Maternal and Child Health Services Title V Block Grant

Pennsylvania

FY 2023 Application/ FY 2021 Annual Report

Created on 8/25/2022 at 9:07 PM

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I. General Requirements

I.A. Letter of Transmittal

August 9, 2022

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 2023. As directed, Pennsylvania's 2021 Annual Report and 2023 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.

Andrea Race
Chief Financial Officer

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 to apply a health equity lens 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 to strengthen staff's ability to use data to make evidence-based decisions in program planning, implementation, and evaluation. Title V program staff seek out training and professional growth opportunities complementing these efforts. In 2020, BFH developed a 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 brings the discussion of health disparities and equity to the forefront internally through workforce development efforts and mandated training for BFH staff and, externally, through the integration of health equity language into grant agreements and participation in learning collaboratives, task forces and book clubs. The BFH has begun and will continue to 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 current iteration of the Health Equity Committee will begin evolving in July 2022 with a new mechanism to include all staff in shaping and managing health equity deliverables to be determined; however, health equity remains a key and guiding priority for BFH.

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 implementing strategies that meaningfully engage the populations being served in the design, conduct, and evaluation of MCH programs and systems.

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

As part of its systems-building work, the BFH has implemented processes to maintain a continuous cycle of feedback through interim needs assessment surveys, focus groups, and client satisfaction initiatives. Through this work, the BFH aims to ensure all MCH voices, including those of the most vulnerable, are heard. These processes were further actualized through the Five-Year Needs and Capacity Assessment completed in 2019 and the most recent Interim Needs Assessment Update in 2022.

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 and birthing people in Pa., access and receipt of timely prenatal care remains a challenge, rates of maternal morbidity and mortality are rising, and women and birthing people are increasingly in need of services and support for perinatal depression and substance use. Perinatal health in Pa. is continually impacted by infant mortality and 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 inform the work of this cycle. Given that the scope of direct services is limited by program capacity and funding, the BFH sees an opportunity to enhance existing strategies and develop system-level strategies to address maternal health. Ongoing work to ensure that women, birthing people, and mothers in Pa. have the support and services they need before, during, and after pregnancy includes home visiting, group prenatal care through Centering Pregnancy, 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 began 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 use Maternal Mortality Review Committee (MMRC) recommendations to inform Title V programming and collaborate with other state and local agencies to ensure that funds are being leveraged to deliver non-duplicative services. These efforts aim to drive improvement in National Performance Measure (NPM) 1 around increasing women's access to and use of preventive medical services.

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

infants with neonatal abstinence syndrome, efforts to build the capacity of Child Death Review (CDR) teams to review premature infant deaths and use of CDR recommendations to inform future programming.

Among children, in addition to enhancing the existing capacity of CDR teams, the BFH aims to address behavioral, mental, and developmental health needs among children and to develop systems-level strategies addressing trauma. Updated programming around maintaining a home free of hazards will continue to drive improvement in the child injury and mortality rates. Title V will also continue to support CDR and efforts aimed to reduce head injury and concussion among youth. Over the course of the funding cycle, the BFH will seek to use CDR recommendations to inform future programming and develop system-level strategies to complement and enhance existing programming on child injury prevention and trauma. These efforts aim to drive improvement in 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 and autism spectrum disorder will also continue. Other strategies, such as efforts associated with improving access to a medical home, have been adapted over the course of the funding cycle and new strategies related to improving access to transition services have been developed. Moving forward, CSHCN programming 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 are being 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 continue to support services for LGBTQ youth, as well as reproductive health services and programming aimed to promote healthy relationships for youth in Pa. These strategies serve to advance the mental, behavioral, and developmental health priority, the priority aiming to address child mortality, a SPM which aims to assess the percentage of youth in Pa. who have a mentor and 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 efforts are made to ensure that data from the CDR and the MMRC are reviewed and utilized to inform program design, planning, and implementation. These efforts connect to priority 6 and aim to drive improvement in tracking the extent to which policies and programs are modified as a result of data use and review of available evidence. Additionally, a strategy connecting to priority 7 aims to continue to build knowledge and understanding of health equity in the BFH. This strategy, and others developed over the course of the funding cycle, aims to drive improvement in the new SPM which will track the marked disparities between Black and white persons for key MCH indicators – mortality rates among infants, children, and mothers.

The BFH intends to achieve its objectives, maintain infrastructure, and support public health services and systems through partnerships. BFH works with local Title V agencies and selects partners throughout the state to provide public health, enabling, or direct services to the MCH population. BFH uses population and public health data to

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 maintaining 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, birthing people, children, and families. In Federal Fiscal Year 2021 (FFY21), $23,954,647 federal Title V dollars were expended, $11,087,519 on preventive and primary care for children, $7,215,266 on children with special health care needs (CSHCN), and $2,395,464 on administrative costs. Pennsylvania (Pa.) bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations; $49,045,442 state funds were expended in FFY21. Additionally, the BFH expended $3,241,422 in other federal funds implementing MCH programming. Total state and federal Title V expenditures for FFY21 were $73,000,089. In Pa., state match funds primarily support services for infants, children, and CSHCN. As such, federal Title V funds are used to augment the systems of care for those populations while also providing support for pregnant women, birthing people, mothers, and the MCH workforce. Over time, Pa. has increased its capacity to serve a greater proportion of the MCH population by shifting reimbursable direct service expenditures to the appropriate payors and utilizing federal and non-federal Title V funds for population health programs, such as school health services and newborn screening.

III.A.3. MCH Success Story

The Pennsylvania Newborn Child Testing Act was amended via Act 133 of 2020 and went into effect on May 24, 2021. As a result of this Act, all diseases screened for via dried blood spots by the Pennsylvania newborn screening program are now mandated for screening. This list of disorders includes thirty-six core conditions recommended by the Health and Human Services committee that make up the national recommended uniform screening panel (known as the RUSP). In addition to the core conditions, Pennsylvania screens all babies for twenty-five medical disorders that can be detected in the differential diagnosis of the thirty-six core conditions.

Prior to Act 133, all babies born in the Commonwealth were screened for 10 conditions that were paid for through state appropriations. Birthing hospitals, birthing centers, and midwives in Pennsylvania had the option to elect which, if any, of the twenty-six supplemental conditions on the newborn screening panel they had their clients screened for. The Pennsylvania Newborn Screening and Follow-up Program (NSFP) was concerned with the existence of this screening inequity based on where a parent chose to deliver their child within the Commonwealth. Act 133 ensures every newborn in the Commonwealth has access to the same essential core condition screenings.

The NSFP also initiated a waiver program, in conjunction with Act 133, to assist families identified to have a financial hardship with the cost of screening for the additional twenty-six core conditions. Pa. home birth midwives successfully utilize the waiver program to ensure the cost of screenings are waived for their eligible clients.

In addition to screening for the RUSP conditions, Krabbe disease was also added to the Pennsylvania panel, making Pennsylvania one of the leaders in screening for this devastating neurodegenerative disorder. After just seven months of screening, four babies have been diagnosed with Krabbe disease. Thanks to the changes associated with Act 133, these children were identified prior to the development of symptoms and are being cared for by experts at a Krabbe treatment center. Act 133 will allow Pennsylvania to expand statewide screening in the future to include screening for any disorder added to the RUSP or added by the Newborn Screening and Follow-up Technical Advisory Board, ensuring babies born within the state benefit from the positive outcomes associated with early screening, diagnosis, and treatment.

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 13 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 June 2021, Pa.'s 19 large counties (counties where 75,000 or more are employed) accounted for 76.5% of total employment within the state. All but two of those counties are considered urban. In 2020, 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 December 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. In 2020, 53 of Pa.'s 67 counties had 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 became even more pronounced from 2010-2020, as most of the population growth in Pa. 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 15 counties without Federally Qualified Health Centers (FQHC), all but one are rural. As of September 2021, of the estimated 495,949 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 HPSAs were in Allegheny, Beaver, Franklin, and York counties. Small areas of several urban counties are considered medically underserved. As of 2017, approximately 17.6% of Pa.'s population lived in an area designated as medically underserved. In 2020, there were 66 general acute care hospitals, with a total of 7,674 beds, in rural Pa. Eight rural counties had no hospitals. On average, there were 2.19 hospital beds for every 1,000 rural residents compared to 2.74 hospital beds for every 1,000 urban residents.

Across the state in 2020, the 151 general acute care hospitals (including 15 Critical Access Hospitals [CAH]) with over 33,700 licensed beds handled over 1.29 million admissions. CAHs 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 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. As of January 2022, Pa. had 16 federally designated CAHs. An additional 82 federal and specialty hospitals handled over 133,000 admissions. There are nine children's hospitals in Pa., four of which are in either

Philadelphia or Pittsburgh. The other five are in Allentown, Bethlehem, Danville, Erie, and Hershey. They may be inaccessible to children who live in rural areas or in areas not near these hospitals.

Supplementing the hospitals are over 350 FQHCs or rural health center delivery sites providing primary care services in 44 counties. FQHCs are an important resource for groups in Pa. that have been economically and socially marginalized. In 2020, 87% of FQHC patients were at or below 200% FPL, 48% were on Medicaid, and 54% were members of a racial or ethnic minority.

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 eleven CMHDs are in urban areas and tailor services to the needs of their local communities. The newest, in Delaware county, launched in January 2022 in response to community needs observed during the COVID-19 pandemic. It was approved by the Pennsylvania Department of Health to act in its official capacity as a health department on April 2, 2022. The Delaware County Health Department is the first one established in Pennsylvania in 33 years. 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 from state, federal, and local government going toward local office priorities. At a local level, CMHDs currently cover nearly 42% 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 that provide and support public health programs throughout Pa. To organize the state health centers, Pa. is divided into six community health districts, each covering a geographic region of the state. Each health district 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. was uninsured. By gender, 6.5% of men were uninsured compared to five percent of women. Only 5.2% of white persons were uninsured compared to 6.9% of Black/African American persons and 12.5% of Hispanic persons. 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 incomes below 400% of the FPL, unemployed or employed less than full-time, less than a high-school graduate and non-white. In 2021, over 337,000 residents selected a Marketplace plan, of which 70% received financial assistance. While the uninsured rate has fallen for all racial and ethnic groups because of the ACA, as of 2019, white persons are still more likely to be insured than Black/African American persons.

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 who are autistic). 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 February 2022, there were 144,230 children enrolled in CHIP. As of October 2021, CHIP and Medicaid combined provided health and long-term care coverage to more than 3.5 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 minoritized population increased from 36 to 40% nationally, and from 21 to 24% in Pa. From 2016-2020, non-white residents made up more of the population in urban areas (30%) than in rural areas (nine percent). From 2010 to 2020, the Hispanic identifying population increased in Pa. by 45.8%, and the from 2010-2019, the Black/African American identifying population 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 five percent of the total population to nine percent. As of 2019, approximately one in three Pa. children are children of color. With the total minoritized 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 2019, the infant mortality rate for white infants was 4.5 per 1,000 live births. The rate for Black/African American infants was nearly three times that, and for Hispanic infants, it was 31% higher. For Black/African American infants, the disparity has persisted since at least 1999, and for Hispanic infants, since 2012. Preterm births are a leading cause of infant death. In 2019, the percentage of preterm births for white infants was 9.1%. Black/African Americans had a percentage that was one and a half times that of white infants (roughly 50% higher), and for Hispanic infants, the percentage was 15% higher than that of white infants. The disparity for preterm births for Black/African American infants has been roughly the same since 2003. From 2015 to 2019, the maternal mortality rate for white birthing persons was 8.9 per 100,000 births. The rate for Black/African American birthing persons was nearly 2.5 times the rate for white birthing persons. In 2019, one percent of white mothers had no prenatal care; for Black/African American 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 white mothers, and more than three times that of white mothers for Hispanic mothers. Since 2003, the rate for Hispanic mothers has been at least twice that of white mothers 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 white persons was

3.2 per 1,000 females aged 15-17. Despite teen pregnancy rates for Black/African American persons having dropped over 67% from 2010-2019, rates are still more than three times that of white persons. Like Black/African American, despite a decline in teen pregnancy rates from 2010 to 2019, the teen pregnancy rate for Hispanic persons was more than five times that of white persons. That disparity has been roughly the same since 2010. With the projected increase in minoritized populations, unaddressed health inequities have the potential to place a greater burden on these populations and the health care system.

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 five percent, but the number of residents 65 and older increased more than 21%. Counties with large elderly populations could face the possibility of diverting resources from MCH populations toward their older residents.

Of the approximately 5 million households in the state in 2019, over 3.2 million of these households were 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/African American children and over 42% of Hispanic children live in female-led families compared to only 18.4% of white children. 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 2019-20 National Survey of Children's Health, 22.3% 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 $40,342 to $104,161; 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 2020, women in Pa. earned 79 cents for every dollar a man earned, less than the 83 cents national average. The wage gap is even greater for women from minoritized populations.

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/African American residents and 28.1% of Pa.'s Hispanic residents lived in poverty and families with Black/African or Hispanic householders were more than three times as likely to be living in poverty than white households. 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 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/African American 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 or equivalency 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 (LGBT) 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 or gender identity, which is not explicitly banned 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 November 2021, there were 18 hospitals participating in the model. The 2021-22 SHIP annual 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 2022 SHA in March 2022.

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. The Department is currently developing an 18-month plan to aid in the preparation of documents for re-accreditation, due in March 2024.

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 all diseases screened for via dried blood spots by the Pennsylvania newborn screening program are now mandated for screening. This list of disorders includes thirty-six core conditions recommended by the Health and Human Services committee that make up the national recommended uniform screening panel (known as the RUSP). In addition to the core conditions, Pennsylvania screens all babies for twenty-five medical disorders that can be detected in the differential diagnosis of the thirty-six core conditions. 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. 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. As of February 2022, Pa. has had over 2.28 million positive cases and more than 43,000 Pennsylvanians have died. Over 7.2 million Pennsylvanians are fully vaccinated, and more than 3.2 million Pennsylvanians have received an additional dose. COVID-19 mitigation orders were lifted effective May 31, 2021. The order requiring universal face coverings was lifted statewide effective June 28, 2021. On December 10, 2021, the statewide school mask mandate in Pa. was lifted, though some schools opted to continue requiring them at the local level. However, DOH continues to urge Pennsylvanians to get vaccinated if eligible and to follow CDC guidance for wearing a mask where required by law, rule, and regulations, including healthcare, local business, and workplace guidance. 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.

Of further concern is the effect COVID-19 has had on the mental health of children and youth. In its Declaration of a National Emergency in Child and Adolescent Mental Health, the American Academy of Pediatrics mentions that rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020, and by 2018 suicide was the second leading cause of death for youth ages 10-24. And according to the 2019 Youth Risk Behavior Survey, 36.7% of high school students reported being sad or hopeless every day for two weeks in a row, preventing them from doing some of their usual activities. The additional stress, disruption, and adversity experienced by families and children has exacerbated these trends that existed before COVID-19. This is borne out by the results of the CDC's Adolescent Behaviors and Experience Survey (ABES), in which the percentage of high school students reporting being 'sad or hopeless for two weeks" increased to 44.2%. In addition, ABES found that of the group that reported feeling sad and hopeless, one in two felt they were not connected with persons at school. ABES also found that students who felt connected to persons at school were less likely to report poor mental health during the pandemic (28.4%) compared to students that did not feel connected (45.2%). According to the Surgeon General's Advisory on Protecting Youth Mental Health, a number of risk factors have contributed to youth mental health symptoms during the pandemic, such as having parents or caregivers who were frontline workers or at elevated risk of burnout, experiencing disruptions in routine, experiencing more adverse childhood experiences, or experiencing trauma such as losing a family member or caregiver to COVID-19. A wide and varied number of groups were mentioned in the Advisory as having been at higher risk of mental health challenges during the pandemic, such as youth who have intellectual/developmental disabilities, are in a racial and ethnic minority, identify as LGBTQ+, are low-income, live in rural areas or immigrant households, have been in the juvenile justice/child welfare systems, and/or are runaways or homeless. Title V will be monitoring trends and working to address the issue through its priority to improve mental health, behavioral health, and developmental outcomes for children and youth with and without special health care needs.

Another emerging issue is the Supreme Court ruling on Dobbs v. Jackson Women's Health Organization, which effectively overturned Roe v. Wade and has potential to impact reproductive health and the Title V population, with health implications for pregnant people, children, and families. Abortion remains legal in Pennsylvania. There have been several bills passed during the current legislative session to restrict abortion access, but all were ultimately

vetoed by the Governor. According to the Robert Wood Johnson Foundation (RWJF), access to safe and high-quality reproductive medical care, including abortion, is an essential element of comprehensive healthcare and health equity, and restricting access to abortion compromises the health of pregnant people. RWJF goes on to say research has shown that states that have restricted access to abortion have increased their maternal mortality rates by nearly 40%, and women denied abortions are more likely to experience economic hardship and insecurity in later years. Ana Langer, professor of practice of public health and coordinator of the Women and Health Initiative at the Harvard T.H. Chan School of Public Health, stated laws restricting abortion access compel women and pregnant people to risk their lives and health by seeking out unsafe abortion care. According to the World Health Organization, 23,000 women die from unsafe abortions each year, and a recent University of Colorado study estimated that banning abortion in the U.S. would lead to a 21% increase in the number of pregnancy-related deaths overall and a 33% increase among Black women. According to the Association of Maternal & Child Health Programs (AMCHP), poor maternal health outcomes disproportionately impact women and birthing people with low incomes, women and birthing people of color, and women and birthing people in rural communities.

Another issue that will have effects on the health of Pennsylvanians are real or potential changes to insurance status and/or coverage. One change to insurance coverage is the extension of Medicaid postpartum coverage for mothers and birthing people who are eligible because of their pregnancy from 60 days after giving birth to one year after birth, effective April 1, 2022, under the American Rescue Plan Act. Extending postpartum coverage for those covered through Medicaid will provide health care continuity, allowing birthing parents to maintain uninterrupted relationships with and access to care providers through a critical period in their and their babies' lives. Throughout the pandemic, The Centers for Medicare and Medicaid Services (CMS) issued a Public Health Emergency (PHE), under which some requirements and conditions for Medicaid, such as eligibility redeterminations and disenrollments, were waived. The waiving of these conditions allowed those on Medicaid to maintain continuous Medicaid coverage during the pandemic. With the PHE set to expire July 15, 2022, eligibility redeterminations and disenrollments would resume and those who are not otherwise eligible would lose their Medicaid coverage. DHS will track state and federal policy changes and adapting as needed. The impending change in administration could also have an impact on insurance coverage. There could be changes to Medicaid eligibility and/or the Medicaid expansion under the ACA dependent upon the new administration's priorities. Title V will monitor changes in state and federal policies that could impact coverage and attempt to meet the needs of the insured and uninsured as necessary.

In addition to the aforementioned issues, the DOH recognizes racism is a public health crisis. As the Society for Public Health Education detailed in a presentation on Multiracial Health Equity, racism is theorized to be a fundamental cause of health disparities. However, research and advocacy primarily center on the experience of monoracial (single-race) populations of color. The multiracial population is the fastest-growing racial-ethnic group in the US, increasing 36% in size from 2010-2020. In Pa., the multiracial population has changed considerably since 2010, growing from 237,835 people in 2010 to 774,484 people in 2020, a 226% increase. Although research has been inconsistent in its use of multiracial categories when comparing against monoracial populations, data suggests that disparities do exist between monoracial and multiracial populations. The DOH is evaluating policies and practices to identify and combat 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 is 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.

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 disinvested communities ripe for resource development often face significant challenges 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 urging 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 disproportionately impacted these critical climate issues. The DOH is working to better understand and prepare for the adverse health effects of climate related events. In early 2022, the Acting Secretary of DOH formed a workgroup committed to climate change work as it intersects with public health; Title V staff participate on the workgroup.

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 CMHDs, 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 2023 Application/FY 2021 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 may be compiled and considered in aggregate in future years. Health equity remains the overarching framework of the BFH's needs assessments.

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

i. Public Input Survey:

This was the second year that the BFH launched 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. In 2021, the survey was revised to incorporate feedback received from 2020 survey respondents. Specifically, demographic questions and response options were updated to be more inclusive and gender-affirming and terms such as health equity, social determinants of health, strategies, and priorities were further defined. Between April and May 2022, 91 people responded to the survey. There were 53 responses from service providers and 38 from service recipients or caregivers. Respondents resided in or served one of 45 counties, 67% of the counties in the state. 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.

In September 2021, the Bureau of Family Health also conducted a separate survey of providers serving children and youth with special health care needs (CSHCN) on the topics of bullying, safe relationships, reproductive health, and transition. Anecdotal evidence as well as population data suggest that there are gaps in services that could promote prevention and support in these areas. There were 28 respondents and preliminary findings are incorporated into the CSHCN section, below.

i. Focus Groups:

Stakeholders and service recipients were also engaged through meetings and focus groups. In February of 2022, the BFH organized four virtual focus groups with CSHCN and their families, engaging 21 youth. Discussion topics included bullying, reproductive/sexual health, healthy relationships, and transition to adulthood. Additionally, the BFH facilitated discussion at a virtual site visit with eight adolescent health

providers participating in the Leadership Education in Adolescent Health (LEAH) fellowship in March 2022. Providers were asked about adolescent health needs, service gaps, 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 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

i. 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. The most recent five-year rate available from the National Vital Statistics System suggests that there were 14.6 maternal deaths per 100,000 live births during 2016-2020 in Pennsylvania and the rate of maternal mortality remained nearly three times higher among Black people (45.1) as it is among white people (15.0) in Pa. during 2016-2020. Similarly, state inpatient hospitalization data suggest that the rate of severe maternal morbidity has continued to rise with a significant increase to 87.9 delivery hospitalizations per 10,000 involving severe maternal morbidity in 2019 (up from 77.0 in 2018). The rate of morbidity is over 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. The percentage of women who received a preventive medical visit decreased from 75.2% in 2019 to 74.3% in 2020. Similarly, Pregnancy Risk Assessment and Monitoring System (PRAMS) data from 2020 suggest that the percentage of people with a recent live birth who received adequate prenatal care (74.5%), a teeth cleaning during their most recent pregnancy (43.9%), or a postpartum check-up (87.2%) all reached a five-year low in 2020. Black birthing people were also less likely to have received adequate prenatal care or a postpartum check-up then their white counterparts and the racial disparity in receipt of adequate prenatal care has widened between 2018 and 2020. The newly available 2020 data likely demonstrate the impact of COVID-19 and associated lockdowns on receipt of routine care. As Pennsylvania continues to respond to the ongoing pandemic, strategies that encourage birthing and pregnant people to resume a regular care schedule and connect them to safety net preventive physical and mental health care services remain integral to the 2023 action plan.

Newly available state data suggest that changes should be noted for several related indicators. Two recently published reports on maternal death in the state indicated that accidental poisoning, a category that includes drug-related overdose, is one of the leading causes of pregnancy-associated deaths in the state. Opioid use disorder at delivery has steadily increased in Pennsylvania from 15.47 deliveries where maternal opioid use was present in 2016 to 16.75 in 2019. These data suggest renewed focus on provision of adequate system-level supports for people with substance use disorder before, during, and after pregnancy. Associated strategies are and will continue to be encompassed within the existing strategy on preventing maternal mortality. PRAMS data from 2016-2019 suggested 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, followed by a slight decline to 17.7% in 2020. Postpartum depression also increased from 11.6% in 2019 to 12.9% in 2020. Behavioral health and depression screening rates before, during, and after pregnancy have consistently increased from 2016 to 2020 and

screening and referral remain important strategies of the 2023 action plan. Finally, both NVSS and PRAMS data suggest a continued decline in the percentage of birthing people who smoke during pregnancy (~9% of people smoked during pregnancy in 2020). Results from the 2022 public input survey (see Table 1) further confirm that continued focus on access to healthcare before, during, and after pregnancy, care navigation, and incorporation of reproductive, mental, and behavioral health services remain necessary to address unmet needs in communities and networks of care across the state. Parental leave, access to contraception and reproductive health services, and the importance of meeting needs of the family related to childcare and housing were cited with increased frequency in 2022.

Table 1: Common themes across Title V Public Input Survey Responses to Question about Unmet Women's/Maternal Health Needs in Pennsylvania by Respondent Type, 2022

Themes – Service Recipients	Responses - Examples
1. Affordable and accessible healthcare before, during, and after pregnancy	"preventive healthcare"; "access to a community hospital or birthing center – traveling to an unfamiliar area is stressful"; "disparities in healthcare access for new moms, especially minorities"; "There is minimal postnatal care and no pelvic floor therapy like offered in other countries"; "access to healthcare for people who work"; "Ongoing, consistent, free, or inexpensive healthcare in all areas – mental, physical, emotional, dental – and access to good nutrition!"; "Free and quick pregnancy testing by health care workers in the community, not an ER visit"; "Early prenatal care and access to specialized care for people with certain health concerns before pregnancy"; "healthcare that doesn't break the bank"; "easy access to birth control"; "there is insufficient postpartum healthcare – the first week after birth is a period of peak mental and physical risk and yet they are discharged"; "there is no local birth hospital"; "Dental treatment is difficult to schedule and there are long waits"
2. Increased focus on meeting family needs (parental leave, food security, economic security, transportation, childcare)	"The needs of the family have to come first"; "Lack of maternity leave with pay"; "need to eat healthy and maintaining foods during pregnancy and after birth"; "there is no reliable transportation or childcare for people to get to health care"; "Available jobs for pregnancy people within the local community"; "nutrition and food security"; "a living wage"; "lack of financial and infrastructure support for healthcare and childcare"; "no paid maternity or paternity leave"; "Guaranteed paid family leave"
3. Patient-centered care	"Listening to their needs and not guessing what they think the person needs"; "Women and birthing families can make health care decisions when given all of the information and guided when confused" "Care based on each person's immediate needs not what they may possibly do in the future"; "full autonomy over their body";
4. Health education and parenting skills	"Education about the need for routine healthcare, importance of early and regular prenatal and postpartum care, breastfeeding, safe sleep, and how to access doulas"; "Education on adequate parenting skills"; "public education to combat old wives' tales about pregnancy"; "understanding of how their health impacts their child's health"; "Education on natural labor methods and the benefits of breastfeeding"
5. Non-clinical support during and after pregnancy	"Doula option for all women!"; "feeding support such as lactation services"; "Access to quality lactation consultants outside of the hospital"
6. Mental health	"Mental health is as important as physical health as they go hand in hand"; "Mental health screening and resources during postnatal visits and with the child's pediatrician"
Themes - Providers	**Responses – Examples**
1. Healthcare access and coordination before, during, and after pregnancy	"All birthing people in Pennsylvania should be linked to a primary care provider"; "Access to healthcare including testing for sexually transmitted infection and pregnancy"; "Access to abortion"; "Easy access to birth control"; "Reliable postpartum care that lasts longer than 6 weeks"; "Adequate and quality prenatal care"; "Interconception care"; "there is a lack of health care for minority populations and in rural areas"; "Not enough focus is placed on postpartum care and making it patient-centered"; "Many initiatives are focused on obstetrics and pediatrics but family physicians should be involved"; "there are no programs that help patients navigate back into primary care following pregnancy"; "the cost of contraception and long-acting reversible contraceptives is rising and access is becoming more difficult for patients"; "appointments after work hours"
2. Increased focus on meeting family needs (housing, food security, economic security, childcare)	"Health concerns are secondary to needs such as housing, employment, and education"; "Safe, accessible, and affordable childcare"; "Due to the pandemic there is food insecurity, loss of wages, and increased childcare expenses"; "Increased access to food, childcare, and housing after birth"; "Adequate and affordable housing is the number one request and barrier for families"; "resources to address intimate partner violence"; "Access to cell phone and wifi to access information about health and appointments"; "Transportation"; "Families need diapers and formula (especially because of the shortage); "paid maternity leave"
3. Improved access to mental and behavioral healthcare	"Mental healthcare access and ongoing care"; "increased access to mental health providers"; "we have seen a sharp increase in the incidence of perinatal mental health needs"; "there are long waitlists for mental health services for people on Medicaid and limited number of providers"; "Substance use treatment"; "medications for opioid use disorder"; "Access to treatment for substance use disorder and opioid use disorder"
4. Health education and parenting skills	"Equitable access to quality education and support during the perinatal period"; "Skills related to child development and parenting"; "Breastfeeding education"; "Education on risks of pregnancy and impact of compounding illness/co-morbidities on pregnancy outcomes"; "Education on how to talk with your children about reproductive health"; "How to self advocate for their own care during pregnancy"
5. Non-clinical support during and after pregnancy	"general assistance during pregnancy – such as support provided by Healthy Beginnings Plus"; "Access to allied health professionals such as doulas and peer breastfeeding counselors"; "Additional support and companionship during pregnancy"; "father involvement"; "Breastfeeding support at the workplace"
6. Culturally sensitive staff and patient-centered care	"People who look like who they are caring for and understand their culture"; "Access to culturally sensitive, compassionate, anti-racist, and patient-centered healthcare"; "Trusted professionals"

ii. 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 with a low birthweight was unchanged in Pa. from 2009 to 2019. The percentage of infants born preterm reached a 10-year high of

9.9% in 2019 followed by a decline to 9.6% in 2020. 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 2019, 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 preventing preterm birth remain important focuses.

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 mothers who initiated breastfeeding in 2016 to 82% in 2019. PRAMS data indicate that the percentage of people with a recent birth who report any breastfeeding at six months has remained near 50% (49.8% in 2020, down from 51.1% in 2019). Additionally, the prevalence of breastfeeding initiation and exclusive breastfeeding remains lower among Black infants as compared to white infants. PRAMS data also suggest that continued breastfeeding remains less prevalent among young birthing people (≤19 years) and among individuals with lower incomes. 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 38.8% in 2020). Similarly, the percentage of infants placed to sleep without soft objects or loose bedding has also significantly increased (46.1% in 2016 to 56.0% 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 20. Additional work may be needed to advance the practice of placing infants on their back to sleep. While five-year estimates suggest a nominal increase in the practice, annual estimates demonstrate fluctuation around 82% and no consistent pattern since 2015.

Table 2: Common themes across Title V Public Input Survey Responses to Question about Unmet Infant/Perinatal Health Needs in Pennsylvania by Respondent Type, 2022

Themes – Service Recipients	Responses - Examples
1. Increased focus on meeting family needs (food security, parental leave, infrastructure/environment)	"Increased access to health food and appliances to store and cook the food"; "Food security"; "access to food and formula"; "safe and affordable baby formula – WIC puts a lot of stipulations and doesn't cover sensitive versions" "paid parental leave"; "paid parental leave so that infants can be around their parents longer"; "no paid maternity of paternity leave – needed for recovery, bonding, and childcare coverage"; "lack of financial and infrastructure supports for parents"; "short maternal leave policies"; "People of color need access to affordable housing, safe places for their children to grow up and quality educational systems";
2. Health education and parenting skills	"Education on caring for infants"; "Access to hospitals, doctors, and agencies that can teach safe practices"; "Teach mom to eat healthy so that the baby eats health as well"; "food and nutrition education"; "parental understanding of ACES, wellness, and developmental milestones"; "educate parents on the benefits and importance of breastfeeding"
3. Improved access to quality healthcare and providers for parent and infant	"People of color need access to good knowledgeable healthcare providers"; "Trusted healthcare providers/workers who understand and look like vulnerable and underrepresented populations";
Themes - Providers	**Responses – Examples**
1. Health education and parenting skills	"Parent education on common health issues in infants and infant nutrition"; "Parenting classes"; "Infant sleep practices"; "Parenting support for parents with opioid use disorder"; "Child development information for parents"; "Addressing vaccine hesitancy among parents"; "moms need feeding advice"; "Support and education on the mother about the changing family dynamic after birth"; "improper parent care and parental substance use is a concern"; "information on car seat safety and safe sleep"; "evidence-based education during the perinatal period"; "Emphasis on attendance at well visits"
2. Non-clinical support and social support in the community	"Need for more lactation support prenatally, in the hospital, and in the community"; "support for the child's family and caregivers"; "more support for families – creating a cultural norm for community involvement in care"; "Parenting support and mental health supports for parents"; "more community support for mothers in the postpartum period, especially for mothers experiencing multiple stressors related to housing, poverty, etc."
3. Increased focus on meeting family needs (transportation, parental leave, childcare and adequate insurance)	"Patients without transportation cannot access providers"; Transportation to appointments and car seats" "Paid parental leave; "paid leave from work"; "housing"; "unable to bond with newborns to due to lack of paid maternity leave"; "high quality, affordable childcare" "Insurance coverage and affordability of formula"; "
4. Increased access to home visiting and early referral to Early Intervention	"Access to newborn assessments in the home"; "Home visiting and evaluation"; "Universal access to home visiting in the weeks following discharge"; "Early referral to Early Intervention"; "Access to timely Early Intervention"

Many of the indicators of infant/perinatal health in Pa. remain unchanged and the existing priorities are sufficiently broad to respond to the persistent unmet needs identified through analysis of statewide data. While safe sleep education, home visiting, and breastfeeding awareness activities are underway, additional strategies to better support parents and caregivers with needs identified in the 2022 public input survey (Table 2) and advance development of protective factors to prevent adverse infant health outcomes will continue to be considered. While parent/caregiver support was also highlighted as a need in 2021, 2022 public input survey respondents more frequently cited the importance of parental leave, food security (including access to formula), and the availability of resources and support within the community.

iii. 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 135.0 in 2019. The rate 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. Recent data from the National Vital Statistics System suggest that the rate of mortality among children in Pa. between the ages of 1 and 9 has gradually increased from 15.1 deaths per 100,000 in 2017 to 17.20 deaths per 100,000 in 2020. Similar to the patterns apparent in hospitalization data, the child mortality rate is 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 over 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 continued gradual increase in the percentage of children ages 9 through 35 months who received a developmental screening using a parent-completed tool (27.3% in 2017-2018 to 35.5 in 2019-2020) and a minor increase in the percentage of children ages 6 through 11 who are physically active at least 60 minutes per day (29.3% during 2017-2018 to 30.2% during 2019-2020). Additionally, as of 2019-2020 9.1% of children ages 1-17 had tooth decay or a cavity in the past year, a decrease from 11.5% in 2017-2018 per the NSCH.

Conversely, 2019-2020 data suggest a continued 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, nearly half of all children ages 6 to 11 (49.1%) were bullied at least once in the past 12 months per 2019-2020 data; bullying remains more common among children ages 6-11 than among youth ages 12 to 17. Data from 2019-2020 and national trends indicate that routine care, such as preventive physical and dental visits, were likely disrupted for children across the state due to the COVID-19 pandemic. For example, only 78.9% of children were reported as having received a preventive dental visit in 2019-2020 per the NSCH (down from 82.1% during 2017-2018). The need for access to dental healthcare and resumption of routine care were also highlighted in responses from the 2022 public input survey (Table 3). The BFH 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.

Data from the public input survey (Table 3) also reaffirm the continued importance of the existing priority around improving the mental, behavioral, and developmental health of children with and without special health care

Table 3: Common themes across Title V Public Input Survey Responses to Question about Unmet Child Health Needs in Pennsylvania by Respondent Type, 2022

Themes – Service Recipients	Responses - Examples
1. Accessible healthcare in the community	"Healthcare providers that promote recovery and health in the child's life and community"; "Having the right healthcare"; "Online services so that kids can get an initial assessment and referrals" "Easy access to healthcare in schools and community health centers, including dental"; "Children in poverty often cannot afford dental care and their problems worsen if left untreated"; "more healthcare options for parents of low income" "Access to lead screenings in our community"
2. Mental, behavioral, and emotional health	"Mental health needs"; "there is not much in our community on emotional or mental health disorders, or autism"; "We need to do a better job of partnering with schools to reduce and eliminate bullying; end bullying via social media"; "Mental health is brain health – work to reduce the stigma"; "Address issues of sexuality and expression"; "Address/stop self-harm such as cutting"; "There is a need for psychiatric and mental health services"
3. Safe environments and communities for children / basic needs (childcare, food security)	"Creating a community that does not endanger children, keeping them free from violence"; "Safe places to play"; "Clean air, water, and high quality food resources" "In an area with many children below the poverty line, with that comes poor housing next to industrial sites, absentee landlords, high lead levels, lack of grocery stores, and green spaces"; "food and nutrition"; "eating healthy"; "healthy food in their neighborhoods"; "Quality, affordable childcare that operates 24/7"
4. Support and education for families on decision-making related to their child's health	"Support for families to make the functional decisions that promote health and growth"; "Education on nutrition and stress management"; "Educate parents on proper use of antibiotics"; "Parents often know what is wrong so dig in and help them discover it don't be dismissive"; "Prevent child neglect"
Themes - Providers	**Responses – Examples**
1. Access to routine preventive healthcare including dental care	"Dental care"; "Glaring need for pediatric dental providers in western Pennsylvania"; "too many youth are behind on annual preventive visits"; "dental health"; "attending well child visits"; "children need dental care"; "routine physicals and vaccinations (many parents have become more vaccine reluctant since COVID-19)
2. Access to mental healthcare and increased focus on child social/emotional health	"Mental health programs"; "Social and emotional health"; "mental health care"; "combating the effects of COVID on social and emotional development"
3. Nutrition and physical activity	"Nutrition and physical activity"; "Obesity is one of the greatest concerns from the last 12 months, rates were high before and have gotten higher";
4. Increased focus on meeting family needs (transportation, food security, childcare)	"Access to transportation for medical appointments"; "Food security"; "Families needs for quality childcare persists"
5. Parental health education	"Vaccine hesitancy in parents"; "parental education on effects of screentime and decreased physical activity";

needs.

Identification of additional strategies will be ongoing in 2023.

iv. 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. National Vital Statistics System data suggest that the adolescent mortality rate significantly increased to 33.3 deaths per 100,000 in 2020, the highest rate of mortality among youth aged 10 to 19 since 2010 when it was 34.0. Three-year estimates (2018-2020) suggest that the mortality rate remains nearly three times higher among youth aged 15 to 19 (44.9 deaths per 100,000) as compared to youth aged 10 to 14 (15.0 deaths per 100,000). The mortality rate remains over two times higher among Black adolescents as compared to white adolescents. While the overall mortality rate increased, a decrease was observed in the rate of adolescent deaths attributed to motor vehicles (7.0 deaths per 100,000 during 2018-2020 compared to 10.0 during 2015-2017) and in the suicide rate (8.2 suicides per 100,000 during 2018-2020 compared to 9.4 during 2015-2017). However, corresponding data from YRBS still demonstrate an increase in the 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 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 204.7 in 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 on five or more days weekly increased from 42.4% in 2017 to 48.1% in 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 observed increase in adolescent mortality rates, persistent mental health challenges among youth, and disparities by race and gender identity, 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 service providers engaged during the LEAH site visit also highlighted the continued importance of mental health services and promoted universal depression screening for adolescents at annual well visits. Providers also emphasized the need for mental health providers who are gender-affirming, bilingual, willing to work with youth with a disability, and representative of the populations they serve with regard to race and sexual orientation. A directory of youth mental health providers was suggested to facilitate referrals for youth requiring services. 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: Common themes across Title V Public Input Survey Responses to Question about Unmet Adolescent Health Needs in Pennsylvania by Respondent Type, 2022

Themes – Service Recipients	Responses - Examples
1. Mental health	"Mental health – bullying and suicide, especially among young teens"; "Mental health – teenage daughter and her friends are dealing with so much with everything happening in the world"; "Mental health and sleep"; "Mental health services"; "Increasing rates of depression, anxiety, and suicide"; "Schools don't hold bullies accountable"
2. Education on risk behaviors and sexual/reproductive health	"Education on risk-taking behaviors"; "lack of education on STDs, general health, and hygiene issues"; "Education on substance abuse and sexual confusion"; "Smoking – a lot of youth use vapes"
3. Access to trusted adults and care providers	"Mentors that guide them in decision-making"; "Access to quality care providers who care"; "More information for families in their native language"
4. Safe spaces to socialize	"Teens need places to congregate safely without risk of harm – their social environment becomes more important than their home environment"; "Playgrounds are unsafe and not maintained in the city"
Themes - Providers	**Responses – Examples**
1. Mental health	"mental health"; "mental health needs are unmet"; "mental health care in schools"; "mental health and substance abuse prevention and care"; "Access to mental health care"; "mental health – combating COVID, anger management, and what they see on social media"; "affordable, accessible mental health support"; "mental health needs including bullying prevention"
2. Sex education and access to reproductive healthcare	"sex education, access to birth control, education on health relationships"; "educational resources on teen pregnancy and birth control in schools"; "sexual health"; "access to contraception"; "sex education and access to sexual health services – inconsistent across PA"
3. Access to timely and patient-centered preventive healthcare	"a lot of middle to high school students who have trouble accessing primary care or have to wait months for an opening; sometimes parents cannot take them due to work schedules"; "dental needs are important"; "oral healthcare"; "LGBTQ affirming care"

v. 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 2019-2020, 58.9% of

CSHCN aged 12 to 17 experienced bullying in the past 12 months as compared to 35.8% of children without special health care needs. The prevalence of experiencing two or more adverse childhood experiences also remains higher among CSHCN in Pa. as of 2019-2020 (30.6% among CSHCN; 13.9% among children without special health care needs).

The percentage of CSHCN who receive care in a well-functioning system in Pa. decreased slightly from 18.2% in 2017-2018 to 17.1% in 2019-2020. 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 2019-2020, the percentage of CSHCN receiving care in a well-functioning system is lowest among CSHCN aged 12 to 17 (5.4%) as compared to CSHCN aged 6 to 11 (31.1%) or 0 to 5 (14.6%). Upon reviewing the well-functioning system's component parts, the areas where most improvements are needed are access to a medical home and transition services. The percentage of CSHCN aged 12 to 17 receiving transition services increased slightly from 22.5% during 2017-2018 to 23.5% during 2019-2020 whereas the percentage of CSHCN aged 0 through 17 in Pa. with a medical home has varied with no consistent pattern in recent data. While there was a slight increase from 42.9% of CSHCN with a medical home during 2017-2018 to 43.6% during 2019-2020, the proportion has remained at less than 50% for years.

The existing priorities around mental health, developmental outcomes, and well-functioning system are sufficiently broad to encompass strategies related to bullying, trauma, and care coordination. In 2021 and 2022, the BFH started assessing gaps in care and services related to these topic areas. Preliminary results from the 2021 survey of providers suggest that few CSHCN providers currently provide services related to bullying, reproductive health, or safe relationships, whereas services related to transition and care coordination are more common. However, responses from the 2022 public input survey (Table 5) also suggest that CSHCN and their families require support with care navigation, especially in light of ongoing provider shortages and long waitlists. Results from the surveys and family/youth focus groups conducted in 2022 are currently being analyzed to help to inform the selection of a priority topic area and identification of strategies.

The newly available 2019-2020 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 63.0% during 2017-2018 to 73.9% during 2019-2020. Several other apparent improvements include an increase in the percentage of CSHCN ages 6-17 who were physically active for at least 60 minutes daily (21.6% during 2019-2020 compared to 17.7% 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 (18.0% during 2019-2020 to 13.6% during 2018-2019). However, physical inactivity and the prevalence of tooth decay/cavities remain higher among CSHCN as compared to children without special health care needs during 2019-2020. 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.

Table 5: Common themes across Title V Public Input Survey Responses to Question about Unmet Health Needs of Children with Special Health Care Needs in Pennsylvania by Respondent Type, 2022	
Themes – Service Recipients	**Responses - Examples**
1. Provider shortages and more timely access to specialty care (waitlists)	"We cannot find an orthodontist or oral surgeon to remove teeth"; "Long waiting lists for programs like Youth Advocate Program (YAP)"; "Appointments for psychologist and psychiatrist have a huge waiting list when these children are in need of immediate services"; "There are not enough resources for children with special health care needs – I have been trying to find an ASD therapist and clinics are understaffed and have long waitlists"; "ASD children need more specialized and trained professionals that work with their abilities"; "Even with consolidated waiver my son could not join any day programs"; "there are a lot of waitlists or lack of knowledge about available programs"
2. Education for providers, educators and others on CSHCN	"there is not enough education for care providers"; "24/7 caregivers have too little experience – had never worked with another child before mine"; "Education for other children, teachers, and parents so that special needs children are not bullied or ostracized"
3. Support for families in care access and advocacy	"Need closer places so that families aren't traveling so much and looking for help with siblings and places to stay"; "Support and financial support for parents – all of the fighting for services and school to help them try to be their best is hard work, I am tired of fighting the system to try to help my children succeed"
4. Mental health services	"Mental health and inclusion"; "Suicide prevention"; "We need good adolescent mental health services that are not focused on just medication"
Themes - Providers	**Responses – Examples**
1. Access to care navigators and specialty care providers	"social worker that works with all of the different medical providers"; "Coordination of care, especially for those with complex medical needs"; "Support groups and health system navigators – community-based support for both patient and family" "Lack of available special health care needs providers in rural Pennsylvania"; "There is a lack of pediatric specialists to treat the special needs population" "Access to behavioral health services and psychiatrists" "Lack of dental care providers"; "Due to COVID appointments have been done online"
2. Shortage of homecare providers and home health services	"Lack of providers and in-home nursing care staffing shortage"; "In-home nursing and home health aid services – parents cannot return to work due to the crisis of not having care for their child"; "Nursing shortage for approved hours of shift nursing"; "Homecare – many children need more care than their parents can provide, parents get tired and need help and respite" "Insurance doesn't cover home care and there is a shortage of nursing care and home health aides"

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 live births. As of 2019, there were 11.9 NAS cases per 1,000 live births, a decrease from 15.8 cases per 1,000 live births in 2018. Rates of NAS continue to vary markedly across the state with the highest rates observed in the northwestern region. Strategies that support infants born with NAS are linked to the well-functioning system priority.

Responses from the public input survey (Table 6) suggest that as the BFH continues to support a well-functioning system of care for CSCHN, including infants, additional focus on care navigation supports for parents/caregivers, increased education for families of infants, and information and streamlined referral for programs like Early Intervention may be needed.

Table 6: Common themes across Title V Public Input Survey Responses to Question about Unmet Health Needs of Infants with Special Health Care Needs in Pennsylvania by Respondent Type, 2022	
Themes – Service Recipients	**Responses - Examples**
1. Care navigation and support for parents/caregivers of infants with special health care needs	"Work with families to get access to tools so that they don't have to struggle, some families need more help than others"; "Assign a case worker or social worker so that each family has help ensuring adequate care and growth"; "Doctors, teachers and school social workers should help parents"; "We have seen so many specialists and doctors, I wish we had a healthcare navigator to help manage and keep track of everything... it's just too much"; "Assign a case manager"
2. Parent and caregiver education on needs of infants and available care	"Offer special healthcare education to everyone who has a child – most special health care needs are not identified until after the child is born"; "Education for families of infants with special health care needs to understand the child's different needs"; "Educate everyone and not just some"; "Parents need to understand developmental milestones and how to follow through on recommendations for Early Intervention and specialty care"
3. Increased promotion of Early Intervention program	"Friends and family with a child in the NICU had no idea that Early Intervention was available and free to them"
Themes - Providers	**Responses – Examples**
1. Centralized contact for Early Intervention and increased number of providers	"Need more direct access to specialists at primary care provider offices – including a specific contact person for Early Intervention"; "Increased number of Early Intervention service providers (e.g. speech therapists) to decrease wait times"
2. Timely access to care and availability of providers that accept Medicaid	"Many doctors offices have long waitlists – additional funding to expand staff allowing patients to be seen more quickly"; "We cannot refer families and then expect them to be on a waitlist for 6-8 months – access to services in a more timely manner"; "Increased Medicaid payments to physicians/mandate that all hospital associated clinical sites have to accept Medicaid"
3. Care navigation and support for parents/caregivers of infants with special health care needs	"parents are overwhelmed and undereducated – have people who are dedicated to sitting with parents and assisting them with applications and follow-up planning"; "Doula services would provide support and education for the family coping with the emotional and physical demands of [caring for a newborn] with special needs"; "patient advocacy and support to navigate the healthcare system and benefits"; "families need guidance on using pediatric specialty services"; "need more community-based social workers to assist in navigating confusing systems, especially at points of referral and transition" ;
4. Care coordination and referrals	"Warm handoff"; "partnership between health systems and home visitation agencies"; "community connections and follow-up on referrals"; "Support linkage to certified recovery specialists for children born to parents with history of addiction"

3. Capacity Assessment

i. Changes in Organizational Structure and Leadership:

There have been several changes in the leadership of the Department of Health over the past year. In December of 2021 Acting Secretary Alison Beam stepped down and Keara Klinepeter assumed the role of Acting Secretary of the Department of Health effective January 2022. Ms. Klinepeter then resigned in April 2022 and Dr. Denise A. Johnson, the Department's current Physician General, is now also Acting Secretary. The BFH's Director (Tara Trego), Division Directors (Erin McCarty, Cindy Dundas, and Kathy Jo Stence), Title V Block Grant Coordinator and Manager (Morgan Williams-Fake and TaWonda Jones-Williams) and MCH epidemiology staff (Nhiem Luong and Caryn Decker) continue to lead the planning, evaluation, and data analysis required to administer the Title V program. A vacancy in the director position for the Division of Newborn Screening and Genetics was filled in July 2022 by Jennifer Bixler.

ii. 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. According to a recent workforce capacity survey conducted in early 2022, approximately 47% of BFH staff have been in their current positions for less than three years. This percentage is slightly higher than last year (43%), suggesting that there has been some turnover in the past 12 months. However, retention is still better than it was two years ago when over 50% of staff had been with the Bureau for fewer than three years. Among staff with a short tenure, most were program staff; the majority of managers and directors (55%) 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 to 84% in 2022 (up from 82% in 2021 and 70% in 2020); this increase was influenced in part by the fact that over half of all staff who are new to their current position have worked in the field of public health for three years or more. 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.

iii. 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	
Association for Maternal and Child Health Programs (AMCHP)	AMCHP leads and supports programs nationally to protect and promote the optimal health of women, children, youth, families and communities. AMCHP has served as a national resource, partner, and advocate for state public health leaders and others working to improve maternal and child health public health systmes. In 2021, the BFH was awarded a grant from AMCHP to replicate an evidence based initiative and has collaborated with AMCHP in order to build capacity for a systems change initiative to ultimately improve the system in which children receive health care.
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.
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.
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.
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.
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.

Other Federal Investments	
Adolescent and Young Adult Behavioral Health Collaborative Improvement and Innovation Network (AYA-BH CoIIN)	BFH staff are participating in the AYA-BH CoIIN. The collaborative works to improve the health of young people by strenghening the capacity of state maternal and child health programs and clinical providers to address the behavioral health needs of AYAs. A primary focus is on increasing depression screenings and follow-up care provided to AYAs.
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.
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. The CLPPP is funded by the Centers for Disease Control and Prevention (CDC).
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.
Maternal Mortality Review Committee	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.
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.
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.
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.
Traumatic Brain 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. The Department provides training and develops educational materials for individuals within the domestic violence sector and individuals that may come in contact with individuals of domestic violence. 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.

Other HRSA Programs	
Pennsylvania Association of Community Health Centers (PACHC)	The BFH utilizes Title V funds to contract with PACHC to improve primary care and community systems 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	
Brain Injury Association of Pennsylvania (BIAPA)	BIAPA's mission is to foster an inclusive community of education, advocacy, supports, and research to maximize the quality of life for those with brain injuries and their families. The BFH collaborates with BIAPA to provide opportunities for individuals with brain injuries, their family members and professionals to improve the lives of individuals with brain injuries through training, awareness and support programs.
Centering Pregnancy Programs	The BFH partners with Lancaster General Hospital (LGH) located in Lancaster City, Albert Einstein Health Network (AEHN) located in Philadelphia and WellSpan York, to provide the Centering Pregnancy Program (CPP).
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.
Eastern Pa. Special Needs Association (EPSNA)	The BFH partners with the EPSNA, operated through the Health Promotion Council, 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.
Local County and Municipal Health Departments	The BFH partners with the CMHDs which are in located in Allegheny County, Allentown City, Bethlehem City, Bucks County, Chester County, Erie County, Montgomery County, Philadelphia County, Wilkes-Barre City and York City. The CMHDs have direct access to Title V eligible participants at the local level and are able to serve this population in many different capacities across a wide range of physical health, mental health, and social services.
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.
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.
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.
Safety in Youth Sports	The BFH collaborates with the Pennsylvania Athletic Trainers Society to educate and train personnel involved in youth sports, both school-based and club-based, regarding general traumatic brain injury knowledge, concussion prevention, concussion identification, and concussion management. Target populations include medical providers, school and club coaches, athletic trainers, school nurses, parents, athletes and students. These trainings are provided exclusively by athletic trainers (ATs). This program assists schools to fulfill the requirements of the 2011 Safety in Youth Sports Act.

Other programs within the state Department of Health	
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.
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 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.
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.
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.
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.
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.
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.
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 and Maternal Mortality Review processes begin when the BHSR provides vital statistics information to the BFH on a monthly and a quarterly basis.

Other governmental agencies	
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). The BFH also 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	
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.
Specialty Care Program	The BFH administers 26 grants 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, and Cooley's anemia. The Specialty Care Program utilizes 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.
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 Pennsylvania 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.
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.

Family/Consumer Partnerships and Leadership Programs	
Alliance for Innovation on Maternal Health (AIM)	Department staff participate with the Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiative. Based on proven safety and quality implementation strategies, AIM works to reduce preventable maternal mortality and severe morbidity across the United States.
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.
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.
Pennsylvania Perinatal Quality Collaborative (PQC)	The PA PQC is administered by the Jewish Healthcare Foundation and WHAMGlobal and affiliated with with the Northeast PQC (NEPaPQC). The PA PQC serves as the action arm of the MMRC for implementation of recommedations. The focus areas for 2022 include maternal substance use (including Opioid Use Disorder), substance-exposed newborns (including Neonatal Abstinence Syndrome, immediate postpartum long-acting reversible contraception (LARC), perinatal depression screening and follow-up (MOMD), and severe hypertension (PA AIM). Each focus area includes strategies and goals to reduce racial/ethnic disparities.
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.
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.
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.
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.

iv. 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. In 2022 the BFH also updated a series of data briefs which provide a snapshot of health status across the Title V population domains. As described in the overview, ongoing needs assessment activities conducted in interim years will inform the five-year needs and capacity assessment in 2025.

v. Capacity to Address Emerging Issues

Several emerging issues were identified through stakeholder engagement. Adolescent health providers identified youth mental health services and the availability of providers as a persistent need. The BFH currently supports youth mental health programming in select counties and has the capacity to assess how it can contribute to system-level efforts that better facilitate youth access to needed care.

The BFH is identifying potential strategies that may address emerging issues for CSHCN such as bullying, and gaps in the provision of services related to safe relationships and reproductive health. While the BFH has youth programming in these areas, it will need to build upon and expand its capacity to offer similar support to CSHCN once a topic area is identified.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$23,480,555	$23,732,205	$23,748,778	$23,928,946
State Funds	$48,774,500	$45,232,580	$48,640,500	$46,813,492
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$72,255,055	$68,964,785	$72,389,278	$70,742,438
Other Federal Funds	$5,231,068	$5,267,011	$7,343,533	$3,423,394
Total	$77,486,123	$74,231,796	$79,732,811	$74,165,832

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$23,732,205	$23,954,647	$23,928,946	
State Funds	$47,572,500	$49,045,442	$47,605,500	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$71,304,705	$73,000,089	$71,534,446	
Other Federal Funds	$6,463,826	$3,241,422	$7,917,414	
Total	$77,768,531	$76,241,511	$79,451,860	

	2023	
	Budgeted	Expended
Federal Allocation	$23,954,647	
State Funds	$53,009,500	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$76,964,147	
Other Federal Funds	$8,127,554	
Total	$85,091,701	

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, birthing people, children, and families. Title V FFY 21 expenditures, both federal and non-federal, aligned with Pennsylvania's seven MCH priority needs identified during the 2020 Needs and Capacity Assessment process. Priority needs were addressed through the following strategies:

- **Reduce or improve maternal morbidity and mortality, especially where there is inequity -** Federal Title V funds were expended to implement evidence-based or evidence-informed home visiting programs, culturally relevant, community-based maternal care models, including doulas, and preconception, postpartum, and interconception care initiatives for women and birthing people. Federal Title V funds in partnership with other federal funds were expended on staff who reviewed the Maternal Mortality Review Committee findings to inform, develop, modify, and evaluate public health programs and policies in Pennsylvania. Other federal funding and federal Title V funding were used to support state-level program management and public health systems development.

- **Reduce rates of infant mortality (all causes), especially where there is inequity -** 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, and develop collaborations, particularly with the Safe Sleep program. 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. Federal Title V funds were also expended to support Perinatal Periods of Risk studies. Other federal funds were used to support participation in the SUID/SDY Case Registry.

- **Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs -**. Federal Title V funds were expended to expand the evidence-informed Health Resource Center (HRC) program and make available office visits and counseling/health education to youth as part of a reproductive health visit at a family planning provider. Federal Title V funds were expended to implement evidence-based strategies to address bullying, evidence-based or evidence-informed mentoring programs, SafeTeens/SafeTeens Answers!, and increase protective factors for LGBTQ-identified youth through evidence-based or evidence-informed behavioral health programs. Federal Title V funds were expended to provide training to professionals working in both the brain injury and substance use arenas. Other federal funds were expended in partnership with federal Title V funds to implement the Personal Responsibility Education Program and Abstinence Education Grant Program.

- **Improve the percent of children and youth with special health care needs who receive care in a well-functioning system -** Federal Title V funds were expended to inform quality improvement activities and implement identified strategies to improve newborn screening (NBS) data collection, reporting, and case management, including interagency coordination, utilize evidence-based or informed strategies to provide service coordination, implement the Autism Diagnostic Clinic, implement the BrainSTEPS program, support leadership development and training for children with special health care needs (CSCHN), implement targeted home visiting programs, offer resources and information to families of CSHCN, and develop collaborations between systems of care serving CSHCN. Additionally, Federal Title V funds were expended 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 DHS' Office of Children, Youth, and Families to help support enrollment of impacted infants into Plans of Safe Care. Federal Title V funds were expended on staff who used Child Death Review (CDR) findings to inform, develop, modify, and evaluate public health programs and policies in Pennsylvania. Federal Title V funds were expended on state-level program management and related systems development activities, such as collaborating with the Department of Human Services programs serving CSHCN. Non-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. Other federal funds were expended to provide direct and enabling services through the Traumatic Brain Injury program and implement newborn hearing screenings and interventions while federal Title V funds were used to support state-level program management of the Traumatic Brain Injury program, the newborn hearing screening program, and public health systems development.

- **Reduce rates of child mortality and injury, especially where there is inequity -** 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, on staff who used CDR findings to inform, develop, modify, and evaluate public health programs and policies in Pennsylvania, to improve safety in youth sports including providing trainings on the ConcussionWise™ curriculum, and to utilize the Coaching Boys into Men curriculum to promote violence prevention. Other federal funds were expended to enhance childhood blood lead level surveillance and implement lead poisoning prevention activities. Federal Title V was expended to support state-level management of these programs as well as related public health services and system 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 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), the National Survey for Children's Health (NSCH), 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 and SUID/SDY 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 were expended 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 funds were expended to improve and expand reproductive health and family planning services and to support staff training in and implementation of health equity principles. Federal Title V funds were expended 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) 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 FFY21 to support MCH programming throughout the state, improving the health of women, birthing people, 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 FFY21, $23,954,647 federal Title V dollars were expended, $11,087,519 (46% of the total Title V federal expenditures) on preventive and primary care for children, $7,215,266 (30% of the Total Title V federal expenditures) on CSHCN, and $2,395,464 (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 FFY21, $49,045,442 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 FFY21 were $73,000,089. Additionally, the BFH expended $3,241,422 in other federal funds implementing MCH programming. State MCH grand total expended for FFY21 was $76,241,511. 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 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 complied 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 FFY21 Title V expenditure data reported on Form 2 as compared to the planned budget for FFY21, 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 FFY21 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 in the pregnant women domain; however, delays in program implementation contributed to decreased expenditures. Second, an increased birth rate in 2021, along with new programming targeted at addressing infant mortality, increased in Title V and state match related expenditures for infants. Third, the addition of programs 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 2021. 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. The result of these efforts led to a significant increase in enabling services expenditures for 2021.

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 91% of pregnant women, 99% of infants, 33% of children, and 51% of CSHCN in FFY21. The COVID-19 pandemic continued to impact service numbers especially in reduced school health screenings. 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 2023 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 (MMRC) and collaborating with the Pennsylvania Department of Human Services (DHS) 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 Sudden Unexplained 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. Federal funds are budgeted to support Perinatal Periods of Risk studies. 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 Child Death Review (CDR) and collaboration 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 Health Resource Center program, increase protective factors for LGBTQ-identified youth through evidence-based or evidence-informed behavioral health programs, implement Olweus Bullying Prevention Program for 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. 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 DHS' 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, implement newborn hearing screenings and interventions, 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 collaboration with DHS 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 healthy 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 MMRC 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 2023 that is level with the FFY 2021 award.

Pennsylvania's proposed budget for FFY 2023 is in full compliance with the federally mandated threshold requirements. Of Pennsylvania's proposed federal grant award for 2023, $10,368,088 (43.3% of the total grant

award) is designated for the support of preventive and primary services for children, and $8,544,331 (35.6% of total grant award) is designated for the support of services for children with special health care needs. Administrative costs are budgeted at $2,395,464, 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 2023 are $53,009,500. 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 2023 is $76,964,147. Federal Title V and state funds will be monitored on a monthly basis to ensure the match requirements are met for FFY 23.

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 2023 is $8,127,554. State MCH budget grand total for 2023 is $85,091,701.

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, laboratory, 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 and birthing people, 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 uses 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, birthing people, infants, and children, including children with special health care needs (CSHCN). 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 lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) 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, and Cooley's Anemia. 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 a 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 and collaborates with other agencies and organizations to support babies born with NAS.

- 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, and 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 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 continues 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 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 capable of researching innovative and 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 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 is 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 and subsequent retention is important to the Bureau of Family Health (BFH). 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 Core Services, and the MCH Leadership Competencies. The BFH is adapting its workforce development efforts toward a transformative approach: building a workforce able to respond to challenges at both the community and state-level, addressing the root causes of health inequities, and ensuring 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. BFH continues adapting and implementing innovative strategies to foster a culture of equity, inclusion, and collaboration. The COVID-19 crisis imposed unique program delivery challenges to maintain adequate services aimed at improving the health of mothers, birthing people, children, and families. The BFH staff attended and offered virtual training options as well as limited in-person trainings and conferences. Trainings and conferences offered intersectional cultural/linguistic competence skills, data management, systemic anti-racial dismantling, health equity, meaningful engagement, and as well as policy/system capacity building.

In 2021, the Division of Newborn Screening and Genetics (NSG) planned to provide a statewide training for audiologists. As a result of the COVID-19 pandemic, the training was postponed and in response the Infant Hearing Screening Advisory voted to host the training remotely. The training is currently being developing into an online learning module to be housed on TRAIN PA, Pennsylvania's gateway to the TRAIN Learning Network. The trainings are anticipated to be available in fall 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 2021 even as the grant ended on June 30, 2021. To ensure that the needs of all populations are being met through the services offered by the Department, all Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE) providers required to annually attend a one-day LGBTQ cultural competence training. 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. Going forward a new training provider may need identified as the Persad Center's contract with the Department has ended.

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 2021 and will attend them in 2022 and 2023. 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 2021 and will continue these workforce development opportunities in 2022 and 2023. Events included the PA Community on Transition 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. An in-person training occurred in 2022 titled "Fit to Lead" and included topics on leadership, team building, and integrity for high school and college student-athletes. There are no current plans for a conference in 2023. 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. Another virtual conference titled "Health Matters: Healthcare & Services for Children with Disabilities & Special Healthcare Needs" was held in 2022. There are no current plans for a conference in 2023. 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. In addition, CSDO plans to host an annual symposium. Offered for the first time in 2019 and delayed due to the COVID-19 pandemic, the 2022 CYSHCN Symposium recentered the conversation around a well-functioning system. CSDO is planning a 2023 symposium to include topics of traumatic brain injury and healthy relationships, among others.

The Division of Bureau Operations (DBO) 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 attended conferences, such as the 2021 Family Voices Virtual Family Engagement Convening annual family engagement conference. 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. Staff also attended, both virtually and in-person, the Health Equity Summit hosted by the DOH Office of Health Equity in conjunction with the American Lung Association in April 2022 that focused on various current and emerging topics such as rural health equity, disability equity, and pathways to prevention.

In January 2021, the Department of Health (DOH) 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 DOH Antiracism and Health Equity Task Force, Support and Training subcommittee, formed in May 2021, continues to work and collaborate on the development of training and training resources to assist the DOH workforce, including the BFH to build capacity to meet this deliverable.

The Department is also exploring new mechanisms for recruiting and retaining qualified public health staff. The Department is in the process of updating its workforce development plan for the 2022-2027 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.

Internal surveys of BFH staff conducted as part of the internal capacity assessment in 2021 and in 2022 suggest capacity building on decision making, program development based on data and evidence, change management, and data and data disaggregation 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 on these topic areas may benefit all staff, including those 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.

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. A similar training was conducted for staff and grantees in 2022. DBO also conducted Data and Data Disaggregation training for staff in 2021.

Additionally, in February and April 2021, the BFH held informational meetings with the Children's Hospital of Philadelphia (CHOP) Leadership Education in Adolescent Health (LEAH) fellows program and the joint CHOP and Children's Hospital of Pittsburgh (CHP) Leadership Education in Neurodevelopmental Disabilities (LEND) 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. The BFH hosted another meeting with the LEAH fellows in March 2022 and plans to host a meeting with the LEND fellows later in 2022.

Surveying BFH staff will occur at least annually to determine internal staff capacity and training needs around the aforementioned topics. A series of comprehensive internal staff capacity and training surveys were conducted in 2021 to inform trainings and existing workforce capacity efforts, including the weekly resource email. Additionally, the creation of a resource library is ongoing, compiling literature and other supplemental resources to be used by BFH staff. This will potentially be made available to grantees as well.

Since the pilot in June 2020, the BFH continues to produce a weekly resource email (WRE) which includes 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. Anecdotally, staff have shared that the trainings and resources are beneficial and aid in furthering their understanding of various topic areas, programs, or issues. Staff have forwarded the email on to grantees, and state and community partners as they see fit. Partners include OCDEL, MMRC members, among others.

In May 2021, the BFH began using a Department Constant Contact account to implement the WRE. Constant Contact is an online email platform which allows for the easy creation and dissemination of content that also captures analytics. Through this platform, the BFH can better measure the success of the WRE. Emails are curated and disseminated weekly. On average 27% of staff open the WRE and on average 28% of the resources are accessed or clicked on through their weblink. There are slight variations from week to week, as content is new each week along with other variables including, staff schedules and workload, priorities, and the overall need to utilize the resources. PDFs of all the WRE's are housed in a centralized folder accessible to staff at any time.

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 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 teleworking.

Another aspect of the BFH staff engagement includes regular all 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 2021, a few highlights included updates and education on the PA State Health Assessment (SHA) where Maternal and Infant Health serves as a key theme and the release of the SHA indicator's dashboard; and updates regarding the Interventions to Minimize Preterm and Low Birth Weight Infants Using Continuous Improvement and Teen Outreach Programs.

A quarterly newsletter was introduced in 2021 to share information, spotlight a division quarterly, and highlight new and ongoing initiatives within the Bureau. The newsletter is also disseminated via Constant Contact. On average, 54% of staff open email and 40% of staff access the PDF version of the newsletter.

As described in the Cross-Cutting section, the BFH also plans to offer training to increase understanding of the social determinants that greatly influence the health of populations and further increase understanding on health disparities and health equity. 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 collaborating with BFH workforce development efforts to increase staff capacity to reduce health disparities and promote health equity in the population served by Title V. Throughout 2022 and 2023, the BFH will work to identify additional training resources related to health equity, social determinants of health and cultural competency and anticipate offering in-person staff trainings. Careful consideration as to how best approach the topics of racial equity and health equity as training topics in both in-person and virtual settings. The virtual series of introductory health equity trainings, "Exploring the Social and Structural Determinants of Health" from the Mid-Atlantic Regional Public Health Training Center and "Health Equity and Environmental Justice 101" from the Colorado Department of Public Health and Environment (hosted on TRAIN PA), taken by staff in 2022 precede more advanced in-person trainings expected be shared with staff throughout 2022 and 2023.

The BFH continues to take advantage of opportunities to further staff's capacities around these complex and systemic issues. In March 2021, a diverse team of members from across the Bureau participated in the National MCH Workforce Development Center and the Maternal Health Learning and Innovation Center Virtual Spring Skills Institute "Strengthening Skills for Health Equity". The team 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 participate on the PA Title V team for the AMCHP Healthy Beginnings Cohort, sharing skills and resources with both AMCHP and our community partner, Healthy Start of Pittsburgh.

In 2021, a small team, including 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 state staff from other agencies. This workshop served 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. To ensure that the antiracism work did not end at the conclusion of this workshop and that it permeates throughout each individual action and program, the Department established an Antiracism and Health Equity Task Force in May 2021 to continue the momentum started through the Anti-Racism Institute. BFH staff participate on the Task Force and its subcommittees, including the Training and Support subcommittee, to leverage ideas and resources that are offered, but also to ensure alignment with Departmental workforce development and training efforts.

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 in 2022 with services beginning in early 2023.

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 and through a health equity lens. The Bureau of Family Health (BFH) recognizes the benefits of FCPs and has established diverse means of incorporating families and consumers into the Title V decision-making process. Commitment to expanding meaningful community partnerships grounded in health equity principles is a BFH priority. Promoting equity in policies, regulations, and standards based on family engagement practices strengthens the core of the public health care system while decreasing health care disparities among Pennsylvania's MCH population domains. The BFH focuses on continuously supporting, offering, and engaging in opportunities to establish partnerships with families, assuring they are key partners in BFH's program development and policy-making decisions. Prioritizing equitable, effective, and meaningful engagement practices with stakeholders promotes dialogue and strategic planning efforts to create positive outcomes. Active client and 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 population domains.

BFH continues to implement a client and family engagement framework composed of four phases: Communication, System, Unification, and Adaptation. The framework involves strategies to increase awareness and provide guidance in implementing engagement practices meaningful to MCH populations. It focuses on amplifying the role of family, youth, and community in MCH public health. The Communication phase involves 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.

BFH engagement practices are driven by the principles of the Family Voices: Family Engagement in Systems Assessment and Family Engagement in Systems toolkit. BFH staff continue to participate in external trainings and conferences that enhance the engagement framework, including the Annual Family Voices Leadership Conference 2021.

The BFH is dedicated to expanding and increasing its role in collaborating with community-based organizations (CBO). In 2021, BFH applied for and was accepted to the learning and practice cohort Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention sponsored by the Association of Maternal and Child Health Programs (AMCHP). The project aims to identify and address racism in policy and data and find structures that sustain inequities in perinatal health, including preterm birth, in Black, Indigenous, Hispanic/Latine/x, Asian, Pacific Islander, and other birthing people of color. The 18-month learning and practice cohort will provide BFH with an opportunity to pilot new approaches to achieving health equity, community engagement, and partnerships that could be applied to other topic areas in the future. AMCHP identified and facilitated BFH's match with Pittsburgh Healthy Start, a CBO, to develop strategies to dismantle systemic inequities. The project aligns with Pennsylvania Title V MCH Services Block Grant priorities for 2021-2025 as well as BFH's mission to equally protect and equitably promote the health and well-being of pregnant people, their partners, children, and all families in Pa.

The cohort will identify levels and impacts of racism in everyday MCH practice, develop action plans that disrupt inequities in funding and data flow, foster sustainable and equitable relationships between MCH programs and CBOs, and find sustainable and equitable funding opportunities for training and compensation of a culturally reflective perinatal workforce (inclusive of midwives, doulas, community health workers, and lactation providers).

The cohort goals are as follows:

- Develop sustained, two-way partnerships between state and community organizations through ongoing transparency, communication, and trust-building.
- Uplift and support the continued engagement of community in developing state-level practice and throughout the public health workforce.
- Gain a clear understanding of what community partners need from Title V programs, and of the challenges and barriers that Title V programs experience.

BFH staff also joined community stakeholders in serving on the Alleghany County Infant Health Equity Action plan committee. HRSA awarded funding to grantee Pittsburgh Healthy Start of Allegheny County to reduce disparities in infant mortality among non-Hispanic Black or non-Hispanic American Indian/Alaska Native populations by creating an action plan driven by data-informed policies and strategies. BFH will continue to collaborate with stakeholders to implement the infant health equity action plan, Allegheny County BIRTH Plan for Black Babies and Families: Battling Inequities and Realizing Transformational Health Outcomes. BFH will continue to invest in equitable and sustainable partnerships, support and enhance efforts in collaborating with internal and external stakeholders and build relationships and collaborating with agency partners.

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 domain requesting input from Title V service recipients 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 assessment include coordinating with providers to offer transportation to in-person events, exploring childcare options, better advertisement of incentives such as meals, and consideration of additional monetary incentives for participation. Continuing to include opportunities for virtual participation to expand accessibility is being strongly considered. Additionally, for the 2021 interim needs assessment, public input surveys in English and Spanish were made available both online and via PDFs to improve accessibility for those with limited English proficiency as well as those with limited digital access. The survey instructions also included multiple points of contact for questions or concerns about the survey, including the Healthy Baby Line. The BFH will continue to consider how feedback and engagement opportunities can be made more inclusive and accessible and communicated more clearly and broadly.

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 50% of board members 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 five family members on the TBI Advisory Board. The Infant Hearing Screening Advisory Committee has one volunteer parent representative. The Newborn Screening and Follow-up Technical Advisory Board has one volunteer parent representative. 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 family members of individuals with disabilities and six 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 networking opportunities 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 importance of timely, quality, readily accessible MCH data as data are critical for informing and evaluating Title V programs, conducting ongoing needs assessment, and for federal reporting. Accordingly, 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. Data-related initiatives are further described in the cross-cutting domain narrative as well as in the SSDI and Other MCH Data Capacity sections of this report and application.

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 staff, 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. In 2021, the Bureau of Epidemiology hired an additional supervisory PhD level Epidemiologist to support all of the MCH epidemiologists housed in the BFH. The Department of Health (DOH) also employs a statistician dedicated to MCH activities who provides support to the BFH.

As the BFH continues to expand its access to MCH data sources, these staff are critical to providing support through data linkage and analysis. Internal epidemiology staff provide daily support to staff for data-related needs and aid in the conduct and coordination of ongoing interim and five-year needs and capacity assessment activities.

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

The State Systems Development Initiative (SSDI) grant complements the Title V Maternal and Child Health Services Block Grant (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, linkages, analysis, and 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 2020, the BFH focused on the following activities:

1. Build and expand state MCH data capacity to support the Title V MCHSBG 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, supported by both Centers for Disease Control and Prevention (CDC) and Title V funds, 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 DOH and by external 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. During this reporting period, PA PRAMS was able to increase the sample size from 1,788 to 2,605. Larger sample sizes help ensure that the data gathered are generalizable to the 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 the PA PRAMS sample size and administer additional temporary supplemental modules when applicable. In 2021, PA PRAMS participated in a 12-month COVID-19 vaccine supplement. The Social Determinants of Health supplement was implemented in May 2022 and will remain in the field for the 2022-2023 birth year, for a total of 11 months. 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 PA PRAMS 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.

   By completing project activities and disseminating 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. SSDI also supports interim needs assessment activities by funding focus groups. While COVID-19 has hindered BFH's ability to physically interact with providers and program recipients, BFH has resumed holding virtual focus groups. During 2022 the BFH held four virtual focus groups with CSHCN and their families to discuss the topics of bullying, reproductive and sexual health, healthy relationships, and transition to adulthood. Findings from these sessions will help identify system-level gaps and inform strategy development in the coming year.

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 continues 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 and monitoring on an annual basis to ensure project activities have been implemented as intended and population needs are being addressed. One example of how this support is provided is through focus groups and surveys to gauge client and customer satisfaction with BFH programs as well as to assess program effectiveness.

   Priority 6 of the 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 2015-2020 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 staff surveys conducted in 2021 and 2022 suggest capacity building on data-driven decision making, program development, and assessment is still needed. The goal of ongoing staff training is to build the Bureau's data capacity by increasing awareness and knowledge of available datasets, how to identify disparities and trends in state-level and programmatic data, and how to use data to inform programming.

   The BFH continues to promote development of SMART (specific, measurable, attainable, relevant, time-bound) measures to monitor program progress. In 2021, training on the Title V performance measurement framework and SMART measures were held for staff. The BFH also has an ongoing training initiative around data disaggregation. During the first training held in 2021, staff were provided with tools and resources that would assist them in assessing their data collection and quality and characterizing the service population. In 2022, a second training was held on the importance of disaggregating program outcomes in an effort to ensure that programs are effective and equitable for all populations. 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.

   In 2022, BFH implemented online technical assistance (TA) request forms. Through this process, staff can request TA to establish measurable goals with their grantees and consult with Division of Bureau Operations (DBO) staff, including epidemiologists, on technical issues and data presentation. A separate form was created for requests related to data collection. These processes, along with TA documents, will be part of the training and resource infrastructure to build staff capacity around identifying sources of data, conducting basic data analysis, using data to inform program development and evaluation, and developing process and impact measures.

Several process measures have been defined for each SSDI goal to measure progress on objectives and activities.

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

The BFH is also creating a streamlined process for data and training/TA requests. Standardizing 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) and 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 births and deaths; 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. 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. In 2021, the BFH applied for and received an analytic file of occurrent, resident birth, death, and fetal deaths that can be used to inform Title V programs and needs assessment activities. Updates to the file will be provided on a quarterly basis. While aggregated birth and death records data are released publicly each year via Pa.'s Enterprise Data Dissemination Informatics Exchange, this is the first time an application for access to a regularly updated analytic birth, death, and fetal file to support Title V activities has been approved and the data made available to the BFH. In the coming months, epidemiology staff supporting the BFH will be performing data linkage and working with program staff to conduct analysis that can support and inform Title V strategies. Vital records data are 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.

The BFH receives de-identified aggregate data from the PA Department of Human Services, Office of Medical Assistance 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 does not currently receive any WIC data. This data is available via a signed agreement with WIC. However, after reviewing the WIC system it was determined that examining each WIC case for potentially relevant information was not the best use of BFH staff time and resources currently.

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

To alleviate suffering and aid citizens whose personal resources are depleted 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 incorporates the principles of NIMS. The continual refinement of plans and procedures and the mandated use of NIMS accommodates situational changes and promotes preparedness for all kinds of emergency situations.

The CEOP is designed to assist state-level leaders and emergency management personnel handle 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 the 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 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 of these 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 work location for staff to be physically present during an emergency. 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 the 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 revealed 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. PEMA periodically conducts drills 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 BFH.

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 2021, only 5.8% of the nearly 12.6 million noninstitutionalized civilians in Pa. were uninsured. 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 331,000 enrolled in 2020, rising again slightly in 2021 with 337,000 enrolled.

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 (CMHD) 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. The BFH provides safety net pharmaceutical services through a metabolic formula program for children with medical confirmation of cystic fibrosis (funded by Title V), and patients with spina bifida, maple syrup urine disease, and phenylketonuria, funded from state funds. 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. Effective November 1, 2020, any new or renewal applicant will be required to provide either a letter of denial of coverage from their insurance and Medicaid or submit a signed insurance/Medicaid refusal form due to religious objection. 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, relationships, decision making, and sexuality, sexually transmitted infection screening, 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 12 Philadelphia area schools, five Philadelphia community sites as well as 29 additional sites in ten counties across the state with high rates of teen pregnancy, STIs, and youth leaving school before graduation.

Finally, the sickle cell community-based services and support program, part of the larger Specialty Care Program (SCP) is Title V-funded. 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 currently collaborates with Medicaid in several areas. The BFH has standing bimonthly meetings with representatives from the Office of Medical Assistance Programs and other DHS staff to discuss issues particular to the systems of care serving children with special health care needs. Additionally, the Division of Newborn Screening and Genetics 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 and for newborns 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. DHS announced its expansion of home visiting services for some individuals covered by Medicaid in Pa. in 2019. In collaboration with the physical health Medicaid managed care organizations (MCOs), all first-time parents and parents of children with additional risk factors covered by Medicaid are eligible for at least two home visits effective July 2020. Approximately 97% of the over 2.9 million individuals in Pennsylvania's Medicaid program are enrolled in a managed care program with the remainder enrolled in the Fee-for-Service program. Additionally, children receiving shift care covered by Medicaid are eligible for at least one home visit, also effective July 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 was unable to participate in the task force's quarterly workshops as the initiative was temporarily suspended due to the COVID-19 pandemic. The BFH has resumed its participation, to learn about the initiative and identify opportunities to align Title V programming. 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 maintains quarterly meetings with DHS to discuss issues related to maternal health, infant health, and early childhood.

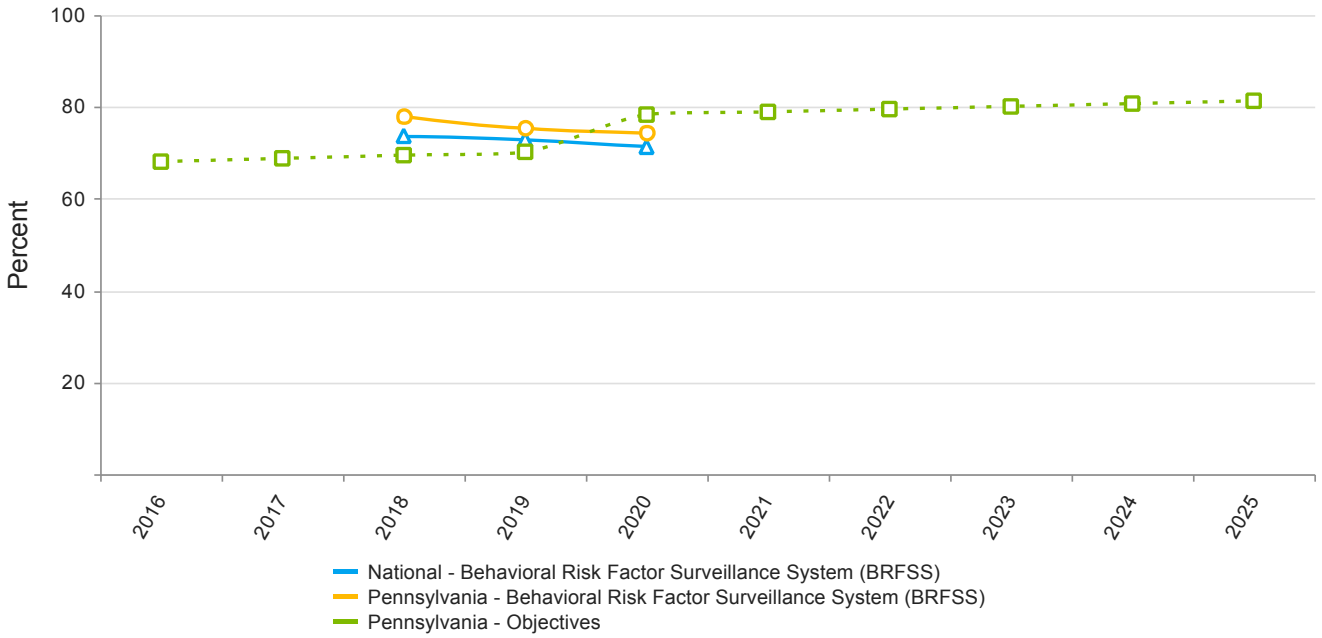
To further solidify the coordination and collaboration with Medicaid, the BFH has a Memorandum of Understanding (MOU) between the two agencies. The goal of the MOU is to clearly define areas of collaboration to eliminate duplication of services while providing for opportunities to share resources and 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

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				78.2	78.8
Annual Indicator			77.6	75.2	74.3
Numerator			1,651,482	1,609,089	1,571,902
Denominator			2,128,688	2,140,534	2,115,148
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS 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 with 2018 survey data.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	68.7	69.4	70.1	78.2	78.8
Annual Indicator	66.4	65.3	77.6		
Numerator					
Denominator					
Data Source	NIS	NIS	NIS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	79.4	80.0	80.6	81.2

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

State Provided Data			
	2019	2020	2021
Annual Objective			24
Annual Indicator			55.2
Numerator			891
Denominator			1,615
Data Source			CMHD final reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.5	25.0	25.5	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

State Provided Data			
	2019	2020	2021
Annual Objective			85
Annual Indicator			75.6
Numerator			198
Denominator			262
Data Source			CPP quarterly reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.9	86.8	87.7	88.6

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

State Provided Data			
	2019	2020	2021
Annual Objective			80
Annual Indicator			78.3
Numerator			2,243
Denominator			2,865
Data Source			IMPLICIT ICC quarterly and annual reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	82.4	83.6	84.8	86.1

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			3
Annual Indicator			3
Numerator			
Denominator			
Data Source			Philadelphia Department of Public Health
Data Source Year			2021
Provisional or Final ?			Final

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

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			25
Annual Indicator			2
Numerator			
Denominator			
Data Source			Alliance of PA Inc. quarterly and annual reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	27.0	30.0	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

State Provided Data			
	2019	2020	2021
Annual Objective			80
Annual Indicator			88
Numerator			373
Denominator			424
Data Source			IMPLICIT ICC and CPP quarterly reports CMHD annual
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	80.8	81.6	82.4	83.2

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

State Provided Data			
	2019	2020	2021
Annual Objective			3
Annual Indicator			0
Numerator			0
Denominator			1
Data Source			2021
Data Source Year			IMPLICIT
Provisional or Final ?			Final

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

ESM 1.8 - Number of MMRC recommendations implemented annually

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			3
Numerator			
Denominator			
Data Source			Philadelphia MMRC reporting to the Department
Data Source Year			2021
Provisional or Final ?			Final

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

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			2
Numerator			
Denominator			
Data Source			meetings held
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

Women/Maternal Health - Annual Report

For reporting year 2021, the Bureau of Family Health (BFH) conducted activities in the Women/Maternal Health domain through Title V funding with additional federal funds from the Centers for Disease Control and Prevention (CDC) for support of maternal mortality prevention initiatives. 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 and a half 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 Hispanic/Latinx. Several factors contribute to poor maternal 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). Poor mental health, substance use (including substance use during pregnancy) and IPV have particularly negative consequences on a family.

In the United States, about 1.5 million women report being victims of some form of IPV every year. Of these reported cases, approximately 325,000 are pregnant during the acts of violence. The reason for this spike in IPV during pregnancy is unknown but could be due to relationship dynamic changes between partners, or that the frequency of prenatal visits yields more positive screens simply because patients are being screened more frequently. What is known is that intimate partner violence affects pregnancy more than any other common pregnancy complication. Experiencing IPV during pregnancy is associated with higher rates of depression, suicide attempts, and behavioral risk factors including the use of tobacco, alcohol, and drugs. 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 seven birthing people experience symptoms of peripartum 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. According to the American Journal of Emergency Medicine, domestic violence cases increased by 25%-33% globally in 2020. 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 disproportionately affected groups, 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.

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

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 can connect with and gain the trust of the birthing people they are serving.

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 Hispanic/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 Hispanic/Latinx birthing people receiving no prenatal care.

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, pregnancy, postpartum, 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.

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

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 inequities 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 inequities among disproportionally affected 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 2021, 1,615 pregnant and birthing people were served through CMHDs home visiting programs. As of a result of COVID-19, the number of pregnant and birthing people enrolled in and served by home visiting programs decreased from previous years. This was due to discontinuation of in-person visits, adjustment to connecting virtually, and CMHDs emergency response to the pandemic. Despite the continuing challenges of the pandemic, 55% of enrolled participants successfully completed home visiting programs, exceeding the original goal of 24%. If the increased percentage continues in future years, BFH staff will consider revising the goals for this measure. 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.

COVID-19 continued to present challenges for the CMHDs with staffing being affected by vaccine requirements causing the CMHDs to lose home visiting nurses and other staff. Additionally, with the rise in cases, CMHDs remained flexible with home visiting protocols utilizing virtual methods to connect with participants as needed. Several of the CMHDs had waiting lists as the need for services increased due to financial challenges and employment instability affecting families. The need for infant related supplies also increased so CMHDs implemented contactless drop-offs. Other barriers to connecting with families included participants lacking adequate data and technology to access remote services that utilized Zoom or GoToMeeting as well as many participants not feeling comfortable to return to in home visits due to continued COVID-19 concerns. The CMHDs continually work to find solutions to these barriers and challenges to provide the services needed to support their communities.

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

In 2021, the BFH continued its partnership with Lancaster General Hospital (LGH) in Lancaster City to provide the Centering Pregnancy Program (CPP). The CPP aims 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 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 2021, 56 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 increased SUD screenings in LGH's medical practices, the SUD CPP group continued to have an increase in referrals. The program sessions remained virtual in 2021. The virtual format was more successful for the SUD group by eliminating barriers such as transportation and childcare, allowing participants to attend more frequently, and fostering stronger connections within the group.

Combined, LGH's program served 121 families with a continued emphasis on improving birth outcomes and reducing inequities among this disproportionately affected population in Lancaster City. Of those served, 59.5% were white, and 11.6% were Black/African American, with 37% of participants identifying as Hispanic/Latinx. Program outcomes were positive. LGH saw higher than expected rates for full-term births with 92.9% of their participants delivering at full term. Breastfeeding rates were also positively affected with 86% of participants breastfeeding at birth versus 81% of birthing people prior to the implementation of the CPP. CPP participants were screened for depression and referrals were made to mental health professionals as necessary. The CPP had high patient satisfaction rates, with LGH reporting that 95% of birthing people that completed either the traditional CPP or SUD program were satisfied with the experience.

In 2020, a Request for Application was posted for current CPPs to expand previously established programs. The two awarded applicants for the expanded CPPs were Albert Einstein Health Network located in Philadelphia, with a focus on behavioral health screenings and referrals, and WellSpan York, who expanded to serve their Spanish-speaking population by offering culturally and linguistically relevant group prenatal care. Both awardees began their programs in early Spring 2021 and served over 140 birthing persons.

The CPPs submitted data related to family planning and birth spacing, specifically how many adolescents and women talked with a healthcare professional about birth spacing and birth control methods. 75.6% of participants enrolled in CPPs talked with a health care professional about birth spacing and birth control methods, not meeting the goal of 85%. 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.

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

In 2021, the BFH partnered with the University of Pennsylvania to continue implementation of the Title V funded IMPLICIT Interconception Care (ICC) Program, wherein maternal screenings are conducted at well-child visits (WCVs). The ICC program 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. This model of care promotes utilizing scheduled WCVs to improve the health of birthing people between pregnancies. As birthing people are often more focused on their baby's health than on their own and may not attend their scheduled postpartum visit(s), WCVs provide an opportunity to address maternal health risk factors during the interconception period. At each WCV, birthing people are screened for four behavioral risk factors to assess their health (smoking status, depression, contraception use, and multivitamin with folic acid use), and

counseled and referred for services as necessary. In 2021, the grantee continued to work toward strengthening the 13 existing IMPLICIT Network (Network) sites and increasing utilization of the ICC model of care, while transitioning the IMPLICIT Network hub from Shadyside Hospital Foundation to the University of Pennsylvania.

The effectiveness of the IMPLICIT ICC model of care is measured by how many birthing persons are screened and how many individuals with high-risk behaviors receive an intervention. Two thousand eight hundred sixty-five unique birthing person-baby dyads were served in 2021. Of these, 78.3%, or 2,243 birthing persons, were screened for all four risk factors at a minimum of one WCV. ICC screening was performed at 5,161 WCVs in 2021. This is lower than the 2020 overall screening rate of 78.8% across all sites and did not meet the objective of increasing the percent of women screened for risk factors during WCVs to 81.2%. Of the individuals that received ICC screening, 17.6% screened positive for tobacco use, 14.7% for depression, 18.4% for lack of contraception use, and 42.1% for lack of multivitamin with folic acid use. Interventions for positive screens were documented at the following rates: 88.7% for tobacco use, 86.6% for depression, 75% for contraception use, and 59.6% for multivitamin with folic acid use.

The grantee reported that the ongoing strains of COVID-19 on participating providers and the IMPLICIT Network hub, in addition to key staff turnover, contributed to the lower-than-anticipated screening rates. The Network will continue to provide support to ICC sites to improve screening and intervention rates in 2022.

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, education, and advocacy during pregnancy, labor, and in the early postpartum period. In addition, doulas help empower pregnant people to establish and maintain positive communications with care providers, resulting in increased engagement in healthcare decision-making. Doulas spend up to 11 times longer with clients than other health care providers and encourage pregnant or postpartum people experiencing warning signs to seek medical attention prior to experiencing a life-threatening emergency. Doula care also improves maternal health outcomes by reducing unnecessary medical procedures that can result in serious short- and long-term complications.

Community-based doulas provide pregnant people and their partners with low-cost or free education, support, and counseling during pregnancy, birth, and the postpartum period; focus on eliminating health barriers and disparities; and promote healthy bonding between pregnant people and their babies. In contrast to conventional doulas, community-based doulas share the same background, culture, and language as the pregnant people they support. They also have additional training in social determinants of health, trauma, and racial equity that supplements the traditional doula education curriculum.

The Philadelphia Department of Public Health (PDPH) provides care through the Doula Support Program (DSP) to Philadelphia residents. The DSP focuses on prenatal and postpartum people with a history of a 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. Due to COVID-19, in person visits with doulas was changed to virtual connections with program participants; however, the program was still able to serve 30 people in 2021. Of these participants, 66% identified as

Black/African American with 10% identifying as Hispanic/Latinx. Almost 100% of program participants were covered by Medicaid. To foster a sense of community among program participants, the DSP started a virtual parent group that meets twice a month to offer support and facilitate connections among program participants. In 2021, PDPH trained three community-based doulas, meeting the goal, to provide services through this program.

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

ESM: Number of behavioral health providers trained in pregnancy intention

The unintended pregnancy rate for birthing people with opioid use disorder (OUD) is 84.9%, significantly more than the national average of 45%. Further, according to the DOH's "Neonatal Abstinence Syndrome: 2019 Report", 1,608 Pa. infants were diagnosed with opioid-related NAS after birth, compared to 2,140 the year before. In 2021, 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 OUD. The Alliance is currently comprised of three family planning councils, each serving a region within Pa; a family planning council representing Western Pa. ceased participation in the Alliance since beginning this project.

At the beginning of this project, each council was tasked with developing a pilot program to identify and address the specific needs of their region. Projects selected for implementation included training behavioral health providers on assessing their clients' 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 substance use disorders (SUDs).

The Alliance provided services to improve the preconception health of and reduce unintended pregnancy rates for 3,120 individuals in 2021, 77.3% of whom were diagnosed with a SUD and 63.1% with an OUD. One thousand four hundred seventy-five women (including 747 with an OUD) and 1,642 men with an SUD received services, such as limited scope contraceptive care and sexual and reproductive health education, as a result of this initiative. Unfortunately, due to the continuing impact of the COVID-19 pandemic on the Alliance's ability to provide in-person services, counseling, education, and training at behavioral health providers and in schools, fewer individuals were served in 2021 than initially anticipated.

It is critical that initiatives intended to improve birth outcomes prioritize groups that have been historically economically and socially marginalized, such as populations of color. Although efforts have been made throughout this initiative to better engage individuals that identify as Black/African American, Indigenous, and people of color (BIPOC), the majority (78.3%) of clients served by this program in 2021 were white; however, the percentage of white clients ranges between the pilot projects, from a minimum of 56% to a maximum of 83.1%. Overall, the program population is slightly less majority-white than the state of Pa. (78.3% compared to 81.6%). The program also serves more Hispanic/Latinx clients than the state population (15.9% compared to 7.8%). The overall racial and ethnic composition of the clients served did not shift substantially from 2020 to 2021, despite the COVID-19 pandemic and its disproportionate burden on people of color and the agencies that serve them.

In 2021, the Alliance trained two behavioral health providers to assess for pregnancy intention as part of their routine intake and counseling. This is significantly less than the number of providers trained in this area in 2020 – 36 – and does not meet the objective of increasing the number of behavioral health providers trained in pregnancy intention assessment. The decrease in provider trainings is reflective of a lack of new partnerships with SUD treatment sites, as a result of COVID-19 pandemic-related barriers, competing priorities, and the natural project trajectory. In addition, as the Alliance has received feedback from the councils and their partner sites, they have identified other

critical training needs, such as in trauma-informed care, and have pivoted to develop and implement trainings to address these gaps. In 2021, the Alliance provided an additional 18 providers with professional development in how to address trauma and sexual health in SUD treatment settings.

The current initiative ends in 2022; if the BFH selects to replicate elements of the pilot projects in future partnerships, a focus on serving communities of color will be key. By increasing access to integrated sexual and reproductive health services for groups that are disproportionately affected by SUD, the BFH hopes to reduce the incidence of unintended pregnancy and improve health outcomes for birthing people with OUD 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 services by 1% annually, following a positive screening

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

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 when receiving care through Title V funded programs. The BFH requires all Title V funded CMHDs home visiting programs to utilize evidence-based/informed screening tools to assess behavioral health issues during the perinatal period. By doing so, 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. Many of the CMHDs and the CPPs use the Edinburgh Depression Scale, a validated tool comprised of ten questions that can be used in both the prenatal and postpartum periods. In 2020, the BFH made the decision to no longer require the use of the 5Ps tool, a quick, non-threatening tool that assesses risk for alcohol dependency, substance misuse, interpersonal violence, and depression base on five domains (Parents, Peers, Partner, Pregnancy, and Past). 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. Going forward, the BFH is asking partners to utilize evidence-based tools for screening in lieu of the 5Ps tool which is not considered an evidence-based tool as it lacks published, peer-reviewed research studies.

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 2021, 1,940 birthing people received a depression screening at their child's WCV; of the 285 positive screenings, intervention was documented for 247, or 86.6%, of these individuals.

Given the importance of providing follow-up services for behavioral health issues, the BFH chose to measure the percent of women enrolled in home visiting, CPP or IMPLICIT programs that are referred for behavioral health services, following a positive screening. Warm handoff referrals, where the home visitor or healthcare provider assists the participant in setting up a behavioral health appointment, help to increase the likelihood that they will follow through with the appointment. In 2021, 87.9% of pregnant and birthing people enrolled in the home visiting, CPP, or IMPLICIT programs were referred for behavioral health issues, following a positive screening. The focus on providing referrals for behavioral health services following a positive screen helped to exceed the first year goal of

80% of participants that received referrals. Reasons pregnant and birthing people may not be screened include refusal or early withdrawal from the program. Additionally, with many programs still holding virtual sessions due to COVID-19, participants are not always comfortable discussing mental health issues through a virtual platform.

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.

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 3% annually, starting with reporting year 2022

The "fourth (4^{th}) trimester" generally refers to the first three months postpartum. The mainstream maternal health framework does not provide routine care for birthing people until six weeks after childbirth, halfway through this period. However, birthing people experience significant biological, psychological, and social changes during this period that that can lead to poor outcomes if not promptly and adequately addressed. In the weeks following childbirth, pre-existing conditions and new health concerns that go unaddressed can result in the exacerbation of these health issues and, in some cases, maternal death. By ensuring individuals receive a postpartum visit in the early fourth trimester – before 28 days have elapsed – birthing people can be connected to the care they need, and rates of maternal mortality and morbidity will decrease.

In May 2018, the American College of Obstetricians and Gynecologists (ACOG) called for a new paradigm for postpartum care that addresses the current needs for birthing people and protects against morbidity and mortality for birthing people after pregnancy. Improved 4th 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.

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

As a result of the ACOG recommendations, the IMPLICIT Network began planning a new initiative, the 4^{th} Trimester, or 4TM, model of care, to address gaps in postpartum care and decrease rates of maternal morbidity and mortality in the early postpartum period. This care model enables providers to identify birthing people who are at increased risk of postpartum health problems, develop tailored care recommendations for families, and increase the number of birthing people receiving maternal health care within 28 days of delivery.

In 2021, the BFH began working with the University of Pennsylvania and the Network to develop a plan for piloting the 4TM model of care with the goals of addressing gaps in postpartum care and decreasing rates of maternal mortality in the early postpartum period. The Network developed the 4^{th} trimester (4TM) model and began piloting the program at eight sites in February 2021. Unfortunately, due to COVID-19-related staffing limitations, the 4TM pilot project experienced significant barriers to establishing timely, consistent, and accurate data collection, reporting, and analysis. Consequently, the Network was unable to provide baseline data for all sites regarding the individuals who received a maternal health assessment within 28 days of delivery through this initiative. Due to this limitation, the Network's reports in 2021 instead focused on the progress that was being made with regards to pilot readiness and

implementation. The Network continues to support 4th Trimester sites' efforts to implement the new care model and standardize, collect, share, and analyze data.

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

Maternal mortality (MM) and morbidity, and the pervasive disparities between racial and ethnic groups, continues to be a strong area of focus. In 2020, the overall rate of MM in the United States was 23.8 deaths per 100,000 births. Further, the rate for non-Hispanic/Latinx Black/African American birthing people was 55.3 deaths per 100,000 live births compared to 44.0 deaths per 100,000 live births in 2019.

In addition to racial and ethnic disparities in MM rates, birthing people experience disparities in MM based on age; MM rates for individuals aged 40+ were 7.8 times higher than the rate for women under 25 with 13.8 deaths per 100,000 live births for those under age 25, 22.8 for those aged 25–39, and 107.9 for those aged 40 and over.

To reduce risk factors associated with maternal deaths, particularly where there are racial/ethnic inequities, data regarding the incidence/causes of MM and prevention recommendations must be shared with health providers and the public. The Maternal Mortality Review Committee (MMRC), a requirement of Pennsylvania's 2018 Maternal Mortality Review Act, serves as the formal process to investigate the causes of pregnancy-associated deaths and develop prevention strategies. Per legislative requirement, MMRC membership 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. In addition to clinical guidance, MMRC members consider the impacts of social determinants of health, with a goal of reducing racial bias and health inequity. This initiative is dually funded through the CDC and Title V.

Since its inception in 2018, the committee has only reviewed 44 maternal death cases (52% of the 2018 deaths). Due to the difficulties experienced by the MMRC in reviewing all Pa. maternal deaths in a timely fashion, the committee underwent several modifications in 2021. These resulted in the MMRC's first public-facing report, a reorganization of the committee itself, and the establishment and strengthening of new partnerships.

The MMRC's first report was published in January 2022. Recommendations were provided for system, provider, and community levels related to four primary themes: build infrastructure to identify and support pregnant and postpartum individuals with mental health concerns; build infrastructure to identify and support pregnant and postpartum individuals who use substances; build infrastructure to provide more comprehensive medical care for all pregnant and postpartum individuals; and build infrastructure to identify and support pregnant and postpartum individuals with history of intimate partner violence. These themes were presented to the Pennsylvania Perinatal Quality Collaborative (PA PQC), the action arm of the MMRC, for potential implementation of specific recommendations within these themes.

As part of a reorganization effort, all existing MMRC members were asked to reapply, if interested in continuing their service. In addition, an attempt was made to recruit new partners and community members who represent Pennsylvania's diverse geographic regions, clinical and community specialties, and racial and ethnic backgrounds. For purposes of consistency, clear processes for case review and the development of recommendations were also established.

In addition to these reorganization efforts, MMRC program staff worked to strengthen partnerships with external stakeholders. Staff attended the Pennsylvania Coroner's Association Annual Meeting to convey the critical role coroners' and medical examiners' records play in the work of the MMRC. To better understand and address MM throughout Pa., program staff also worked to develop a formal relationship, through the implementation of new data and grant agreements, with the decade-old Philadelphia MMRC. With these documents in place, Philadelphia MMRC was able to implement four recommendations: educating community-based home-visiting and family support programs on early warning signs of maternal morbidity to ensure timely referral for clinical treatment; establishing a cardiology task force to make city-wide recommendations on enhanced care for women identified to be at high risk of cardiomyopathy or infarction; establishing grants for Intimate Partner Violence/MMR groups; and increasing community investment, beginning with focus groups to ensure an understanding of what the community wants and needs.

On October 1, 2020, Pennsylvania became the 38th state to join the Alliance for Innovation on Maternal Health (AIM). AIM is a national data-driven maternal safety and quality improvement initiative which provides implementation support and data tracking
assistance to participating states to support the adoption of AIM's patient safety bundles. AIM also enables states to track their success on improving maternal outcomes through AIM's national data center. The PA PQC had three initiatives in 2021: an expanded focus on maternal OUD, NAS, and contraceptive care, including access to immediate postpartum long-acting reversible contraception (LARC); Moving on Maternal Depression (MOMD) to improve prenatal and postpartum depression screening and follow-up rates and reduce associated racial/ethnic disparities; and the PA AIM initiative to adopt the PA AIM Bundle to improve severe hypertension in pregnancy treatment and reduce associated racial/ethnic disparities. Each of these initiatives have made considerable progress in improving the safety of pregnant and parenting people in Pa.

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 DOH, DHS and MIECHV annually (maternal health)

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 2020, the Department of Human Services (DHS) expanded home visiting services for all first-time parents, parents of children with additional risk factors and families who wish to be enrolled covered by Medicaid. These services will be provided in collaboration with the physical health Medicaid managed care organizations (MCOs). Numerous County Municipal Health Departments (CMHD) are contracting with MCOs to provide these services and others are considering this option. The MCOs or other referral source refer the expectant or parenting person to an evidence-based or evidence-informed home visiting program who will complete an assessment and determine the needs of the family. DHS is still working to evaluate the data from 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). OCDEL is a collaborative effort between the Pennsylvania Departments of Education and Human Services focused on improving systems so all children can reach their full potential. 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 idea of the effectiveness of the CMHDs home visiting programs as compared to the MIECHV Program. The outcomes for the first full year of data collection reported by the CMHDs were as follows: 10.5% of infants were born preterm following program enrollment; 81.1% 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 72.5% of home visits; 63.6% of caregivers were screened for IPV; and 80% of caregivers with positive screens for IPV received referral information. When compared to MIECHV data, the outcome measures for the CMHDs scored higher for four out of the five measures. The only measure to score lower was the percent of caregivers that were asked if they had concerns with their child's development, behavior, and learning. The CMHDs will continue to collect the five outcome measures, reporting them on a yearly basis.

BFH staff met with DHS and MIECHV twice in the past year, not meeting the goal of quarterly meetings. The intent of these meetings is to collaborate between agencies and programs to provide care to the people in Pa. Initial attempts at this collaboration were not as successful as hoped but BFH staff continue to pursue common goals to align work and improve the system of care available to the families served. To foster more productive collaboration, BFH staff will focus on specific MCH topics at each meeting to aid in shaping conversations going forward.

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 BFH priority to reduce maternal morbidity and mortality. In addition to existing work, the BFH is incorporating additional programming around community-based maternal care models, such as culturally concordant doula services for low-income birthing people. The BFH is also piloting a program to link birthing people with care in the early postpartum period, to reduce mortality rates for individuals in the year following childbirth. Finally, revitalization and reorganization efforts related to the state's Maternal Mortality Review Committee (MMRC) are ongoing and will increase capacity of the MMRC to make recommendations and for the BFH to implement those recommendations.

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 state's diverse maternal health initiatives, the BFH participates in both intra-agency collaboration with internally-administered programs such as PRAMS and interagency coordination with Departments with overlapping programmatic and/or population needs such as the DHS and the DDAP.

The BFH, in partnership with the University of Pennsylvania, will use Title V funding to support a targeted evaluation of the March of Dimes Supportive Pregnancy Care group prenatal care and educational programming model as delivered to pregnant persons between 15 and 24 years of age in Philadelphia in a hybrid virtual and in-person format by the Children's Hospital of Philadelphia.

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

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 provide a safe and supportive environment for their children. This support and education aim to improve the overall health and well-being of the families served, improve birth outcomes, and increase birth spacing.

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

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 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. However, BFH staff is assessing whether Title V home visiting services should continue to be a core service. As of July 1, 2020, the Department of Human Services, Medical Assistance (MA) Managed Care Organizations (MCOs) are required to offer home visiting services to MA eligible first-time parents,

parents/caregivers of children who have been identified as having additional risk factors or to any infant and the infant's parent/caregiver who requests these services. If BFH staff determines that Title V home visiting services are duplicative of the other available home visiting programs, a plan will be identified for each CMHD. Further, protocols will be put in place to ensure participants not covered by MA continue to receive home visiting services.

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

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 groups with higher risk of poor health outcomes.

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

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 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 remains high both across the nation and in Pa. The national rate of NAS per 1,000 birth hospitalizations was 6.1 in 2019 according to Healthcare Cost and Utilization Project State Inpatient Databases. In Pennsylvania the rate of NAS per 1,000 birth hospitalizations was two times higher than the national rate in 2019 at 12.9 NAS hospitalizations per 1,000 birth hospitalizations. According to the PA DOH's NAS surveillance data published in its 2019 Annual Report, among infants born in Pa. between January 10, 2019 and December 31, 2019, a total of 1608 cases of NAS were reported; 44 of these NAS cases were infants born at Lancaster County hospitals and birthing facilities, and 41 were Lancaster County residents. SUD also negatively impacts 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.

Albert Einstein Healthcare Network (AEHN) and WellSpan York will continue to offer expanded CPP to better accommodate the needs of the communities they serve. AEHN CPP focuses on providing behavioral health screenings, initial counseling, and making warm handoffs to behavioral health services as needed. A social worker functions as a patient navigator to connect CPP participants to the necessary resources including behavioral health services. WellSpan York will continue to help meet the needs of their community by providing a culturally and

linguistically competent CPP to Spanish-speaking birthing people in York county. This group is led by a program coordinator who is also a certified bilingual medical interpreter with a Spanish speaking physician responsible for oversight of the CPP cohorts. This dynamic builds trust and helps facilitate productive discussions during the group sessions.

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 reducing the incidence of maternal mortality and morbidity.

Strategy: Implement care models that include preconception and interconception care

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 who receive interconception care tend to have healthier pregnancies and lower-risk births, this strategy may help lower rates of maternal morbidity and mortality.

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

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, interprofessional, evidence-based approach to ICC. The ICC model 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 2,000 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 a minimum of two years to further 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. In the coming year, the BFH will continue to work with the University of Pennsylvania and the IMPLICIT Network to strengthen and expand the IMPLICIT ICC model of care throughout Pa. 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 due to historical marginalization, doula support has the potential to reduce health disparities and improve health equity. Unfortunately, culturally and racially concordant doula care is inaccessible for many pregnant people, due to financial constraints and the limited availability of doulas in communities where the majority of people live below the poverty threshold.

To address this need, the BFH is working on several programs to increase the number of community-based doulas that are being trained in communities at high risk for maternal and infant mortality. By connecting more pregnant people with higher risk of poor birth outcomes 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 inequities. 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) developed a Doula Support Program (DSP) tailored to the needs of 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' systems and make referrals; NAS education; and harm and stigma reduction for birthing people with SUD/OUD.

In addition to the PDPH DSP, the BFH issued an RFA in 2022 for Pa. communities with high rates of racial disparities in preterm birth and infant mortality 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 who are high risk for poor birth outcomes to access culturally safe and concordant care during pregnancy, labor, and the postpartum period. It will also increase the number of individuals from these communities who are trained and employed as community-based doulas, resulting in a positive economic impact for these individuals. The RFA for this community-based doula initiative will fund up to two three-year grants using Title V funds, with an anticipated start date of July 1, 2022.

Additionally, Delaware County Health Department (DCHD), which was established in January 2022, intends to

implement a doula program. Currently, the program is in the pre-development stage with plans to assess the availability and accessibility of doulas in the county, establish training needs and interest, and partner with local organizations and hospitals to develop a plan to best meet the doula services needs of the community.

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 Title V partners to ensure screening among pregnant and postpartum people for risk factors related to behavioral health.

Many of the CMHDs use 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.

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 result in maternal behavior change that may lead to improved health outcomes. Over the next year, the IMPLICIT Network will work to increase ICC screening rates across Pa., maintain or increase intervention rates for positive screens, and expand the IMPLICIT ICC model of care to new sites in Pennsylvania.

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. Title V partners 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.

The BFH continues its work 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. As such, the home visiting, Centering Pregnancy, and IMPLICIT programs will track the number of behavioral health services referrals made because of the positive screens.

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

Following 2018 recommendations from the American College of Obstetricians and Gynecologists, the IMPLICIT Network developed a new 4th trimester (4TM) model of care initiative to address gaps in postpartum care and decrease rates of maternal mortality in the early postpartum period. This model enables providers to identify birthing people who are at increased risk of postpartum health problems, 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, are being identified and addressed. Participating sites 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. Each year, at least 500 birthing people are expected to receive care through the 4TM initiative. A cohort of 250 people will be followed for a minimum of two years, to evaluate the effectiveness of the 4TM model of care. In the next year, the IMPLICIT Network will continue to support, strengthen, and expand the 4TM program in Pennsylvania and to standardize, collect, share, and analyze data regarding the people that receive screening, referrals, and follow-up care in the first month postpartum.

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.

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

Maternal death during pregnancy, childbirth, or in the postpartum period is a tragedy with a catastrophic impact on families. A thorough review of maternal death leads to determining recommendations to prevent future pregnancy-

related deaths. In January 2022, the MMRC published a legislative report documenting findings and recommendations resulting from the cases reviewed to date. Through this report, the MMRC recommended that Pennsylvania builds infrastructure to identify and support pregnant and postpartum individuals who have mental health concerns, use substances, and/or have a history of intimate partner violence. In addition, the MMRC recommended that Pennsylvania provides more comprehensive medical care for all pregnant and postpartum individuals. Although healthcare-related recommendations were shared with the Pennsylvania Perinatal Quality Collaborative (PA PQC) so that they may assist with implementation, some recommendations will require support from, and coordination with, other internal and external stakeholders.

In 2023, the BFH will work to identify partners to assist with implementing these recommendations; address barriers associated with implementation; and implement a minimum of one recommendation.

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

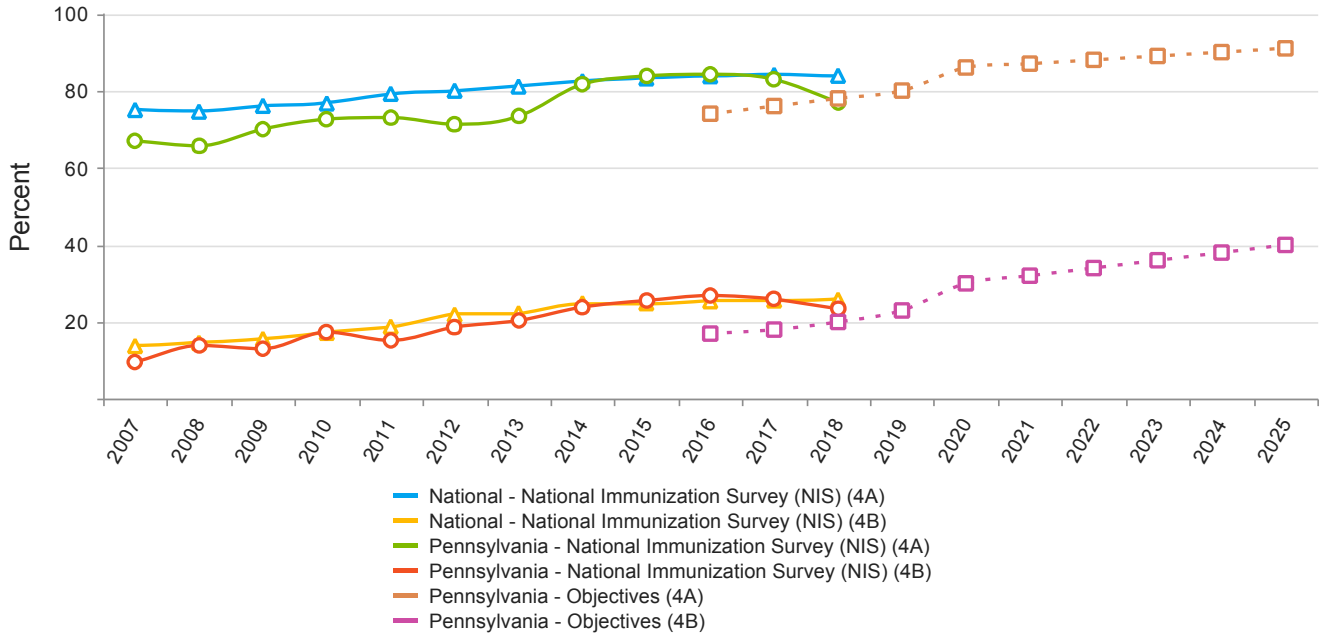
Effective collaboration and coordination are important to create a high-quality system of support for birthing people and families in Pa. Collaboration can increase service utilization through effective referral processes. Further, agencies that communicate with one another and share information can 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 focused 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 birthing people and those that are at higher risk of poor outcomes. 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

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	76	78	80	86	87
Annual Indicator	81.8	83.8	84.2	82.9	76.9
Numerator	108,050	111,838	113,497	105,668	95,850
Denominator	132,020	133,410	134,782	127,530	124,715
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	88.0	89.0	90.0	91.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	18	20	23	30	32
Annual Indicator	23.7	25.6	26.9	25.9	23.6
Numerator	30,174	32,912	35,760	32,327	28,555
Denominator	127,300	128,398	132,966	124,942	121,059
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	34.0	36.0	38.0	40.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			60
Annual Indicator			41.2
Numerator			21
Denominator			51
Data Source			K10 program
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			4
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

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

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

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		10
Numerator		
Denominator		
Data Source		agenda and meeting minutes
Data Source Year		2021
Provisional or Final ?		Final

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

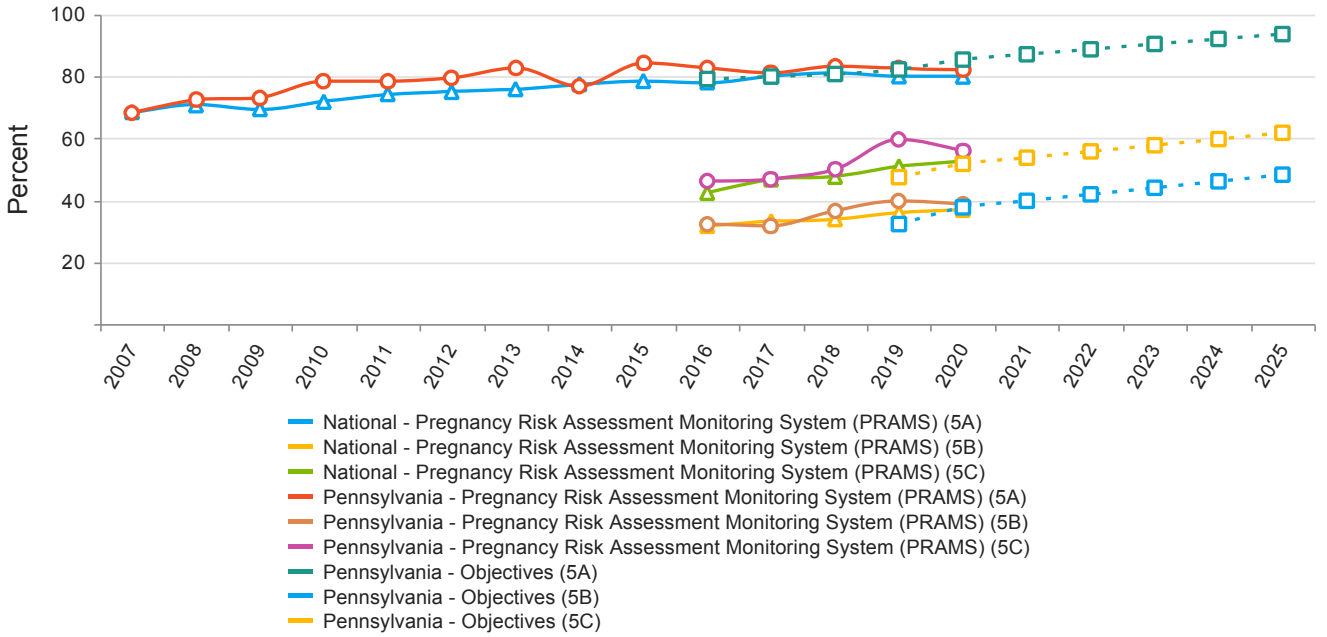
ESM 4.4 - Award 15 mini-grants to community partners to provide breastfeeding support.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		15
Numerator		
Denominator		
Data Source		quarterly vendor/grantee reports
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79.8	80.6	82.1	85.3	87
Annual Indicator	84.0	81.2	83.1	82.4	81.8
Numerator	110,308	103,722	104,542	101,724	98,852
Denominator	131,259	127,773	125,760	123,405	120,823
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	79.8	80.6	82.1	85.3	87
Annual Indicator	84	81.2	83.1		
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2015	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.6	90.3	91.9	93.5

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**	**2021**
Annual Objective		32.3	37.7	39.8
Annual Indicator	31.5	36.6	39.8	38.8
Numerator	38,141	44,262	46,940	45,339
Denominator	121,226	120,893	118,085	116,778
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			32.3	37.7	39.8
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	41.9	44.0	46.1	48.2

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**	**2021**
Annual Objective		47.4	51.7	53.7
Annual Indicator	46.9	50.1	59.5	56.0
Numerator	56,601	60,875	70,513	65,435
Denominator	120,631	121,402	118,424	116,863
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			47.4	51.7	53.7
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	55.7	57.7	59.7	61.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			0
Numerator			
Denominator			
Data Source			infant program that implements recommendations
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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					
	2017	2018	2019	2020	2021
Annual Objective	2	3	3	0	0
Annual Indicator	6	6	6	0	5
Numerator					
Denominator					
Data Source	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	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	3.0	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					
	2017	2018	2019	2020	2021
Annual Objective	0	8	9	18	9
Annual Indicator	3	8.6	17.4	0	36.1
Numerator		11,639	23,337		47,314
Denominator		135,498	134,091		131,006
Data Source	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	grantee quarterly reports and annual birthing data
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
2022	2023	2024	2025	
Annual Objective	37.0	39.0	20.0	0.0

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	0	2	4	8	8
Annual Indicator	2	1.9	8.9	0	32.5
Numerator		2	9		27
Denominator		107	101		83
Data Source	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	grantee quarterly reports, birthing hospital count
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.0	38.0	40.0	0.0

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

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		0
Numerator		
Denominator		
Data Source		PPOR vendors quarterly and annual reports
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			70.5
Annual Indicator			64.6
Numerator			197
Denominator			305
Data Source			Pennsylvania newborn screening data system
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	71.0	71.5	72.0	72.5

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 2021, the DNSG received Health Resources and Services Administration (HRSA) funding for activities related to newborn hearing screening.

Three laws 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.

Pa. experienced hospital closures and an expansion in midwifery services during the pandemic and ended 2021 with 92 birthing hospitals/free standing birthing centers and 113 midwives performing deliveries. Based on newborn screening data, 135,881 infants were born in Pa. in 2021, with 96.2% of births occurring in hospitals and free-standing birth centers, and 3.8% of births occurring in other settings (e.g., clinic/doctor's office, home birth), a slight increase in home births over the previous year. Newborn screening encompasses three types of screenings: dried blood spot, hearing, and critical congenital heart defects (CCHD). In 2021, the DNSG's contracted laboratory, PerkinElmer Genetics, performed 135,557 (99.7%) initial dried blood spot screenings. The number of infants receiving a hearing screening in 2021 was slightly less at 131,750 (97%). In addition, 131,983 (97%) 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 2021, 324, or 0.3% of Pa. 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. remained at 5.9 per 1,000 live births in 2019. The rate for Black infants was 12.7, more than two times the goal of 5.0 for Healthy People 2030. The rate for Black infants was higher than the rate for Latinx infants (5.9), which also did not meet the Healthy People 2030 goal, and nearly triple the rate for white infants (4.5). In 2019, 9.6% of Pa. babies were born prematurely. The rate of low birth weight babies was 8.3. Health disparities persist again when stratifying the rate by race and ethnicity: Asian/Pacific Islander (8.8) Black/African American (14.4), Latinx (9.1), white (7.0), and multi-race (10.4)

Nearly half of the 2019 deaths (most recent year complete data is available) reviewed by local Child Death Review (CDR) teams were deaths among infants. There were 382 total infant deaths reviewed, representing 46.4% of all cases reviewed. Prematurity remains the leading cause of death for infants. Of the total 382 infants' deaths reviewed, 162 (42.4%) were due to prematurity. An examination of Pa.'s reviewed infant deaths for 2019 revealed that 67 (7.8%) of the 854 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. Many teams were unable to

complete a review of all children's deaths occurring in 2019 due to COVID-19 mitigation efforts which impacted the ability of teams to meet and some key team members capability to devote time and resources to CDR.

In 2021, the BFH participated in Cohort 2 and started Cohort 3 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 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.

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 implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within PA birthing facilities

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

ESM: Percent of facilities that progressed by one or more steps 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 2021, 88 of Pa.'s 92 birthing facilities were engaged in the K10 Initiative. The program's goal was for 60% of eligible K10 facilities to complete at least one step by the end of 2021. This goal was not met, as only 41% (21 of 51 eligible facilities) completed at least one step. However, results show that facilities are still actively working on steps in a year when many hospitals and birthing facilities dealt with issues surrounding COVID-19 mitigation efforts and staffing shortages, which made finding resources to submit K10 steps more challenging. Additionally, 37 of the 88 K10 facilities have completed all 10 steps and are K10 designated, meaning they that they are no longer completing 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 designated as Baby-friendly in comparison to mothers who delivered at a facility where at least six of the ten steps were followed. After the completion of the seventh year of the initiative, 52 hospitals have implemented six or more steps and 37 of those hospitals have completed all ten steps of the K10 Initiative.

Facilities participating in the K10 Initiative have been grouped into five regions and participate in regional biannual collaborative meetings. The 2021 collaborative meetings focused on an overview of the K10 and First Food programs. 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.

The most common K10 barriers recognized continue to be 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 37 K10 designated facilities available to offer guidance to the other K10 facilities. The COVID-19 pandemic and mitigation efforts remained a barrier in 2021 as all technical support, collaborative meetings and trainings were still not able to take place in person. Fortunately, K10 staff were able provide support and host events in a virtual format so that K10 hospitals could continue to access the necessary support and resources.

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.

The PA Breastfeeding Awareness and Support Program and the Safe Sleep Program met four times over the course of 2021: July 8, August 30, October 18, and December 18 to discuss and implement possible collaborative and educational efforts between the programs. Collaborative and cross educational actions taken over the course of 2021 included: the addition of the Safe Sleep Program coordinators and grantees to the Breastfeeding Awareness and Support Program's First Food Breastfeeding monthly newsletter, allowing all staff to stay up to date on current breastfeeding news and efforts; creating cross educational material on preventing SIDS through the intersection of safe sleep practices and breastfeeding for dissemination on social media; and, sharing safe sleep resources to First Food's breastfeeding community partners via their monthly newsletter and social media platform.

Future action steps discussed in these meetings included providing cross educational presentation opportunities at upcoming breastfeeding collaborative meetings and a continued emphasis on providing educational information and resources via the monthly First Food newsletter and social medial platforms.

Strategy: Collaborate with community-based organizations to increase the 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 2021, PA AAP collaborated 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 conducted 10 regional collaborative meetings in 2021. These biannual collaboratives educated and supported birthing facilities and community partners on breastfeeding best practices and policies as well as the Department's K10 Initiative. These collaboratives also served as an avenue for professionals to network and brainstorm with peers to share knowledge and promote collaboration. Regions are the Southwest, Southcentral, Southeast, Northwest, and Northcentral/Northeast. Special topics discussed at the 2021 collaboratives included: addressing health disparities and encouraging equity in the breastfeeding community, engaging fathers and partners in breastfeeding, and supporting breastfeeding people in their return to work and school.

PA AAP also provided breastfeeding educational opportunities to community partners in 2021. These opportunities included providing breastfeeding literature and resources on the newly created First Food website and social media platforms, a statewide breastfeeding outreach event for Mother's Day, and a webinar on health equity and breastfeeding.

Lastly, PA AAP awarded 15 mini-grants to community partners to provide breastfeeding support and education based on demographic needs. All applications were reviewed and scored by a grant review team, which included representatives from the program. The selected mini grants had representation from each region in Pa. and focused on increasing breastfeeding initiation and duration rates. Projects of note include: a mini grant through the Wright Center in Lackawanna County which focuses on increasing breastfeeding rates among mothers with substance use disorders; a mini grant through the Mitzvah Center in Chester County which focuses on providing peer to peer support for breastfeeding parents; and, a mini grant through the Pettaway Pursuit Foundation which focuses on providing a pathway for Black, Indigenous, and people of color (BIPOC) certified lactation consultants in the Greater Philadelphia area to obtain the clinical knowledge necessary to become International Board Certified Lactation Counselors.

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

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)

Another tool being utilized to address infant mortality rates is data from the local Child Death Review (CDR) teams. Each team makes prevention recommendations based upon findings from reviews of deaths determined to be preventable and reports those recommendations to the BFH. In 2021, the State CDR Team implemented a new prevention recommendation framework. 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 and those strategies are assessed for effectiveness and feasibility. Selected strategies are presented to entities who have the capability to implement/lead prevention strategies or are already involved in developing/ implementing similar prevention strategies.

The actionable recommendations from local teams concerning infant deaths 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.

In 2021, the framework was unable to identify an actionable recommendation for the infant health domain. The framework will continue to be utilized, and when a relevant recommendation is made, BFH staff will work together to implement as appropriate. In addition to providing training to local CDR teams to enhance the quality of recommendations, BFH has partnered with East Stroudsburg University to assess functioning of local CDR teams and data quality. The assessment will lead to the development of a training and technical assistance plan to improve the performance of local CDR teams including the development of viable recommendations.

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 3% 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

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 initial grant period with the Trustees of the University of Pennsylvania ended and a new three-year grant period (July 1, 2021 to June 30, 2024) began for the infant safe sleep initiative during 2021. The grantee was fully engaged in recruitment and implementation in 2021 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 2021, despite the ongoing pandemic, safe sleep work generally continued without significant adverse impacts. In 2021, the grantee pivoted from in-person recruitment and training to a virtual platform with minimal challenges. In 2021, the grantee faced challenges associated with the nursing shortage and the ability to train all staff at a hospital in one live session. As a result, the grantee began offering multiple sessions of the training and opened them to participants from multiple hospitals. The grantee reported positive outcomes as participants were able to engage in peer-to-peer learning.

By the end of 2021, the hospital-based model safe sleep program was fully implemented in 27 of the 38 (36%) birthing hospitals which exceeded the ESM goal of 20% of birthing hospitals with implementation. Over 47,000 infants or 36% of the births in 2021 had parents who received safe sleep education through the model program exceeding the 25% ESM goal.

It is important to note that since the ESMs were developed, both the number of birthing hospitals and annual births have declined. There is no doubt that the high-quality program development by the grantee and ongoing support of participating hospitals has been instrumental in 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 three for 2021 due to the current grant period that began on July 1, 2021. The grantee exceeded the goal ending the year with five hospitals recruited to implement the model safe sleep program in the next year. The grantee was even able to recruit and begin implementation for one hospital during 2021 due to strong commitment from the hospital and grantee.

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. The ESM related to social marketing messaging was ended in 2020, however, the grantee continued the campaign into 2021 and disseminated 43 messages.

At the end of the initial grant period during 2021, the grantee concluded the social marketing campaign. While the social marketing campaign was well received, the inability to link outcomes in any meaningful way to the NPMs or NOMs or shift to a clearly evidence-based strategy indicated opportunities for more responsible use of the funding.

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 number of targeted prevention initiatives or interventions implemented utilizing PPOR data

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

To address 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.

Using Title V funds, the Montgomery County Health Department (MCHD) completed a 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 focused 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 focuses 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 2021, the BFH awarded Title V-funded grants to the Maternal and Child Health Consortium of Chester County (MCHC), Allegheny County Health Department (ACHD), and the Philadelphia Department of Public Health (PDPH) to conduct PPOR studies in their local communities. Although each organization began the six-stage PPOR process in January 2021, they are operating under timelines unique to their circumstances and plans. In 2021, both PDPH and ACHD made significant progress toward completing the first two stages of the PPOR process, which are focused on analyzing linked vital record data, identifying the period(s) of risk that has the largest opportunity gaps, and using key informant interviews and/or community focus groups to identify which causes and factors contribute most to gaps and disparities. Through their efforts, they determined that the greatest proportion of preventable feto-infant deaths, and the highest racial disparities occur during the Maternal Health/Prematurity period. This suggests that reducing the distribution of very low birthweight infants would help reduce overall infant mortality rates and disparities for these communities. The third grantee, MCHC, was unable to complete these analyses during 2021 due to delays they experienced in receiving vital records data from the Pennsylvania Department of Health's Bureau of Health Statistics and Registries.

None of the PPOR projects initiated in 2021 have finalized or begun implementation of their community action plans. Once the first stages of the PPOR process are complete, grantees will work with their PPOR community stakeholder groups to select, develop, and implement action plans to address specific drivers of feto-infant mortality and improve

local birth outcomes, particularly for Black/African American birthing people and their infants. These community action plans must each include at least three targeted, evidence-based, or evidence-informed prevention initiatives or interventions for implementation that are rooted in an antiracist, life-course framework. The plans, once completed, will describe each grantee's selected initiatives and interventions and a projected timeline for completion.

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

Strategy: Review and analyze data from iCMS to identify submitters (birthing hospitals, birth centers, and midwives) 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 requested repeat filter papers as a concern. In 2021, data indicates that 98% (8120/8307) of the requested repeat filter papers were collected. Repeat specimens may be required because the initial specimen was unacceptable for testing or inconclusive results were found. If a repeat filter paper is required, PerkinElmer Genetics (PEG) contacts the submitter (hospital, birth center, or midwife) to facilitate the repeat specimen collection. In some instances, the primary care physician is notified by PEG. The DNSG also provides case management when a repeat filter paper is requested. Case management includes letters, faxes, emails, and phone calls to physicians and families.

The Nursing Services Consultant (NSC) monitors a report which identifies requested repeats not obtained. In addition, the NSC reviews every case closed without a requested repeat to ensure appropriate case management by the CHN. The NSC also provides technical assistance to the submitter if made aware of non-responsiveness from the CHN. 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.

The NSC also monitors two additional monthly reports. The first report itemizes the unacceptable filter papers received, by submitter, with the reasons the specimen was rendered unacceptable, which leads to repeats being requested. The second report identifies filter papers that were missing essential information (and the specific information) at the time of submission by submitter, which leads to delays in reporting. The NSC provides hospitals with their individual reports monthly, while providing technical assistance. Providing individual reports to submitters leads to on-site review of trends and education/re-education of staff. Also, in 2021, after multiple inquiries about how to correctly complete a metabolic screen filter paper, the DSNG developed a document titled Filter Paper Completion Guidelines, detailing the various sections of the filter paper with information on how to correctly complete each section. This document was posted to the newborn screening page on the PA DOH website as a provider resource, emailed to all hospitals and birth centers, and mailed to all midwives. Additional education and technical assistance were provided by DNSG staff who met with midwives and physicians servicing the Plain community at the Central Pennsylvania Clinic in Belleville to discuss unique challenges in obtaining repeats and minimize the need for repeat filter papers.

The BFH developed a SPM that mirrors national outcome measure (NOM) 12. The SPM, percent of newborns receiving an on-time report out for an abnormal result, is also linked to the ESM, because without a repeat filter paper, there is no on-time report out or physician follow-up. During 2021, the DNSG began monitoring and collecting programmatic data related to this indicator and will use this baseline data to track progress and improvement at the state level.

PEG modified an existing report to include the initial call out date. The NSC monitors this report on a quarterly basis to ensure initial call out dates are noted and compares data for random cases to the documentation in the web-based case management system (iCMS). If dates are missing or mismatched on both reports, the NSC alerts the laboratory. Significant improvement in documenting initial call out date for out-of-range results has been noted since this process was implemented.

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

The ESM identifies newborns born in Pennsylvania to ensure they receive an initial newborn screening. Without DBS screening, potentially devastating conditions present at birth may go undetected until the infant becomes symptomatic. The baby's development may already be affected by the time symptoms appear, and some of the conditions screened can be life threatening if treatment is delayed.

The DNSG has a data share agreement with the Vital Records Registry to identify newborns with a birth certificate but without documentation of the DBS screening in iCMS. The CHN provides case management services, which includes contacting the families and birth facility to notify both parties of the missed DBS screening. In addition, technical assistance is provided by the NSC, which includes education to birth facilities to inform them of the importance of timely screening and screening verification. As a result, in 2021, 0.3% of all babies born in Pennsylvania did not undergo newborn DBS screening. The data share gives the DNSG access to review cases missing filter papers and identify the reason(s) for the infant not having been screened, such as missed, transferred, parent refusal, expired, and non-resident.

In 2021, a pre-existing online newborn screening education module, with a focus on timeliness, was updated and posted on TRAIN PA website and is available to providers. This module, previously funded by NewSTEPs, was originally completed by the University of Pittsburgh via an intergovernmental agreement with the DNSG in 2019.

The DNSG continues to release a quarterly newborn screening newsletter. The newsletter provides submitters 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 to re-enforce the need of complete and timely newborn screening.

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 a sudden unexplained

infant death (SUID) to the child death review (CDR) program 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 the CDR program for collaboration between programs four times per year

The DNSG and Division of Bureau Operations (DBO) entered into a data sharing agreement to begin analyzing data submitted to the CDR program 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 program 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. The DNSG and DBO were not able to complete a data match and review of the 2020 CDR cases due to the 2020 CDR data not being finalized until March 2022. The data match completed in 2019 did not identify any correlation between CDR cases and missed CCHD screenings. Several of the CDR cases were appropriately excluded from CCHD screening due to the infant's weight at the time of birth being less than 1500 grams.

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

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: Increase access to and use of Child Death Review 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: Increase percent of prematurity cases reviewed by local CDR teams that include identification of the underlying causes of death by 5% each year

Many local CDR teams were unable to meet consistently in 2021 due to COVID-19, impeding the ability to meet this ESM. Of the deaths occurring in 2019, local CDR teams reviewed and entered 282 infant deaths due to prematurity. Of the deaths occurring in 2020, local CDR teams reviewed and entered 208 infant deaths due to prematurity. Due to lags in teams meeting, the review and data entry of 2020 prematurity deaths may not be complete.

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

Scheduling a training for local CDR teams on identifying the underlying causes in prematurity deaths has been delayed due to securing access to a virtual training platform that is easily accessible for partners without Microsoft Teams. Training objectives and a presenter to facilitate have been identified and the training will be scheduled in 2022. The participants will be able to:

- Identify risk factors in preterm births.

- Define how health inequities and disparities impact preterm births.
- Match prevention strategies to reduce preterm births.

Local CDR teams were provided with written materials on effective reviews from the National Center for Fatality Review and Prevention, including review tips and prevention ideas on infant deaths resulting from prematurity. These materials have recently been updated and will be shared with local CDR teams.

I. Overview of Approach to Infant/Perinatal Health Domain

To promote positive infant health outcomes and well-being across the life course, the 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 reducing, or even eliminating, the effects of the condition.

II. Other Federal Funding and State-Funded Activities/Future 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%. Breastfeeding individuals 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

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, individuals 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 per year to discuss possible collaborations, such as joint promotion and education, outreach, and media and marketing efforts.

The programs will provide further education on safe sleep practices and breastfeeding to attendees of the PA Breastfeeding Awareness and Support Program's biannual First Food collaborative meetings, which provide breastfeeding education and resources to medical and community partners across the state. By combining resources and efforts, these programs will serve a larger population statewide.

The BFH will provide further statewide cross education opportunities by holding quarterly meetings between The PA Breastfeeding Awareness and Support Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to discuss collaboration potential between the programs on joint promotion, education, outreach, and media and market efforts. This will ensure that parents enrolled in Pa.'s WIC program receive cross education on breastfeeding and safe sleep practices via a variety of programs and resources.

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

PA AAP was awarded grant funding in the summer of 2020 to administer a program to increase breastfeeding support and awareness statewide and the program officially started in October of 2020. In 2023, 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.

Future planned educational opportunities include public library breastfeeding story kits that will engage and empower community partners utilizing libraries as meeting spaces to promote and support breastfeeding in their communities and webinars on breastfeeding in the workplace, breastfeeding and breast milk in childcare facilities, and gender and LGBTQ+ inclusive best practices for breastfeeding/chestfeeding

PA AAP will conduct 10 regional collaborative meetings each year. These biannual collaboratives will educate and support birthing facilities and community partners on breastfeeding best practices and policies as well as the K10 Initiative. They will also serve as an avenue for professionals to network, share knowledge, and collaborate with their peers. The regions are the Southwest, Southcentral, Southeast, Northwest, and Northcentral/Northeast. By hosting the collaborative meetings regionally, each region's specific needs and barriers are the focus. 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 beyond the control of practitioners, but sleeping safety is 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: 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)

In 2023, the BFH will continue to utilize data from the local Child Death Review (CDR) teams to inform the prevention recommendation framework.
Recommendations for deaths determined to be preventable will be reported to the BFH and implemented as appropriate.

A template and process for sharing recommendations from local CDR teams were developed, piloted, and received feedback. The feedback primarily addressed the quality of recommendations from local CDR teams, many of which lacked the necessary specificity to make them viable. Training to assist teams develop stronger recommendations will be offered in regional meetings.

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 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 2023, 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, so 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 challenges identified in 2020 and 2021, the grantee modified in-person training sessions to live online sessions. In 2022, the grantee will work to create self-paced online modules to meet the needs of smaller hospital and other challenges identified with the nursing shortage. The online modules are anticipated to be fully operational in 2023.This shift not only meets the needs of the hospital now but will create lasting resources and potential future cost savings.

The hospital-based model program will be available for implementation in hospitals that serve infants but do not have a post-partum unit, following demand from 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.

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. Preterm birth and low birth weight are two primary causes of infant mortality; Pa.'s infant mortality rate for Black/African American infants reflect the racial disparity evident in these other markers. Pa. Perinatal Periods of Risk (PPOR) studies provide an analytic framework for studying racial disparities in fetal and infant mortality rates in urban communities. The PPOR process uses vital records to categorize fetal and infant deaths into four periods of risk based on birthweight and age at death. These factors then correspond to specific factors associated with birth outcomes, which determine the period(s) of risk with the most disparity in deaths. 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 currently or formerly pregnant people and other community members took place in 2021, and more are scheduled for 2022.

In the coming year, BFH will continue to partner with the Maternal and Child Health Consortium of Chester County, the Allegheny County Health Department, and the Philadelphia Department of Public Health to identify and address specific, local drivers of feto-infant mortality using the PPOR framework. Each grantee will develop a community action plan for perinatal health, based on the results of their PPOR study, that includes at least three evidence-based or -informed prevention interventions or initiatives that address racial disparities in feto-infant mortality. The three grantees are expected to implement their action plans, evaluate the results, and expand selected 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

A repeat filter paper for newborn screening can prove crucial for timely diagnosis 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. 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 Health Resources and Services Administration (HRSA) recommends newborn screening (NBS) time-critical conditions should be reported out within five days of life, and all results (normal and out-of-range) from first specimens should be reported out within five days of specimen receipt by the DNSG laboratory, PerkinElmer Genetics (PEG). PEG made changes to an existing report in 2021 capturing initial report out dates. PEG geneticists are expected to include the first report out date to the laboratory results page on the DNSG's web-based Case Management System (iCMS), a software application designed to track and manage newborn screening results and follow-up processes. The laboratory results page is the source document from which initial report out dates are pulled for iCMS generated reports. The Nursing Services Consultant will review the report quarterly and report any identified missing dates or timeframes exceeding HRSA recommendations to PEG.

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 requested repeat filter papers as a concern. In 2021, data indicates that 98% (8,120/8,307) 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'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 by 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, infants 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. 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 entered into a data sharing agreement to analyze 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 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 with a confirmed CCHD are to 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.

In addition to completing a SUID to CCHD quarterly data match, the programs also plan on matching 2021 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 Pennsylvania 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 as the parent education they provide can be influential in the parent's decision on whether to proceed with future DBS screening. 2021 SUID cases will be matched to 2021 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 total 382 infant deaths reviewed in 2019 (the most recent data available), 162 (42.4%) 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.

The 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.

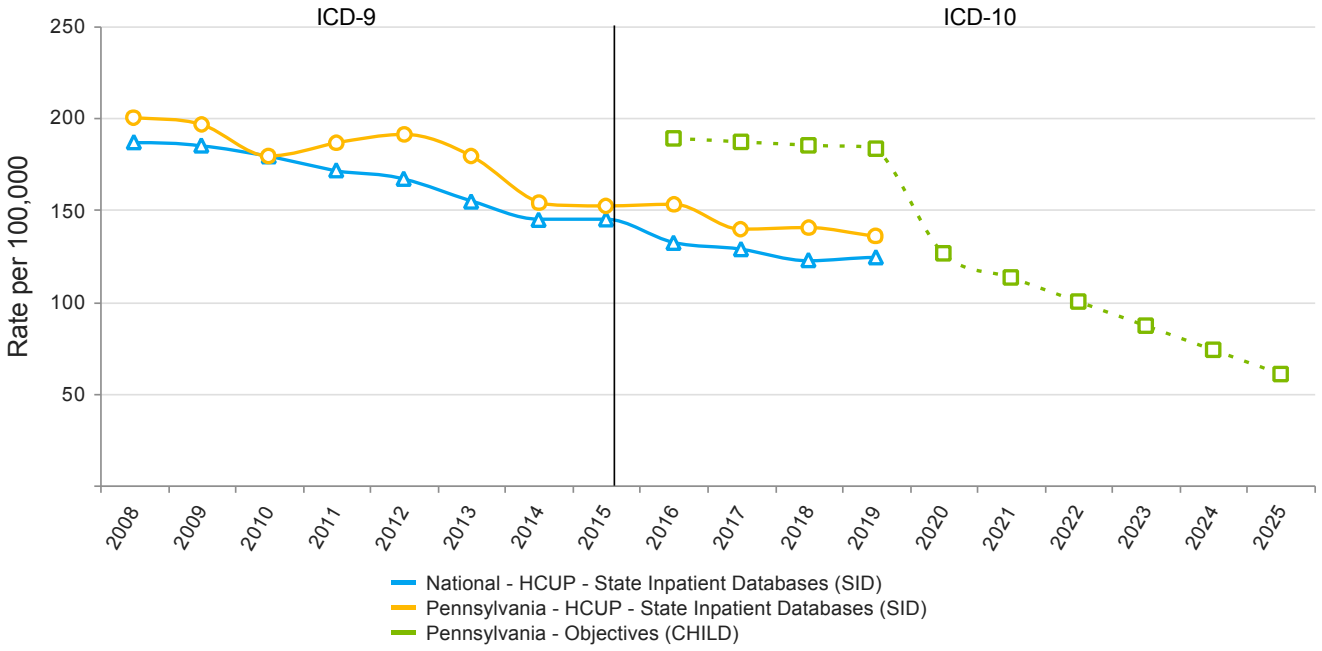
To strengthen local CDR teams' ability to identify the underlying causes of infant deaths due to prematurity, the BFH will develop guidelines to assist local CDR teams in their reviews of these cases. Annually, the BFH will provide training on the guidelines to local CDR teams. Training can be delivered 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

National Performance Measures

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Indicators and Annual Objectives



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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	186.8	184.9	183.1	126.2	113.1
Annual Indicator	152.0	152.5	139.4	139.8	135.4
Numerator	1,654	2,201	2,004	1,997	1,928
Denominator	1,088,130	1,443,388	1,437,802	1,428,611	1,423,977
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	100.0	86.9	73.8	60.7

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			0
Numerator			
Denominator			
Data Source			child program areas implementing recommendations
Data Source Year			2021
Provisional or Final ?			Final

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

ESM 7.1.2 - Number of ConcussionWise trainings to athletic personnel

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			30
Annual Indicator			15
Numerator			
Denominator			
Data Source			quarterly grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	32.0	34.0	36.0	38.0

ESM 7.1.3 - Number of comprehensive in-home child safety education visits.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	180.0	90.0	0.0

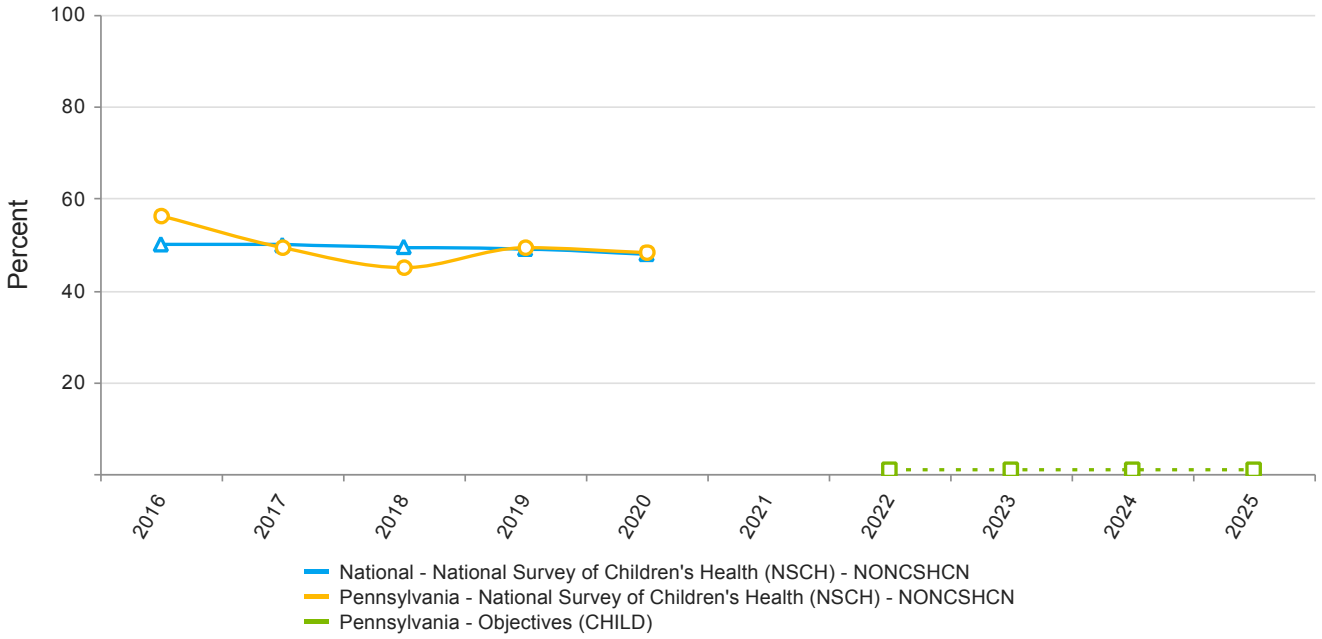
ESM 7.1.4 - Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	900.0	450.0	0.0

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	**2021**
Annual Objective		
Annual Indicator	49.3	48.3
Numerator	1,027,215	985,573
Denominator	2,085,050	2,039,338
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2018_2019	2019_2020

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

State Provided Data			
	2019	2020	2021
Annual Objective			2
Annual Indicator			0
Numerator			
Denominator			
Data Source			CSHCN programs implementing recommendations
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	4.0	5.0	6.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			475
Annual Indicator			302
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	498.0	523.0	549.0	576.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator			20
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	52.0	0.0	0.0	0.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator			22
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			40
Annual Indicator			0
Numerator			
Denominator			
Data Source			Philadelphia Department of Public Health
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	43.0	46.0	46.0	49.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			6
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator			103
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	110.0	115.0	120.0	125.0

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			500
Annual Indicator			315
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	515.0	530.0	545.0	560.0

ESM 11.9 - Number of calls received through the SKN Helpline

Measure Status:	Inactive - Logging of SKN calls will continue to be reporting via Form 7.

State Provided Data			
	2019	2020	2021
Annual Objective			800
Annual Indicator			396
Numerator			
Denominator			
Data Source			SKN call logs
Data Source Year			2021
Provisional or Final ?			Final

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator			43
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			40
Annual Indicator			137
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	44.0	48.0	52.0	56.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			15
Annual Indicator			11
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	19.0	23.0	27.0	31.0

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		11.2
Numerator		3,592
Denominator		31,964
Data Source		quarterly vendor/grantee reports
Data Source Year		2021
Provisional or Final ?		Final

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

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
ESM 7.1.3 - Number of comprehensive in-home child safety education visits.	Active
ESM 7.1.4 - Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits.	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	Inactive
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 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 1,907 deaths of children 21 years of age and under in 2019 (most recent CDR data available). Of the total deaths, 824 (43.2%) were reviewed. Slightly less than half (46.4%) of all deaths reviewed were infant deaths. Children 18 through 21 years of age accounted for 29.6% of child deaths reviewed. Combined, these two age groups represented 76.0% of all child deaths reviewed in Pa. in 2019.

In Pa., the rate of death for Black/African American children increased from 88.5 per 100,000 population in 2018 to 91.7 per 100,000 population in 2019. Nationally, for the same time, the rate increased for Black/African American children from 88.6 per 100,000 to 90.2 per 100,000. Black/African American children continue to die at a rate nearly twice that of white children.

While the national rate remained relatively flat in 2019, the Pa. rate saw a slight decrease in the rate of death for white children. The Pa. rate was 44.8 per 100,000 population in 2019 compared to 46.5 per 100,000 population in 2018. In 2019, the national rate of death for white children was 46.1 per 100,000 population and in 2018, the rate was 47.0 per 100,000 population.

The rate of death for Asian/ Pacific Islander children residing in Pa. decreased from 37.4 per 100,000 population in 2018 to 31.0 per 100,000 population in 2019. The national rate for this same population decreased in 2018 from 33.5 per 100,000 population to 31.9 per 100,000 population in 2019.

Of the 97 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent cause of death was cancer, which was identified in 15 cases (15.5%). In the 101 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 29 cases (28.7%). Assault, weapon, or person’s body part includes causes of death involving firearms, sharp instruments, or when a person’s body part has been used as a primary means of the assault or injury. The 244 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 75 cases (30.7%).

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. Due to COVID-19 mitigation efforts beginning in March 2020, many of Pa. CDR teams were unable to meet. Teams may not have been able to complete reviews of 2019 deaths timely. Most teams have resumed regular meeting schedules and continue to work toward full case review levels. Plans for an Annual Resource Building Summit for local CDR teams were postponed again. 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.

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 2020 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 families whose incomes are below the federal poverty threshold. 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 two times lower than the share of white children in the population.

In 2021, lead abatement or remediation efforts continued through the federally funded Lead Hazard Control Program (LHCP). The grant, through the Department of Housing and Urban Development (HUD), runs from 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 communities.

The department worked with local partners across Pa. in areas with older housing stock, and in some instances, elevated blood lead levels, to identify and remove lead hazards in housing units occupied by families with children six years of age and under, whose incomes are below the federal poverty threshold. 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.

In 2021, the LHCP held a total of 15 events educating the public about lead exposure and lead poisoning as well as the LHCP and its benefits to families and the community. Fifty-one units were evaluated for LHCP services; of those evaluated, 13 homes have been remediated making them lead safe.

The LHCP also participated with the Section 3 program. The Section 3 program requires that recipients of certain HUD financial assistance programs provide training, employment, contracting, and other economic opportunities to persons whose incomes are below the federal poverty threshold, especially recipients of government assistance for housing, and to businesses that provide economic opportunities to this population. Recipients of HUD financial assistance and their contractors and subcontractors are required to provide economic opportunities, to the greatest extent possible, consistent with existing Federal, State, and local laws and regulations. As of today, LHCP partners have provided over 200 working hours of training and employment to persons who are eligible for the Section 3 program.

Furthermore, efforts to reduce lead exposure and lead poisoning in children continued through the Childhood Lead Poisoning Prevention Program (CLPPP). Using funds received from the Centers for Disease Control and Prevention

for a four-year grant (September 2017 through September 2021), 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 another five-year grant (September 2021 through September 2026) to continue implementing lead poisoning prevention strategies and activities. The CLPPP will continue to partner with local health departments to ensure blood lead testing and reporting, enhance blood lead surveillance, and improve linkages of lead-exposed children to recommended services. 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. In the past year, the group has been committed to the development and implementation of several initiatives. In addition to the creation of a toolkit and county specific fact sheets, the Lead-Free Promise Project, a coalition of more than 45 organizations, was established. The coalition's goal is to get all children tested at age one and age two and ensuring all poisoned children are referred to Early Intervention Services.

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 uses the Healthy Families America (HFA) Program to educate parents and families on the importance of well child visits, child development, safety, and nutrition. In 2021, the HFA program enrolled and served over 100 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 2021, PDPH served 47 youth through this program.

Children in Pa. are also increasingly experiencing trauma and adverse childhood experiences (ACES) early in life. As of 2019-2020, 20.8% of children in Pa. had experienced at least one ACE and ACES were most 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 that developed a plan to make Pa. a trauma-informed, healing-centered state with the following priorities: building a network to connect and support community-based, grassroots movements across the commonwealth, prioritizing changes at the state level to affect culture, policy, and practice, healing from the trauma of a major disaster like the COVID-19 pandemic, and healing the damage of racism, communal, and historical trauma.

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

This ESM sought to establish a baseline of children without a medical provider or insurance seen by Community Health Nurses at State Health Centers across the state, as well as the number of those children referred to a medical home within six months. However, due to staff time being diverted to address the COVID-19 pandemic as well as a lack of clarity on how and what should be tracked, data collection was not implemented, and the ESM target not met.

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)

The state CDR Team implemented a new prevention recommendation framework. 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 Pennsylvania and other jurisdictions and best practices. This work will culminate in the development of a white paper for each type of death examined through the prevention framework. The white papers will serve as vehicles for sharing prevention strategies with partners that are positioned to act. The first type of death the team agreed to examine was Motor Vehicle Accidents. The state team reviewed death data and other injury data, discussed prevention practices currently in place within the state and identified potential partnerships to focus on these types of deaths/injuries. The white paper for Motor Vehicle Accidents is being drafted and feedback from the State CDR Team will be sought during the June 2022 meeting.

In 2021, there were no state-level recommendations from the CDR teams for Title V staff to review for implementation related to child health. While the CDR teams continued to move forward with death reviews, they did not result in actionable recommendations at the state level.

The BFH contracts with the Philadelphia Medical Examiner's Office (MEO) to conduct the Sudden Death in the Young (SDY) case registry. The MEO is responsible for identifying cases in Philadelphia, reviewing the deaths via its Child Death Review Team and Advanced Review Team, and entering the data learned from the reviews into the National Case Reporting System. The review teams' meetings serve to identify underlying causes and risk factors associated with the sudden and unexpected deaths in children birth to age 20 years and to use that information to address infant and child mortality through prevention efforts. The families of the deceased are given an opportunity to consent to have the child's deoxyribonucleic acid (DNA) samples used for research or DNA banking which are stored at the SDY Biorepository. Of the 58 identified cases in 2021, 13 families (22.4%) 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. The opportunity for further research enhances prevention efforts at the local level and has the potential to reduce mortality rates for these deaths on a national level. BFH is anticipating receiving recommendations resulting from the SDY reviews.

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

The BFH 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. To achieve this goal, the SYSP uses the Sports Safety International's ConcussionWise Training curriculum. Each training is delivered by a certified ConcussionWise Instructor. Target personnel included medical providers, school and club coaches, school nurses, parents, athletes, and students.

In 2021, the program's grantee, The Pennsylvania Athletic Trainers' Society (PATS), continued to face significant barriers due to the COVID-19 pandemic. Recruitment of new and existing ConcussionWise Instructors stagnated as the primary focus was on the prevention and reduction of COVID-19 infections in student athletes. Scheduled trainings were often cancelled or postponed due to COVID-19 related school closures and cancellations of athletic activities. Despite these challenges, the program adapted trainings to be delivered virtually. A total of 38 trainings were conducted for diverse populations and reached 604 individuals. However, only 15 trainings were provided to athletic personnel, short of the goal of 30 trainings.

Strategy: Provide comprehensive home assessments to identify potential home health and safety hazards

Strategy: Provide home-safety interventions such as integrated pest management and preventive safety devices to address the leading causes of child injury and death

Objective: Increase the number of eligible households that receive a home assessment or intervention by 3% by June 30, 2021

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 2021, the Safe and Healthy Homes Program (SHHP), funded with Title V money, ended as the BFH's second iteration of healthy homes programming that targeted regions across the state with the highest injury rates. The SHHP incorporated the American Academy of Pediatrics guidance and interventions to reduce the risks of injuries, and it provided 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 were offered to families who participated in the SHHP.

The global pandemic continued to have a strong impact on the ability of the SHHP grantees to implement the in-home programming. Participants continued to be hesitant about opening their homes to non-household individuals. Grantees reported last minute cancellations from families due to illness in addition to typical schedule changes.

The SHHP service model continued to allow grantees to provide primary prevention education and home assessment over the phone. The grantee had the participating family travel inside the home to describe conditions and answer questions to identify hazards. This self-assessment did not yield the same level of identification of hazards and resulting interventions as in-person grantee expertise assessment, however, it allowed for a continuation of program services despite mitigation closures.

Due to the SHHP ending halfway through 2021, the related strategies and evidence-based strategy measures (ESMs) are not continuing. Despite not having targets in the current action plan, the ESM results are described below. The SHHP continued to fill 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 2021, the SHHP grantees wrapped up in-home or phone assessments by April 30 to allow time for follow up and end of grant activities. During this partial year, the SHHP grantees completed 159 comprehensive home assessments, identified 984 health and safety hazards, and provided 987 health and safety interventions. While the SHHP came to an end, the education and interventions remain to provide children and their families with healthier and safer homes.

The BFH continues to serve as a statewide resource on healthy homes providing information and referrals to appropriate organizations. In 2021, the BFH began the Prevent Injuries in Children (PIC) program. The PIC program is a primary prevention program that combines in-home education and interventions to increase child safety practices including the use of home safety equipment. The PIC program is targeted to counties with the greatest need based on injury, death, race and ethnicity, and emergency department visits using both rates and numbers.

I. Overview of Approach to Child Health Domain

Strategies in the child health domain focus on reducing childhood injury, improving developmental, behavioral, and mental health outcomes, and mortality prevention among children in Pennsylvania (Pa.).

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

While the action plan does not address lead poisoning prevention 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. The major causes of elevated blood lead levels among U.S. children are lead-based paint and lead dust. Houses built before 1978 are likely to contain some lead paint which releases lead dust when it deteriorates or is destabilized during renovations. In 2023, 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. Using 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, and improve linkages of lead-exposed children to recommended services.

The BFH will use 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. Safe Kids PA Coalitions and Partners will continue to conduct activities through education, collaboration and advocacy throughout Pennsylvania. 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.

III. Priorities

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 with children ages 0-17 without a provider 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, made to medical home within six months

ESM: Percentage of children without a provider 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, made to a medical home within six months to establish a baseline. This measure is important to track progress towards ensuring all children are linked to a medical home so that they continue to receive primary and preventive medical care on schedule. The goal of this strategy is to ensure that health status, which includes mental health, behavioral health, and developmental milestones, remains stable and that children grow into healthy adults.

This ESM has been modified to no longer include children without medical insurance being referred to a medical home in the count. It was determined, due to the complexity and variability associated with insurance eligibility and use of insurance, that attempting to include those without medical insurance would cause confusion and result in unnecessarily ambiguous data.

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

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 are 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.

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 2023, the BFH will continue to enhance and strengthen the CDR program through data quality and analysis for SUID, SDY and CDR cases. Pa. continues to seek to improve data quality for CDR, SDY, and SUID through training efforts at regional and statewide meetings and targeted technical assistance. COVID-19 mitigation efforts prevented BFH from moving forward with its plan to have two statewide trainings on death scene investigations including doll reenactments to improve the quality of death scene investigations for children who die suddenly and unexpectedly. These trainings, which are intended to be hands-on with investigators, would be ineffective in virtual setting. The BFH plans to hold these meetings now in Spring 2023. 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.

Using the information learned during the assessment phase of the prevention recommendation framework process developed in 2021, the State CDR team will brainstorm prevention strategies. The strategies will be assessed for effectiveness and feasibility and 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 2023. The evaluation will seek to streamline processes and to assess effectiveness. Additionally, the BFH will continue to look for opportunities to share the CDR recommendations more widely.

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.

Strategy: Provide in-home child safety education visits

Strategy: Provide home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits

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.

Objective: Annually increase the number of comprehensive in-home child safety education visits completed

Objective: Annually increase the number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits

ESM: Number of in-home child safety education visits completed

ESM: Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits

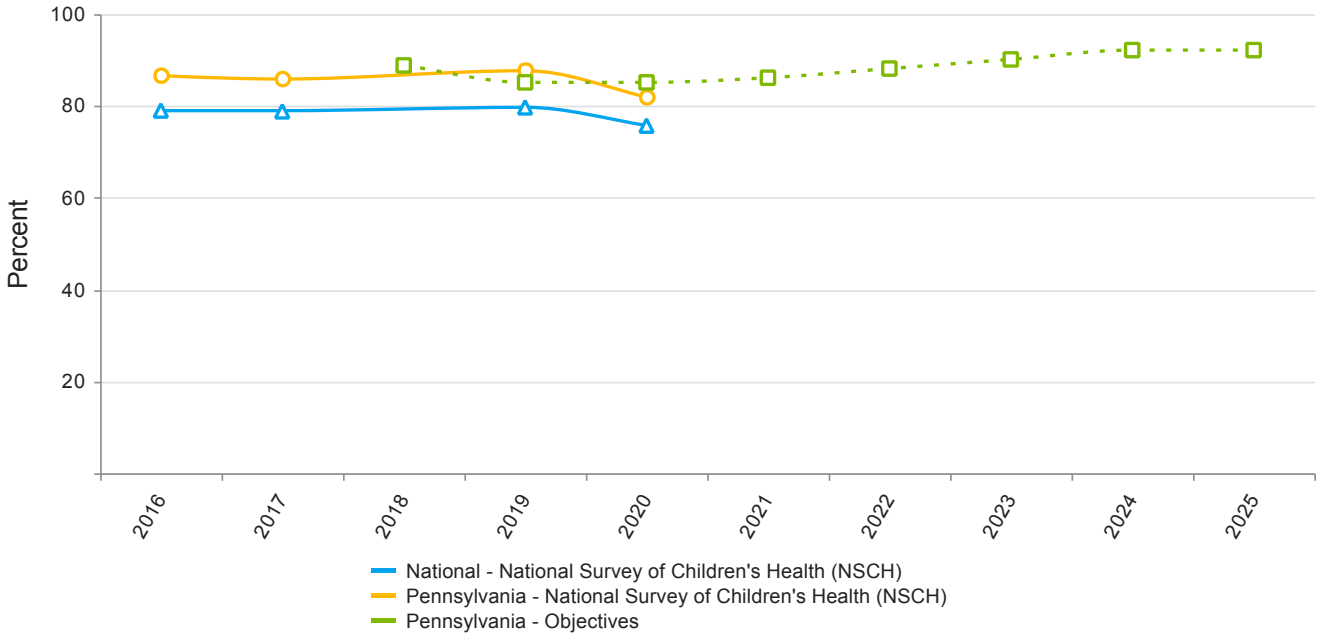
The Prevent Injuries in Children (PIC) program, started in 2021, will continue to be provided in association with other home visiting programs as an additional and separate component that provides education as well as interventions to families. PIC providers are required to complete motivational interviewing 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.

As prevention programing, the immediate process measures track the work completed and potential for reduction in injuries and death. The number of in-home child safety education visits completed will measure the reach of the PIC program and seek to increase the number annually. Additionally, the number of home safety interventions performed because of needs identified during comprehensive in-home child safety education visits represent potential injuries that are prevented.

Adolescent Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		88.7	85	85	86
Annual Indicator	86.5	85.7	85.7	87.7	81.8
Numerator	775,554	715,291	715,291	659,147	679,581
Denominator	897,142	834,394	834,394	751,698	830,408
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	88.0	90.0	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					
	2017	2018	2019	2020	2021
Annual Objective	15	18	21	25	30
Annual Indicator	18	15	12	7	3
Numerator					2,698
Denominator					89,993
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	quarterly vendor/grantee reports
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	33.0	35.0	38.0	38.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			4,500
Annual Indicator			540
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	4,550.0	4,600.0	4,650.0	4,700.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			90
Annual Indicator			99
Numerator			4,589
Denominator			4,635
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	90.0	90.0	90.0

ESM 10.4 - Number of community-based organization staff trained in the OBPP

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			45
Annual Indicator			9
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	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

State Provided Data			
	2019	2020	2021
Annual Objective			3,880
Annual Indicator			4,681
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			10,000
Annual Indicator			49,943
Numerator			
Denominator			
Data Source			grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	11,000.0	12,100.0	13,310.0	14,641.0

ESM 10.7 - The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			360
Annual Indicator			151
Numerator			
Denominator			
Data Source			grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			150
Annual Indicator			53
Numerator			
Denominator			
Data Source			grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	160.0	170.0	180.0	190.0

ESM 10.9 - Number of CDR recommendations implemented (adolescent health)

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			0
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			35
Annual Indicator			145
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	39.0	43.0	47.0	51.0

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	2021
Annual Objective			55
Annual Indicator		59.5	63.1
Numerator		13,448	9,536
Denominator		22,602	15,110
Data Source		Grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2021
Annual Objective			8
Annual Indicator		9.4	11.1
Numerator		2,127	1,677
Denominator		22,602	15,110
Data Source		Grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8.0	9.0	9.0	10.0

State Performance Measures

SPM 5 - Percent of children ages 6-17 who have one or more adult mentors

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			94
Annual Indicator			93.1
Numerator			1,500,973
Denominator			1,612,808
Data Source			NSCH, Indicator 5.9, Pa. data
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.0	94.0	94.0	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 community-based organization staff trained in the OBPP	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 community-based organization staff trained in the OBPP	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 community-based organization staff trained in the OBPP	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

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. 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 had, "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., teen pregnancy rates and teen birth rates are trending downward. However, disparity in teen pregnancy rates in PA remains, particularly by race and ethnicity, as shown in the table below.

2019 Pennsylvania Teen Pregnancy Rates, per 1,000 youth (ages 15-17)	
Race/Ethnicity	
4.9	White
21.5	Black
2.4	Asian/Pacific Islander
19.3	Multi-Race
20.2	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 2021, 1,519 youth completed an evidence-based program at a PREP facility. The bureau has eight subgrantees that provide PREP programming.

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 2021, 59% of currently active adolescent health grantees received LGBTQ cultural competency training, an increase of 60% from the previous year. The COVID-19 pandemic led to the cancellation of all in-person trainings in 2020. A virtual model was developed to deliver the training at the end of 2020, which led to an increase in training numbers in 2021. To continue providing trainings specific to the LGBTQ population, the BFH will partner with the chosen MCH workforce development vendor going forward.

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). Per the 2019-2020 National Survey of Children’s Health, 20.8% of Pa. children 17 years of age and younger have experienced one ACE, and 17.7% 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 (RFA) was released in 2019 and sites were selected in Philadelphia, Allegheny, Fayette, Lawrence, and Mercer Counties. There were 34 TOP Clubs in schools during calendar year 2021, serving a total of 1,006 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 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 2021, the BFH also began work with the National Improvement Partnership Network (NIPN) on the Adolescent and Young Adult Behavioral Health Collaborative Improvement and Innovation Network (AYA-BH CoIIN). The AYA-BH CoIIN is working to improve the health of adolescents and young adults, 10-25 years of age, by strengthening the capacity of state MCH programs and clinical providers to address the behavioral health needs of these youth. The BFH, along with clinical partners, will continue work on the 18-month long project through December 2022 to increase intergovernmental collaboration on mental health needs of adolescents and young adults, as well as increase the rate at which depression screens are administered to this population in the clinical setting.

In late 2021, the BFH issued an RFA soliciting a vendor to create and facilitate a Youth Advisory Council (YAC) representative of the diversity of young people in Pa. The establishment of such a council is rooted in achieving truly adolescent-friendly care, including providing youth with the opportunity to identify their needs and concerns and engage them in decisions and courses of action. This cannot be accomplished without youth input and will prove vital to programs' efficacy. The YAC will provide the necessary forum for young people to be involved in community, organization, and program development while embracing a structure of established best practices that build upon central ideas of shared understanding, decision-making, and action among all members and stakeholders. YAC members will be tasked with actively engaging and impacting decisions related to MCH issues as identified by the BFH and other adolescent-serving agencies. The RFA resulted in seven responses, which will be reviewed and culminate in the issuance of a grant agreement to begin work on the project on July 1, 2022.

Priority: Improve mental health, behavioral health and developmental outcomes for children 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 2% 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

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 convenient to youth. AccessMatters operates HRCs in twelve Philadelphia area schools and five Philadelphia area community sites. There are an additional twenty-nine sites in ten additional counties across the Commonwealth. The twenty-nine 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 Philadelphia, Delaware, Berks, Lackawanna, Lycoming, Dauphin, Allegheny, Fayette, Beaver, Lehigh, and Venango Counties. In calendar year 2021, 2.6% of youth attending schools with an HRC used the HRC services, a decrease from the 7% of youth who used the services in 2020. This did not meet the goal of 30% of youth utilizing HRC services. During calendar year 2021, service delivery was impacted as many schools continued virtual instruction or pivoted between in-person and virtual instruction due to the COVID-19 pandemic. Services through HRCs were not used in school settings compared to previous years and were mainly used through community sites. For school settings using in-person instruction, the focus was on student re-engagement and instruction, particularly during the first half of calendar year 2021. Therefore, outside agencies implementing HRC services were not allowed to perform service delivery in school settings. Community-based sites experienced fewer service interruptions throughout the year.

There were 540 referrals for services outside the scope of HRC service delivery made to school and community-based resources for youth using services through HRCs during calendar year 2021. Referrals are made for services which fall outside the scope of HRC service delivery. This did not meet the goal of 4,500 referrals provided to school and community-based resources. However, 99.52% of visits to an HRC included counseling in calendar year 2021, exceeding the goal of 90.00%.

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.

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 5% 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

In 2019, the BFH was accepted to participate in the Children's 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 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. Nine of the initial thirteen staff completed the training process and were fully certified in the CYO OBPP in December 2021, falling short of the goal of 45. The remaining four initially trained staff were lost to turnover in 2020. In calendar year 2021, 4,681 youth participated in bullying prevention programming, exceeding the goal of 3,880 youth.

Going forward, this ESM will be revised to the number of community-based organization staff trained in the OBPP as it is constrained by the number of community-based organizations that are funded.

SPM: Percent of children ages 6-17 who have one or more adult mentors

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

ESM: Number of youths participating in evidence-based or evidence informed mentoring programs

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. 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 population of focus and their capacity to reach youth. In state fiscal year 2021, a total of 10,964 unique youth mentees received evidence-based mentoring from 532 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. This ESM will not be carrying forward as these programs are scheduled to end as of June 30, 2022.

NPM 10: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year

Strategy: Increase the dissemination of information to youth through social media and other technology-based platforms

Objective: Annually increase the number of users who access SafeTeens.org by 2% each year

Objective: Annually increase the number of text messages received on the SafeTeens Answers! text line by 2% 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

Maternal and Family Health Services (MFHS), a family planning provider, continued their promotion of the SafeTeens Answers! text line which is staffed by Planned Parenthood of the Rocky Mountains. Youth can text their sexual health and healthy relationship questions 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 2021, the number of texts received, and subsequent responses continued to decrease. The most common question topics received by the text line continue to be 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.

In state fiscal year 2021, the BFH began monitoring and reporting the number of youths accessing the SafeTeens.org site, which saw 49,943 individuals spending an average of over a minute on the site linking to topics including exercise and fitness, body image, cyberbullying, and dealing with divorce. This greatly exceeded the goal of 10, 000 individuals.

The BFH also tracked the number of referrals made for in-person counseling and health services to adolescents because of texts received through the SafeTeens Answers! text line. In state fiscal year 2021 there were 151 referrals, not meeting the goal of 360 referrals, for in-person services, including counseling, made because of the text line. This number is down 26% from the previous year. However, the SafeTeens website and text line are typically promoted at all health fairs as well as at MFHS health resource centers in the Scranton School District. During the pandemic, most of these events were cancelled or went virtual, which may account for the reduction in texts received and subsequently referred for service.

SPM: Percent of children 6-17 who have one or more adult mentors

Strategy: Increase protective factors for LGBTQ-identified youth through evidence-based or evidence-informed behavioral health programs

Objective: Increase the percentage of Lesbian, Gay, Bi-Sexual, Transgender and Queer (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

ESM: Percent of LGBTQ-identified youth participating in evidence-based or evidence-informed behavioral health programs who report an increase in positive coping strategies, specifically, support-seeking, problem-solving, distraction and escape strategies over the course of the program period

The BFH awarded Grants to Hugh Lane Wellness Foundation, Inc. and Students Run Philly Style (SRPS) to provide evidence-based or evidence-informed programs to enhance positive behaviors, personal strengths, and interpersonal relationships for LGBTQ youth. These two programs were selected to provide behavioral health programming focused on improving mental health, reducing substance use, or providing suicide prevention education for LGBTQ youth ages 12-21 in Pa. The programs began in October of 2020. However, they did not begin to serve youth until January 2021 as time was provided to start up the programming. In state fiscal year 2021, Hugh Lane Wellness Foundation, Inc. provided Mental Health First Aid Screenings to 82 youth. Of those 82-youth screened, two were provided referral services. Hugh Lane also provided AFFIRM to thirteen youth. AFFIRM is an affirmative cognitive-based therapy group for LGBTQ youth to learn stress coping skills and to improve well-being. SRPS provided the OUTRun Program. This program improves health outcomes and increases protective factors for LGBTQ youth by providing inclusive, informed support through their research-based mentoring services. LGBTQ youth experience increased health disparities due to toxic bias and stigma compared to their heterosexual and cisgender peers. Throughout the program SRPS will increase its ability to support LGBTQ youth by incorporating awareness and training on health disparities faced by LGBQ youth in its programming. In state fiscal year 2021, a total of 243 youth mentees received evidence-based mentoring. Of those 243 youth mentees, 35, or 14.4% of youth identified as LGBTQ.

NPM 10: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year

Strategy: Individuals working in the field of drug and alcohol or brain injury will have a greater understanding of the correlation between substance abuse 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 began implementation of the Acquired Brain Injury (ABI) and Opioid Training Program, funded by Title V 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 provided a grant to the Brain Injury Association of Pennsylvania (BIAPA) 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. COVID-19 presented issues and delays with the creation of the curriculum and the approval process. Due to these delays and access to entities, only one training was able to be conducted prior to the grant deadline of May 31, 2021. The program received additional funds in November of 2021, but no additional trainings were able to be scheduled before the end of the year. In 2021 a Request for Applications (RFA) was issued to continue this work beginning January 1, 2022. The BIAPA was awarded the grant and will proceed with implementation in 2022. Due to the barriers, the BFH provided training to 53 professionals, not meeting the goal of 150 professionals trained.

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

NPM 10: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year

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

In 2021, Pa.'s Child Death Review (CDR) team began to pilot a new prevention framework. The framework process consists of three steps: assessment; development; and evaluation. Assessment includes a review of data (CDR data and other relevant data), current prevention strategies occurring in PA and other jurisdictions and best practices. 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. Title V staff did not receive any recommendations in 2021.

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 per year

ESM: Number of young adult and adolescent males receiving trainings through Coaching Boys into Men curriculum

In 2021, 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 uses 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 145 individuals were served during 2021, surpassing the goal of 35 individuals served.

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

NPM 10: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year

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 3% by June 30, 2022

ESM: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method

ESM: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method

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 additional adolescent clients with reproductive health counseling

services. In state fiscal year 2021, BFH provided 19,101 adolescents with services, exceeding the goal of 15,475 youth served. However, this was a decrease in reach by 17% from the previous state fiscal 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 ESMs have been 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 has enabled the BFH to provide reporting requirements that are consistent with those required by Title X. In state fiscal year 2021, 63% of adolescents aged 21 years of age or younger at risk of unintended pregnancy were provided a most effective or moderately effective contraceptive method by reproductive health providers surpassing the goal of 55%. Additionally, 11% of those adolescents were provided a LARC, meeting the goal of 8%.

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 continue to focus on two 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's survey again 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.

The BFH issued an RFA to establish a Youth Advisory Council (YAC) comprised of youth. The YAC will advise the Department on relevant issues to improve health outcomes and increase protective factors for youth. Youth representatives on the YAC will serve as leaders to educate, advocate and form partnerships to create positive change across all MCH populations. The priority of the council, facilitators and youth alike, will be to ensure that the Department and other adolescent-serving agencies are making programmatic and policy decisions reflective of the communities being served and beneficial to the population at large, including adolescents.

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 educate 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.

III. Priorities

Priority: Improve mental health, behavioral health and developmental outcomes for children 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

Health Resource Centers (HRCs) will continue to provide medically accurate education and counseling services. 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 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 operates the 46 HRCs in 11 counties (Philadelphia, Delaware, Berks, Lackawanna, Lycoming, Dauphin, Allegheny, Fayette, Beaver, Lehigh, and Venango) throughout Pa. through funding from Title V. It is anticipated these HRCs will remain operational in 2023 with no additional HRCs opening unless one of the current 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. The current HRC grant will be ending, and priority areas and future implementation will be reevaluated during the coming year.

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, thereby improving their mental and behavioral health outcomes. Results from Pennsylvania's Title V public input survey conducted in 2022 reaffirm this strategy's importance. Of the 35 survey respondents who answered a question asking about the importance of sexual health services in schools, most respondents indicated that such services were very important (77%) or important (14%) 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 community-based organization staff trained in the OBPP

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 Olweus Bullying Prevention Program (Olweus or OBPP) model is an evidence-based approach currently being used by school districts across the state. The BFH worked with Clemson University to develop a training and certification program for Olweus in community youth organizations to supplement current Olweus activities across Pa. The BFH selected eight community youth organizations (CYOs) through a competitive RFA. The agreements with the CYOs began January 1, 2020, and staff members from each organization were provisionally certified in Olweus in February 2020 and fully certified in December 2021. Bullying prevention programming, including ongoing staff training, will continue at these eight organizations in 2023.

The BFH issued another RFA in spring 2021 and selected three 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 youths participating in the OBPP at a community-based organization. This ESM has been revised as the number of individuals able to be trained in OBPP is constrained by the number of community-based organizations that are funded. 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 will also continue participating in the Children's Safety Network Child Safety Learning Collaborative (CSLC) on bullying prevention through its close in April 2023. 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 the dissemination of information to youth through social media and other technology-based platforms

Objective: Annually increase the number of users who access SafeTeens.org by two percent each year

Objective: 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 2023, 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 use local health centers.

Additionally, the BFH will continue to support the toll-free SafeTeens telephone hotline, a text-based hotline that fields questions from respondents and provides factual responses and referrals to local community partners as appropriate. The grantee responsible for the management of both the website and the hotline continues to submit quarterly data including the number of calls received, most often asked questions, number of hits on the website, and the most searched questions. 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 Brain Injury and Opioid Initiative, formerly known as the Acquired Brain Injury (ABI) and Opioid Training program, to deliver a training curriculum focused on the correlation of ABI and opioid use. The BFH will partner with the Brain Injury Association of Pennsylvania to deliver training to professionals who serve adolescents and are within the brain injury and drug and alcohol field on a statewide level. The Brain Injury and Opioid Initiative will focus on those impacted by opioid misuse by providing outreach, education, and technical assistance to health and human services personnel who work with or are likely to encounter individuals with a brain injury or their family members. Through the training program, the outcome will be to improve the mental health, behavioral health, and developmental outcomes of adolescents with brain injuries and opioid use by increasing the knowledge base of both substance use and brain injury professionals to identify when the correlation between brain injury and opioids needs addressed.

SPM: Percent of children ages 6-17 who have one or more adult mentors

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

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 and cisgender peers. LGB youth 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 and transgender youth are more likely to have attempted suicide than their cisgender peers. 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 will work with Hugh Lane Wellness Foundation, Inc., and Students Run Philly Style to provide evidence-based or evidence-informed program to enhance positive behaviors, personal strengths, and interpersonal relationships for LGBTQ youth. Hugh Lane Wellness Foundation Inc. will implement the AFFIRMING Youth Project across Western Pennsylvania. They will use 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 use 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 referred to the program. Students Run Philly Style will implement their OUTPace program, formerly known as OUTRun, 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 14% of youth participants. The grantee's goal was to reach 100 LGBTQ youth during this period, and they exceeded their goal and reached 144 LGBTQ youth.

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

NPM 10: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year

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. The framework process consists of three steps: assessment; development; and evaluation. Assessment includes a review of data (CDR data and other relevant data), current prevention strategies occurring in Pa. and other jurisdictions and best practices. In 2023, the BFH will continue to use data from the local CDR teams to inform the prevention recommendation framework. Recommendations for deaths determined to be preventable will be reported to the BFH and implemented as

appropriate.

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 trainings through the 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, 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 resulting from interpersonal violence. The Ed Snider Youth Hockey Foundation will continue to incorporate CBIM into their life skills program during their youth hockey seasons through June 30, 2023. The BFH plans to issue an RFA in spring 2023 to continue the work of this program and expand it through multiple regions of Pennsylvania.

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

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

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

ESM: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method

ESM: The 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 state to provide adolescents aged 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 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 their healthcare needs are being addressed.

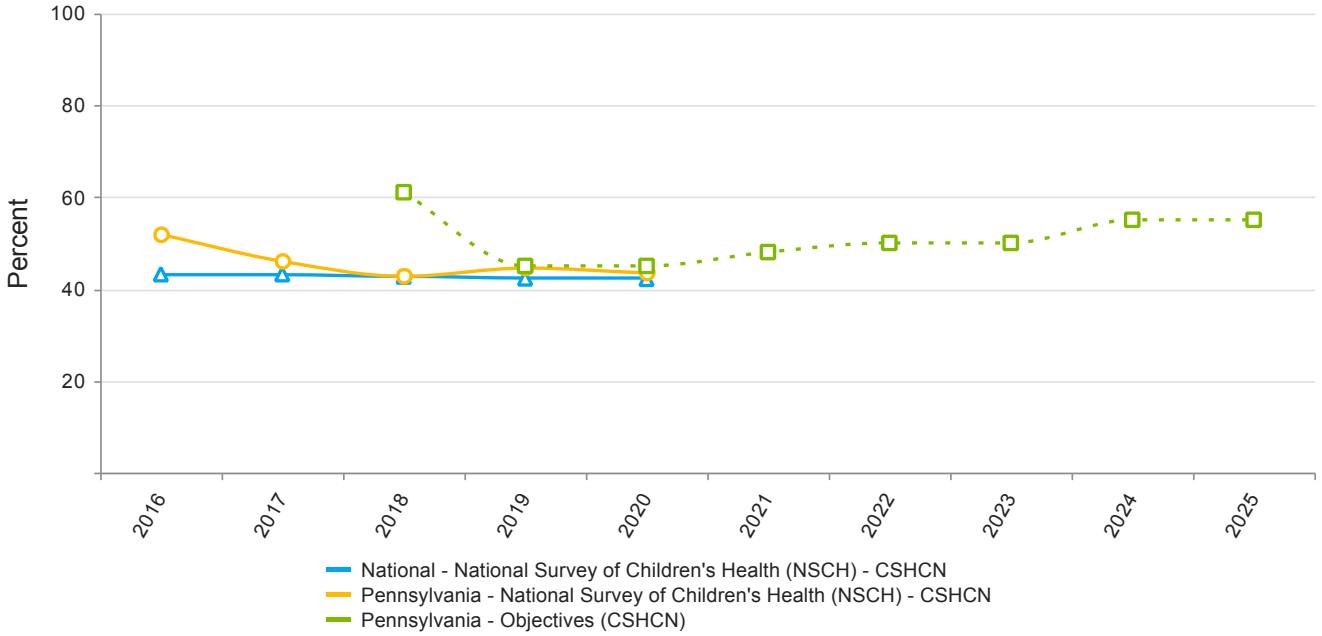
The BFH will track the percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method, as well as the percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a long-acting reversible contraception (LARC) method. These measures are in line with the Office of Population Affairs' Title X performance measures and aim to increase access to contraception by encouraging providers to ask about clients' pregnancy intentions and inform them of the wide range of contraceptive methods available.

Children with Special Health Care Needs

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		61	45	45	48
Annual Indicator	51.8	45.9	42.9	44.5	43.6
Numerator	267,920	234,614	223,990	244,784	255,237
Denominator	517,187	511,324	521,926	549,735	585,504
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	50.0	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

State Provided Data			
	2019	2020	2021
Annual Objective			2
Annual Indicator			0
Numerator			
Denominator			
Data Source			CSHCN programs implementing recommendations
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	4.0	5.0	6.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			475
Annual Indicator			302
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	498.0	523.0	549.0	576.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator			20
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	52.0	0.0	0.0	0.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator			22
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			40
Annual Indicator			0
Numerator			
Denominator			
Data Source			Philadelphia Department of Public Health
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	43.0	46.0	46.0	49.0

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			6
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator			103
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	110.0	115.0	120.0	125.0

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			500
Annual Indicator			315
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	515.0	530.0	545.0	560.0

ESM 11.9 - Number of calls received through the SKN Helpline

Measure Status:	Inactive - Logging of SKN calls will continue to be reporting via Form 7.

State Provided Data			
	2019	2020	2021
Annual Objective			800
Annual Indicator			396
Numerator			
Denominator			
Data Source			SKN call logs
Data Source Year			2021
Provisional or Final ?			Final

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator			43
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			40
Annual Indicator			137
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	44.0	48.0	52.0	56.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			15
Annual Indicator			11
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	19.0	23.0	27.0	31.0

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		11.2
Numerator		3,592
Denominator		31,964
Data Source		quarterly vendor/grantee reports
Data Source Year		2021
Provisional or Final ?		Final

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

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
Annual Objective	50.0	55.0	60.0	65.0

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
Annual Objective	50.0	55.0	60.0	65.0

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	Inactive
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 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	Inactive
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 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 2019-2020 National Survey of Children's Health (NSCH), 22.3% (585,504) of children in Pa. have a special health care need, exceeding the national average of 19.4%. Of those CSHCN, only 20.5% report receiving care in a well-functioning system in Pa., which is a decrease from 21.6% in the 2018-2019 NSCH. 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 2021 was allocated to serve children with the following conditions: Cooley's Anemia, cystic fibrosis, sickle cell disease (SCD), spina bifida, hemophilia, epilepsy, Tourette Syndrome, 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 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 2021, the SCP served 6,941 individuals from birth through age 21 years, and an additional 4,323 individuals aged 22 and older through matching state funds.

In 2021, the SCP continued the grantee requirement to dedicate a certain percentage of funds to a Client Assistance Fund (CAF; formerly called a Patient Assistance Fund), 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 CAF, long-term planning and solutions through the treatment plan, and care coordination to eliminate barriers. 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 Community-Based Services and Support program.

The BFH also provided state matching funds to support outreach and education-based grants for Pa. residents diagnosed with epilepsy and Tourette Syndrome. Through the Epilepsy Foundation of Eastern Pa. and the Epilepsy Association of Western and Central PA, the Epilepsy Program educated 2,902 first responders, 3,556 school employees, 398 secondary students, 22 family members/caregivers, and 204 community members. 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.

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. 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 to provide 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 program provides comprehensive non-medical services to families, as well as professional training for home health professionals and school nurses. Empowering families to become advocates for their children, collaborating with providers and insurance companies, engaging with other families, and moving toward self-sufficiency are emphasized. For the majority of 2021, TACHP was administered by two grantees: The Children's Hospital of Pittsburgh, covering the western and north-central Pa., and the Health Promotion Council of Southeastern PA, covering the eastern and south-central Pa. The Children's Hospital of Pittsburgh decided to withdraw from the program, and their contract was terminated effective September 10, 2021. Maximum program capacity is 270 children, and as of the end of 2021, the remaining vendor had 56 children enrolled.

The BFH's Head Injury Program (HIP), funded through state funds that are not part of the state match, provided 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. In 2021, the HIP added telerehab as an option for Cognitive Rehabilitation Therapy.

In March 2021, the BFH's Acquired Brain Injury Program (ABIP) expanded the age for eligible individuals. The ABIP, funded by Title V, provided rehabilitative and therapeutic services for individuals between the age of 18 and 25 with non-traumatic acquired brain injury. Services were provided in Pa. by specialized brain injury providers. Rehabilitation services are offered in an outpatient or home and community-based setting.

The BFH also administered the TBI State Partnership Grant, funded by the Administration for Community Living (ACL) through May 31, 2021. The primary goal of this grant was to maximize the health, independence, and overall well-being of individuals with TBI in Pa. The grant provided education, training, and technical assistance services to the juvenile justice and older adult populations, through the grantee the Brain Injury Association of Pennsylvania (BIAPA). Throughout Pa., 24 juvenile justice trainings were provided to 570 individuals and nine older adult trainings were provided to 408 individuals. Through the grant, a NeuroResource Facilitation Program (NRFP) was implemented to connect individuals with TBI to appropriate resources, provided through the grantee Counseling and Rehabilitation, Inc. Throughout Pa., 80 individuals participated in NRFP. Pa. also served as an ACL mentor state and assisted other states with developing "Return to Learn" programs and creating programming within the juvenile justice systems in their states. The BFH was awarded the new ACL TBI State Partnership Grant, in effect from August 1, 2021 through July 31, 2026. The BFH executed a grant with the BIAPA to expand the NRFP and educational programs within the juvenile justice and older adult populations. A grant agreement was also executed with the Pennsylvania Coalition Against Domestic Violence to create training and educational materials for individuals working with victims of domestic violence and emergency personnel.

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 2021, Chester County Health Department provided home visiting services to 43 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 uses 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), offers home visiting services to families with children ages 0 to 21. The MHCT targets services to CSHCN but serves all children The MHCT receives 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 2021, enrolling 34 children and their families. All 34 new enrollees were identified as CSHCN. Due to COVID-19, in person home visiting support was suspended and transitioned to phone and video calls and emails. The first two quarters of 2021 were the last for PDPH's MHCT program. PDPH conducted a needs assessment in 2020 which indicated that stakeholders and families prioritized advocacy, coalition building, and organization of resources over direct services like the MHCT program. As of July 2021, PDPH transitioned all current MHCT participants to other CSHCN programs that best serve their needs.

Additionally, the PDPH offered mini-grant project opportunities to community organizations. All funded projects were procured through a 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 life skills and foster community while encouraging personal growth; a program for CSHCN and their siblings to promote social interaction and friendship; and training for staff and residents of emergency and supportive housing to inform them of the resources available for children with developmental disabilities. Many of the mini-grant activities continued to be offered virtually due to COVID-19.

In 2021, the BFH partnered with PDPH on a new initiative to improve the system in which CSHCN receive care. The BFH was awarded a $15,000 grant from the Association of Maternal and Child Health Programs (AMCHP) to replicate an evidence-based program, Innovative Approaches (IA), a systems change initiative started in North Carolina. The overarching goal of IA is to support the development of community based and family-focused systems of care for families of CSHCN. The core components of IA include counties assembling an effective coalition of stakeholders, assessing community systems, and identifying areas of improvement, developing and implementing strategies to address areas, building capacity to undergo systems change, improving the community service delivery system, and ensuring CSHCN get the support and resources needed to thrive. The BFH worked with PDPH to build capacity in 2021 with the goal of moving toward full implementation of this initiative in 2022.

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: 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. This program aims to better understand deaths among Pa.'s children and identify interventions designed to prevent future deaths.

The 2021 Child Death Review Annual report examines child deaths that occurred in 2019. Of the total 824 cases reviewed in 2019, the category of medical conditions represented the single highest frequency with 413 cases (50.1% of the total deaths reviewed). Through obtaining information from annual recommendation reports and quality data from local CDR teams, the BFH will examine findings of trauma-related 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. No recommendations related to CSHCN were made to Title V staff in 2021.

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 reentry 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.

BrainSTEPS continues to provide students, families, school teams, and medical providers with consultation to assist the student's transition back into the classroom setting. The program focused on continuous quality improvement efforts to ensure streamlined collaboration among each student's care team and family. This allows CSHCN to receive care in a well-functioning system. Through collaboration with students, their families, and the care team, person-centered plans were created. Person-centered plans allow for the student's and family's needs and concerns to be addressed and for the family to be partners in the decision making. In 2021, BrainSTEPS teams provided 269 consultation hours to develop 302 person-centered plans. Due to barriers created by COVID-19, the BFH was unable to meet the goal of 475 person-centered plans. To promote consistency of the BrainSTEPS teams, BIAPA provided training, workshops, and technical assistance to team members to ensure they are following the established program model. BrainSTEPS Team Leaders established annual individual team goals for their coverage area. Goal development included 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 provided training and technical assistance to Concussion Management Teams on concussion recognition and best practices. This additional support helped to ensure a designated number of new students were referred to the program along with helping additional school districts implement Concussion Management Teams within their school district.

The BFH has received inquiries from other states regarding adopting the BrainSTEPS program model and providing technical assistance. The BFH looks forward to collaborating with and aiding other states who seek to

implement “return to learn” programming. The BrainSTEPS program continues 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 continued 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. The program focuses on populations in rural areas as CSHCN and their families face a variety of barriers to accessing services.

Through the evidence-based Community Health Worker (CHW) model, CHWs are used 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 CHWs 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 program assists in 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 and express their satisfaction or dissatisfaction with the services provided. CHWs support families and have helped 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 or those who are at-risk of being diagnosed as well as CSHCN who have recently moved to or within Pa. Families from racial and ethnic minority groups are prioritized. 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 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. The family and CSHCN are involved throughout all C2H processes.

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. In 2021, 20 family satisfaction surveys were received at the end of services and 100% of families who returned these surveys reported they felt they were partners in decision making when it came to the development of their care plan and individualized goals. Despite numerous outreach methods encouraging the completion of the satisfaction survey, the BFH has been unsuccessful in receiving surveys from the 138 families enrolled in the program in 2021. Therefore, the BFH did not meet the goal of 50 families.

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

In 2020, an RFA was released to fund the Sickle Cell Community-Based Services and Support (CBSS) program. The CBSS replaced the Sickle Cell Community-Based Organization grants that had been in place in previous years. The RFA process resulted in two successful new grants. The goal of the CBSS is to ensure individuals diagnosed with sickle cell disease (SCD) and sickle cell trait are supported with collaborative care planning across systems and can be an active member of their community. 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 living with SCD. The purpose of this collaborative relationship is to improve care and begin to systemically remediate disparities, alleviate barriers to care, and ultimately improve health outcomes and quality of life for those living with SCD.

The Sickle Cell CBSS program shifted the focus of services to increase system-level change and support beginning in October of 2020.The shift brings the CBSS program into alignment with the state programming strategies found in the Title V Maternal and Child Health Services Block Grant to States Program Guidance: (6) integrate systems of public health, health care and related community services to ensure equitable access and coordination to achieve maximum impact; and, (7) promote the effective and efficient organization and utilization of resources to ensure access to necessary comprehensive services for CSHCN and families through public health services, systems, and population health efforts. The shift further differentiated funding for programs and services provided through insurers/payors and allowed CBSS grantees to increase the population size served.

The CBSS realignment 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 living with sickle cell disease and the needs of the care providers. These agreements are required to support and increase communication between medical care providers (such as health systems, insurance providers, primary care practices, specialists, mental/behavioral care providers, and pharmaceutical companies) working to reduce service duplication, streamline referral processes, simplify care plans, and improve information-sharing. This increased collaboration between care providers resulted in individuals receiving coordinated and comprehensive care and allowed care providers to improve systems-function through policy and procedural changes.

In 2021, the CBSS implemented plans for annually increasing the number of collaborative agreements with medical care providers and developed a defined expectation to increase the number of agreements to maximize participating providers without impacting the quality of cross-system communication.

In 2021, the CBSS established 22 collaborative agreements with medical institutions, which exceeded the goal of

eight.

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 utilized 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 funded 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 FQHC Program worked toward 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. Nine FQHCs participated in the program by developing projects within the above five areas designed to reach specific subpopulations of CSHCN. The program provided 6,041 services to 3,542 CSHCN. These clients represented 11.08% of the 31,964 CSHCN in the participating FQHCs. This fell below the goal of 18% of CSHCN served. The ongoing impacts of COVID-19 quarantining and precautions limited the FQHCs in fully implementing some portions of the projects. PACHC, the Bureau and the FQHCs are continuing to work to minimize COVID-related impacts and assess if the ongoing goals are feasible.

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. Title V began funding the Room2Breathe program in July 2021. Partnering with Children's Hospital of Philadelphia, community health workers are trained on the evidence-based program and 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 are 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 also receive assistance with pest management services and referrals for other identified needs related to social determinants of health. The BFH chose 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 is measured by the number of participants who complete the 12-month follow-up visit. Sixty-eight children were served by the program in 2021. Of these participants, 46% identified as Black/African American, 25% as Latinx, and 29% of participants' race data was unknown/not reported. Successful completion data will not be available until July 2022.

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. The BFH holds bimonthly meetings with the DHS's, Office of Medical Assistance Programs. 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.

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 continued to collaborate with the PA DHS' Office of Medical Assistance Programs in 2021. Meetings were 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. In 2021, six meetings were held, which exceeded the goal of four meetings annually.

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

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 certified registered nurse practitioner with oversight by a physician and psychologists in Philadelphia to assess and diagnose children aged 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) by Early Intervention, children are referred to the ADC. Children are then assessed using the Childhood Autism Rating Scale (CARS) and the Telehealth Autism Spectrum Disorder Pediatric Survey (TELE ASD PEDS) assessment from Vanderbilt University. The ADC, which began in 2018, continues to increase the number of children evaluated and diagnosed. In 2021, 103 children were evaluated and 90 were diagnosed with autism. 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 ABA principles. In 2021, 125 families were trained in

ABA principles and strategies. The use of telehealth in the ADC has provided an opportunity to expedite the diagnostic process and facilitate the initiation of appropriate treatments. By identifying ASD and initiating services early, outcomes across the life span for these children and families can be significantly improved.

In 2021, the ADC evaluated children within Berks County (the ADC's primary site) and increased evaluations by expanding into five neighboring counties. The ADC evaluated 103 children, 90 of whom were diagnosed with ASD. This exceeded the goal of 50 evaluations. This increase in evaluations was made possible due to the expansion into neighboring counties, a more streamlined intake process with Early Intervention services, and expanded support from the hospitals. The goals for this ESM are being increased for future years to reflect this expansion.

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 collaborated with the PA Department of Education and BIAPA to conduct outreach and program promotion targeting families with school-aged children and professionals working with children in medical and school settings. In 2021, BrainSTEPS conducted 15 presentations to a diverse audience of 1,281 participants. Outreach and promotion were conducted to increase knowledge of the program, the population it serves, and how to easily access resources. Increased awareness of the BrainSTEPS program, services, and resources contribute to the system of care for CSHCN, by allowing earlier identification and treatment of mild TBI, and fewer long-term complications.

In 2021, BrainSTEPS received 315 referrals. Due to the barriers within schools related to COVID-19, the BFH was unable to meet the goal of 500 referrals. BrainSTEPS currently has 30 BrainSTEPS teams across the state to provide support for each referral received in their respective location.

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 collaborates with organizations serving CSHCN to advance Pa.'s system of care for CSHCN to assist with annually increasing calls. The BFH utilizes partnerships 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 distributed information regarding the SKN helpline and have participated in virtual training days to bring awareness to the helpline in 2021. The pandemic has made it difficult to attend in-person conferences, but the BFH plans to attend and exhibit at conferences throughout Pa. in the future to increase the number of calls. In 2021, 396 calls were received through the helpline. Therefore, the BFH was unable to meet the goal of 800 calls.

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 CBSS develops partnerships with and between community-based service providers as the CBSS program shifts to systems-level supports. Grantees seek out new and known community-based service providers to establish and strengthen partnerships. These partnerships 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. These partnerships are used to identify impactful social determinants of health and to remediate barriers to care and support community integration. Through this work, the CBSS promotes increased interconnectivity and organization of community-based providers, which collaboratively strengthens the overall system of care.

In 2021, the CBSS implemented plans for annually increasing the number of collaborative agreements with community-based providers and developed a defined expectation to increase the number of agreements to maximize participating providers without impacting the quality of cross-system communication.

In 2021, the CBSS established 43 collaborative partnerships with community-based organizations which include school districts and corporations, exceeding the goal of 8 collaborations. Also, during 2021, the CBSS held a total of 12 community events including World Sickle Cell Day activities and town hall meetings.

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. The Parent/Family Leadership Institute addresses relationships,

sexuality, dignity of risk, and supporting self-advocacy. The Youth Leadership Institute creates a network among peers while building leadership and self-advocacy skills. PEAL conducted youth leadership institutes and weekly youth virtual events. Youth were instructed on self-sufficiency and how to reach their potential as self-advocates while chatting with other young people. 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. During 2021, 137 youth with special health care needs attended the Leadership Development and Training Program, significantly surpassing the goal of 40 youth.

In addition, 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 2022. During 2021, PEAL served 180 CSHCN and 668 individuals aged 22 and older through outreach.

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 C2H program, individuals enrolled age 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 C2H program was implemented in 2020 and began serving youth 14 years of age at that time. The BFH objective for 2021 was 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. In 2021,12 youth enrolled in the C2H program and 11, or 91.6%, of those youth had a complete transition plan as part of their individualized care plan. However, the BFH did not meet the goal of 15 youth receiving a transition plan, because only 12 youth were enrolled.

SPM: Percent of hospitals making referrals to EI

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

ESM: Percent of NAS cases reported within iCMS referred to EI

Under the Governor's statewide emergency disaster declaration for the heroin and opioid epidemic, a first for a public health emergency, the Department of Health was 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) saw the opportunity to begin using iCMS, the newborn screening reporting and case management system, as a long-term solution for the state's NAS reporting repository so that data could be collected and analyzed. The

declaration also allowed for the creation of a command center to track progress and enhance the coordination of health and public safety agencies, helping commonwealth agencies address the opioid epidemic. The opioid disaster declaration expired in August 2021, following 15 renewals, when the General Assembly declined to extend it. The declaration proved an important tool in helping reduce overdose deaths in the state by nearly 20% from 2017 to 2020. Reporting of infants diagnosed with NAS remains in effect under existing Department authority.

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 DNSG continued to ensure birth facilities are routinely connecting families with health and social services to promote optimal child development and family well-being throughout 2021. The NAS reporting form submitted by hospitals includes detailed information pertaining to the plan of safe care and post-discharge referrals. This information is analyzed for completeness, accuracy, and effectiveness.

The DNSG created a full-time NAS Nursing Services Consultant position that focuses on monthly technical assistance centered around required reporting data, EI referrals, and state-wide assessment of safe plans of care. The NAS consultant organizes and participates in statewide and regional NAS meetings and uses information gathered during these meetings in conjunction with the NAS 2020-2021 data reported in iCMS to develop DNSG follow-up policies and procedures along with helpful tools for safe plan of care coordinators.

Every infant diagnosed with NAS is eligible for, at minimum, Early Intervention (EI) at-risk-tracking services. With the transition of NAS reporting to iCMS in 2020, the DNSG began collecting EI referral data on the NAS case notification form as reported by hospitals. To further validate EI referral data, the DNSG signed a memorandum of understanding with the PA Departments of Education and Human Services, Office of Child Development and Early Learning, Bureau of Early Intervention Services and Family Supports (BEISFS) in 2020 to share EI enrollment data. NAS data collected via iCMS is shared with the BEISFS and cross-checked between data systems to verify the percentage of infants diagnosed with NAS who have received a referral for EI services. Findings will be included annually in NAS reports published by the Department. Additionally, the upcoming 2020 Annual NAS Report will be the first NAS report, published by the Department, to contain EI referral data. The DNSG has been working in conjunction with the BEISFS to identify strategies and educational opportunities aimed toward improving EI referral rates for infants diagnosed with NAS. In 2021, staff from the BEISFS presented educational information regarding EI services and referrals to hospitals and providers during a Pennsylvania Perinatal Quality Collaborative learning event as well as an event for Newborn Screening Awareness. Additionally, the BEISFS reports having contacted individual counties with low EI referral rates to provide ongoing education. The DNSG has distributed educational information to hospitals and NAS coordinators regarding the importance of services and EI referral processes via quarterly departmental newsletter and email correspondence.

SPM: Percent of eligible infants with a Plan of Safe Care

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

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) in the Department of Human Services 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 Family Services (OCYF) conducts oversight of these programs from a regional level.

Through a formal collaboration, the DNSG and OCYF have the ability to work closely with one another, as they serve similar populations and collaborate with the same community partners. Through the identification and development of collaborative opportunities, both entities have the ability to 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.

In September 2021, a formal data exchange summary was finalized and signed by DNSG and OCYF. The data exchange summary provides the DNSG with the ability to send identifiable NAS data to OCYF on a quarterly basis. The first data exchange was executed in October, 2021. OCYF is in the process of analyzing NAS data received and findings have not yet been reported.

I. Overview of Approach to Children with Special Health Care Needs Domain

The BFH will continue to provide evidence-based or -informed services for CSHCN that are family-centered, and community based and coordinated. As stated in the CSHCN report section, according to the 2019-2020 National Survey of Children's Health, the percent of Pennsylvania's CSHCN has risen to 22.3%, exceeding the national average of 19.4% and, with only 20.5% of those families reporting receiving care in a well-functioning system, much work remains to advance this Pa. 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 the priority to promote 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 support grants, and the rest are state match funded. Barriers to services are consistent across SCP conditions and the SCP will continue to support focus on services to increase system-level change and support.

The SCP will continue to require grantees to allocate funds to a Client Assistance Fund (CAF), 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 2023, the Technology Assisted Children's Home Program (TACHP) program vendor will continue to utilize state match funding to provide coordination of care and work to connect enrollees with needed resources. In addition, the vendor will work to increase the capability of families to engage with the program while avoiding duplication of services with other programs. In addition to the elements listed above, TACHP will collaborate with BFH Specialty Care Programs to help align program goals and expectations as appropriate and in accordance with legislative requirements of the state funding. The BFH 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 used in 2023 to support outreach and education-based grants for individuals diagnosed with epilepsy and Tourette 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 under-resourced populations. Statistical data shows that the rate of diagnosis should be similar across the entire population, however, the rate is lower in rural and urban populations. 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.

The Administration for Community Living (ACL) awarded the Traumatic Brain Injury (TBI) State Partnership Program Grant, in effect from August 1, 2021 through July 31, 2026, to the BFH. The BFH will maintain and expand the NeuroResource Facilitation Program in PA along with providing TBI education for professionals, caregivers, and family members within the juvenile justice and older adult populations. NeuroResource Facilitation and the education component will be provided by the grantee Brain Injury Association of Pennsylvania. The BFH will also fund a grant with the Pennsylvania Coalition Against Domestic Violence to provide trainings and create educational materials on the correlation of domestic violence and brain injury. The trainings and educational materials will be provided to individuals working with victims of domestic violence and emergency personnel. 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. In 2021, the HIP partnered with the Brain Injury Association of Pennsylvania on a research project to determine the efficacy and feasibility of providing cognitive rehabilitation therapy via telerehab. Because of the data provided by this project, the BFH was able to permanently offer services to its recipients via telerehab. Through this expansion of services, the HIP's goal is to allow more individuals with TBI access to rehabilitation, 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.

To ensure that 30% of Pa.'s block grant funds are dedicated to CSHCN, the BFH requires the county and municipal health departments (CMHD) 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 included in the maternal domain. As new grant agreements are developed, BFH will continue to assist the CMHD 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 nonprofit community-based organizations through an annual RFA, 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 in Philadelphia, with a focus on CSHCN between the ages

of birth and 21. Projects should respond to needs expressed by Philadelphia families and promote equal rights and equal opportunity.

PDPH maintains a website that serves as a central repository of systems navigation and resources for families and providers of CSHCN. A CSHCN program coordinator follows up with families as needed and is responsible for reviewing current CSHCN policies and services in the area. Additionally, work with community providers and stakeholders, as well as families, is done to assess unmet needs, develop new approaches, and facilitate change.

A priority in Pa. is to improve the percentage of children who receive care in a well-functioning system. In 2021, the BFH partnered with PDPH on a new initiative to improve the system in which CSHCN receive care. The BFH was awarded a $15,000 grant from the Association of Maternal and Child Health Programs (AMCHP) to build capacity to replicate an evidence-based program, Innovative Approaches (IA), a systems change initiative started in North Carolina. In 2023, the BFH will utilize Title V funding to expand upon the work with PDPH to implement system change and improvements for CSHCN in Philadelphia County. The overarching goal is to support the development of community based and family-focused systems of care for families of CSHCN. The core components include assembling an effective coalition of stakeholders, assessing community systems and identifying areas of improvement, developing and implementing strategies, building capacity to undergo systems change, improving the community service delivery system, and ensuring CSHCN get the support and resources needed to thrive.

III. Priorities

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: 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 well-being 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 well-being 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 2021 Child Death Review Annual report examines child deaths that occurred in 2019. Of the total 824 cases reviewed in 2019, the category of medical conditions represented the single highest frequency with 413 cases (50.1% of the total deaths reviewed). Through obtaining information from annual recommendation reports and quality data from local CDR teams, the BFH will examine findings of trauma-related and other types of 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 use those findings to inform prevention strategies and programming within the Department and to support program implementation at the state or regional level.

In 2023, the BFH will continue to use data from the local Child Death Review (CDR) teams to inform the prevention recommendation framework. 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.
Recommendations for deaths determined to be preventable will be reported to the BFH and implemented as appropriate.

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 the PA 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 that 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 2023 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 among 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.

There is potential for the BrainSTEPS program model to be adopted by other states, as Colorado has adopted the program and the BFH has received other inquiries. The BFH looks forward to aiding 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 a minimum of 80% of families will report that they were partners in decision making through the Community to Home program.

ESM: Percent of families reporting through surveys that they were partners in decision making

In 2019, the BFH implemented the Community to Home (C2H) Program to identify and eliminate systemic issues for CSHCN. The program focuses on populations in rural areas as CSHCN and their families face a variety of barriers to accessing services.

Using the evidence-based Community Health Worker (CHW) model, CHWs 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 CHWs 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 from racial and ethnic minority groups are prioritized. 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. This ESM has been revised for 2023 to better depict and measure the work toward making families feel like true partners in decision-making.

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. 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. 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 Support (CBSS) program requires the two grantees to identify and develop collaborative agreements with medical care providers across the state. 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 pharmaceutical companies) 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 allow care providers to improve systems-function through policy and procedural changes.

In 2023, the CBSS will continue to implement plans to annually increase the number of collaborative agreements with medical care providers, maximizing 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 continue building the Federally Qualified Health Center (FQHC) Program. Through a grant to 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 state, many of which 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. COVID-related barriers have slowed the implementation of several FQHC projects and may require the projected percentages of CSHCN receiving quality care goals to be re-evaluated.

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

In 2023, the Philadelphia Department of Public Health, in partnership with Children's Hospital of Philadelphia, will continue to train CHWs on the evidence-based Room2Breathe Asthma home visiting program. The CHWs 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 will 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 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 2023. 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 2023, the BFH will continue the Autism Diagnostic Clinic (ADC) through the grantee Easterseals Eastern PA. This program utilizes telehealth technology to increase access to autism evaluations, diagnosis, parent education, and referral for treatment. The ADC has the capacity to identify and evaluate children as young as 18 months for ASD. 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 principles. By identifying ASD and initiating services early, outcomes across the life span for these children and families can be significantly improved.

In 2023 the ADC will continue to evaluate children at its primary site in Berks County as well as in Lehigh, Northampton, Carbon, Monroe, and Pike counties.

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 PA Department of Education and BIAPA to conduct outreach and program promotion, Targeting families with school-aged children and professionals working with children in medical and school settings. Outreach and promotion will continue to focus on increasing knowledge of the BrainSTEPS 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 to educate individuals on the BrainSTEPS Program.

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 Support program (CBSS) will support and develop partnerships with and between community-based service providers as the CBSS programs shift to a systems-level focus. 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, remediate barriers to care, and promote community integration. Through this work, the CBSS program will be promoting increased interconnectivity and organization of community-based providers, which will strengthen the overall system of care.

In 2023, the CBSS will continue increasing the number of collaborative agreements between the CBSS and community-based providers. The CBSS continues to be an integral part of alleviating barriers to care and strives to achieve health equity for those living with sickle cell disease.

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 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. Outreach activities will include kinship care as caregivers. PEAL will plan a one-day family engagement conference in partnership with fathers of CSHCN and other agencies. The conference will provide fathers trainings, information about resources, and networking with other fathers of CSHCN. PEAL will conduct two Behavioral and Mental Health Support trainings per program year for caregivers and professionals working with CSHCN. They will also be

conducting two health care mini conferences per program year focused on the health care needs of rural and urban communities. PEAL will use webinars and social media platforms to implement an educational campaign regarding issues and solutions affecting CSHCN, including toolkits for families of CSHCN addressing specific needs related to health, health care, and education.

The BFH partners with the PEAL Center to implement the Leadership Development and Training Program which provides Parent/Family and Youth Leadership Institutes. The Parent/Family Leadership Institute addresses relationships, sexuality, dignity of risk, and supporting self-advocacy. 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 2023 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.

SPM: Percent of hospitals making referrals to EI

Early Intervention (EI) services in Pennsylvania provide coaching supports to families with children who have developmental delays or disabilities. Infants diagnosed with NAS are eligible for, at minimum, at-risk tracking EI services. In tracking services, children considered to be “at-risk” are assessed routinely for developmental delays.

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

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 the Neonatal Abstinence Syndrome: 2019 Report, published by the Pennsylvania Department of Health’s Bureau of Epidemiology, there were 1,608 NAS cases reported in 2019 with a statewide incidence rate of 11.9 cases per 1,000 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, vision, learning, and behavioral problems.

Pa. birthing hospitals began reporting all NAS cases to the Division of Newborn Screening and Genetics (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 (POC) 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 birthing people 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 plans of safe care (POSC) coordinators and other state agencies to develop consistent discharge plans of care for all families affected by NAS across the state. 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 birthing people 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, EI referrals and state-wide assessment of POSC. 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 POSC 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 early intervention (EI) referrals. The DNSG has a signed memorandum of understanding with the Bureau of Early Intervention to share EI enrollment data.

Objective: Annually increase the percentage of reported NAS cases receiving a referral to EI

ESM: Percent of NAS cases reported within iCMS referred to Early Intervention

Post-discharge information, to include referrals to EI, is a required section of the electronic NAS report form submitted by hospitals when an infant is diagnosed with NAS. A signed memorandum of understanding with the Bureau of Early Intervention provides the ability to cross-check NAS data in iCMS with the EI database to verify the percent of infants receiving a referral to EI. Findings can be utilized to provide education, in conjunction with the Bureau of Early Intervention, to hospitals and counties with low EI referral rates. Ongoing data analysis allows the DNSG to track trends and measure performance outcomes. The overall goal of this initiative is to improve EI referral rates resulting in improved outcomes for infants, families, and caregivers impacted by NAS.

SPM: Percent of eligible infants with a Plan of Safe Care (POSC)

The Child Abuse Prevention and Treatment Act (CAPTA) requires that a POSC be developed for every infant under one year of age born and identified as affected by substance use, withdrawal symptoms resulting from prenatal drug exposure, or fetal alcohol spectrum disorder.

Post-discharge information, to include initiation of POSC, is a required section of the electronic NAS report form

submitted by hospitals when an infant is diagnosed with NAS. A signed memorandum of understanding with the Department of Human Services' Office of Children, Youth and Families (OCYF) provides the ability to cross-check NAS specific data with Childline referral data received by OCYF to verify the percent of infants diagnosed with NAS with POSC initiation. Ongoing data analysis allows the DNSG, in conjunction with OCYF, to track trends, provide targeted education to hospitals and counties as needed, and measure performance outcomes relating to POSC for infants diagnosed with NAS.

Strategy: Collaborate with the Office of Children, Youth, and Families (OCYF) to help support the enrollment into 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) in the Department of Human Services is primarily responsible for monitoring the delivery of services by county and private children and youth social service agencies. OCYF conducts oversight of these programs from a regional level.

Objective: Annually identify and develop collaborative opportunities to share data and trends in NAS reporting and follow-up.

ESM: Frequency data will be shared to enable OCYF and DNSG identify all infants who should have a Plan of Safe Care.

Through a formal collaboration, the DNSG and OCYF will 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 will share data and explore trends in NAS reporting. A Memorandum of Understanding (MOU) allows 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 POSC and Childline referrals. This NAS specific data can be utilized to identify concerns in the development of POSC 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.

In September 2021, a formal data exchange summary was finalized and signed by DNSG and OCYF. The data exchange summary provides the DNSG with the ability to send identifiable NAS data to OCYF on a quarterly basis. The first data exchange was executed in October 2021. OCYF is analyzing NAS data received.

The DNSG and OCYF are developing a separate data exchange summary, which would allow OCYF to share substance affected infant (SAI) data with DNSG. DNSG will use the provided data to identify the number or percent of newborns receiving a Childline referral who also meet criteria for NAS. The DNSG will further utilize this data to compare the total number of NAS infants reported to Childline to the total number of NAS infants reported to the Pennsylvania Department of Health per county; and to identify the need for technical assistance based on the failure to appropriately report NAS infants to Childline or initiate a POSC.

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

State Provided Data			
	2019	2020	2021
Annual Objective			5
Annual Indicator			3
Numerator			
Denominator			
Data Source			Bureau of Family Health internal documentation
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	4.0	4.0	5.0

SPM 6 - Rate of mortality disparity between black and white infants

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			9.1
Annual Indicator			9.35
Numerator			
Denominator			
Data Source			NVSS
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8.9	8.6	8.2	7.7

SPM 7 - Rate of mortality disparity between black and white children, ages 1-4

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			11.2
Annual Indicator			0
Numerator			
Denominator			
Data Source			HealthyPeople 2030
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	10.7	9.7	8.7	6.7

SPM 8 - Rate of maternal mortality disparity between black and white persons

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			26.4
Annual Indicator			0
Numerator			
Denominator			
Data Source			NVSS
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.9	25.4	24.6	22.6

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

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. 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 BFH monitors the health status of the MCH populations through multiple means including 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.

Work within this domain incorporates the maintenance and development of BFH's public health workforce at the state level by emphasizing and enhancing the usage of these data resources 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 inequities in 2020.

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

The first step in data-driven decision making is accessing and interpreting public health data. Title V staff have continually expressed a desire for increased training and assistance in this area. Through the internal workforce survey administered as part of the 2019-2020 five-year Title V needs and capacity assessment, staff indicated additional training on how to use population health data to understand the needs of a maternal and child health population was a priority. Title V staff responding to an internal data capacity and workforce development survey administered in 2021 reaffirmed the importance of training in this area; they identified data access, data interpretation, and using data to understand population needs as areas where they required additional technical assistance.

In 2021, the BFH developed several new resources to improve Title V staff's access to and use of Pennsylvania's maternal and child health data. In August, an internal Title V data dashboard that amasses data from various sources, including the national outcome measure and national performance measure dataset provided by the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB), was finalized and disseminated to program staff. The PowerBI interactive report interface is designed to be user-friendly and dynamic – it will be updated regularly as new data become available. In the fall of 2021, the BFH also developed and implemented a standard data request form and process for program administrators seeking data. This initiative is ongoing, and the goal is to help facilitate staff's access to internal and external datasets and to track how staff are using data to inform their work. This process requires staff to provide a thorough explanation of the request and provides oversight of and assistance with the procurement of the data and other information relevant to its analysis. Additionally, throughout 2021, a series of static, public-facing Title V data briefs were updated to include the most recent data on key indicators for all population domains. 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. The finalized briefs were disseminated to staff and the public in 2022.

Another 2021 initiative related to this priority was training staff on the importance of data disaggregation and steps they could take to assess and break down programmatic data. The BFH developed and delivered two introductory trainings on data disaggregation in 2021 and is working with staff to assess their service recipient data to better understand who Title V programs are serving across the BFH. While program staff have started using the tools provided to begin reviewing and disaggregating their service recipient data, results from a recent internal workforce capacity survey suggest that almost half of all staff in the Bureau (48.9%) do not feel that they fully understand how to disaggregate their data or why it is important. Accordingly, this remains an important training priority. The next step with this initiative in 2022 and 2023 will be to provide additional training on disaggregation of program outcomes by key demographics to assess whether programs are equitable and effective for all subgroups and populations.

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: 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 10% of programs per year

ESM: Number of technical assistance requests for data made to DBO each year using the established guidelines

In fall 2021, the Division of Bureau Operations (DBO) implemented a process for technical assistance requests. A training was provided to the staff which included a link to the form; the form can also be accessed via a dedicated group created in Microsoft Teams. While DBO technical assistance can spread over a variety of categories, the primary focus is assisting in setting program goals as well as process and outcome measures that enable programs to track progress toward addressing Title V priorities and performance measures and developing evidence-based program analysis. BFH promotes the use of specific, measurable, attainable, realistic, and time bound (SMART) goals to establish and measure program performance. DBO will also aid BFH staff to assist their grant partners to establish quantifiable incremental goals and collect data necessary to track grantee performance. As described above, a request form in Microsoft Teams has also been created to initiate data requests. Once a request is submitted, staff meet to discuss what data needs collected, how the data will be utilized, and the sources from which

the data will be obtained. DBO will then oversee the data collection process and obtain any data access required.

By the end of 2021, DBO received and completed two technical assistance requests, meeting the ESM goal - one to assist with survey use and selecting data to measure performance for the Olweus Bullying Prevention Program, and another to create a Social Determinants of Health data entry form for the Pennsylvania Maternal Mortality Review Committee. DBO received and fulfilled one data request from the Division of Child and Adult Health Services for use in a funding formula for the County and Municipal Health Departments. In 2021, a policy was modified, and two programs were created as a result of staff's use of data-driven decision-making (SPM). Staff requested and used data on family and infant health indicators, as well as programmatic data, to inform development of a funding formula that will be used to distribute Title V funds to county and municipal health departments across the state. Additionally, staff used data on child injury, mortality, emergency department visits, and racial inequities to identify the counties with the greatest need for the newly developed Preventing Injuries in Children Program. Finally, staff in the Department of Human Services Office of Childhood Development and Early Learning (OCDEL) requested and used PRAMS data from the BFH to inform development of their Early Childhood Comprehensive Systems Health Integration Prenatal-to-Three Program.

Strategy: Increase staff access and use of National Survey for Children's Health 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 of staff trained annually on availability of NSCH data and how to access that data

Staff was unable to be trained as the data was not available and the ESM goal was not met. In June 2021, HRSA approved BFH's request to transfer MCHSBG funds to the U.S. Census to cover the cost of the NCSH oversample. The transfer took place in October 2021, and the surveys for the oversample are estimated to begin mailing in June 2022, with data becoming available in fall 2023. Once the data are available, staff will be trained on availability and use of data. The oversample will increase the number of completed surveys in the state and may improve the precision of estimates for rare outcomes and small populations.

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, a joint research project between the CDC and state health departments, is a critical and unique source of maternal 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. 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.

PRAMS has been a data source in PA since 2007, however, 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 is producing and disseminating at least two PA PRAMS data analysis products per year. These products may be topic briefs, information sheets, abstracts and posters, journal articles, or descriptive analysis reports. BFH staff work with the PRAMS Committee to prioritize analysis topics and the most appropriate forms of data dissemination. The PRAMS committee is multidisciplinary and specific to Pa. Composed of BFH staff and various MCH stakeholder groups, the committee meets annually to discuss Title V priorities and share updates on PRAMS supplements, PRAMS weighted data, and other topics. For example, starting in May 2021, the PA PRAMS project implemented a 12-month supplemental questionnaire to collect data pertaining to respondents' experiences with the COVID-19 vaccine. This supplement followed the COVID-19 supplement that took place from May 2020 until December 2020. The data from the COVID-19 supplement, which reflected the impact the COVID-19 pandemic had on individuals who recently gave birth, became available in 2021. A data brief for the COVID-19 supplement was finalized, provided to stakeholders, and made publicly available on the DOH website.

In May 2021, PA PRAMS streamlined its data request process and has since received several data requests. The updated process for internal and external PRAMS data sharing allowed for programs and researchers to review the available data. These requests include internal DOH requests from Oral Health, Tobacco Control, Fetal Alcohol Spectrum Disorder (FASD) Medical Committee (regarding the Opioid Supplement), State Health Assessment/State Health Improvement Plan, and the Asthma program. Externally, PA PRAMS has received requests for data to assist in research being conducted by Des Moines University on how prenatal health insurance status affects infant health and by Drexel University comparing Philadelphia and Pennsylvania estimates of prenatal vaccine uptake (influenza, Tdap). PA PRAMS is currently working with Brown University to assess postpartum health care used among foreign born and U.S.-born woman and is in the early stages of working with Penn State University to study the effects of income on fertility intentions for Pa. residents living in counties impacted by the Marcellus Shale natural gas boom, during and after the Marcellus Shale growth.

To demonstrate how PRAMS data is applied to public health research and process improvement, PA PRAMS provides at least two Data to Actions to stakeholders annually. The two completed Data to Actions demonstrate how PRAMS data have been used to identify needs and help create programs to improve maternal and infant health. The 2021 Data to Action #1 reflected on leveraging of PRAMS data for the Five-Year Title V Needs and Capacity Assessment. The 2021 Data to Action #2, Pennsylvania's Early Childhood Comprehensive Systems (ECCS): Health Integration Prenatal-to-Three program, outlined how implementing this program will help close the gap between new parents and the resources available to them and create healthy beginnings for all Pennsylvanians. The ECCS programs is funded through a HRSA grant applied for and awarded to the Office of Child Development and Early Learning (OCDEL). PA PRAMS data was used to help OCDEL demonstrate the need for the grant and will be routinely monitored to gain an understanding of this program's effectiveness.

In December 2021, the BFH published "Prevalence and Associated Risk Factors of Postpartum Depression among Mothers in Pennsylvania, United States: An Analysis of the Pregnancy Risk Assessment Monitoring System (PRAMS) Data, 2012-2015" in the International Journal of Translational Medical Research and Public Health. The paper used PRAMS data to gain a better understanding of postpartum depression in Pennsylvanian mothers to determine high risk characteristics and effective monitoring and response techniques.

Due to a lack of implementation of PRAMS data in policy updates, this ESM has not been met.

Strategy: Increase the number and quality of local 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 5% each year

As noted elsewhere in this application, 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 are tasked with reviewing all deaths of children and youth aged 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 decreased from 75% in 2013 to 43.2% in 2019 (most recent data available). COVID-19 and the subsequent inability of teams to meet had a significant impact on these rates, but these trends have been occurring for several years.

To address the challenges that local CDR teams have meeting the obligations of Act 87, the BFH has explored several options to provide support to local CDR teams. 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.

BFH began developing data quality summaries with local teams which are anticipated to provide more targeted technical assistance. This process will continue through 2023. 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.

BFH has also begun testing importing information from Vital Statistics into the case registry for all local CDR teams. Philadelphia County already uses the Vital Statistics import feature in the case reporting system and BFH is piloting the process with the Dauphin County CDR team. Importing data from Vital Statistics into the case registry requires less manual entry from the local CDR teams, which BFH expects will lead to improved timeliness and data quality. BFH has made the import feature available to all local CDR teams.

The CDR State Team continued to meet virtually and is implementing the new prevention framework. The framework is a three-step process that includes: Assessment, Development, and Evaluation. The framework process will result in the development of a white paper promoting prevention recommendations for a particular type of death. Using the information learned during the assessment phase, the State CDR Team will identify and prioritize prevention strategies. The strategies will be assessed for effectiveness and feasibility. Selected strategies will be made actionable. The team will determine to which entities the white paper will be targeted. Targeted entities will have the capability to implement/lead prevention strategies or already be involved in developing/implementing similar

prevention strategies. The State CDR Team will define success in sharing of the white papers and how success will be measured. This information will become the basis for the evaluation which will occur on a yearly basis. In 2021, the CDR State team implemented the framework focusing on Motor Vehicle accident-related deaths. The team met throughout the year to discuss these deaths and a white paper is currently being written on this topic.

BFH is leveraging Title V funds to partner with East Stroudsburg University to assess the current Pennsylvania CDR system. The expected outcome of this process is to better meet the needs of the local CDR teams; increase the number of case reviews; and to increase the quality of those reviews and subsequent data. The vendor will assess CDR teams for the following:

- Local CDR teams' capacity and identify potential barriers to and strengths of effective CDR reviews.
- Evaluate data quality entered by the local teams.
- Identify any training or technical assistance needs to support local teams.

The goal to increase the number of child fatality cases reviewed and entered into the case reporting system by local CDR teams by 5% was not met this year. Teams were negatively impacted by their inability to meet due to changes in leadership and increases in team member duties related to COVID-19.

Priority: 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 overarching Healthy People 2030 health equity goal is to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all." In alignment with this goal, BFH recognizes the deconstruction of institutionalized systems of oppression as necessary to advance health equity and improve the social, environmental, and economic determinants of health.

The BFH has maintained its commitment to address and combat health disparities in all MCH populations by maintaining and monitoring language in 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) examines the submitted plans and will develop further guidance on plan development and technical assistance for grantees as needed.

To further this effort, in 2021, the HEC developed language for the health disparity plan requirement to be included in Title V funded Request for Applications (RFAs). Approved in March 2022, inclusion of this language allows RFA review committees to consider applicants' ability and readiness to address health disparities in the program(s) being funded and provide recommendations for related deliverables to include in the resulting grant agreements.

At the commonwealth and Department level, BFH supports and has assigned staff to participate on several health equity and antiracism task forces and workgroups to expand health equity principles and knowledge, ensuring information is being shared with the workgroups and back to BFH staff.

The first, the Office of Health Equity (OHE) Culturally Linguistically Appropriate Services (CLAS) taskforce, has six key objectives:

- Foster cultural competence
- Reflect and respect diversity
- Ensure language access
- Build community partnerships
- Collect diversity data
- Benchmark, plan and evaluate

CLAS standards help ensure an equity lens across all health care services by considering cultural health beliefs, preferred languages, health literacy levels, and communication needs. In 2021, the OHE set out to include Culturally Linguistically Appropriate Services (CLAS) / Health Equity language in all state documents with vendors. This contract language aims to utilize the National CLAS Standards to provide services in an equitable manner to the populations served, identify specific group(s) or population segments who experience a disproportionate burden, and address the specific social and environmental conditions (social determinants of health) that put disproportionately affected groups at increased risk of a disease, health condition, or problem. The contract language encourages contractors to improve the quality of their work with regards to equity and reducing disparities. Training is provided to DOH project officers as well as contractors. A taskforce sub-committee published a Department-wide CLAS newsletter to educate staff on CLAS standards and notify them of upcoming CLAS events.

The second group, the Department of Health (DOH) Anti-racism and Health Equity Task Force, formed in May 2021 with BFH staff serving on the steering committee and both the support and training and the policy subcommittees. The purpose of the Antiracism and Health Equity Task Force is to lead the DOH's efforts to become an antiracist institution, mindful of historically disinvested communities; and achieve equity and inclusion for all staff and health equity in the commonwealth. Current initiatives include the development of a standard health equity terms and definitions document for DOH and an analysis of Department policies and practices through an equity lens.

Additionally, staff participate on the Pennsylvania Interagency Health Equity Team (PIHET), which convenes over 12 state agencies working to address health equity, and diversity, equity, and inclusion within their respective sectors. Resources and ideas are shared to strengthen cross-sector collaboration. Finally, staff participate in commonwealth-wide efforts coordinated through the Governor's Office, including, a Human-Centeredness Community, Anti-Racism Book Club, and an externally focused Equity Workgroup.

The BFH recognizes and continues to explore the necessary changes that 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.

SPM 6(A): Rate of the mortality disparity between black and white infants

SPM 7(B): Rate of the mortality disparity between black and white children, ages 1-4

SPM 8(C): Rate of the maternal mortality disparity between black and white persons

Over the course of the funding cycle, the BFH continues to identify and develop strategies to address the priority to support and effect change toward the advancement of 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 or birthing people will serve as the BFH's long-term measure of progress toward advancing health equity. To improve MCH health outcomes, the gap between racial and ethnic majority and racial and historically marginalized populations must begin to shrink because of comprehensive programming, policy change, and organizational action. The BFH continues to identify ways 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. As understanding increases among staff and grantees, the BFH will strive to identify additional strategies and performance measures to address the other components of the priority. Due to the complexity of the systems changes required to achieve the targets for these strategies, during 2021, the targets were not met.

Strategy: Increase staff understanding of Health Equity principles

The BFH established a Health Equity Committee (HEC) in 2018 as part of its commitment to address health disparities and achieving health equity for the maternal and child health population in Pa. To address the complex health equity goals, the HEC developed a three-year workplan, a large portion of which was to identify and address staff's understanding of health equity concepts, the incorporation and understanding of community engagement, and communication around BFH reporting. The three-year work plan concludes in September 2022. Endeavors, collaborations, and resources, internal and external to the BFH, will shape the direction of this complex work.

Objective: Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff

ESM: Percentage of staff trained annually on the principles of Health Equity and the effectiveness of Health Equity plans

To ensure the trainings offered would be effective and well received, the HEC piloted trainings and conducted evaluation in summer 2021. The HEC approved the trainings, which are being termed Health Equity Prerequisites, related to the following competencies, identified through the 2019 BFH Health Equity Assessment, for BFH staff:

- Health equity and related evidence-based practices including:
    - The historical context surrounding health disparities and health inequity.
    - Power and privilege; and
    - Examining evidence-based practices through a health equity lens.
- Community engagement including using community engagement to identify, track, and measure social determinants of health.
- Communicating about health equity in BFH reporting.

The HEC training plan was delayed due to COVID-19 and trainings were not implemented until 2022; therefore, this ESM was not met.

The HEC administered its second health equity assessment in November 2021. This assessment specifically sought to gather staff feedback on their personal understanding and use of health equity concept, principles, and practices. Feedback from the surveys will help guide the direction of the Bureau's health equity work and training needs. The feedback collected from staff and resources internal and external to the BFH will aid in developing a plan to increase understanding and practice of equity.

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 that 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 utilized to inform policy and program decision-making for individuals who plan to be or are pregnant as well as those who have recently given birth. 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 infant, child, and adolescent death prevention strategies.

III. Priorities

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. As described in the 2021 report, Title V staff have continually expressed a desire for increased training and assistance in this area.

In 2023, the BFH will continue to advance this priority through the development of resources, tools, and trainings. Additionally, existing resources such as the Title V data dashboard will be regularly updated to provide staff with the most recent data available. The static Title V data briefs will be updated periodically, the most recently updated version was disseminated in 2022.

BFH will continue to promote the use of specific, measurable, attainable, realistic, and time bound (SMART) goals in

establishing and measuring program performance. The BFH will also continue to work with programs by providing tools to aid in the collection of data necessary to measure progress.

Division of Bureau Operations (DBO) staff promotes the use of standard operating procedures for developing better data quality and reporting. This includes use of a standard data request form to promote a consistent method for requesting and accessing data. This will also allow DBO to track data and other 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 analysis and attainment of goals and objectives. Data gathered via the request process will be used as a baseline with measures being tracked in subsequent years to determine trends and progress towards goals and objectives.

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

DBO staff will continue to 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 continue to promote program staff's use of SMART goals to develop objectives.

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.

BFH staff can collaborate with data experts within the bureau and request assistance via an online technical assistance request form. Examples include assistance with survey and focus group questions, data collection and presentation tools, and statistical analysis.

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 of 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 are 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 intends to start forwarding the Child and Adolescent Health Measurement Initiative's (CAHMI) notifications about availability of new NSCH data to staff in 2023 to increase internal awareness of NSCH data and its uses.

In 2021, the BFH reached 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 continue to use Title V funds 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. Data from the next oversample will be available in the fall of 2023; prior to that, staff will plan for how best to communicate the data's availability and support the BFH in analyzing and using the data.

The BFH is hopeful that the NSCH oversample will make it possible for MCH epidemiologists to better characterize and understand the needs of children across Pennsylvania. In 2023, the BFH will continue to consider how to identify and serve children with a higher risk of poor health outcomes or development of a special health care need due to medical, social, or structural determinants of health. The NSCH and the CSHCN Screener have long been utilized by CAHMI to estimate the prevalence of CSHCN across the nation and in each state. The resulting estimate is instrumental in allowing Title V programs to assess what proportion of the CSHCN population is being served and whether their needs are being met. However, while children who may have an increased risk of developing a special health care need are included within the MCHB definition, such children are not identified using the CSHCN Screener and little guidance exists on how to operationalize this component of the definition in order to quantify and adequately serve this population at the state level. Researchers supporting CAHMI, including Christina Bethell and her team, recently published an article using aggregated 2016-2019 data from the NSCH which demonstrates that social and relational factors and experiences are associated with the development of mental, behavioral, and emotional conditions among children.

This research provided Pennsylvania's Title V epidemiology staff with a foundational framework for exploring how to identify and estimate the population of children who may have an elevated risk of developing a special health care need due to medical, social, or relational factors. A population-level estimate and further characterization of the population in Pennsylvania would be a useful first step toward informing primary and secondary prevention efforts and associated public health programming that may interrupt the chronic disease pathway. Utilizing the NSCH public use datasets from 2016 to 2019, and available literature, Pennsylvania modified the scoring of the CSHCN Screener and incorporated measures from the social and relational health risk domains defined and validated by Bethell et al. in their 2022 article, "Social and Relational Health Risks and Common Mental Health Problems Among US Children" to calculate initial estimates of the population of children who may be at elevated risk of adverse mental or developmental health outcomes in the state. Specifically, a child was included in preliminary estimates if on the NSCH it was indicated that they met any of the following criteria:

- The child needed or used prescription medication, used more medical care, mental health or educational services than most children of the same age, were limited in their ability to do things that most children their age can do, needed special therapy, or have an emotional, behavioral, or developmental problem requiring

treatment or counseling. These measures are captured within the CSHCN Screener questions, but the approach differs from the standard scoring of the CSHCN screener in that children meeting the duration criteria (have a condition that lasts or is expected to last for at least 12 months) were excluded.

- The child or their family sometimes or often could not afford enough to eat, sometimes or often could not cover costs of basic needs, lived in an unsafe neighborhood or neighborhood where child witnessed or experienced violence, or was treated or judged unfairly due to race or ethnicity. These are the same measures included in the social risk domain by Bethell et al. 2022 in the aforementioned article.
- The child experienced two or more adverse childhood experiences, had a caregiver/parent with fair or poor self-reported mental health, had a caregiver/parent who usually or always felt that their child was hard to care for or were aggravated by or angry with their child, or had a caregiver/parent who indicated that they are not coping well with demands of raising children or do not have someone to turn to for emotional support. These are the same measures included in the relational risk domain by Bethell et al. 2022 in the aforementioned article.

Now that a potential method has been piloted, the BFH is considering the utility of an estimate within the scope of its Title V work and whether medical, social, and relational risks could be assessed at the program level. While this framework holds promise and the method and use of the NSCH to develop such an estimate is grounded in the existing literature, next steps are indefinite. In the meantime, the BFH will continue to analyze the NSCH public use files as they become available and is committed to continually considering how the data can be leveraged to inform public health practice.

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. Access to and use of the dataset are critical to the survival of the PRAMS dataset.

The BFH plans to annually produce and disseminate 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. For example, during the 2021 birth year, PA PRAMS participated in the COVID Vaccine Supplement. This weighted data set is anticipated to be disseminated to PRAMS states with the core PRAMS 2021 data set in summer/fall 2022. PA PRAMS is also participating in the Postpartum Assessment of Women Survey (PAWS), sponsored by Columbia University. This project is being implemented to gain a better understanding of the causes of postpartum mortality and morbidity. PAWS data collection ran from January 2021 to March 2022 and datasets are expected to be available to states in September 2022. Using the data from the COVID Vaccine Supplement and the PAWS project,

DOH Epidemiology staff will provide descriptive analysis of the datasets. This data will also be disseminated to BFH staff, the PRAMS Committee, and other partners. Data briefs will be created specifically for the COVID Vaccine Supplement and PAWS project and will be made available on the PA DOH public website.

To increase and improve the data products being produced, PA PRAMS will continue to use the streamlined data request process implemented in May 2021. To advance the type of data that is available, PA PRAMS and Bloustein Center for Survey Research at Rutgers University (BCSR), will explore ways to increase response rates in 2022 and beyond by adding a teaser to the envelope and changing the PA PRAMS survey cover design to coincide with the new Phase 9 questionnaire. PA PRAMS will also explore options for promoting PRAMS across the state. CDC PRAMS is developing and implementing a new web option to complete the PRAMS questionnaire. When available, the BCSR staff will implement the option as an alternative method for completing the Pa. questionnaire. PA PRAMS has submitted its interest in being an early adopter of this new model. This is anticipated to be available beginning in summer 2022, potentially affecting the PRAMS weighted data set disseminated to states in Fall of 2023. Additionally, the BFH is currently collaborating with the Allegheny County Health Department (ACHD) and the Bloustein Center for Survey Research at Rutgers University to collect information on individuals in Allegheny County who have recently given birth. The intent of the project is to oversample people who have just given birth in Allegheny County using the current core PRAMS methodology and oversampling Black birthing people in the county to inform local programming and policy decisions. To accomplish this, PA PRAMS will add an additional stratum of Black and Multi Race individuals in Allegheny County.

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 5% 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 aged 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.

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 began sharing data quality summaries with local teams to provide more targeted technical assistance. This process will continue through 2023. 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 continue to be used. For all other cases, the NCFRP's core variables will continue to be used.

In 2023, BFH will continue to partner with East Stroudsburg University to provide an assessment of the current Pennsylvania CDR system. The expected outcome of this process is to better meet the needs of the local CDR teams; increase the number of case reviews; and to increase the quality of those reviews and subsequent data. The vendor will assess CDR teams for the following:

- Local CDR teams' capacity and identify potential barriers to and strengths of effective CDR reviews.
- Evaluate data quality entered by the local teams.
- Identify any training or technical assistance needs to support local teams.

Priority: 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

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 serve populations who experience the greatest inequities. 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. At a program level, this will aid in understanding the disparities and the populations that are most negatively impacted by inequities. 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 to inform the development of additional action plan strategies. The BFH plans to continue to nurture and strengthen both efforts in 2022 and throughout 2023.

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.

Throughout 2022 and 2023, the BFH plans to explore capacity building and the technical assistance needs for both staff and grantees around health equity and the health equity plans. The BFH will continue to identify ways to strengthen the approaches and support offered for the health disparities language integrated into grant agreements as the agreements are executed. Grantees will continue to submit workplans to BFH project officers in accordance with those grant deliverables. The BFH will continue to examine the submitted plans and develop further guidance on plan development and technical assistance for grantees, utilizing health equity principles, as needed. Additionally, the BFH will continue developing 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.

Staff must have the capacity to frame challenges, ask strategic questions, and prioritize action steps and activities. Staff will provide insight on the transition from current practices to the intentional consideration of health disparities and the underlying causes when developing policies and programs. These skills will also be needed to develop and implement interventions focused on social needs and the social**,** environmental, and economic determinants of health. Also, staff will educate grantees on the important aspects necessary to develop and evaluate comprehensive health disparity plans. These changes to the workforce will aid to increase the capacity of staff who have systems leadership skills and can lead others through the changes needed to eliminate system inequities.

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 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.

Participation and collaboration will remain paramount to supporting and effecting change at the organizational and system level. The BFH will remain active on Commonwealth and Department level health equity and antiracism task forces and workgroups to expand health equity principles and knowledge, ensuring information is being shared with the workgroups and back to BFH staff. In addition to the PA Department of Health's Office of Health Equity (OHE) Culturally Linguistically Appropriate Services (CLAS) taskforce, the DOH Anti-racism and Health Equity Task Force and the Commonwealth-wide efforts (Human-Centeredness Community, Anti-Racism Book Club, and an Equity (externally focused) Workgroup), as well as the Pennsylvania Interagency Health Equity Team (PIHET), the BFH seeks to explore participation in new equity focused partnerships, for example the Health Equity Action Teams (a regional approach to address the social determinants of health through OHE).

The BFH will continue to work closely with OHE. Throughout 2022, OHE staff funded through Title V will increase understanding and use of CLAS among Department of Health staff, stakeholders, and community organizations. Additionally, the staff coordinated the 2022 Health Equity Summit (Summit) for over 300 community members, DOH staff, partners, and health equity champions across the state. The Summit was held at the University of Pittsburgh and was also available virtually. The theme of the 2022 Summit, "Momentum to Action: Highlighting Key Topics and Charting the Course of the Elimination of Disparities" signaled the intent to catalyze efforts to eliminate health disparities in Pennsylvania by 2030.The Summit's goals were to increase awareness of health disparities in Pennsylvania, educate participants on innovative approaches to reducing health disparities and addressing health equity, and develop action steps to reduce/eliminate health inequalities in underserved, marginalized, oppressed communities by 2030.The work started at the Summit will continue into 2023.

Throughout 2022 and 2023, the OHE will establish a statewide Latino Committee to reduce health disparities in this population by bringing together Latino leaders throughout Pennsylvania. The OHE is also exploring initiating a Health Equity Podcast, where health equity champions will be interviewed to further the reach of various health equity topics.

Title V staff will participate in these efforts as appropriate.

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 that address the priority 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 minoritized 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

This strategy is 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.

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; and
  - 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 hosted the first round of staff trainings for BFH staff on health equity and related evidence-based practices, including the social determinants of health via the Mid-Atlantic Public Health Training Center in June 2022. Further trainings will continue throughout 2023. The MCH Workforce Development grant is also anticipated to begin in 2023 which will incorporate health equity capacity building.

The BFH will be designing and implementing assessment tools to accompany 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.

Staff will analyze the 2021 BFH Health Equity Assessment to identify priorities and offer recommendations to advance health equity. The assessment surveyed staff on where they believe the Bureau is related to advancing health equity, their position, and their knowledge and experience around health equity. Additionally, there were questions related to staff experiences collaborating with community members and groups, and the utilization and analysis of data. The results will help the BFH understand the capacity building needed for targeted training in health equity, the social determinants of health and cultural competency and help staff and the BFH better serve those within the maternal child health population. Training modules based on these survey results, will be identified through 2022 and 2023, which will increase health equity expertise and assuring staff have a solid understanding of the issues and potential solutions.

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.

In order to better incorporate health equity into all staff job duties, the BFH plans to begin restructuring the Health Equity Committee in July 2022 and will explore how best to carry out health equity deliverables and activities through the end of 2022 and into 2023.

III.F. Public Input

After submission of the 2020 Annual Report/2022 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 regularly schedules 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. The BFH also leverages annual meetings with other grantees and partners, such as the Leadership Education in Adolescent Health (LEAH) and Leadership Education in Neurodevelopmental and Disabilities (LEND) fellowship programs, as opportunities for feedback and engagement on overall Title V priorities and current strategies.

Drafts of the executive summary section, the year 3 state action plan table, and the needs assessment summary update of the 2021 Annual Report/2023 Application as well as updated data briefs were posted to the BFH's Title V site and e-mailed to stakeholders through Pennsylvania's Title V listserv in June of 2022 for public comment. The documents were available for review and comment for a period of two weeks.
The BFH received one public comment requesting a different term be used to describe special health care needs and the increased 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 continues to 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. The comment requested BFH consider eliminating the term "vulnerable populations" which may unintentionally further stigmatize specific groups of people and be cognizant of programs that may lead to perpetuating cycles of harm, such as home visiting programs that could contribute to disproportionate incidences of involvement with Children & Youth Services for minoritized populations. 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 and to program design that does not perpetuate historical harm; 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.

III.G. Technical Assistance

The Bureau of Family Health (BFH) did not request technical assistance in 2021. As the Pennsylvania Title V Program works to implement an action plan designed to address seven 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 - 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 Action Plan 2021-2025_y3.pdf

Supporting Document #02 - Public Input Survey Theme Tables by Population Domain and Title V Partnerships Coordination and Collaboration.pdf

Supporting Document #03 - Visual Exec Summary_Pop.Fact.Sheets_NeedsAssessmentUpdate.pdf

Supporting Document #04 - ESMs Linked to SPMs Detail Sheets.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Combined Org Charts 2022.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Pennsylvania

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 23,954,647	
A. Preventive and Primary Care for Children	$ 10,368,088	(43.2%)
B. Children with Special Health Care Needs	$ 8,544,331	(35.6%)
C. Title V Administrative Costs	$ 2,395,464	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 21,307,883	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 53,009,500	
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)	$ 53,009,500	
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)	$ 76,964,147	
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)	$ 8,127,554	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 85,091,701	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,559,106
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,084,590
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 449,999
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)	$ 913,750
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 209,362
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 105,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 307,177
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 496,750
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	$ 841,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 23,732,205 (FY 21 Federal Award: $ 23,954,647)		$ 23,954,647	
A. Preventive and Primary Care for Children	$ 10,812,330	(45.6%)	$ 11,087,519	(46.2%)
B. Children with Special Health Care Needs	$ 8,000,468	(33.7%)	$ 7,215,266	(30.1%)
C. Title V Administrative Costs	$ 2,373,220	(10%)	$ 2,395,464	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 21,186,018		$ 20,698,249	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 47,572,500		$ 49,045,442	
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)	$ 47,572,500		$ 49,045,442	
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)	$ 71,304,705		$ 73,000,089	
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)	$ 6,463,826		$ 3,241,422	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 77,768,531		$ 76,241,511	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,928,662	$ 757,143
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500	$ 94,446
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 138,196
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 245,000	$ 161,125
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 300,000	$ 58,576
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,946,564	$ 1,053,300
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	$ 308,030
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 227,700	$ 103,535
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	$ 1,041,100	$ 216,486
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees		$ 350,585

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 2,029,074	$ 2,212,384
2. Infants < 1 year	$ 1,910,935	$ 2,784,981
3. Children 1 through 21 Years	$ 8,470,228	$ 8,302,538
4. CSHCN	$ 8,524,719	$ 7,215,266
5. All Others	$ 624,227	$ 1,044,014
Federal Total of Individuals Served	$ 21,559,183	$ 21,559,183

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 0	$ 0
2. Infants < 1 year	$ 6,773,200	$ 5,818,279
3. Children 1 through 21 Years	$ 34,620,000	$ 34,034,583
4. CSHCN	$ 4,941,678	$ 4,079,031
5. All Others	$ 6,674,622	$ 5,113,549
Non-Federal Total of Individuals Served	$ 53,009,500	$ 49,045,442
Federal State MCH Block Grant Partnership Total	$ 74,568,683	$ 70,604,625

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:	**2023**
	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 prenatal and infancy periods 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 IA.3.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Services for Children with Special Health Care Needs reported of Form 2, line 1B includes infrastructure and services for family 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:	**2021**
	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 prenatal and infancy periods 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 IA.3.	

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.

Form 3b
Budget and Expenditure Details by Types of Services

State: Pennsylvania

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 1,538,980	$ 1,543,180
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 7,100	$ 0
B. Preventive and Primary Care Services for Children	$ 1,531,880	$ 1,518,501
C. Services for CSHCN	$ 0	$ 24,679
2. Enabling Services	$ 8,223,005	$ 10,188,896
3. Public Health Services and Systems	$ 14,192,662	$ 12,222,571
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		$ 60,589
Physician/Office Services		$ 1,408,697
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 45,442
Laboratory Services		$ 7,545
Other		
Cognitive Therapy Services		$ 20,907
Direct Services Line 4 Expended Total		$ 1,543,180
Federal Total	$ 23,954,647	$ 23,954,647

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 8,676,500	$ 7,404,345
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 6,773,200	$ 5,818,279
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 1,903,300	$ 1,586,066
2. Enabling Services	$ 4,411,350	$ 4,602,489
3. Public Health Services and Systems	$ 39,921,650	$ 37,038,608
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		$ 1,454,570
Physician/Office Services		$ 1,289,912
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 4,528,366
Other		
Therapeutic Rehab		$ 131,497
Direct Services Line 4 Expended Total		$ 7,404,345
Non-Federal Total	$ 53,009,500	$ 49,045,442

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: 135,881 **Data Source Year: 2021**

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	135,557 (99.8%)	1,111	167	167 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	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
Gaucher	8,756 (6.4%)	0	0	0 (0%)
Fabry	8,756 (6.4%)	0	0	0 (0%)
Niemann-Pick	8,756 (6.4%)	1	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 Pennsylvania newborns, long-term follow-up is not performed by the NSFP.

Form Notes for Form 4:

All RUSP CORE and secondary conditions, as well as KRABBE are included in the Newborn Line 7 aggregate counts.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2021**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The Data Source Year for Total Births by Occurrence is 2021. The source for total births by occurrence is provisional 2021 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:	**2021**
	Column Name:	**Data Source Year Notes**
	Field Note: Data source year for Screening Counts is 2021. In PA, there were 10 conditions on the mandatory screening panel and submitters elected which of the other 27 conditions on the supplemental follow-up panel were screened for. The combined lists of disorders on the screening panel and follow-up panel aligned with the CORE RUSP conditions. On May 21, 2021, with the implementation of Act 133, all 35 CORE and 26 Secondary RUSP conditions, as well as Krabbe disease became mandated for screening by the Pennsylvania Newborn Screening and Follow-up Program. The RUSP CORE and secondary conditions, as well as KRABBE are included in the Line 7 aggregate counts.	

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 2021

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	1,055	66.6	0.2	6.7	20.7	5.8
2. Infants < 1 Year of Age	135,557	33.1	0.0	0.0	0.0	66.9
3. Children 1 through 21 Years of Age	53,346	15.8	0.3	5.2	1.0	77.7
3a. Children with Special Health Care Needs 0 through 21 years of age^	16,424	53.2	1.2	17.7	3.4	24.5
4. Others	24,196	15.4	0.0	15.5	1.6	67.5
Total	214,154					

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	130,693	No	132,401	90.8	120,220	1,055
2. Infants < 1 Year of Age	129,642	No	135,881	99.8	135,609	135,557
3. Children 1 through 21 Years of Age	3,147,010	No	3,218,669	33.0	1,062,161	53,346
3a. Children with Special Health Care Needs 0 through 21 years of age^	731,454	No	748,065	50.9	380,765	16,424
4. Others	9,503,189	No	9,315,038	0.3	27,945	24,196

^Represents a subset of all infants and children.

Form Notes for Form 5:

The Bureau 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 divisions' "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:	**2021**
	Field Note: Services/programs represented in the pregnant women served count include the following: County Municipal Health Home Visiting, Doula Support Program, Centering Pregnancy Program, Breastfeeding, Safe and Healthy Homes Program.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	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 treatment centers, infants served by the hemoglobin treatment centers. 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: County Municipal Health Department Home Visiting, BrainSTEPS, Community to Home, Safe Sleep Initiative, Room2Breathe, and specialty care programs for Cooley's anemia, cystic fibrosis, hemophilia, sickle cell anemia, and spina bifida.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Services and programs represented in the children served count include the following: Mentoring, Bullying, Reproductive Heath grants, LGBTQ Behavioral Health, Health Resource Centers, Alliance Opioid Project, Youth Care Team, Medical Home Community Team, Room2Breathe, County Municipal Health Home Visiting, Safe and Healthy Homes Program, Autism Diagnostic Clinic, Community to Home, Cooley's Anemia, cystic fibrosis, epilepsy, Federally Qualified Health Centers, hemophilia, Leadership Development & Training, Male Involvement Initiative, Safety in Youth Sports, Sickle Cell Clinics, spina bifida, Sickle Cell Community-Based Services and Supports, Technology-Assisted Children's Program, Tourette's, metabolic formula program, and Community Health.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**

	Field Note: Services and programs represented by in the CSHCN count include the following: Bullying Prevention, Room2Breathe Program, County Municipal Health Department Home Visiting, Medical Home Community Team, Safe and Healthy Homes Program, Autism Diagnostic Clinic BrainSTEPS, Community to Home, Cooley's Anemia, Cystic Fibrosis, FQHC, Hemophilia, Leadership Development & Training, Sickle Cell Clinics, Spina Bifida, Sickle Cell CBSS, Tourette's, infants enrolled in the metabolic formula program, infants served by newborn screening case management, infants in metabolic treatment centers, infants served by the metabolic treatment centers, infants served by the cystic fibrosis treatment centers, infants served by the hemoglobin treatment centers.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**
	Field Note: Services and programs represented in the 22+ served count include the following: IMPLICIT Interconception Care Program, Alliance Opioid Project, County Municipal Health Department Home Visiting, Pacify breastfeeding app, Breastfeeding, Acquired Brain Injury, Autism Diagnostic Clinic, BrainSTEPS, Cooley's anemia, cystic fibrosis, epilepsy, hemophilia, Leadership Development & Training, Safety in Youth Sports, Sickle Cell Clinics, spina bifida, sickle cell community-based supports and services, Tourette's, metabolic formula program, cystic fibrosis pharmacy program, and the spina bifida pharmacy program. 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 Total % Served**
	Fiscal Year:	**2021**
	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: County Municipal Health Department Home Visiting, Doula Support Program, Centering Pregnancy program, Safe Sleep Initiative, Breastfeeding, Smoking Cessation, Safe and Health Homes program, and Pennsylvania Pregnancy Risk Assessment Monitoring System. The true numerator is 120,250. The denominator (132,401) is from the National Vital Statistics Rapid Release Report, published May 2022 (Births: Provisional Data for 2021, page 9). The calculated percentage using these values is 90.8%.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2021**
	Field Note: The denominator (132,401) is from the National Vital Statistics Rapid Release Report, published May 2022 (Births: Provisional Data for 2021, page 9).	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

	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 and hemoglobin treatment centers and infants served by the Federal Hearing Grant through the Guide By Your Side program. This number represents the best unduplicated estimate of infants served. Other services/programs represented by this count include: Community Municipal Health Department Home Visiting, Safe Sleep, Safe and Healthy Homes programs, Sudden Death in the Young, BrainSTEPS, Room2Breathe, Community to Home, Cooley's anemia, cystic fibrosis, hemophilia, sickle cell anemia and spina bifida. The true numerator is 135,557. The denominator (135,881) is PA Newborn Screening Internet Case Management System Provisional Data for 2021. The calculated percentage using these values is 99.8%.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: The denominator (135,881) is PA Newborn Screening Internet Case Management System Provisional Data for 2021.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: This is the number of children receiving a school growth screen (1,060,978) and represents the best unduplicated estimate. However, many children were unable to be screened due to receiving virtual instruction. Other services represented include: PREP and PREP training, Mentoring, Bullying Rooms2Breathe, Medical Home Community Team, Reproductive Health Grants, Injury Prevention, LGBTQ Behavioral health, Health Resource Centers, Sexual Risk Avoidance Education/Teen Outreach Program, Youth Care Team, County Municipal Health Home Visiting, Safe and Healthy Homes program, Alliance Opioid Project, BrainSTEPS, Community to Home, Cooley's anemia, cystic fibrosis, Federally Qualified Health Centers, hemophilia, Leadership Development & Training, sickle cell clinics, sickle cell community -based services and supports, Technology Assisted Children's Home Program, Tourette's, Federal Hearing Grant, and the metabolic formula program. The true numerator is 1,060,978. Denominator (3,218,669) is Pa. civilians aged 1 to 21 from 2019 U.S. Census, percentage is 33%.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2021**
	Field Note: Denominator (3,218,669) is Pa. civilians aged 1 to 21 from 2019 U.S. Census	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

	Field Note: Services and programs represented in the CSHCN served count include the following: Bullying Prevention, Room2Breathe, County Municipal Health Department Home Visiting, Medical Home Community Team, Safe and Healthy Homes program, Autism Diagnostic Clinic, BrainSTEPS, Community to Home, cystic fibrosis, Federally Qualified Health Centers, hemophilia, Leadership Development & Training, sickle cell clinics, sickle cell community-based services and supports, Technology Assisted Children's Home Program, Tourette's, School Health, Federal Hearing Hear through the Guided By Your Side program, metabolic formula program, newborn screening case management, metabolic treatment centers, cystic fibrosis treatment centers, and hemoglobin treatment centers.. The true numerator is 380,276. The denominator (747,434) is the product of the NSCH 2019-2020 percentage of children aged 0-17 with special health care needs (22.3%) multiplied by the total 2019 Pennsylvania child population (age 1-21) from the U.S. Census Bureau source described in the child field note (3,218,669) plus the total 2021 provisional Pennsylvania infant population (135,881). The calculated percentage is 50.8%.	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2021**
	Field Note: Denominator (747,434) is the product of the NSCH 2019-2020 percentage of children aged 0-17 with special health care needs (22.3%) multiplied by the total 2019 Pennsylvania child population (age 1-21) from the U.S. Census Bureau source described in the child field note (3,218,669) plus the total 2021 provisional Pennsylvania infant population (135,881).	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	Field Note: Services represented include: County Municipal Health Department Home Visiting, IMPLICIT Interconception Care Program, Alliance Opioid Project, PREP and PREP training, Pacify Breastfeeding app, Breastfeeding, Safe Sleep, metabolic formula program, cystic fibrosis and spina bifida pharmacy programs, Tourette's program, Autism Diagnostic Clinic, Acquired Brain Injury, BrainSTEPS, Safety in Youth Sports, Juvenile Justice, Leadership Development Training, epilepsy and Specialty Care Programs for Cooley's Anemia, Cystic Fibrosis, 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 24,909. The denominator (9,315,038) is the 2019ACS 1-Year Estimate for Pa. (12,801,989), less the sum of the counts in the child (3,218,669) infant (135,881), and pregnant women (132,401) field notes. The 2019 Estimate was used due to concerns about the data quality of the 2020 experimental estimates. The calculated percentage is 0.3%.	
10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2021**
	Field Note: The denominator (9,315,038) is the 2019ACS 1-Year Estimate for Pa. (12,801,989), less the sum of the counts in the child (3,218,669) infant (135,881), and pregnant women (132,401) field notes	

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 2021

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	129,679	83,735	16,849	16,760	71	5,807	0	3,501	2,956
Title V Served	120,250	91,029	12,747	9,139	121	4,208	0	2,645	361
Eligible for Title XIX	59,550	21,546	12,971	11,257	78	1,232	47	0	12,419
2. Total Infants in State	135,881	102,862	14,403	10,327	136	4,756	0	2,989	408
Title V Served	135,565	102,617	14,369	10,302	136	4,744	0	2,989	408
Eligible for Title XIX	51,981	23,983	14,102	12,237	94	1,467	98	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: The source for total deliveries in the state (total births by occurrence) is the preliminary 2020 Pennsylvania Birth Files and data were provided by the Pennsylvania Office of Administration, Division of Health Informatics. The Non-Hispanic Asian and Non-Hispanic Native Hawaiian or Other Pacific Islander categories are one combined category in the data source.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2021**
	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 (120,250) for 2021.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2021**
	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 2021.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**
	Field Note: The count for total infants in state (135,881) is from calendar year 2021 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 2021.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2021**

	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 (131,672) for 2021.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2021**
	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 2021.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Pennsylvania

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 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"		132

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	Special Kids Network	Special Kids Network
2. Number of Calls on Other Toll-Free "Hotlines"		396
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		1,268
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		2,252,778

Form Notes for Form 7:

The number of calls received by the Healthy Baby hotline reported in Annual Report Year 2021 reflects updates to data collection strategies. 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 2021 Healthy Baby numbers are direct, intentional calls to the hotline.
The COVID-19 pandemic significantly impacted calls to the hotline for 2021. There was significant decrease in the number of calls received as compared to past years. All calls logged for the 2021 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.
The number of hits to the State's Title V Program Website reported represents unique page views.
The number of hits to the State Title V Program Social Media Websites represents the number of profile visits to the Department of Health's Twitter account and the number of page visits to the Department of Health's Facebook page from January to December 2021.

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 Sreet
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 346-3000
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) 346-3000
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 2023

No.	Priority Need
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
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

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 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
2020	77.5 %	0.1 %	97,735	126,130
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
2019	87.8	2.7	1,107	126,067
2018	77.0	2.5	993	128,996
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
2016_2020	14.6	1.5	99	677,750
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**
2020	8.3 %	0.1 %	10,802	130,393
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
2020	9.6 %	0.1 %	12,486	130,457
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
2020	25.0 %	0.1 %	32,651	130,457
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
2020/Q3-2021/Q2	1.0 %			
2019/Q4-2020/Q3	2.0 %			
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
2019	6.4	0.2	866	134,625
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
2019	5.9	0.2	796	134,230
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
2019	4.2	0.2	560	134,230
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
2019	1.8	0.1	236	134,230
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**
2019	236.9	13.3	318	134,230
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
2019	88.7	8.1	119	134,230
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
2020	7.1 %	0.8 %	8,566	120,625
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
2019	12.9	0.3	1,646	127,338
2018	14.1	0.3	1,840	130,058
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
2019_2020	9.1 %	1.2 %	223,415	2,460,098
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
2020	17.2	1.2	221	1,281,516
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
2020	33.3	1.5	513	1,538,635
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
2018_2020	7.0	0.5	169	2,407,568
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
2018_2020	8.2	0.6	198	2,407,568
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
2019_2020	22.3 %	1.6 %	585,504	2,624,842
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
2019_2020	17.1 %	3.0 %	100,319	585,504
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
2019_2020	3.5 %	0.8 %	77,352	2,189,018
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
2019_2020	8.9 %	1.1 %	193,462	2,174,204
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
2019_2020	56.9 %	5.6 %	182,816	321,032
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
2019_2020	89.0 %	1.4 %	2,333,109	2,622,938
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
2019_2020	15.1 %	2.3 %	167,825	1,113,042
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
2017	79.1 %	3.0 %	111,000	140,000
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
2020_2021	66.1 %	1.1 %	1,637,291	2,476,991
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
2020	78.4 %	2.6 %	596,554	760,770
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
2020	95.2 %	1.1 %	723,993	760,770
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
2020	95.5 %	1.2 %	726,408	760,770
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
2020	12.6	0.2	4,895	389,645
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
2020	12.9 %	1.2 %	15,545	120,757
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
2019_2020	2.0 %	0.5 %	52,027	2,607,492
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				78.2	78.8
Annual Indicator			77.6	75.2	74.3
Numerator			1,651,482	1,609,089	1,571,902
Denominator			2,128,688	2,140,534	2,115,148
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS 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 with 2018 survey data.

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	68.7	69.4	70.1	78.2	78.8
Annual Indicator	66.4	65.3	77.6		
Numerator					
Denominator					
Data Source	NIS	NIS	NIS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	79.4	80.0	80.6	81.2

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	76	78	80	86	87
Annual Indicator	81.8	83.8	84.2	82.9	76.9
Numerator	108,050	111,838	113,497	105,668	95,850
Denominator	132,020	133,410	134,782	127,530	124,715
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	88.0	89.0	90.0	91.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	18	20	23	30	32
Annual Indicator	23.7	25.6	26.9	25.9	23.6
Numerator	30,174	32,912	35,760	32,327	28,555
Denominator	127,300	128,398	132,966	124,942	121,059
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	34.0	36.0	38.0	40.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79.8	80.6	82.1	85.3	87
Annual Indicator	84.0	81.2	83.1	82.4	81.8
Numerator	110,308	103,722	104,542	101,724	98,852
Denominator	131,259	127,773	125,760	123,405	120,823
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	79.8	80.6	82.1	85.3	87
Annual Indicator	84	81.2	83.1		
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2015	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	88.6	90.3	91.9	93.5

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**	**2021**
Annual Objective		32.3	37.7	39.8
Annual Indicator	31.5	36.6	39.8	38.8
Numerator	38,141	44,262	46,940	45,339
Denominator	121,226	120,893	118,085	116,778
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			32.3	37.7	39.8
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	41.9	44.0	46.1	48.2

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**	**2021**
Annual Objective		47.4	51.7	53.7
Annual Indicator	46.9	50.1	59.5	56.0
Numerator	56,601	60,875	70,513	65,435
Denominator	120,631	121,402	118,424	116,863
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			47.4	51.7	53.7
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				
	2022	**2023**	**2024**	**2025**
Annual Objective	55.7	57.7	59.7	61.7

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	186.8	184.9	183.1	126.2	113.1
Annual Indicator	152.0	152.5	139.4	139.8	135.4
Numerator	1,654	2,201	2,004	1,997	1,928
Denominator	1,088,130	1,443,388	1,437,802	1,428,611	1,423,977
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	100.0	86.9	73.8	60.7

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		88.7	85	85	86
Annual Indicator	86.5	85.7	85.7	87.7	81.8
Numerator	775,554	715,291	715,291	659,147	679,581
Denominator	897,142	834,394	834,394	751,698	830,408
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	88.0	90.0	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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		61	45	45	48
Annual Indicator	51.8	45.9	42.9	44.5	43.6
Numerator	267,920	234,614	223,990	244,784	255,237
Denominator	517,187	511,324	521,926	549,735	585,504
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.0	50.0	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	**2021**
Annual Objective		
Annual Indicator	49.3	48.3
Numerator	1,027,215	985,573
Denominator	2,085,050	2,039,338
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2018_2019	2019_2020

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

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

State Provided Data			
	2019	2020	2021
Annual Objective			70.5
Annual Indicator			64.6
Numerator			197
Denominator			305
Data Source			Pennsylvania newborn screening data system
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	71.0	71.5	72.0	72.5

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

State Provided Data			
	2019	2020	2021
Annual Objective			5
Annual Indicator			3
Numerator			
Denominator			
Data Source			Bureau of Family Health internal documentation
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	4.0	4.0	5.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
The goals for future years were reduced after identifying the baseline number of programs or policies modified as a result of staff's use of evidence-based, data-driven decision making in 2021. While the number of data requests increased in 2021, it will take time for staff to use data to inform programming and decision-making.

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
Annual Objective	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2021 was used to develop MOUs and agreements with partners, data will be available in 2022.

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
Annual Objective	50.0	55.0	60.0	65.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2021 was used to develop MOUs and agreements with partners, data will be available in 2022.

SPM 5 - Percent of children ages 6-17 who have one or more adult mentors

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			94
Annual Indicator			93.1
Numerator			1,500,973
Denominator			1,612,808
Data Source			NSCH, Indicator 5.9, Pa. data
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.0	94.0	94.0	95.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Rate of mortality disparity between black and white infants

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			9.1
Annual Indicator			9.35
Numerator			
Denominator			
Data Source			NVSS
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8.9	8.6	8.2	7.7

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	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: In 2020 (2019-2020 year) the rate was recorded at 12.7 for black infants and 4.5 for white infants, highlighting a rate difference of 8.2. The goal will be to reduce by a rate of 1.5 per 1,000 live births. Measure comes from HP2030 data, Incremental decrease each year to reach intended rate decrease of 1.5 per 1,000 live births. (Decrease the difference in the rates between black and white by: 2021- 0.15 decrease; 2022- 0.2 decrease; 2023- 0.3 decrease; 2024- 0.4 decrease; 2025- 0.45)- continuing from the 2017 disparity rate and actual rates that can be obtained. Included is an estimate of for 2021 (2020-2021) of 9.35	

SPM 7 - Rate of mortality disparity between black and white children, ages 1-4

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			11.2
Annual Indicator			0
Numerator			
Denominator			
Data Source			HealthyPeople 2030
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	10.7	9.7	8.7	6.7

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	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: HealthyPeople 2030 changed the parameters of child mortality rates to combine all child mortality rates ages 1-19. This SPM will be revisited in the future to better capture the measures and the actual annual indicators, using a comparable data source, if possible.	

SPM 8 - Rate of maternal mortality disparity between black and white persons

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			26.4
Annual Indicator			0
Numerator			
Denominator			
Data Source			NVSS
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.9	25.4	24.6	22.6

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	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	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. In 2021, it was determined that 3-year rates will be used to measure the maternal mortality disparity rates, as they are more reliable than annual rates. This SPM will be visited to better capture the measures and the actual annual indicators utilizing 3-year estimates.	

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

State Provided Data			
	2019	2020	2021
Annual Objective			24
Annual Indicator			55.2
Numerator			891
Denominator			1,615
Data Source			CMHD final reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.5	25.0	25.5	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

State Provided Data			
	2019	2020	2021
Annual Objective			85
Annual Indicator			75.6
Numerator			198
Denominator			262
Data Source			CPP quarterly reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.9	86.8	87.7	88.6

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

State Provided Data			
	2019	2020	2021
Annual Objective			80
Annual Indicator			78.3
Numerator			2,243
Denominator			2,865
Data Source			IMPLICIT ICC quarterly and annual reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	82.4	83.6	84.8	86.1

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

State Provided Data			
	2019	2020	2021
Annual Objective			3
Annual Indicator			3
Numerator			
Denominator			
Data Source			Philadelphia Department of Public Health
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			25
Annual Indicator			2
Numerator			
Denominator			
Data Source			Alliance of PA Inc. quarterly and annual reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	27.0	30.0	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 and 2025 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

State Provided Data			
	2019	2020	2021
Annual Objective			80
Annual Indicator			88
Numerator			373
Denominator			424
Data Source			IMPLICIT ICC and CPP quarterly reports CMHD annual
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	80.8	81.6	82.4	83.2

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

State Provided Data			
	2019	2020	2021
Annual Objective			3
Annual Indicator			0
Numerator			0
Denominator			1
Data Source			2021
Data Source Year			IMPLICIT
Provisional or Final ?			Final

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Due to COVID-19 related staff turnover/vacancies, the 4TM pilot project has experienced significant barriers to establishing timely, consistent and accurate data collection, reporting and analysis. 4TM reports to DOH have not included baseline data and have instead focused on the progress that is being made with regards to pilot readiness/implementation.

ESM 1.8 - Number of MMRC recommendations implemented annually

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			3
Numerator			
Denominator			
Data Source			Philadelphia MMRC reporting to the Department
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			2
Numerator			
Denominator			
Data Source			meetings held
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			60
Annual Indicator			41.2
Numerator			21
Denominator			51
Data Source			K10 program
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			4
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		10
Numerator		
Denominator		
Data Source		agenda and meeting minutes
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		15
Numerator		
Denominator		
Data Source		quarterly vendor/grantee reports
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			0
Numerator			
Denominator			
Data Source			infant program that implements recommendations
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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					
	2017	2018	2019	2020	2021
Annual Objective	2	3	3	0	0
Annual Indicator	6	6	6	0	5
Numerator					
Denominator					
Data Source	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	Quarterly reports - Infant Safe Sleep Initiative
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.0	3.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**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	
2.	**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					
	2017	2018	2019	2020	2021
Annual Objective	0	8	9	18	9
Annual Indicator	3	8.6	17.4	0	36.1
Numerator		11,639	23,337		47,314
Denominator		135,498	134,091		131,006
Data Source	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	grantee quarterly reports and annual birthing data
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	37.0	39.0	20.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**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	
2.	**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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/21 to 6/30/24. Recruiting was paused for the last year of the prior grant period and began 7/1/21 with the new grant.	

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	0	2	4	8	8
Annual Indicator	2	1.9	8.9	0	32.5
Numerator		2	9		27
Denominator		107	101		83
Data Source	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	grantee quarterly reports, birthing hospital count
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.0	38.0	40.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**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	
2.	**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.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Grant period is 7/1/21 to 6/30/24	

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

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		0
Numerator		
Denominator		
Data Source		PPOR vendors quarterly and annual reports
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			0
Numerator			
Denominator			
Data Source			child program areas implementing recommendations
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			30
Annual Indicator			15
Numerator			
Denominator			
Data Source			quarterly grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	32.0	34.0	36.0	38.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.3 - Number of comprehensive in-home child safety education visits.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	180.0	90.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Objective for 2024 is for a half year.

ESM 7.1.4 - Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	900.0	450.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Objective for 2024 is for a half year.

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	15	18	21	25	30
Annual Indicator	18	15	12	7	3
Numerator					2,698
Denominator					89,993
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	Quarterly reports	quarterly vendor/grantee reports
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	33.0	35.0	38.0	38.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			4,500
Annual Indicator			540
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	4,550.0	4,600.0	4,650.0	4,700.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			90
Annual Indicator			99
Numerator			4,589
Denominator			4,635
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	90.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.4 - Number of community-based organization staff trained in the OBPP

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			45
Annual Indicator			9
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	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

State Provided Data			
	2019	2020	2021
Annual Objective			3,880
Annual Indicator			4,681
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			10,000
Annual Indicator			49,943
Numerator			
Denominator			
Data Source			grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	11,000.0	12,100.0	13,310.0	14,641.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			360
Annual Indicator			151
Numerator			
Denominator			
Data Source			grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			150
Annual Indicator			53
Numerator			
Denominator			
Data Source			grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	160.0	170.0	180.0	190.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.9 - Number of CDR recommendations implemented (adolescent health)

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1
Annual Indicator			0
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			35
Annual Indicator			145
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	39.0	43.0	47.0	51.0

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	2021
Annual Objective			55
Annual Indicator		59.5	63.1
Numerator		13,448	9,536
Denominator		22,602	15,110
Data Source		Grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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	2021
Annual Objective			8
Annual Indicator		9.4	11.1
Numerator		2,127	1,677
Denominator		22,602	15,110
Data Source		Grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8.0	9.0	9.0	10.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			2
Annual Indicator			0
Numerator			
Denominator			
Data Source			CSHCN programs implementing recommendations
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	4.0	5.0	6.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			475
Annual Indicator			302
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	498.0	523.0	549.0	576.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator			20
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	52.0	0.0	0.0	0.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator			22
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			40
Annual Indicator			0
Numerator			
Denominator			
Data Source			Philadelphia Department of Public Health
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	43.0	46.0	46.0	49.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
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.

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

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			4
Annual Indicator			6
Numerator			
Denominator			
Data Source			agenda and meeting minutes
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator			103
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	110.0	115.0	120.0	125.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			500
Annual Indicator			315
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	515.0	530.0	545.0	560.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.9 - Number of calls received through the SKN Helpline

Measure Status:	Inactive - Logging of SKN calls will continue to be reporting via Form 7.		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			800
Annual Indicator			396
Numerator			
Denominator			
Data Source			SKN call logs
Data Source Year			2021
Provisional or Final ?			Final

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

State Provided Data			
	2019	2020	2021
Annual Objective			8
Annual Indicator			43
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	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

State Provided Data			
	2019	2020	2021
Annual Objective			40
Annual Indicator			137
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	44.0	48.0	52.0	56.0

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

State Provided Data			
	2019	2020	2021
Annual Objective			15
Annual Indicator			11
Numerator			
Denominator			
Data Source			quarterly vendor/grantee reports
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	19.0	23.0	27.0	31.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

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

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data collection has been delayed resulting in a delay in both establish baseline numbers as well as establishing objectives.

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

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		11.2
Numerator		3,592
Denominator		31,964
Data Source		quarterly vendor/grantee reports
Data Source Year		2021
Provisional or Final ?		Final

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

Field Level Notes for Form 10 ESMs:

None

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 2 is labeled as a cross-cutting SPM, the infant strategy and associated ESM, listed below, are also linked to SPM 2. 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 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:	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 2030 data. Additionally, disparity data layered with social determinants of health data, tools like the Pennsylvania's Health Equity Analysis Tool and/or Environmental Health Indicators Map, can provide guidance on Pennsylvanians who are experiencing worse infant mortality rates and can help 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:	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 social determinants of health data, tools like the Pennsylvania's Health Equity Analysis Tool and/or Environmental Health Indicators Map, can provide guidance on Pennsylvanians who are experiencing worse child mortality rates and can help 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. Healthy People 2030 only measures child mortality rates for children ages 1-19. If possible, a comparable data source will be identified to capture the measure and calculate disparities between black and white children, ages 1-4.
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 social determinants of health data, tools like the Pennsylvania's Health Equity Analysis Tool and/or Environmental Health Indicators Map, can provide guidance on Pennsylvanians who are experiencing worse maternal mortality rates and can help 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. Utilizing 3-year maternal mortality rates would offer better reliability. As a result of this data issue, 3-year maternal mortality data should be used to calculate the estimated disparity rates and measures in the future.
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 not

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

Measure Status:	Active
Goal:	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
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents and women enrolled in Centering Pregnancy programs who talked with a healthcare professional about birth spacing and birth control methods **Denominator:** Number of women enrolled in Centering Pregnancy programs
Data Sources and Data Issues:	Data will come from the Centering Pregnancy Program's quarterly and annual reporting.
Significance:	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.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually provide breastfeeding education, community outreach and improve breastfeeding initiation and duration rates.</td></tr>
<tr><td>Definition:</td><td>
<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 regional breastfeeding collaborative meetings held by Grantee.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The number of regional breastfeeding collaborative meetings held will be collected by the breastfeeding program staff.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

Measure Status:	Active
Goal:	Increase the number of targeted prevention initiatives or interventions implemented in selected communities, using PPOR data.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of targeted prevention initiatives or interventions implemented **Denominator:**
Data Sources and Data Issues:	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.
Evidence-based/informed strategy:	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.
Significance:	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.

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 7.1.3 - Number of comprehensive in-home child safety education visits.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	Annually increase the number of comprehensive in-home child safety education visits completed.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Count of the number of comprehensive in-home child safety education visits completed through the Pennsylvania Prevent Injuries in Children Program. **Denominator:**
Data Sources and Data Issues:	Quarterly reports from the Pennsylvania Prevent Injuries in Children Program.
Evidence-based/informed strategy:	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 it 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 comes from 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. https://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/Evidence-Based%20Strategies%20FINAL.pdf
Significance:	This number identifies the number of families that have received comprehensive in-home child safety education visits to prevent or reduce injury to children ages 0-9. Providing one-to-one in-home education showed increases in safety practices. The Pennsylvania Prevent Injuries in Children (PIC) Program will focus on the leading causes of injury that lead to hospitalization. The counties served by the PIC Program have the greatest need across the state based upon on injury, death, race and ethnicity, and emergency department visits using both rates and numbers for children ages 0-9.

ESM 7.1.4 - Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits.
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>ESM Subgroup(s):</td><td>Children 0 through 9</td></tr>
<tr><td>Goal:</td><td>Annually increase the number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits.</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>Count of the number of home safety interventions performed as a result of needs identified during in-home child safety education visits completed through the Pennsylvania Prevent Injuries in Children 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 the Pennsylvania Prevent Injuries in Children Program.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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 it 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 comes from 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.

https://www.childrenssafetynetwork.org/sites/childrenssafetynetwork.org/files/Evidence-Based%20Strategies%20FINAL.pdf</td></tr>
<tr><td>Significance:</td><td>This number identifies the number of home safety interventions performed for families as a result of needs identified during comprehensive in-home child safety education visits to prevent or reduce injury to children ages 0-9. Home safety interventions performed in conjunction with one-to-one in-home education showed increases in safety practices. The Pennsylvania Prevent Injuries in Children (PIC) Program will focus on the leading causes of injury that lead to hospitalization. The counties served by the PIC Program have the greatest need across the state based upon on injury, death, race and ethnicity, and emergency department visits using both rates and numbers for children ages 0-9.</td></tr>
</table>

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.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To annually increase percent of visits to HRCs that include counseling</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 visits to the HRCs that include counseling</td></tr>
<tr><td>Denominator:</td><td>Total number of visits to the HRCs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 10.4 - Number of community-based organization staff trained in the OBPP
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>Increase the number of community-based organizations participating in a bullying awareness and prevention program</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 community-based organization staff trained in the OBPP</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 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.</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 10.5 - 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:** 500 **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.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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</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 a most effective or moderately effective contraceptive 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 Department of Health 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 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.</td></tr>
</table>

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:** 100 **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:** 500 **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>Inactive - Logging of SKN calls will continue to be reporting via Form 7.</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:** 100 **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>500</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 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>The goal is to ensure that all State Health Centers are documenting and reporting all referrals of children ages 0-17 with or without special health care needs, who do not have a provider, that are made to a medical home within 6 months in order to e</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 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 initial goal is to establish a baseline of children without a provider who are 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.</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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually increase the percentage of CSHCN receiving quality care through project-funded FQHC health systems.</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 a count of the CSHCN served through the funded programs in the project-funded FQHC programs.</td></tr>
<tr><td>Denominator:</td><td>The denominator is a count of the total number of CSHCN receiving care in the project-funded FQHC programs.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 2021

	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	Yes	Quarterly	3		• PRAMS • death records • NBS • NAS surveillance data
2) Vital Records Death	Yes	Yes	Quarterly	3	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 • NAS surveillance data
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 • NBS • EI
10) National Center for Fatality Review and Prevention	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 • coroner/medical records • medical provider records • police records • PDMP data • EMS records • mental health provider data • obituaries

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Designated BFH staff have access to vital records birth files for specific operations related to PRAMS, Child Death Review, SUID/SDY registries, Maternal Mortality Review, newborn screening, and neonatal abstinence syndrome surveillance. In 2021 an internal request for direct access to an analytic file that can be used to inform other Title V programs and needs assessment activities was approved and a dataset provided to the BFH for the first time. However, the analytic file solely includes occurrent, resident births; the bureau responsible for vital records denied BFH access to data on births to residents occurring out of state indicating that provision of such data would be a violation of interstate data sharing agreements. Additionally, quarterly updates to provisional birth files have not been provided to the BFH to date despite an agreed upon schedule.
Data Source Name:	**2) Vital Records Death**
	Field Note: Designated BFH staff have access to vital records death files for specific operations related to Child Death Review, SUID/SDY registries, and Maternal Mortality Review. In 2021 an internal request for direct access to an analytic file that could be analyzed to inform other Title V programs and needs assessment activities was approved and a dataset provided to the BFH for the first time. However, the analytic file solely includes occurrent, resident deaths; the bureau responsible for vital records denied BFH access to data on deaths among residents occurring out of state indicating that provision of such data would be a violation of interstate data sharing agreements. Additionally, quarterly updates to provisional death and fetal death files have not been provided to the BFH to date despite an agreed upon schedule.
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:	**9) Neonatal Abstinence Syndrome (NAS) Case Reporting**
	Field Note: insufficient character count for full data source name: Neonatal Abstinence Syndrome (NAS) Case Reporting Surveillance Data
Data Source Name:	**10) National Center for Fatality Review and Prevention**
	Field Note: insufficient character character for full data source name: National Center for Fatality Review and Prevention - Case Reporting System