be provided at no-charge to participating families based on their specific child safety needs.

Geographically, counties are ranked for priority based on injury, death, race and ethnicity, and emergency department visits using both rates and numbers. Eight categories were used to establish the county prioritization with data calculated for the combined 0-9 age group and all given equal weight in the ranking and prioritization process. Seven levels of priority were established to award grant funds to ensure that areas in greatest need are prioritized for interventions.

Nearly all counites fall within the seven priority levels; however, funding is only available for ten counties currently. Depending on the level of interest for funding and success of implementation for the PIC program, scalability throughout the state is a possibility in future years.

Objectives and ESMs for this child injury prevention programming are to be determined once final funding awards are established. PIC provider capacity and county specifics will determine targets for the services provided. Challenges in securing data and associated analysis due to the pandemic priorities and mitigation efforts in 2020 unfortunately put the procurement of PIC providers in 2021 behind schedule.

III. Priorities

Priority: Reduce rates of child mortality and injury, especially where there is inequity

NPM 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Strategy: Use Child Death Review data to inform child safety programming

Objective: Annually increase the number of recommendations from CDR teams related to preventing child death that are reviewed for feasibility and implemented each year

ESM: Number of recommendations from CDR teams that are implemented (child health)

PA's Child Death Review (CDR) program was developed to promote the safety and well-being of children by reducing preventable childhood deaths through review and exploration of the factors contributing to these fatalities. This is accomplished through systemic, multi-agency reviews of the circumstances surrounding the deaths of children 21 years of age and under. The BFH utilizes a combination of federal Title V and other federal funds to facilitate the review process, provide training and technical assistance to local teams, facilitate the State CDR Team, and make recommendations regarding prevention programs and policies. The BFH uses these data and team recommendations to inform program goals and interventions.

In 2018, the PA Department of Health (DOH) was awarded a grant by the CDC for the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry. The PA DOH was awarded the grant funds by the CDC based in part on the expectation that Philadelphia Medical Examiner's Office would be receiving part of the funding award to implement the SDY component of the grant. Federal Title V funds will be used to supplement activities for this program and the SUID case registry. The SDY Case Registry gathers information to learn more about young people who die suddenly and unexpectedly. Babies, children, and young adults up to age 21 are included in the SDY Case Registry.

In 2022, the BFH will continue to enhance and strengthen the CDR program through data quality and analysis for both SUID, SDY and CDR cases. PA continues to improve data quality for CDR, SDY, and SUID through training efforts at regional and statewide meetings and targeted technical assistance. To improve the quality of death scene investigations for children who die suddenly and unexpectedly, the BFH will host two statewide trainings on death scene investigations to include doll reenactments. COVID-19 mitigation efforts have pushed this training to Spring 2022. The increased quality of the information available regarding a child's death due to enhanced child death scene investigations will improve the review process and will provide more complete data.

The State CDR Team, which began meeting again in 2018, is tasked with developing policies, training, and recommendations at the state and local levels. The State CDR Team has prioritized developing and delivering Death

Scene Investigation training for local teams and data quality improvement. Local CDR team prevention recommendations are shared with the State CDR team along with an overview of the data to assess if any of the recommendations need state level support. The State CDR Team implemented a new prevention recommendation framework in 2021.

The framework process consists of three steps: assessment; development; and evaluation. The process results in the development of a white paper that is shared with groups or entities with ability for implementation or that are working on similar prevention strategies. Recommendations are also shared within the BFH. The BFH reviews known partner agency programming to see if recommendations can be made to those partners. Assessment includes review of data (CDR data and other relevant data), current prevention strategies occurring in Pennsylvania and other jurisdictions, and best practices.

Using the information learned during the assessment phase, the State CDR team will brainstorm prevention strategies. The strategies will be assessed for effectiveness and feasibility and be made actionable. The team determines the target audience(s) for each white paper. Targeted entities should have the capability to implement/lead prevention strategies or already be involved in developing/implementing similar prevention strategies. The State CDR Team will develop a minimum of one white paper per year. This process will be evaluated by the BFH and the State CDR Team in 2022. The evaluation will seek to streamline processes and to assess effectiveness. Additionally, the BFH will continue to look for opportunities to more widely share the CDR recommendations.

Strategy: Reduce head injury amongst participants in school and non-school related sports

Objective: Annually increase the number of ConcussionWise trainings provided by the Safety and Youth Sports Program to athletic personnel by two per year

ESM: Number of ConcussionWise trainings to athletic personnel

To ensure appropriate protections exist for youth athletes who participate in organized school and non-school sponsored sporting activities, the BFH will provide traumatic brain injury (TBI) education. TBI education will be provided through the Safety in Youth Sports Program, which will include in-person and web-based trainings. The program is designed to promote safe and appropriate removal from play in the event of a suspected concussion as well as evidence-based return-to-play protocol. These efforts help to ensure concussion symptoms are identified early and treated properly and reduce repeat incidence, which often cause more serious head injuries. Trainings will be provided to individuals affiliated with youth sports including coaches, parents, athletes, and school personnel. The program will continue to focus efforts on eliminating health disparities within its target population by ensuring equitable coverage throughout the Commonwealth. The BFH will continue to partner with the Pennsylvania Athletic Training Society on these activities.

Priority: Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs

NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Strategy: 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 State Health Center (SHC)

Objective: Ensure that all SHCs are documenting and reporting all referrals of children ages 0-17, who do not have a provider or insurance, made to medical home within six months

ESM: Percentage of children without a provider or insurance referred to medical homes

BFH partners with the Bureau of Community Health Systems (BCHS) to provide maternal and child health services throughout the state. BCHS oversees the operations of SHCs, located in counties that do not have a local health department. Community Health Nurses located in SHCs will document and report all referrals of children ages 0-17, who do not have a provider or insurance, made to a medical home within six months to establish a baseline. This measure is important to ensure that all children are linked to a medical home so that they continue to receive medical care. The goal is to ensure that health status, which includes mental health, behavioral health, and developmental milestones, remains stable and that children grow into healthy adults.

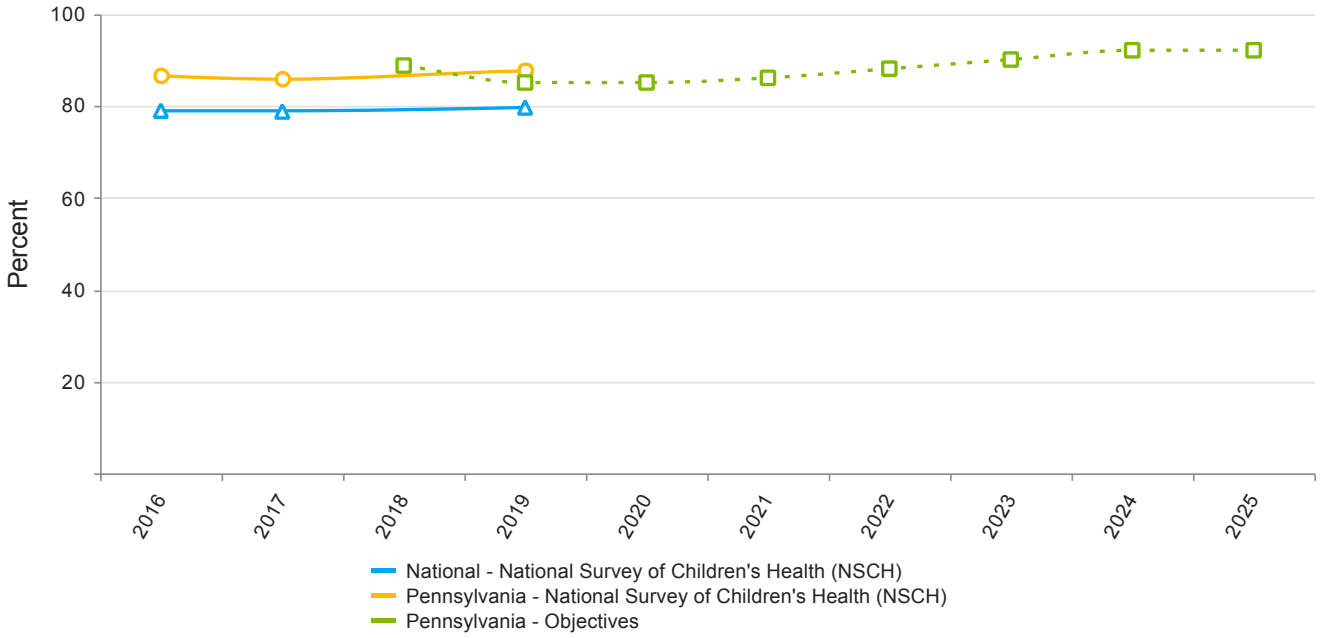
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	27.9	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	7.1	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	9.3	NPM 9 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	21.6 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.1 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	88.8 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	14.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	12.8 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	15.4 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	68.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	77.0 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	93.8 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	94.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	13.3	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			88.7	85	85
Annual Indicator		86.5	85.7	85.7	87.7
Numerator		775,554	715,291	715,291	659,147
Denominator		897,142	834,394	834,394	751,698
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	86.0	88.0	90.0	92.0	92.0	92.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15	18	21	25
Annual Indicator	13	18	15	12	7
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	33.0	35.0	38.0	38.0	41.0

ESM 10.2 - Number of referrals provided to school and community-based resources (HRCs)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4,500.0	4,550.0	4,600.0	4,650.0	4,700.0	4,750.0

ESM 10.3 - Percent of visits that include counseling (HRCs)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

ESM 10.4 - Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.0	45.0	60.0	60.0	60.0	60.0

ESM 10.5 - Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3,880.0	3,880.0	3,880.0	3,880.0	3,880.0	3,880.0

ESM 10.6 - The number of users who accessed the SafeTeens.org site

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10,000.0	11,000.0	12,100.0	13,310.0	14,641.0	15,796.0

ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	360.0	360.0	360.0	360.0	360.0	360.0

ESM 10.8 - Number of substance use and brain injury professionals receiving brain injury and opioid training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	150.0	160.0	170.0	180.0	190.0	200.0

ESM 10.9 - Number of CDR recommendations implemented (adolescent health)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

ESM 10.10 - Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	39.0	43.0	47.0	51.0	55.0

ESM 10.11 - 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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		59.5
Numerator		13,448
Denominator		22,602
Data Source		Grantee reports
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.0	55.0	55.0	55.0	55.0	55.0

ESM 10.12 - The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		9.4
Numerator		2,127
Denominator		22,602
Data Source		Grantee reports
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	9.0	9.0	10.0	11.0

State Performance Measures

SPM 5 - Percent of children ages 6-17 who have one or more adult mentors

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	94.0	94.0	94.0	94.0	95.0	95.0

State Action Plan Table

State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 1

Priority Need

Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

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

Strategies

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

ESMs	Status
ESM 10.1 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services	Active
ESM 10.2 - Number of referrals provided to school and community-based resources (HRCs)	Active
ESM 10.3 - Percent of visits that include counseling (HRCs)	Active
ESM 10.4 - Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization	Active
ESM 10.5 - Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization	Active
ESM 10.6 - The number of users who accessed the SafeTeens.org site	Active
ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line	Active
ESM 10.8 - Number of substance use and brain injury professionals receiving brain injury and opioid training	Active
ESM 10.9 - Number of CDR recommendations implemented (adolescent health)	Active
ESM 10.10 - Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum	Active
ESM 10.11 - 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	Active
ESM 10.12 - The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 2

Priority Need

Reduce rates of child mortality and injury, especially where there is inequity

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Annually increase the number of recommendations from CDR 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

Strategies

Implement Child Death Review (CDR) recommendations as they become available

Young adult and adolescent males will increase their understanding of healthy relationships through evidence-based or -informed programs

ESMs	Status
ESM 10.1 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services	Active
ESM 10.2 - Number of referrals provided to school and community-based resources (HRCs)	Active
ESM 10.3 - Percent of visits that include counseling (HRCs)	Active
ESM 10.4 - Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization	Active
ESM 10.5 - Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization	Active
ESM 10.6 - The number of users who accessed the SafeTeens.org site	Active
ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line	Active
ESM 10.8 - Number of substance use and brain injury professionals receiving brain injury and opioid training	Active
ESM 10.9 - Number of CDR recommendations implemented (adolescent health)	Active
ESM 10.10 - Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum	Active
ESM 10.11 - 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	Active
ESM 10.12 - The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 3

Priority Need

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

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase the percentage of clients who are provided a most effective or moderately effective contraceptive method by 3% by June 30, 2022

Strategies

Increase the number of youth who are receiving sexual health services and education, including effective contraception methods

ESMs	Status
ESM 10.1 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services	Active
ESM 10.2 - Number of referrals provided to school and community-based resources (HRCs)	Active
ESM 10.3 - Percent of visits that include counseling (HRCs)	Active
ESM 10.4 - Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization	Active
ESM 10.5 - Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization	Active
ESM 10.6 - The number of users who accessed the SafeTeens.org site	Active
ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line	Active
ESM 10.8 - Number of substance use and brain injury professionals receiving brain injury and opioid training	Active
ESM 10.9 - Number of CDR recommendations implemented (adolescent health)	Active
ESM 10.10 - Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum	Active
ESM 10.11 - 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	Active
ESM 10.12 - The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 4

Priority Need

Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs

SPM

SPM 5 - Percent of children ages 6-17 who have one or more adult mentors

Objectives

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

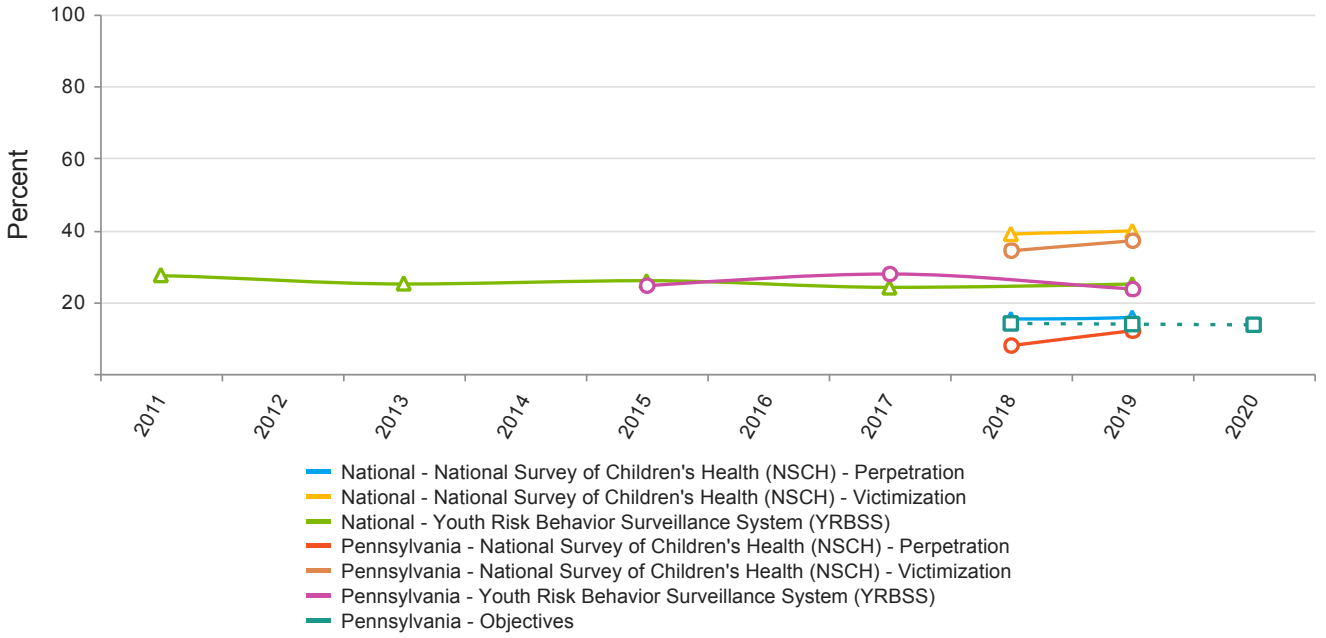
Strategies

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

2016-2020: National Performance Measures

2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	14.5	14.3	14.1	13.9	13.7
Annual Indicator	24.7	24.7	27.9	27.9	23.5
Numerator	122,928	122,928	143,541	143,541	130,221
Denominator	497,526	497,526	514,783	514,783	553,081
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	**2018**	**2019**	**2020**
Annual Objective			13.9	13.7
Annual Indicator			8.0	11.9
Numerator			66,453	94,807
Denominator			835,614	796,529
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2017	**2018**	**2019**	**2020**
Annual Objective			13.9	13.7
Annual Indicator			34.4	36.9
Numerator			287,648	293,739
Denominator			835,614	796,529
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	90	100	100
Annual Indicator	76	83	70.6	55.6	37
Numerator			12	15	10
Denominator			17	27	27
Data Source	quarterly reports	quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 9.5 - Number of evidence-based mentoring programs implemented in high risk areas of PA

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	7	9	11
Annual Indicator	0	0	8	11	10
Numerator					
Denominator					
Data Source	n/a	n/a	n/a	n/a - see field note	n/a
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 9.6 - The number of organizations certified as a safe space provider

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		40	60	80	100
Annual Indicator	20	30	33	34	35
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		150	175	200	230
Annual Indicator	135	368	324	67	0
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	15	15	30	30
Annual Indicator	0	0	0	13
Numerator				
Denominator				
Data Source	n/a	n/a	n/a	grantee reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	250	425	475	525
Annual Indicator	250	425	16,150	14,227
Numerator				
Denominator				
Data Source	n/a	n/a	n/a - see field note	n/a
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: State Performance Measures

2016-2020: SPM 5 - Percent of youth ages 8-18 participating in evidence-based or evidence-informed programs who increased or maintained protective factors or decreased risk factors

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	25	50	55
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	N/A	N/A	N/A	N/A	N/A
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Adolescent Health - Annual Report

The Bureau of Family Health (BFH) provides services to the adolescent health population domain through a combination of Title V funding and other federal funding, as described below. Within the BFH, most adolescent health programs are situated in the Division of Child and Adult Health Services (DCAHS). By administering most adolescent federal grants in the same division, expertise about emerging needs and best practices for the population is easily shared among Title V and other federally funded programs. Based on overall population needs and the existing capacity and accomplishments of other programs, the BFH has developed strategies for the Title V action plan that do not duplicate other funding sources and fill gaps that are not addressed by the existing system of care.

In 2019, the sex and race/ethnicity of Pennsylvania's Adolescent population (n=1,553,565) were distributed as shown in the table below.

2019 Pennsylvania Adolescents (ages 10-19)	
Sex	
48%	Male
52%	Female
Race/Ethnicity	
77%	White
15%	Black
4%	Asian/Pacific Islander
4%	Multi-race
12%	Hispanic

According to 2019 Youth Risk Behavior Surveillance System (YRBSS) data, 40.6% of ninth through 12th grade students in Pennsylvania (PA) responded affirmatively that they, "ever had sexual intercourse." In 2019, 30.4% ninth to 12th grade students reported that they had sexual intercourse with at least one person during the three months before taking the survey. Additionally, 11.4% of ninth to 12th grade students who were currently sexually active reported that they "did not use any method to prevent pregnancy" during their last sexual intercourse encounter. These combined data demonstrate the need for programming on the prevention of pregnancies and sexually transmitted infections, including HIV/AIDS in PA.

In PA, there is a downward trend of teen pregnancy rates and teen birth rates. Despite this trend, there remains a disparity in teen pregnancy rates in PA, particularly by race and ethnicity, as shown in the table below.

2018 Pennsylvania Teen Pregnancy Rates, per 1,000 youth (ages 15-17)	
Race/Ethnicity	
5.2	White
24.6	Black
2.2	Asian/Pacific Islander
17.3	Multi-Race
20.5	Hispanic

The BFH implements several initiatives aimed at addressing the disparate impact of teen pregnancy on racial and ethnic minority youth, and provides parenting supports for youth with the greatest need. The Personal Responsibility

Education Program (PREP), funded by the Administration for Children and Families, educates youth on abstinence, contraception, and adulthood preparation subjects. Evidence-based curricula are implemented in settings including drug and alcohol facilities, residential treatment facilities, and community-based health or human service agencies. During calendar year 2020, 1,683 youth completed an evidence-based program at a PREP facility (a decrease of 41% from the previous year). The decrease was due to many of the programs being implemented in community-based and school facilities that were closed due to the COVID-19 pandemic. The bureau has nine subgrantees that provide PREP programming.

The BFH also utilized Support for Expecting and Parenting Teens, Women, Fathers, and their Families funding from the Office of Adolescent Health. Funding was used for the Support. Empower. Learn. Parenting Health Initiative (SELPHI) program which helped expectant and parenting adolescents and their families navigate key social and health services in Philadelphia. Philadelphia has the highest teen birth rate of any county in PA and ties for the third-highest teen birth rate among the 11 largest counties in the United States. In calendar year 2020, SELPHI served 164 clients, including 56 pregnant women. Federal funding for this program ended on June 30, 2020.

Adverse Childhood Experiences (ACEs) can have lasting effects on one's health and behaviors. ACEs typically fall into three categories: abuse, neglect, and household challenges (e.g., witnessing domestic violence in the home or having a parent or guardian who is incarcerated). The 2018-2019 National Survey of Children's Health reveals that 20.6% of PA children 17 years of age and younger have experienced one ACE, and 18.32% have experienced two or more ACEs.

While ACEs and risk factors are associated with negative health outcomes, protective factors are those characteristics in relationships, communities, and society that lower the likelihood of negative outcomes, or even counter the effects of risk factors. The BFH aims to increase protective factors among adolescents through evidence-based and evidence-informed mentoring programs. The Teen Outreach Program (TOP), funded by the Title V Sexual Risk Avoidance Education Grant, promotes abstinence from sexual activity among youth through an evidence-based approach that aims to affect positive youth behavior change and improve outcomes for youth. The program implements strategies to build protective factors for participants and promote the optimal transition of youth living in high-risk communities from middle childhood to adolescence. A competitive Request for Applications was released in 2019 and sites were selected in Philadelphia, Allegheny, Fayette, Lawrence, and Mercer Counties. There were 33 TOP Clubs in schools during calendar year 2020, serving a total of 859 youth.
Lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) youth face unique challenges, including higher rates of bullying and harassment than their non-LGBTQ peers. The 2019 Gay, Lesbian, and Straight Education Network (GLSEN) National School Climate Survey reports most of the PA's LGBTQ youth regularly heard anti-LGBTQ remarks at school and had been victimized at school. Many LGBTQ youth did not have access to in-school resources and supports. Only 14% of students attended a school with a comprehensive anti-bullying/harassment policy that included specific protections based on sexual orientation and gender identity/expression. Due to the lack of support for these youth, 51% of LGBTQ students who were bullied never reported it to school staff. Among those students who did report bullying to staff, only 22 % said reporting resulted in effective intervention by staff. While these statistics are specific to youth attending school, youth in out-of-home placement experience bullying and harassment at even higher rates. A study found 78% of LGBTQ youth were removed or ran away from their out-of-home placements because of hostility based on their sexual orientation or gender identity. Other research has found that approximately 56% of LGBT youth in out-of-home care have spent some time without stable housing because they felt safer on the streets than in group or foster homes.

According to the 2019 YRBSS, 40.5% of LGB high school students in PA seriously considered suicide (survey participants were only asked about their sexual orientation). Compared with the percentages for heterosexual peers, these numbers are exceptionally high. The survey results showed that 13.7% of straight teens had seriously

considered suicide. Rates are even higher among LGBTQ youth who come from highly rejecting families: families whose behaviors rejected their child's LGBTQ identity, such as preventing a gay youth from attending family events or physically hurting a child because of their LGBTQ identity.

In addition to the aforementioned programming, the BFH began implementation of the Acquired Brain Injury (ABI) and Opioid Training Program, funded by the Title V Maternal and Child Health (MCH) Block Grant in 2019. The ABI and Opioid Training Program was developed to create and deliver a training curriculum that focuses on the correlation of ABI and opioid use/misuse. The BFH contracted with the Brain Injury Association of Pennsylvania to create and deliver training to professionals who serve adolescents and are within the brain injury and drug and alcohol field on a statewide level. Development of the curriculum was completed in 2020 and the first training sessions were scheduled for May of 2020; however, these training sessions were cancelled due to the COVID-19 pandemic. Virtual training sessions were developed with the assistance of the Pennsylvania Department of Drug and Alcohol Programs using their Training Management System. Virtual sessions were conducted in late 2020.

Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages

NPM 9: Percent of adolescents, ages 12 – 17, who are bullied or who bully others

Objective 1: For the duration of the grant cycle, BFH will annually increase the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth

ESM: Percent of adolescent health vendors receiving LGBTQ cultural competency training

PREP grantees are required to attend LGBTQ cultural competency training. In addition, PREP grantees must attend additional LGBTQ-focused trainings: both a "101" that serves as an introduction to LGBTQ issues that may arise during PREP implementation, and an Advanced Topics training, on topics ranging from bullying, to transgender youth, to health disparities. In addition to the PREP implementation sites' training requirements, the BFH offers optional LGBTQ cultural competency training to all adolescent health vendors/grantees. In 2020, 37 percent of currently active adolescent health grantees received LGBTQ cultural competency training, a decrease of 34 percent from the previous year. The COVID-19 pandemic led to the cancellation of all in-person trainings. Therefore, the requirement of many providers to participate was waived as a result. Trainings that had to be canceled or postponed were rescheduled at the end of the year once a virtual model was developed to deliver the training. To continue providing trainings specific to the LGBTQ population, the BFH will partner with the chosen MCH workforce development vendor going forward.

Objective 2: Increase the number of adolescents participating in a bullying awareness and prevention program

In 2019, the BFH was accepted to participate in the Child Safety Network Child Safety Learning Collaborative (CSLC) with a focus on bullying prevention efforts. This collaborative allows the BFH to join a national network of peers to share lessons learned, implement evidence-driven strategies and programs, participate in ongoing trainings, and receive technical assistance from nationally renowned content experts.

ESM: Number of trainers trained in the Olweus Bullying Prevention Program

The Olweus Bullying Prevention Program (OBPP) is the most used bullying prevention program in PA. In addition,

PA has the largest cadre of OBPP trainers in the nation. Clemson University's Institute on Family and Neighborhood Life is the hub for Olweus training and consultation for North America; therefore, BFH staff met with Clemson University and the PA Department of Education staff in early 2017 to determine how the BFH can best support implementation of OBPP and its trainers and address the objective: increase the number of adolescents participating in a bullying awareness and prevention program.

Based on these discussions, the BFH and Clemson University have partnered to develop a program to train and certify community youth organizations (CYOs) to implement OBPP. Thirteen staff from the eight selected CYOs were trained and provisionally certified in the CYO OBPP in February 2020. Program implementation was planned to begin in spring and early summer of 2020. Delays related to COVID-19 including organizational closures and staff furloughs occurred, preventing youth from receiving programming in calendar year 2020.

BFH will continue to report on this ESM in future years, as well as an additional ESM: number of youth participating in the Olweus Bullying Prevention Program at a community-based organization.

Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages

Objective 1: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ sensitive organizations which provide services to youth

ESM: Number of organizations certified as a safe space provider

The BFH continued to support Persad Center (Persad) and Mazzoni Center (Mazzoni) with Title V funds to provide services to LGBTQ youth through June 30, 2020. Persad implemented the Safe Spaces Project, which provided suicide prevention training to youth, and engaged in coalition building activities with known ally organizations and new partners to help the organizations become Safe Space certified. To address ESM 9.6 (the number of organizations certified as a safe space provider) in calendar year 2020, Persad provided one organization (30 individuals) with training to become Safe Space certified; however, due to COVID-19 and state closures, the facility had to lay employees off and suspend this certification. There were 127 youth who took advantage of the Safe Spaces provided by Persad in 2020, 384 fewer youth than were reached last year.

Mazzoni provided training on health disparities related to sexual orientation, gender identity and appropriate standards of care for LGBTQ individuals and LGBTQ cultural competency training to medical, behavioral health and social service providers. During calendar year 2020, Mazzoni trained 611 participants in cultural competency and health disparities. The number of trained participants has decreased from the previous year due to COVID-19 and only being able to provide services for three months. The services were suspended in March and they were unable to provide services for the duration of the grant. The Grant ended June 30, 2020. Mazzoni was able to provide training to sixteen community-based organizations, including county agencies and hospital programs. Mazzoni continued to utilize electronic training evaluation forms and complete training needs assessments before providing trainings to tailor them to the audiences Mazzoni is serving.

This ESM will no longer be reported on after 2020. There will be a new ESM created to include new LGBTQ programming focusing on evidence-based or evidence-informed behavioral health services, suicide prevention and substance use prevention.

Objective 2: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ youth who have access to suicide prevention interventions

ESM: Number of LGBTQ youth receiving evidence-informed suicide prevention programming

The BFH provided Title V funding to Persad to implement the Yellow Ribbon Suicide Prevention Program. They were unable to reach any youth from January 1, 2020 to June 30, 2020. Persad staff report that this training has been in less demand due to the "Safe 2 Say Something" programming that is being implemented in schools across the state. "Safe 2 Say Something" is a violence prevention program run by the Pennsylvania Office of Attorney General that provides a confidential way to report potential safety concerns, including recognizing suicide warning signs. Additionally, schools were shut down in March of 2020 due to the COVID-19 pandemic and this made it difficult to reach youth as schools tried to implement remote learning. Persad implemented the Yellow Ribbon Suicide Prevention Program within their Signs of Suicide program, an evidence-informed intervention that is modified to be LGBTQ inclusive. The Signs of Suicide program included screening and education and aimed to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes towards suicide and depression, and increase help-seeking behavior among youth. Persad utilized this program in schools and community centers throughout Allegheny and Washington counties. The program was also used to raise awareness of suicide prevention in the community. Signs of Suicide has been shown to significantly lower rates of suicide attempts and increase youths' knowledge of depression and suicide. The program demonstrates significant reductions in self-reported suicide attempts.

This ESM will no longer be reported on after 2020. The Grant ended on June 30, 2020. There will be a new ESM added to include new LGBTQ programming focusing on evidence-based or evidence-informed behavioral health services, suicide prevention and substance use prevention.

Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages

SPM: Percent of youth ages 8-18 participating in evidence-based or evidence-informed programs who increased or maintained protective factors or decreased risk factors

Current mentoring grantees are unable to accurately collect and report the percent change in protective factors or risk factors influencing positive youth development and health outcomes. Each mentoring grantee is implementing an evidence-based or evidence-informed model unique to their agency, and uniform data collection is not feasible. As such, this SPM will be discontinued and a new measure corresponding to this work was developed. The new SPM is described in greater detail in the application narrative.

Objective 1: Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling, and adult supervision programs

ESM: Number of youth participating in evidence-based or evidence informed mentoring, counseling, or adult supervision programs

Objective 2: For the duration of the grant cycle, the BFH will annually increase the number of evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages 8-18

ESM: Number of evidence-based programs implemented in high risk areas of Pennsylvania

The benefits of youth forming supportive, healthy relationships between mentors and mentees are both immediate and long-term. Increased high school graduation rates and a better attitude about school; overall healthier relationships and lifestyle choices; higher college enrollment rates and higher educational aspirations; higher self-esteem and self-confidence; improved behavior, both at home and at school; stronger relationships in part due to improved interpersonal skills; and decreased likelihood of initiating drug and alcohol use are all outcomes that can be obtained through effective mentoring programs for youth.

The BFH awarded three grants to implement youth mentoring programming. Three organizations, Big Brothers Big Sisters Independence Region, City Year Philadelphia, and Students Run Philly Style began program implementation in January 2018 and were selected based on their ability to increase protective factors in the target population and their capacity to reach youth. In state fiscal year 2020, a total of 12,905 unique youth mentees received evidence-based mentoring from 592 mentors. This did not meet the goal of 15,270 youth outlined in the mentoring grantees' work statements due to COVID-19 causing closures and shifts to virtual programming along with slight changes in reporting. The mentoring grantees' work statements do not specify unique youth. In prior reporting periods, youth may have been counted multiple times if they received multiple forms of mentoring. Reporting changes were made in state fiscal year 2019 to collect data on unique youth served.

A comprehensive LGBT health needs assessment conducted by Bradbury-Sullivan LGBT Community Center revealed that the LGBT community in the Lehigh Valley has the highest obesity rate in PA when compared to other LGBT respondents across Pennsylvania. Additionally, two-thirds of youth served by Bradbury-Sullivan are LGBT youth of color who are at increased risk for obesity and Type II Diabetes. To address this disparity, the BFH partnered with Bradbury-Sullivan to implement the Healthy Eating and Active Living (HEAL) Program with the goals of increasing knowledge about healthy eating and active living and improving the overall health and wellness for participants. The HEAL Program began on April 1, 2018 and provided youth participants with healthy eating and recreational activities on a weekly basis that were guided by adults. Adults also supervised and led a weekly healthy living discussion group designed to facilitate and promote healthy habits. The HEAL program served 29 unduplicated youth in calendar year 2020. Data on unduplicated youth served in calendar year 2020 is incomplete due to the switch to virtual programming when the COVID-19 pandemic began. Multiple virtual platforms were utilized, and youth often used different usernames for each platform. Tracking unduplicated youth was not feasible, so total participation was tracked, totaling 3,811 participant encounters with the program. The HEAL program ended on June 30, 2020.

To increase protective factors among LGBTQ youth transitioning to adulthood, the BFH partnered with Persad Center to implement the Youth Age Opportunity Program (YAOP), funded by Title V. YAOP served LGBTQ youth ages 17 to 24 years old who experienced skill and opportunity barriers to launch successfully into adulthood. Youth were offered screenings and assessments during Persad Center's drop-in hours. This program was piloted in 2019. Persad Center had staff turnover in the beginning of 2020. Due to their grant ending in June of 2020, Persad made the decision to discontinue the YAOP because they were beginning to have issues recruiting youth for this program.

In 2018, BFH developed a program in partnership with the Pennsylvania Coalition Against Domestic Violence (PCADV) to address healthy relationships and intimate partner violence. Funded with Title V funds, the program titled Healthy Adolescents Promoted by Partnerships for Youth (HAPPY) was operational in Delaware and Lawrence Counties. Services began in the summer of 2018. HAPPY engaged community-based adolescent health providers and reproductive health providers to accomplish three goals: 1.) Decrease the incidence of adolescent relationship abuse in PA through improved case identification and clinic based direct assessment/interventions; 2.) Increase

adolescent health and safety by promoting healthy relationships; and 3.) Improve core and other community partners' capacity to prevent adolescent relationship abuse. Community teams, located in the individual counties, met with youth to assess for incidents of adolescent relationship abuse using evidence-based practices and educational materials. The primary point of contact for youth was through school personnel, who was usually the school nurse. Appropriate referrals were made to medical professionals and domestic violence agencies when necessary. The community teams also provided outreach services in the schools and communities to inform youth and adults about available services.

A total of 298 youth was reached in calendar year 2020 either through medical clinical visits, educational and outreach activities, or warm referrals for family planning or domestic violence services. The HAPPY program ended in June of 2020, therefore the total number of youth reached represents only a portion of the calendar year. Also, the switch to virtual learning in schools in March of 2020 due to the COVID-19 pandemic impacted the number of youth who could be served. No youth were reached by the HAPPY program once the switch to virtual learning occurred.

There was also a State Leadership Team (SLT) within the HAPPY program which was comprised of individuals from across the Commonwealth and served as an advisory committee to the community teams. The SLT met quarterly and worked towards assisting the community teams with program implementation and providing any additional technical assistance requested by the community teams. There was also an evaluation team from the Children's Hospital of Pittsburgh which was evaluating the HAPPY Program. The evaluation team collected program specific data including number of youth served by provider type, number of adolescent relationship abuse prevention cards distributed, and number of warm referrals made. The data was then analyzed to take a more qualitative approach to programming and to look at areas which may have needed additional support.

The SLT continued to meet during the pandemic and aided the evaluation team and the community teams to prepare for final program evaluation. Overall, final data extracted showed that most partners in the project felt more equipped to discuss adolescent relationship abuse after participation in the project. It was also determined that educational material distribution and protocol development between community teams indicated the likelihood of more youth understanding where to go and who to reach out to when feeling unsafe in a relationship.

In 2020, the BFH continued to work with the Ed Snider Youth Hockey Foundation to implement the Male Involvement Initiative program and address intimate partner violence. The program utilizes the Coaching Boys into Men (CBIM) curriculum to promote violence prevention, greater gender equity and respectful and non-violent relationships with dating partners. The Foundation has provided CBIM to adolescent and young males during their NEXT SHIFT life skills hockey program and 136 individuals were served during 2020.

When combining numbers reached for all programs within the ESM: number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs, a total of 14,227 youth were served in reporting year 2020 The 2020 goal is 525 youth served. This goal was underestimated due to being developed prior to the three youth mentoring grants being in place. The 2020 goal for ESM 9.5: number of evidence-based mentoring, counseling or adult supervision programs implemented in high risk areas of PA, was eleven. In 2020, youth were attending programming in 10 counties, all selected for their high-risk, high-need youth populations. The decrease in the number of programs was due to the YAOP ending prematurely.

Moving forward, these two ESMs will be replaced with a measure more focused on mentoring specifically. This ESM was originally created to be utilized for multiple programs, many of which are no longer in existence.

Priority: Adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support

NPM 10: Percent of adolescents, ages 12-17, with a preventative medical visit in the past year

Objective 1: In the first year of the grant cycle, BFH will annually increase the number of counties with an HRC available to youth ages 12-17 either in a school or community-based setting

ESM: Number of counties with an HRC available to youth ages 12-17

Objective 2: Beginning in the second year of the grant cycle, the BFH will annually increase the number of youth ages 12-17 utilizing HRC services

ESM: Number of youth receiving services at an HRC

ESM: In schools with an HRC, the percent of youth within that school utilizing the HRC services

In response to National Performance Measure (NPM) 10 (percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year), the BFH supports teen pregnancy prevention services through AccessMatters, who uses Title V funds to provide a variety of services to high school students through the Health Resource Center (HRC) program. The HRC program provides sexual and reproductive health education, confidential, individual level counseling, screening for chlamydia, gonorrhea, and pregnancy testing, referrals and direct linkages to core family planning services, and distribution of safer sex materials (male and female condoms and dental dams). HRCs are in high schools or clinics near a school and are open during hours that are convenient to youth. AccessMatters operates HRCs in twelve Philadelphia area schools and five Philadelphia area community sites. There are an additional twenty-eight sites in ten additional counties across the Commonwealth. The twenty-eight additional HRCs, considered expansion sites from the original HRCs, operate in areas with high rates of teen pregnancies, STIs and youth leaving school before graduation.

Currently, there are HRCs operating in eleven counties. The counties are Philadelphia, Delaware, Berks, Lackawanna, Lycoming, Dauphin, Allegheny, Fayette, Beaver, Lehigh, and Venango Counties. The goal for ESM 10.1: the number of counties with an HRC available to youth ages 12-17 for 2020, is eleven counties.

In calendar year 2020, the HRCs provided services to 8,975 youth. The goal for ESM 10.2: the number of youth receiving services at an HRC during this period, was 4,500 youth. It should be noted that although the goal for this ESM was met, the number of youth served decreased from previous years due to the COVID-19 pandemic and the switch to online learning for schools.

The goal for ESM 10.3: In schools with an HRC, the percent of youth within that school utilizing the HRC services, was 21 percent. In calendar year 2020, the percent of youth, of all school-based HRCs, who utilized HRC services was 7% percent. Due to the COVID-19 pandemic, community-based sites providing HRC services were able to reach more youth than school sites were due to the switch to virtual learning in school settings.

To increase visibility and youth-friendliness of the HRCs, the expansion sites were given additional funding to form Youth Advisory Boards. The Boards promote the services of the HRCs, design health awareness campaigns, inform HRC services, and ensure HRC services are teen friendly. AccessMatters continues to provide training and technical assistance to sites for developing and maintaining Youth Advisory Boards.

The ESMs for the HRC Program are going to be revised for the 2021-2025 Action Plan to better measure the

success of the program. ESM 10.3 will remain, and two new ESMs will be added to capture the number of referrals for youth provided to school and community-based resources as well as reporting on the percentage of visits to an HRC which include counseling.

Objective 3: For the duration of the grant cycle, the BFH will annually increase the number of LGBTQ youth with a medical visit in the past year

ESM: Number of youth receiving services at a drop-in site funded by the BFH

Mazzoni Center provided, with Title V funds, a drop-in health center for youth to obtain a variety of health care and social services. Mazzoni Center held 856 medical visits at their drop-in health center in calendar year 2020. This was 2,308 fewer visits than last year. Moreover, 1,605 youth received case management visits (3,197 less youth than calendar year 2019), and 1,318 unduplicated youth received one service. Mazzoni Center's grant ended June 30, 2020. There were only two quarters of data recorded due to the grant terminating and less youth being seen during the last quarter due to the onset of the COVID-19 pandemic. This will be the last year this ESM will be reported on.

Objective 4: Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit

ESM: Number of youth receiving health education and counseling services from a reproductive health provider

In April 2019, the BFH increased the age limit for adolescents eligible for Title V services from 17 years of age or younger to 21 years of age or younger to provide more adolescent clients with reproductive health counseling services. In calendar year 2020, BFH provided 23,218 adolescents with services, far exceeding the goal of 15,375 youth served and increasing reach by 1.5 percent over the previous year. The BFH periodically reassesses the scope of services that are billable to Title V. In 2018, the family planning councils reported that more youth are obtaining services under their parents' insurance plans or are otherwise able to pay for services. For youth who are unable to pay, there is a wider range of services needed than were previously allowable. As such, the list of allowable billing codes grew.

Two new ESMs will also be added to address the number of adolescents provided with the most effective or moderately effective contraceptive method, as well as those provided with Long-acting Reversible Contraception (LARC). Inclusion of these updated measures will enable the BFH to provide reporting requirements that are consistent with those required by Title X.

Maternal and Family Health Services, a family planning provider, continued their promotion of the SafeTeens Answers! text line. Staffed by Planned Parenthood of the Rocky Mountains, youth can text their sexual health and healthy relationship questions to the text line and receive a complete, age-appropriate, and medically accurate response within a few hours. Referrals to the appropriate hotlines are also provided if a texter identifies a need for prenatal care, LGBTQ support, suicide intervention, or information on rape, abuse, or neglect. During calendar year 2020, 1,918 texts were received, and 1,043 responses were subsequently sent. Additionally, 204 teens were referred to in-person services. The most common question topics were pregnancy related, including how to know if one is pregnant and identification of the most effective birth control method. Identification of sexually transmitted testing sites, as well as where to obtain emergency contraception were also very commonly requested.

This ESM will no longer be reported on after 2020. There will be several new ESMs which will more accurately reflect

work being done by the BFH. Going forward, the BFH will be monitoring and reporting on the number of youth accessing the SafeTeens.org site, as well as the number of referrals made for in-person counseling and health services to adolescents as a result of texts received through the Safe Teens Answers! text line.

Adolescent Health - Application Year

I. Overview of Approach to Adolescent Health Domain

The Bureau of Family Health's (BFH) approach to addressing Adolescent Health will be evolving to address two new priorities: reducing rates of child and adolescent mortality and improving mental, behavioral, and developmental health outcomes. The BFH will aim to increase access to mental health services, increase protective factors, and utilize other strategies to provide adolescents in Pennsylvania (PA) with the supports they need.

As part of this effort, the BFH is evaluating the extent to which new and existing programs advance adolescent health priorities in the state. In addition to assessing program efficacy, the BFH is also seeking public input on strategies that stakeholders perceive as important within their communities or networks of care. The public input survey conducted as part of ongoing needs assessment activities is one way that the BFH seeks public feedback on special topics or strategies and, this year, the survey asked respondents for their feedback on two specific adolescent health strategies: community-based mentoring programming and sexual health services at drop-in centers in schools. This type of feedback will be useful as the BFH continues to assess and adapt programming to meet the ever-changing needs of adolescents in the state.

II. Other Federal Funding and State-Funded Activities/Future Efforts

In addition to Title V-supported activities, the BFH addresses disparities in teen pregnancy and teen birth rates through the Personal Responsibility Education Program (PREP). Funded by the Administration for Children and Families, PREP aims to reduce teen pregnancy rates among youth who have disparate risks and educates youth on abstinence, contraception, and adulthood preparation subjects. Evidence-based curricula are implemented in settings serving at-risk, high-need youth including drug and alcohol facilities, residential treatment facilities, and community-based health or human service agencies.

The BFH also implements the Teen Outreach Program (TOP), funded by the Title V Sexual Risk Avoidance Education Grant. TOP promotes abstinence from sexual activity among youth through an evidence-based approach that aims to affect positive youth behavior change and improve outcomes for youth. The program implements strategies to build protective factors for participants and promote the optimal transition of youth living in high-risk communities from middle childhood to adolescence.

Suicide rates in PA have increased by 34% from 1999-2019. In May of 2019, Governor Wolf announced the establishment of a statewide Suicide Prevention Task Force which was responsible for developing a statewide strategy to prevent suicide and promoting resources and training. The task force's initial report indicated that mental health and wellness services as well as suicide prevention strategies are needed among school-aged youth and adolescents.

III. Priorities

Priority: Improve mental health, behavioral health and developmental outcomes for child and youth with and without special healthcare needs

NPM 10: Percent of adolescents, ages 12-17, with a preventative medical visit in the past year

Strategy: Improve the mental and behavioral health of youth while increasing access of care for youth

through Health Resource Centers (HRCs)

Objective: Annually increase the number of youth ages 12-17 utilizing HRC services by two percent each year

ESM: In schools with an HRC, the percent of youth within that school utilizing the HRC services

ESM: Number of referrals provided to school and community-based resources

ESM: Percent of visits that include counseling

Medically accurate education and counseling services will continue to be provided through Health Resource Centers (HRCs). Services provided include sexual and reproductive health education, confidential individual counseling, screening for sexually transmitted infections (STIs), pregnancy testing, referrals and linkages to family planning services, and distribution of safer sex materials, such as male and female condoms and dental dams. HRCs are primarily located in school settings, but a small number are also located in clinical community-based programs in areas where schools are not an option due to varying reasons. The services provided through HRCs aim to improve the mental and behavioral health of adolescents and children while improving access to care by adolescents and children in alternative settings such as schools.

AccessMatters is the agency who operates the HRCs through funding from Title V. Currently, there are 45 HRCs operating in 11 counties throughout PA. These counties are Philadelphia, Delaware, Berks, Lackawanna, Lycoming, Dauphin, Allegheny, Fayette, Beaver, Lehigh, and Venango Counties. It is anticipated these HRCs will remain operational in 2022 and there will not be any additional HRCs opening unless one of the already existing HRCs closes. All areas where HRCs are operating represent areas with high rates of teenage pregnancies, high rates of STIs, and high rates of youth leaving school before graduation.

HRCs are staffed by an experienced counselor, social worker, or health educator trained to encourage clients' critical thinking around sexual activity and to promote healthy relationships and behaviors regarding human sexuality. Services offered through HRCs will allow youth to develop healthy coping skills when making decisions regarding their sexual and reproductive health. By helping youth develop healthy coping skills when making decisions regarding their sexual and reproductive health, they can improve their mental and behavioral health outcomes. Preliminary results from Pennsylvania's Title V public input survey conducted this year reaffirm the importance of this strategy. Of the survey respondents who answered a question asking about the importance of sexual health services in schools, all respondents indicated that such services were very important (81%), important (17%), or moderately important (2%) in their community or network of care.

Strategy: Improve interpersonal relationships among youth through staff training and implementation of the Olweus Bullying Prevention Program (OBPP) for Community Youth Organizations

Objective: Annually increase the number of community-based organization staff trained in a bullying awareness prevention program by five percent each year

ESM: Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization

ESM: Number of youth participating in the OBPP at a community-based organization

Youth violence and bullying are major public health issues for individuals, families, and communities. Both are complex problems which, over time, can lead to poor developmental, health, and social outcomes for targets, bystanders, and aggressors. Solutions require widespread, sustained prevention and intervention efforts targeting individuals, families, schools, and communities.

There is no single cause of bullying among children. Individual, family, peer, school, and community factors can all place a child or youth at risk for bullying. These factors work individually as well as collectively to contribute to increasing the likelihood a child will bully others. Family risk factors for bullying include a lack of warmth and involvement on the part of parents, overly permissive parenting (including a lack of limits for children's behavior), a lack of supervision by parents, harsh, physical discipline, parent modeling of bullying behavior and victimization by older siblings. Peer risk factors for bullying include having friends who bully and having friends who have positive attitudes about violence. Additionally, some aggressive children who take on high status roles may use bullying to enhance their social power and protect their prestige with peers. Conversely, some children with low social status may use bullying to deflect taunting and aggression that is directed towards them, or to enhance their social position with higher status peers.

The BFH will continue to work in collaboration with Clemson University to improve the bullying prevention infrastructure throughout the Commonwealth. The Olweus Bullying Prevention Program (Olweus or OBPP) model is an evidence-based approach currently being used by school districts across the state. The BFH has an agreement with Clemson University to develop a training and certification program for Olweus in community youth organizations which will supplement current Olweus activities across PA. The BFH selected eight community youth organizations through a competitive RFA. The agreements with the community youth organizations began January 1, 2020 and staff members from each organization were provisionally certified in Olweus in February 2020. Provisionally certified staff members were scheduled to train leadership teams and co-workers and begin implementation of the program in the spring and summer of 2020. The COVID-19 pandemic has resulted in implementation delays as many of the community youth organizations have furloughed staff. Clemson University created a virtual leadership team training for community youth organizations able to use it; however, training of co-workers and implementation continue to be delayed until youth can return to in-person programming. Several community youth organizations began implementation in January and February 2021 and the remaining organizations are planning to begin implementation by summer 2021.

The BFH is planning to issue a competitive RFA in spring 2021 to select five additional community youth organizations to be trained and certified in the OBPP beginning in January 2022.

The BFH will track the number of community-based organization staff trained in OBPP who are implementing the program, as well as the number of youth participating in the OBPP at a community-based organization. A goal of the OBPP is to have all staff at the implementation site trained in OBPP, including direct care staff, support staff, and others, to improve the social climate at that agency.

The BFH has also been participating in the Children's Safety Network Child Safety Learning Collaborative (CSLC) on bullying prevention. This collaborative allows the BFH to join a national network of peers to share lessons learned, implement evidence-driven strategies and programs, participate in ongoing trainings, and receive technical assistance from nationally renowned content experts.

Strategy: Increase protective factors and improve interpersonal relationships for youth through evidence-based or –informed mentoring programs

Objective: Annually increase the number of youth participating in evidence-based or evidence-informed mentoring programs by 50 participants each year

SPM: Percent of children ages 6-17 who have one or more adult mentors

ESM: Number of youth participating in evidence-based or evidence-informed mentoring programs

The National Mentoring Partnership, Inc., recognizes that mentoring as a youth development strategy is not only a proven foundational asset for a young person's successful path to adulthood, but is a cost-effective prevention and early intervention strategy. Research on evidence-based mentoring has indicated children and youth benefit greatly from a caring, sustained relationship with a mentor. Mentoring may positively impact social-emotional development, behavioral/risk-related behavior, and academic performance. By utilizing mentoring programs to support positive youth development among youth particularly at risk for poor developmental and health outcomes, BFH intends to provide youth with the building blocks to become healthy, caring, and responsible young adults.

The BFH issued one statewide RFA for agencies to implement mentoring programs in 2017. This RFA process was a competitive bid method to ensure the most qualified agencies are selected to provide high-quality programming. Three organizations, Big Brothers Big Sisters Independence Region (BBBS IR), City Year Philadelphia, and Students Run Philly Style were selected because of the competitive bid process. Each organization awarded a grant began program implementation in January 2018, utilizing Title V funds.

Each Youth Mentoring grantee will continue to use evidence-based mentoring approaches to provide opportunities for youth ages 8-18 to increase protective factors. By utilizing frameworks promoting positive youth development, youth will be provided with building blocks for healthy development to help them grow into healthy, caring, and responsible young adults.

BBBS IR will continue to follow the evidence-based Big Brothers Big Sisters of America model to provide mentoring services to youth age 8 to 18. Each mentee will be matched with a mentor to receive one-on-one mentoring with the goals of improving mentee attitudes toward avoiding risk, increasing the number of mentees having a special adult in their lives, and improving educational expectations, social acceptance, scholastic competence, and grades. BBBS IR also plans on increasing staff and mentor knowledge of opiate and substance use issues to reduce mentee substance abuse.

City Year Philadelphia will continue providing mentoring to students ages 8 to 16 in high-poverty, urban schools. Using MENTOR's model, The Elements of Effective Practice for Mentoring, AmeriCorps members will provide academic support, attendance and behavior coaching, social-emotional skill development, positive school climate initiatives, and afterschool programming for youth. City Year Philadelphia hopes to achieve outcomes including increasing the number of youth engaged in schools, increasing the number of students graduating, and decreasing the rates of health problems and engagement in risky behaviors.

Students Run Philly Style will continue to utilize their own evidence-based model which integrates best practices from the Big Brothers Big Sisters of America and MENTOR models. Youth ages 11 to 18 will be matched with a mentor to train for 10k, half and full marathon races with the goals of increasing physical activity, goal setting, resiliency, connectedness with mentors and peers, and participation in positive community activities.

The developmental assets fostered through youth mentoring serve as protective factors to help youth avoid negative

risky behaviors. The positive effects of these protective factors increase as the number of assets a youth has increases. Enhancing the developmental assets of youth and adolescents promotes positive youth development outcomes and provides an opportunity for youth to transition into healthy young adults who can realize their individual potential around critical developmental tasks. Preliminary results from Pennsylvania's Title V public input survey conducted this year reaffirm the importance of this strategy. Of the survey respondents who answered a question asking about the importance of mentoring programs, 83% indicated that they are very important or important in their community or network of care, and 17% indicated that they are moderately or slightly important.

The BFH developed a SPM to measure the success of the youth mentoring programs – percent of children ages 6 to 17 who have one or more adult mentors. Quality mentoring relationships positively influence youth academically and personally, and having a mentor serves as a protective factor for the mentee. The BFH will also track the number of youth participating in evidence-based or evidence-informed mentoring programs. The Youth Mentoring grants are expected to serve a total of 15,270 youth each state fiscal year.

Strategy: Increase protective factors for LGBTQ-identified youth through evidence-based or evidence-informed behavioral health programs

Objective: 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.

SPM: Percent of children ages 6-17 who have one or more adult mentors

ESM: Percentage of LGBTQ-identified youth participating in an evidence-based or evidence-informed behavioral health program who report an increase in positive coping strategies, specifically, support-seeking, problem solving, distraction, and escape strategies over the course of the program period.

Lesbian, Gay, Bisexual, Transgender, and Questioning/Queer (LGBTQ) youth experience a high rate of health disparities compared to their heterosexual peers. They are twice as likely to be excluded, bullied, or assaulted at school, and nearly 40% less likely to have a family member to whom they can turn to for support. Increasing protective factors, including family and community support and easy access to healthcare for LGBTQ youth, can help to decrease the risk for behavioral health concerns including depression, anxiety, substance use and suicidal thoughts and behavior.

The BFH issued one statewide RFA for agencies to implement an evidence-based or evidence-informed mental health, substance use or suicide prevention program for LGBTQ youth ages 12-21 in 2020. This RFA process was a competitive bid method to ensure the most qualified agencies were selected to provide high-quality programming. Two organizations, Hugh Lane Wellness Foundation, Inc., and Students Run Philly Style were selected as a result of the competitive bid process. Each organization began program implementation in October 2020, utilizing Title V funds. Hugh Lane Wellness Foundation Inc. will implement the AFFIRMING Youth Project across Western Pennsylvania. They will utilize the evidence-based intervention, Mental Health First Aid to screen all youth and identify and understand youths' mental health, suicidality, and substance use. Additionally, they will utilize the ALGEE (Assess for suicide, Listen nonjudgmentally, Give reassurance and information, Encourage appropriate professional help, Encourage self-help and other strategies) method to respond to any potential crisis situations that might arise with youth who are referred to the program. Students Run Philly Style will implement their OutRun program with LGBTQ youth in Philadelphia. The program pairs adults with Philadelphia youth as they train together in preparation to run a long-distance race. Students Run Philly Style will recruit 100 adult mentors who will be trained in the evidence-based SRPS trauma-informed and strength-based program that will enhance the mentor and mentee relationship and focus on best practices when working with LGBTQ youth, who make up 19% of youth participants.

Strategy: Increase the dissemination of information to youth through social media and other technology-based platforms

Objective 1: Annually increase the number of users who access SafeTeens.org by 2% each year

Objective 2: Annually increase the number of text messages received on the SafeTeens Answers! text line by two percent each year

ESM: The number of users who accessed the SafeTeens.org site

ESM: The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line

In 2022, the BFH will continue to increase PA adolescents' access to sexual and reproductive health care services by maintaining and expanding SafeTeens.org. The website will continue to provide medically accurate sexual and reproductive health information that connects teens to local health centers. The website provides teen-focused features and updates on several topics including human development, healthy relationships, decision-making, disease prevention, abstinence, sexual orientation, and gender identity all with an emphasis on encouraging teens to utilize local health centers.

Additionally, the BFH will continue to support the toll-free SafeTeens telephone hotline, which is a text-based hotline that fields questions from respondents and provides factual responses and referrals to local community partners as appropriate. Data, including the number of calls received, most often asked questions, number of hits on the website and the most commonly searched topics, continues to be submitted quarterly by the grantee responsible for the management of both the website and the hotline. The BFH will track the number of users who accessed SafeTeens.org and the number of teens referred to in-person counseling or health services through the text line as the key measures of success for these initiatives.

Strategy: 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

Objective: Increase the number of brain injury and opioid trainings provided to substance use and brain injury rehabilitation programs by 1 per year

ESM: Number of substance use and brain injury professionals receiving brain injury and Opioid training

The BFH will continue to provide the Acquired Brain Injury (ABI) and Opioid Training program to deliver a training curriculum that focuses on the correlation of ABI and opioid use. The BFH will partner with an outside entity to deliver training to professionals who serve adolescents and are within the brain injury and drug and alcohol field on a statewide level. The ABI and Opioid Training program will ensure that appropriate health and health related services, screenings and information are available to the MCH population. Through the training program the outcome will be to improve the mental health, behavioral health, and developmental outcomes to adolescents with ABI and opioid use.

Priority: Reduce rates of child mortality and injury, especially where there is inequity

Strategy: Implement Child Death Review (CDR) recommendations as they become available

Objective: Annually increase the number of recommendations from CDR teams related to preventing adolescent deaths that are reviewed for feasibility and implemented each year

ESM: Number of CDR recommendations implemented (adolescent health)

PA's Child Death Review (CDR) program was developed to promote the safety and well-being of children by reducing preventable childhood deaths through review and exploration of the factors contributing to these fatalities. This is accomplished through systemic, multi-agency reviews of the circumstances surrounding the deaths of children 21 years of age and under.

In 2021, the State CDR team began to pilot a new prevention framework. Using available data sources, best practices, local CDR team prevention recommendations and current prevention efforts, the State Team will develop actionable prevention recommendations for prioritized causes of death. The recommendations and the information used to form them will be synthesized into a series of white papers, one for each cause of death. The State Team will develop a minimum of one white paper per year. The white papers will be directed to groups/entities that have resources to implement recommendations or who are already working on similar prevention efforts. The white papers will also be shared internally within BFH and other bureaus in the Department of Health as appropriate, as will applicable local CDR team prevention recommendations.

The BFH will review for feasibility and implement prevention related CDR recommendations to reduce and prevent adolescent deaths and will track the number of CDR recommendations implemented.

Strategy: Young adult and adolescent males will increase their understanding of healthy relationships through evidence-based or -informed programs

Objective: Annually increase young adult and adolescent males receiving trainings through the Coaching Boys into Men Curriculum by 4 each year

ESM: Number of young adult and adolescent males receiving evidence-based or -informed trainings through Coaching Boys into Men Curriculum

The Male Involvement Initiative program focuses on the intimate partner relationship behaviors of young men to increase their knowledge and awareness of Intimate Partner Violence, gender equity and bystander intervention. The Ed Snider Youth Hockey Foundation was awarded a grant to use the Coaching Boys into Men (CBIM) curriculum and tools to teach young male athletes skills to build respectful and non-violent relationships with dating partners, and ultimately, prevent sexual assault and adolescent relationship abuse. Young male athletes engaged in the CBIM program learn about personal responsibility, insulting language, disrespectful behavior, modeling respect, and promoting equality among other important life lessons. Through implementation of CBIM it is anticipated that there will be a reduction in adolescent mortality and injury that could result from interpersonal violence. The Ed Snider Youth Hockey Foundation will continue to incorporate CBIM into their life skills program during their youth hockey seasons throughout the year.

Priority: Support and effect change at the organizational level 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

Strategy: Increase the number of youth who are receiving sexual health services and education, including effective contraception methods

Objective: Increase the percentage of clients who are provided a most effective or moderately effective contraceptive method by three percent by June 30, 2022

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

ESM: The number and 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: The number and percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method

The BFH will continue to partner with the four Title X family planning councils in the Commonwealth to provide adolescents age 21 years and younger with health education and counseling services during a reproductive health visit. The BFH recognizes that adolescents who face prejudice and discrimination because of their life experience or family circumstances may experience a disproportionate rate of teen pregnancy and sexually transmitted infections. By working with the Title X family planning councils per the Quality Family Planning Guidelines (Guidelines) issued jointly by the CDC and the Office of Population Affairs, the BFH will provide opportunities for adolescents to receive additional counseling on how to prevent a pregnancy and communicate with parents/guardians. Recognizing that work with adolescents is most effective when providers fully understand the impact of prejudice and discrimination on vulnerable adolescents, the BFH will continue to fund, through Title V, office visit and counseling codes to allow providers to spend additional time with adolescents during a reproductive health care visit to assess and address their needs and to build on their assets. Counseling should be presented in a teen-friendly environment. The Guidelines also acknowledge, in many cases, a reproductive health visit is the only usual health care adolescents and women are receiving; therefore, it is critical that providers have additional time to spend with adolescents to make sure all of their healthcare needs are being addressed.

The BFH will track the number and 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, as well as the number and percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a long-acting reversible contraception (LARC) method. These measures are in line with the Office of Population Affairs' Title X performance measures and aim to increase women's access to contraception by encouraging providers to ask about clients' pregnancy intentions and informing them of the wide range of contraceptive methods that are available.

Children with Special Health Care Needs

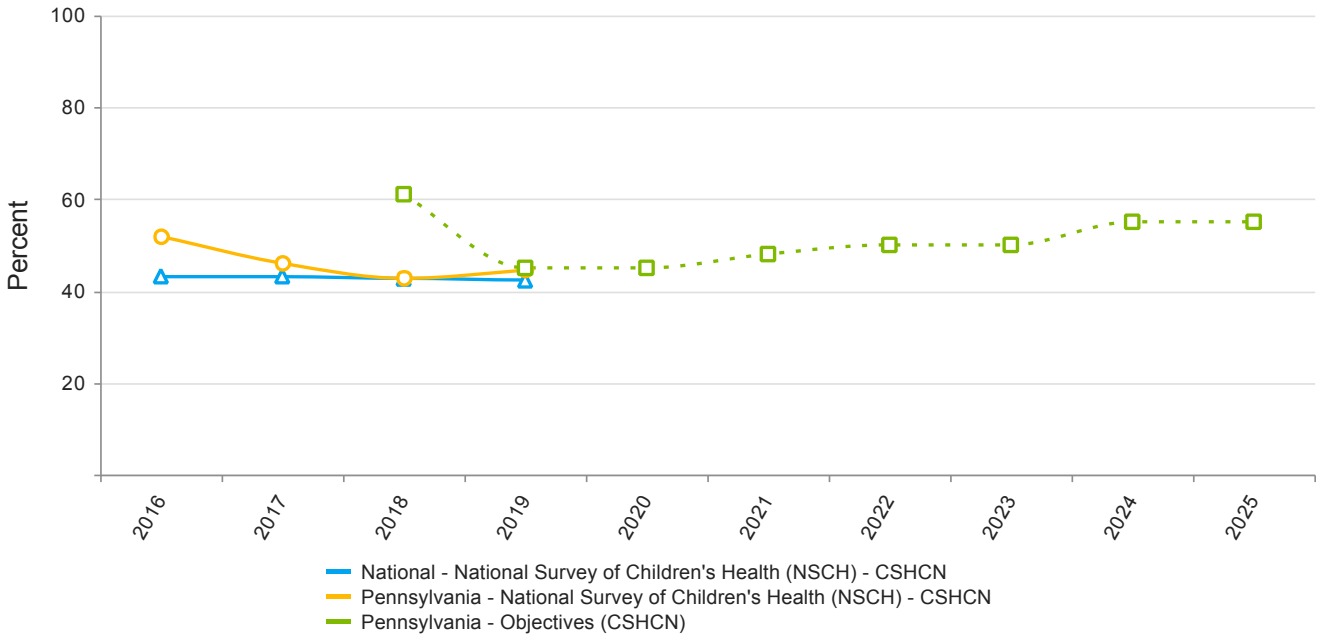
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	21.6 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	53.1 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	88.8 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.0 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			61	45	45
Annual Indicator		51.8	45.9	42.9	44.5
Numerator		267,920	234,614	223,990	244,784
Denominator		517,187	511,324	521,926	549,735
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	48.0	50.0	50.0	55.0	55.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	3.0	4.0	5.0	6.0	7.0

ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	475.0	498.0	523.0	549.0	576.0	604.0

ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	55.0	58.0	61.0	64.0

ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	8.0	8.0	8.0	8.0

ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	43.0	46.0	46.0	49.0	50.0

ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	500.0	515.0	530.0	545.0	560.0	575.0

ESM 11.9 - Number of calls received through the SKN Helpline

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	800.0	825.0	850.0	875.0	900.0	925.0

ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	8.0	8.0	8.0	8.0

ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	44.0	48.0	52.0	56.0	60.0

ESM 11.12 - 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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	19.0	23.0	27.0	31.0	35.0

ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0

State Performance Measures

SPM 3 - Percent of hospitals making referrals to Early Intervention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0

SPM 4 - Percent of eligible infants with a Plan of Safe Care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0

State Action Plan Table

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 1
Priority Need
Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs
NPM
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Objectives
Annually increase the number of recommendations from CDR teams related to preventing CSHCN death that are reviewed for feasibility and implemented each year
Strategies
Prevention recommendations from CDR teams, including recommendations related to addressing trauma will be regularly reviewed and implemented

ESMs	Status
ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)	Active
ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams	Active
ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)	Active
ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs	Active
ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program	Active
ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)	Active
ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic	Active
ESM 11.8 - Number of referrals to BrainSTEPS program	Active
ESM 11.9 - Number of calls received through the SKN Helpline	Active
ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs	Active
ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program	Active
ESM 11.12 - 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	Active
ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes	Active
ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 2

Priority Need

Improve the percent of children and youth with special health care needs who receive care in a well-functioning system

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

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

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

Strategies
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

ESMs	Status
ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)	Active
ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams	Active
ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)	Active
ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs	Active
ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program	Active
ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)	Active
ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic	Active
ESM 11.8 - Number of referrals to BrainSTEPS program	Active
ESM 11.9 - Number of calls received through the SKN Helpline	Active
ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs	Active
ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program	Active
ESM 11.12 - 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	Active
ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes	Active
ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 3

Priority Need

Improve the percent of children and youth with special health care needs who receive care in a well-functioning system

SPM

SPM 3 - Percent of hospitals making referrals to Early Intervention

Objectives

Annually increase the percentage of reported NAS cases receiving a referral to EI

Strategies

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

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 4

Priority Need

Improve the percent of children and youth with special health care needs who receive care in a well-functioning system

SPM

SPM 4 - Percent of eligible infants with a Plan of Safe Care

Objectives

Annually identify and develop collaborative opportunities to share data and trends in NAS reporting and follow-up.

Strategies

Collaborate with the Office of Children, Youth, and Families (OCYF) to help support the enrollment into Plan of Safe Care.

Children with Special Health Care Needs - Annual Report

The mission of the Bureau of Family Health (BFH) is to equally protect and equitably promote the health and well-being of pregnant people, their partners, their children, and all families in Pennsylvania (PA). Children with special health care needs (CSHCN) are children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and health-related services beyond those usually required. The BFH provides services for CSHCN that are family-centered, community based, and coordinated. According to the 2018-2019 National Survey of Children's Health, 20.8% (549,735) of children in PA have a special health care need, exceeding the national average of 18.9%. Of those CSHCN, only 21.6% report receiving care in a well-functioning system in PA. Clearly, there is a significant need for evidence-based programming and services for this population.

Not only are CSHCN a priority within the Title V work carried out by the BFH, but more than two million dollars in state funding in 2020 was allocated to serve children with the following conditions: Cooley's Anemia, cystic fibrosis, sickle cell disease (SCD), spina bifida, hemophilia, epilepsy, Tourette Syndrome, Charcot-Marie-Tooth (CMT) Disease, and services for children who are technology dependent. The BFH's mission for CSHCN is to provide statewide leadership, in partnership with key stakeholders, to create systemic changes at the local, regional, and statewide level to improve health and health related outcomes for at risk individuals and families.

The Specialty Care Program (SCP) consists of 28 grants across 13 grantees (11 hospital systems, and two community organizations). The SCP targets individuals diagnosed with one of five conditions: Cooley's Anemia, cystic fibrosis, hemophilia, sickle cell disease, and spina bifida. The SCP increased access to care, with the goal of improving client health outcomes, by providing comprehensive care coordination, individualized care planning, mental health screening, client engagement, and vocational planning. Identified barriers to care were consistent across conditions; examples include access to reliable transportation, gaps between insurance and services, coordination between care providers, and support to participate in community-based activities. In 2020, the SCP served 10,229 individuals from birth through age 21 years, and an additional 7,130 individuals aged 22 and older through matching state funds.

In 2020, a Request for Applications (RFA) was released to fund grantees for the Child Rehabilitation program for children with neuromuscular and orthopedic conditions. Only one proposal was received and was declined as it did not meet the requirements of the RFA. Understanding the importance of medical care for children with these medical conditions, future programming will be evaluated.

In 2020, a RFA was released to fund the Sickle Cell Community Based Support Services (CBSS) program. The CBSS is replacing the Sickle Cell Community-Based Organization grants that had been in place in previous years. The RFA process resulted in two successful new grants for CBSS. The goal of the CBSS is to assure individuals diagnosed with sickle cell disease and sickle cell trait are supported with collaborative care planning across systems and active within their communities. These grants are designed to enhance communication and service provision between the client and the health care systems, enhance equitable access to services, support client integration into the community, and educate the community on the needs of those with SCD. The Grantees will guide health care systems and communities to act in partnership with clients to bring the full support of the clients' families and community resources to improve care and begin to systemically remediate disparities, alleviate barriers to care, and ultimately improve health outcomes and quality of life for those with SCD.

In 2020, the SCP continued the grantee requirement to dedicate a certain percentage of funds into a Patient Assistance Fund (PAF), addressing critical barriers or needs that affect the client's ability to adhere to treatment or impact the client's quality of life. The intent is for grantees to assist clients and their families by providing immediate

assistance through the PAF, long-term planning and solutions through the treatment plan, and care coordination to eliminate barriers. In previous years, a combination of Title V funds and state matching funds are used to support spina bifida and sickle cell programs and services. State matching funds support the Cooley's Anemia, hemophilia, spina bifida, sickle cell clinics and cystic fibrosis programs, and Title V funds alone support the sickle cell CBSS program.

The Autism Diagnostic Clinic (ADC), through a grant with Easterseals Eastern PA and in collaboration with two children's hospitals in Philadelphia, uses telehealth technology to connect a developmental pediatrician in Philadelphia to a specially trained occupational therapist in Berks County to assess and diagnose children age 18 months to three years of age with Autism Spectrum Disorder (ASD). After being screened using the Modified Checklist for Autism in Toddlers (M-CHAT), children between the age of 18 months to three years of age are referred to the ADC by Early Intervention. Children are then assessed using the Autism Diagnostic Observation Schedule (ADOS-2). The clinic, which began in 2018, continues to increase the number of children evaluated and diagnosed. In 2020, 65 children were evaluated and 57 were diagnosed with autism. Children who are diagnosed with ASD are referred to appropriate services and their families are connected to Applied Behavioral Analysis (ABA) training while they wait for services, education, and community-based services. The use of telehealth in the ADC has provided an opportunity to expedite the diagnostic process and facilitate the initiation of appropriate treatments. The ADC has reduced the amount of time a family waits for assessment and diagnosis for school aged children from around five to eight years to two to three years. The ADC is funded by Title V.

The BFH maintains ongoing, bi-monthly meetings with the Department of Human Services (DHS), Office of Medical Assistance Programs (which houses the state Medicaid program). These meetings are used to improve the systems of care for CSHCN. Topics of discussion include barriers to care, health disparities, and access to Medicaid services. This ongoing collaboration has improved communications between state agencies serving CSHCN, reduced duplication, improved appropriate referrals, and contributes to a well-functioning system of care.

The BFH also provided state matching funds to support outreach and education-based grants for PA residents diagnosed with epilepsy, Charcot-Marie Tooth Disease (CMT), and Tourette Syndrome. Through the Epilepsy Foundation of Eastern PA and the Epilepsy Association of Western and Central Pa., the Epilepsy Program educated first responders, school employees, secondary students, family members, caregivers, and the general public. The program also raised awareness of epilepsy though online and in-person community outreach events and provided epilepsy resources and supports to people with epilepsy and their family members and caregivers.

Charcot-Marie Tooth (CMT) is an inherited peripheral nerve disorder affecting about 1 in 2,500 people. This genetic disorder affects nerves in arms, hands, feet, and legs. Weakness in limbs, hammer toes, and loss of sensation in extremities are common symptoms. The Charcot-Marie Tooth Association (CMTA) received funding to provide education and outreach to increase awareness and knowledge of CMT in Pennsylvania. With the arrival of COVID-19, CMTA reorganized their traditional outreach delivery model, an in-person weeklong children's camp, to a 100% virtual camp. CMTA increased their social media presence with CMT-related education and professional development activities. CMTA produced several professional webinars and educational series for CMT affected individuals, caregivers, and families, and also sponsored in-home lockdown activities for children and youth affected by CMT. The CMTA received a grant for the period of July 2018 through June 2020. Funding ended June 30, 2020 and was not renewed in the state budget.

The BFH works with the Pennsylvania Tourette Syndrome Alliance, Inc. (PA-TSA) to provide support and education to individuals affected by Tourette Syndrome (TS), their families and healthcare and other professionals. The Pennsylvania Tourette's Program is a state funded program and is used as part of the state match for Title V. PA-TSA provides statewide support and community services to promote awareness and understanding of TS. Due to

COVID-19, PA-TSA was unable to hold their annual retreat. Instead, they focused on social media campaigns and updating their website. PA-TSA also assisted the Tourette Association of America to create an urban outreach pilot program in Philadelphia because there are consistently fewer diagnoses of TS in urban areas. The aim is to increase awareness in urban areas by assisting providers to diagnose TS appropriately while also increasing the rate of those diagnosed with TS who seek treatment. If successful, the program will be rolled out to other cities around the country.

The Technology Assisted Children's Home Program (TACHP) is funded through state funds that are used as part of the Title V match and helps the state achieve its goals around providing enabling services for CSHCN that are family-centered, community-based, and coordinated. The program provides for the coordination of care for technology dependent children 0-22 years of age. Technology-assisted refers to the use of a medical device (such as a feeding tube, catheter, EKG monitor, or ventilator) to compensate for the loss or diminished capacity of a vital body function. The scope of the program is to provide comprehensive non-medical services to families, as well as professional training for home health professionals and school nurses. In addition, there is an emphasis on empowering families to become advocates for their children, collaborating with providers and insurance companies, engaging with other families, and moving towards self-sufficiency. TACHP is administered by two grantees: The Children's Hospital of Pittsburgh, covering the western and north-central part of the state, and the Health Promotion Council of Southeastern PA, covering the eastern and south-central part of the state. Maximum program capacity is 270 children, and as of the end of 2020, approximately 106 children were enrolled between the two vendors.

The BFH's Head Injury Program (HIP), funded through state funds that are not part of the state match, provides rehabilitative and therapeutic services to individuals age 18 and over with a Traumatic Brain Injury (TBI). Rehabilitation services are provided in a residential, outpatient or home and community-based setting.

Recognizing the need for rehabilitative and therapeutic services for individuals between age 18 and 21 with non-traumatic acquired brain injury, the BFH implemented the new Acquired Brain Injury Program (ABIP) in July 2020. The ABIP provides rehabilitation services to youth with an acquired brain injury within this age range and is funded by Title V. Services are provided in PA by specialized brain injury providers. Rehabilitation services are offered in an outpatient or home and community-based setting.

The BFH also administers the TBI State Partnership Grant, funded by the Administration for Community Living (ACL). The primary goal of this grant is to maximize the health, independence, and overall well-being of individuals with TBI in PA. The grant provides education, training and technical assistance services to the juvenile justice and older adult population on TBI and screening for TBI, through the grantee Brain Injury Association of Pennsylvania (BIAPA). Throughout PA, 15 juvenile justice trainings were provided to 809 individuals and six older adult trainings were provided to 158 individuals. Through the grant a NeuroResource Facilitation Program (NRFP) has been implemented to connect individuals with TBI to appropriate resources, provided through the grantee Counseling and Rehabilitation, Inc. Throughout PA, 63 individuals have participated in NRFP. The BFH also serves as an ACL mentor state and assists other states with developing return to learn programs and creating programming within the juvenile justice systems in their states.

The BFH administers the Title V funded Special Kids Network (SKN) helpline, an information and resource hotline. The SKN helpline assists providers and parents of CSHCN with accessing statewide and local services and supports. SKN connects families to resources within their community to allow CSHCN to be successful and develop to their full potential. SKN serves children and youth across PA with physical, developmental, behavioral, or emotional needs from birth through age 21. Information and resources provided by the SKN helpline include education, advocacy, housing needs, Medical Assistance programs, waiver programs, transitional resources, equipment and

assistive devices, early childhood and childcare, and other supports and services. In 2020, the SKN assisted 323 CSHCN through the helpline.

The BFH provides a grant with Title V funding to the Parent Education and Advocacy Leadership (PEAL) Center, to implement the Leadership Development and Training Program. The grant with PEAL allows the BFH to strengthen the partnership with PA's Family to Family Health Information Center and to improve upon the systems of care for CSHCN and their families. PEAL conducted youth leadership institutes prior to the pandemic and created weekly youth virtual events during. Youth were instructed on self-sufficiency and how to reach their potential as self-advocates while chatting with other young people. Focus groups were conducted with grandparents raising CSHCN to assist with identifying the need for supports and linkage to resources. In addition, PEAL has partnered with other organizations to plan and deliver a conference for fathers of CSHCN, which will be held in 2021. During 2020, PEAL served 850 CSHCN and 2,731 individuals age 22 and older through outreach.

The County Municipal Health Departments (CMHDs), funded by Title V, offer a variety of programs aimed toward CSHCN. CMHDs provide home visiting services to families with CSHCN if they are referred to the program. In 2020, Chester County Health Department provided home visiting services to over 230 CSHCN and those at risk for developmental delays due to congenital birth conditions, prematurity, mothers with substance use disorder, or mental health issues.

The Chester County Health Department utilizes the evidence-based Ages and Stages Questionnaires (ASQ) developmental screening questionnaire during home visits and makes referrals to Early Intervention as necessary. The home visiting nurses encourage parents and caregivers to focus on stimulation activities and provide education on infant development.

The Philadelphia Department of Public Health (PDPH), through the Medical Home Community Team (MHCT), offer home visiting services to families, with children ages 0 to 21, to address medical and social needs. The MHCT receive referrals from medical homes through the PA Medical Home Initiative (MHI) and partners with the pediatric care team and the child's family to ensure all medical and social needs are met. Services include comprehensive family needs assessment, individualized health education, and referrals and linkages to behavioral health and community organizations. After a comprehensive assessment is conducted with the family, an intervention plan is developed to meet the family's stated goals. MHCT staff supports families until the connection to appropriate care is made and families are better able to navigate through health and social systems. MHCT provides person-centered, family focused, comprehensive, and coordinated supports to enrolled children and their families. The MHCT collaborates closely with MHI staff to promote the program and ensure that the activities of the MHCT do not duplicate those of the MHI. The MHCT collaborated with ten Medical Home practices in 2020 enrolling 57 children and their families. Out of the 57 new enrollees, 55 were identified as CSHCN. The MHCT targets service to CSHCN but serves all children. Due to COVID-19, in person home visiting support was suspended and transitioned to phone and video calls and emails. Despite these efforts, referrals to the program were down almost 50% during the second quarter of 2020. It was determined that this will be the last year that PDPH will implement the MHCT program. PDPH conducted a needs assessment which indicated that stakeholders and families prioritized advocacy, coalition building, and organization of resources over direct services like the MHCT program. Beginning in FY 2021, PDPH will have transitioned all current MHCT participants to other CSHCN programs that will best serve their needs.

Additionally, the PDPH offered mini-grant project opportunities to community organizations. All funded projects were procured through a competitive Request for Application (RFA) process, were under $3,000, and promoted trainings or collaboration to improve systems that serve CSHCN. Projects included work with Easterseals to implement trainings and programs for families outside of normal program times and assist with accessible transportation in an effort to reduce barriers to participation and increase family involvement; animal therapy to help increase social

and motor skills and create a sense of community; a program for CSHCN and their siblings to promote social interaction and friendship; and training and outreach initiatives on Autism Spectrum Disorder and other developmental disabilities. Due to COVID-19, 2020 mini-grant recipients were unable to complete their approved projects and were given an extension to complete those projects in 2021.

The Allegheny County Health Department (ACHD) implemented strategies and activities aimed at reducing lead exposure and lead poisoning in children under 6 years of age in Allegheny County. The goals are to strengthen blood lead level testing, population-based interventions, and linkage of services to lead-exposed children. Prior to COVID-19 and the discontinuation of in-person services, ACHD conducted door-to-door outreach to provide lead education and offer to set up home inspections. These visits were made in targeted neighborhoods identified to be high-risk by the ACHD's Epidemiologists. The Epidemiologists based their assessment on property age, condition of homes, level of education, incidence of elevated blood lead levels, and recent births. The program also conducted outreach and follow-up with children identified with blood levels ≥ 5 µg/dL. The goal is to ensure that these children have a medical home, are connected with early intervention services, if necessary, and families are provided education regarding the risk of lead exposure and prevention and reduction of lead exposure in the home. In 2020, ACHD provided lead assessments to 52 families and lead education to 43 families. Additionally, over 40 lead outreach and prevention events and presentations were provided to the community. Due to COVID-19, in-person services were transitioned to phone and video calls, text messages, and emails to communicate resources and education to families as well as to ensure follow-up. This program was funded by Title V for a one-year period. ACHD will continue their lead prevention and education program utilizing other funding.

Priority: MCH populations are able to obtain, process, and understand basic health information needed to make appropriate health decisions

Objective 1: Annually increase the number of students who are receiving BrainSTEPS and/or Concussion Management Team services

The BrainSTEPS program operates across PA through 28 Intermediate Units (IU) and one school district. The IUs link with school districts to provide individualized support services for students who have had a TBI. BrainSTEPS teams prepare the student and family for return to school post TBI. The teams consist of education professionals, medical professionals, and family members who have received program training, and provide a link between medical and school personnel. There are currently 260 active BrainSTEPS Team members in place to support students. Annual student referrals have shown a decrease due to COVID-19 school shutdowns during the spring. The program has served a total of 5,553 referrals since program inception in 2007, and although the program served 620 students last year, the total of 320 new referrals does not meet the goal of 500 new referrals annually. The BrainSTEPS program expanded its focus to include the needs of students involved in distance and remote learning due to COVID-19, releasing guidelines and best practices that have been disseminated in multiple national conferences. The program also developed new trainings for both teachers and parents to help them meet the needs of students with brain injury engaged in distance learning.

The BrainSTEPS program continued outreach to increase public awareness of the program's services. The Regional Team Lead Facilitator in the Philadelphia area assisted in program promotion, facilitation of new referrals, and BrainSTEPS Team development. A Regional Team Leader provided additional outreach in midwestern PA, focusing on Allegheny County and the Pittsburgh Public Schools region. The BrainSTEPS Program staff provided additional outreach to the hospital and medical rehabilitation community in the Philadelphia and Pittsburgh areas. The program continued to evaluate existing education and training curriculum to ensure the materials are current.

The Concussion "Return to Learn" (RTL) Management Team Model, utilized by BrainSTEPS, has entered its eighth

year. Concussion Management Teams support both student athletes and non-athletes at the local and district level who are returning to school, while also promoting recovery. The Concussion Management Team model was implemented by BrainSTEPS to help manage the increase in concussion reporting following the passage of the Safety in Youth Sports Act. PA was the first state to systematically roll out a program and facilitate RTL Concussion Management Teams. The state of Colorado has adopted the BrainSTEPS model into their educational practice with assistance from PA's grantee. The BrainSTEPS program continued participation in the U.S. Centers for Disease Control and Prevention's (CDC) Evaluation of Return to School Programs for Traumatic Brain Injury, which is designed to identify the RTL program strategies or components that are best suited for widespread adoption. The CDC plans to disseminate the results of the study to demonstrate the effectiveness of RTL programs after traumatic brain injury of all severities (e.g., mild, moderate, and severe) in children.

One goal of BrainSTEPS is to expand the number of Concussion Management Teams based within school districts across PA. There are now over 3,000 Concussion Management Teams providing support for the student and family, an increase of 500 from the prior year. For concussed students who are still symptomatic after four weeks or have not returned to their academic baseline, BrainSTEPS Teams are available to schools to provide more intensive student concussion support, consultation, and training. BrainSTEPS teams are also available to consult with Concussion Management Teams at any time. BrainSTEPS activities are performed by the grantee Brain Injury Association of Pennsylvania.

Priority: Appropriate health and health related services, screenings and information are available to the MCH populations

NPM: Percent of children with and without special health care needs having a medical home

The Title V-funded Medical Home Initiative (MHI) went into inactive status on June 30, 2020. The BFH continued to maintain contact with statewide associations offering medical home services after June 30, 2020 and expected that the medical home network of primary care practices would operate according to medical home principles.

The BFH identified a vendor to carry out an evaluation of the Medical Home Initiative. In early March 2020, the principle investigator and BFH staff participated in a virtual webinar where an announcement of the upcoming Medical Home Initiative evaluation was made. Medical Home Initiative providers were briefed on the plan for evaluation, expected outcomes, and data collection to gather a baseline of Medical Home data. Medical Home sites were also solicitated for participation in the evaluation.

Shortly after the announcement of the evaluation, the governor enacted the stay at home order for the COVID-19 pandemic. Travel to sites was restricted and medical practices were consumed with the pandemic response. It was determined that any data collected during this time period would not be representative of how medical practices typically adhere to the Medical Home Initiative model nor the effectiveness of the model in improving outcomes, but rather a reflection of the current challenges associated with the pandemic occurring in the health care system. As such, the decision was made to cancel the evaluation of the Medical Home Initiative. In the coming year, BFH will explore other strategies to address the priority of increasing the number of CSHCN who receive care in a well-functioning system, including consulting with the Department of Human Services about the roll-out of their Patient-Centered Medical Home Program and identifying potential opportunities for collaboration.

In preparation for the evaluation and restructuring of the MHI, the BFH participated in a short-term Action Learning Collaborative. The American Academy of Pediatrics offered this collaborative to support pediatric primary care practices in collecting social determinants of health (SDOH) data and overcoming barriers to care that clients experienced due to SDOH. The collaborative ran from October 2019 through April 2020.

Objective 1: Starting with reporting year 2015, annually increase the number of pediatric primary care providers (PCPs) engaged in efforts to adopt medical home principles and practices for their populations

ESM: Number of providers participating in a learning collaborative, education and/or, statewide technical assistance

In 2020, the 143 medical home primary care practices (PCP) that reported data to the MHI served approximately 914,487 children and youth. This number was an estimate based upon the client population within those PCPs. Among the clients served by the PCPs, approximately 173,752 were CYSHCN. This number was based upon the estimate that 19% of children in PA have special health care needs. The PCPs served 34.4% of PA's children under 18, which fell short of the goal of 63%; this result was one of the reasons the BFH initiated an evaluation of MHI effectiveness.

The MHI had 382 encounters (e.g., education, technical assistance, meetings, and electronic communications) with medical home PCPs and PCPs considering a medical home approach. This count, which was not unduplicated, fell short of the 2020 goal of 520 encounters.

Objective 2: Starting with reporting year 2016, increase the number of youth/young adults and parents/caregivers who are trained, engaged, supported, and involved at all levels of program planning and implementation of medical home activities

ESM: Number of youth/young adults and parents/caregivers involved in aspects of medical home activities

Practice Coordinators and Parent Advisors offer onsite education, support, and technical assistance to PCPs, and support PCPs who want to achieve national medical home accreditation. They partner with PEAL and other advocacy organizations to facilitate family member/caregiver engagement by showing PCPs how to recruit Parent Partners. Parent Partners serve on PCP transformation teams to assist PCP professionals in medical home adoption. In 2020, the MHI had 202 Parent Partners, which exceeded the goal of 200 participants.

Objective 3: Annually develop a minimum of one collaboration with a child-serving system that involves them in the provision of medical home services

ESM: Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations

The BFH reallocated MHI funding in 2020 to make funds available for the evaluation. Consequently, the MHI prioritized maintenance of medical home PCPs until the program was suspended on June 30, 2020. The MHI did not develop any new collaborations in 2020.

Priority: Appropriate health and health related services, screenings and information are available to the MCH populations

Objective 1: Annually increase the number of families of children with special health care needs (CSHCN) served by the Community to Home (C2H) program

ESM: Number of families who receive services through the evidence based or evidence informed strategies of the C2H program

As of October 1, 2019, the BFH funded two grants for a new program titled Community to Home (C2H) and began implementation in 2020. The C2H program is a home visiting program utilizing an evidence-based Community

Health Worker model to provide care coordination. The BFH is partnering with grantees CareStar and Health Promotion Council to implement the C2H Program. This program provides services to individuals residing in rural Pennsylvania and is available in 48 of Pennsylvania's 67 counties. Due to delays in the contracting process, the first referrals were not received until March 2020. During the first 10 months of service (March-December 2020), C2H received 100 referrals and enrolled and provided services to 53 individuals. The C2H program did not meet its 2020 goal to serve 200 individuals in its first year.

The COVID-19 pandemic impacted the program in ways the BFH did not foresee when developing 2020 goals in 2019. The pandemic has hindered the grantees' ability to conduct effective and meaningful in-person outreach and promotion and parents have been hesitant to engage in home visiting services due to the concern of possibly exposing their child to the virus. Additionally, the C2H program includes eligibility requirements such as: the family must reside in a rural county within PA, the child must be newly diagnosed or be a new resident to PA, the family must meet 300% of federal poverty guidelines, and the child must be 21 years of age or younger. If a referred individual does not meet the eligibility requirements for ongoing service enrollment, the grantees still provide information and resources to families so they can seek support and services through a different avenue.

Objective 2: Annually increase the number of collaborations between systems of care serving CSHCN

ESM: Number of new formal collaborations developed between systems of care serving CSHCN

A collaboration is defined as a partnership between PA's Title V programs serving CSHCN and an organization that results in assisting families with obtaining information or providing support. For 2020, the BFH's goal was to establish two new collaborations. This goal was met.

BFH executed contracts and collaborated with two new grantees, CareStar and Health Promotion Council in late 2019, and began to fully develop and implement the new C2H program throughout 2020. These grantees provide in-home care coordination services to CSHCN using the Community Health Worker model. Throughout 2020, despite the impact of the Covid-19 pandemic, the C2H grantees conducted outreach to over 1000 agencies and entities in order to promote the program, seek referrals and create relationships within the CSHCN service network. CareStar has become a member of the Centre County Human Services Council and seeks other opportunities to join additional councils and community networks. Additional collaborations and partnerships with community resources will be explored throughout the C2H program period.

Additionally, eight of the BrainSTEPS IUs focused on new collaboration efforts during 2020. Some of the notable collaboration efforts in 2020 include Delaware IU#25 collaborated with medical professionals at Children's Hospital of Philadelphia (CHOP) and Al DuPont in the state of Delaware for children who live and attend school in PA. Appalachian IU#8 has conducted trainings for school district personnel, local nursing groups, and athletic trainers. They also recorded a presentation for the Center for Health Promotion and Disease Prevention with the lead physician at this Center being a strong supporter of the BrainSTEPS program. Lastly, Lincoln IU#12 formalized a partnership for referrals from WellSpan Pediatric Neurology. BrainSTEPS will continue to establish new collaborations within its system of care during the program period.

Children with Special Health Care Needs - Application Year

I. Overview of Approach to Children with Special Health Care Needs Domain

Services for children with special health care needs (CSHCN) are an important component of the Title V work carried out by the Bureau of Family Health (BFH). The BFH will continue to provide services for CSHCN that are family-centered, community based and coordinated, as well as evidence-based or -informed. As stated in the CSHCN report section, according to the 2018-2019 National Survey of Children's Health, the percent of Pennsylvania's CSHCN has risen to 20.8, exceeding the national average of 18.9 and, with only 21.6% of those families reporting receiving care in a well-functioning system, much work remains to advance this BFH priority. Strategies related to this priority will address the six core outcome areas for systems of care for CSCHN: 1) Family Professional Partnership, 2) Medical Home, 3) Adequate Health Insurance, 4) Early and Continuous Screening and Surveillance, 5) Easy to Use Services and Supports, and 6) Transition to Adult Health Care. BFH has begun to map state assets associated with each of the six core outcome areas and will use this information to identify system strengths and opportunities for improvement. This information, coupled with research about successful public health services and systems interventions implemented by other states and input from stakeholders, including families and communities, will inform the development of new strategies. Over the course of the funding cycle, additional strategies may be also identified which complement existing work and address new priority on promoting mental, behavioral, and developmental health outcomes.

II. Other Federal Funding and State-Funded Activities/Future Efforts

The ongoing goal of the Specialty Care Program (SCP) is to facilitate improved health outcomes by identifying and removing barriers to care. The SCP includes grant funded programming for individuals with Cooley's Anemia, cystic fibrosis, hemophilia, sickle cell disease (which includes health system-based as well as community-based grants), and spina bifida. Title V funds the sickle cell community-based services and supports grants, and the rest are state match funded. Barriers to services are consistent across SCP conditions and, the SCP is shifting the focus of services to increase system-level change and support. This shift moves from predominantly enabling clinical services and toward improvements in system coordination.

The SCP will continue to require grantees to allocate funds to a Client Assistance Fund (CAF), formerly called the Patient Assistance Fund, to address barriers to care that diminish patients' adherence to treatment and impact their quality of life. The intent is for grantees to provide families with immediate assistance through the CAF, while they overcome long-term barriers via unified care planning, mental health screening, client engagement, and vocational planning. The SCP will continue to pair the revised model with ongoing data collection and evaluation components.

During 2022, the TACHP program vendors will continue to provide coordination of care and work to connect their enrollees with needed resources. In addition, vendors will be working on increasing the level and capability of families to engage and inform the program while avoiding duplication of services with other programs. In addition to the elements listed above, there will be collaboration with BFH Specialty Care Programs to help TACHP to align program goals and expectations as appropriate and in accordance with legislative requirements of the funding. The BFH also will continue its collaboration with the Department of Human Services to identify and work toward filling identified gaps in service for programs serving CSHCN.

State match funds will again be utilized in 2022 to support outreach and education-based grants for individuals diagnosed with epilepsy and Tourette's Syndrome. The BFH will continue to collaborate with Pennsylvania foundations and associations dedicated to these conditions. The Epilepsy Foundation of Eastern PA and the Epilepsy Association of Western and Central PA will maintain their focus on outreach and education to first

responders, school employees, secondary students, family members/caregivers, and the general public.

The Pennsylvania Tourette Syndrome Alliance (PA-TSA), Inc. provides support and education to individuals affected by Tourette Syndrome (TS), their families and healthcare and other professionals. The Pennsylvania Tourette's Program is a state funded program and is used as part of the state match for Title V. TS remains widely misunderstood by the public and misdiagnosed by health care professionals. The BFH and PA-TSA believe it is important to continue to reach out to community organizations to identify and serve underserved populations. Statistical data shows that the rate of diagnosis should be similar across the entire population. PA-TSA will focus on community outreach and engage in in-person and virtual activities to promote TS awareness within Pennsylvania and promote the availability of treatment in an effort increase the rate of treatment. PA-TSA will continue to focus on expanding their social media outreach (Facebook, Twitter, Instagram, YouTube and more) in effort to reach those who primarily rely on these platforms for information such as teens and young adults. Focusing on electronic media has also been key because of social distancing restrictions on large in-person events like retreats.

In 2021, the BFH concluded the Administration for Community Living (ACL), Traumatic Brain Injury (TBI) State Partnership Program Mentor State Funding Grant, in effect from June 1, 2018 through May 31, 2021. The BFH applied for a No-cost Extension in order to complete all planned work that was put on-hold due to COVID-19. The No-cost Extension was in effect from June 1, 2021 through December 31, 2021. The BFH will also have completed an application for the ACL, TBI State Partnership Program Grant, effective from July 1, 2021 through June 30, 2026. If awarded, the BFH will maintain and expand the NeuroResource Facilitation Program in PA along with providing TBI education for professionals, caregivers and family members. NeuroResource Facilitation and the education component will be provided by the grantee Brain Injury Association of Pennsylvania. In addition, BFH will continue to collaborate with ACL and other state grantees to increase the impact of the TBI Program nationally. The overall goal of this project is to create and strengthen person-centered, culturally competent systems of services and supports that maximize the independence and overall health and well-being of people with TBI across the lifespan, their family members, and their support networks.

The BFH's Head Injury Program (HIP), funded through state funds not part of the state match, provides rehabilitative and therapeutic services to individuals with a TBI. To be eligible for the HIP, an individual must be a U.S. citizen, 18 years of age or older, have resided in PA at the time of injury and application, and sustained a TBI after July 2, 1985. The HIP has partnered with the Brain Injury Association of Pennsylvania on a telerehab research project. The purpose of the project is to determine the efficacy and feasibility of providing cognitive rehabilitation via telerehab. Through this project, the BFH is hoping to permanently offer services to its recipients via telerehab thereby improving access to care, especially in rural areas.

The BFH will continue providing services through the Acquired Brain Injury Program (ABIP) that was implemented in July 2020 with Title V funding. The program will provide short term rehabilitation for individuals age 18 through 25 who sustained an acquired brain injury. Specialized brain injury providers will provide rehabilitation in an outpatient or home and community-based setting. In March of 2021, the age limit was expanded from 18 through 21, to 18 through 25. Through this age expansion, the BFH's goal is to reach more individuals with acquired brain injury and meet the needs of an age group with limited rehabilitation resources.

The Parent Education Advocacy and Leadership Center (PEAL) assists families and CSHCN by offering services in six key areas: outreach, individual assistance, resources, trainings, leadership development and partnerships. PEAL is PA's Family-to-Family Health Information Center (F2F) as designated by the Health Resources and Services Administration, Maternal Child Health Bureau. F2Fs are family-staffed organizations that provide support, information, resources, and training around health issues to help families of CSHCN and the professionals who serve them. The BFH provides Title V funds to PEAL to conduct outreach and training to families and CSHCN. PEAL

conducts Parent/Family Leadership Institutes throughout the state. These Institutes allow parents and families of CSHCN the opportunity to learn how to access education, health care and community supports. PEAL conducts Youth Leadership Institutes (YLIs) and maintains a network of youth with disabilities and special health care needs across the state. Youth are instructed on self-sufficiency and how to reach their potential as self-advocates. YLIs will continue to increase as they expand throughout the state and youth participation increases. PEAL also conducts focus groups with grandparents serving as caregivers of CSHCN, which will inform the development of trainings relevant to grandparents of CSHCN and provide support and resources. PEAL reaches out to fathers of CSHCN by planning and partnering with other agencies to conduct a one-day family engagement conference. This conference will give fathers the opportunity to attend trainings, learn about resources, and network with other fathers of CSHCN.

In order to ensure that 30% of PA's block grant funds are dedicated to CSHCN, the BFH implemented a requirement that the county and municipal health departments (CMHD) must allot a minimum of 30% of their total Title V budget for CSHCN. This includes specific programming designed to meet and serve the needs of CSHCN as well as home visiting initiatives that are included in the maternal section. As new grant agreements are developed, BFH will continue to work with the CMHD to assist in determining the best means of serving CSHCN in their communities.

The Philadelphia Department of Public Health (PDPH) will continue to offer mini-grant opportunities for services to CSHCN to non-profit community-based organizations through a competitive RFA process, funded by Title V. The services offered must work to develop collaborations between systems of care serving children and youth with special health care needs. The target population for the project must be located in Philadelphia, with a focus on children with special health care needs between the ages of birth and 21. Projects should respond to needs expressed by Philadelphia families and promote equal rights and equal opportunity. The RFA is released annually and all applicants are required to meet the requirements outlined in the RFA. The proposals are evaluated by a panel of independent reviewers and those that are awarded will be reimbursed for the services provided.

Beginning in 2021, PDPH will establish and maintain a central repository for families and providers of CSHCN by way of a website that will provide systems navigation and resources. A CSHCN program coordinator will follow-up with families as needed and be responsible for reviewing current CSHCN policies and services in the area. Additionally, work with community providers and stakeholders, as well as families, will be done to assess unmet needs, develop new approaches, and facilitate change.

III. Priorities

Priority: Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs

Strategy: Prevention recommendations from Child Death Review (CDR) teams, including recommendations related to addressing trauma, will be regularly reviewed and implemented

By collaborating with Child Death Review (CDR) teams to review data related to trauma and fatality for CSHCN, and by implementing recommendations, the BFH aims to facilitate changes that will promote the safety and wellbeing of children, including CSHCN. Implementing safety and well-being measures will contribute to prevention of adverse health outcomes and mortality, an integral component of a well-functioning public health system for CSHCN and their families. By adopting recommendations that prevent or mitigate the effects of trauma, the BFH aims to improve CSHCN health outcomes over time.

Objective: Annually increase the number of recommendations from CDR teams related to preventing CSHCN death that are reviewed for feasibility and implemented each year

ESM: Number of recommendations from CDR teams that are implemented (CSHCN)

The mission of the PA CDR program is to promote the safety and wellbeing of children and reduce preventable child fatalities. PA's CDR Program continues to explore and pursue opportunities for supporting local teams in their work. The BFH recognizes the importance of evidence-based prevention strategies and the value of effective death reviews to inform those strategies. Through this program, deaths among PA's children can be better understood, and interventions designed to prevent future deaths can be identified.

The 2020 Child Death Review Annual report examines child deaths that occurred in 2018. Of the total 1,063 cases reviewed in 2018, 553 cases, or 52%, the cause of the child's death was due to a medical condition. Through obtaining information from annual recommendation reports and quality data from local CDR teams, the BFH will examine findings of trauma related to deaths of CSHCN and recommendations made for individual cases as well as systemic barriers identified at the local level. The BFH can further review information for feasibility and make additional recommendations about how to utilize those findings to inform prevention strategies and programming within the Department and to support program implementation at the state or regional level.

In 2021, the State CDR team began to pilot a new prevention framework. Using available data sources, best practices, local CDR team prevention recommendations and current prevention efforts, the State Team will develop actionable prevention recommendations for prioritized causes of death. The recommendations and the information used to form them will be synthesized into a series of white papers, one for each cause of death. The State Team will develop a minimum of one white paper per year. The white papers will be directed to groups/entities that have resources to implement recommendations or who are already working on similar prevention efforts. The white papers will also be shared internally within BFH and other bureaus in the Department of Health as appropriate, as will applicable local CDR team prevention recommendations.

Priority: Improve the percent of children and youth with special health care needs who receive care in a well-functioning system

NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Strategy: Families are partners in decision making, and are satisfied with the services received

Family-centered care ensures that the organization and delivery of services, including health care, meet the emotional, social, and developmental needs of children; and that the strengths and priorities of their families are integrated into all aspects of the service system. Family-centered care recognizes that families are the ultimate decision-makers for their children, with children gradually taking on more of this responsibility as they mature.

Objective: Annually increase the number of person-centered plans developed with the BrainSTEPS teams by five percent each year

ESM: Number of person-centered plans developed by BrainSTEPS teams

The BFH, in partnership with Department of Education and the Brain Injury Association of Pennsylvania (BIAPA), has implemented a brain injury school re-entry program called BrainSTEPS (Strategies, Teaching Educators, Parents, and Students) since 2007. The program provides services to any student who has experienced an acquired brain injury or with a prior injury which is still impacting student performance. Once referred, the student receives services from the point of referral through school graduation. BrainSTEPS coordinates collaboration between families and the medical, rehabilitation, and education sectors to ensure students receive care in a well-functioning system. Families

are partners in the development and monitoring of individualized, student-centered care plans. The BrainSTEPS program will continue in 2022 through BIAPA.

BrainSTEPS will continue to provide students, families, school teams and medical providers with consultation to assist the student's transition back into the classroom setting. The program will focus on continuous quality improvement efforts to ensure streamlined collaboration among each student's care team and family. This will allow for CSHCN to receive care in a well-functioning system. Through collaboration with students, their families and the care team, a person-centered plan will be created. Person-centered plans will allow for the student's and family's needs and concerns to be addressed as well as, for the family to be partners in the decision making. To promote consistency of the BrainSTEPS teams, BIAPA will provide training, workshops, and technical assistance to team members to ensure they are following the established program model. BrainSTEPS Team Leaders will establish annual individual team goals for their coverage area. Goal development will include outreach to the medical community. The plan is to increase overall knowledge of the program and build a network within the medical community to ensure students are referred to the program.

The BrainSTEPS program has developed a Concussion "Return to Learn" Management Team Model. This initiative enables schools to take ownership and implement in-house school Concussion Management Teams. These teams systematically improve the effectiveness of the program by ensuring students with mild TBI receive necessary accommodations and appropriate referrals to BrainSTEPS. Program personnel will continue to provide training and technical assistance to Concussion Management Teams on concussion recognition and best practices. The additional support will ensure a designated number of new students are referred to the program along with helping additional school districts implement Concussion Management Teams within their school district.

There is potential for the BrainSTEPS program model to be adopted by other states, as Colorado has already adopted the program and the BFH has received other inquiries. The BFH looks forward to collaborating with and providing assistance to other states who seek to implement "return to learn" programming. The BrainSTEPS program will continue to collect and use programmatic data to help measure the population served, pinpoint additional areas for outreach and aid in overall evaluation of program materials and training curriculum. The program will continue to participate in the CDC Evaluation of Return to School Programs for Traumatic Brain Injury.

Objective: Annually increase the number of families reporting through satisfaction surveys that they were partners in decision making through the Community to Home program by five percent

ESM: Number of Families reporting satisfaction measures through surveys

In late 2019, the BFH implemented the Community to Home (C2H) Program to identify and eliminate systemic issues for CSHCN. Due to delays in the contracting process, referrals were not received until March 2020. The program focuses on populations in rural areas as CSHCN and their families face a variety of barriers to accessing services.

Utilizing the evidence-based Community Health Worker (CHW) model, CHWs are utilized to provide in-home care coordination and education within six rural regions of PA, which include 48 of PA's 67 counties. CHWs engage with families to assess their needs and develop an individualized care management plan with measurable goals. The CHW connect CSHCN and their families to appropriate supports and services to better address their needs. The goal of the C2H program is to provide CSHCN and their families with tools to allow them to become self-sufficient and connect them to appropriate resources. This will assist with improving the percent of children and youth with special health care needs who receive care in a well-functioning system. Also, CSHCN and their families are active members of the care management plan in order for them to be partners in the decision making and express their

satisfaction or dissatisfaction with the services provided. CHWs support families by helping them learn how to navigate the necessary health and human services systems.

The target population includes rural, low-income families of CSHCN with a recent diagnosis as well as CSHCN who have recently moved to or within PA. Families are served using a short-term delivery process, and a needs assessment occurs during the initial home visit. The assessment results along with input from the families, inform the development of a care management plan customized to meet the family's needs. The care management plan consists of goals and necessary steps needed for CHWs to assist families in navigating necessary systems. The CHW provides information and referrals to connect CSHCN and their families to the services needed to succeed in living with their special health care needs. The CHWs work collaboratively with other systems of care to deliver and connect CSHCN and their families to the most appropriate services. Throughout all C2H processes the family and CSHCN will be involved.

At the conclusion of C2H services, families are provided with a client satisfaction survey that measures their engagement and overall satisfaction with the program. The survey also measures if they felt they were partners in decision making when it came to the development of their plan and individualized goals for their family. It is expected that 75% of families will report that they felt they were partners in decision making while enrolled in C2H in 2021, the first full year of the program.

Strategy: CSHCN receive coordinated, ongoing, comprehensive care within the medical system

A quality medical system ensures that children have continuity of care from visit to visit, from infancy through transition into adulthood. In addition, the medical system must be supported to provide care coordination services so that each family and the range of professionals serving them work together as an organized team to implement a specific care plan and to address issues as they arise. Collaboration between the primary, specialty, and subspecialty providers to establish shared management plans in partnership with the child and family, and to clearly articulate each other's role, is a key component of a quality medical system. Equally key is the partnership between the primary care provider and the broad range of other community providers and programs serving CSHCN and their families.

Objective: Annually increase the number of collaborative agreements with medical providers through the Sickle Cell Community-Based program by eight per year

ESM: Number of medical provider collaborative agreements established by the Sickle Cell Community-Based program

The Sickle Cell Community-based Services and Supports (CBSS) program is a Title V funded program that is part of the SCP. The CBSS shifted the focus of services to increase system-level change and support beginning in October of 2020. This change requires the two grantees to identify and develop collaborative agreements with medical care providers across the state. The nature of the collaborative agreements will be based upon the needs of individuals with sickle cell disease and the needs of the care providers, and will be required to support and increase communication between medical care providers (such as health systems, insurance providers, primary care practices, specialist care, mental/behavioral care providers, and other health care providers) to reduce service duplication, streamline referral processes, simplify care plans, and improve information-sharing across care providers. Increased collaboration between care providers will result in individuals experiencing coordinated and comprehensive care, and also allow care providers to improve systems-function through policy and procedural changes.

By 2022, the CBSS will have established a baseline, implemented plans for annually increasing the number of collaborative agreements between the CBSS and medical care providers and a defined expectation to increase the number of agreements so as to maximize participating providers without impacting the quality of cross-system communication.

Objective: Annually increase the percentage of CSHCN receiving quality care through project-funded FQHC health systems.

ESM: Percentage of CSHCN receiving quality care in participating FQHC health systems

The BFH will utilize Title V funds to continue building the Federally Qualified Health Center (FQHC) Program. Through a grant with the Pennsylvania Association of Community Health Centers (PACHC), the FQHC Program funds federally qualified health centers, FQHC look-alikes, Rural Health Clinics, and free clinics to reach CSHCN. PACHC represents the largest network of primary care practices in the Commonwealth, many of whom are medical homes. The program goals are: 1) to improve programmatic, clinical, and operational performance within FQHCs related to CSHCN and 2) to increase CSHCN access to well-functioning, continuous systems of care. The program attains these goals by engaging CSHCN and their families in their care; by screening often and early for mental, behavioral, emotional, and developmental conditions; by referring clients to appropriate services immediately upon positive screens; by increasing access to quality care; and by transitioning CSHCN successfully through all life stages.

Objective: Increase the percent of families who successfully complete the Room2Breathe Asthma home visiting program by three percent annually

ESM: Percent of families who successfully complete the Room2Breathe Asthma home visiting program

Receiving care within a well-functioning system can improve the health status of individuals, families, and communities at large. Health systems depend on a comprehensive and integrated range of clinical and public health interventions that respond to the health problems identified within the community as well as mechanisms to hold providers accountable for access and quality and to ensure that the voice of those receiving services are heard. The Philadelphia Department of Public Health established the Room2Breathe Asthma program in 2019. Partnering with Children's Hospital of Philadelphia, community health workers (CHW) will be trained on the evidence-based program. The team of CHW will provide home-visiting services to families of children diagnosed with asthma. In addition to in-home visits, other methods of communication such as video calls and text messages shall be used to contact families. Services provided through the program include education, medication adherence, care coordination with primary care physicians, referrals to community resources, and environmental assessments to reduce in home triggers. Families will also receive assistance with pest management services and referrals for other identified needs around the social determinants of health. The BFH is choosing to measure the number of children who successfully complete the Room2Breathe Asthma program to assess if the system is functioning well for families with CSHCN, assisting them in obtaining optimal health. Successful completion will be measured by the number of participants who complete the 12-month follow-up visit.

Strategy: Initiate regular meetings and collaboration between the Department of Health and Department of Human Services

The Department of Health (DOH) and DHS each have an integral role in providing services to the maternal and child health (MCH) population. As PA's Medical Assistance administrator, DHS oversees many programs serving vulnerable populations, including CSHCN. Through collaboration, it can be ensured that the DOH is not duplicating services provided by DHS but is preserving Title V funds for otherwise unmet needs of the MCH population.

Objective: Convene quarterly meetings between agencies that provide services related to CSHCN

ESM: Number of meetings held annually between DOH and DHS (CSHCN)

The BFH will continue to collaborate with the PA DHS' Office of Medical Assistance Programs in 2022. Meetings will be held to discuss issues within the system of care for CSHCN, share resources, reduce duplication of services, and ensure that the proper funding sources are being utilized for individuals and families. This collaboration will strengthen the system of care for CSHCN across PA.

Strategy: CSHCN are screened early and continuously for special health care needs

Within the CSHCN domain, screening includes ongoing monitoring and assessment of children and youth to promote health and well-being through family-centered care. It is critical to identify, as early as possible, children in the general population who have special health care needs so that they and their families can receive appropriate services to reduce long term consequences and complications. CSHCN also require ongoing assessments to identify newly emerging issues including developmental and behavioral issues, oral health, and psychosocial issues, and to prevent secondary conditions that may interfere with development and well-being.

Objective: **Annually increase the number of children screened for Autism Spectrum Disorder through the Autism Diagnostic clinic by five each year**

ESM: Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic clinic

In 2022, the BFH will continue expansion of the Autism Diagnostic Clinic (ADC) through the grantee Easterseals Eastern PA, in collaboration with Children's Hospital of Philadelphia (CHOP) and Saint Christopher's Hospital for Children. This program utilizes telehealth technology to increase access to autism evaluations, diagnosis, parent education, and referral for treatment. A third-party entity will be utilized to evaluate the program for overall effectiveness and the feasibility for replication in other areas of the state as well as diagnosing conditions other than Autism Spectrum Disorder (ASD). The ADC currently has the capacity to identify and evaluate children as young as 18 months for ASD, though most are between the ages of two and five years. Once a child is diagnosed, the ADC will provide care coordination services to assist families in enrolling in therapeutic and other services, as well as training families in applied behavioral analysis while services are initiated. By identifying ASD and initiating services early, outcomes across the life span for these children and families can be significantly improved.

By 2022, the ADC will have developed a baseline for the number of children screened within Berks County (the ADC's primary site) and have established an annual expected increase in screenings. The ADC will implement expansion plans into a second county, while also preparing a plan for expansion into a third county by June 2023.

Strategy: Community-based services are organized so families can use them easily

A community-based system of services is an infrastructure that operates across sectors, and multiple service programs – each with its own funding streams, eligibility requirements, policies and procedures – to serve CSHCN. Given this complex structure of systems, it is imperative that Title V funded programs work within communities to facilitate structure and organization of available services.

Objective: Conduct outreach and BrainSTEPs program promotion to increase referrals by 15 per year

ESM: Number of referrals to BrainSTEPS program

The BrainSTEPS program will collaborate with the Department of Education and BIAPA to conduct outreach and program promotion in the community. Families with school-aged children and professionals working with children in

medical and school settings will be the target of these outreach opportunities, to raise their awareness of BrainSTEPS services. Outreach and promotion will continue to focus on increasing knowledge of the program, the population it serves, and how to easily access resources. Increased awareness of the BrainSTEPS program, services, and resources will contribute to the system of care for CSHCN, by allowing earlier identification and treatment of mild TBI, and fewer long-term complications. The BFH, along with partners, will continue to participate in conferences and other outreach opportunities that come available in order to educate individuals on the BrainSTEPS Program.

Objective: Annually increase the number of calls received through the Special Kids Network (SKN) helpline by 25 calls

ESM: Number of calls received through the SKN Helpline

The Special Kids Network (SKN) helpline is housed within the BFH and answered by a program administrator. Funded by Title V, the SKN helpline provides information about resources and services and information on how to navigate different systems of care via telephone. Through the SKN helpline, the BFH is helping families connect with community-based services and understand their organization so that families can use them more easily.

By doing so, the BFH aims to improve the percent of CSHCN who receive care in a well-functioning system. The SKN helpline is also used to receive referrals to the Community to Home (C2H) program. The BFH will collaborate with organizations serving CSHCN to advance PA's system of care for CSHCN that will assist with annually increasing calls. The BFH will use partners such as PEAL, Parent to Parent and the C2H grantees, CareStar and Health Promotion Council, to assist in the promotion of the SKN helpline. The BFH and the grantees will distribute information regarding the SKN helpline and will exhibit at conferences throughout PA.

Objective: Annually increase the number of partnerships engaging community-based providers established by the Sickle Cell Community-Based program by eight per year

ESM: Number of community-based provider partnerships established by the Sickle Cell Community-Based program

The Sickle Cell Community-based Services and Supports program (CBSS) will support and develop partnerships with and between community-based service providers as the CBSS programs shift to systems-level supports. Grantees will seek out new and known community-based service providers to establish new and strengthen existing partnerships. These partnerships will be used to support education and communication related to sickle cell disease within the everyday-living setting (such as education, employment, religious worship, and recreation) and to support increased integration of CSHCN into community activities. The partnerships will also be used to identify impactful social determinants of health and to remediate barriers to care and community integration. Through this work, the CBSS program will be promoting increased interconnectivity and organization of community-based providers, which will also strengthen the overall system of care.

By 2022, the CBSS will have established a baseline, implemented plans for annually increasing the number of collaborative agreements between the CBSS and community-based providers and a defined expectation to increase the number of agreements so as to maximize participating providers without impacting the quality of cross-system communication.

Strategy: Youth with SHCN receive services to make appropriate transitions

The primary goal of Title V in the transition of CSHCN is to improve the system that serves them while simultaneously preparing youth and their families with the knowledge and skills necessary to promote self-determination, wellness, and successful navigation of the adult service system. As adolescents approach adulthood, they take on increasing responsibility for their health and health care. For youth with special health care needs, this transition is especially important, as their medical needs may be complex and they will eventually need to manage their medications and other aspects of their health themselves.

Objective: 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

ESM: Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program

The BFH partners with PEAL to implement the Leadership Development and Training program which provides Parent/Family and Youth Leadership Institutes. PEAL's mission as the Parent Training and Information Center, and Family to Family Health Information Center for PA aligns with a number of the priorities of the BFH. PEAL has the capacity to conduct outreach and deliver leadership development and training activities to youth with special health care needs and their families. The Parent/Family Leadership Institute addresses relationships, sexuality, dignity of risk, and supporting self-advocacy and the Youth Leadership Institute creates a network among peers while building leadership and self-advocacy skills. The BFH along with PEAL will increase the outreach and promotion of the Youth Leadership Institute to increase attendance. By increasing attendance to the Youth Leadership Institute, the BFH and PEAL will be able to reach more individuals and prepare youth for successful transition to adulthood, including adult health care.

Objective: Of youth aged 14 and older being served in Community to Home, 50% will have appropriate transition plans within 6 months of receiving services

ESM: Number of youth 14 and older enrolled in Community to Home program who received a transition plan to transition to adult healthcare

Youth with special health care needs who are of transition age of 14 years and older are a sub-population of CSHCN and face many challenges, including transitioning to the adult health care system. In the Community to Home (C2H) program, individuals enrolled who are 14 years and older have an individualized care plan that includes a transition plan preparing transition to adult health care, independent living, post-secondary education and employment. C2H services support transitioning youth during and after services end through the creation of a comprehensive transition plan. Youth transition plans are reviewed and monitored by the BFH for completeness and thoroughness. The BFH objective for 2022 is that at least 50% of youth 14 years old and over enrolled in C2H have appropriate transitions plans as part of their individualized care plans. The C2H program was implemented in 2020 and began serving youth 14 years of age at that time.

Strategy: 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

Objective: Annually increase the percentage of reported NAS cases receiving a referral to EI

SPM: Percent of hospitals making referrals to EI

ESM: Percent of NAS cases reported within iCMS referred to EI

Newborns exposed to addictive drugs including opioids, benzodiazepines, and barbiturates while in their mother's womb may experience drug withdrawal symptoms known as neonatal abstinence syndrome (NAS). This array of withdrawal symptoms develops shortly after birth because the infant is no longer exposed to the drug for which they developed a physical dependence.

According to research completed by the PA Health Care Cost Containment Council, there were more than 1,833 NAS-related stays in 2018 or 14.4 cases per 1000 births. In addition to longer hospital stays, babies born with NAS were much more likely to experience complications such as low birth weight, difficulty feeding, prematurity, and respiratory distress. Babies born with NAS also may experience long-term health and developmental problems, including hearing and vision problems and learning and behavioral problems.

Under the Governor's emergency disaster declaration for the heroin and opioid epidemic, the Department of Health is authorized to mandate hospitals to report cases of NAS. Initially, cases were reported to the Bureau of Epidemiology. The Division of Newborn Screening and Genetics (DNSG) in the BFH saw the opportunity to begin using the newborn screening internet Case Management System (iCMS) as a long-term solution for the state's NAS reporting repository so that data could be collected and analyzed.

PA birthing hospitals began reporting all NAS cases to the DNSG directly through iCMS beginning January 1, 2020. iCMS is a web-based software application used by the DNSG for case management, tracking the management and follow-up of newborn filter paper and point-of-care screening results for infants born in PA. All PA birth hospitals have an assigned NAS coordinator for their facility who is responsible for reporting all NAS case data into iCMS. All NAS coordinators receive iCMS training so that they are prepared to comply with the mandatory state reporting requirements.

The long-term goal of the DNSG is to develop a NAS follow-up program that will support both mothers and infants affected by NAS. The DNSG will ensure birth facilities are routinely connecting families with health and social services to promote optimal child development and family well-being. The NAS reporting form submitted by birthing hospitals includes detailed information pertaining to the plan of safe care. The DNSG analyzed NAS data collected during 2020 and plans to share the data with plan of safe care coordinators and other state agencies to develop consistent discharge plans of care for all families affected by NAS across the commonwealth. The NAS coordinator will use the data to track trends in NAS and make meaningful comparisons between geographic regions to plan prevention and treatment efforts for women and infants.

The DNSG has created a full-time NAS Nursing Services Consultant position that will focus on monthly technical assistance centered around required reporting data, early intervention (EI) referrals and state-wide assessment of safe plans of care. The NAS consultant will organize and participate in statewide and regional NAS meetings and use information gathered during these meetings in conjunction with the NAS 2021 data reported in iCMS to develop DNSG follow-up policies and procedures along with helpful tools for safe plan of care coordinators. The DNSG will also develop quarterly key performance measure reports to share with PA birthing hospitals that will focus on timeliness of NAS case reporting and percentage of NAS cases receiving EI referrals. The DNSG has a signed memorandum of understanding with the Bureau of Early Intervention to share EI enrollment data.

Strategy: Collaborate with the Office of Children, Youth, and Families (OCYF) to help support the enrollment into Plan of Safe Care.

Objective: Annually identify and develop collaborative opportunities to share data and trends in NAS reporting and follow-up.

SPM: Percent of eligible infants with a Plan of Safe Care

ESM: Frequency data will be shared to enable OCYF and DNSG identify all infants who should have a Plan of Safe Care.

The BFH houses the DNSG, which oversees reporting of NAS cases by all PA birthing facilities. The Bureau of Children and Family Services (BCFS) is primarily responsible for monitoring the delivery of services by county and private children and youth social service agencies. The Office of Children, Youth and Families (OCYF) conducts oversight of these programs from a regional level.

Through a formal collaboration, the DNSG and OCYF could work closely with one another, as they serve the same population and collaborate with the same community partners. Through the identification and development of collaborative opportunities, both entities could share data and explore trends in NAS reporting. The development of a Memorandum of Understanding (MOU) will allow the DNSG and OCYF to enter into a data sharing agreement to compare and develop NAS specific data between programs, specifically in the areas of Plans of Safe Care and Childline referrals. This NAS specific data can be utilized to identify concerns in the development of Plans of Safe Care and Childline referrals for infants identified as having NAS. By combining resources and efforts, these programs can better serve patients and families impacted by NAS.

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	10.0	15.0	20.0	25.0

SPM 6 - Rate of mortality disparity between black and white infants

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.1	8.9	8.6	8.2	7.7	7.2

SPM 7 - Rate of mortality disparity between black and white children, ages 1-4

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.2	10.7	9.7	8.7	6.7	4.7

SPM 8 - Rate of maternal mortality disparity between black and white persons

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	26.4	25.9	25.4	24.6	22.6	20.6

State Action Plan Table

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development

SPM

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

Objectives

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

Strategies

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

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 2

Priority Need

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

SPM

SPM 6 - Rate of mortality disparity between black and white infants

Objectives

Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff

Strategies

Increase staff understanding of Health Equity principles

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 3

Priority Need

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

SPM

SPM 7 - Rate of mortality disparity between black and white children, ages 1-4

Objectives

Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff

Strategies

Increase staff understanding of Health Equity principles

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 4

Priority Need

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

SPM

SPM 8 - Rate of maternal mortality disparity between black and white persons

Objectives

Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff

Strategies

Increase staff understanding of Health Equity principles

2016-2020: State Performance Measures

2016-2020: SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	20	38	56
Annual Indicator	0	1.3	1.3	1.3	0
Numerator			1	1	0
Denominator			79	79	1
Data Source	N/A	BFH internal data collection	BFH internal data collection	BFH internal data collection	BFH internal data collection
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		32	42	55	66
Annual Indicator	29	18	59.6	68.2	91.9
Numerator			28	30	34
Denominator			47	44	37
Data Source	BFH internal data collection	BFH internal data collection	BFH internal data collection	BFH internal data collection	BFH internal data collection
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Cross-Cutting/Systems Builiding - Annual Report

The Bureau of Family Health's (BFH) work within the cross-cutting/systems building domain is focused on the bottom tier of the maternal and child health (MCH) pyramid in the development of public health services and systems. The work of this domain solidifies the foundation and growth of all the programming work throughout the BFH as it is focused on building or enhancing workforce capacity especially related to data, implementing and maintaining continuous quality improvement processes, and strengthening systems and infrastructure to enhance program delivery and address key social determinants of health. The state priorities addressed in the cross-cutting/systems building domain are the following: MCH populations are able to obtain, process and understand basic health information needed to make health decisions; Title V Staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs and; appropriate health and health related services, screenings and information are available to the MCH populations. These priorities incorporate some of the ways the BFH monitors the health status of the MCH populations which include the use of Child Death Review (CDR) teams, Sudden Unexpected Infant Death (SUID)/Sudden Death in the Young (SDY) case registry, and the Pregnancy Risk Assessment Monitoring System (PRAMS). While SUID/SDY and PRAMS receive federal funding from the Centers for Disease Control and Prevention (CDC) which is used to support staffing, Title V funds are used to supplement the provision of these monitoring systems and activities by supporting data collection activities and the implementation of prevention strategies based on findings from all three of these data sources.

For example, in 2020, the BFH provided Title V funds to the Philadelphia Medical Examiner's Office (MEO) to operate the SDY Program. The MEO is responsible for identifying SDY cases in Philadelphia, reviewing the deaths via its CDR Team and Advanced Review Team and entering data from the reviews into the National Case Reporting System. The families of the deceased are also given an opportunity to consent to have the child's deoxyribonucleic acid (DNA) samples used for research or DNA banking in the SDY Biorepository. The MEO employs bereavement counselors who, in addition to providing bereavement services to families, also inform families of their option to participate in the research and banking of DNA through the SDY program. Of the 60 identified cases in 2020, 22 families (37%) provided consent. The MEO has had more success in obtaining consents from families than all other jurisdictions participating in the SDY case registry due to the work of the bereavement counselors. This opportunity for further research has the potential to enhance prevention efforts at the local level and reduce mortality rates for these deaths on a national level.

Additionally, Title V funds were used to partially support the Behavioral Risk Factor Surveillance System (BRFSS). As BRFSS is the federal data source for the NPM 1: percent of women who have an annual preventive medical visit, using Title V funds to achieve an adequate BRFSS sample maintained a vital data source for Title V outcome reporting in 2020. These resources create a robust supply of data to be used by BFH staff and shared with grantees and other partners within the MCH system of care to improve the health of the MCH population in Pennsylvania (PA).

Work within this domain incorporates maintaining and continuing development of the BFH's public health workforce at the state level by emphasizing and enhancing the usage of these data resources to continue to drive program decision-making. Additionally, the BFH is partnering with current grantees in new ways. The BFH has begun and will continue to develop technical assistance documents and guidance for grantees not only on the development of localized plans to reduce health disparities, but also on the use of evidence-based practices targeted to those populations most at risk of poor health outcomes. The BFH prioritized addressing health disparities in 2020.

Priority: MCH populations are able to obtain, process, and understand basic health information needed to make health decisions

SPM: Percentage of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable

Objective 1: Beginning in the first year of the grant cycle, disseminate at least one simple and clear message about basic health information

For this reporting year, one grantee (1.3% of grantees) continued to disseminate basic health information, with a focus on infant safe sleep. The infant safe sleep initiative seeks to increase knowledge of safe sleep risk reduction methods through a hospital-based model program and supporting social marketing plan. As part of this work the program created materials to simplify the safe sleep message for all populations. Safe sleep risk reduction methods go beyond just the ABC's (Alone, Back, and Crib) of safe sleep, to include the prenatal period and an infant's awake time. As part of the bundled intervention approach, brochures, palm cards, and posters with simple and consistent messaging for the hospital setting were developed. The brochures and palm cards were given to families. The posters were placed in every postpartum hospital room of the participating hospitals and used for the Southeastern Pennsylvania Transportation Authority (SEPTA) bus and subway advertisements. The main message is ABC for Alone, Back, and Crib to focus on the most important steps for creating a safe sleep environment for infants. While 19 safe sleep steps are outlined by the American Academy of Pediatrics, providing this information to parents of infants would be overwhelming. The safe sleep materials have focused on the most important and actionable steps and presented them in an easy to digest and memorable format.

As part of the ongoing review of the needs of participating hospitals, materials were translated into additional languages during this year. To date, the brochure has been translated into 19 languages which represent the needs of the patients at the hospitals implementing the model program. The grantee implementing the infant safe sleep initiative will continue to regularly review the needs of hospitals to determine if brochures are needed in additional languages.

The infant safe sleep initiative's social marketing component reinforces the simple and clear messages combined with consistent messaging in the community, such as through social media and transit advertisements. The social marketing messages are simple with a picture depicting a safe sleep environment and direct people to the safe sleep website (www.pasafesleep.org) for additional detailed information. According to the social media platform analytics, the social media messages have been well received and spread with likes, shares, and retweets more organically than anticipated as the messages were lasting for a longer duration than is typical for social media messaging. The organic spreading of messages from friend to friend will likely have a greater impact on both raising awareness and changing behavior as the message is coming from someone the recipient knows and trusts.

Priority: Appropriate health and health related services, screenings and information are available to the MCH population

Objective: By the end of the grant cycle, all Title V vendors will have developed a plan to identify and address health disparities in the population they serve

Healthy People 2020 defined a health disparity as "a particular type of health difference that is closely linked with social, economic, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

The BFH is making a commitment to address and combat health disparities in all MCH populations by inserting language into all grant agreements requiring grantees to do the following:

- Develop a plan to identify, address and eliminate health disparities in the populations served by Title V.
- Align their work plan with the goals and strategies of the *National Stakeholder Strategy for Achieving Health Equity.*

The BFH has integrated the health disparities language into grant agreements as the agreements have been executed. Grantees have submitted workplans to BFH project officers in accordance with grant deliverables. The BFH's Health Equity Committee (HEC) is tasked with examining the submitted plans and will be developing further guidance on plan development and technical assistance for grantees as needed.

To expand the BFH's understanding of health equity and related concepts, in the fall of 2018, BFH staff attended interpersonal implicit racial bias trainings developed by AccessMatters. Building on the content of the initial trainings, AccessMatters piloted a Day 2 training for nineteen BFH staff on institutional implicit racial bias training in June 2019. The objectives of this training were to:

- Explain the term institutional racism
- Identify at least two ways in which maternal and child health organizations perpetuate institutional racism
- Describe social determinants of health
- Explore issues of reproductive justice in maternal and child health context

After the success of the initial implicit bias training and the pilot for a second day of training, BFH developed a new, expanded contract with AccessMatters to further deliver this training to new BFH staff, Department of Health (DOH) staff at large and health, medical and social service providers who are partners in MCH services. A grant agreement was initiated for the period of July 2019 to June 2020. Due to a delay in contract execution and scheduling challenges, training for this project did not begin until late 2019, with the bulk of trainings occurring in 2020. In March 2020, the COVID pandemic and subsequent restrictions on large gatherings forced the training to be paused. This triggered a restructuring of the training from a physical format to a virtual online version and the grant agreement with the vendor was extended through September 2020. The training included Day 1 - Cultivating Awareness of Implicit Bias and Racial Microaggressions and Day 2 – Challenging Institutional Racism in the MCH setting. Training for Day 1 was considered the introduction to this series with day 2 being provided as additional information for those individuals who participated in Day 1. In 2020, there were a total of 21 training days provided on Interpersonal Implicit Racial Bias. Of these 21 days, five days were provided to BFH staff; four days of training were provided to other staff within DOH; and 12 days of training were provided to other MCH external partners including County Municipal Health Departments (CMHDs) staff and Title V providers.

AccessMatters submitted a report to the BFH summarizing the trainings, participant feedback, and recommendations for increasing awareness of how racism and white supremacy show up in the field of MCH and what steps can be taken to eliminate harmful policies and practices. Overall, the training was well received and informative. The virtual format for this training was not ideal as much of the time was spent on discussions, which were hindered somewhat due to the online format. The timing for delivery of this training was uncanny as many states throughout the country saw protests and movements for social justice in the summer of 2020, including PA. The training provided an opportunity for attendees to discuss and process the events witnessed on social and mainstream media.

As part of the BFH's commitment to addressing health disparities and achieving health equity, the HEC was formed in December 2018. The HEC is comprised of internal BFH staff representing all four divisions and a representative from the DOH's Office of Health Equity. The two main goals outlined for the first year were to: 1) develop a training plan for internal staff on health disparities and health equity; and 2) develop an approach for internal staff to provide technical assistance to grantees developing plans to address health disparities.

The HEC began by defining its scope and function. A vision and mission statement were created as was a charter document. The charter is an iterative document and outlines ground rules and processes for participation and decision-making for the HEC. In addition to the goals defined above, the HEC had some additional tasks for its first year. It developed a proposed revision to the BFH mission statement to include health equity which was presented to the Bureau Director for review. The HEC also crafted and distributed a short-term technical assistance document to provide BFH administrators with resources and strategies to aid grantees in completing health disparities plans by the end of the fiscal year.

To aid with addressing the first-year goals and guide the development of a three-year workplan for the HEC, the BFH applied for and was accepted into the 2019 Cohort of the National MCH Workforce Development Center. Five members of the HEC and one member of the DOH executive staff traveled to the MCH Workforce Development Center in March 2019 to participate in four days of intensive learning on skills, tools and approaches to creating systems change. This onsite learning period resulted in the construction of the framework for PA's project on achieving health equity and the development of relationships with the MCH Workforce Development Center staff and other participating states. The BFH developed the following aim statement for the MCH Workforce Development Cohort nine-month project:

> "To build the skills of the Bureau of Family Health staff to provide technical assistance to grantees/vendors around the development, implementation and evaluation of Health Disparities plans by December 31, 2019."

Over the course of Cohort participation, the HEC completed the following activities:

- Created a Cohort workplan, logic model and measurement framework
- Attended monthly webinars hosted by the MCH Workforce Development Center on different systems change tools
- Developed a communications plan
- Incorporated the designated PA Cohort team coaches into the established monthly HEC meeting and held travel team meetings
- Conducted a baseline survey of BFH staff to access individual and organizational knowledge and capacity to address health equity
- Hosted a two-day site visit culminating in the construction of a draft three-year workplan.

Further, to address identified system leverage points and to move the work of the HEC forward, the HEC divided itself into sub-teams with each sub-team responsible for different aspects of the HEC workplan.

To date, the HEC has completed several objectives from its workplan. It designated the World Health Organization's definition of health equity as their definition of health equity. An elevator speech for health equity was developed. Analysis of the baseline survey results have been conducted and used to decide on training needs. A follow-up survey was conducted to gather feedback on the utility of the short-term technical assistance document. A centralized, shared folder has been created to store the BFH grantee health disparities plans. The HEC also created a parking lot to house health equity ideas from committee members and designate sub-team ownership if needed. Additionally, staff presented lessons learned from BFH's HEC work and Cohort participation during the 2020 AMCHP virtual conference. The HEC had the opportunity to participate in providing feedback regarding the Cohort experience, which highlighted areas of opportunity for the MCH Workforce Development Center and the committee.

The HEC work is not without challenges. HEC members need to balance competing time commitments. There are still knowledge and awareness gaps around health equity and health disparities and why this work is important. The baseline survey completed by BFH staff was long and complex and did not result in exactly what was needed. The HEC intended the survey to assess the needs of the BFH related to knowledge and understanding of health disparities, health equity and related concepts to plan future workforce development activities. The survey however focused more on personal and organizational approaches and capacity to integrate and apply health equity to daily work, processes, procedures, and policies than on specific health equity concepts. Prioritizing the vast amount of systems work and appropriately defining scope and delegation of tasks between sub-teams and the HEC are also challenges. The HEC will continue to work through these challenges over the coming year as it completes the objectives of the workplan.

In addition to the work of the HEC and Bureau wide trainings, another aspect of the BFH health equity work is to continue to develop technical assistance documents researching and summarizing the evidence-base for intervention strategies around specific topics and target populations at increased risk of experiencing poor health outcomes. These documents will be created specifically for use by grantees.

Priority: Title V staff and grantees identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs

SPM: Percent of Title V staff who analyze and use data to steer program decision-making

Objective 1: By December 2021, develop resources and tools to increase the utilization of 17-alpha-hydroxy progesterone caproate or 17P by eligible women

The BFH partnered with the March of Dimes (MOD), the Children's Hospital of Philadelphia Research Institute Policy Lab and the PA Department of Human Services on a pilot program to help prevent preterm births through increased awareness about the use of 17P. This pilot program was funded through a combination of Title V funds and SSDI funds.

This project worked to understand what factors influence consumers and clinicians to access or fail to access 17P. Initial studies indicated that 17P could be a successful intervention for extending the gestation of women at risk for preterm birth; however, not all women who could potentially benefit from this treatment were utilizing it. Preterm births disproportionally affect African American infants. In 2018, the preterm birth rate for the state was 9.5%. Steep disparities persist with the African American rate at 13.6% compared to the rate for white women at 8.7%.

The partnership between the BFH and MOD worked to develop interventions to increase 17P utilization and reduce the preterm birth rate in Pennsylvania. In order to develop effective interventions, the BFH and MOD attempted to determine baseline data of current 17P utilization and barriers from both clinicians and consumers who did not recommend or use 17P but would have been viable candidates based on a history of pre-term delivery.

Through this initiative, the MOD identified key clinical contacts and explored community platforms to engage community leaders regarding increasing 17P utilization rates. The MOD also explored the need for, and format of, consumer and clinical education to increase compliance and extend gestation among at-risk pregnant women. In addition, the MOD completed a statistical analysis of State birth certificate and Medicaid claims data to determine the overall number of eligible pregnant women and the incidence of repeat preterm births among eligible women. Finally, the MOD conducted interviews of women that received 17P to better understand barriers they experienced in accessing this medication.

Using multisource linked administrative data set of birth certificates and medical assistance claims, the project identified 4,781 Medicaid-covered 17P-eligible pregnancies (i.e., having a history of spontaneous preterm singleton) in 2014-2016, accounting for three percent of Medicaid-covered singleton live births in PA. Among these eligible live births, 1,364 mothers received at least one prescription of 17P, resulting in a statewide initiation rate of 28.5%. The severity of the prior qualifying preterm birth was the strongest predictor for the use of 17P. In this statewide population-based cohort of Medicaid enrollees, 17P use was not associated with reduced risk of recurrent preterm birth or admission to NICU. However, interview findings shed light on strengths and areas of opportunity in preventing preterm birth among women at highest risk for adverse birth outcomes. The provision of comprehensive counseling for patients represents a critical juncture for patient decision-making, with real potential to affect treatment adherence. Innovative, patient-centered modes of preterm birth prevention strategies show promise, and efforts to implement these models should focus on supporting providers in administrative processes. Moreover, findings identified the need for policymakers, payers, and health systems to incentivize adherence to clinical recommendations by reducing administrative, financial, and logistical barriers for patients and providers.

On October 29, 2019, the Bone, Reproductive and Urologic Drugs Advisory Committee of the U.S. Food and Drug Administration (FDA) met and announced that research on 17P indicated it is not effective in preventing preterm birth in the populations it studied. As a result of this development, the MOD and BFH agreed to suspend this initiative, effective February 1, 2020. On October 5, 2020, the FDA's Center for Drug Evaluation and Research proposed that 17P be withdrawn from the market after concluding that the available evidence does not show Makena is effective for its approved use. 17P will remain on the market until the manufacturers decide to remove the drugs or the FDA Commissioner mandates their removal. If and/or when the FDA conducts additional research and finds that 17P is an effective intervention for preventing preterm birth, the BFH may consider reinstating this or a similar initiative.

SPM: Percent of Title V staff who analyze and use data to steer program decision-making

Objective 1: By 12/31 each year, the BFH will identify one strategy to improve data collection for BFH programs

Objective 2: By 12/31 each year, the BFH will develop at least one actionable goal for each BFH program

Objective 3: By 12/31 each year, the BFH will disseminate data from at least two programs

To support this SPM and its objectives, the PA PRAMS project will produce and disseminate data analysis products

for both internal and external partners. PRAMS will also track data requests and follow up with any program requesting data to determine if the data request resulted in new or modified programs or policies. PRAMS is a critical and unique source of maternal and child health data that has been operating in PA since 2007. The project's mission is to promote the collection, analysis, and dissemination of population-based data of high scientific quality and to support the use of data to develop policies and programs to reduce maternal and infant morbidity and mortality. Inherent in the PRAMS design and methodology is the ability to add supplemental questions to collect data on and respond to emerging public health problems affecting the maternal and infant populations. In December 2020 CDC provided the weighted data set for the Opioid Supplement and Call back survey. The final full year data set for 2019 was weighted by CDC and provided to BFH in January 2021. This is the most recent data available for PRAMS.

Staff are currently analyzing the Opioid Supplement and Call Back Data collected in 2019 with the goal of informing programmatic activities and public health practice related to opioid use among those with a recent live birth and their infants.

BFH, Rutgers and researchers at Columbia University are conducting a Postpartum Assessment of Women Survey (PAWS) from January 2021 to March 2022 for all batches of the 2020 PRAMS surveillance year. The purpose of the PAWS is to conduct surveillance of women's health needs, health insurance status, health care utilization, and social determinants of health in the year following childbirth. Data from this effort will inform the development of programs and policies to mitigate maternal morbidity and mortality in the extended postpartum period. Women who responded to the PA PRAMS 2020 questionnaire who consented to participate in the study will be re-contacted 12 months after the birth of their baby. For implementation of the PAWS, PA increased the PA PRAMS operational sample from 1,693 to 2,218 and is using the current two-strata sampling by birthweight: low birthweight (under 2,500 grams) and normal birthweight (2,500+ grams).

For October 2020 through March 2021 births, PA PRAMS participated in the CDC COVID-19 Supplement. The purpose of this project was to utilize the existing PRAMS methodology to implement rapid surveillance of maternal behaviors and experiences related to the COVID-19 pandemic.

PA PRAMS data was presented in several ways over the last year. Two 'Data to Action' reports were prepared in 2020 as part of the Cooperative Agreement with the CDC which included: 1) Pennsylvania Tobacco Control Strategies: Targeting Efforts to Improve Impact and 2) PRAMS Data Change Approaches to Combatting Pennsylvania's Rising Congenital Syphilis Cases. The PA PRAMS Coordinator presented analysis of postpartum depression for a PA Moving on Maternal Depression learning community conference call on February 26, 2020. In April 2020, the PA PRAMS Coordinator and MCH Epidemiologist presented 'Smoking Before, During and After Pregnancy' PA PRAMS data 2012-2018 to PA DOH Tobacco Control staff. In April 2020, the PRAMS Coordinator and a representative from the PA Coalition for Oral Health were prepared to provide an oral presentation on 'Pregnancy and Oral Health: An Important Connection, A Successful Outreach Campaign in Pennsylvania' at the Pennsylvania Public and Community Health Annual Conference; however, the conference was cancelled due to COVID-19 outbreak. In fall of 2020, PA PRAMS staff finalized "The Pennsylvania Pregnancy Risk Assessment Monitoring System: Phase 7 Descriptive Analysis Report,". The report was posted to the PA PRAMS web page and can be found at https://www.health.pa.gov/topics/Research/Pages/PRAMS.aspx.

PA PRAMS data was used in the CDC Morbidity and Mortality Report articles: "Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018" published May 2020 and "Characteristics of Marijuana Use During Pregnancy — Eight States, Pregnancy Risk Assessment Monitoring System, 2017" published August 2020. Additionally, PA PRAMS data was featured in the Maternal and Infant Health section of the 2020 Statewide Health Assessment of Pennsylvania.

There was no travel to conferences in 2020 due to COVID-19. However, the PA PRAMS Steering Committee was able to meet virtually in November 2020; key topics discussed were the COVID-19 and PAWS supplements and presentation of Marijuana Supplement data.

ESM: Percent of BFH staff who participated in the Data Application and Interpretation in Public Health training

A new methodology for assessing the SPM, percentage of Title V staff who analyze and use data to steer program decision-making, was developed by surveying Title V staff to determine the extent to which their programs were using data to steer decision making. Based on 2020 BFH Data survey, approximately 92% of staff self-identified they could use population data to determine the needs of a MCH population. This was an increase from the 2017 baseline of 18% and an increase over the previous year. The BFH was able to increase this percentage, in part, due to the Data Application and Interpretation in Public Health training deployed to BFH staff in 2018. In order to continue to increase the percentage of staff using data to direct programmatic decision-making, BFH will continue to educate Title V staff, using group level data analysis training analysis and one on one training for staff on this topic as needed.

It is also important to note that several BFH staff assisted with analyzing data for the Needs and Capacity Assessment. While modest, it does demonstrate staff's ability to identify and analyze a variety of data. Staff from all divisions of the Bureau supported this process and analyzed data from internal sources, such as CDR, PRAMS and BRFSS as well as external sources such as CDC WONDER, the National Survey of Children's Health and the National Health and Nutrition Examination Survey. The volume of data able to be analyzed for the needs assessment is a result of data training provided to staff, the addition of an MCH Epidemiologist, MCH Epidemiological Research Associate and the Bureau's focus on prioritizing evidence-based, data-informed strategies.

Grantees also became the BFH's source for client satisfaction data. The BFH began requiring grantees to submit data on their clients' satisfaction with services provided by the grantees in 2018. Grantees must submit draft surveys to BFH program administrators for approval prior to implementation. In 2019, a template client satisfaction survey was developed and distributed by staff to grantees who either did not have a survey developed or needed assistance in developing one. A technical assistance document that included principles, examples, and resources related to the construction of surveys was developed to help program administrators review grantees' client satisfaction surveys. A preliminary review of data submitted to the BFH indicates most clients are satisfied with services provided by the grantees. In 2019, a Spanish version of the template survey was created.

Support from senior management has been essential to the success achieved thus far; the BFH completed the restructure of the Division of Bureau Operations (DBO) to include data utilization and program evaluation as primary components of the work of the division. This Division is dedicated to increasing the BFH's data analytic capacities on a programmatic level. The staff identified to form the data workgroup charged with guiding BFH efforts to address priority eight have been incorporated into the DBO and new staff have been acquired. The data workgroup's previous work is being folded into the duties of the DBO.

In addition to data analysis, the BFH has focused on the integration of evidence-based and evidence-informed practices across all BFH administered programming. One part of this includes the evidence-based training listed above, another part was the development of a literature library. As BFH staff review topics and potential evidence-based/research-informed practices they are encouraged to collect this information and store it in on the BFH SharePoint page. This allows all staff to access the information and prevent future duplication of efforts.

Cross-Cutting/Systems Building - Application Year

I. Overview of Approach to Cross-Cutting Domain

The priorities and associated efforts of the cross-cutting domain have been designed to address public health system issues that impact all maternal and child health (MCH) population groups. The Bureau of Family Health (BFH) has fully committed to building capacity internally for data driven and evidence-based decision making in program design and implementation. This commitment and the associated priority on strengthening staff capacity is a continuation of the workforce development efforts that the BFH integrated into the 2015-2020 action plan.

Additionally, the BFH continues to make a concerted effort to address and combat health disparities in all MCH populations. Some of the work has already been initiated by the BFH Health Equity Committee (HEC) which has a current focus on building capacity by training internal staff on health equity principles. The committee's long-term goal is to measurably improve MCH outcomes in Pennsylvania (PA) by achieving health equity through the identification of health disparities and amelioration of the underlying causes of the disparities. This work and other associated strategies that will be developed over the course of the funding cycle will address the new priority aiming to support and effect system change to advance health equity and deconstruct systems of institutionalized oppression.

II. Other Federal Funding and State-Funded Activities/Future Efforts

Several of the monitoring systems which underpin and inform the work of the cross-cutting domain are jointly funded by Title V and another federal funding source. The Pregnancy Risk Assessment Monitoring System (PRAMS) is an important source of maternal and child health data which can be utilized to inform decision-making and programming across all domains. In PA, the PRAMS program is supported by both Centers for Disease Control and Prevention (CDC) and Title V funds. The CDC funds are used to fund a full-time PRAMS Coordinator and to support a small portion of survey operations. Title V funds supplement the remaining costs of PA PRAMS survey operations. Similarly, the Sudden Unexpected Infant Death (SUID)/Sudden Death in the Young (SDY) case registries are supported by CDC funds for staffing. Title V funds are utilized to support data collection and implementation of resulting prevention strategies across population domains.

Priority: Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development

The BFH's commitment to strengthening Title V staff's ability to make data-driven decisions in the development and implementation of public health programming and strategies is actualized in cross-cutting priority 6 of the state action plan. The first step in making a data-driven decision is accessing and interpreting public health data. Title V staff have expressed a desire for increased training and assistance in this area; through the workforce capacity survey administered as part of the 2019-2020 five-year MCH needs and capacity assessment, staff indicated that they viewed additional training on how to use population health data to understand the needs of a maternal and child health population as a priority. In order to respond to that need and facilitate access to and use of state data on key maternal and child health indicators by Title V staff, the Bureau intends to develop and disseminate two data-specific resources: 1) an internal data dashboard; and, 2) data briefs by population domain.

Development of an internal data dashboard using PowerBI is ongoing. By amassing data from various datasets and sources into a centralized location and an interface that is designed to be dynamic and user-friendly, the Bureau hopes to improve staff's familiarity and comfort with data and its interpretation. In its final form, the dashboard will incorporate federally available national outcome measure and national performance measure data provided annually by Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB), internal data

from PA's vital records, and population health data from other publicly available sources. The data dashboard will be updated at least once annually as data from the aforementioned sources become available. The dashboard will also be used to develop an updated series of static data briefs which will provide an overview of the health status of each Title V population domain. The data brief format was developed as part of the 2019-2020 five year MCH needs and capacity assessment and was well-received by external stakeholders, agency partners, and Title V staff. Moving forward, the data briefs will be updated biannually; the existing data briefs developed as part of the needs and capacity assessment will remain publicly unchanged in 2021 and an updated version will be developed in 2021 and disseminated externally in 2022.

SPM: 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

Strategy: Assess BFH programs to determine existing data and determine methods for sharing data with internal and external partners

Objective: Review BFH programs to evaluate existing data sources and provide supplemental data sources where available to at least ten percent of programs per year

ESM: Number of technical assistance requests for data made to DBO each year using the established guidelines

The Division of Bureau Operations (DBO) staff will work with programs within the BFH to identify what data is available, meaningful, and measurable to help establish clear objectives and goals. DBO staff will work with program staff to develop objectives that are SMART– specific, measurable, attainable, realistic, and time-bound.

Existing program measures and data sources will be examined to determine quality and sufficiency regarding measuring program performance. In areas where additional data is needed, DBO staff will work with other program staff to determine what data is available or can reasonably be obtained with existing resources.

DBO staff will also implement standard operating procedures for developing better data quality and reporting. This will include use of a standard technical assistance request form to promote a consistent method for requesting information such as collecting and analyzing program data. This will also allow DBO to track technical assistance requests and follow up with program staff to promote data driven decision making. These procedures can be applied to programs throughout BFH to ensure quality and consistency in data collection and attainment of goals and objectives. This information can be used as a baseline with measures being tracked in subsequent years to determine trends and progress towards goals and objectives.

Strategy: Increase staff access and use of National Survey for Children's Health (NSCH) data sources to enhance program planning, design, and implementation

Objective: Disseminate annual NSCH data to program staff after it is released on childhealthdata.org each year to support and develop MCH programming

ESM: Percent staff trained annually on availability of NSCH data and how to access that data

The National Survey of Children's Health (NSCH) is a national survey funded and directed by the HRSA/MCHB that provides rich national and state-level data on the physical and emotional health of children 0 to 17 years old in the

United States. Data is collected on multiple, intersecting aspects of children's health and well-being – including physical and mental health, access to quality health care, and the child's family, neighborhood, school, and social context. The NSCH also provides estimates for 19 Title V Maternal and Child Health Services Block Grant National Outcome and Performance Measures, and data for each state's Title V needs assessment.

The survey is fielded via web-based and mail instruments and is administered by the U.S. Census Bureau in partnership with the MCHB. The Census Bureau oversees the NSCH's sampling plan, collects the data, and creates the sampling weights. The BFH is currently negotiating an agreement with HRSA/MCHB, and the Census Bureau to conduct an oversample for a future NSCH. Oversamples can support more targeted assessment, program planning, and evaluation. BFH is planning to use Title V funds to pay for a state-wide oversample, which increases the number of completed surveys in the state and may enable reporting for smaller populations, such as CSHCN, or rarer outcomes with greater precision. Once completed, oversample data will be available on www.childhealthdata.org for analysis and dissemination by and to BFH staff.

Strategy: To use PRAMS to conduct epidemiological surveillance of the maternal and child health population in PA

Objective: Annually produce and disseminate at least two PRAMS data analysis products

ESM: Percentage of PRAMS data requests resulting in a new or modified program or policy in each calendar year

ESM: Number of programs or policies created or modified as a result of the dissemination of PRAMS data analysis products in each calendar year

PRAMS is a critical and unique source of maternal and child health data. The project's mission is to promote the collection, analysis, and dissemination of population-based data of high scientific quality and to support the use of data to develop policies and programs to reduce maternal and infant morbidity and mortality. PRAMS is a joint research project between the CDC and state health departments. As part of PRAMS participation, the CDC requires states to annually report on two ways PRAMS data have been used to drive program or policy development. These reports are then used by the CDC to justify to Congress why the PRAMS program should continue to receive federal funding. Access to and use of the dataset are, therefore, critical to the survival of the PRAMS dataset.

While PRAMS has been a data source in PA since 2007, the dataset has been underutilized, even within the BFH. To increase visibility of the PA PRAMS dataset and what it can offer BFH staff and MCH stakeholders, the BFH will annually be producing and disseminating at least two PA PRAMS data analysis products. These products may be topic briefs, information sheets, abstracts and posters, journal articles or descriptive analysis reports. BFH staff will work with the PRAMS Committee to prioritize analysis topics and the most appropriate forms of data dissemination. Emerging issues and PA Department of Health (DOH) leadership priorities will also guide analysis. For example, the PA PRAMS collected data in 2019 on opioid and prescription drug use during and after pregnancy and in 2020 on experience with healthcare workers regarding COVID-19, and in 2021 experience with the COVID-19 vaccine. Data analysis of these ongoing public health issues is beginning in 2020 and data products could be ready for dissemination in summer 2021. In March 2021, the PA PRAMS web page was updated to add information of interest to researchers such as data uses, supplemental questionnaires by topic, and links to access code books and multi-state data at the CDC PRAMS site. It is anticipated that as PRAMS data are disseminated to PA DOH staff, MCH stakeholders and the public, there will be a greater understanding of the information contained in the PRAMS survey and this comprehension will drive more requests for PA PRAMS data. In turn, data requests will potentially lead to

new or modified programming or policies.

The BFH currently tracks requests for PA PRAMS data. This tracking resource will be used as the source for the two evidence-based strategy measures related to PRAMS. BFH staff will create a follow-up schedule to touch base with those who received PRAMS data either through a specific request or by receipt of a PRAMS data product. This will enable the BFH staff to determine how PRAMS data are being used to drive programming and policy decisions.

Strategy: Increase the number and quality of local Child Death Review (CDR) team reviews to enhance program planning, design, and implementation

Objective: Annually increase the number of reviews by local CDR teams that include identification of the underlying causes of death

ESM: Increase the Percent of CDR cases reviewed by five percent each year

Act 87 of 2008 requires that all counties in PA either establish a local public health Child Death Review (CDR) team or collaborate with other counties to operate on a regional basis. The teams are comprised of local professionals including coroners, law enforcement, physicians, mental health providers, substance misuse treatment providers, public health, and child welfare services. The local CDR teams should review all deaths of children and youth age 21 years and younger. The purpose of the local CDR teams is to summarize the findings from the reviews of child deaths and to make recommendations regarding how to utilize those findings to inform prevention strategies and programming. The BFH provides training, support, and technical assistance to all of PA's local CDR teams. Over the last few years, the percentage of child deaths reviewed has remained at just under 60%. These percentages of reviewed cases are down from a high of 75% in 2013.

To address the challenges that local CDR teams have in meeting the obligations of Act 87, the BFH will explore several options to provide additional support to local CDR teams. County teams that are not meeting regularly or have little participation do not have the ability to build expertise in the review process. With additional support and technical assistance from BFH, local CDR teams will have the capacity to increase the number of reviews conducted and enhance the quality of the data entered in the National Case Reporting System. With enhanced data quality, local CDR teams will have the ability to design effective data-driven prevention recommendations to reduce the mortality of infants and children and monitor the impact of those prevention recommendations. In addition, the BFH will be able to use this data to inform policies, practices, and programs.

To increase the number of recommendations implemented, BFH will assess the feasibility of recommendations that have the potential to address statewide issues or to enhance BFH programming. BFH has developed and is piloting a method for sharing recommendations to ensure that the basis for the recommendations and the intended outcomes are clear. In addition, follow-up will be made on recommendations shared within and outside of BFH.

In 2022, BFH will develop and share data quality summaries with local teams to provide more targeted technical assistance. The summaries will be developed using the information entered into the National Case Reporting System by local CDR teams. Data quality will be assessed using core variables established by the CDC and the National Center for Fatality Review and Prevention (NCFRP). For sudden unexpected infant deaths cases, the CDC's core variables will be used. For all other cases, the NCFRP's core variables will be used. In 2021, the case reporting system was updated to highlight all the core variables. The sharing of summaries will start with the sudden unexpected infant deaths. Other types of deaths will be added based on number of deaths.

Priority 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

Several strategies under this priority are guided by a series of three-year workplans developed by the BFH's HEC which focus on building system infrastructure through policy and programmatic recommendations to address the social, economic, and environmental determinants of health and deconstruct institutionalized systems of oppression.

BFH's effort to support and effect change at the organization and system level impacts all of PA's NPMs and the associated National Outcome Measures (NOMs). To see significant changes in performance and outcome measures at the population level, programs must acknowledge health disparities and target vulnerable populations. As a leading objective, the BFH has begun to develop a process to review disparities data annually and use this analysis to inform program development, implementation, and evaluation. The BFH CYSHCN programs have established a workgroup to better capture data. At a program level, this will aid in understanding the disparities and the populations that are most negatively impacted by inequalities. Additionally, BFH has expanded collaboration with staff in epidemiology by hiring an epidemiology research associate and developing a plan to identify the factors contributing the most to disparities and the solutions to address these disparities in order to inform the development of additional action plan strategies. The BFH plans to continue to nurture and strengthen both efforts in 2022.

Finally, changes must occur to increase workforce capacity to: identify training and technical assistance resources for staff and grantees so they can identify disparities, the causes, and evidence-informed strategies to address them; understand the impact of institutional racism and structural inequities; measure the effectiveness of interventions; and promote policy and programmatic changes to eliminate disparities. By Fall of 2021, the HEC anticipates hosting the first round of trainings to staff regarding health equity and related evidence-based practices, including the social determinants of health. The MCH Workforce Development grant is also anticipated to begin in 2022 which will incorporate health equity capacity building.

In 2021, BFH plans to build skills and teach internal staff how to provide technical assistance to grantees around health equity and the health equity plans and develop a training plan for grantees to build skills around health equity and how staff can lead grantees through change. It is essential for staff to have the capacity to frame challenges, ask strategic questions, and prioritize action steps and activities. Staff will also need to provide insight on the transition from current practices to the intentional consideration of health disparities and the underlying causes in the development of every policy and program as well as from interventions focused on social needs to social determinants. Also, staff will educate grantees on the important aspects necessary to develop and evaluate comprehensive health equity plans. These changes to the workforce will aid to increase the capacity of staff who can lead others through the changes needed to eliminate system inequities. Additionally, the BFH will continue to expand internal staff and grantees' understanding of the importance of meaningful community engagement, while providing guidance on how to incorporate community engagement into their work. Meaningful community engagement will help to strengthen stakeholder relationships with BFH and aid in building trust so policy and programmatic changes can be made with the communities to promote health equity.

The BFH will continue to work closely with the PA Department of Health's Office of Health Equity (OHE). Throughout 2022, OHE staff funded through Title V will increase understanding and utilization of Culturally and Linguistically Appropriate Services among Department of Health staff, stakeholders, and community organizations. Additionally, staff will begin identifying opportunities to expand the Health Equity Zone model to PA, in partnership with the Department of Human Services, to further support communities in addressing and advancing health equity at a local level.

Recognizing the need to build staff capacity and identify partners in other state agencies ready to begin the work of dismantling systemic racism, a team of BFH staff completed a Dismantling Systemic Racism Workshop, a four-

week training and independent study course for leaders and change agents in PA state government offered in spring of 2021. Issues identified during the workshop inspired the development of a new DOH Anti-Racism and Health Equity Task Force and an innovative state-wide Anti-Racism Book Club. Members of the BFH team are on the DOH Anti-Racism and Health Equity Task Force steering committee and act as facilitators for the Anti-Racism Book Club.

SPM: 6(A): Rate of the mortality disparity between black and white infants
7(B): Rate of the mortality disparity between black and white children, ages 1-4
8(C): Rate of the maternal mortality disparity between black and white persons

Over the course of the funding cycle, the BFH will develop and implement strategies which address the new priority aiming to support and effect change advancing health equity and deconstruct systems of oppression. By doing so, the BFH also aims to narrow the racial gap in adverse health outcomes. As such, the rate of change in reducing the mortality gap for black and white infants, children and mothers will serve as the BFH's long-term measure of progress toward advancing health equity. To improve MCH health outcomes, the gap between majority and minority populations must begin to shrink because of comprehensive programming, policy change and organizational action. As a first step, the BFH aims to orchestrate organizational change from the bottom up by increasing understanding of health equity principles and knowledge of the disparities that exist for infant, child, and pregnancy related mortalities among BFH staff and grantees. Once this baseline understanding is established, the BFH will be better positioned to identify additional strategies and performances measures which address the other components of the priority.

Strategy: Increase staff understanding of Health Equity principles

Objective: Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH Staff

ESM: Number and percentage of staff trained annually on the principles of Health Equity and the effectiveness of Health Equity plans

The BFH established a HEC in 2018 as part of its commitment to addressing health disparities and achieving health equity for the maternal and child health population in PA. The two main goals outlined for the first year were to: 1) develop a training plan for internal staff on health disparities and health equity; and 2) develop an approach for internal staff to provide technical assistance to grantees developing plans to address health disparities.

To address these goals, the HEC has since defined a three-year workplan. A large portion of this workplan entails the identification and implementation of BFH staff training related to health equity. This is a first step in creating organizational change within the BFH. A baseline survey of BFH conducted in July 2019, identified the following topic areas to target with training:

- Education on the concepts around health equity and related evidence-based practices including:
  - The historical context surrounding health disparities and health inequity
  - Power and privilege
  - Examining evidence-based practices through a health equity lens
- Education on community engagement which will include how to use community engagement to identify, track and measure social determinants of health.
- Identifying better ways to communicate about health equity in BFH reporting.

The HEC is currently working to identify training resources related to the above topic areas and it is anticipated BFH staff trainings will begin in the fall of 2021, with more advanced trainings continuing into 2022, originally delayed due to COVID-19. The HEC will be designing and implementing assessment tools to accompany the training implementation to guide the selection of trainings in the future. Certain trainings may also be offered to grantees and other MCH stakeholders as the HEC work evolves. The goal of this work is to bring health equity to the forefront of MCH work at all organizational levels. To monitor and track these training efforts, BFH will establish a new objective and associated ESMs to capture the HEC's stated goals and objectives that are met on-time each year.

Once staff have the capacity to recognize and implement health equity principles, it will be essential for staff to then build on those skills. To address the need to provide technical assistance by staff, technical assistance materials will need to be developed. Additionally, there is a need to develop a mechanism to measure effectiveness of how technical assistance is administered and its quality.

III.F. Public Input

After submission of the 2019 Annual Report/2021 Application and the virtual review with Health Resources and Services Administration (HRSA) staff and external reviewers, the Bureau of Family Health (BFH) posted the full application and state action plan to its Title V website. Visitors to the website can also view the previous years' annual reports and applications. Additionally, the website links visitors to the other state action plans available through the Title V Information Systems (TVIS) as well as to general information about the Title V Maternal and Child Health Services Block Grant (MCHSBG) and the transformation. The BFH maintains a Title V-specific resource e-mail account which is listed on the website so that people can send comments or input on the PA Title V program and its efforts at any time. Additionally, past Title V MCHSBG interim needs assessment reports remain on the site and information about the 2020 Title V Five-Year Needs and Capacity Assessment, including the data briefs, values, and final priorities, were posted to the site, and circulated to stakeholders via e-mail and at events.

As part of ongoing public input, the BFH schedules quarterly, recurring meetings with the County/Municipal Health Departments (CMHD). The CMHD are critical stakeholders in the administration of the Title V MCHSBG at the local level as they administer and report on key strategies and performance measures in the State Action Plan as well as provide other programming and services to the MCH populations in their respective areas of the state. The meetings are designed to continue to strengthen the relationship between CMHD and the BFH and to provide the opportunity to have in-depth discussions on individual sections of the Title V Action Plan. The BFH also provides ongoing technical assistance to local health departments on the application of relevant research and the implementation of evidence-based and promising practices. The BFH leverages the feedback from the CMHD to improve programming support for the CMHD and inform long-term program planning and annual block grant reporting.

Drafts of the executive summary section, the year 2 state action plan table, and the needs assessment summary update of the 2020 Annual Report/2022 Application were posted to the BFH's Title V site and e-mailed to stakeholders through Pennsylvania's Title V listserv in July of 2021 for public comment. The documents were available for review and comment for a period of two weeks. The BFH received one public comment requesting that oral health be made a grant priority. The need around improving oral health and access to oral health services was not adopted as a Title V priority given that there is existing capacity, funding, and programming addressing oral health within the Bureau of Health Promotion and Risk Reduction in the Department. However, given the breadth of the final Title V priorities, the BFH is committed to considering the extent to which the frequently cited needs, including improving oral health, may be addressed through new collaborations and the development and implementation of strategies over the next five-year cycle.
The BFH received one public comment requesting a different term be used to describe special health care needs and the use of inclusive language such as "pregnant and parenting people," "person/people" and "chest/breastfeeding" to raise the visibility of transgender and gender non-conforming people. The Title V population domains defined by HRSA include women/maternal health and children with special health care needs. As such, Pennsylvania's Title V program uses the same verbiage in its application/report as directed by HRSA's guidance. However, Pennsylvania's Title V program will make a concerted effort to use inclusive language and to raise the visibility of transgender and gender non-conforming people who are pregnant or parenting whenever possible, such as in the program descriptions in the action plan narrative. Additionally, the comment requested language reframing for priorities one through seven in order to make the population(s) with the greatest disparities (e.g., Black, Latinx and Indigenous peoples) more explicit, specifically enumerate racism as well as other forms of oppression when addressing inequity and requested consideration of principles of trauma-informed care when making programmatic decisions. Given that the priorities were reviewed and ranked by stakeholders, changes to the verbiage at this point would be an inaccurate reflection of the prioritization process. However, Title V is committed to addressing inequity, including among Black, Latinx and indigenous persons and populations; the populations served by each strategy are

further defined in the action plan narrative. Additionally, Title V identified a need for training and programming addressing trauma through its needs and capacity assessment and associated strategies will be considered for development in future years of the action plan. Conversely, the BFH received one public comment requesting that traditional verbiage, e.g., “women” and “mothers” be used exclusively. Pennsylvania's Title V program is making a concerted effort to employ inclusive language; however, portions of the application/report will continue to include more traditional verbiage as to maintain grant consistency as directed by HRSA's guidance.

Finally, the BFH received one public comment requesting that unique needs of the intellectual and developmental disabilities community be specifically addressed in the development and deployment of priority areas. The comment also requested that fetal alcohol syndrome disorders be addressed via educational programming and resource sharing. Given the breadth of the final Title V priorities, the BFH is committed to considering the extent to which cited needs, including addressing the unique needs of the intellectual and developmental disabilities community, may be addressed through new collaborations and the development and implementation of strategies over the next five-year cycle.

III.G. Technical Assistance

The Bureau of Family Health (BFH) did not request technical assistance in 2020. As the Pennsylvania Title V Program works to implement an action plan designed to address seven new priorities, the BFH will continue to evaluate and identify areas where technical assistance may be needed in the future.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IV. Title V DOH-DHS MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Title V Exec Summary_Popln Fact Sheets_Interim Needs Update.pdf

Supporting Document #02 - Updated Title V files.pdf

Supporting Document #03 - Title V Action Plan 2021-2025_Final y2 .pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Chart Updated.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Pennsylvania

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 23,928,946	
A. Preventive and Primary Care for Children	$ 10,381,678	(43.3%)
B. Children with Special Health Care Needs	$ 7,744,494	(32.3%)
C. Title V Administrative Costs	$ 2,392,894	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 20,519,066	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 47,605,500	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 47,605,500	
A. Your State's FY 1989 Maintenance of Effort Amount $ 20,065,575		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 71,534,446	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 7,917,414	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 79,451,860	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,094,365
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 536,083
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 232,193
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 110,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 580,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 515,875
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	$ 957,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 574,036
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,117,862

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 23,748,778		$ 23,928,946	
A. Preventive and Primary Care for Children	$ 11,444,330	(48.2%)	$ 11,771,621	(49.1%)
B. Children with Special Health Care Needs	$ 7,973,707	(33.6%)	$ 7,217,569	(30.1%)
C. Title V Administrative Costs	$ 2,374,876	(10%)	$ 2,392,894	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 21,792,913		$ 21,382,084	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 48,640,500		$ 46,813,492	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 48,640,500		$ 46,813,492	
A. Your State's FY 1989 Maintenance of Effort Amount $ 20,065,575				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 72,389,278		$ 70,742,438	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 7,343,533		$ 3,423,394	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 79,732,811		$ 74,165,832	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,937,593	$ 903,395
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 206,976	$ 86,249
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 517,300	$ 363,353
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 227,700	$ 149,279
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 110,382	$ 54,274
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 300,000	$ 312,449
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 183,009	$ 171,802
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 790,704	$ 175
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	$ 1,041,100	$ 319,826
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,028,769	$ 1,062,592

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Pennsylvania

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 2,801,202	$ 2,546,642
2. Infants < 1 year	$ 2,303,520	$ 2,581,800
3. Children 1 through 21 Years	$ 7,436,271	$ 8,885,099
4. CSHCN	$ 7,462,669	$ 7,109,308
5. All Others	$ 1,532,390	$ 413,203
Federal Total of Individuals Served	$ 21,536,052	$ 21,536,052

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 0	$ 0
2. Infants < 1 year	$ 6,790,800	$ 6,062,980
3. Children 1 through 21 Years	$ 34,620,000	$ 34,002,479
4. CSHCN	$ 4,365,038	$ 4,312,752
5. All Others	$ 1,829,662	$ 2,435,281
Non-Federal Total of Individuals Served	$ 47,605,500	$ 46,813,492
Federal State MCH Block Grant Partnership Total	$ 69,141,552	$ 68,349,544

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The costs reported on Form 3a for types of individuals served are categorized by the status of the individual at the time they received the service. Pennsylvania considers some services provided during the infancy period as Preventive and Primary Care for Children, as the ultimate outcome of the service is to improve health during childhood. As such, the costs reported on Form 2, Line 1A are not equivalent to Form 3a, Line 1A.3	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Services for Children with Special Health Care Needs reported on Form 2, Line 1B includes infrastructure and services for families of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The costs reported on Form 3a for types of individuals served are categorized by the status of the individual at the time they received the service. Pennsylvania considers some services provided during the infancy period as Preventive and Primary Care for Children, as the ultimate outcome of the service is to improve health during childhood. As such, the costs reported on Form 2, Line 1A are not equivalent to Form 3a, Line 1A.3	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Services for Children with Special Health Care Needs reported on Form 2, Line 1B includes infrastructure and services for families of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.
- CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Pennsylvania

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 1,878,475	$ 2,181,084
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 564,641	$ 636,397
B. Preventive and Primary Care Services for Children	$ 1,201,334	$ 1,544,687
C. Services for CSHCN	$ 112,500	$ 0
2. Enabling Services	$ 8,230,002	$ 9,679,246
3. Public Health Services and Systems	$ 13,820,469	$ 12,068,616
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 463,406
Physician/Office Services		$ 1,717,678
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 2,181,084
Federal Total	$ 23,928,946	$ 23,928,946

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 8,488,500	$ 7,578,725
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 6,790,800	$ 6,062,980
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 1,697,700	$ 1,515,745
2. Enabling Services	$ 4,047,300	$ 4,056,892
3. Public Health Services and Systems	$ 35,069,700	$ 35,177,875
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 1,515,745
Physician/Office Services		$ 1,260,560
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 4,802,420
Direct Services Line 4 Expended Total		$ 7,578,725
Non-Federal Total	$ 47,605,500	$ 46,813,492

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Pennsylvania

Total Births by Occurrence: 134,329 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	133,910 (99.7%)	959	208	208 (100.0%)

Program Name(s)				
Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Glycogen Storage Disease Type II (Pompe)	Maple Syrup Urine Disease
Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	S,S Disease (Sickle Cell Anemia)	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Short chain Acyl-CoA Dehydrogenase Deficiency	132,109 (98.3%)	2	2	2 (100.0%)
Globoid Cell Leukodystrophy (Krabbe)	3,179 (2.4%)	0	0	0 (0%)
Fabry (GLA)	3,176 (2.4%)	0	0	0 (0%)
Niemann-Pick (ASM)	3,177 (2.4%)	0	0	0 (0%)
Gaucher (ABG)	3,177 (2.4%)	0	0	0 (0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
3-Methylcrotonyl-CoA Carboxylase Deficiency	132,633 (98.7%)	4	4	4 (100.0%)
Argininosuccinic Aciduria	132,633 (98.7%)	4	4	4 (100.0%)
Biotinidase Deficiency	132,633 (98.7%)	18	18	18 (100.0%)
Carnitine Uptake Defect/Carnitine Transport Defect	132,633 (98.7%)	0	0	0 (0%)
Citrullinemia, Type I	132,633 (98.7%)	0	0	0 (0%)
Critical Congenital Heart Disease	129,961 (96.7%)	170	11	11 (100.0%)
Cystic Fibrosis	132,633 (98.7%)	24	24	24 (100.0%)
Glutaric Acidemia Type I	132,633 (98.7%)	3	3	3 (100.0%)
Hearing loss	132,769 (98.8%)	1,647	173	173 (100.0%)
Holocarboxylase Synthase Deficiency	132,633 (98.7%)	0	0	0 (0%)
Homocystinuria	132,633 (98.7%)	0	0	0 (0%)
Isovaleric Acidemia	132,633 (98.7%)	2	2	2 (100.0%)
Long-chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency	132,633 (98.7%)	1	1	1 (100.0%)
Medium-chain Acyl-CoA Dehydrogenase Deficiency	132,633 (98.7%)	7	7	7 (100.0%)
Methylmalonic Acidemia (Cobalamin disorders)	132,633 (98.7%)	0	0	0 (0%)
Methylmalonic Acidemia (methylmalonyl-CoA mutase)	132,633 (98.7%)	1	1	1 (100.0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Propionic Acidemia	132,633 (98.7%)	0	0	0 (0%)
S, βeta-Thalassemia	132,633 (98.7%)	4	4	4 (100.0%)
S,C Disease	132,633 (98.7%)	15	15	15 (100.0%)
Severe combined immunodeficiencies	127,633 (95.0%)	1	1	1 (100.0%)
ß-Ketothiolase Deficiency	132,633 (98.7%)	0	0	0 (0%)
Trifunctional Protein Deficiency	132,633 (98.7%)	1	1	1 (100.0%)
Tyrosinemia, Type I	132,633 (98.7%)	0	0	0 (0%)
Very Long-chain Acyl-CoA Dehydrogenase Deficiency	132,633 (98.7%)	1	1	1 (100.0%)
3-Hydroxy-3-Methyglutaric Aciduria	132,633 (98.7%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Pennsylvania Newborn Screening and Follow-up Program (NSFP) provides follow-up services from birth to diagnosis for all Pennylvania newborns, long-term follow-up is not performed by the NSFP.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The Data Source Year for Total Births by Occurrence is 2020. The source for total births by occurrence is provisional 2020 data from the Pennsylvania Newborn Screening Internet Case Management System (iCMS) provided by the Bureau of Family Health.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: The Data Source Year for Total Births by Occurrence is 2020. The source for total births by occurrence is provisional 2020 data from the Pennsylvania Newborn Screening Internet Case Management System (iCMS) provided by the Bureau of Family Health.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**

Field Note:
Data source year for Screening Counts is 2020. In PA, there are 10 conditions on the mandatory screening panel and submitters elect which of the other 27 conditions on the mandatory follow-up panel are screened for. The combined lists of disorders on the screening panel and follow-up panel align with the CORE RUSP conditions. Solely the 10 conditions that are mandated for screening by the Pennsylvania Newborn Screening and Follow-up Program are included in the Line 1 aggregate counts. They are as follows:

Phenylketonuria
Maple Syrup Urine Disease
SS-Disease Sickle Cell Anemia
CH Congenital Hypothyroidism
CAH Congenital Adrenal Hyperplasia
GALT Transferase Deficient Galactosemia (Classical)
GAA Glycogen Storage Disease Type II (Pompe)
MPS I Mucopolysaccharidosis type I
X-ALD X-linked adrenoleukodystrophy
SMA Spinal Muscular Atrophy

4.	**Field Name:**	**Short chain Acyl-CoA Dehydrogenase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
5.	**Field Name:**	**Globoid Cell Leukodystrophy (Krabbe) - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
6.	**Field Name:**	**Fabry (GLA) - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
7.	**Field Name:**	**Niemann-Pick (ASM) - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
8.	**Field Name:**	**Gaucher (ABG) - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
9.	**Field Name:**	**3-Methylcrotonyl-CoA Carboxylase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**

	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
10.	**Field Name:**	**Argininosuccinic Aciduria - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
11.	**Field Name:**	**Biotinidase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
12.	**Field Name:**	**Carnitine Uptake Defect/Carnitine Transport Defect - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
13.	**Field Name:**	**Citrullinemia, Type I - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
14.	**Field Name:**	**Critical Congenital Heart Disease - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
15.	**Field Name:**	**Cystic Fibrosis - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**

	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
16.	**Field Name:**	**Glutaric Acidemia Type I - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
17.	**Field Name:**	**Hearing loss - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
18.	**Field Name:**	**Holocarboxylase Synthase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
19.	**Field Name:**	**Homocystinuria - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
20.	**Field Name:**	**Isovaleric Acidemia - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
21.	**Field Name:**	**Long-chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**

	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
22.	**Field Name:**	**Medium-chain Acyl-CoA Dehydrogenase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
23.	**Field Name:**	**Methylmalonic Acidemia (Cobalamin disorders) - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
24.	**Field Name:**	**Methylmalonic Acidemia (methylmalonyl-CoA mutase) - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
25.	**Field Name:**	**Propionic Acidemia - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
26.	**Field Name:**	**S, βeta-Thalassemia - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
27.	**Field Name:**	**S,C Disease - Total Number Presumptive Positive Screens**

	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
28.	**Field Name:**	**Severe combined immunodeficiencies - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
29.	**Field Name:**	**ß-Ketothiolase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
30.	**Field Name:**	**Trifunctional Protein Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
31.	**Field Name:**	**Tyrosinemia, Type I - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	
32.	**Field Name:**	**Very Long-chain Acyl-CoA Dehydrogenase Deficiency - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The number of presumptive positive screens count includes inconclusive-referral results.	

33.	**Field Name:**	**3-Hydroxy-3-Methyglutaric Aciduria - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**

Field Note:
The number of presumptive positive screens count includes inconclusive-referral results.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Pennsylvania

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,453	35.9	0.1	5.0	17.0	42.0
2. Infants < 1 Year of Age	133,910	35.5	0.0	0.0	0.0	64.5
3. Children 1 through 21 Years of Age	975,578	0.7	0.0	0.0	0.3	99.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	189,936	3.8	0.1	1.6	0.1	94.4
4. Others	16,140	17.8	0.0	22.1	0.8	59.3
Total	1,128,081					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	134,230	No	130,562	92.2	120,378	2,453
2. Infants < 1 Year of Age	133,589	No	134,329	99.7	133,926	133,910
3. Children 1 through 21 Years of Age	3,170,299	Yes	3,170,299	55.4	1,756,346	975,578
3a. Children with Special Health Care Needs 0 through 21 years of age^	687,442	No	687,363	82.0	563,638	189,936
4. Others	9,496,978	No	9,366,799	0.2	18,734	16,140

^Represents a subset of all infants and children.

Form Notes for Form 5:

The Bureau of Family Health does not have the capability to unduplicate numbers between the various divisions or their programs. The four divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the division's "Total" for each of the categories and some counts are estimates due to data collection limitations. The data collection and tracking capabilities vary depending on the type of service/program within each division and come from multiple projects and different sources. As the purpose of Title V is to provide gap filling services, the Bureau decided insurance status of the service population would not be reflected by the statewide estimates provided in the 5a reference data.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Services/programs represented in the pregnant women served count include the following: Safe and Healthy Homes Program, Smoking Cessation, County Municipal Health Department Home Visiting (CMHV), Breastfeeding, One Key Question, Community Health (BCHS).	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: The count provided for infants served is the number of infants receiving at least one newborn screen and also includes infants who received newborn screening case management services, infants served by the metabolic treatment centers, infants served by the cystic fibrosis (CF) treatment centers, infants served by the Hemoglobin treatment centers, and infants enrolled in the Phenylketonuria (PKU) formula program. This number is provided as it represents the best unduplicated estimate of infants served by Title V direct/enabling services. Other services/programs that served infants which are represented by this count include the following: Safe and Healthy Homes Program, Safe Sleep Initiative, County Municipal Health Department Home Visiting (CMHV) and specialty care programs for Autism, Child Rehabilitation, Community to Home, Cooley's Anemia, Cystic Fibrosis, Hemophilia, Sickle Cell and Spina Bifida.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Services and programs represented in the children served count include the following: Safe and Healthy Homes Program, Alliance Opioid Project, Youth Care Coordinator, Health Needs Assessment, Mentoring, Reproductive Heath grants, Teen Special Initiatives/HRCs Training, PREP Training, LGBTQ Medical Services, Bradbury-Sullivan, SELPHI, PA Coalition Against Domestic Violence (PCADV/HAPPY), Health Resource Centers (HRCs), Sexual Risk Avoidance Education Program (SRAE), LGBTQ Youth Services, County Municipal Health Departments Healthy Homes (CMHH), Metabolic Formula Nutrition Education and Counseling, County Municipal Health Department Home Visiting (CMHV), Metabolic Formula Program, Autism Diagnostic Clinic, BrainSTEPS, Child Rehabilitation, Community to Home, Community Health (BCHS), the Technology-Assisted Children's Program (TACHP), Safety in Youth Sports, the Male Involvement Initiative, Leadership Development and Training, Epilepsy Program, Medical Home Initiative, and specialty care programs for Hemophilia, Cooley's Anemia, Spina Bifida, Cystic Fibrosis and Sickle Cell Anemia.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**

	Fiscal Year:	**2020**

Field Note:
Services and programs represented in the CSHCN served count include the following: Safe and Healthy Homes Program, Case Management, Medical Home Program, County Municipal Health Department Home Visiting (CMHV), Metabolic Formula Program, Autism Diagnostic Clinic, Brain Steps, Child Rehabilitation, Community to Home, Community Health (BCHS), Cooley's Anemia, Cystic Fibrosis, Hemophilia, Medical Home Initiative, Spina Bifida, Sickle Cell, Medical Home Initiative, Leadership Development Training, infants served by newborn screening case management, infants served by the Metabolic Treatment Centers, infants served by the Cystic Fibrosis (CF) Treatment Centers, infants served by the Hemoglobin Treatment Centers, and infants enrolled in the Phenylketonuria (PKU) Formula Program.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Services and programs represented in the others 22+ served count include the following: IMPLICIT Interconception Care (ICC) Program, Alliance Opioid Project, LGBTQ medical services, the Metabolic Formula Program, Autism Diagnostic Clinic, Brain Steps Program, Child Rehabilitation, Community to Home, Specialty Care Programs for Cooley's Anemia, Epilepsy, Cystic Fibrosis, Hemophilia, Sickle Cell, Tourette's, and Spina Bifida. Many of the counts included in the Others 22+ field represent training attendees. While the number of persons trained is accounted for, the Title V programs listed above are not currently able to estimate the total target population impacted or the corresponding population domain served.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
The count provided for pregnant women served is the number of pregnant women served through the Keystone 10 Initiative as it represents the best unduplicated estimate of pregnant women receiving direct, enabling and population level services. Other services and programs that serve pregnant women which are represented by this count include the following: Safe and Healthy Homes Program, Community Health (BCHS), Centering Pregnancy Programs (CPP), One Key Question, Smoking Cessation, County Municipal Health Department Home Visiting, Parenting Health Initiative (SELPHI) and the Pennsylvania Pregnancy Risk Assessment Monitoring System (PRAMS). The true numerator is 120,412. The denominator (130,562) is from the National Vital Statistics Rapid Release Report, published May 2021 (Births: Provisional Data for 2020, page 9). The calculated percentage using these values is 92.2%.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
This is the number of infants receiving at least one newborn screen and also includes infants being served by newborn screening case management, the Metabolic, Cystic Fibrosis (CF) and Hemoglobin treatment centers, infants enrolled in the Phenylketonuria (PKU) formula program and infants served by the Federal Hearing Grant through the Guide By Your Side (GBYS) program. This number represents the best unduplicated estimate of infants served. Other services/programs represented by this count include: Sudden Death in the Young (SDY), Autism Diagnostic Clinic, Brain Steps, Child Rehabilitation, Community to Home, Cooley's Anemia, Cystic Fibrosis, Hemophilia, Sickle Cell Anemia and Spina Bifida. The true numerator is 133,910. The denominator (134,329) is PA Newborn Screening Internet Case Management System Provisional Data for 2020. The calculated percentage using these values is 99.7%.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
This is the number of children receiving a school growth screen (1,756,686) and represents the best unduplicated estimate. Other services represented include: Safe and Healthy Homes Program, Alliance Opioid Project, CMHV, Community Health (BCHS), Youth Care Coordinator, Health Needs Assessment, Mentoring, Reproductive Health, Teen Special Initiatives/HRCs Training, LGBTQ Medical Services, LGBTQ Training, LGBTQ Youth Services, Metabolic Formula Program, Reproductive Health, Personal Responsibility Education Program (PREP), PREP Training, Bradbury-Sullivan, SELPHI, PCADV/HAPPY, Sexual Risk Avoidance Education/Teen Outreach Program (SRAE/TOP), Federal Hearing Grant, Autism Diagnostic Clinic, Brain Steps, Child Rehabilitation, Community to Home, Cooley's Anemia, Cystic Fibrosis, Epilepsy, Hemophilia, Leadership Development & Training, Male Involvement Initiative, Medical Home, Safety in Youth Sports, Sickle Cell Anemia, and Spina Bifida. The true numerator is 1,756,686, denominator (3,170,299) is Pa. civilians aged 1 to 21 from 2019 U.S. Census, percentage is 55.4%.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Services and programs represented in the CSHCN served count include the following: Safe and Healthy Homes Program, Medical Home Program, Case Management, County Municipal Health Department Home Visiting (CMHV), Community Health (BCHS), Community to Home, Guide by Your Side Federal Hearing Grant, the Metabolic Formula program, Newborn Screening Case Management, the Metabolic, Cystic Fibrosis (CF) and Hemoglobin Treatment Centers, the Phenylketonuria (PKU) Formula Program, Tech-Assist Children's Program (TACHP), Tourette's, School Health, Specialty Care Programs for Autism, Cystic Fibrosis, Cooley's Anemia, Child Rehabilitation, Hemophilia, Spina Bifida, Sickle Cell Anemia, Leadership Development Training, and the Brain Steps program. The true numerator is 563,942. The denominator (687,363) is the product of the NSCH 2018-2019 percentage of children aged 0-17 with special health care needs (20.8%) multiplied by the total 2019 Pennsylvania child population (age 1-21) from the U.S. Census Bureau source described in the child field note (3,170,299) plus the total 2020 provisional Pennsylvania infant population from iCMS (134,329). The calculated percentage is 82.0%.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Services represented include: IMPLICIT Interconception Care (ICC) Program, Alliance Opioid Project, PREP and PREP training, Teens Special Initiatives/HRCs Training, LGBTQ Youth Services, LGTBQ Youth Services, SELPHI, Metabolic, Cystic Fibrosis and Spina Bifida pharmacy programs, Tourette's program, Autism Diagnostic Clinic, Brain Steps, Safety in Youth Sports, BrainSteps, Juvenile Justice, Leadership Development Training and Specialty Care Programs for Cooley's Anemia, Cystic Fibrosis, Child Rehabilitation, Hemophilia, Sickle Cell, and Spina Bifida. Counts included in this field represent training attendees. While the number of persons trained is accounted for, the Title V programs above are not currently able to estimate the total population impacted or the corresponding domain served. The true numerator is 22,338. The denominator (9,366,799) is the 2019ACS 1-Year Estimate for Pa. (12,801,989), less the count in the child field note (3,170,299), less the count in the infant field note (134,329), less the count in the pregnant women field note (130,562). The calculated percentage is 0.2%.

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Pennsylvania

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	133,605	86,796	17,289	16,716	69	5,945	37	3,468	3,285
Title V Served	120,412	91,031	12,884	9,392	120	4,214	0	2,408	363
Eligible for Title XIX	61,057	22,876	13,867	11,459	80	1,296	36	0	11,443
2. Total Infants in State	134,329	101,553	14,373	10,478	134	4,702	0	2,687	402
Title V Served	133,910	101,236	14,328	10,445	134	4,687	0	2,678	402
Eligible for Title XIX	67,205	25,484	15,152	12,434	93	1,490	63	0	12,489

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: The source for total deliveries in the state (total births by occurrence) is 2019 Pennsylvania Birth Files and data were provided by the Pennsylvania Office of Administration, Division of Health Informatics.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: For the counts of total deliveries in the state served by Title V, population estimate percentages by race/ethnicity from the Census (2019 ACS Community Survey 1-Year Estimates, Detailed Tables. Table ID B03002, Hispanic or Latino Origin by Race, Pennsylvania) were applied to the Form 5B total for pregnant women (120,412) for 2020.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Please note that the race/ethnicity of pregnant women who were eligible for Title XIX services was self-reported. Title XIX data was from calendar year 2020.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: The count for total infants in state (134,329) is from calendar year 2020 and provisional data were provided by the Pennsylvania Bureau of Family Health, Division of Newborn Screening and Genetics. Population estimate percentages by race/ethnicity from the Census (2019 ACS Community Survey 1-Year Estimates, Detailed Tables. Table ID B03002, Hispanic or Latino Origin by Race, Pennsylvania) were applied to the provisional total count for infants for 2020.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**

	Field Note: For the counts of total infants in the state served by Title V, population estimate percentages by race/ethnicity from the Census (2019 ACS Community Survey 1-Year Estimates, Detailed Tables. Table ID B03002, Hispanic or Latino Origin by Race, Pennsylvania) were applied to the Form 5B total for infants (133,910) for 2020.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Please note that the race/ethnicity of infants who were eligible for Title XIX services was self-reported. Title XIX data was from calendar year 2020.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Pennsylvania

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 986-2229	(800) 986-2229
2. State MCH Toll-Free "Hotline" Name	Healthy Baby	Healthy Baby
3. Name of Contact Person for State MCH "Hotline"	Bureau of Family Health	Bureau of Family Health
4. Contact Person's Telephone Number	(717) 346-3000	(717) 346-3000
5. Number of Calls Received on the State MCH "Hotline"		168

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Special Kids Network	Special Kids Network
2. Number of Calls on Other Toll-Free "Hotlines"		323
3. State Title V Program Website Address	https://www.health.pa.gov/topics/Administrative/Pages/Title-V.aspx	https://www.health.pa.gov/topics/Administrative/Pages/Title-V.aspx
4. Number of Hits to the State Title V Program Website		1,222
5. State Title V Social Media Websites	https://www.facebook.com/pennsylvaniadepartmentofhealth https://twitter.com/PAHealthDept	https://www.facebook.com/pennsylvaniadepartmentofhealth https://twitter.com/PAHealthDept
6. Number of Hits to the State Title V Program Social Media Websites		1,718,484

Form Notes for Form 7:

2020 Reporting Year, Line A.5: The number of calls received by the Healthy Baby hotline reported in Annual Report Year 2020 reflects updates to data collection strategies to reflect meaningful and accurate call data. Past collection strategies involved counting all calls from the former caller ID system including spam, advertising, and wrong number calls. All calls reflected in the 2020 Healthy Baby numbers are direct, intentional calls to the hotline.

2020 Reporting Year, Line B.2: The Covid-19 pandemic significantly impacted calls to the hotline for 2020. There was significant decrease in the number of calls received as compared to past years. All calls logged for the 2020 Special Kids Network hotline are direct, intentional calls to the hotline where a provider or family was assisted in identifying resources to meet their needs.

2020 Reporting Year, Line B.4: The number of hits to the State's Title V Program Website reported represents unique page views.

2020 Reporting Year, Line B.6: The number of hits to the State Title V Program Social Media Website represents the number of profile visits to the Department of Health's Twitter account from January to December 2020. Department of Health's Facebook page was available for 2020. The number of views significantly increased in 2020. This is due to COVID-19 and the large number of people that followed social media accounts during the height of the pandemic. The Bureau/State Title V Program does not have an individualized social media profile.

Form 8
State MCH and CSHCN Directors Contact Information

State: Pennsylvania

1. Title V Maternal and Child Health (MCH) Director	
Name	Tara Trego
Title	Director, Bureau of Family Health
Address 1	625 Forster Street
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 547-3385
Extension	
Email	ttrego@pa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Erin McCarty
Title	Director, Division of Bureau Operations
Address 1	625 Forster Street
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 547-3391
Extension	
Email	erimccarty@pa.gov

3. State Family or Youth Leader (Optional)	
Name	Cindy Dundas
Title	Director, Division of Community Systems Development and Outreach
Address 1	625 Forster Street
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 772-2763
Extension	
Email	cdundas@pa.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Pennsylvania

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Reduce or improve maternal morbidity and mortality, especially where there is inequity	New
2.	Reduce rates of infant mortality (all causes), especially where there is inequity	New
3.	Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	New
4.	Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	New
5.	Reduce rates of child mortality and injury, especially where there is inequity	New
6.	Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Revised
7.	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	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 7

Field Note:
Insufficient character count for the full text of the priority. In its complete form, the priority should read: "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."

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Reduce or improve maternal morbidity and mortality, especially where there is inequity	New
2.	Reduce rates of infant mortality (all causes), especially where there is inequity	New
3.	Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	New
4.	Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	New
5.	Reduce rates of child mortality and injury, especially where there is inequity	New
6.	Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Revised
7.	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	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 7

Field Note:
Insufficient character count for the full text of the priority. In its complete form, the priority should read: "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."

Form 10
National Outcome Measures (NOMs)

State: Pennsylvania

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	77.8 %	0.1 %	101,182	130,067
2018	77.5 %	0.1 %	101,845	131,447
2017	76.9 %	0.1 %	103,195	134,115
2016	77.3 %	0.1 %	104,692	135,429
2015	75.3 %	0.1 %	101,914	135,324
2014	75.5 %	0.1 %	103,022	136,365
2013	72.8 %	0.1 %	97,181	133,431
2012	72.8 %	0.1 %	98,877	135,833
2011	72.2 %	0.1 %	98,661	136,706
2010	71.7 %	0.1 %	97,915	136,499
2009	71.6 %	0.1 %	98,769	137,874

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	77.0	2.5	993	129,000
2017	76.4	2.4	1,002	131,085
2016	74.2	2.4	987	132,970
2015	77.4	2.8	782	101,053
2014	71.7	2.3	967	134,893
2013	66.9	2.3	890	133,108
2012	70.4	2.3	946	134,368
2011	68.7	2.3	935	136,119
2010	63.7	2.2	867	136,187
2009	65.3	2.2	907	138,919
2008	57.5	2.0	799	138,903

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	14.8	1.5	102	688,104
2014_2018	13.8	1.4	96	696,142

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.4 %	0.1 %	11,255	133,566
2018	8.3 %	0.1 %	11,222	135,186
2017	8.4 %	0.1 %	11,580	137,350
2016	8.2 %	0.1 %	11,331	138,255
2015	8.2 %	0.1 %	11,453	140,109
2014	8.3 %	0.1 %	11,713	141,638
2013	8.0 %	0.1 %	11,219	140,081
2012	8.1 %	0.1 %	11,492	141,805
2011	8.2 %	0.1 %	11,662	142,786
2010	8.3 %	0.1 %	11,941	143,006
2009	8.3 %	0.1 %	12,187	146,040

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	9.9 %	0.1 %	13,319	134,019
2018	9.5 %	0.1 %	12,915	135,442
2017	9.4 %	0.1 %	12,969	137,527
2016	9.3 %	0.1 %	12,962	139,175
2015	9.4 %	0.1 %	13,224	140,800
2014	9.4 %	0.1 %	13,291	142,051
2013	9.3 %	0.1 %	13,066	139,775
2012	9.5 %	0.1 %	13,407	141,341
2011	9.6 %	0.1 %	13,575	142,053
2010	9.9 %	0.1 %	14,060	142,174
2009	10.1 %	0.1 %	14,592	144,968

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	24.3 %	0.1 %	32,527	134,019
2018	23.5 %	0.1 %	31,862	135,442
2017	22.8 %	0.1 %	31,399	137,527
2016	22.7 %	0.1 %	31,574	139,175
2015	22.2 %	0.1 %	31,304	140,800
2014	22.1 %	0.1 %	31,382	142,051
2013	21.8 %	0.1 %	30,426	139,775
2012	22.2 %	0.1 %	31,448	141,341
2011	22.9 %	0.1 %	32,491	142,053
2010	23.9 %	0.1 %	33,955	142,174
2009	24.5 %	0.1 %	35,533	144,968

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.3	0.2	851	136,060
2017	6.9	0.2	950	138,188
2016	6.7	0.2	937	139,831
2015	6.8	0.2	967	141,500
2014	6.2	0.2	881	142,663
2013	7.1	0.2	1,007	141,349
2012	7.9	0.2	1,134	143,037
2011	6.9	0.2	996	143,631
2010	7.5	0.2	1,078	143,812
2009	7.2	0.2	1,065	146,899

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.9	0.2	806	135,673
2017	6.1	0.2	837	137,745
2016	6.1	0.2	857	139,409
2015	6.1	0.2	867	141,047
2014	5.9	0.2	838	142,268
2013	6.6	0.2	937	140,921
2012	7.1	0.2	1,005	142,514
2011	6.5	0.2	929	143,178
2010	7.2	0.2	1,036	143,321
2009	7.1	0.2	1,040	146,434

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.2	0.2	573	135,673
2017	4.4	0.2	604	137,745
2016	4.5	0.2	621	139,409
2015	4.4	0.2	622	141,047
2014	4.0	0.2	571	142,268
2013	4.8	0.2	679	140,921
2012	5.0	0.2	715	142,514
2011	4.5	0.2	646	143,178
2010	5.1	0.2	734	143,321
2009	4.9	0.2	720	146,434

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.7	0.1	233	135,673
2017	1.7	0.1	233	137,745
2016	1.7	0.1	236	139,409
2015	1.7	0.1	245	141,047
2014	1.9	0.1	267	142,268
2013	1.8	0.1	258	140,921
2012	2.0	0.1	290	142,514
2011	2.0	0.1	283	143,178
2010	2.1	0.1	302	143,321
2009	2.2	0.1	320	146,434

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	232.9	13.1	316	135,673
2017	240.3	13.2	331	137,745
2016	259.7	13.7	362	139,409
2015	252.4	13.4	356	141,047
2014	248.1	13.2	353	142,268
2013	281.0	14.1	396	140,921
2012	287.0	14.2	409	142,514
2011	263.3	13.6	377	143,178
2010	290.3	14.3	416	143,321
2009	295.0	14.2	432	146,434

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	92.1	8.2	125	135,673
2017	86.4	7.9	119	137,745
2016	86.8	7.9	121	139,409
2015	102.8	8.5	145	141,047
2014	76.6	7.3	109	142,268
2013	83.7	7.7	118	140,921
2012	88.4	7.9	126	142,514
2011	85.9	7.8	123	143,178
2010	99.1	8.3	142	143,321
2009	106.5	8.5	156	146,434

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	7.0 %	1.0 %	8,677	123,419
2018	6.0 %	0.9 %	7,722	128,105
2017	8.5 %	0.9 %	11,012	129,866
2016	7.3 %	0.9 %	9,507	130,952
2015	8.0 %	0.9 %	10,620	132,632
2014	6.6 %	0.9 %	8,861	134,793
2013	7.5 %	0.9 %	9,946	133,493
2012	6.1 %	0.9 %	8,175	135,030
2011	7.5 %	0.9 %	10,214	135,619
2010	7.0 %	0.9 %	9,487	135,581
2009	7.1 %	0.9 %	9,803	138,011
2008	7.1 %	0.9 %	9,894	139,733
2007	6.1 %	1.3 %	5,129	83,516

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.2	0.3	1,840	130,029
2017	14.7	0.3	1,919	130,811
2016	15.0	0.3	2,011	134,032
2015	13.1	0.4	1,345	102,351
2014	13.2	0.3	1,812	136,973
2013	12.3	0.3	1,652	134,181
2012	10.8	0.3	1,461	135,176
2011	9.0	0.3	1,228	136,888
2010	7.5	0.2	1,028	137,115
2009	6.1	0.2	849	140,210
2008	4.9	0.2	681	139,975

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	10.0 %	1.3 %	251,106	2,509,215
2017_2018	11.5 %	1.6 %	288,342	2,513,227
2016_2017	12.0 %	1.5 %	299,138	2,493,349
2016	12.4 %	1.6 %	307,206	2,480,436

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	16.4	1.1	212	1,289,265
2018	16.1	1.1	208	1,293,165
2017	15.1	1.1	196	1,299,448
2016	18.1	1.2	236	1,302,893
2015	15.6	1.1	204	1,309,207
2014	15.5	1.1	204	1,312,869
2013	15.5	1.1	204	1,319,788
2012	17.2	1.1	228	1,327,819
2011	16.4	1.1	218	1,329,111
2010	14.8	1.1	198	1,341,623
2009	16.7	1.1	223	1,338,778

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	27.9	1.3	434	1,553,565
2018	30.1	1.4	471	1,565,533
2017	31.8	1.4	500	1,571,488
2016	31.6	1.4	499	1,577,593
2015	31.1	1.4	495	1,590,253
2014	25.6	1.3	410	1,603,732
2013	29.4	1.4	476	1,618,822
2012	32.5	1.4	534	1,644,941
2011	32.1	1.4	536	1,671,249
2010	34.0	1.4	576	1,696,217
2009	31.6	1.4	541	1,713,734

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	7.1	0.5	173	2,430,632
2016_2018	8.2	0.6	201	2,449,751
2015_2017	10.0	0.6	248	2,469,742
2014_2016	10.1	0.6	252	2,489,092
2013_2015	10.1	0.6	254	2,513,155
2012_2014	10.3	0.6	263	2,549,339
2011_2013	12.6	0.7	328	2,600,002
2010_2012	14.2	0.7	378	2,657,908
2009_2011	14.2	0.7	385	2,708,142
2008_2010	14.8	0.7	406	2,743,868
2007_2009	16.5	0.8	456	2,761,043

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	9.3	0.6	225	2,430,632
2016_2018	9.7	0.6	238	2,449,751
2015_2017	9.4	0.6	233	2,469,742
2014_2016	8.2	0.6	205	2,489,092
2013_2015	7.8	0.6	195	2,513,155
2012_2014	7.2	0.5	184	2,549,339
2011_2013	7.6	0.5	198	2,600,002
2010_2012	7.5	0.5	200	2,657,908
2009_2011	7.5	0.5	204	2,708,142
2008_2010	7.0	0.5	192	2,743,868
2007_2009	6.1	0.5	169	2,761,043

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	20.8 %	1.6 %	549,735	2,642,377
2017_2018	19.6 %	1.6 %	521,926	2,658,590
2016_2017	19.1 %	1.4 %	511,324	2,671,110
2016	19.3 %	1.5 %	517,187	2,678,463

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	21.6 %	3.7 %	118,702	549,735
2017_2018	18.2 %	3.2 %	95,161	521,926
2016_2017	16.5 %	2.5 %	84,576	511,324
2016	20.5 %	3.4 %	106,085	517,187

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.2 %	0.7 %	71,417	2,248,361
2017_2018	4.6 %	1.0 %	102,719	2,251,466
2016_2017	3.8 %	0.9 %	83,536	2,206,967
2016	2.2 %	0.6 %	48,948	2,183,465

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	7.9 %	1.1 %	174,804	2,215,840
2017_2018	8.5 %	1.2 %	189,925	2,227,170
2016_2017	8.1 %	1.1 %	179,043	2,205,997
2016	7.5 %	1.2 %	164,358	2,185,239

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	53.1 %	5.7 %	149,790	282,336
2017_2018	60.6 %	5.5 %	162,035	267,247
2016_2017	65.2 %	4.8 %	172,409	264,581
2016	56.5 %	6.1 %	151,226	267,559

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	88.8 %	1.5 %	2,344,413	2,640,133
2017_2018	91.7 %	1.4 %	2,433,973	2,654,034
2016_2017	92.3 %	1.2 %	2,457,710	2,662,332
2016	92.1 %	1.3 %	2,455,051	2,665,532

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	12.8 %	0.1 %	9,493	74,206
2016	12.2 %	0.1 %	9,802	80,202
2014	12.9 %	0.1 %	10,985	84,996
2012	13.1 %	0.1 %	12,217	93,009
2010	12.8 %	0.1 %	12,425	96,762
2008	11.6 %	0.1 %	9,904	85,595

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	15.4 %	0.9 %	79,916	519,253
2017	13.7 %	0.9 %	67,111	490,246
2015	14.0 %	0.9 %	67,345	482,751
2009	11.7 %	0.7 %	65,707	559,897

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	14.5 %	2.1 %	154,540	1,065,948
2017_2018	17.4 %	2.4 %	185,397	1,066,248
2016_2017	16.8 %	2.1 %	181,826	1,082,218
2016	14.2 %	1.9 %	160,750	1,129,655

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.4 %	0.2 %	115,434	2,626,979
2018	4.3 %	0.3 %	114,379	2,640,983
2017	4.4 %	0.3 %	117,688	2,660,673
2016	4.7 %	0.2 %	124,175	2,664,966
2015	4.0 %	0.2 %	108,644	2,686,144
2014	5.4 %	0.3 %	145,714	2,688,940
2013	5.0 %	0.2 %	134,993	2,709,009
2012	5.1 %	0.3 %	139,286	2,732,366
2011	5.4 %	0.3 %	148,564	2,758,314
2010	5.3 %	0.3 %	146,737	2,785,072
2009	5.0 %	0.3 %	138,132	2,770,999

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	78.8 %	3.0 %	111,000	141,000
2015	69.8 %	4.0 %	99,000	142,000
2014	71.8 %	3.5 %	103,000	143,000
2013	70.3 %	3.5 %	102,000	145,000
2012	71.5 %	3.3 %	104,000	146,000
2011	74.9 %	2.9 %	110,000	147,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	68.6 %	1.1 %	1,712,930	2,496,983
2018_2019	69.7 %	1.3 %	1,742,881	2,502,341
2017_2018	65.3 %	1.5 %	1,629,334	2,495,160
2016_2017	63.3 %	1.8 %	1,602,487	2,532,776
2015_2016	60.5 %	2.0 %	1,544,288	2,552,964
2014_2015	63.3 %	2.3 %	1,626,720	2,571,077
2013_2014	59.8 %	1.8 %	1,558,312	2,604,570
2012_2013	64.9 %	2.5 %	1,674,796	2,581,443
2011_2012	54.8 %	1.9 %	1,417,118	2,586,916
2010_2011	58.3 %	2.3 %	1,483,616	2,544,796
2009_2010	47.8 %	1.9 %	1,277,497	2,672,587

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	77.0 %	2.4 %	586,372	761,271
2018	72.0 %	3.0 %	551,038	765,383
2017	67.3 %	2.6 %	521,426	774,307
2016	64.4 %	2.5 %	500,929	777,581
2015	59.0 %	2.7 %	460,883	781,529

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	93.8 %	1.4 %	713,710	761,271
2018	90.0 %	2.2 %	688,844	765,383
2017	90.6 %	1.7 %	701,844	774,307
2016	92.0 %	1.4 %	715,105	777,581
2015	91.7 %	1.4 %	716,890	781,529
2014	93.0 %	1.4 %	732,551	787,571
2013	89.9 %	1.8 %	711,883	792,092
2012	88.4 %	1.8 %	705,991	798,314
2011	81.0 %	2.2 %	655,887	809,289
2010	74.0 %	2.5 %	613,378	829,381
2009	67.9 %	3.0 %	565,784	833,340

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	94.0 %	1.4 %	715,395	761,271
2018	94.3 %	1.4 %	721,661	765,383
2017	93.4 %	1.3 %	723,131	774,307
2016	92.7 %	1.3 %	720,506	777,581
2015	94.8 %	1.1 %	740,468	781,529
2014	95.2 %	1.0 %	749,967	787,571
2013	90.4 %	1.8 %	716,165	792,092
2012	89.4 %	1.8 %	713,612	798,314
2011	83.8 %	2.1 %	678,342	809,289
2010	79.8 %	2.3 %	661,919	829,381
2009	71.9 %	3.0 %	599,084	833,340

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.3	0.2	5,264	394,792
2018	14.1	0.2	5,599	397,138
2017	14.8	0.2	5,899	399,719
2016	15.8	0.2	6,385	403,321
2015	17.8	0.2	7,218	405,994
2014	19.3	0.2	7,892	409,328
2013	20.8	0.2	8,657	416,319
2012	23.7	0.2	10,049	424,484
2011	25.0	0.2	10,816	432,903
2010	27.1	0.3	11,959	440,825
2009	28.7	0.3	12,850	448,436

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.6 %	1.4 %	14,471	124,305
2018	14.7 %	1.4 %	18,520	126,162
2017	10.6 %	1.0 %	13,614	128,956
2016	10.6 %	1.2 %	13,702	129,377
2015	10.1 %	1.1 %	13,329	132,039
2014	10.9 %	1.1 %	14,601	133,589
2013	14.8 %	1.3 %	19,766	133,318
2012	12.4 %	1.3 %	16,782	135,521

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.0 %	0.6 %	53,100	2,637,338
2017_2018	2.3 %	0.8 %	61,869	2,650,598
2016_2017	2.1 %	0.7 %	54,670	2,661,370
2016	1.6 %	0.5 %	42,363	2,664,889

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Pennsylvania

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					78.2
Annual Indicator				77.6	75.2
Numerator				1,651,482	1,609,089
Denominator				2,128,688	2,140,534
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	68	68.7	69.4	70.1	78.2
Annual Indicator	66.5	66.4	65.3	77.6	
Numerator					
Denominator					
Data Source	NIS	NIS	NIS	NIS	
Data Source Year	2015	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	78.8	79.4	80.0	80.6	81.2	81.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Updated 2020-2025 objectives to reflect new wording of BRFSS question (asks about routine check-up without any definition) for 2018. The 2019 reporting year indicator also exceeds previously established objectives, warranting updates for subsequent years. Trend from 2016 reporting year to 2018 reporting year suggests an average annual change of ~-0.6. Built out targets for 2020 to 2025 accordingly using 2019 reporting year indicator as baseline. Projected a positive trend given that the question is less specific and efforts to advance the NPM are ongoing in PA.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	74	76	78	80	86
Annual Indicator	73.3	81.8	83.8	84.2	82.9
Numerator	99,273	108,050	111,838	113,497	105,668
Denominator	135,367	132,020	133,410	134,782	127,530
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	88.0	89.0	90.0	91.0	92.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	17	18	20	23	30
Annual Indicator	20.5	23.7	25.6	26.9	25.9
Numerator	27,408	30,174	32,912	35,760	32,327
Denominator	133,488	127,300	128,398	132,966	124,942
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.0	34.0	36.0	38.0	40.0	42.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79	79.8	80.6	82.1	85.3
Annual Indicator	76.7	84.0	81.2	83.1	82.4
Numerator	101,695	110,308	103,722	104,542	101,724
Denominator	132,585	131,259	127,773	125,760	123,405
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	79	79.8	80.6	82.1	85.3
Annual Indicator	76.7	84	81.2	83.1	
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Data Source Year	2014	2015	2017	2018	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	88.6	90.3	91.9	93.5	95.1

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		32.3	37.7
Annual Indicator	31.5	36.6	39.8
Numerator	38,141	44,262	46,940
Denominator	121,226	120,893	118,085
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			32.3	37.7
Annual Indicator	32.4	31.5		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2012-2015	2016-2017		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	39.8	41.9	44.0	46.1	48.2	50.3

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2018	**2019**	**2020**
Annual Objective		47.4	51.7
Annual Indicator	46.9	50.1	59.5
Numerator	56,601	60,875	70,513
Denominator	120,631	121,402	118,424
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			47.4	51.7
Annual Indicator	46.1	46.9		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2012-2015	2016-2017		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	53.7	55.7	57.7	59.7	61.7	63.7

Field Level Notes for Form 10 NPMs:

None

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	188.7	186.8	184.9	183.1	126.2
Annual Indicator	175.4	152.0	152.5	139.4	139.8
Numerator	2,553	1,654	2,201	2,004	1,997
Denominator	1,455,450	1,088,130	1,443,388	1,437,802	1,428,611
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	113.1	100.0	86.9	73.8	60.7	57.6

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			88.7	85	85
Annual Indicator		86.5	85.7	85.7	87.7
Numerator		775,554	715,291	715,291	659,147
Denominator		897,142	834,394	834,394	751,698
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	86.0	88.0	90.0	92.0	92.0	92.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			61	45	45
Annual Indicator		51.8	45.9	42.9	44.5
Numerator		267,920	234,614	223,990	244,784
Denominator		517,187	511,324	521,926	549,735
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	48.0	50.0	50.0	55.0	55.0	55.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Child Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2020
Annual Objective	
Annual Indicator	49.3
Numerator	1,027,215
Denominator	2,085,050
Data Source	NSCH-NONCSHCN
Data Source Year	2018_2019

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
The goal is to ensure that all State Health Centers are documenting and reporting all referrals of children ages 0-17, who do not have a provider or insurance, made to a medical home within 6 months in order to establish a baseline.

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Pennsylvania

2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	14.5	14.3	14.1	13.9	13.7
Annual Indicator	24.7	24.7	27.9	27.9	23.5
Numerator	122,928	122,928	143,541	143,541	130,221
Denominator	497,526	497,526	514,783	514,783	553,081
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	**2018**	**2019**	**2020**
Annual Objective			13.9	13.7
Annual Indicator			8.0	11.9
Numerator			66,453	94,807
Denominator			835,614	796,529
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2017	**2018**	**2019**	**2020**
Annual Objective			13.9	13.7
Annual Indicator			34.4	36.9
Numerator			287,648	293,739
Denominator			835,614	796,529
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	13.2	12.2	9.8	8.8	7.8
Annual Indicator	12.5	11.5	11.1	10.4	9.5
Numerator	17,295	15,875	15,026	13,874	12,446
Denominator	138,426	137,557	135,851	133,690	131,653
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Pennsylvania

SPM 1 - Percent of newborns with on time report out for out of range screens

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.5	71.0	71.5	72.0	72.5	73.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of hospitals making referrals to Early Intervention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of eligible infants with a Plan of Safe Care

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of children ages 6-17 who have one or more adult mentors

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	94.0	94.0	94.0	94.0	95.0	95.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Rate of mortality disparity between black and white infants

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.1	8.9	8.6	8.2	7.7	7.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
In 2017 the rate was recorded at 28 for black children ages 1-4 and 16.3 for white children of the same ages, highlighting a rate difference of 11.7. The goal will be to reduce by a rate of 5 per 100,000 children, over 5 years. 2017 marked the lowest rates from 2013-2017. Measure comes from HP2020 data. (Decrease the difference in the rates between black and white by: 2021-0.5; 2022- 0.5; 2023- 1; 2024-1; 2025-2)-starting at the 2017 disparity rate

SPM 7 - Rate of mortality disparity between black and white children, ages 1-4

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	11.2	10.7	9.7	8.7	6.7	4.7

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
2019 Reporting Year - Field Note: In 2017 the rate was recorded at 28 for black children ages 1-4 and 16.3 for white children of the same ages, highlighting a rate difference of 11.7. The goal will be to reduce by a rate of 5 per 100,000 children, over 5 years. 2017 marked the lowest rates from 2013-2017. Measure comes from HP2020 data. (Decrease the difference in the rates between black and white by: 2021-0.5; 2022- 0.5; 2023- 1; 2024-1; 2025-2)-starting at the 2017 disparity rate

SPM 8 - Rate of maternal mortality disparity between black and white persons

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	26.4	25.9	25.4	24.6	22.6	20.6

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
2019 Reporting Year - Field Note: In 2016, the rate was recorded at 36.8 for black persons and 10.2 for white persons, highlighting a rate difference of 26.6. The goal will be to reduce by a rate of 3.0 per 100,000 live births over 5 years. Lowest 5 year disparity rate recorded is from 2015. (Decrease the difference in the pregnancy related mortality rates between black and white by: 2021-0.25; 2022- 0.5; 2023- .5; 2024- .75; 2025-2)-starting at the 2016 disparity rate

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	20	38	56
Annual Indicator	0	1.3	1.3	1.3	0
Numerator			1	1	0
Denominator			79	79	1
Data Source	N/A	BFH internal data collection	BFH internal data collection	BFH internal data collection	BFH internal data collection
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The Title V program currently lacks a mechanism for consistently collecting data on the dissemination of health information that is accurate and clearly understandable. The annual indicator represents the one program that includes reporting on this measure in its quarterly reports. Given this limitation, the SPM will be discontinued effective 2021.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: No mechanism to collect the information consistently from all grantees.	

2016-2020: SPM 3 - Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		49	54	59	64
Annual Indicator	48	52	56.7	55.5	56
Numerator			81,272	74,093	74,990
Denominator			143,437	133,575	133,910
Data Source	Newborn Screening Data System	Newborn Screening Data System	Newborn Screening Data System	Newborn Screening Data System	Newborn Screening Data System
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		32	42	55	66
Annual Indicator	29	18	59.6	68.2	91.9
Numerator			28	30	34
Denominator			47	44	37
Data Source	BFH internal data collection	BFH internal data collection	BFH internal data collection	BFH internal data collection	BFH internal data collection
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
A workforce capacity survey was sent to BFH program staff to self identify if they used data to make programmatic decisions. There was a total of 44 staff responses. Of the 44 responses, 30 staff responded that they "agree" or "strongly agree".

2016-2020: SPM 5 - Percent of youth ages 8-18 participating in evidence-based or evidence-informed programs who increased or maintained protective factors or decreased risk factors

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	25	50	55
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Data Source	N/A	N/A	N/A	N/A	N/A
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Programs started 1/1/18 - no numbers to report yet.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Current mentoring grantees are unable to accurately collect and report the percent change in protective factors or risk factors influencing positive youth development and health outcomes. Each mentoring grantee is implementing an evidence-based or evidence-informed model unique to their agency, and uniform data collection is not feasible. Given this limitation, the SPM will be discontinued effective 2021.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Current mentoring grantees are unable to accurately collect and report the percent change in protective factors or risk factors influencing positive youth development and health outcomes. Each mentoring grantee is implementing an evidence-based or evidence-informed model unique to their agency, and uniform data collection is not feasible. Given this limitation, the SPM will be discontinued effective 2021.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Pennsylvania

ESM 1.1 - Percent of women who successfully complete evidence-based or informed home visiting programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	24.0	24.5	25.0	25.5	26.0	26.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Percent of adolescents and women enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	85.0	85.9	86.8	87.7	88.6	89.5

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Percent of mothers served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one well-child visit

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.4	83.6	84.8	86.1	87.3

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 Reporting Year Field Note - IMPLICIT Interconception Care (ICC) program data is reported on a state fiscal year basis.

ESM 1.4 - Number of community-based doulas trained in communities served by the program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Number of behavioral health providers trained in pregnancy intention assessment

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	27.0	30.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 Reporting Year Field Note: Objectives for 2024, 2025, and 2026 are zero as the grant period for the Alliance of Family Planning Councils - Opioid Use Disorder grant will end (if renewals are completed June 30, 2023). Alliance date is reported on a state fiscal year basis.

ESM 1.6 - Percent of women enrolled in home visiting, Centering Pregnancy and IMPLICIT who are referred for behavioral health services following a positive screening

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	80.8	81.6	82.4	83.2	84.4

Field Level Notes for Form 10 ESMs:

None

ESM 1.7 - Percent of women who receive a maternal health assessment within 28 days of delivery through the 4th trimester pilot program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.8 - Number of MMRC recommendations implemented annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.9 - Number of meetings held between DOH, DHS and MIECHV annually

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percent of Keystone 10 facilities that progressed by one or more steps each fiscal year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	60.0	60.0	60.0	60.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Convene five regional breastfeeding collaborative meetings twice per year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.4 - Award 15 mini-grants to community partners to provide breastfeeding support.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	15.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Number of CDR recommendations implemented annually (infant health)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.2 - Number of hospitals recruited to implement the model safe sleep program

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		2	3	3	0
Annual Indicator	2	6	6	6	0
Numerator					
Denominator					
Data Source	quarterly reports from the Infant Safe Sleep Initi	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports - Infant Safe Sleep Initiative	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2016 . Objective projections have only been made for the three year grant period.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. Determination of direction of future programming not yet established. Data is reported for the calendar year 2019.

ESM 5.3 - Percentage of infants born whose parents were educated on safe sleep practices through the model program

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	8	9	18
Annual Indicator	0	3	8.6	17.4	0
Numerator			11,639	23,337	
Denominator			135,498	134,091	
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports - Infant Safe Sleep Initiative	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19. Model program was under development 7/1/16 to 6/30/17 and implementation begins 7/1/17. Objective projections have only been made for the three year grant period.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017. Program implementation began 7/17/17	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. Determination of future direction of programming not yet established. Data is reported for the calendar year 2019. Program implementation began 7/17/17.	

ESM 5.4 - Percentage of hospitals with maternity units implementing the model program

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		0	2	4	8
Annual Indicator	0	2	1.9	8.9	0
Numerator			2	9	
Denominator			107	101	
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports - Infant Safe Sleep Initiative	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19. Model program was under development 7/1/16 to 6/30/17 and implementation begins 7/1/17. Objective projections have only been made for the three year grant period.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. Determination of future direction of programming not yet established. Data is reported for the calendar year 2019.	

ESM 5.5 - Number of targeted prevention initiatives or interventions implemented using PPOR data

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.1 - Number of recommendations from CDR teams that are implemented (child health)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.2 - Number of ConcussionWise trainings to athletic personnel

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		15	18	21	25
Annual Indicator	13	18	15	12	7
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	33.0	35.0	38.0	38.0	41.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
SFY 2016 number does not include the last quarter (report due end of July).

ESM 10.2 - Number of referrals provided to school and community-based resources (HRCs)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4,500.0	4,550.0	4,600.0	4,650.0	4,700.0	4,750.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.3 - Percent of visits that include counseling (HRCs)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	90.0	90.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.4 - Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.0	45.0	60.0	60.0	60.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.5 - Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3,880.0	3,880.0	3,880.0	3,880.0	3,880.0	3,880.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.6 - The number of users who accessed the SafeTeens.org site

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10,000.0	11,000.0	12,100.0	13,310.0	14,641.0	15,796.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	360.0	360.0	360.0	360.0	360.0	360.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.8 - Number of substance use and brain injury professionals receiving brain injury and opioid training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	150.0	160.0	170.0	180.0	190.0	200.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.9 - Number of CDR recommendations implemented (adolescent health)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.0	1.0	1.0	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.10 - Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	35.0	39.0	43.0	47.0	51.0	55.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.11 - 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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		59.5
Numerator		13,448
Denominator		22,602
Data Source		Grantee reports
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	55.0	55.0	55.0	55.0	55.0	55.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.12 - The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		9.4
Numerator		2,127
Denominator		22,602
Data Source		Grantee reports
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	9.0	9.0	10.0	11.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.0	3.0	4.0	5.0	6.0	7.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	475.0	498.0	523.0	549.0	576.0	604.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	52.0	55.0	58.0	61.0	64.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	8.0	8.0	8.0	8.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	43.0	46.0	46.0	49.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	500.0	515.0	530.0	545.0	560.0	575.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.9 - Number of calls received through the SKN Helpline

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	800.0	825.0	850.0	875.0	900.0	925.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	8.0	8.0	8.0	8.0	8.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	44.0	48.0	52.0	56.0	60.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.12 - 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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	19.0	23.0	27.0	31.0	35.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
2020 reporting year field note: due to the time demands surrounding their involvement with the COVID-19 pandemic, Community Health Nurses were unable to identify baseline numbers to establish annual objectives. Objective development is in progress.

ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	20.0	22.0	24.0	26.0	28.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Number of families served through Centering Pregnancy Programs

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		300	340	345	350
Annual Indicator	310	330	323	262	248
Numerator					
Denominator					
Data Source	Quarterly reports from the Centering Pregnancy Pro	Quarterly reports from the Centering Pregnancy Pro	Quarterly reports from the Centering Pregnancy Pro	Quarterly reports from the Centering Pregnancy Pro	Quarterly reports from the Centering Pregnancy Pro
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Number of women in LGH, AEHN and PDPH CPP	

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Number of women in LGH, AEHN and PDPH Centering Pregnancy Programs (CPP).	

2016-2020: ESM 1.2 - Percent of adolescents and women engaged in family planning after delivery

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	82	83	84
Annual Indicator	87	85	84.4	77.6	82.6
Numerator			1,463	1,311	959
Denominator			1,734	1,689	1,161
Data Source	Quarterly reports from the County Municipal Health	Quarterly reports from the County Municipal Health	Quarterly reports from the County Municipal Health	Quarterly reports from the County Municipal Health	Quarterly reports from the County Municipal Health
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Partial data	

2016-2020: ESM 1.3 - Percent of adolescents and women who talked with a health care professional about birth spacing and birth control methods

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	82	83	84
Annual Indicator	94	83	90	90.3	87.9
Numerator			1,560	1,526	1,021
Denominator			1,734	1,689	1,161
Data Source	Quarterly reports from the IMPLICIT Programs	Quarterly reports from the IMPLICIT Programs	Quarterly reports from the IMPLICIT Programs	Quarterly reports from the IMPLICIT Programs	Quarterly reports from the IMPLICIT Programs
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Partial data	

2016-2020: ESM 1.5 - Number of women served through evidence based or informed home visiting programs

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1,500	1,600	1,700	1,800
Annual Indicator	1,585	1,930	1,734	1,689	1,161
Numerator					
Denominator					
Data Source	Quarterly reports from the County/Municipal Health	Quarterly reports from the County/Municipal Health	Quarterly reports from the County/Municipal Health	Quarterly reports from the County/Municipal Health	Quarterly reports from the County/Municipal Health
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
number of women in prenatal and postpartum CMHD HV programs

2016-2020: ESM 1.6 - Percent of eligible women receiving 17-alpha-hydroxy progesterone caproate (17P) treatment compared to baseline data

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			11	12
Annual Indicator			0	0
Numerator			0	0
Denominator			11	12
Data Source			Data not available - see field note	Data not available - see field note
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: On October 29, 2019, the Bone, Reproductive and Urologic Drugs Advisory Committee of the U.S. Food and Drug Administration (FDA) met and announced that research on 17P indicated it is not effective in preventing preterm birth in the populations it studied. This initiative was subsequently suspended, effective February 1, 2020.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: On October 29, 2019, the Bone, Reproductive and Urologic Drugs Advisory Committee of the U.S. Food and Drug Administration (FDA) met and announced that research on 17P indicated it is not effective in preventing preterm birth in the populations it studied. This initiative was subsequently suspended, effective February 1, 2020.	

2016-2020: ESM 4.1 - Percent of facilities designated as a Keystone 10 facility each fiscal year

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		25	17	22	27
Annual Indicator	7	12	17.2	23.8	31.4
Numerator			15	20	27
Denominator			87	84	86
Data Source	Vendor reports and enrollment numbers	Vendor reports and enrollment numbers	Vendor reports and enrollment numbers	Vendor reports and enrollment numbers	Vendor reports and enrollment numbers
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The ESM for Objective 1 has been changed to "Percent of individual facilities becoming Keystone 10 desginated each fiscal year." The 2016 annual indicator has been updated to reflect the new measure.

2016-2020: ESM 4.2 - Percent of counties with breastfeeding initiation rates at or above the 2016 statewide average of 81 percent each fiscal year

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	47	52	57
Annual Indicator	37	45	41.8	44.8	40.3
Numerator			28	30	27
Denominator			67	67	67
Data Source	Vendor reports and PA Health Stats	Vendor reports and PA Health Stats	Vendor reports and PA Health Stats	Vendor reports and PA Health Stats	Vendor reports and PA Health Stats
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
planning activities began in mid summer 2016 so no counties implemented evidence based strategies during that year

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The ESM for Objective 2 has been changed to measure the percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year. 2016 data is the most recent data available and was used to set the baseline for the new ESM.

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
In 2019 the wording of the measure was updated to include "initiation" for clarity. The underlying data being reported is unchanged.

2016-2020: ESM 4.3 - Number of new collaborations developed (between breastfeeding program plus other program)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1	2	2	3
Annual Indicator	3	1	2	2	3
Numerator					
Denominator					
Data Source	BFH internal collection	BFH internal collection	BFH internal collection	BFH internal collection	BFH internal collection
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.4 - Number of media opportunities implemented promoting breastfeeding per fiscal year

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1	2	2	3
Annual Indicator	0	0	2	2	3
Numerator					
Denominator					
Data Source	BFH internal collection	BFH internal collection	BFH internal collection	BFH internal collection	BFH internal collection
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 5.4 - Number of social marketing messages disseminated

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		160	171	86	0
Annual Indicator	0	42	82	166	93
Numerator					
Denominator					
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi	Quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19. Implementation begins 7/1/17. Objective projections have only been made for the three year grant period.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017. Program implementation began 7/17/17. Targets for 2018 and 2019 have been changed with details in the plan narrative due to changes upon implementation.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 Reporting Year Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21 with a determination of future programming not yet established. Data is reported for the calendar year 2019. Program implementation began 7/17/17.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. This work will not continue in the new funding period. Data is reported for the calendar year 2020. Program implementation began 7/17/17.	

2016-2020: ESM 7.1.1 - Number of comprehensive home assessments completed

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		875	900	920	700
Annual Indicator	97	1,069	858	683	336
Numerator					
Denominator					
Data Source	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pa. SHHP	Quarterly reports from Pa. SHHP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Grant period ends 06/30/19 with a determination of future programming not yet established.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Grant period ends 06/30/20 with a determination of future programming not yet established.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. Determination of direction of future programming has not yet been established. Data is reported for the calendar year 2019.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. This work will end at the end of the renewal period. Data is reported for the calendar year 2020. The targets for years 2020 through 2021 have been modified to reflect anticipated progress and the anticipated end of the grant's renewal term.	

2016-2020: ESM 7.1.2 - Number of health and safety hazards identified through comprehensive home assessments

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		7,000	7,200	7,360	5,600
Annual Indicator	936	6,447	6,234	4,088	2,059
Numerator					
Denominator					
Data Source	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pa. SHHP	Quarterly reports from Pa. SHHP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Grant period ends 06/30/19 with a determination of future programming not yet established.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Grant period ends 06/30/20 with a determination of future programming not yet established.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. Determination of future programming not yet established. Data is reported for the calendar year 2019.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: Grant period was 7/1/16 to 6/30/19 and was renewed through 6/30/21. This work will end at the end of the renewal period. Data is reported for the calendar year 2020. Targets for 2020 and 2021 previously were lowered to reflect fewer hazards being identified (described in the narrative) and the anticipated end of the grant's renewal term.	

2016-2020: ESM 7.1.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4,375	4,500	4,600	3,500
Annual Indicator	468	4,845	4,334	3,785	1,770
Numerator					
Denominator					
Data Source	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from Pennsylvania Safe and Healt	Quarterly reports from the Pa. SHHP	Quarterly reports from the Pa. SHHP
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Grant period ends 06/30/19 with a determination of future programming not yet established.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Grant period ends 06/30/20 with a determination of future programming not yet established.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/16 to 6/30/19, renewed through 6/30/21. Determination of future programming not yet established. Data is reported for the calendar year 2019.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: Grant period is 7/1/16 to 6/30/19, renewed through 6/30/21. This work will end at the end of the renewal period. Data is reported for the calendar year 2020. Targets for 2020 through 2022 previously were lowered to reflect fewer hazards being identified (described in the narrative) and the anticipated end of the grant's renewal term.	

2016-2020: ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	90	100	100
Annual Indicator	76	83	70.6	55.6	37
Numerator			12	15	10
Denominator			17	27	27
Data Source	quarterly reports	quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Increased numbers to reflect current status.

2016-2020: ESM 9.5 - Number of evidence-based mentoring programs implemented in high risk areas of PA

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	7	9	11
Annual Indicator	0	0	8	11	10
Numerator					
Denominator					
Data Source	n/a	n/a	n/a	n/a - see field note	n/a
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Includes mentoring, HEAL, YAOP, SRAE, HAPPY, and CBIM.

2016-2020: ESM 9.6 - The number of organizations certified as a safe space provider

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		40	60	80	100
Annual Indicator	20	30	33	34	35
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Updated numbers to match work statements.	

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: Program ended 6/30/2020.	

2016-2020: ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		150	175	200	230
Annual Indicator	135	368	324	67	0
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 Reporting Year Field Note: Program ended 6/30/2020

2016-2020: ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	15	15	30	30
Annual Indicator	0	0	0	13
Numerator				
Denominator				
Data Source	n/a	n/a	n/a	grantee reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Program expected to begin January 2020.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Program is expected to begin January 2020.	

2016-2020: ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	250	425	475	525
Annual Indicator	250	425	16,150	14,227
Numerator				
Denominator				
Data Source	n/a	n/a	n/a - see field note	n/a
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Includes mentoring, HEAL, YAOP, SRAE, HAPPY, and CBIM.

2016-2020: ESM 10.1 - The number of counties with a Health Resource Center (HRC) available to youth ages 12-17

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		10	10	11	11
Annual Indicator	9	8	11	11	11
Numerator					
Denominator					
Data Source	quarterly reports	quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Updated numbers to reflect current program status/goals.

2016-2020: ESM 10.2 - Number of youth receiving services at a Health Resource Center (HRC)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		3,500	4,000	4,500	
Annual Indicator	3,288	3,780	3,425	11,134	8,975
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: SFY 2016 number does not include the last quarter (report due end of July). Previous numbers were extremely low - updated to reflect current numbers and work statements.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Updated the units associated with this ESM from 10,000 to 100,000 to accommodate the annual indicator for 2019.	

2016-2020: ESM 10.4 - Number of youth receiving services at a drop-in site funded by the Bureau of Family Health (BFH)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		3,800	4,000	4,200	4,500
Annual Indicator	3,537	3,520	3,848	3,164	856
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.5 - Number of youth receiving health education and counseling services from a reproductive health provider

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		11,817	15,275	15,375	15,475
Annual Indicator	7,557	10,599	10,692	22,870	23,218
Numerator					
Denominator					
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Previous numbers were way too high, had issues with site counts. Technical assistance provided and reporting issues fixed. Numbers were updated.

2016-2020: ESM 11.1 - Number of families who receive services through the evidence based or evidence informed strategies of the Community to Home (C2H) program

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1,500	1,525	200	200
Annual Indicator	1,597	1,732	1,020	105	53
Numerator					
Denominator					
Data Source	Monthly reports	Monthly reports	Monthly reports	SKN Monthly reports	SKN Monthly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Program was changed from Special Kids Network (SKN) to Community to Home (C2H) effective July 2019. The number reported for 2019 reflects individuals served under SKN from January to June 2019. No clients were seen under Community to Home (C2H).	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: Numbers of families served was reduced in 2020 due to COVID-19 impact on ability to serve CSHCN with a home visiting model.	

2016-2020: ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4	4	2	2
Annual Indicator	4	4	4	2	9
Numerator					
Denominator					
Data Source	BFH internal reports	BFH internal reports	BFH internal reports	BFH internal report	BFH internal report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			520	520	520
Annual Indicator	507	4,070	2,189	864	427
Numerator					
Denominator					
Data Source	Grantee Reports	Grantee Reports	Grantee Reports	Grantee Reports	Grantee Reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This is a duplicated count across activities. MHI had 2,874 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home PCPs and PCPs considering a medical home approach.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This is a duplicated count across activities. MHI had 2,189 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home PCPs and PCPs considering a medical home approach.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This is a duplicated count across activities. The Medical Home Initiative (MHI) had 864 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home PCPs.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 Reporting Year Field Note: This count was duplicated across activities. MHI had 382 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home PCPs. The FQHC Program had 45 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home FQHCs. The Medical Home Initiative was halted on 7/1/2020.	

2016-2020: ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		200	225	200	200
Annual Indicator	196	214	204	204	202
Numerator					
Denominator					
Data Source	Quarterly reports and internal reports	Quarterly reports and internal reports	Quarterly reports and internal reports	Quarterly reports and internal reports	Quarterly reports and internal reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1	2	2	2
Annual Indicator	1	5	3	2	0
Numerator					
Denominator					
Data Source	BFH internal reports	BFH internal reports	BFH internal reports	BFH internal report	BFH internal report
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 Reporting Year Field Note: Medical Home Initiative was halted starting 6/20/2020 to allow for evaluation

2016-2020: ESM 11.6 - Number of families receiving Respite Care Program services

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			500	750
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			N/A - see field note	N/A - see field note
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Program was expected to begin July 1, 2018 but implementation was not possible due to unforeseen circumstances.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Program was expected to begin July 1, 2018 but implementation was not possible due to unforeseen circumstances.	

2016-2020: ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		1,000	1,400	1,500	1,550
Annual Indicator	0	1,304	1,005	1,322	1,001
Numerator					
Denominator					
Data Source	n/a	n/a	n/a	n/a - see field note	n/a - see field note
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Includes reporting data from home visiting, Centering Pregnancy Programs and IMPLICIT ICC.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Includes reporting data from home visiting, Centering Pregnancy Programs and IMPLICIT ICC.	

2016-2020: ESM 14.1.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV)

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		75	80	85	90
Annual Indicator	0	89	76.5	73.2	70.5
Numerator			1,326	1,236	818
Denominator			1,734	1,689	1,161
Data Source	n/a	Grantee Reports	Grantee Reports	Grantee reports	Grantee reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year. Training on the required screening tool did not begin until 2017.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year. Training on the required screening tool did not begin until 2017.	

2016-2020: ESM 14.1.3 - Percent of women who report smoking after confirmation of pregnancy

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		30	28	26	25
Annual Indicator	20	20	6.1	6.2	6.5
Numerator			105	105	76
Denominator			1,734	1,689	1,161
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Partial data	

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: updated 2016 number and made it final	

2016-2020: ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		20	30	40	40
Annual Indicator	30	30	30	30	20
Numerator			3	3	2
Denominator			10	10	10
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Two of 10 CMHD have smoking cessation programs up and running in 2016	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Three of 10 CMHD have smoking cessation programs up an running as of 2017. Year 2018 - 2021 have been updated with more reasonable goals. Updated 2016 number	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Three of 10 CMHD have smoking cessation programs.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Pennsylvania

SPM 1 - Percent of newborns with on time report out for out of range screens
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens and timely follow-up</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of newborns with non-time critical notification by 7 days of life and the number of newborns with time-critical notification by 5 days of life</td></tr>
<tr><td>Denominator:</td><td>The total number of newborns with non-time critical and time-critical report outs, respectively</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>N/A</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source for this measure is the Pennsylvania newborn screening data system.

Receiving call outs from the genetic counselors was put in place in 2019. The Division of Newborn Screening and Genetics’ electronic data system is now set-up to receive those calls directly. A limitation is that there is no back-data available because previously the date the lab results were released was used.</td></tr>
<tr><td>Significance:</td><td>Pennsylvania diagnoses hundreds of babies each year with potentially devastating but treatable disorders. This SPM is evaluating the timeliness of newborn screening testing (e.g. Does the hospital collect and ship the specimen within the recommended time frame? Does the lab receive and test the specimen as quickly as possible?). Other ESMs are in place to measure other aspects of the initial and repeat collection follow-up portions of the screening procedure. However, the benefits of newborn screening depend upon timely collection of the filter paper. Timely detection prevents death, intellectual disability, and other significant health complications.

Pa. has developed ESMs which track progress toward their SPMs. Due to limitations of TVIS which prevent entry of ESMs linked to an SPM, these ESMs do not appear on the MCHB version of Pa.'s State Action Plan. SPM 1 is linked to the following ESMs:

ESM: Percent of newborns with a requested repeat filter paper obtained
ESM: Percent of newborns born in Pennsylvania receiving a DBS screening
ESM: Meet with Child Death Review program for collaboration between programs four times per year</td></tr>
</table>

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
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The goal is that staff will increasingly use evidence-based data to make decisions on program development, implementation and monitoring.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>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</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>N/A</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from tracking of data requests within the Bureau of Family Health (BFH). These requests will include the reason for the request and how the data will be used in program and policy development. Additionally, surveys requesting information regarding how staff have used data to modify or create programs or policies will be distributed and the results will be used for reporting.</td></tr>
<tr><td>Significance:</td><td>The goal of this measure is to annually increase the number of staff making evidence-based, data-driven decisions in program and policy design and implementation. The BFH is committed to moving staff in the direction of using evidence and data in all matters. Tracking these measures will ensure that staff are accessing and using available data in all programmatic and policy decisions and considering this data before new policy and program development.

SPM 2 is linked to the following state-developed ESMs. Due to limitations of TVIS which prevent entry of ESMs linked to an SPM, these ESMs do not appear on the MCHB version of Pa.'s State Action Plan:

• ESM: Number of technical assistance requests for data made to DBO each year using the established guidelines
• ESM: Percent of staff trained annually on availability of NSCH data and how to access that data
• ESM: Percentage of PRAMS data requests resulting in a new or modified program or policy in each calendar year
• ESM: Number of programs or policies created or modified as a result of the dissemination of PRAMS data analysis products in each calendar year
• ESM: Increase the Percent of CDR cases reviewed by 5% each year

Additionally, while SPM 3 is labeled as a cross-cutting SPM, the infant strategy and associated ESM, listed below, are also linked to SPM 3. This linkage is not apparent on MCHB's version of the Pa. State Action Plan due to system limitations.</td></tr>
</table>

	• Strategy: Increase access to and use of Child Death Review data sources to enhance program planning, design and implementation • ESM: Increase percent of prematurity cases reviewed by local CDR teams that include identification of the underlying causes of death by 5% each year • ESM: Number of annual trainings to local CDR teams on guidelines of identifying the underlying causes of prematurity deaths

SPM 3 - Percent of hospitals making referrals to Early Intervention
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Annually increase the percentage of reported neonatal abstinence syndrome (NAS) cases receiving a referral to Early Intervention
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PA birth hospitals making NAS referrals to EI **Denominator:** Total number of PA birth hospitals reporting NAS cases
Healthy People 2030 Objective:	N/A
Data Sources and Data Issues:	The number of PA birth hospitals making NAS referrals to EI will be collected by NAS program staff.
Significance:	The Bureau of Family Health houses the DNSG, which oversees reporting of NAS cases by all PA birthing facilities. The data reported to the NAS program includes EI referral status. Tracking the percent of hospitals making a valid EI referral allows the program to provide target education and technical assistance to hospital staff in need of assistance reporting NAS results and making EI referrals.

SPM 4 - Percent of eligible infants with a Plan of Safe Care
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Annually identify and develop collaborative opportunities to share data and trends in neonatal abstinence syndrome (NAS) reporting and follow-up.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of infants with a Plan of Safe Care **Denominator:** Total number of infants eligible for a Plan of Safe Care
Healthy People 2030 Objective:	N/A
Data Sources and Data Issues:	The number of infants eligible for Plan of Safe Care will be collected by NAS program staff.
Significance:	The Bureau of Family Health houses the DNSG, which oversees reporting of NAS cases by all PA birthing facilities. The data reported to the NAS program includes a Plan of Safe Care status. Tracking the percent of infants receiving a Plan of Safe Care allows the program to collaborate with the PA Department of Human Services' Office of Children Youth and Family (OCYF), the provider of the Plan of Safe Care, to provide technical assistance to hospital staff referring infants to OCYF.

SPM 5 - Percent of children ages 6-17 who have one or more adult mentors
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of adolescents who have a mentor and are participating in evidence-based or evidence-informed mentoring programs</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Children in Pennsylvania who report having at least one other adult they can rely on for advice or guidance</td></tr>
<tr><td>Denominator:</td><td>Total children in Pennsylvania ages 6-17 years</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>AH-03: Increase the proportion of adolescents who have an adult they can talk to about serious problems</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children’s Health (NSCH), Indicator 5.9, Pennsylvania data</td></tr>
<tr><td>Significance:</td><td>Having one or more caring adults in a child’s life is a protective factor and decreases the likelihood of negative health outcomes. Research suggests that “when examining the relationship between child well-being outcomes and having a mentor-like adult, in all cases having a mentor was significantly associated with positive well-being—that is, with a greater likelihood of positive outcomes, and reduced likelihood of negative outcomes” (Murphey et al. 2013). Evidence-based and evidence-informed mentoring programs have been proven to positively impact youth participants when the programs have been implemented with fidelity. This SPM will track progress toward improving mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs for youth participating in mentoring programs.

Murphey, D., Bandy, T., Schmitz, H., Moore, T.A. Caring Adults: Important for Positive Child Well-being. (Publication No. 2013-54, December 2013). Retrieved from: https://www.childtrends.org/wp-content/uploads/2013/12/2013-54CaringAdults.pdf.

Pa. has developed ESMs which track progress toward their SPMs. Due to limitations of TVIS which prevent entry of ESMs linked to an SPM, these ESMs do not appear on the MCHB version of Pa.'s State Action Plan.

SPM 5 is linked to the following state-developed ESM:
• ESM: Number of youths participating in evidence-based or evidence-informed mentoring programs
• ESM: Percentage of LGBTQ-identified youth participating in an evidence-based or evidence-informed behavioral health program who report an increase in positive coping strategies, specifically, support-seeking, problem solving, distraction, and escape strategies over the course of the program period</td></tr>
</table>

SPM 6 - Rate of mortality disparity between black and white infants
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	The goal is to narrow the mortality gap between majority and minority populations as a result of comprehensive programming, policy change and organizational action
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Number of deaths to infants from birth through 364 days of age **Denominator:** Number of live births
Healthy People 2030 Objective:	MICH-02: Reduce the rate of all infant deaths (within 1 year). (Baseline: 5.8 infant death per 1,000 live births within the first year of life in 2017, Target: 5.0 infant deaths per 1,000 live births)
Data Sources and Data Issues:	Data Source: National Vital Statistics System (NVSS) for states and territories; United Nations Interagency Group for Child Mortality Estimation for the Freely Associated States in the Pacific Basin. Data will be tracked using currently reported infant mortality data provided to the Department of Health (birth and death certificates, etc.) and captured as part of the annual DOH Healthy People 2020 data (soon to be Healthy People 2030). Additionally, disparity data layered with data on the social determinants of health or, once completed, the Health Equity or Health Opportunity Index will provide guidance to population of Pennsylvanians that are experiencing worse infant mortality rates and decipher the underlying causes of those poor health outcomes. With the knowledge of the underlying causes, BFH will be able to better target strategies, form partnerships and equitably address the disparities in equity seeking populations. When calculating the disparity, the rates for black and white infants were subtracted to identify the gap (or distance between each data point). In 2017 the rate was recorded at 14 deaths per 1,000 live births for black infants and 4.8 deaths per 1,000 live births for white infants, highlighting a rate difference of 9.2. The goal will be to reduce this gap by a rate of 1.5 per 1,000 live births over five years.
Significance:	The goal of this measure is to annually decrease the difference in disparities for infant mortality. BFH is committed to eliminating the disparity and to do so requires intentionality. Tracking these measures will ensure that staff and vendors are knowledgeable of and can apply health equity principles to their work, can access and use available data in all programmatic and policy decisions, and consider health equity and data before policy and program development. In the long term, it will be essential that institutions and systems change to meet this need. Infant mortality, or the death of a child within the first year of life, is a sentinel measure of population health that reflects the underlying well-being of mothers and families, as well as the broader community and social environment that cultivate health and access to health-promoting resources. After a period of stagnation from 2000 to 2005, the U.S. infant mortality rate has continued to decline to record low levels below 6 per 1,000 live births. However, significant disparities continue to persist between racial groups, especially for infants born to non-Hispanic black, American Indian/Alaskan Native, and Puerto Rican

women. The infant mortality rate among non-Hispanic blacks is more than twice that of non-Hispanic whites. Leading causes of infant mortality include prematurity, birth defects, and sudden unexpected infant deaths. Infant mortality continues to be an extremely complex health issue with many medical, social, and economic determinants.

Pa. has developed ESMs which track progress toward their SPMs. Due to limitations of TVIS which prevent entry of ESMs linked to an SPM, these ESMs do not appear on the MCHB version of Pa.'s State Action Plan.

SPMs 6, 7 and 8 link to the following state-developed ESM:
• ESM: Percentage of staff trained annually on the principles of Health Equity and the effectiveness of Health Equity plans

SPM 7 - Rate of mortality disparity between black and white children, ages 1-4
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	The goal is to narrow the mortality gap between majority and minority populations as a result of comprehensive programming, policy change and organizational action
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of deaths among children ages 1 through 4 years **Denominator:** Number of children ages 1 through 4 years
Healthy People 2030 Objective:	MICH-03: Reduce the rate of child deaths aged 1 to 19 years. (Baseline: 25.2 deaths among children aged 1 to 19 years per 100,000 population occurred in 2018, Target: 18.4 deaths per 100,000 population).
Data Sources and Data Issues:	B. Child mortality rates are reported annually. When calculating the disparity, the rates for black and white infants were subtracted to identify the gap (or distance between each data point). In 2017 the rate was recorded at 14 deaths per 1,000 live births for black infants and 4.8 deaths per 1,000 live births for white infants, highlighting a rate difference of 9.2. The goal will be to reduce this gap by a rate of 1.5 per 1,000 live births over five years. Data Source: National Vital Statistics System (NVSS); Population estimates come from the U.S. Census Bureau. Data will be tracked using currently reported child mortality data provided to the Department of Health (birth and death certificates, etc.). Additionally, disparity data layered with data on the social determinants of health or, once completed, the Health Equity or Health Opportunity Index will provide guidance to population of Pennsylvanians that are experiencing worse child mortality rates and decipher the underlying causes of those poor health outcomes. With the knowledge of the underlying causes, BFH will be able to better target strategies, form partnerships and equitably address the disparities in equity seeking populations. Child mortality rates are reported annually. When calculating the disparity, the rates for black and white children were subtracted to identify the gap (or distance between each data point). In 2017 the rate was recorded at 28 deaths per 100,000 children for black children ages 1-4 and 16.3 deaths per 100,000 children for white children of the same ages, highlighting a rate difference of 11.7. The goal will be to reduce this gap by a rate of 5 deaths per 100,000 children, over 5 years. 2017 marked the lowest rates from 2013-2017.
Significance:	The goal of this measure is to annually decrease the difference in disparities for child mortalities. BFH is committed to eliminating the disparity and to do so requires intentionality. Tracking these measures will ensure that staff and vendors are knowledgeable of and can apply health equity principles to their work, can access and use available data in all programmatic and policy decisions, and consider health equity and data before policy and program development. In the long term, it will be essential that institutions and systems change to meet this need. Although the risk of death for children declines sharply beyond infancy, there were still over 6,000 deaths among U.S. children ages 1 through 9 in 2014. Unintentional injury continues

	to be the leading cause of death in children 1 to 9 years. Other leading causes include congenital malformations, malignant neoplasms, and homicide. Pa. has developed ESMs which track progress toward their SPMs. Due to limitations of TVIS which prevent entry of ESMs linked to an SPM, these ESMs do not appear on the MCHB version of Pa.'s State Action Plan. SPMs 6, 7 and 8 link to the following state-developed ESM: • ESM: Percentage of staff trained annually on the principles of Health Equity and the effectiveness of Health Equity plans

SPM 8 - Rate of maternal mortality disparity between black and white persons
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	The goal is to narrow the mortality gap between majority and minority populations as a result of comprehensive programming, policy change and organizational action
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of pregnancy-related deaths (death while pregnant or within 1 year of its end, regardless of outcome, duration or site of pregnancy–from any cause related to or aggravated by pregnancy or its management; not from accidental/incidental causes) **Denominator:** Number of live births
Healthy People 2030 Objective:	MICH-04: Reduce the rate of maternal mortality. (Baseline:17.5 maternal deaths per 100,000 live births in 2007, Target: 15.7 maternal deaths per 100,000 live births)
Data Sources and Data Issues:	Data Source: National Vital Statistics System (NVSS) for states and territories; Pregnancy Mortality Surveillance System from the Centers for Disease Control and Prevention. Data will be tracked using current reported maternal mortality obtained through the Centers for Disease Control and Prevention's Pregnancy Mortality Surveillance System which utilizes Department of Health death certificates for all women who died during pregnancy or within 1 year of pregnancy, linked live birth or fetal death certificates, and additional data when available. Additionally, disparity data layered with data on the social determinants of health or, once completed, the Health Equity or Health Opportunity Index will provide guidance to population of Pennsylvanians that are experiencing worse maternal mortality rates and decipher the underlying causes of those poor health outcomes. With the knowledge of the underlying causes, BFH will be able to better target strategies, form partnerships and equitably address the disparities in equity seeking populations. Maternal mortality rates are reported annually. Maternal mortality rates are low, but a serious and increasingly important factor to address. When calculating the disparity, the maternal mortality rates for black and white persons were subtracted to identify the gap (or distance between each data point). In 2016, the rate was recorded at 36.8 for black persons and 10.2 for white persons, highlighting a rate difference of 26.6. The goal will be to reduce by a rate of 3.0 per 100,000 live births over 5 years. Lowest 5 year disparity rate recorded is from 2015.
Significance:	The goal of this measure is to annually decrease the difference in disparities for maternal mortalities. BFH is committed to eliminating the disparity and to do so requires intentionality. Tracking these measures will ensure that staff and vendors are knowledgeable of and can apply health equity principles to their work, can access and use available data in all programmatic and policy decisions, and consider health equity and data before policy and program development. In the long term, it will be essential that institutions and systems change to meet this need. Maternal mortality is a sentinel indicator of health and health care quality worldwide. After a

century of general improvement, the U.S. maternal mortality rate more than doubled over the past decade. Although most of this increase was likely due to changes in the ascertainment and identification of maternal deaths, at least part of the increase appears to be real and may be attributable to increases in chronic health conditions, such as cardiovascular disease and diabetes. There are also significant racial disparities with Black women having rates of maternal mortality at least 3 times that of White women. Maternal deaths can be prevented or reduced both by improving underlying maternal health as well as health care quality for leading causes of maternal death, such as hemorrhage and preeclampsia.

MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. Obstet Gynecol. 2016 Sep;128(3):447-55. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5001799/

CDC Pregnancy Mortality Surveillance System. Division of Reproductive Health. National Center for Chronic Disease Prevention and Health Promotion. 2017. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

Pa. has developed ESMs which track progress toward their SPMs. Due to limitations of TVIS which prevent entry of ESMs linked to an SPM, these ESMs do

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To ensure that each grantee establishes and maintains a policy and process to review information provided to patients and ensure it is clear and can be understood
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of grantees who have updated or developed new materials that are accurate and can be understood by the patient population **Denominator:** The total number of Title V grantees
Healthy People 2020 Objective:	(AHS-6.1): Reduce the proportion of persons who are unable to obtain or understand the need to receive necessary medical care, dental care, or prescription medicines.
Data Sources and Data Issues:	Grantee reporting and/or site visits. National Action Plan to Improve Health Literacy, U.S. Department of Health and Human Services, 2010; The Center for Disease Control and Preventions “Simply Put”; and the U.S. National Library of Medicine’s website “How to Write Easy-to Read Health Materials.” In order to develop materials that can be used and understood by individuals: identify the target audience; the issue that needs to be addressed; invite the intended audience to determine needs and evaluate their level of understanding; determine and design messaging based on feedback provided; and design, pretest, edit, publish, and evaluate.
Significance:	According to Healthy People 2020, 10% of all individuals were unable to obtain care or medicines in 2007. The target set is 9%. When families do not have an understanding of the health care information provided to them, this places the patient at risk for failing to follow through on medical recommendations, adhering to recommended behaviors like safe sleep and breastfeeding. Without prevention and timely intervention, patients frequently need more care and face a difficult rehabilitative process. If materials provided to families is written and presented in a manner that it can be understood, this will result in increased knowledge and/or a change in behavior.

2016-2020: SPM 3 - Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	By tracking this measure the DOH will be able to identify submitters (hospitals, birthing facilities, and midwives) that are not meeting the standard for collection to receipt times
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of dried blood spot filter papers received at the lab within 48 hours after collection **Denominator:** The total number of dried blood spot filter papers received by the lab
Healthy People 2020 Objective:	Not applicable.
Data Sources and Data Issues:	Newborn screening data system. No data collection issues or limitations.
Significance:	By receiving the newborn screening dried blood spot filter papers within 48 hours of collection, the contracted laboratory will be able to report out critical results to DOH within five days of life, the industry standard. This allows DOH staff to begin the follow-up process earlier in the newborn's life, leading to a quicker referral turnaround, diagnosis and treatment. Many newborn screening conditions are time sensitive, the sooner they are detected and acted on the better the outcome is for the long-term health of the newborn and the family.

2016-2020: SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase the percentage of Title V staff who analyze and use data to steer programmatic decision-making
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Title V staff who analyzed and used data at least once during the reporting year **Denominator:** Number of Title V staff
Healthy People 2020 Objective:	Not applicable.
Data Sources and Data Issues:	Counts for the numerator will be obtained from Bureau of Family Health (BFH) internal data collection performed by the Priority 8 workgroup. This workgroup is responsible for all matters pertaining to the data priority. Counts for the denominator will be determined by BFH personnel records.
Significance:	As the Title V block grant administrator, the BFH has purposely chosen a state priority related to data collection and analysis. Through internal assessment of all program data collection strengths and needs, the BFH aims to increase the capacity of all staff to incorporate relevant data into programmatic decision-making.

2016-2020: SPM 5 - Percent of youth ages 8-18 participating in evidence-based or evidence-informed programs who increased or maintained protective factors or decreased risk factors
Population Domain(s) – Adolescent Health, Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth participating in programming who increased protective factors or decreased risk factors</td></tr>
<tr><td>Denominator:</td><td>Number of youth participating in programming</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>AH-3 Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver.
AH-3.1 Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems.
AH-4 Increase the proportion of adolescents who transition to self-sufficiency from foster care.
AH-4.1 Increase the proportion of adolescents in foster care who exhibit positive early indicators of readiness for transition to adulthood.
AH-5 Increase educational achievement of adolescents and young adults.
AH-5.1 Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade.
AH-5.2 Increase the proportion of students who are served under the Individuals with Disabilities Education Act who graduate high school with a diploma.
AH-11 Reduce adolescent and young adult perpetration of, and victimization by, crimes.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Programs will utilize pre and post assessments to measure changes in protective factors and risk factors of youth participating in programming.</td></tr>
<tr><td>Significance:</td><td>Adolescent Health programming is a part of the Bureau of Family Health. This particular performance measure was selected to measure how well youth in the evidence-based or evidence-informed mentoring programs are provided with skills, experiences, relationships, and behaviors to help them increase their protective factors and decrease their risk factors. This will, in turn, give the youth a better chance of succeeding in school and becoming contributing members of their communities.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Pennsylvania

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Pennsylvania

ESM 1.1 - Percent of women who successfully complete evidence-based or informed home visiting programs
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of women completing evidence-based or -informed home visiting programs
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women who complete Title V home visiting programs **Denominator:** Number of women enrolled in Title V home visiting programs
Data Sources and Data Issues:	Data will come from the County Municipal Health Department home visiting programs' quarterly and annual reporting.
Significance:	Home visiting programs support families by providing health check-ups, screenings, referrals, parenting advice, and guidance in navigating other programs and services in the community. Additionally, home visiting programs monitor progress on children's developmental milestones and help parents to provide a safe and supportive environment for their children to grow. This support and education aim to improve the overall health and well-being of the families served, improve birth outcomes and increase spacing between pregnancies.

ESM 1.2 - Percent of adolescents and women enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase time between pregnancies among Centering Pregnancy Program participants by increasing the percent of adolescents and women enrolled in Centering Pregnancy programs who talk with a professional about birth spacing or birth control methods</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents and women enrolled in Centering Pregnancy programs who talked with a healthcare professional about birth spacing and birth control methods</td></tr>
<tr><td>Denominator:</td><td>Number of women enrolled in Centering Pregnancy programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from the Centering Pregnancy Program’s quarterly and annual reporting.</td></tr>
<tr><td>Significance:</td><td>Conceiving within 12 months of delivery can cause heightened health risks for both mother and infant. The Centering Pregnancy Program (CPP) curriculum covers birth control and birth spacing at numerous points throughout the pregnancy and postpartum periods to encourage women to actively participate in interconception care.</td></tr>
</table>

ESM 1.3 - Percent of mothers served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one well-child visit
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Change maternal behaviors and improve birth outcomes by screening women for four behavioral risk factors at well-child visits
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of mothers served through the IMPLICIT ICC program screened for four risk factors at a minimum of one well-child visit **Denominator:** Number of mothers served through the IMPLICIT ICC program in attendance at well-child visits
Data Sources and Data Issues:	Data will come from the IMPLICIT Interconception Care Program's quarterly and annual reporting.
Significance:	Many women do not attend the six-week postpartum visit; instead, they are focused on the health needs of their child and are likely to take their children to well child visits. Working within the child-well visit framework allows an opportunity to address mothers' health.

ESM 1.4 - Number of community-based doulas trained in communities served by the program
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of trained community-based doulas
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of doulas trained **Denominator:**
Data Sources and Data Issues:	Data will come from the Philadelphia Department of Public Health's quarterly and annual reporting.
Significance:	Doula support can improve birth outcomes and has the potential to reduce health disparities and improve health equity.

ESM 1.5 - Number of behavioral health providers trained in pregnancy intention assessment
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of behavioral health providers trained in assessing pregnancy intention
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of behavioral health providers trained in assessing pregnancy intention **Denominator:**
Data Sources and Data Issues:	Data will come from the Alliance of PA Inc.'s quarterly and annual reports.
Significance:	Studies indicate that unintended pregnancies are associated with adverse physical and mental health, economic and social outcomes which impact women, their families and society. The unintended pregnancy rate for women with substance use disorder (SUD), particularly opioid use disorder (OUD), is 86% compared to the national unintended pregnancy rate of 45%. To address this need, behavioral health providers are being trained to assess pregnancy intention and contraceptive needs so that they may facilitate access to family planning services for women in SUD treatment facilities.

ESM 1.6 - Percent of women enrolled in home visiting, Centering Pregnancy and IMPLICIT who are referred for behavioral health services following a positive screening
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of women enrolled in Title V home visiting, Centering Pregnancy, and IMPLICIT programs who are referred for services following a positive screening</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of women enrolled in Title V home visiting, Centering Pregnancy and IMPLICT programs referred to behavioral health services following a positive screening</td></tr>
<tr><td>Denominator:</td><td>The number of women enrolled in Title V home visiting, Centering Pregnancy, and IMPLICIT programs screened positive for behavioral health needs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from quarterly and annual reporting from the County Municipal Health Departments, Centering Pregnancy, and IMPLICIT Interconception Care Programs.</td></tr>
<tr><td>Significance:</td><td>Screening tools can identify the need for services and improve birth outcomes for both mothers and infants. Additionally, screening provides home visitors with the opportunity to assess women’s behavioral health status and provide referrals, as necessary, to improve health in both the prenatal and postpartum periods.</td></tr>
</table>

ESM 1.7 - Percent of women who receive a maternal health assessment within 28 days of delivery through the 4th trimester pilot program
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To implement care models that encourage women to receive care in the early postpartum period and increase the percent of women that receive postpartum care within 28 days of delivery</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of women served by the IMPLICIT Network’s 4th trimester pilot sites that receive a maternal health assessment within 28 days of delivery through the 4th trimester project</td></tr>
<tr><td>Denominator:</td><td>The number of women served by the IMPLICIT Network’s 4th trimester pilot sites</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from quarterly and annual reporting from the IMPLICIT 4th trimester pilot program.</td></tr>
<tr><td>Significance:</td><td>Women experience significant biological, psychological, and social changes in the 28 days after delivery that may not be sufficiently addressed by the mainstream maternal health framework. Concerns regarding maternal mental health, birth control and birth spacing, physical recovery from childbirth, substance use, and other issues often go unrecognized in these early weeks increasing the risks of maternal morbidity and mortality, particularly among women who are low-income, African American, or have chronic medical conditions.</td></tr>
</table>

ESM 1.8 - Number of MMRC recommendations implemented annually
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Reduce the maternal mortality rate in Pennsylvania by implementing recommendations from the Maternal Mortality Review Committee (MMRC)
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of MMRC recommendations implemented **Denominator:**
Data Sources and Data Issues:	Data will come from the program areas that implement the MMRC recommendations
Significance:	Maternal mortality and morbidity are on the rise in Pennsylvania and the United States with African American women being at highest risk for poor maternal health outcomes. A formal process is needed to further investigate the cause of deaths in order to develop effective prevention strategies. Recommendations from the Maternal Mortality Review Committee (MMRC) can be used to inform programming.

ESM 1.9 - Number of meetings held between DOH, DHS and MIECHV annually
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To convene quarterly meetings between agencies that provide services related to maternal health including the Department of Health (DOH), Department of Human Services (DHS) and DHS' Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of meetings held between the DOH, DHS and DHS' MIECHV Program. **Denominator:**
Data Sources and Data Issues:	Agendas and meeting minutes will serve as the data source and will be used to determine the number of collaborative meetings held.
Significance:	Effective collaboration and coordination are important to create a high-quality system of support for mothers, infants, children and their families. Cross-sector work enables the public health system to implement health-promoting interventions at the systems, community, and individual/family levels.

ESM 4.1 - Percent of Keystone 10 facilities that progressed by one or more steps each fiscal year
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Annually increase the percent of PA birthing facilities designated as a Keystone 10 facility each fiscal year
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Keystone 10 facilities completing one or more steps during state fiscal year. **Denominator:** Number of facilities enrolled in initiative at the beginning of the state fiscal year, excluding Keystone 10 designated facilities.
Data Sources and Data Issues:	The number of steps completed by PA birthing facilities participating in Keystone 10 will be collected by the breastfeeding program staff.
Significance:	Improving breastfeeding initiation and duration rates is necessary to reduce infant mortality, as breastfeeding has been found to decrease the risk of hospitalization in the first year of life, the development of chronic health conditions, and the occurrence of Sudden Unexpected Infant Death (SUID) by at least 50%. Mothers in the United States are 13 times more likely to stop breastfeeding before six weeks after birth if they deliver in a hospital not participating in a 10-step breastfeeding initiative in comparison to mothers who delivered at a facility where at least six of the ten steps were followed. The program will continue to implement and promote the Keystone 10 initiative and encourage participants to complete Keystone 10 steps. Education will be given to participants on the positive outcomes breastfeeding has on mothers and their babies, and how completing Keystone 10 steps leads to better breastfeeding rates.

ESM 4.2 - Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Annually collaborate with the Safe Sleep Program to identify and develop collaborative opportunities
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>10</td></tr><tr><td>**Numerator:**</td><td>Number of collaborative meetings held between the Breastfeeding Program and the Safe Sleep Program</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	The number of collaborative meetings held with the Safe Sleep Program will be collected by the breastfeeding program staff.
Significance:	The Breastfeeding Awareness and Support Program is currently pursuing collaborative opportunities within the Department of Health with the Safe Seep Program with the intent of incorporating breastfeeding awareness, support, education, materials and messaging within the work of the Safe Sleep Program. The Program will also incorporate applicable education, materials and messaging from the Safe Sleep Program within their breastfeeding work. Building collaborative relationships helps ensure that women and families receive consistent, public health focused messaging on particular topics and better ensures that the professionals that interact with these populations are educated and also have a point of contact for questions and additional information. It has been anecdotally reported that it is the conflicting or incomplete messages that women/families receive that impact their decisions to breastfeed and they often do not know where to turn for assistance. It is therefore important for others serving those populations to have an effective understanding of breastfeeding.

ESM 4.3 - Convene five regional breastfeeding collaborative meetings twice per year.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Annually provide breastfeeding education, community outreach and improve breastfeeding initiation and duration rates.
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** Number of regional breastfeeding collaborative meetings held by Grantee. **Denominator:**
Data Sources and Data Issues:	The number of regional breastfeeding collaborative meetings held will be collected by the breastfeeding program staff.
Evidence-based/informed strategy:	The regional collaborative meetings shall educate and support birthing facilities and community partners on breastfeeding best practices and policies, the Keystone 10 Initiative, and offer a productive avenue for professionals to meet with peers for brainstorming, planning, and sharing of knowledge. The regional collaborative meetings shall improve resources for breastfeeding families at state birthing facilities.
Significance:	In 2020, the Breastfeeding Awareness and Support Program constructed an RFA allowing organizations to compete for grant funding to administer a program that would increase breastfeeding support and awareness statewide. PA AAP was awarded the grant funding in the summer of 2020 and the program officially started in October of 2020. PA AAP will collaborate with community-based organizations and partners by hosting regional collaborative meetings for birthing facilities and community partners and distributing mini-grants focused on improving initiation and duration breastfeeding rates in areas of need based on target population demographics.

ESM 4.4 - Award 15 mini-grants to community partners to provide breastfeeding support.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Annually provide breastfeeding education, community outreach and improve breastfeeding initiation and duration rates.
Definition:	**Unit Type:** Count **Unit Number:** 15 **Numerator:** Number of mini-grants awarded to community partners by the Grantee **Denominator:**
Data Sources and Data Issues:	The number of breastfeeding mini-grants awarded to community partners will be collected by the breastfeeding staff.
Evidence-based/informed strategy:	The Grantee shall identify the demographics of the target population, barriers attributing to low breastfeeding rates, including outreach services, in the breastfeeding Grant application. All breastfeeding Grant efforts shall focus on improving breastfeeding initiation and duration rates. The Grantee shall determine breastfeeding Grant recipients based on state breastfeeding rates and the highest potential population impact.
Significance:	In 2020, the Breastfeeding Awareness and Support Program constructed an RFA allowing organizations to compete for grant funding to administer a program that would increase breastfeeding support and awareness statewide. PA AAP was awarded the grant funding in the summer of 2020 and the program officially started in October of 2020. PA AAP will collaborate with community-based organizations and partners by hosting regional collaborative meetings for birthing facilities and community partners and distributing mini-grants focused on improving initiation and duration breastfeeding rates in areas of need based on target population demographics.

ESM 5.1 - Number of CDR recommendations implemented annually (infant health)
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Implement recommendations that are provided from the Child Death Review Team on infant deaths and SUID related deaths in order to inform infant programming
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of recommendations implemented **Denominator:**
Data Sources and Data Issues:	Data will come from infant program areas that review and implement recommendations.
Significance:	Data from Child Death Review can inform providers and systems of care on the need for targeted interventions to reduce the rate of infant death.

ESM 5.2 - Number of hospitals recruited to implement the model safe sleep program
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Annually increase the number of hospitals that have been recruited to implement the model safe sleep program
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of hospitals that have committed to implementing the model safe sleep program within the next year. **Denominator:**
Data Sources and Data Issues:	Data will be collected from quarterly reports from the Infant Safe Sleep Initiative. Due to the Infant Safe Sleep Initiative being a three year grant, projections are not being made past the grant period as future programming is undetermined at this time.
Significance:	The number of hospitals that have committed to implementing the model safe sleep program will foreshadow the reach of the program in the coming year.

ESM 5.3 - Percentage of infants born whose parents were educated on safe sleep practices through the model program
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the percentage of infants born whose parents were educated on safe sleep practices through the model program</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Numerator is the number of infants whose parents were educated on safe sleep practices through the model program for a year.</td></tr>
<tr><td>Denominator:</td><td>Denominator is the number of infants who were born in Pennsylvania during the year.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Quarterly annual reports from the Infant Safe Sleep Initiative will provide the numerator. Birth certificates for live births from the Department’s Vital Records will provide the denominator. The Infant Safe Sleep Initiative will run on a fiscal year (July to June) while vital records typically run on a calendar year. A determination will need to be made as to which year of vital records to use or if a special data run will need to be collected. Due to the Infant Safe Sleep Initiative being a three year grant, projections are not being made past the grant period as future programming is undetermined at this time.</td></tr>
<tr><td>Significance:</td><td>This will show the reach of the hospital based model program in comparison to all births. Education has a history of success as seen through the Back to Sleep campaign in the 1990’s that saw a drastic decline in SIDS rates. The hospital based model program not only will address SIDS, but further reach to provide education on accidental strangulation and suffocation.</td></tr>
</table>

ESM 5.4 - Percentage of hospitals with maternity units implementing the model program
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Annually increase the percentage of infants born whose parents were educated on safe sleep practices through the model program
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Numerator is the number of hospitals that have implemented the model program.</td></tr><tr><td>**Denominator:**</td><td>Denominator is the number hospitals in Pennsylvania with a maternity unit.</td></tr></table>
Data Sources and Data Issues:	Quarterly annual reports from the Infant Safe Sleep Initiative will provide the numerator. Data from the Division of Newborn Screening and Genetics will identify the number of hospitals in Pennsylvania with a maternity unit. Due to the Infant Safe Sleep Initiative being a three year grant, projections are not being made past the grant period as future programming is undetermined at this time.
Significance:	This will show the reach of the hospital based model program in all hospitals eligible to implement the model program. Nearly all births in Pennsylvania occur in a hospital. Using a hospital based model program will allow for growth to provide this life saving education to the parents of 97 percent of births.

ESM 5.5 - Number of targeted prevention initiatives or interventions implemented using PPOR data
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of targeted prevention initiatives or interventions implemented in selected communities, using PPOR data.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of targeted prevention initiatives or interventions implemented</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Using the PPOR process, selected communities (Grantees) will use data to identify primary causes of disparities, determine local risk factors for infant mortality, and select targeted interventions or initiatives for implementation. Grantees will provide the BFH with the number of initiatives or interventions that they implement as part of the PPOR process.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The Perinatal Periods of Risk (PPOR) is a comprehensive approach for addressing high infant mortality rates and disparities in those rates. PPOR was initially developed between 2000-2004 by CityMatCH and its member health departments with support of the CDC and the March of Dimes. It was adapted for U.S. cities from an approach used by the WHO. Designed as a “data to action” tool for use in cities with high infant mortality rates, PPOR brings community stakeholders together to build consensus, support, and partnership around vital records data. PPOR has also been used successfully by Healthy Start sites, suburban counties, groups of rural counties, and tribal organizations, and has become a common part of state infant mortality surveillance.

PPOR provides an analytic framework and steps for investigating and addressing the specific local causes of high fetal and infant mortality rates and disparities. Initial analyses are based on vital records data (births, deaths, and fetal deaths); later steps utilize all available sources of data and information. All six stages of the PPOR process (readiness, data analysis, planning, implementation, evaluation, and re-investment) contribute to making data a powerful agent for systems change, but at the core of PPOR are its analytic methods.</td></tr>
<tr><td>Significance:</td><td>Identified communities (Grantees) will conduct the 6-step Perinatal Periods of Risk (PPOR) process to identify the areas of greatest risk and racial disparity in infant mortality, and implement targeted, community-based programming based on that knowledge. As part of the PPOR process, local fetal and infant death records are categorized into four periods of risk, based on birthweight and age at death and that correspond to specific factors associated with birth outcomes. MCH programs can use PPOR to integrate health assessments, initiate planning, identify gaps, target more in-depth inquiry, and suggest clear interventions for addressing fetal and infant mortality. In addition, PPOR fosters greater cooperation in improving MCH through more effective data use, strengthened data capacity, and greater shared understanding of complex infant mortality issues. In this way, PPOR will increase the use of relevant data to inform decision-making and evaluate population and programmatic needs at the community level.</td></tr>
</table>

ESM 7.1.1 - Number of recommendations from CDR teams that are implemented (child health)
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Implement recommendations that are provided from the Child Death Review Team on child health deaths in order to inform child programming
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of recommendations implemented **Denominator:**
Data Sources and Data Issues:	Data will come from child program areas that review and implement recommendations.
Significance:	Data from Child Death Review can inform providers and systems of care on the need for targeted interventions to reduce the rate of child death

ESM 7.1.2 - Number of ConcussionWise trainings to athletic personnel
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Annually increase the number of ConcussionWise trainings provided by the Safety in Youth Sports program to athletic personnel
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of ConcussionWise trainings provided to athletic personnel **Denominator:**
Data Sources and Data Issues:	Data will be collected through quarterly reports from the vendor/grantee.
Significance:	Evidence shows that repeated head injuries or experiencing multiple head injuries during a short period of time can lead to much more serious injury. It is essential that youth athletes are immediately removed from play in the event of a suspected concussion, that an appropriate medical professional evaluate the potential injury, and that evidence-based return to play protocol is followed to ensure the health and safety of youth athletes. To accomplish this, athletic personnel must receive effective, evidence-based training as they are responsible for decisions involving removal from play and following return to play protocol. Athletic personnel who take the ConcussionWise training will be equipped with the knowledge and skills to identify a potential head injury, appropriately remove athletes from play, and follow effective return to play protocol.

ESM 10.1 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the percentage of adolescents who utilize a HRC within their school</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth ages 12-17 receiving services at an HRC.</td></tr>
<tr><td>Denominator:</td><td>Number of youth ages 12-17 attending school with a HRC.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee that subcontracts with schools and community organizations for the HRCs that are established. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” The HRCs fill this primary care gap by being available and accessible in the schools youth attend and in the communities where they reside. Expanding the number of HRCs in the state will expand availability of vital health services for youth. Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed.</td></tr>
</table>

ESM 10.2 - Number of referrals provided to school and community-based resources (HRCs)
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To annually increase the number of referrals provided to school and community-based organizations for youth visiting Health Resource Centers (HRCs)
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** The number of referrals provided to school and community-based resources within the reporting year **Denominator:**
Data Sources and Data Issues:	Data collection and analysis will be performed by the Grantee. A report on this ESM will be a grant deliverable as required by the work statement and will be reported to the Department of Health via quarterly reports.
Significance:	Health Resource Centers (HRCs) support the overall health and well-being of youth. HRCs are located in schools and community-based settings that are private and easily accessible to youth. For many students, the HRC is a place where they can get help and support in a caring and non-judgmental environment. The HRC helps to link students with school and community resources to meet their health needs.

ESM 10.3 - Percent of visits that include counseling (HRCs)
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To annually increase percent of visits to HRCs that include counseling
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of visits to the HRCs that include counseling **Denominator:** Total number of visits to the HRCs
Data Sources and Data Issues:	Data collection and analysis will be performed by the Grantee. A report on this ESM will be a grant deliverable as required by the work statement and will be reported to the Department of Health via quarterly reports.
Significance:	Health Resource Centers (HRCs) support the overall health and well-being of youth. HRCs are located in schools and community-based settings that are private and easily accessible to youth. For many students, the HRC is a place where they can get help and support in a caring and non-judgmental environment. The HRC provides counseling promoting heathy relationships and behaviors regarding human sexuality and encouraging critical thinking around sexual activity.

ESM 10.4 - Number of trainers trained in the OBPP who currently implement the OBPP in a community-based organization
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the number of community-based organizations participating in a bullying awareness and prevention program
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of trainers trained in the Olweus Bullying Prevention Program **Denominator:**
Data Sources and Data Issues:	Data collection and analysis will be performed by the vendor(s) selected by DOH to carry out the activities of the bullying program. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.
Significance:	According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17% of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others. Bullying affects youth negatively in many ways. Youth who are bullied are more likely to experience depression and anxiety, changes in sleep and eating patterns and decreased academic achievement and school participation. Academic success has a direct impact on their employment prospects and future earnings potential, which impact health and access to health care in adulthood. Youth who bully others are more likely to experience alcohol and drug abuse in adolescence. This serious health problem can persist long after adolescence. LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.

ESM 10.5 - Number of youth participating in the Olweus Bullying Prevention Program (OBPP) at a community-based organization
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of youth participating in the Olweus Bullying Prevention Program at a community-based organization</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>The number of youth who participated in the Olweus Bullying Prevention Program at a community-based organization during the reporting year</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the vendors selected by Department of Health to carry out the activities of the bullying prevention program. It will be a grant deliverable as required by the work statement and reported to the Department via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17% of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others.

Bullying affects youth negatively in many ways. Youth who are bullied are more likely to experience depression and anxiety, changes in sleep and eating patterns and decreased academic achievement and school participation. Academic success has a direct impact on their employment prospects and future earnings potential, which impact health and access to health care in adulthood.

Youth who bully others are more likely to experience alcohol and drug abuse in adolescence. This serious health problem can persist long after adolescence.

LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.</td></tr>
</table>

ESM 10.6 - The number of users who accessed the SafeTeens.org site
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Annually increase the number of users who accessed SafeTeens.org
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** The number of users who accessed SafeTeens.org within the reporting year **Denominator:**
Data Sources and Data Issues:	Data collection and analysis will be performed by the Grantee. It will be a grant deliverable as required by the work statement and reported to the Department of Health via quarterly reports.
Significance:	SafeTeens.org provides medically accurate sexual and reproductive health information that connects teens to local health centers. Title V funds are used for outreach and marketing of the website to Pennsylvania youth. The Bureau of Family Health will track the number of users who accessed SafeTeens.org as the key measure of success for this initiative.

ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line within the reporting year</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee. It will be a grant deliverable as required by the work statement and reported to Department of Health via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>The SafeTeens Answers! text line provides medically accurate sexual and reproductive health information that connects teens to local health centers. Title V funds are used for outreach and marketing of the text line to Pennsylvania youth. The BFH will track the number of users who are referred to in-person counseling or health services through the SafeTeens Answers! text line as the key measure of success for this initiative.</td></tr>
</table>

ESM 10.8 - Number of substance use and brain injury professionals receiving brain injury and opioid training
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Annually increase the number of substance use and brain injury professionals receiving brain injury and opioid training
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The number of substance use and brain injury professionals receiving evidence based or evidence informed brain injury and opioid training **Denominator:**
Data Sources and Data Issues:	Data will be collected through enrollment and attendance records provided by the training provider.
Significance:	The BFH offers brain injury and opioid training to professionals within the brain injury or substance use field. The BFH partnered with the Brain Injury Association of PA to develop training curriculum. Research has shown that when an individual overdoses from substances, the lack of oxygen to the brain can cause brain injury. Also, individuals who have brain injury are more vulnerable to becoming addicted to opioids. The intent of the training is to make professionals in the brain injury and substance use fields aware of the correlation between brain injury and substance use as well as provide resource information that may be used for the clientele they serve.

ESM 10.9 - Number of CDR recommendations implemented (adolescent health)
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Implement a minimum of one CDR recommendation annually within Adolescent Health programming
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of CDR recommendations implemented within the reporting year. **Denominator:**
Data Sources and Data Issues:	Data on the number of recommendations reviewed for feasibility and implemented will be collected internally by the Bureau of Family Health.
Significance:	Pennsylvania's Child Death Review (CDR) program was developed to promote the safety and well-being of children by reducing preventable childhood deaths through review and exploration of the factors contributing to these fatalities. This is accomplished through systemic, multi-agency reviews of the circumstances surrounding the deaths of children 21 years of age and under. The BFH will review for feasibility and implement prevention-related CDR recommendations in order to reduce adolescent deaths overall and will track the number of CDR recommendations implemented.

ESM 10.10 - Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Annually increase the number of young adult and adolescent males receiving Coaching Boys Into Men (CBIM) training
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of young adult and adolescent males receiving CBIM training **Denominator:**
Data Sources and Data Issues:	Data will be collected through attendance records provided by the training provider.
Significance:	The CBIM program provides male youth with the skills to build respectful and non-violent relationships with dating partners CBIM offers a curriculum that addresses respect, integrity and personal responsibility. The training focuses on disrespectful behavior, understanding consent and crossing boundaries. The intention is to prevent sexual assault and adolescent relationship abuse while promoting gender equality. Data on enrollment and attendance will provide a baseline for the goal of increasing numbers annually.

ESM 10.11 - 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
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	By the end of the grant period, increase the number and 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
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Title V family planning clients who are provided a most effective or moderately effective contraceptive method **Denominator:** Total number of Title V family planning clients
Data Sources and Data Issues:	Data collection and analysis will be performed by the Grantee. It will be a grant deliverable as required by the work statement and reported to Department of Health via quarterly reports.
Significance:	The BFH will track the number and 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, as well as the number and percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a long-acting reversible contraception (LARC) method. These measures are in line with the Office of Population Affairs' Title X performance measures and aim to increase women's access to contraception by encouraging providers to ask about clients' pregnancy intentions and inform them of the wide range of contraceptive methods that are available.

ESM 10.12 - The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By the end of the grant period, increase the percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a long-acting reversible contraception (LARC) method</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Title V family planning clients who are provided LARC method</td></tr>
<tr><td>Denominator:</td><td>Total number of Title V family planning clients</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>The BFH will track the number and 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, as well as the number and percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method. These measures are in line with the Office of Population Affairs' Title X performance measures and aim to increase women's access to contraception by encouraging providers to ask about clients' pregnancy intentions and inform them of the wide range of contraceptive methods that are available.</td></tr>
</table>

ESM 11.1 - Number of recommendations from CDR teams that are implemented (CSHCN)
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of recommendations from CDR teams related to preventing CSHCN death that are reviewed for feasibility and implemented each year
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of recommendations made by CDR teams that are implemented for CSHCN **Denominator:**
Data Sources and Data Issues:	The local Child Death Review Teams' Prevention Recommendations report is compiled annually from the National Center for Fatality Review and Prevention's Case Reporting System (NCFRP-CRS). One issue that BFH has with data input in this system is that there is little consistency with the type of data that local CDR teams input in the system and often there is little detail around the recommendations they make, making feasibility and implementation difficult. Follow-up contacts to CDR teams would need to be made in order to better understand why recommendations were made when reviewing cases and better determine trends. Technical assistance with local team members will likely be necessary for more consistent data input in order to increase the number of recommendations that CDR teams make during child death reviews.
Significance:	The mission of the Pennsylvania Child Death Review (CDR) program is to promote the safety and wellbeing of children and reduce preventable child fatalities. This is accomplished through timely reviews of child deaths. Information obtained from the reviews is used to determine how future deaths can be prevented. By examining CDR findings of trauma related to deaths of CSHCN and identifying systematic barriers, the BFH can review this information for feasibility and make additional recommendations about how to utilize those findings to inform prevention strategies and programming within the Department. Rather than barriers and recommendations only being identified at a local level by CDR teams, the Department would be able to support program implementation for this issue at a state or regional level.

ESM 11.2 - Number of person-centered plans developed by BrainSTEPS teams
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of person-centered plans developed by BrainSTEPS teams
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The numerator is the number of person-centered plans developed by BrainSTEPS teams **Denominator:**
Data Sources and Data Issues:	Data will be collected through quarterly reports from the vendor/grantee.
Significance:	Person-centered planning has gained wide acceptance as a best practices model for individuals with traumatic brain injuries (TBI) because of the positive outcomes experienced by survivors and their families when involved in the process and the individualized services that are provided. This type of planning has been shown to promote self-efficacy and community engagement among individuals with disabilities including TBI. It also helps to ensure service providers are delivering culturally competent care by including the individual in decision-making, including priority and goal setting. Person-centered planning is particularly important for addressing the needs of individuals with TBI because of the highly individualized nature of every brain injury. The utilization of this type of planning will likely lead to better outcomes for students served by BrainSTEPS than if all students received the same accommodations, services, and supports.

ESM 11.3 - Number of families reporting satisfaction measures through surveys (Community to Home)
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of families reporting through satisfaction surveys that they were partners in decision making through the Community to Home program
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The number of families who report through satisfaction surveys that they were partners in decision making while enrolled in the Community to Home program. **Denominator:**
Data Sources and Data Issues:	Grantees will provide families with client satisfaction surveys at the conclusion of services and data collected will be reported within quarterly reports.
Significance:	Community Health Workers (CHWs) have been shown to be valuable for community programs that aim to improve health. Many times, CHWs are members of the communities in which they serve and are able to develop a trusting, one-on-one relationship with consumers and providers. The Community to Home program is designed to improve access to care, increase knowledge, prevent disease and improve select health outcomes. Community to Home utilizes CHWs to provide care-coordination through home visiting. This evidence-based model of care coordination services will improve access to information and help families to navigate the health care system for CSHCN as well as engage and empower them to be partners in decision making. At the conclusion of services in the Community to Home program, families will be provided with a client satisfaction survey that will measure their engagement and overall satisfaction of the program. The satisfaction survey will also measure if they were partners in decision making during their involvement with Community to Home.

ESM 11.4 - Number of medical provider collaborative agreements established by the Sickle Cell Community-Based programs
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of collaborative agreements with medical providers through the Sickle Cell Community-Based programs by eight per year
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The numerator is a count of formal collaborations with medical care providers established through the Specialty Care Program Child Rehabilitation and Sickle Cell Community-Based Programs. **Denominator:**
Data Sources and Data Issues:	Data source will be the Data Collection and Recording Tool developed for the Specialty Care Programs. Data will be self-reported by grantee and verified with copies of written collaborative agreements.
Significance:	By increasing collaborations across medical care providers (including insurers, mental/behavioral health services, specialist care, primary care providers) individuals receiving care within these systems will experience fewer barriers to care, fewer delays in receiving services, and fewer duplicated services. By tracking the collaborations developed, what types of providers are engaging in collaboration, and how these entities interact, the Specialty Care Program can gauge the impact service accessibility and provision for individuals with the identified chronic health conditions.

ESM 11.5 - Percent of families who successfully complete the Room2Breathe Asthma home visiting program
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percent of families who successfully complete the Room2Breathe Asthma home visiting program
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of families who complete the Room2Breathe Asthma home visiting program</td></tr><tr><td>**Denominator:**</td><td>Number of people enrolled in the Room2Breathe Asthma home visiting program</td></tr></table>
Data Sources and Data Issues:	Data collection will come from Philadelphia Department of Public Health quarterly and annual reporting on the Room2Breathe Asthma home visiting program. Program completion will be measured by the number of participants who complete the 12-month follow-up visit.
Evidence-based/informed strategy:	Room2Breathe Asthma program is an evidence-based program modeled on Children's Hospital of Philadelphia's community asthma prevention program. This program provides education, environmental assessments to control asthma triggers, medication adherence and links children to medical homes by coordinating care with patients' primary care providers.
Significance:	Improving access to and quality of care for CSHCN through home visiting can enhance family engagement and positively impact health care outcomes (with potential cost savings) for families, society, and the health care system.

ESM 11.6 - Number of meetings held annually between DOH and DHS (CSHCN)
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To convene regular collaborative meetings between the Department of Health and Department of Human Services to improve services and systems for CSHCN
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** The number of meetings held annually between the Department of Health and the Department of Human Services to discuss services and systems for CSHCN **Denominator:**
Data Sources and Data Issues:	Data source will be documentation from meetings held between agencies.
Significance:	The Departments of Health and Human Services both have a significant number of programs serving CSHCN, and Title V funds are not meant to duplicate or replace Medicaid funded programs. As such, it is imperative that collaboration occurs between these agencies.

ESM 11.7 - Number of children screened for Autism Spectrum Disorder through the Autism Diagnostic Clinic
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of children screened for Autism Spectrum Disorder (ASD) prior to five years of age
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The numerator is the count of children screened for ASD by the Easterseals of Eastern PA Autism Diagnostic Clinic **Denominator:**
Data Sources and Data Issues:	Data source will be the Data Collection and Recording Tool developed for the Easterseals of Eastern PA Autism Diagnostic Clinic. Data will be self-reported by grantee.
Significance:	By screening for ASD as early as possible, families and children can be enrolled for services and begin receiving education and support prior to entering into primary education settings. Evidence demonstrates that children identified with ASD and receiving appropriate service prior to beginning primary education have significantly improved outcomes across their life span.

ESM 11.8 - Number of referrals to BrainSTEPS program
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of referrals to the BrainSTEPS program by conducting outreach and BrainSTEPS program promotion
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The number of referrals to the BrainSTEPS program **Denominator:**
Data Sources and Data Issues:	Data will be collected through quarterly reports from the vendor/grantee.
Significance:	Due to the nature of Traumatic Brain Injuries (TBIs), it is possible for this type of injury to go undiagnosed or to not connect emerging symptoms with a previous TBI. Students with TBI experience better outcomes when their injuries are identified and treated timely and appropriately. Therefore, it is essential to raise the awareness of parents about brain injury and the BrainSTEPS program, so that they can easily access this resource in the event of a student brain injury.

ESM 11.9 - Number of calls received through the SKN Helpline
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of calls received through the Special Kids Network (SKN) Helpline by program promotion</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of calls received through the SKN Helpline</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected by the BFH using SKN call logs.</td></tr>
<tr><td>Significance:</td><td>SKN is an information and resource helpline which assists providers and parents of children and youth with special health care needs (CSCHCN) to access local services and supports. SKN connects families to resources within their community to allow CSCHN to be successful and develop to their full potential. SKN serves children and youth with physical, developmental, behavioral, or emotional needs from birth through age 21 across Pennsylvania. The SKN Helpline provides information and resources on topics such as education, transportation, housing, funding sources, transitional resources, equipment and assistive devices, advocacy, and childcare.

The BFH will conduct program promotion by providing outreach to community members, local organizations and CSHCN and their families. The BFH will collaborate with community-based organizations, faith-based organizations, health care agencies, social service agencies and other agencies or organizations to assist in the promotion of the SKN Helpline. These agencies and families that we connect with through outreach will be provided information regarding the SKN Helpline and will be encouraged to contact the SKN helpline to access information on services and supports.</td></tr>
</table>

ESM 11.10 - Number of community-based provider partnerships established by the Sickle Cell Community-Based programs
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of partnerships engaging community-based providers established by the Sickle Cell Community-Based programs by eight per year
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** Count of formal partnerships with community-based service providers entered into by the Specialty Care Program and Sickle Cell Community-Based Programs **Denominator:**
Data Sources and Data Issues:	Data source will be the Data Collection and Recording Tool developed for the Specialty Care Programs. Data will be self-reported by grantee and verified with copies of written partnership documents.
Significance:	By tracking formal partnerships between community-based services and other providers the Specialty Care Program can gauge the impacts of support, barriers and the social determinants of health on everyday-life tasks and improve access to supportive services for individuals with the identified chronic health conditions.

ESM 11.11 - Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of youth with special health care needs receiving leadership development and training</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of youth with special health care needs receiving evidence-based or evidence-informed leadership development and training through the Leadership Development and Training Program</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected through attendance records provided by the grantee via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>The BFH’s Leadership Development and Training Program, conducted in partnership with PEAL, offers training opportunities for youth. The training sessions are developed and facilitated with the collaboration of CSHCN. The sessions provide the youth with the opportunity to learn leadership skills as well as other skills to become self-advocates and feel empowered. The trainings will also provide guidance to assist youth during their transition into adulthood. Data will be collected on enrollment and attendance at the training sessions. This will provide a baseline for the goal of increasing numbers annually.</td></tr>
</table>

ESM 11.12 - 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
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of youth aged 14 and over being served by the Community to Home who receive a transition plan within six months of receiving services</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of youth aged 14 and over enrolled in Community to Home who have a transition plan as part of their individualized care plan that includes transition to adult health care</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be provided in quarterly reports from Community to Home grantees.</td></tr>
<tr><td>Significance:</td><td>Youth with special health care needs who are of transition age of 14 years and older are a sub-population of CSHCN and face many challenges, including transitioning to the adult health care system. Transition planning is a partnership involving the individual with special needs, their family, local service providers, school personnel, health care providers and healthcare systems who support youth transitioning to adulthood. The purpose of transition planning for youth with special needs is to identify opportunities and experiences during their school years that will help them better prepare for life as an adult. Transition planning can assist the youth in securing employment, pursuing post-secondary education, meeting health care needs and experiencing a meaningful community life.

In the Community to Home program, individuals enrolled who are 14 years and older will have an individualized care plan that includes a transition plan preparing transition to adult health care, independent living, post-secondary education and employment. Through development of thorough and appropriate transition plans families will feel more secure and empowered as their child transitions to the next stages of life and independence. Youth will be given tools and opportunities that will support them in living a self-directed life.</td></tr>
</table>

ESM 11.13 - Percentage of children without a provider or insurance referred to medical homes
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To ensure that all State Health Centers are documenting and reporting all referrals of children ages 0-17, who do not have a provider or insurance, made to a medical home within 6 months in order to establish a baseline.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Total number of children without a provider or insurance that are referred to a medical home</td></tr>
<tr><td>Denominator:</td><td>Total number of children that Community Health Nurses see in their State Health Centers without a provider or insurance</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source will include a data entry table utilizing SharePoint allowing all staff access. It will include drop down fields in columns detailing the age of the child (0 to 17 years of age), the county in which the referral was made and the date in order to pull data for a 6 month period of time. Community Health Nurses will be instructed to enter these numbers after encounters that they have with children and families in their State Health Centers.

Limitations of this measure include:
a) Federally Qualified Health Centers (FQHC)/medical homes may not be available in the county where the child is referred
b) The location of the FQHC/medical home may not be geographically convenient for travel</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence-based strategy will measure the percentage of children without a provider or insurance that are referred by Community Health Nurses to medical homes in the state of Pennsylvania. The American Academy of Pediatrics in May 2020 stated that “medical homes improve health outcomes for the population, increase satisfaction for children and families, and decrease cost of care.” Children and youth with and without special health care needs, who access medical homes, receive increased rates of preventative services such as childhood immunizations, well-visits, and the assessment of vital signs. (American Academy of Pediatrics, May 2020). The provision of these services has a positive impact on families and their ability to live healthy lives. It allows parents to feel less stressed about the physical and mental development of their children. Parents also miss less days of work which stabilizes productivity in the workplace while reducing financial burden in the home. (American Academy of Pediatrics, May 2020). In addition to reduced financial burden in the home, the utilization of medical homes impacts health care costs by reducing the rate of children’s hospital stays and emergency room visits. (American Academy of Pediatrics, 2020).</td></tr>
<tr><td>Significance:</td><td>The goal is to establish a baseline of children without a provider or insurance seen by Community Health Nurses at State Health Centers across the state of Pennsylvania and the number of children referred to a medical home within 6 months. The percentage of children that meet the criteria and are referred to a medical home will then be calculated. This measure is important in order to ensure that all children are linked to a medical home so that they continue to receive medical care. The goal is to ensure that health status remains stable and that children grow into healthy adults.</td></tr>
</table>

ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Annually increase the percentage of CSHCN receiving quality care through project-funded FQHC health systems.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator is a count of the CSHCN served through the funded programs in the project-funded FQHC programs. **Denominator:** The denominator is a count of the total number of CSHCN receiving care in the project-funded FQHC programs.
Data Sources and Data Issues:	Data source will be the Data Collection and Recording Tool developed for the FQHC program. Data will be self-reported by grantee and verified with copies of written collaborative agreements.
Evidence-based/informed strategy:	Project-funded FQHC health systems receive technical assistance to develop and implement engagement policies to support quality care for CYSHCN. Project-funded FQHCs receive direct technical assistance to develop and implement identified projects. As the projects are implemented and completed the results and models are shared across all FQHCs to support broad systemic change. Through the project-based model, FQHC health systems receive funding for participating in quality improvement activities for services directed to CYSHCN. The model supports policies and programs becoming established through funded projects, as well project sharing for broader implementation, to increase actively engaging CYSHCN.
Significance:	By supporting customized, systemic change within each project-funded FQHC health system that can focus on client and family engagement; early and continuous screening and referrals; access to care; transitions; and, coordinated, comprehensive and continuous care that CSHCN will experience improved health outcomes in the short and long-term.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Number of families served through Centering Pregnancy Programs
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of families served through Centering Pregnancy Programs</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>The numerator is the number of families enrolled in Centering Pregnancy programs</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected through Quarterly reports from the Centering Pregnancy Programs.</td></tr>
<tr><td>Significance:</td><td>Quantitative studies of Centering Pregnancy Programs have shown that women who receive prenatal care through the Centering Pregnancy model compared to traditional prenatal care have a reduced number of low birth weight babies and preterm births, a higher number or prenatal visits and increased breastfeeding rates. These factors will improve the health of families in Pennsylvania.</td></tr>
</table>

2016-2020: ESM 1.2 - Percent of adolescents and women engaged in family planning after delivery
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Annually increase the percentage of adolescents and women engaged in family planning after delivery
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The numerator is the number of women engaged in family planning after delivery</td></tr><tr><td>**Denominator:**</td><td>The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants</td></tr></table>
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the County Municipal Health Departments.
Significance:	Family planning services have important health, social, financial, environmental and economic benefits. Access to contraception helps people to avoid pregnancies they do not want, and to plan and space the pregnancies they do want. Interconception care allows women to improve their health before becoming pregnant ultimately improving the health of their children.

2016-2020: ESM 1.3 - Percent of adolescents and women who talked with a health care professional about birth spacing and birth control methods
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the percentage of adolescents and women who talked with a health care professional about birth spacing and birth control methods</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The numerator is the number of women served through the IMPLICIT program who talked with a health care professional about birth spacing or birth control methods</td></tr>
<tr><td>Denominator:</td><td>The denominator is the number of women who are served through the IMPLICIT Programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected through Quarterly reports from the IMPLICIT Programs.</td></tr>
<tr><td>Significance:</td><td>Annually increasing the number of women who are discussing birth control and birth spacing with a health professional will likely improve women’s interconception health and ultimately the health of their children. The IMPLICIT program works on the schedule of children’s well visits to screen mothers for four risk factors: smoking, depression, contraception and multivitamin use. Increasing the number of health care professionals discussing birth control methods will in turn increase the number of women utilizing birth control.</td></tr>
</table>

2016-2020: ESM 1.5 - Number of women served through evidence based or informed home visiting programs
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Annually increase the number of women served by evidence-based or informed home visiting programs
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** The number of women enrolled in home visiting programs **Denominator:**
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the County/Municipal Health Departments and Nurse Family Partnership.
Significance:	Evidence based home visiting programs have achieved positive outcomes in reducing the incidence of low birth weight babies, fewer repeat pregnancies, improved child development and increased rates of immunizations. All of these factors together will likely improve the health of women and their children.

2016-2020: ESM 1.6 - Percent of eligible women receiving 17-alpha-hydroxy progesterone caproate (17P) treatment compared to baseline data
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Help prevent preterm births by increasing the use of 17P by increasing identification of women eligible to receive this treatment</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of women receiving 17P</td></tr>
<tr><td>Denominator:</td><td>Number of women eligible to receive 17P</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>• Data collection and analysis will be performed by the vendor selected by Department to carry out the activities of this program. It will be a grant deliverable as required by the work statement and reported to the Department via quarterly reports.
• There is currently no baseline data available for utilization of 17P. Current utilization will be determined from a retrospective review which will then be used as the baseline to measure outcomes for the program.</td></tr>
<tr><td>Significance:</td><td>17P is shown to be a successful intervention for extending the gestation of women at risk for preterm birth however, not all women who could benefit from this treatment utilize it. Preterm births disproportionally affect African American infants. In 2016, the preterm birth rate for the state was 9.3 percent. Steep disparities persist with the African American rate at 13.2 percent compared to the rate for white women at 8.5 percent. The BFH is working to develop interventions to increase 17P utilization and reduce the preterm birth rate in Pennsylvania. In order to develop effective interventions, the BFH and March of Dimes will determine baseline data of current 17P utilization and then utilize that data to increase identification and utilization among eligible women.</td></tr>
</table>

2016-2020: ESM 4.1 - Percent of facilities designated as a Keystone 10 facility each fiscal year
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of facilities becoming Keystone 10 designated
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of facilities enrolled in initiative which are Keystone 10 designated each fiscal year **Denominator:** Number of facilities enrolled in initiative at the beginning of the fiscal year
Data Sources and Data Issues:	Data for the numerator will be gleaned both from the vendor reports as well as from the DOH website on which the listing of hospitals achieving steps is provided. The denominator is the total number of facilities enrolled in the initiative at the beginning of the fiscal year. The denominator will change as new facilities are added to the initiative (funding dependent).
Significance:	The Breastfeeding Awareness and Support Program is currently funding an initiative called the Keystone 10 Initiative within Pennsylvania birthing facilities. The goal of this initiative is to facilitate the adoption and implementation of ten evidence-based steps, commonly known as the Ten Steps to Baby Friendly Hospitals. Evidence demonstrates that breastfeeding rates at facilities increase as those facilities implement the evidence based steps. Monitoring the increase in the number of facilities completing all steps and becoming Keystone 10 designated will ensure movement by these facilities towards increasing breastfeeding rates.

2016-2020: ESM 4.2 - Percent of counties with breastfeeding initiation rates at or above the 2016 statewide average of 81 percent each fiscal year
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of counties with breastfeeding rates at or above the 2016 statewide average of 81</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of counties with a breastfeeding initiation rate at or above the state average at the end of the fiscal year</td></tr>
<tr><td>Denominator:</td><td>67 counties</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The numerator will indicate the number of counties with a breastfeeding rate at or above the state average of 81 percent and the denominator is a fixed number of 67 counties (2016 was used as the baseline data for this initiative as that was the most recent data available at the time the initiative was developed). Data will come from vendor reports and PA Health Stats.</td></tr>
<tr><td>Significance:</td><td>The Breastfeeding Awareness and Support Program is currently undertaking initiatives to work with targeted counties to assist in the implementation of data based strategies. Implementation of data based strategies like intervention, providing partner/family support, and conducting media or social marketing have been shown to increase breastfeeding initiation and duration rates among women. The counties targeted for these activities are those consistently having lower breastfeeding rates than the overall Pennsylvania rate.</td></tr>
</table>

2016-2020: ESM 4.3 - Number of new collaborations developed (between breastfeeding program plus other program)
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Annually develop a minimum of one collaborative opportunity with programs serving the MCH population
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** Number of collaborations developed **Denominator:**
Data Sources and Data Issues:	Numerator will be the number of collaborative opportunities developed, meaning that a focus on breastfeeding is incorporated into other programs as applicable. This information will be collected by the breastfeeding program staff.
Significance:	The Breastfeeding Awareness and Support Program is currently pursuing collaborative opportunities within the Department of Health and with outside entities with the intent of incorporating breastfeeding awareness, support, education, materials and messaging within the work of other programs. The Program will also incorporate applicable education, materials and messaging from other programs within their breastfeeding work. Building collaborative relationships helps ensure that women and families receive consistent, public health focused messaging on particular topics and better ensures that the professionals that interact with these populations are educated and also have a point of contact for questions and additional information. It has been anecdotally reported that it is the conflicting or incomplete messages that women/families receive that impact their decisions to breastfeed and they often do not know where to turn for assistance. It is therefore important for others serving those populations to have an effective understanding of breastfeeding.

2016-2020: ESM 4.4 - Number of media opportunities implemented promoting breastfeeding per fiscal year NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Annually implement a minimum of one media opportunity promoting breastfeeding as the infant feeding norm for the state
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** Number of media opportunities implemented **Denominator:**
Data Sources and Data Issues:	The Numerator will capture the number of media opportunities implemented by the breastfeeding program staff.
Significance:	The use of media to promote breastfeeding is an evidence based strategy that has been shown to increase breastfeeding rates. The Breastfeeding Awareness and Support Program is currently exploring media opportunities available to promote breastfeeding. Media encompasses the range of opportunities available from traditional print materials to advertising to a web presence and current social media platforms. This range is being utilized both to reach a diverse segment of the population and also to allow some flexibility in implementation as opportunities are often funding dependent and funding is not always available.

2016-2020: ESM 5.4 - Number of social marketing messages disseminated
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of social marketing messages disseminated to increase population awareness of safe sleep practices</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>The number of social marketing messages disseminated; the type of message will be counted, if multiple methods are used</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Quarterly annual reports from the Infant Safe Sleep Initiative will provide the number and type of social marketing messages disseminated. An applicant has been selected; however, a grant agreement is pending for programming that will begin July 1, 2016. At this time only the general types of social marketing that will be implemented is known. The grantee anticipates planning for social marketing will be a 6 month process and will then be able to better estimate the number of messages to be disseminated. The BFH would prefer to hold off on projecting the number of social marketing messages to be disseminated until the planning has at least begun. Due to the Infant Safe Sleep Initiative being a three year grant, projections are not being made past the grant period as future programming is undetermined at this time.</td></tr>
<tr><td>Significance:</td><td>This will show the quantity of safe sleep messages that are disseminated to the public. Educating the public at large will provide safe sleep messages not only to parents, but allow for a consistent message to reach family, friends and other caretakers. Conflicting messages from family and friends can influence parents to not implement the life-saving safe sleep education provided through the hospital based model and other messaging. Additionally, this will allow the parents of infants not born in a hospital to receive safe sleep messages.</td></tr>
</table>

2016-2020: ESM 7.1.1 - Number of comprehensive home assessments completed
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Annually increase the number of comprehensive home assessments completed
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program. **Denominator:**
Data Sources and Data Issues:	Quarterly reports from Pennsylvania Safe and Healthy Homes Program will provide this information.
Significance:	This number identifies the number of homes that have been evaluated for health and safety hazards that could cause injury to children ages 0-9. The holistic approach of a comprehensive home assessment has been demonstrated to be less expensive than conducting separate assessments and subsequent intervention of individual hazards. The Pennsylvania Safe and Healthy Homes Program will focus on hazards that are leading causes of injuries that lead to hospitalizations. The regions of the Pennsylvania Safe and Healthy Homes Program have a total injury rate higher than the state rate, both a fatal and nonfatal injury rate higher than the state rate or a fatal injury rate more than two times the state rate for individuals under age 25.

2016-2020: ESM 7.1.2 - Number of health and safety hazards identified through comprehensive home assessments
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	Annually increase the number of health and safety hazards identified
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** The number of health and safety hazards identified through comprehensive home assessments performed through the Pennsylvania Safe and Healthy Homes Program. **Denominator:**
Data Sources and Data Issues:	Quarterly reports from Pennsylvania Safe and Healthy Homes Program will provide this information. The projected objectives are calculated by multiplying the number of home assessments completed by the average number of hazards identified in each home. It is estimated there will be an average of 8 hazards identified in each home that an assessment is completed in.
Significance:	This number identifies the number of health and safety hazards that have been identified in homes that have been evaluated for health and safety hazards that could cause injury to children ages 0-9. The holistic approach of a comprehensive home assessment has been demonstrated to be less expensive than conducting separate assessments and subsequent intervention of individual hazards. The Pennsylvania Safe and Healthy Homes Program will focus on hazards that are leading causes of injuries that lead to hospitalizations. The regions of the Pennsylvania Safe and Healthy Homes Program have a total injury rate higher than the state rate; both a fatal and nonfatal injury rate higher than the state rate; or a fatal injury rate more than two times the state rate for individuals under age 25.

2016-2020: ESM 7.1.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of health and safety interventions performed</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments through the Pennsylvania Safe and Healthy Homes Program.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Quarterly reports from Pennsylvania Safe and Healthy Homes Program will provide this information. It is estimated that grantees will provide an average of 5 interventions (give items to residents) per home assessed. The number of interventions does not equal the number of hazards found as not all hazards require a countable item intervention.</td></tr>
<tr><td>Significance:</td><td>This number identifies the number of health and safety interventions that have been performed to reduce the leading causes of injuries to children ages 0-9. All allowable interventions are evidence based or evidence informed and have a direct connection to the prevention of injuries that often lead to hospitalization. The families targeted with the Pennsylvania Safe and Healthy Homes Program frequently do not have the education to understand the need for these interventions and more importantly do not have the available resources to otherwise implement the interventions.</td></tr>
</table>

2016-2020: ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescent health vendors receiving LGBTQ cultural competency training</td></tr>
<tr><td>Denominator:</td><td>Number of adolescent health vendors</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the adolescent health vendors. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17 precent of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others.

Bullying affects youth negatively in many ways. Youth who are bullied are more likely to experience depression and anxiety, changes in sleep and eating patterns and decreased academic achievement and school participation. Academic success has a direct impact on their employment prospects and future earnings potential, which impact health and access to health care in adulthood.

LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.

Bias based on gender; social/socio-economic class and privilege; gender orientation, sexual preference, and gender identity; mental, physical and emotional ability/disability; physical appearance (most notably obesity); and religion are frequently at the center of bullying and discrimination in schools. Improving knowledge and competency in these areas can help programs more effectively prevent bullying and more appropriately react to bullying when it happens.</td></tr>
</table>

2016-2020: ESM 9.5 - Number of evidence-based mentoring programs implemented in high risk areas of PA
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of evidence-based or evidence-informed mentoring, counseling and adult supervision programs available to youth ages 8 -18</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>20</td></tr>
<tr><td>Numerator:</td><td>The measure of this strategy will be a count of evidence-based programs being implemented. We anticipate funding up to 4 separate programs throughout Pennsylvania</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be based on how many programs are selected by the Bureau of Family Health to implement programming. Additionally, those programs will report to the Bureau on any additional programs they may contract with to provide the same services. Programs will be implemented statewide, with an emphasis on high risk areas in which youth are most likely to engage in risky behaviors such as unsafe sexual activity.</td></tr>
<tr><td>Significance:</td><td>Selecting programs in high risk areas will support the Bureau of Family Health in reaching its State Performance Measure of helping youth increase their assets by 50%. Programming will be implemented statewide, with an emphasis on high risk areas in which youth are most likely to engage in risky behaviors and provide a greater need for programming. For example, Healthy Youth PA is a program funded by the Title V State Abstinence Education Grant Program and uses a combined approach of mentoring, adult supervision, and counseling to increase assets of youth. Healthy Youth PA targets 10 counties in Pennsylvania that have the highest pregnancy rates of females age 15-17. A similar approach will be taken with the newly developed programs, although programming will be implemented statewide as programming will not just focus on reducing teenage pregnancy rates.

This ESM is not directly linked to NPM 9, but it is linked to the following SPM: Percent of youth ages 8-18 participating in a mentoring program who increased assets by 50%.</td></tr>
</table>

2016-2020: ESM 9.6 - The number of organizations certified as a safe space provider
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To annually increase the number of Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) sensitive organizations which provide services to youth</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>Number of LGBTQ sensitive organizations that provide services to youth</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.

This ESM is not directly linked to NPM 9, but is linked to the following priority: Protective factors are established for adolescents and young adults prior to and during critical life stages.</td></tr>
<tr><td>Significance:</td><td>Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face a variety of challenges, both environmental and individual, that shape how they view themselves as well as their perception of how they view others. LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide

LGBTQ youth suffer alarmingly high rates of bullying and violence in schools, alcohol and drug use, sexually transmitted infections (including HIV/AIDS), suicide and homelessness. To help LGBTQ youth better manage their life experiences, support from adults is essential and, in some cases, life changing. Parents and caregivers play an important role in the self-esteem of any child; receiving support from their parents and/or caregivers is integral to the positive physical, mental and emotional health of LGB youth. While some LGBTQ youth may not receive support and positive reinforcement from parents and/or caregivers, the support they receive from one staff person at a local agency (possibly a manager, facilitator or program director) can positively affect their outcomes.</td></tr>
</table>

2016-2020: ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To annually increase the number of LGBTQ youth who have access to suicide prevention services</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of LGBTQ youth who have access to suicide prevention services</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.

This ESM is not directly linked to NPM 9, but is linked to the following priority: Protective factors are established for adolescents and young adults prior to and during critical life stages.</td></tr>
<tr><td>Significance:</td><td>LGBTQ youth face a variety of challenges, both environmental and individual, that shape how they view themselves as well as their perception of how they view others. LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide. LGBTQ youth suffer alarmingly high rates of bullying and violence in schools, alcohol and drug use, sexually transmitted infections (including HIV/AIDS), suicide and homelessness.

Some statistics include:
o 84.6 percent of LGBTQ students reported being verbally harassed, 40.1 percent reported being physically harassed and 18.8 percent reported being physically assaulted at school in the past year because of their sexual orientation.
o Nearly two-thirds (61.1 percent) of students reported that they felt unsafe in school because of their sexual orientation.
o 38.4 percent of LGBTQ youth drank alcohol before age 13, compared with 21.3 percent of heterosexual youth.
o LGBTQ youth report rates of suicide attempts from 20 to 40 percent and lifetime prevalence suicide attempt rates ranging from 7 to 20 percent as adults.

To help LGBTQ youth better manage their life experiences, support from adults is essential and, in some cases, life changing. Parents and caregivers play an important role in the self-esteem of any child; receiving support from their parents and/or caregivers is integral to the positive physical, mental and emotional health of LGBTQ youth. While some LGBTQ youth may not receive support and positive reinforcement from parents and/or caregivers, the support they receive from one staff person at a local agency (possibly a manager, facilitator or program director) can positively affect their outcomes.</td></tr>
</table>

2016-2020: ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the number of community-based organizations participating in a bullying awareness and prevention program
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of trainers trained in the Olweus Bullying Prevention Program **Denominator:**
Data Sources and Data Issues:	Data collection and analysis will be performed by the vendor(s) selected by DOH to carry out the activities of the bullying program. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.
Significance:	According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17% of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others. Bullying affects youth negatively in many ways. Youth who are bullied are more likely to experience depression and anxiety, changes in sleep and eating patterns and decreased academic achievement and school participation. Academic success has a direct impact on their employment prospects and future earnings potential, which impact health and access to health care in adulthood. Youth who bully others are more likely to experience alcohol and drug abuse in adolescence. This serious health problem can persist long after adolescence. LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.

2016-2020: ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs
Definition:	**Unit Type:** Count **Unit Number:** 20,000 **Numerator:** A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs **Denominator:**
Data Sources and Data Issues:	Data will be collected from organizations implementing programming. The data will include a count of youth being served.
Significance:	Engaging youth to participate in evidence-based or evidence informed mentoring, counseling, or adult supervision programs will support the Bureau of Family Health in reaching its State Performance Measure of helping youth increase their assets by 50%. This particular performance measure was selected to measure how well youth in the mentoring program are provided with skills, experiences, relationships, and behaviors to help them increase their developmental assets. Increasing developmental assets, in turn, will give the youth a better chance of succeeding in school and becoming contributing members of their communities. Providing opportunities for youth to increase the number of developmental assets they have is the primary organizing concept of this approach. By utilizing the Search Institute's 40 Developmental Assets framework, youth will be provided with building blocks for healthy development to help them grow into healthy, caring and responsible young adults. The Search Institute's developmental assets framework includes 20 external assets organized under the following four categories: support, empowerment, boundaries and expectations, and constructive use of time; and 20 internal assets organized under these four categories: commitment to learning, positive values, social competencies, and positive identity.

2016-2020: ESM 10.1 - The number of counties with a Health Resource Center (HRC) available to youth ages 12-17
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of counties with an HRC available to youth ages 12-17 either in a school or community based setting</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>20</td></tr>
<tr><td>Numerator:</td><td>Number of HRCs available to youth ages 12-17</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee that subcontracts with schools and community organizations for the HRCs that are established. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” The HRCs fill this primary care gap by being available and accessible in the schools youth attend and in the communities where they reside. Expanding the number of HRCs in the state will expand availability of vital health services for youth. Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed.</td></tr>
</table>

2016-2020: ESM 10.2 - Number of youth receiving services at a Health Resource Center (HRC)
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number annually of youth ages 12-17 utilizing HRC services</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>Number of youth ages 12-17 receiving services at an HRC</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collection and analysis will be performed by the Grantee that subcontracts with schools and community organizations for the HRCs that are established. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” The HRCs fill this primary care gap by being available and accessible in the schools youth attend and in the communities where they reside. Expanding the number of HRCs in the state will expand availability of vital health services for youth. Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed.</td></tr>
</table>

2016-2020: ESM 10.4 - Number of youth receiving services at a drop-in site funded by the Bureau of Family Health (BFH)
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of adolescents and young adults who identify as Lesbian, Gay, Bisexual, Transgender, and/or Questioning (LGBTQ) with a medical visit in the past year</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of youth ages 14-24 receiving services at a BFH-funded drop-in center</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be collected from the Grantee that provides a drop-in center for LGBTQ individuals ages 14-24. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.</td></tr>
<tr><td>Significance:</td><td>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed. Drop-in centers provide an access point for LGBTQ youth to receive services that is accessible and sensitive to the barriers they may face.</td></tr>
</table>

2016-2020: ESM 10.5 - Number of youth receiving health education and counseling services from a reproductive health provider
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase the number of adolescents receiving health education and counseling services during a reproductive health visit
Definition:	**Unit Type:** Count **Unit Number:** 50,000 **Numerator:** Number of adolescents **Denominator:**
Data Sources and Data Issues:	Data will be collected from the four family planning providers. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed. As one of the access points for youth to receive health care services, the reproductive health visit provides an opportunity for youth to receive health education and counseling, including education and counseling about STIs, HIV/AIDS, pregnancy prevention, general wellness, reducing risky behaviors, and healthy relationships.

2016-2020: ESM 11.1 - Number of families who receive services through the evidence based or evidence informed strategies of the Community to Home (C2H) program
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of families of children and youth with special health care needs served by C2H
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** The numerator is the number of families who received services through the evidence based or evidence informed strategies **Denominator:**
Data Sources and Data Issues:	Data will be collected through monthly reports from the Pennsylvania Elks Major Projects, Inc.
Significance:	Community Health Workers (CHWs) have been shown to be valuable for community programs that aim to improve health. Many times CHWs are members of the communities in which they serve and are able to develop a trusting, one-on-one relationship with consumers and providers. CHW programs are designed to improve access to care, increase knowledge, prevent disease and improve select health outcomes. There are several CHW program models that have been designed to improve outcomes of patient health. More than one model can be combined into a program to ensure that the program effectively meets the needs of the target population. The Care Coordinator/Manager Model and the Outreach and Enrollment Agent Model are the evidence based models that are currently being utilized by the service coordinators, and the Community Organizer and Capacity Builder Model is the evidence based model that is utilized by the RCs. The combination of these models of service provision will likely improve access to information and help families to navigate the health care system for CSHCN. This ESM is not directly linked to NPM 11, but is linked to the following priority: Appropriate health and health related services, screenings and information are available to the MCH populations.

2016-2020: ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually increase the number of collaborations between systems of care serving CSHCN
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The numerator is the number of collaborations developed between BFH and other organizations with a vested interest in CSHCN **Denominator:**
Data Sources and Data Issues:	Data will be collected using a spreadsheet that will be developed, when a collaboration is made.
Significance:	Families of children and youth with special health care needs require more assistance than families of typical children, and need additional support. As children move through the life span, different needs are identified, so accessing information and resources can be an ongoing need for caregivers. No organization can assist families alone and by establishing a working relationship with other organizations families of CSHCN will benefit from a better system of care. This ESM is not directly linked to NPM 11, but is linked to the following priority: Appropriate health and health related services, screenings and information are available to the MCH populations.

2016-2020: ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of pediatric providers participating in a learning collaborative, education and/or statewide technical assistance</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Numerator will be compiled from several data sources each fiscal year. The BFH funds a vendor to implement the PA Medical Home Initiative which focuses on building the number of medical homes available to children and youth with special health care needs. The vendor will report quarterly and annually the number of pediatric providers participating in any of the mentioned activities as an unduplicated number. Additionally, the Medical Home Program Project Officer will report on practices involved in these activities aside from those provided by the vendor as an unduplicated number.</td></tr>
<tr><td>Significance:</td><td>The medical home concept was introduced by the American Academy of Pediatrics almost 40 years ago with focus on the location of a child’s medical record, particularly a child with a special health care need. Since that time, medical home has expanded to be more of a home base for care delivered through a partnership between a healthcare provider and the child/family being served and has grown to encompass adult care as well. The original guidelines have been updated on several occasions and continue to stress care that must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Evidence continues to build that demonstrates the medical home approach to care shows associations pediatric medical homes and improved health outcomes, increase in family satisfaction with care provided and decreased healthcare costs.

The NPM focuses on the number of children having a medical home and the best way to ensure that children have access to providers practicing the components of medical homes is to focus on training, education and provision of technical assistance, with particular attention paid to providers within health care systems and medical training programs.</td></tr>
</table>

2016-2020: ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase involvement of youth/young adults and parents/caregivers in BFH medical home activities</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Focus is on increasing the number of youth/young adults and parents/caregivers involved in the medical home activities being implemented by the BFH. Unduplicated numbers will be collected from the vendor implementing the PA Medical Home Initiative for the BFH at the end of each fiscal year. Additionally, unduplicated numbers will also be tabulated by the Medical Home Project Officer that capture non-vendor activities each fiscal year.</td></tr>
<tr><td>Significance:</td><td>Family involvement serves as a key component of all Title V work involving children and youth with special health care needs and family centered care is a cornerstone of medical home activities as it recognizes that families are the primary caregivers of their children. It is equally important that youth and young adults are enabled to be partners in their own care to the extent possible. Individuals will be given the opportunities to participate in a number of facets of medical home activities, ranging from directly helping families of other children, to helping practices address issues of concerns of families to helping plan the direction of medical home activities overall.</td></tr>
</table>

2016-2020: ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Annually develop a minimum of two collaborations with oral or behavioral entities that involves them in the provision of medical home services
Definition:	**Unit Type:** Count **Unit Number:** 10 **Numerator:** Number of collaborations developed **Denominator:**
Data Sources and Data Issues:	The BFH's PA Medical Home Program is currently pursuing collaborative opportunities within the Department of Health and with outside entities with the intent of integrating oral and behavioral health services within medical homes. Collaborations will be deemed developed if a mutual agreement between entities is reached and provides for movement towards a definitive goal, in this case, integration of services. Numerator will be the number of collaborative opportunities developed.
Significance:	Good oral health has a positive impact on overall health and conversely, poor oral health can have negative effects on overall health. Children with special health care needs are often not able to perform activities of daily living, like those needed to keep their gum, teeth and the like healthy with consistency and effectiveness, therefore are likely to suffer from poor oral health. Treatments for special needs, like certain medications for instance, can also negatively impact oral health. Additionally, access to dental health continues to be a concern in many parts of the state, and access to a pediatric dentist able to effectively treat children with special needs is even harder to find. Behavioral health is another issue of concern for families of children with special health care needs. A disability can mask an underlying behavioral health concern or can worsen a child's mental state and create behavioral health issues. As with oral health, the lack of access to providers and/or long waiting lists are concerns in most parts of the state, particularly providers that are able to treat children with one or more conditions. An opportunity to serve children's oral and behavioral health needs more effectively, therefore, lies in integrating that care with their sources of physical health, their medical home. Integration can take many forms: providing joint onsite care; having another provider in close proximity and making appointments before the family leaves; providing telehealth services, and perhaps even providing some cross training (pediatrician providing a behavioral health screenings, an oral health professionals referring a child to a pediatrician).

2016-2020: ESM 11.6 - Number of families receiving Respite Care Program services
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of families receiving Respite Care Program services in order to reduce stress on caregivers who care for children with special healthcare needs
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** Number of families receiving Respite Care Program services **Denominator:**
Data Sources and Data Issues:	Data collection and analysis will be performed by the Department and the vendor selected by Department to carry out the activities of the Respite Care Program. It will be a grant deliverable as required by the work statement and reported to the Department via quarterly reports.
Significance:	In 2015, the Behavioral Risk Factor Surveillance System (BRFSS) survey for Pennsylvania was conducted. Data from this survey concluded that almost 60% of survey respondents averaged up to eight hours a week providing care to a family member or friend with a health need or disability, while 20% of respondents averaged 40 or more hours a week providing care. Due to the need to provide this care and assistance, parents and caregivers may have more stress, less time for themselves and struggle to balance work and family responsibilities. The Respite Care Program was developed to provide non-emergent respite care services to caregivers and help to reduce the stress associated with providing this care.

2016-2020: ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Annually increase the number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health risk factors
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT program who are screened for behavioral health risk factors **Denominator:**
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.
Significance:	Moving forward the Department is including in Title V Grant Agreements with the County Municipal Health Departments that Grantees conduct behavioral health screenings for women in prenatal and home visiting programs using the 5Ps. The IMPLICIT program was created around behavioral health screenings in the postpartum period. Increasing the number of women enrolled in these programs will allow more women to be screened and possibly identified as needing behavioral health interventions and in turn lead to healthier women and children as help is received. This ESM is not directly linked to NPM 14, but is linked the following priority: Women receiving prenatal care or home visiting are screeend for behavioral health concerns and referred for assessment if warranted.

2016-2020: ESM 14.1.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV)
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Annually increase the percentage of women with a home visitor who have a conversation about IPV
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator will consist of the number women in home visiting programs who have a conversation about IPV **Denominator:** The denominator will consist of the number of women in home visiting programs
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the home visiting programs.
Significance:	IPV happens in every community. Home visitors are in a position to address IPV and begin a conversation. A simple conversation could save or improve the life and health of a family by removing the stigma surrounding women and children living in unhealthy relationships. The Institute for Health and Recovery's 5P's tool screening, which the DCAHS is requiring all home visitors be trained on and utilize, allows for the identification of women in need of support and referrals for mental health, substance abuse assessment and IPV. Incorporating IPV screening into the home visiting curriculum will allow us to gain an understanding of the prevalence of IPV in the population served. This ESM is not directly related to NPM 14, but it is related to the following priority: Women receiving prenatal care or home visiting are screeened for behavioral health concerns and referred for assessment if warranted.

2016-2020: ESM 14.1.3 - Percent of women who report smoking after confirmation of pregnancy
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Annually decrease the percentage of women who report smoking during pregnancy
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The numerator is the number women in home visiting, IMPLICIT and centering pregnancy programs who report smoking after confirmation of pregnancy</td></tr><tr><td>**Denominator:**</td><td>The denominator is the number of pregnant women in home visiting, IMPLICIT and centering pregnancy programs</td></tr></table>
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.
Significance:	Decreasing the number of women who report smoking after pregnancy confirmation will decrease the number of preterm births, low birth rate, respiratory problems and SIDS and increase the health of babies before and after birth. The DCAHS chose to focus on smoking after confirmation of pregnancy due to the fact that nearly 50% of pregnancies are unintended and it is a better indication of behavioral changes and overall health throughout the pregnancy.

2016-2020: ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Annually decrease the percentage of women who report smoking before, during and after pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator is the number of vendors implementing evidence based or evidence informed tobacco free programs **Denominator:** The denominator will consist of the number of vendors
Data Sources and Data Issues:	Data will be collected through vendor reporting.
Significance:	Increasing the number of evidence based or evidence informed tobacco free programs will help to decrease the number of women who report smoking before, during and after pregnancy. Women who smoking before pregnancy have more difficulty becoming pregnant. Women who smoke during pregnancy are more likely to deliver preterm babies, low birth weight babies and babies who are more likely to die from Sudden Infant Death Syndrome (SIDS). Women who smoke after pregnancy have babies with weaker lungs increasing risk factors for other health problems.

Form 11
Other State Data

State: Pennsylvania

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Pennsylvania

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	No	Annually	12		• PRAMS • death records • NBS
2) Vital Records Death	Yes	No	Annually	12	Yes	• birth records
3) Medicaid	Yes	No	Annually	12	No	
4) WIC	No	No	Less Often than Annually	12	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	• PRAMS • WIC • CDR • NEDSS • EI
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	• EI
7) Hospital Discharge	Yes	Yes	Annually	12	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	Yes	• birth records

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Neonatal Abstinence Syndrome (NAS) Case Reporting	Yes	Yes	Daily	0	Yes	• birth records • NEDSS • EI
10) National Center for Fatality Review and Prevention - Case Re	Yes	Yes	Daily	3	Yes	• birth records • death records
11) PA Maternal Mortality Review Program	Yes	Yes	More often than monthly	3	Yes	• birth records • death records

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: The BFH receives subsets and/or limited access to vital records birth files for specific operations related to PRAMS, Child Death Review, SUID/SDY registries, Maternal Mortality Review, and newborn screening but internal requests for direct access to the electronic data source or to an analytic file that could be used to inform other Title V programs or needs assessment activities have been denied or are outstanding. Accordingly, analysis of and linkage between vital records and other MCH datasets is limited or not possible.
Data Source Name:	**2) Vital Records Death**
	Field Note: The BFH receives subsets and/or limited access to vital records death files for specific operations related to Child Death Review, SUID/SDY registries, and Maternal Mortality Review but internal requests for direct access to the electronic data source or to an analytic file that could be used to inform other Title V programs or needs assessment activities have been denied or are outstanding. Accordingly, analysis of and linkage between vital records and other MCH datasets is limited or not possible.
Data Source Name:	**3) Medicaid**
	Field Note: The BFH receives de-identified, aggregate data from the Office of Medicaid Programs on Title XIX eligible deliveries and infants by race and ethnicity for Title V reporting (Form 6) on an annual basis and has received aggregate data on active Medicaid members that have a specific condition or special health care need to inform CSHCN programming upon request.
Data Source Name:	**7) Hospital Discharge**
	Field Note: Inpatient discharge data from the Pennsylvania Health Care Cost Containment Council (PHC4) can be linked to vital records and other data sources solely by special request and linkage must be performed by PHC4 staff.

Other Data Source(s) (Optional) Field Notes:

Data Source Name:	**10) National Center for Fatality Review and Prevention - Case Re**
	Field Note: National Center for Fatality Review and Prevention - Case Reporting System (Child Death Review)
Data Source Name:	**11) PA Maternal Mortality Review Program**
	Field Note: Data sources include but are not limited to Coroner/Medical records, medical provider records, police records, Prescription Drug Monitoring Program data, Emergency Medical Services records, mental health provider data, and obituaries