Maternal and Child Health Services Title V Block Grant

Pennsylvania

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

pennsylvania
DEPARTMENT OF HEALTH

July 17, 2023

Shirley Payne, PhD, MPH
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 Dr. Payne:

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 2022 Annual Report and 2024 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
Digitally signed by Andrea Race
Date: 2023.07.17 11:43:02 -04'00'

Andrea Race
Chief Financial Officer

Department of Health
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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: January 31, 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 partner groups, the BFH applies a life course approach across the Title V population domains. An intentional effort to apply a health equity mindset to improve the health and well-being of the most underserved and expand the scope of work of Title V in Pa. to include an examination of a range of social determinants of health (SDOH) –most importantly those systems and policies reinforcing discrimination and increasing the allostatic load of populations marginalized by institutional systems of oppression and power – is foundational.

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

The BFH continues to implement components of a family engagement workplan 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 most underserved, are heard. These processes were further actualized through the Five-Year Needs and Capacity Assessment completed in 2019 and the most recent Interim Needs Assessment Update in 2023.

The BFH was committed to performing a comprehensive and transparent needs assessment that engaged partners at each phase and identified the most pressing MCH health needs. Areas of need among the MCH health populations became evident following analysis of state and national data and through conversation with families and

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

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

The BFH recognizes the importance of evaluating performance and adapting to meet the ever-changing needs of the MCH populations in Pa. The strategies, objectives achieved, and lessons learned from the 2015-2020 action plan inform the work of this cycle. Given that the scope of direct services is limited by program capacity and funding, the BFH sees an opportunity to enhance existing strategies and develop system-level strategies to address maternal health. Ongoing work to ensure that women, birthing 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 supports Title V strategies including implementing community-based maternal care models such as a doula program and a fourth trimester pilot program aimed at improving care in the postpartum period. The BFH will use Maternal Mortality Review Committee (MMRC) recommendations to inform Title V programming and collaborate with other state and local agencies to ensure that funds are being leveraged to deliver non-duplicative services. These efforts aim to drive improvement in 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 related to the provision of screening and specialty care to children with conditions such as sickle cell anemia and autism spectrum disorder will also continue. Other strategies, such as efforts associated with improving access to a medical home, have been adapted over the course of the funding cycle and new strategies related to improving access to transition services have been developed. Moving forward, CSHCN programming 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. A youth advisory committee will also provide a mechanism to gather youth input on relevant issues and better ensure strategies developed are reflective and respectful of the communities being served. These strategies serve to advance the mental, behavioral, and developmental health priority, the priority aiming to address child mortality, a SPM which aims to assess the percentage of youth in Pa. who have a mentor, and 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 identify areas or populations for interventions, and then selects qualified grantees. For all grant agreements, BFH staff develop objectives, work statements, and budgets, and provide oversight and monitoring of grantee progress toward the stated goals. The BFH also coordinates efforts and collaborates with other Bureaus within the Department of Health (DOH) as well as with agencies at the local, state, and federal level. Given that many other organizations share the mission of advancing the health of MCH populations in Pa., remaining abreast of the work of these other entities remains essential. Convening of regular cross-agency meetings has been incorporated into the action plan and these intra- and interagency relationships, and the corresponding work, have been and will continue to be formalized through the creation of memoranda of understanding.

Given the breadth of the BFH's work to support the MCH system of care in Pa. and the ebb and flow of other funding sources, the BFH continually evaluates how Title V funds can be leveraged and combined with other state and federal funds to make the most positive impact on population health outcomes. As programming, other activities, and agencies receive Title V funds, the BFH will continually ensure that work is represented on its action plan with corresponding performance measures for accountability and to ensure that dollars are spent as intended to advance specific MCH outcomes.

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

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 2022 (FFY22), $24,213,971 federal Title V dollars were expended, $10,267,208 on preventive and primary care for children, $7,983,272 on children with special health care needs (CSHCN), and $2,421,397 on administrative costs. Pennsylvania (Pa.) bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations; $48,897,957 state funds were expended in FFY22. Additionally, the BFH expended $3,136,141 in other federal funds implementing MCH programming. Total state and federal Title V expenditures for FFY22 were $73,111,928. In Pa., state match funds primarily support services for infants, children, and CSHCN. As such, federal Title V funds are used to augment the systems of care for those populations while also providing support for pregnant women, birthing people, mothers, and the MCH workforce. Over time, Pa. has increased its capacity to serve a greater proportion of the MCH population by shifting reimbursable direct service expenditures to the appropriate payors and utilizing federal and non-federal Title V funds for population health programs, such as school health services and newborn screening.

III.A.3. MCH Success Story

Students Run Philly Style (SRPS) is a youth running and mentorship program with overall goals of improving health outcomes and increasing protective factors for youth. The organization serves Philadelphia youth, ages 11-21, 19% of whom self-identify as LGBTQ+. To better serve the needs of all youth, SRPS introduced OUTPace which is funded by the Maternal and Child Health Services Block Grant. OUTPace provides LGBTQ+ youth and allies with resources, activities, and welcoming spaces to help them build self-confidence, learn skills to overcome challenges, and expand their communities by meeting others like themselves. Through OUTPace, youth are matched with adult mentors who also identify as LGBTQ+.

SRPS uses RunSignUp, a race registration platform. The organization saw an opportunity to collaborate with RunSignUp to expand inclusivity and honor OUTPace's commitment to creating welcoming spaces for its youth. Running is a sport which typically only features male and female divisions for participants. SRPS wanted to have an option for youth and mentors who identify as nonbinary to have equal access.
In 2020, SRPS began the process to include a nonbinary race registration option for their own races. In 2021, the Philadelphia Distance Run, organized by SRPS, became the first major road race in the country to offer a nonbinary division with equal prize money for elite nonbinary athletes. In January 2022, RunSignUp announced full nonbinary support on the platform, allowing a more inclusive registration experience. Since then, hundreds of races, including the Blue Cross Broad Street Run and the Philadelphia Marathon, two of the largest races in Philadelphia, have enabled nonbinary registration through RunSignUp.

A student, Zen, stated "What it means for me to be a non-binary runner is that I get to be myself, and not wear a façade when it comes to doing everyday things like running. It means that I get to be recognized for who I really am, and that is Zen." Non-binary runners no longer have to check the boxes that put a label on them as male or female; they are able to identify as who they are.

In June 2022, SRPS OUTPace program was recognized by the Philadelphia Gay News and LGBTQ+ Community at the Stonewall Awards Brunch for their efforts to become more open and inclusive for the youth in their program.

III.B. Overview of the State

The Keystone State

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 nearly 13 million people. In addition to its rural and urban composition 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.

Demographics

Following a national trend, Pa. is becoming more racially and ethnically diverse. From 2010 to 2021, the minoritized population increased from 36 to 42% nationally, and from 21 to 26% in Pa. From 2017-2021, non-white residents made up more of the population in urban areas (30%) than in rural areas (11%). From 2010 to 2021, the Hispanic identifying population increased in Pa. by 50.7%, and the Black/African American identifying population increased by 6.2%. From 2000 to 2021, the rural population became more racially diverse, as the non-white or Hispanic rural population increased from five percent of the total population to 11%. 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.

In general, Pa. is growing older. In 2021, more than 23% of Pennsylvanians were under the age of 20 and 33% were 55 and older. The percentage of population aged 65 and older was greater in Pa. (18.2%) than the US overall (16.8%). From 2010-2021, Pa.'s population grew only two percent with the number of residents under 18 years old decreasing four percent and the number of residents 65 and older increasing more than 25%. Counties with large elderly populations could face the possibility of diverting resources from MCH populations toward their older residents.

Of the approximately 5.2 million households in the state in 2021, nearly 3.3 million of these households were defined as families, with an average size of 3.01 members. The U.S. Census Bureau categorizes families as: married-couple families, male householder (no spouse present) and female householder (no spouse present). While married families are most common, over 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. Nearly 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 2.66 million children in the state, approximately 1.77 million live in a married family. Over 220,000 children live in male-led families; and over 656,000 children live in female-led families, which are less likely to have an unmarried partner present.

The racial distribution varies between types of households with children. While 74% of children in married families are identified as white, 64% of children in male-led families and 42% of children in female-led families identify as

white. Nearly 58% of Black/African American children and over 40% of Hispanic children live in female-led families compared to only 15.8% of white children. Female-led families are more likely to have grandchildren in their households and are more likely to have a child with a disability in their household when compared to other households.

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, five percent of the Pa. workforce is LGBTQ. As of 2021, Pa. has 42,577 same sex households (sixth nationally), 53.8% of whom are married.

LGBTQ residents face ongoing health inequities in terms of their absence in statewide surveillance systems and 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 orientation and gender identity 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 50 municipalities have passed separate ordinances to prohibit discrimination based on sexual orientation and gender identity.

Economy, Income, and Poverty

As of November 2022, 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 2021, 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 2022, had a seasonally adjusted unemployment rate that was higher than the national average. In 2021, 26% 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 industry with the greatest number of employees in Pa. in 2021 was educational services, health care, and social assistance, growing eight percent since 2010. Employment in agriculture, forestry, and fishing (which includes farming) increased from 2010-2020. Median income varies by county from $43,615 to $109,969; for families with children, it is $88,347. However, there are stark differences in median income when considering family type. The median income for married families is $119,089, $50,659 for male-led families and $31,826 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 slightly smaller percentage of Pa. residents (12.1%) lived in poverty compared to the national rate (12.8%). However, there are still large swaths of the population living in poverty, as 24.8% of Pa.’s Black/African American residents and 22.5% Hispanic residents lived in poverty and families with Black/African American or Hispanic householders were more than three times as likely to be living in poverty than white households. Of the 1.39 million families with related children under 18, 13.9% were living below the poverty level during the previous year. Female-led families were more likely than married or male-led families to be living below the poverty level. For

families with children under 18, female-led families were more than 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.

Future earnings are related to a person's level of educational attainment. In 2021, there were approximately 820,000 adolescents (15 to 19 years old) in Pa., with nearly 88% of them enrolled in school. School enrollment among adolescents is consistent by race and ethnicity, with Hispanic adolescents having the lowest enrollment at 82.7%.For the more than 9.1 million people aged 25 years and over in Pa. in 2021, nearly 92% have a high school diploma or equivalent or higher, varying a bit by county, and more than 34% 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 $47,140 and ranges from $28,562 for those with less than a high school diploma or equivalency to $78,261 for graduate or professional degree holders. Of the approximately 1.13 million individuals ages 18 to 24-years, 36.8% have earned a high school diploma or equivalent as their highest educational attainment, 40.9% are enrolled in college or graduate school, and 13.8% 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.

Health Care and Health Insurance

The health care delivery system in Pa. is made up of many interlocking pieces; hospitals, Federally Qualified Health Centers (FQHC), primary health care providers, general acute care hospitals, critical access hospitals (CAH), County/Municipal Health Departments (CMHDs), and state health centers, among others, all play a part in providing care to Pa.'s citizens. Another significant piece of health care delivery in Pa. is Medicaid, administered by the Department of Human Services (DHS) through Managed Care Organizations (MCOs).

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, as of 2021, 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 2020, there was one primary care provider in direct practice for every 1,002 residents in urban counties, as compared to one primary care physician for every 1,483 residents in rural counties. Of the 15 counties without an FQHC, all but one are rural. As of September 2022, an estimated 580,050 residents lived in a designated Primary Care Health Provider Shortage Area. Small areas of several urban counties are considered medically underserved. In 2021, there were 61 general acute care hospitals, with a total of 7,404 beds, in rural Pa. Nine rural counties had no hospitals. On average, there were 2.18 hospital beds for every 1,000 rural residents compared to 2.85 hospital beds for every 1,000 urban residents.

Across the state in 2021, the 147 general acute care hospitals (including 16 Critical Access Hospitals [CAH] as of January 2022) with over 34,690 licensed beds handled over 1.34 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. An additional 83 federal and specialty hospitals handled over 140,000 admissions. There are eight children's hospitals in Pa., four of which are in either Philadelphia or Pittsburgh. The other four are in Allentown, Bethlehem, Danville, 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 minoritized population.

Other important partners in the delivery of services within the MCH system of care are the 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 DOH 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 Pa. 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 46% of Pa.'s population. In addition, several CMHDs have either applied for or achieved public health accreditation through the Public Health Accreditation Board. As a result, those communities have access to higher-quality programming and services.

Counties without CMHDs have state health centers, operated by the DOH, that provide and support public health programs. 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 use 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 2021, 5.5% of the approximately 12.8 million civilian noninstitutionalized population in Pa. was uninsured. By gender, 6.5% of men were uninsured compared to 4.6% of women. Only 4.6% of white persons were uninsured compared to 6.1% of Black/African American persons and 12.6% 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 5.1% to 13.0% 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 most racial and ethnic groups because of the ACA, as of 2021, 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 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. Children and pregnant women have the highest income limits for Medicaid eligibility in Pa. and both limits are higher than the median United States 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, Pa. covers 24 optional benefits, 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. According to the 2019-20 National Survey of Children's Health, 22.7% 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. Children with special health care needs (CSHCN) are served by Special Needs Units (SNU) within Medicaid. SNU are housed within physical health MCOs 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 of MCOs 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 administered by 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 May 2023, there were 123,714 children enrolled in CHIP. In February 2023, CHIP and Medicaid combined provided health and long-term care coverage to almost 3.7 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 older Pennsylvanians and people with disabilities. In State Fiscal Year (SFY) 2019, Medicaid accounted for 59% of all federal funds received by Pa. and 36% of total state expenditures.

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. More specific data are discussed throughout this Application/Report, especially the Needs Assessment, Women/Maternal Health, and Cross-Cutting sections. 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.

Statutes and Regulations

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. The Pennsylvania newborn screening program mandates screening for thirty-six conditions and aligns with the national Recommended Uniform Screening Panel.
- 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.

Planning, Priorities, and Emerging Issues

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 2023-2028 SHIP was developed in partnership with a broad representation of public health system stakeholders. The 2023-2028 SHIP 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 SHIP priorities are: 1) health equity; 2) chronic disease prevention; and 3) whole person care.

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.

Impacting Pa. residents, the health care system, and the broader landscape of the MCH system of care are several important, emerging issues. In January 2023, there was a change in administration following the end of Governor Wolf's second term. He was succeeded by Josh Shapiro, previously the Attorney General. More directly impacting the Pa. DOH, Dr. Deborah Bogen, previously the director of the Allegheny County Health Department, was appointed acting Secretary of the Department. Dr. Bogen's priorities, reflecting the SHIP, are health equity, whole-person care, and chronic disease prevention. Governor Shapiro has also proposed funds to expand maternal health programming and study ways to reduce maternal mortality and morbidity, access to mental health services, and increase Supplemental Nutrition Assistance Program benefits.

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. The DOH continues to focus on outbreak prevention and management, vaccine promotion and distribution, and supporting hospitals, long-term care facilities, schools, and vulnerable populations by focusing resources on communities with high health disparities and low access to vital services. As of March 1, 2023, Pa. has had more than 3.52 million confirmed and probable cases, and more than 50,000 Pennsylvanians have died. Nearly 8.7 million Pennsylvanians are fully vaccinated, with more than 4.2 million Pennsylvanians having received an

additional dose and nearly 2.1 million Pennsylvanians having received the bivalent booster dose. DOH, along with other state agencies, is transitioning out of emergency status with the end of the federal declaration of a nationwide emergency.

Another issue that will have effects on the health of Pennsylvanians are real or potential changes to insurance status and/or coverage, including the extension of Medicaid postpartum coverage for mothers and birthing people eligible because of their pregnancy, from 60 days after the pregnancy ends to one year postpartum, 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 people 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. However, with the passage of the Consolidated Appropriations Act of 2023, continuous coverage for MA and CHIP ended on April 1,2023, and DHS returned to normal eligibility processes. Recipients must complete an annual renewal application to avoid a loss of coverage. 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 902,765 people in 2021, a 280% 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 (Task Force), established in 2021, was tasked by the Secretary's office to develop action steps and initiatives to further this work. Title V-funded staff sit on the Antiracism and Health Equity Task Force and I look for opportunities to align the work of the Title V State Action Plan with Task Force initiatives. Additionally, Pa.'s Title V program participated 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 Task Force.

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. 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 2024 Application/FY 2022 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. Health equity remains the overarching framework of the BFH's needs assessments.

Ongoing 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 third 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 2023, three new strategies were implemented to improve the response rate to the public input survey. First, the links to the public input survey were disseminated using Constant Contact. This allowed the BFH to take a more active role in monitoring how many people were reached via email and clicked on the links. The second strategy was to remind current grantees and contractors receiving Title V funds that participating in feedback surveys is an expectation of their funding agreement; a question was also added to the survey to track vendor participation. Finally, the survey remained open for eight weeks in 2023. Despite these measures, the response rate was similar to that observed in previous years. Between March and May 2023, 94 responses to the survey were received, 63 from service providers and 31 from service recipients or caregivers. Statewide representation improved from last year as respondents represented all of Pennsylvania's (Pa.) 67 counties, either as residents or by where they provided services. 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.

   ii. Focus Groups:
   Stakeholders and service recipients were also engaged through meetings and focus groups. The BFH facilitated discussion at a virtual meeting with CYSHCN providers participating in the Leadership Education in Neurodevelopmental Disabilities (LEND) fellowship and at a site visit with adolescent health providers participating in the Leadership Education in Adolescent Health (LEAH) fellowship in April 2023. Providers were asked about emerging health needs, service gaps, and client engagement, and for feedback on the BFH's plans for the upcoming 2025 five-year needs and capacity assessment.

   Data resulting from these sessions 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 15.6 maternal deaths per 100,000 live births during 2017-2021 in Pa. and the rate of maternal mortality remained over three times higher among Black people (40.4) as it was among white people (13.3) in Pa. during 2017-2021. Similarly, state inpatient hospitalization data suggest that the rate of severe maternal morbidity increased again in 2020 to 89.5 delivery hospitalizations involving severe maternal morbidity per 10,000 delivery hospitalizations (up from 87.8 in 2019). The rate of morbidity remains nearly 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 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 again from 74.3% in 2020 to 71.3% in 2021. Similarly, Pregnancy Risk Assessment and Monitoring System (PRAMS) data from 2021 suggest that the percentage of people with a recent live birth who received adequate prenatal care (71.9%), reached a new low in 2021. The percentage of people who received a postpartum check-up increased slightly from 87.2% in 2020 to 90.7% in 2021. Similarly, the percentage of people who received a teeth cleaning during pregnancy increased slightly from 43.9% in 2020 to 45.2% in 2021. Black birthing people remain less likely to have received adequate prenatal care or a postpartum check-up then their white counterparts. While the racial disparity in receipt of adequate prenatal care narrowed between 2020 and 2021, the disparity in receipt of a postpartum care visit widened. The newly available 2021 data suggest that birthing people have resumed routine care following the end of restrictions associated with COVID-19 but also demonstrate that inequities in care access were likely exacerbated by the pandemic and persist. Strategies that address these inequities in receipt of care and connect birthing and pregnant people to safety net preventive physical and mental health care services remain integral to the 2024 action plan.

   Newly available data suggest that changes should be noted for several related indicators. A recently published national report suggests that maternal mortality rates significantly increased in 2021 across all age and racial groups, according to data from the NVSS. This change has been attributed to the COVID-19 pandemic. Annual data are not available at the state-level due to small numbers; however, multiyear estimates suggest that maternal mortality rates may have increased in Pa. in 2021 as well. These rates will be monitored closely, as new and provisional data become available, to assess whether the rate declines as the health impact of COVID-19 is lessened through vaccination and other treatment options. Previously published reports on maternal death in Pa. indicated that accidental poisoning, a category that includes drug-related overdose, is one of the leading causes of pregnancy-associated deaths in the state. In 2021, there was a three percent increase in overall drug overdose deaths as compared to 2020. While the impact on maternal mortality is yet to be established as the state's Maternal Mortality Review Committee continues to review cases, continued focus on provision of adequate system-level supports for people with substance use disorder before, during, and after pregnancy is increasingly important. Approximately 16.5 per 1,000 delivery hospitalizations occurred among pregnant women with opioid use disorder in Pennsylvania in 2020. While this represents an increase from 15.5 in 2016, in recent years (2017-2020) this rate has fluctuated at or around 16.5. Associated strategies are and will continue to be encompassed within the existing strategy on preventing maternal mortality.

The percentage of people with a recent live birth who self-reported depression during pregnancy decreased from 17.7% in 2020 to 16.1% in 2021, per PRAMS survey data. Prevalence of self-reported postpartum depression also decreased to 11.7% in 2021, mirroring the prevalence last reported in 2019 (11.6%) and depression screening rates remain higher during postpartum visits (91.0% asked about depression per PRAMS) than prenatal care visits. Accordingly, behavioral health and depression screening and referral both before and during pregnancy also remain important and are strategies of the 2024 action plan. Finally, both NVSS and PRAMS data suggest a continued significant decline in the percentage of birthing people who smoke during pregnancy (7.3% of people smoked during pregnancy in 2021). While results from the 2023 public input survey (Table 1) further confirm a need for continued focus on access to preventive and specialty health care before, during, and after pregnancy respondents also highlighted the need for a culturally competent, unbiased workforce who can provide respectful, patient-centered care. Parental leave, access to affordable childcare, and the importance of meeting needs of families related to transportation and housing were also frequently cited in 2023

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 has stagnated around 5.5 deaths per 1,000 live births since 2020; preliminary estimates for 2021 and 2022 suggest minimal change (5.4 in 2021; 5.5 in 2022). However, the infant mortality rate is higher among infants born preterm and with a very low birthweight. Following a slight increase from 9.6% to 9.8% in 2021, preliminary 2022 data suggest that approximately 9.6% of infants were born preterm in Pa., consistent with prior years' data. Additionally, the rate of infant mortality remains highest among Black/African American infants as compared to white infants. The black-white gap in infant mortality has persisted for decades and remained nearly three times higher among Black/African American infants as compared to white infants according to preliminary 2022 data (11.0 Black/African American infant deaths per 1,000 live births vs. 4.3 white infant deaths per 1,000 live births). 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.

This priority and associated strategies are linked to two NPMs; NPM 4 measures the percentage of infants breastfed and NPM 5A-5C focuses on the percentage of infants experiencing safe sleep practices. Birth certificate data suggest a continued gradual increase in breastfeeding initiation. Preliminary data suggest that approximately 81% of infants were breastfed in 2022. PRAMS data indicate that the percentage of people with a recent birth who report any breastfeeding at six months remains near 50% (49.8% in 2020, 52.1% in 2021). Despite an overall increase in breastfeeding at the state-level the prevalence of breastfeeding initiation and duration 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 income. 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 42.6% in 2021). Similarly, the percentage of infants placed to sleep without soft objects or loose bedding has also significantly increased (46.1% in 2016 to 64.0% in 2021). However, differences still exist when evaluating safe sleep practices by maternal age and race/ethnicity; these practices are less common among birthing people under the age of 20 and birthing people of color. 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.

The existing priorities are sufficiently broad to respond to the persistent unmet needs identified through analysis of statewide data. Respondents to the 2023 public input survey emphasized the importance of lactation support, parent/caregiver education and support, and renewed focus on meeting family needs related to childcare and transportation to promote infant health. While breastfeeding awareness activities are underway, additional strategies to better support parents and caregivers with needs identified in the 2023 public input survey (Table 2) will be considered.

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 continued to decline from 152 deaths per 100,000 in 2016 to 132.5 in 2020. The rate of nonfatal injury hospitalization is highest among children less than 1 and is nearly two times higher among Black/African American 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 17.9 deaths per 100,000 in 2021. 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/African American 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.

Newly available two-year estimates from the National Survey of Children's Health (NSCH), indicate that there was minimal change in the prevalence of physical activity or tooth decay. Approximately 31% of children ages 6 through 11 were physically active at least 60 minutes per day during 2018-2019 and 2020-2021 and the percentage of children ages 1-17 who had tooth decay or a cavity in the past year remained at 10% during both 2018-2019 and 2020-2021.

Data from 2020-2021 suggest a slight increase in the percentage of children reported to be in excellent or very good health (88.8% during 2018-2019 to 90.2% during 2020-2021). Additionally, a significant decrease in the prevalence of children ages 6 to 11 who were bullied at least once in the past 12 months was observed; the prevalence decreased from 32.0% during 2018-2019 to 29.0% during 2020-2021. However, bullying remains more common among children ages 6 to 11 than among youth ages 12 to 17. Data from 2020-2021 and national trends indicate that resumption of routine care, such as vaccination and preventive physical health and dental visits, continues to be slow following disruptions caused by the COVID-19 pandemic. For example, only three of every four children in Pa. received a preventive medical or dental visit during 2020-2021, per the NSCH. The need for access to preventive health care and resumption of routine care were again highlighted in responses from the 2023 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 to improve the mental, behavioral, and developmental health of children with and without special health care needs and suggest that supporting parents and caregivers with child mental health and providing education on child wellness to inform care decision-making may be warranted. Identification of additional related strategies will be ongoing in 2024.

iv. Adolescent Health:

The existing Title V priorities for the adolescent health domain are to 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. The adolescent mortality rate increased again from 33.3 deaths per 100,000 in 2020 to 37.0, the highest rate of mortality among youth aged 10 to 19 since 2010 when it was 34.0. Three-year estimates (2019-2021) suggest that the mortality rate was twice as high among youth aged 15 to 19 (44.8 deaths per 100,000) as compared to youth aged 10 to 14 (20.3 deaths per 100,000). The mortality rate remains over two times higher among Black/African American 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 (8.0 deaths per 100,000 during 2019-2021 compared to 8.2 during 2016-2018) and in the suicide rate (8.4 suicides per 100,000 during 2019-2021 compared to 9.7 during 2016-2018). However, new data from the Youth Risk Behavior Surveillance System demonstrate a significant increase in the prevalence of high school aged youth who self-reported depression (34.5% in 2019 to 43.7% in 2021) or suicidal ideation (17.2% in 2019 to 18.1% in 2021).

Notably, the rate of nonfatal injury hospitalizations among youth ages 10 to 19 also increased significantly from 204.7 hospitalizations per 100,000 children in 2019 to 226.4 in 2020, the first observed increase in five years. The percentage of adolescents who are active for at least 60 minutes per day on five or more days weekly significantly decreased from 48.1% in 2019 to 41.7% in 2021. 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 and mental/behavioral health.

Given the observed increase in adolescent mortality rates, persistent mental health challenges among youth, and disparities by race, 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 indicated that the lack of youth-serving providers is a significant challenge. Providers also emphasized the need for adults in the lives of youth, including parents and teachers, trained in mental health first aid and knowledgeable about how to talk to those youth when they need support. Other emerging issues identified by the LEAH fellows were access to birth control and reproductive healthcare, access to youth-oriented resources such as treatment for substance use disorder, and the impact of gun violence on youth mental and physical health. Responses from the public input survey (Table 4) align with the fellows' observations regarding the importance of addressing mental and behavioral health needs among adolescents, facilitating access to routine healthcare, and ensuring that youth have non-clinical

social support outside of their family unit.

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., CSHCN are twice as likely to be bullied as compared to children who do not have a special health care need. As of 2020-2021, 48.2% of CSHCN aged 12 to 17 experienced bullying in the past 12 months as compared to 20.5% 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 2020-2021 (29.0% among CSHCN; 11.2% among children without special health care needs).

The percentage of CSHCN who receive care in a well-functioning system in Pa. decreased slightly from 21.6% in 2018-2019 to 18.0% in 2020-2021. 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 2020-2021, the percentage of CSHCN receiving care in a well-functioning system is lowest among CSHCN aged 12 to 17 (6.4%) as compared to CSHCN aged 6 to 11 (26.5%) or 0 to 5 (34.6%). Upon reviewing the well-functioning system's component parts, the areas where improvements are most needed are still access to a medical home and transition services. The percentage of CSHCN aged 12 to 17 receiving preparation for adult transition increased slightly to 29.5% during 2020-2021 and the percentage of CSHCN aged 0 through 17 in Pa. with a medical home also nominally increased from 44.5% during 2018-2019 to 45.6% during 2020-2021. However, the proportion of CSHCN with a medical home in Pa. 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. Results from surveys and family/youth focus groups conducted in 2022 informed the identification of new strategies on bullying and safe relationships among CSHCN which are currently under development.

The newly available 2020-2021 data from NSCH also suggest change in several CSHCN indicators. The percentage of CSHCN ages 0 through 17 who are continuously and adequately insured decreased slightly from 72.1% during 2018-2019 to 68.5% during 2020-2021. Several other apparent changes include a decrease in the percentage of CSHCN ages 6-17 who were physically active for at least 60 minutes daily (24.8% during 2018-2019 compared to 20.5% during 2020-2021). Conversely, the percentage of CSHCN ages 1 through 17 who had decayed teeth or cavities in the past year decreased from 15.1% during 2018-2019 to 11.4% during 2020-2021. Physical inactivity and the prevalence of tooth decay/cavities also remain higher among CSHCN as compared to children without special health care needs.

LEND fellows engaged during the April site visit further emphasized how continuity of care, education, and opportunities for socialization and recreation among CSHCN were interrupted by the COVID-19 pandemic. While the fellows suggested that some families are working to reengage with services and social opportunities, this process has been slow, and some programs or services are no longer offered or have been restricted. These changes have had impacts on receipt of health care services among CYSHCN, mental well-being, development, and social life. Many of these needs including increased support for families of CSHCN in the education system and improved care coordination were also identified by respondents to the 2023 Public Input Survey (Table 5). Another challenge identified again

this year was the continued in-home nursing care shortage. Associated strategies that work to improve care coordination and navigation can be encompassed within the existing well-functioning system priority. The BFH will continue to partner with sister agencies such as the Departments of Human Services and Education to identify opportunities to support families of CSHCN in navigating related services.

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 2020, there were 14.0 NAS cases per 1,000 live births, an increase from 11.9 cases per 1,000 live births in 2019. 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, non-clinical support for parents/caregivers, and coordination with Early Intervention to ensure early identification and referral of infants with special health care needs to available services may be needed.

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, with a change in administration effective January 2023. In January 2023, Dr. Debra Bogen was named the new Acting Secretary of Health, taking over the role from Dr. Denise A. Johnson. Dr. Bogen is a pediatrician and previously was a director for a county health department in Pa. The BFH's Director (Tara Trego), Division Directors (Erin McCarty, Cindy Dundas, Kathy Jo Stence, and Jennifer Bixler), 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.

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 2023, approximately 36% of BFH staff have been in their current positions for less than three years. This percentage is lower than last year (47%), suggesting minimal turnover in the past 12 months. Among staff with a short tenure, most were program staff but there has been some change at the management level as well. Additionally, the percentage of BFH staff who report at least three years of public health experience continued to increase to 92% in 2023 (up from 84% in 2022, 82% in 2021, and 70% in 2020). 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:

See pp. 16-25 of the Needs Assessment Update in *Supporting Documents*.

iv. Preparation for Five-Year Needs and Capacity Assessment

Beginning in 2022, the BFH initiated an internal project to evaluate progress on current priorities and assess existing strategies with a health equity lens. As part of this project, the BFH developed a supplemental fact sheet which further clarifies the 2021-2025 priorities and sets the stage for a renewed focus on and commitment to health equity in the coming funding cycle.

Since the end of the current five-year funding cycle is approaching, the BFH has been actively preparing for the upcoming 2025 Title V Five-Year Needs and Capacity Assessment (5YNCA). To date, the BFH has developed a plan and timeline, convened an internal steering committee, and started raising awareness about the upcoming assessment through presentations at partner and stakeholder meetings. Epidemiology staff are also in the process of performing in-depth analyses of the NOMs, NPMs, and other key indicators, to identify specific inequities that could be addressed by Title V and to develop an initial priority list. For more information on BFH's 5YNCA and anticipated activities, please see the overview and timeline.

v. Capacity to Address Emerging Issues

A common emerging need across population domains was the importance of meeting basic family needs such as transportation, housing, food security, and enhancing social support networks for families. While the Title V program does not have the capacity to resolve all of these systemic challenges, the BFH will continue to consider how it can best promote system and policy change to address the social determinants of health in collaboration with its agency and community-based partners. As the BFH prepares for its comprehensive five-year needs assessment in 2025, it will also continue to assess its existing capacity and how that capacity might need built upon or enhanced to best meet the dynamic needs of the MCH populations.

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$23,748,778	$23,928,946	$23,732,205	$23,954,647
State Funds	$48,640,500	$46,813,492	$47,572,500	$49,045,442
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$72,389,278	$70,742,438	$71,304,705	$73,000,089
Other Federal Funds	$7,343,533	$3,423,394	$6,463,826	$3,241,422
Total	$79,732,811	$74,165,832	$77,768,531	$76,241,511

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$23,928,946	$24,213,971	$23,954,647	
State Funds	$47,605,500	$48,897,957	$53,009,500	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$71,534,446	$73,111,928	$76,964,147	
Other Federal Funds	$7,917,414	$3,136,141	$8,127,554	
Total	$79,451,860	$76,248,069	$85,091,701	

	2024	
	Budgeted	Expended
Federal Allocation	$24,213,971	
State Funds	$52,971,500	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$77,185,471	
Other Federal Funds	$7,295,387	
Total	$84,480,858	

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 22 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 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 Department of Human Services' 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 funds were 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 payor. These Title V funded direct services include pharmacy and other charges for children and CSHCN. Title V is the payor of last resort for all direct services. The state match funded direct services include pharmacy, laboratory, physician/office, and other charges for pregnant women, infants, and CSHCN.

Federal Title V, state, and other federal funds were expended in FFY22 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 FFY22, $24,213,971 federal Title V dollars were expended, $10,267,208 (42.4% of the total Title V federal expenditures) on preventive and primary care for children, $7,983,272 (32.9% of the Total Title V federal expenditures) on CSHCN, and $2,421,397 (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 FFY22, $48,897,957 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 FFY22 were $73,111,928. Additionally, the BFH expended $3,136,141 in other federal funds implementing MCH programming. State MCH grand total expended for FFY22 was $76,248,069. 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 FFY22 Title V expenditure data reported on Form 2 as compared to the planned budget for FFY22, 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 FFY22 Title V expenditure data reported on Forms 3a and 3b. Several factors led to the significant variations. First, new programming targeted at addressing infant mortality increased Title V related expenditures for infants and a decrease in births led to decreased state match expenditures. Second, the addition of programs serving all Title V population domains, including postpartum people and families, as well as shifts in funding and legislative additions targeting CSHCN and their families led to an increase in expenditures in the all others population domain for the state match in 2022 and a decrease in expenditures in the same population domain for Title V. 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 federal Title V enabling services expenditures for 2022. The notable exception is the significant increase in state match funding expended on direct services for CSHCN in 2022, which reflects an expansion of therapeutic rehabilitation services.

Expenditures are monitored on a monthly basis to ensure compliance with legislative financial requirements. Federally and state funded Title V programs served an estimated 2.6 million individuals from the MCH population. Title V served 92% of pregnant women, 99% of infants, 45% of children, and 53% of CSHCN in FFY22. 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 2024 budget estimates, both federal and non-federal, align with Pennsylvania's seven maternal and child health (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 Unexpected Infant Death (SUID) prevention strategies, including safe sleep promotion, based upon the data reported in the SUID Case Registry. Federal funds are budgeted to support Perinatal Periods of Risk studies. Other federal funds are budgeted to support participation in the SUID 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 DHS 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. 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 Pregnancy Risk Assessment Monitoring System (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 2024 that is level with the FFY 2022 award.

Pennsylvania's proposed budget for FFY 2024 is in full compliance with the federally mandated threshold requirements. Of Pennsylvania's proposed federal grant award for 2024, $10,492,369 (43.3% of the total grant

award) is designated for the support of preventive and primary services for children, and $7,711,350 (31.8% of total grant award) is designated for the support of services for children with special health care needs. Administrative costs are budgeted at $2,421,397, 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 2024 are $52,971,500. 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 2024 is $77,185,471. Federal Title V and state funds will be monitored monthly to ensure the match requirements are met for FFY24.

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 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 2024 is $7,295,387. State MCH budget grand total for 2024 is $84,480,858.

Budgeted amounts outlined on Form 3b reflect Pennsylvania's intent to spend the majority of its anticipated FFY24 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, durable medical equipment, 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, 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 services for lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth. 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 through the Family Impact Initiative and by partnering with organizations such as the Parent Education, Advocacy and Leadership Center (PEAL 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, and hematology treatment centers, and a metabolic formula program. NSG is responsible for the BFH's breastfeeding education, awareness, and support activities. In addition, NSG administers a neonatal abstinence syndrome (NAS) program 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 and family engagement, data collection and analysis, cultural humility, health equity, and 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 those most impacted by inequities, particularly the role of Medicaid in the provision of direct service, especially for CSHCN and populations marginalized by institutional systems of oppression and power. While the BFH continues to support gap-filling direct services, 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 humble 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 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 and supports 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 grantees and local Title V staff 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 knowledge and capacity building skills to address intersectional cultural and linguistic competence, data management, health equity, and policy and system capacity building, among other topics. With the end of the COVID-19 public health emergency, the BFH intends to offer and participate in trainings through a hybrid model.

> 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 Committee voted to host the training remotely. The training presentation was developed in 2022. The content was recorded and will be formatted into online learning modules that will be housed on TRAIN PA, Pennsylvania’s gateway to the TRAIN Learning Network. The trainings are anticipated to be available in summer 2023. Throughout 2023, 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, 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.
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> The Division of Child and Adult Health Services (CAHS) will offer training and technical assistance to grantees, upon request. To ensure that the needs of all populations are being met through the services offered by the Department, all Personal Responsibility Education Program (PREP) providers are 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 continued to be facilitated by Persad Center through 2022 and provided 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 be identified in collaboration with the MCH Workforce Development Grant or the grantees, as the Persad Center’s contract with the Department has ended. Starting July 1, 2023, Sexual Risk Avoidance Education providers will be required to annually attend health equity and healthy relationship-based trainings. Additionally, in 2023 and continuing throughout 2024, CAHS plans to offer implicit bias and cultural competency trainings to the Maternal Mortality Review Committee (MMRC), to build the committee’s capacity

to provide recommendations that improve the health of pregnant and parenting people.

In 2022, 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 (TBI) 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 2022 and will attend again in 2023. Attending these conferences increases 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 Children with Special Health Care Needs (CSHCN) system of care in 2022 and will continue to participate in these workforce development opportunities in 2023 and 2024. Events included the PA Community on Transition Conference and national conferences. Some of these events included presentations on CSDO's CSHCN programming. The CSDO staff will take part in training opportunities intended to improve their ability to identify and develop programming to address systematic 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 continue hosting an annual symposium for providers and professionals serving CSHCN. The 2022 CYSHCN Symposium centered the conversation around a well-functioning system. CSDO's 2023 symposium included topics such as traumatic brain injury and healthy relationships, among others. CSDO grantees, through Title V, provide training opportunities to staff, key partners, families, and members of the community to increase their capacity on a variety of topics. The Male Involvement Initiative (MII) Program held its first conference in 2022 titled "Fit to Lead". The topics included leadership, team building, and integrity for high school and college student-athletes. In 2023, the 2nd Annual Fit to Lead Conference was held, with topics centered around empowerment, respect of self and others, and the promotion of equality. The Ed Snider Youth Hockey Foundation, part of the MII Program, provided the Coaching Boys Into Men (CBIM) curriculum to young male athletes, ages ten years and older, on topics such as intimate partner violence, gender inequity, and bystander intervention before they begin hockey practice. In 2022, 19 trainings were conducted by the Brain Injury Association of Pennsylvania (BIAPA) through the Brain Injury and Opioid training program. The trainings were provided to brain injury and substance use professionals on the intersection of brain injury and opioid use. The CBIM and the BIAPA trainings are further described in the Adolescent Health Domain Report Year narrative. The Parent Education and Advocacy Leadership (PEAL) held a virtual conference in 2022 titled "Health Matters: Healthcare & Services for Children with Disabilities & Special Healthcare Needs". They also held a conference for fathers of CSHCN titled "Dads Together" which focused on the needs of fathers and how they can support each other. In 2023, PEAL conducted the 2nd Annual Health Matters conference titled "Health Matters: Supporting Children & Youth with Disabilities", which was provided in-person and virtually. Described in more detail in the Children with Special Health Care Needs Domain Report Year narrative, in 2022, PEAL provided four Youth Leadership Academies where CSHCN learned about self-advocacy and health care related services, and two-Family Leadership Institutes which built the capacity of parents and other caregivers of CYSHCN to learn how to support their youth as they begin their transition to adulthood. Additionally, PEAL provided three Behavioral and Mental Health Support trainings and two conferences on topics that included communication, consent, and stigma, which is further described in the Adolescent Health Domain Report Year narrative. Lastly, The Pennsylvania Athletic Trainer's Society provided ConcussionsWise training to youth, coaches, and parents throughout the 12 Pennsylvania Interscholastic Athletic Association districts, delivering information on concussion basics, as well as steps to prevent and properly care for concussions when they occur, described in more detail in the Child Health Domain Report Year narrative.

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 staff engaged in an opportunity to participate in AMCHP's Family Engagement Community of Practice (CoP) 2022 to 2023. The goal of the AMCHP Family Engagement CoP is to increase Title V capacity to engage families in their work. DBO also coordinated the state Title V team's participation in AMCHP's Learning and Practice Cohort for the Healthy Beginnings with Title V: Advancing Anti-Racism in Preterm Birth Prevention. BFH staff will continue to explore external opportunities for enhancing knowledge and skills associated with family engagement strategies. In 2022, DBO provided technical assistance to two BFH supported advisory groups. For the Pennsylvania State Child Death Review Team, DBO collaborated with a local adverse childhood experiences (ACES) expert. The presentation increased awareness of the impacts of ACES, protective factors and how they intersect with health equity, and how this information may impact future recommendations from the statewide team. The BFH also collaborated with a local school psychologist to assist the State CDR team with understanding programming in schools to reduce youth deaths by suicide. Local CDR teams were provided an opportunity to practice examining data and developing prevention recommendations related to sudden unexpected infant deaths during the 2022 Resource Building Summit. In June 2023, BFH along with a workgroup of county investigators, developed, facilitated, and hosted training for first responders to hone their infant death scene investigation knowledge and skills. While this training was funded through a cooperative agreement with the Centers for Disease Control and Prevention, the response to register for this training exceeded the space available for the two-day training. The BFH provides training, support, and technical assistance to all of the Pa. local CDR teams and will continue to do so in 2023 and 2024. By collaborating with the Governor's Office of Performance Excellence, the Office of Advocacy and Reform, and CSDO, DBO coordinated a "Diversity, Equity, and Inclusion for Traumatic Brain Injury" presentation for the Traumatic Brain Injury Advisory Board. This session supported the board's desire to increase awareness and engage board members on the need to diversify the board and how diversification will impact the services provided to the brain injury community. 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 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 to build new skills and expand their knowledge of best practices that can be incorporated into BFH programming. The 2023 AMCHP conference included a presentation by CSDO staff on the new Family Impact Initiative. Throughout 2022, staff also participated in both virtual and in-person capacity building opportunities hosted by national, state, and Bureau entities. In January 14 staff participated in HRSA's Title V Partnership Meeting. In June, the Health Equity Committee introduced a mandatory Health Equity prerequisite 2-part training series, which all staff completed. In August and November, the PA DOH Culturally and Linguistically Appropriate Services Task Force hosted an Unconscious Bias and Culturally Responsive Refugee and Migrant Health Trainings, which 23 staff participated in across the two events. Lastly, in December, staff participated in a Continuous Improvement for Healthier PA training that was incorporated into the quarterly BFH staff meeting. This training identified the connections between bias, social location, and health equity; demonstrated continuous quality improvement as a vehicle to improve health equity outcomes; and established a continuous quality improvement environment through the Healthy Government Framework, further described in the Cross-Cutting Systems Building Application Year narrative section.

The DOH Antiracism and Health Equity Task Force, formed in May 2021, continues to work and collaborate on the development of training and training resources to assist the DOH workforce to become an antiracist institution that is mindful of historically disinvested communities, committed to achieving equity and inclusion for all staff, and health equity in the state. BFH staff participate on the Task Force's "Staff Training and Support" subcommittee. Throughout

2022, the subcommittee collaborated on a Shared Language document, which was finalized and made available to the DOH in January 2023. This list of definitions establishes a common level of understanding of terms meaningful for the DOH as it works to become more intentional about centering health and racial equity principles. The purpose is to encourage consistency and collaboration across the program areas. The document will be updated as the DOH staff learn and grow, and language evolves. As the list is neither an exhaustive nor definitive list of correct or incorrect terms, but rather the beginning of guidance for the work conducted within the DOH, an expanded list of definitions is underway. Short, online learning modules, along with supplementary resources are currently being developed to help staff understand how the terms apply to their daily work. The first modules are anticipated to be released in the summer and fall of 2023. BFH staff also participate on the Task Force's "Policy and Practice" subcommittee. In 2022, the subcommittee updated the DOH Health Promotion Program Development Framework, a guide for developing and implementing health promotion and health education programs, to center health equity in public health program development and planning.

The DOH is also exploring new mechanisms to recruit and retain qualified public health staff. The DOH is updating its workforce development plan for the 2022-2027 period and has established a workgroup, on which BFH staff participate, to assist in the curation of the plan. 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 DOH are also included with the Application as supporting documents.

Internal surveys of BFH staff conducted as part of capacity assessment activities suggest capacity building on decision making, program development based on data and evidence, change management, and data disaggregation and interpretation is still warranted and desired. Additionally, there has been some turnover in both programmatic staff and staff at the management level. Accordingly, 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.

As described in the Cross-Cutting section, the BFH offered 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. In 2023, these training needs are still present. In 2024, the BFH will develop a workforce development plan, and continue discussions on critical thinking principles, public health ethics, challenge biases and limiting beliefs, explore ways to reduce harm and create positive systems, and move from awareness to practice. Additionally, the BFH will leverage the findings from the 2021 HEC Health Equity Assessment by continuing to offer training opportunities to increase staff understanding of the social determinants of health, health equity, and health disparities.

The BFH 2023 Internal Capacity survey included questions to staff to inform trainings and existing workforce capacity efforts, including the weekly resource email. To better understand the professional knowledge or skills that BFH staff would like to improve upon to advance their development as public health professionals, staff were asked to prioritize the following training topic areas for the following themes: Technical Skills, Essentials for Public Health Services, Communications, and Specific Topics. Table 1 describes the responses for each topic, ranked in priority order with the highest priority being one and the lowest priority being five. The rankings were determined by using staff's first and second choice selections.

Table 1: Ranking of Training Topics, 2023 Internal Capacity Survey

Technical Skills	
Rank	Topics
1	DOH Contracting and Grant Management
2	How to Access and How to Utilize Data
3	Budgeting basics
4	SharePoint
5	Excel
Essentials for Public Health Services	
Rank	Topics
1	Program Planning
2	Program Evaluation
3	Assess and Investigate Public Health
4	Program Implementation
5	Engaging Communities and Grantees
Communication Skills	
Rank	Topics
1	Critical Thinking
2	Clear and Concise Communication
3	Conflict Management
4	Presentation Skills
5	Customer Service
Specific Topics	
Rank	Topics
1	Biases and their Impact in Decision Making
2	Overview of Performance Measures
3	Motivational Interviewing
4	Trauma Informed Care
5	Safe Spaces and Psychological Safety

Staff participated in external opportunities including the AMCHP Leadership Lab, Children's Safety Network webinars, NewSTEPS meetings, Coping with Change, The Introverted Leader, and the CityMatCH MCH Epidemiology training. Staff attended state and Department sponsored trainings on Critical Thinking, Lean Leadership and Six Sigma, and BFH sponsored trainings such as the Health Equity Prerequisite series, and trainings offered as part of quarterly staff meetings. Surveying BFH staff will continue at least annually to determine staff capacity and training needs.

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.

Throughout 2022, DBO staff provided training to Bureau staff and grantees on the "Pennsylvania Title V MCH Block Grant Performance Measure Framework" as a refresher and to build the capacity of the MCH workforce to apply the Title V performance measure framework to programming. This training reinforced public health principles, Title V and the Performance Measure Framework, developing SMARTIE (specific, measurable, attainable, relevant, time-bound, inclusive, and equitable) goals, and disaggregating data. The BFH aims to integrate more evaluation

measures into its grant agreements and increase understanding on the need for and benefit of these changes to effectively serve the MCH population. Training staff and grantees on how to collect and analyze data, develop enhanced process and outcome measures, and use these tools to inform program decisions and improve program effectiveness began in 2022. DBO also conducted a training on how and why to disaggregate program outcome data in June 2022. This training built on a prior training, provided in 2021, that focused on the basics of data disaggregation and how to collect and consider service population data. The goal of these trainings was to build staff capacity to collect and use program data with intention and consideration for health equity principles. These topics will be continually revisited with staff and additional training may be developed in 2023 and 2024 addressing specific barriers and challenges staff have identified in their efforts to disaggregate programmatic data.

Since June 2020 the BFH has produce a resource email (RE) which includes a combination of the following: live webinars and trainings, recorded webinars and trainings, articles, reports, tools, and upcoming national health observances relevant to public health, leadership building, health equity, behavioral health, and the maternal child health population. Resources are compiled from nonpartisan research organizations like Brookings and Mathematica, and public health organizations like the APHA, American Academy of Pediatrics, and AMCHP, to name a few. The RE serves as a tool for staff seeking workforce development opportunities, highlighting upcoming events, recent reports, and resources for each population domain. In May 2021, the BFH began using a Department Constant Contact account to implement the RE. 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 RE. Emails are curated and disseminated every other week.

A quarterly newsletter was introduced in 2021 to share information, spotlight a division, and highlight new and ongoing initiatives within the Bureau. The newsletter is also disseminated via Constant Contact. During 2022, there were three newsletters sent out to highlight the Divisions of CSDO, DBO, and NBSG. Newsletter features have included details on existing programs, “Tips for the Bureau”—highlighting important process changes or updates—and Health Equity Committee and Title V MCH Block Grant updates. Fun elements like word searches and summer book reading lists have also been incorporated into several issues for staff to learn more about the BFH programs and general public health. On average, 47% of staff opened the email and 35% of staff accessed the PDF version of the newsletter in 2022. The frequency and content will continue to be evaluated throughout 2023 to address timing issues and ensure the newsletter remains relevant. The images below are snapshots from two previously disseminated newsletters. The first image is the front page of the newsletter, Upstream. The second image highlights general content that was included in the newsletter issue.

As part of the BFH 2023 Internal Capacity Survey, staff were asked to share their perceptions on the RE and the quarterly newsletter, with the results detailed in Table 2.

Table 2: Resource Email and Newsletter Response Rates, 2023 Internal Capacity Survey

Questions	Responses					
	Very Beneficial	Beneficial	Neutral	Somewhat Beneficial	Not at all Beneficial	Total
How beneficial to your work is the BFH Quarterly Newsletter titled "Upstream"?	4 (10%)	9 (23%)	16 (41%)	8 (21%)	2 (5%)	39 (100%)
How beneficial to your work do you find the resources shared within the BFH Resource Email?	5 (13%)	16 (41%)	8 (21%)	8 (21%)	2 (5%)	39 (100%)

In 2024, both the resource email and the newsletter are expected to continue and will be adapted to staff needs.

In 2020, DBO released a request for applications (RFA) to solicit applications from institutions and organizations to be funded to develop and deliver online learning modules, in-person, and live virtual educational sessions. The overall goal of this funding is to improve capacity around public health concepts and topics, including health equity and social determinants of health, among Bureau staff, grantees, and partners. Applications were received in 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 addressed in the work statement. As a result, the RFA was withdrawn and revised to better reflect the capacity building needs of the Bureau and its partners. In September 2022, an updated RFA was released and included a deliverable to achieve a multi-layered learning agenda, to facilitate learning that impacts systems change and addresses the updated 10 Essential Public Health Services. The Bureau plans to enter a grant agreement with a selected vendor in fall 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 engagement practices are driven by the principles of the Family Voices: Family Engagement in Systems Assessment and Family Engagement in Systems toolkit. Building family-centered systems is necessary to effectively support and serve families across the lifespan. BFH is working within a framework that involves strategies to increase awareness and provide guidance in implementing engagement practices meaningful to MCH populations. The BFH is focused on amplifying the roles of family, youth, and community in MCH public health, including a dedication to understanding factors influencing racial disparities in MCH outcomes and supporting emancipatory community engagement to move efforts for healthier outcomes for all Pennsylvanians forward.

BFH continues to evaluate and assess its current implementation of a system centered in a client and family engagement framework. BFH staff continue to participate in internal and external workgroups, trainings, and conferences that enhance the engagement framework.

The BFH is dedicated to expanding and increasing its role in collaborating with community-based organizations (CBO). As such, the BFH participated in an 18-month learning and practice cohort which ended the beginning of 2023, 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 aimed 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 cohort provided 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 aligned with Pa. 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 aimed to 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 were to: 1) Develop sustained, two-way partnerships between state and community organizations through ongoing transparency, communication, and trust-building; 2) Uplift and support the continued engagement of community in developing state-level practice and throughout the public health workforce; and 3) Gain a clear understanding of what community partners need from Title V programs, and of the challenges and barriers that Title V programs experience.

The cohort experience with Healthy Start Pittsburgh was successful and resulted in the development of an action plan committed to the values of equitable Title V/CBO framework inclusive of community voices and lived experience. Throughout the course of the cohort, the partnership evolved and was extended for eight months ending in October 2023. The second phase will focus on completion of the action plan as well as researching best practices and crafting a framework to guide sustained collaborations with community partners, particularly those focused on disrupting inequities. BFH realizes the importance of this partnership and envisions more successful collaborations in the future. AMCHP will continue to offer support during this new phase in the Healthy Beginnings Learning Cohort.

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. The BFH continues to offer support and 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 (BIRTH Plan). The BFH shares engagement opportunities with the Allegheny County BIRTH Plan with internal listservs and partners. The 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.

BFH has engaged in an opportunity to participate in AMCHP's Family Engagement Community of Practice (CoP). The goal of the AMCHP Family Engagement CoP is to increase Title V capacity to engage families in their work. The CoP provides a platform to share ideas, innovations, lessons learned, successes, and best practices from subject matter experts. The CoP is an eight-month commitment with meetings once per month from October 2022 to May 2023.

The intentional focus of the BFH is to ensure family and community voice remains a cornerstone in policy restructuring, development, programming, evaluation, and collaboration. The BFH is currently reviewing practices for compensating partners with lived experience as well as defining meaningful engagement activities for the Bureau. The goal is to create consistency where appropriate while assessing the effectiveness of current measures.

Engagement with consumers and their families also remains an integral component of interim needs assessment activities. Annually the BFH requests input from Title V service recipients about their experiences with the care system and factors influencing their health through the Public Input Survey. The goal of the survey is to inform the BFH's assessment of MCH health status and identify strategies that address Title V priorities. Since 2021, the survey has been made available in both English and Spanish and was 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. Focus groups are also scheduled on an as-needed basis to seek deeper insight on identified issues and inform program development. As the BFH plans for the next five-year needs and capacity assessment it is considering how to improve family and consumer participation. Several possible strategies 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. 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 also intends to continue partnering with families, community-based organizations, and advisory boards to ensure that those with lived experience have an opportunity to provide feedback on the BFH's programming and Title V strategies.

The BFH convenes several advisory boards and committees that 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. The Family Impact Initiative (FII) Program, funded by Title V, facilitates a Parent Advisory Committee which includes 20 parents and caregivers of children with special health care needs. The FII also employs a part time parent advocate. A BFH staff member 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 children and youth with special health care needs and their family members. The Health Promotion Council employs two family members of individuals with a disability.

In July 2022, the BFH entered into a grant agreement with Penn State Health Milton S. Hershey Medical Center to develop and facilitate a Youth Advisory Council (YAC). The YAC will help the BFH achieve adolescent-friendly care by providing youth with the opportunity to identify their needs and concerns and engage them in decisions and courses of action to improve programming efficacy. The YAC was developed to provide this forum for young people to be involved in community, organization, and program development at both the statewide and regional level using a youth-friendly framework comprised of three regional councils representing the eastern, central, and western portions of Pa.

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 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 PhD level Epidemiologist Supervisor in the Bureau of Epidemiology (BOE) who was hired to support all of the MCH epidemiology staff housed in the BFH. 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. Additionally, the BOE applied for, and was matched with, a 2023 summer intern from the AMCHP Graduate Student Epidemiology Program whose project focuses on severe maternal morbidity analysis. The Department of Health (DOH) also employs a statistician dedicated to MCH activities who provides support to the BFH.

In 2022, the ERA supporting the Title V program participated in the CityMatCH MCH Epidemiology training course hosted by HRSA, CityMatCH, and the Centers for Disease Control (CDC). The training course was an intensive program, combining lectures, discussion, hands-on exercises, and opportunities for individualized technical assistance. Participation in the course provided an opportunity to build capacity and hone analytic and epidemiological skills related to needs assessment and prioritization, specialized regression methods, performance measurement and trend analysis, evaluation, and other analytic topics. A strong foundation in these skills is essential to supporting the BFH and methods learned during the training course have already been applied in practice. Epidemiology staff supporting the BFH will continue to pursue such training opportunities as appropriate to learn new methods and approaches beneficial to the BFH and its programming.

As the BFH continues to expand its access to MCH data sources, epidemiology staff provide critical support through data linkage and analysis, assist staff with 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. In 2022, the Department applied for and was awarded the SSDI grant for the period of December 2022 through November 2027 and new objectives will be reported on in the coming years.

For the grant project year beginning in December 2021, 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), Title V, and SSDI 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 to 2,649. Larger sample sizes help ensure 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 remained in the field for the 2022 birth year sample, 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.

   The COVID-19 supplemental questions were added from May 2020 until December 2020 to determine how COVID-19 had an impact on wellbeing of the respondents' lives. The PRAMS COVID supplement was published in February 2022 and a data brief released in March 2022.

   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.

   Completing project activities and disseminating findings, moves the BFH closer to its goal to develop, enhance, and expand 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. 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"). Annual internal BFH staff surveys suggest capacity building on data disaggregation and interpretation to inform decision-making, program development, and evaluation is desired. 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 SMARTIE (specific, measurable, attainable, relevant, time-bound, inclusive, and equitable) 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 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 or outcome 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, the BFH used Title V funds to sponsor a state-wide oversample for the National Survey of Children's Health (NSCH) to 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. In 2022, BFH staff received a refresher training on NSCH, the online data query, and the oversample in anticipation of the oversample data becoming available in fall 2023.

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 maternal and child health (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 also created a streamlined process for data and training/technical assistance (TA) requests. Standardizing the process with specific questions and prompt follow-up expedites data requests while enabling BFH to track the types of requests it receives. This process supports 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 annual statewide resource meeting occurring in Harrisburg. TA is, and will continue to be, provided to local CDR teams as requested. TA 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. 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 death file to support Title V activities has been approved and the data made available to the BFH. Updates to the files are scheduled on a quarterly basis but delays are common and to date the BFH has not received updated data from the vital records data team on the scheduled release dates. Despite these challenges, in 2022 epidemiology staff supporting the BFH performed initial data linkage, assessed trends in key indicators such as infant mortality using preliminary data, and worked with program staff to conduct analysis that can support and inform Title V strategies. Vital records data are readily available for PRAMS survey operations. However, while PRAMS data transfers and processes are uninterrupted and consistent, data transfers needed for CDR/SUID reviews are also often delayed and do not occur on the scheduled monthly release date. In 2022 the Department launched a new data request workflow as part of a department-wide data modernization initiative. The goal of the new workflow is to allow for better tracking of outstanding requests and facilitate interdepartmental data sharing. Existing data transfers, including the quarterly Title V and monthly CDR/SUID data transfers of vital records data, are also tracked within the workflow. As such, there may be the potential for improved timeliness of data transfers in the future. In the meantime, BFH staff continue to follow up on outstanding data requests until scheduled transfers are completed.

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 Pennsylvania (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 Pa. 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.

The CEOP outlines the organization of emergency response assets at all levels of government in Pa., 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. The 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 Pa.'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 populations at increased risk of disproportionate impacts 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. 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 the administrator of Pa.'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 Senior Management 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 populations who are at-risk or have additional medical needs during an emergency.

Overall, there were no gaps identified during the Title V needs assessment related to emergency planning. The COVID-19 pandemic forced 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 telework as another tool to the BFH COOP, which was not previously considered as 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 is committed to collaborating with diverse partners to expand the reach and capacity of Title V statewide and to leveraging those partnerships to aid the Bureau of Family Health (BFH) in its efforts to ensure access to quality health care and needed services for maternal and child health (MCH) populations across the state. These partnerships include other public health programs, federal, state, and local agencies, private sector entities, families, and consumers. A comprehensive list and full descriptions of partnerships and collaborations can be found in *Supporting Documents* as well as the *Needs Assessment Update* and throughout the Title V MCHSBG application and report. A selection of key partners with shared program goals is highlighted below:

Other Governmental Agencies

- **Department of Human Services (DHS)**

  As the administrator of Medicaid, known as Medical Assistance (MA), and Children's Health Insurance Program (CHIP) in Pennsylvania, DHS plays a key role in providing health care services to millions of Pennsylvanians. In April 2022, Pa. expanded Medicaid coverage for one year postpartum which early research has shown will improve maternal and infant health outcomes and help decrease racial disparity in birth outcomes. Title V partners and collaborates with several of DHS's offices and programs to improve successful outcomes for shared populations across the life course and provide gap-filling services including:

  - Home visiting services available through Managed Care Organizations (MCOs) overseen by the Office of Medical Assistance Programs. More on these services can be found in *Women/Maternal Health*.
  - Information sharing relationships which help improve service quality, delivery, and access. An example of these relationships can be found in *Children with Special Health Care Needs*.

- **Department of Education (PDE)**

  As the state education agency, PDE oversees public school districts, public charter schools, Career and Technology Centers/Vocational Technical schools, Intermediate Units, the education of youth in State Juvenile Correctional Institutions, and publicly funded preschools. Through joint administration of the Office of Child Development and Early Learning (OCDEL) with DHS, PDE also oversees early childhood education and family support programs. Title V works with PDE both directly and indirectly to positively impact children of all ages and their families through activities such as:

  - Participating in the Pennsylvania Early Childhood Comprehensive Systems (ECCS) Health Integration Prenatal-to-Three Project (more information on this project can be found in *Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)*.
  - Ensuring that Title V-funded home visiting services are not duplicative of those provided through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.
  - Helping youth who have experienced a traumatic brain injury return to learning through the BrainSTEPS program. More information on this program can be found in *Children with Special Health Care Needs.*
  - Administering youth-serving school-based programs or school-based resources. More information on some of these programs can be found in *Adolescent Health*.

Other Programs within the Pennsylvania Department of Health

- **The Bureau of Community Health Systems**, through the six health districts, operates a network of state health centers as well as a school health division and works with Title V to support public health programs and community health activities. An example of this relationship can be found in *Child Health*.

- **The Bureau of Health Promotion and Risk Reduction** works with Title V primarily to advance the arenas of child safety and injury prevention in Pa. More information on this collaboration can be found in *Child Health.*

- **The Bureau of Women, Infants, and Children (WIC)** works with Title V in several ways, including developing and supporting breastfeeding education, collaborating on community-based breastfeeding initiatives, and sharing data to ensure quality service delivery to shared populations. An example of this relationship can be found in *Perinatal/Infant Health*.

State and Local MCH Programs

- **The Child Death Review (CDR) Program** is funded through Title V and a grant provided by the Centers for Disease Control and Prevention (CDC) and administered by the BFH and leverages the capacity and expertise of a wide range of partners including the PA State Coroner's Association, DHS, the PA State Police, Bureau of Emergency Management Services, the PA District Attorney's Association, as well as medical examiners, pediatricians, and neonatologists to identify risk and implementation and evaluation of targeted prevention efforts. More on the relationship between CDR and Title V in Pa. can be found in *Cross-Cutting/Systems Building*.

Other Federal Investments

- **The Maternal Mortality Review Committee (MMRC)** works with the BFH through Title V funding and a grant provided by the CDC to develop and implement recommendations to reduce the maternal mortality rate in Pa. More information on this partnership can be found in *Women/Maternal Health*.

Other HRSA Programs

- **Federally Qualified Health Centers (FQHCs)** works with Title V through the Pa. Association of Community Health Centers to improve care access and health equity, especially for children with special health care needs, in medically underserved areas across the state. An example of this relationship can be found in *Children with Special Health Care Needs*.

Other MCHB Investments

- **The Leadership Education in Adolescent Health and Youth 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. More information about this partnership can be found in *Needs Assessment Update.*

- **The Leadership Education in Neurodevelopmental Disabilities (LEND) Program** at Children's Hospital of Philadelphia (CHOP) and Children's Hospital of Pittsburgh 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. More information about this partnership can be found in *Needs Assessment Update*.

The BFH seeks the input of other bureaus and agencies during Needs Assessment activities to aid in developing a nuanced and comprehensive understanding of Pa.'s health care delivery systems' effectiveness. The BFH also participates in other statewide assessment activities, such as the MIECHV Program needs assessment and ECCS assessment activities, both with OCDEL.

The BFH also participates in activities and initiatives centered on new, innovative health care delivery models such as the Pediatric Shift Care Initiative with DHS to develop recommendations to address identified barriers associated with pediatric shift care, supporting proposals for Medicaid reimbursement for doula services, and implementing expanded telehealth care models, such as autism diagnostic clinics.

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. Finally, the BFH Director sits on OCDEL's Early Childhood Comprehensive Systems Advisory Committee and BFH staff participated in strategic planning activities for the Health Integration Prenatal-to-Three Project, which is funded through a grant with HRSA.

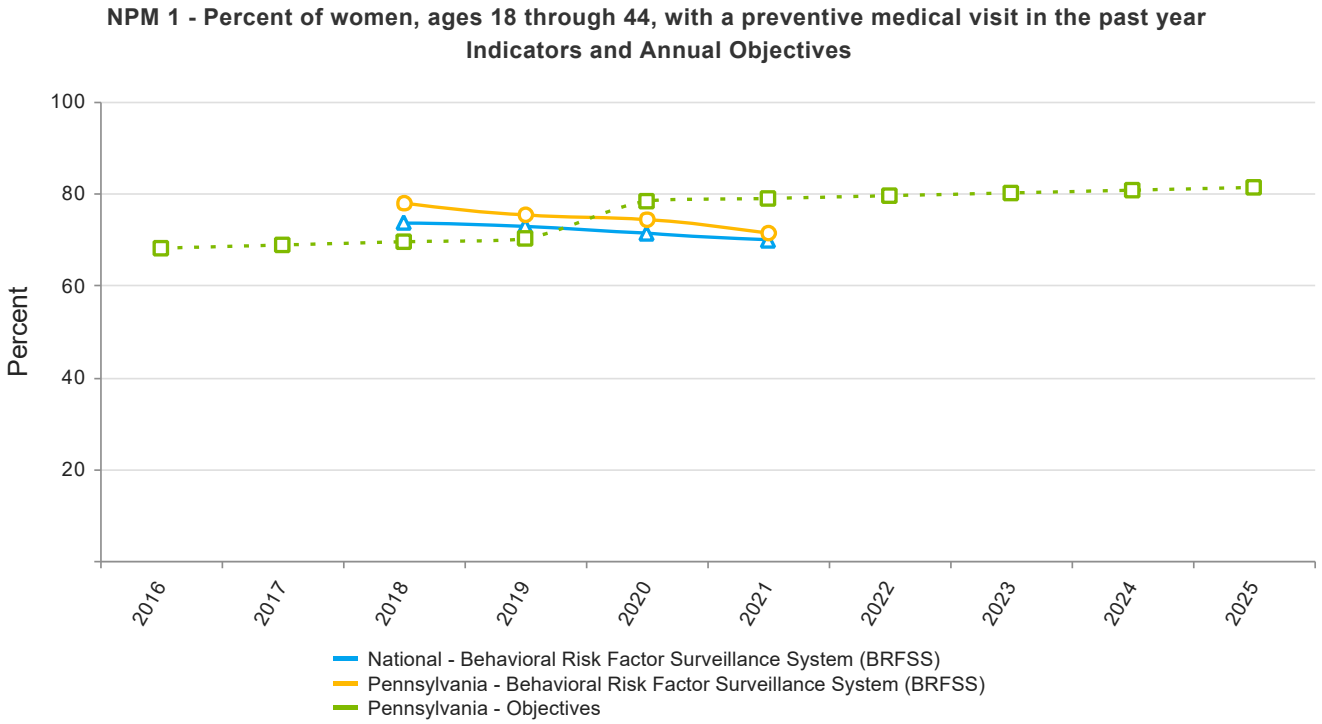
Such coordination and collaboration with DHS and Medicaid remain essential to advance the common goal of working to improve the health of MCH populations. DHS announced its expansion of home visiting services for some individuals covered by Medicaid in Pa. in 2019. In collaboration with the physical health Medicaid managed care organizations (MCOs), all first-time parents, parent/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 and are Medicaid eligible 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. DHS used the task force recommendations published in a whitepaper to inform current efforts to improve Pennsylvania's pediatric shift nursing model to better serve patients, families, home health care workers, and MCOs. 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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			78.2	78.8	79.4
Annual Indicator		77.6	75.2	74.3	71.3
Numerator		1,651,482	1,609,089	1,571,902	1,536,221
Denominator		2,128,688	2,140,534	2,115,148	2,154,160
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	69.4	70.1	78.2	78.8	79.4
Annual Indicator	65.3	77.6			
Numerator					
Denominator					
Data Source	NIS	NIS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			24	24.5
Annual Indicator			55.2	45
Numerator			891	618
Denominator			1,615	1,374
Data Source			CMHD final reports	CMHD final reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			85	85.9
Annual Indicator			75.6	89.3
Numerator			198	167
Denominator			262	187
Data Source			CPP quarterly reports	CPP quarterly reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.8	87.7	88.6

ESM 1.3 - Percent of women and birthing people 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	2022
Annual Objective			80	82.4
Annual Indicator			78.3	80.3
Numerator			2,243	2,880
Denominator			2,865	3,587
Data Source			IMPLICIT ICC quarterly and annual reports	IMPLICIT ICC quarterly and annual reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			3	4
Annual Indicator			3	0
Numerator				
Denominator				
Data Source			Philadelphia Department of Public Health	Philadelphia Department of Public Health, Healthy
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			25	27
Annual Indicator			2	7
Numerator				
Denominator				
Data Source			Alliance of PA Inc. quarterly and annual reports	Alliance of PA Inc. quarterly and annual reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	0.0	0.0

ESM 1.6 - Percent of birthing people 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	2022
Annual Objective			80	80.8
Annual Indicator			88	90.4
Numerator			373	433
Denominator			424	479
Data Source			IMPLICIT ICC and CPP quarterly reports CMHD annual	IMPLICIT ICC and CPP quarterly reports CMHD annual
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			3	3
Annual Indicator			0	58.2
Numerator			0	336
Denominator			1	577
Data Source			2021	2022
Data Source Year			IMPLICIT	IMPLICIT
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	3.0	3.0	3.0

ESM 1.8 - Number of MMRC recommendations implemented annually

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			1	1
Annual Indicator			3	0
Numerator				
Denominator				
Data Source			Philadelphia MMRC reporting to the Department	Philadelphia MMRC reporting to the Department
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			2	4
Numerator				
Denominator				
Data Source			meetings held	meetings held
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 women and birthing people 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 birthing people 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 2022, 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, 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 2021, there were 2.8 million persons of reproductive age (15-49 years old) who identified as female living in Pennsylvania (Pa.). The racial composition of this population is 78% white, 14% Black/African American, five percent Asian/Pacific Islander and three percent multi-race. Ten 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 often. What is known is that IPV 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. Available data suggests a higher rate of IPV in some Black, Indigenous, and other People of Color (BIPOC) communities. However, the broader context of those statistics, including social determinants of health, systemic racism, and policing of these communities must be taken into consideration. What is known is that the harm caused by IPV is compounded by the inequities survivors face in accessing health care and other social supports they need to improve the health and lives for themselves and their families.

People who are pregnant or recently pregnant are more likely to get very sick from COVID-19 compared to people who are not pregnant. Further, people who have COVID-19 during pregnancy are at an increased risk for complications such as delivering preterm and/or a stillborn infant. Preliminary data from Pa.'s 2021 pregnancy associated deaths, defined as deaths during or within 365 days of the end of the pregnancy regardless of outcome, shows that the number of deaths due to natural causes doubled from 2020. The most common immediate cause of death for natural deaths was cardiac-related, followed by COVID-19-related deaths. The COVID-19 pandemic has resulted in a host of additional challenges for birthing people in Pa. and has disproportionately harmed the health and economic well-being of BIPOC communities, who have suffered a higher risk of hospitalization and death due to the disease. An important driver of these inequities is that BIPOC are more likely to be essential workers in industries that are not amenable to working from home, putting them at greater risk of contracting COVID-19. Moreover, communities of color are more likely to face food insecurity, unstable housing, and loss of income and health insurance.

An additional and critical note on this section, and throughout this report and application, the BFH acknowledges that

the state of being pregnant, the act of giving birth or otherwise ending a pregnancy, and the act of parenting and caregiving are inclusive of all genders while also recognizing that data sources may not be.

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 2020, 73.7% of all birthing people in Pa. received prenatal care in the first trimester. 77.2% of white, 64.8% of Black/African American, and 65.3% of Hispanic/Latinx birthing people receiving prenatal care in the first trimester. Racial disparities are evident and continue to persist with 1.1% of white birthing people, 4% of Black/African American birthing people and 3% 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 before, during, and in between pregnancies. 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.

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

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

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

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

The BFH continued its partnership with the county and municipal health departments (CMHDs) to provide local services to residents in their communities. The eleven CMHDs are in Allegheny County, Allentown City, Bethlehem City, Bucks County, Chester County, Delaware County, Erie County, Montgomery County, Philadelphia County, Wilkes-Barre City, and York City. Delaware County Health Department was newly established in 2022 and is building their infrastructure. 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. In 2022, 1,374 pregnant and birthing people were served through CMHD home visiting programs. In 2022, the CMHDs returned to providing in-person home visits with 45% of enrolled participants successfully completing 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.

Ten of the eleven CMHDs serve prenatal and postpartum birthing people and their infants through home visiting programs. 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.

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 are provided in collaboration with the physical health Medicaid managed care organizations (MA MCOs). Numerous CMHDs are contracting with MA MCOs to provide these services and others are considering this option. The MA MCOs or other referral sources refer the expectant or parenting person to an evidence-based or evidence-informed home visiting program that completes an assessment and determine the needs of the family.

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. The BFH requires the CMHDs collect five outcome measures also collected by the MIECHV Program to better understand the effectiveness of the CMHDs home visiting programs as compared to the MIECHV Program. The outcomes for 2022 reported by the CMHDs are as follows: 8.1% of infants were born preterm following program enrollment; 93.9% 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 98.2% of home visits; 84.9% of caregivers were screened for IPV; and 85.7% of caregivers with positive screens for IPV received referral information. While the data has limitations due to the small number of families served, when compared to MIECHV data, the outcome measures for the CMHDs scored higher for all five measures. The CMHDs will continue to collect the five outcome measures, reporting them on a yearly basis.

Due to the implementation of the MA MCO home visiting program, and the continuation of MIECHV, BFH continues to monitor the home visiting services provided by the CMHDs to avoid the duplication of services.

Strategy: Increase the percent of adolescents, women and birthing people 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, women and birthing people who talked with a health care professional about birth spacing or birth control methods by 1%

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

In 2022, 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 2022, 57 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 91% 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 2022. 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 111 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 15% were Black/African American, with 36% of participants identifying as Hispanic/Latinx. Program outcomes were positive. LGH saw higher than expected rates for full-term births with 93% of their participants delivering at full term. Breastfeeding/chestfeeding rates were also positively affected with 91% of participants breastfeeding/chestfeeding at birth versus 79% of birthing people receiving traditional prenatal care in the same practice. 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. This will be the last year for the CPP with LGH as their grant agreement will end on June 30, 2023.

Additionally, Albert Einstein Health Network (AEHN), located in Philadelphia and WellSpan York continued their expanded CPPs. Combined, in 2022, AEHN and WellSpan York served 110 birthing persons. WellSpan York continued to serve their Spanish-speaking population with the Centering sessions being led by a Spanish-speaking coordinator and the inclusion of Spanish-speaking healthcare providers. After over a year of providing CPP virtually, the sessions returned to in-person with both healthy food options and transportation, which had been a major barrier, being provided to participants.

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. Eighty-nine percent of

participants enrolled in CPPs talked with a health care professional about birth spacing and birth control methods, exceeding 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 and birthing people enrolled in IMPLICIT ICC program screened for risk factors during well-child visits (WCV) by 1.5% each year

ESM: Percent of women and birthing people served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one WCV

Interconception care (ICC) is the use of medical and psychological interventions to address individuals' risk factors between pregnancies, with the aim of improving future maternal and infant health outcomes. ICC has the capacity to reduce the persistent racial disparities in maternal and infant birth outcomes. The leading underlying causes of infant mortality, particularly among Black/African American babies, are low birth weight and preterm birth (factors which are often connected). By offering biomedical, psychosocial, and behavioral interventions prior to pregnancy, the influence of risk factors for adverse pregnancy outcomes, such as preterm birth, can be minimized.

The setting of ICC has taken multiple forms, with most birthing people being provided this care only during annual well-woman visits or at their postpartum checkup(s). However, in a system where most people do not routinely receive early postpartum care, birthing people may not see their maternal care provider until at least 6 weeks postpartum, if at all; many do not, or cannot, attend the six-week postpartum visit, due to time, childcare, work, and transportation constraints. Often, the first appointment a birthing person has with a provider after their baby's birth is with their infant's doctor – not their own, when they take their newborn or child to their routine WCV.

Family physicians are ideally positioned to lead health care system change related to ICC; even parents that lack providers of their own are likely to take their infants to their WCV. WCVs in the first two years of life occur frequently (at one and two weeks and at one, two, four, six, nine, 12, 15, 18 and 24 months), presenting family health providers with regular opportunities to screen for and address maternal risk factors. Working within the WCV framework provides an opportunity for family health providers to address maternal health during the interconception period.

In 2022, the BFH continued to partner with the University of Pennsylvania and the IMPLICIT Network to strengthen and expand the Title V-funded IMPLICIT ICC Program, wherein maternal screenings are conducted at WCVs. The IMPLICIT Network developed, piloted, and implemented a model for ICC in Pennsylvania in 2012. Since that time, the IMPLICIT ICC model of care has been successfully implemented in a variety of sites in several states and is showing promising results in reducing unintended pregnancies and improving preconception health.

The IMPLICIT ICC model promotes utilizing scheduled WCVs to improve the health of birthing people between pregnancies. 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. 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.

The effectiveness of the ICC model of care is measured by how many birthing people are screened for modifiable

maternal risk behaviors, and how many of those with positive screens receive either an intervention or a referral to services. In 2022, the IMPLICIT Network reached 3,587 unique parent-baby dyads who may not have received care otherwise. Of the individuals that received ICC screening, 15% screened positive for tobacco use, 11.7% for depression, 20.2% for lack of contraception use, and 41.3%for lack of multivitamin with folic acid use. Approximately 27% of the individuals who were served last year identify as Black/African American; continued efforts to expand the reach of this model is critical if it is to significantly impact statewide maternal racial health disparities.

The IMPLICIT Network experienced staffing challenges that impeded its ability to meet all grant goals regarding screening and intervention rates for 2022. ICC screening was performed at 8,551 well-child visits, resulting in an overall screening rate of 80.3%; this is lower than the target of 82.4%. The Network met grant goals for smoking, depression, and multivitamin interventions, but fell shy of meeting the targeted intervention rate for contraception. Interventions for positive screens were documented at the following rates: 88.8% for tobacco use, 96.2% for depression, 70% for contraception use, and 63.1% for multivitamin with folic acid use. Maternal behavioral change after intervention for each of the four behavioral risk factors continues to be tracked; a cohort of 700 people who gave birth in 2020 are being followed longitudinally to evaluate the effectiveness of the IMPLICIT ICC model of care.

In 2022, the IMPLICIT Network established a Health Equity Committee (HEC) to improve the quality of care for all through a more inclusive health equity lens. The HEC's priority focus in 2022 was creating opportunities to collect feedback from, and collaborate with, the communities the Network serves.

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

Objective: Increase the number of community-based doulas providing services in priority 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 or parenting people with substance use issues. The doulas also help address social determinants of health by discussing housing, employment, and

mental health. In 2022, the program served 52 pregnant or parenting people. Of these participants, 86% identified as Black/African American, and almost six percent identified as Hispanic/Latinx. Almost 90% 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 2022, through the RFA process, the BFH awarded a grant to Pittsburgh's Healthy Start program, to implement a community-based doula program using the HealthConnect One (HC One) model. Healthy Start operates in Allegheny and Westmoreland counties, in areas with high rates of racial disparities in preterm birth and infant mortality.

The HC One training curriculum and program model has been identified as an AMCHP "best practice". HC One community-based doula programs provide no-cost, culturally concordant perinatal services to individuals at high risk for poor birth outcomes. Services are generally provided from the 24th week of pregnancy until three months postpartum and are intended to enhance infant health, strengthen families, and establish family supports.

The HC One model has been shown to decrease medical interventions during labor and delivery, improve birth experiences, and increase breastfeeding rates, among other positive outcomes. HC One community-based doula programs have the potential to reduce racial disparities and promote equity in health outcomes, mitigate risk factors, and promote the development of protective factors. In areas where an HC One community-based doula program has already been implemented, the program has been demonstrated to reduce medical interventions during labor and birth, improve bonding between parent and baby, improve rates of breastfeeding/chestfeeding, and support infant care.

No new doulas were trained through these initiatives during the reporting year. The PDPH doula program was staffed at maximum capacity and did not need to hire or train new doulas to provide doula care to the program's service population. The start date for the Healthy Start HC One doula program was July 1, 2022. Due to the intensive, extensive, and comprehensive nature of the HC One 20-session doula training, no doulas completed the HC One training in the 2022 reporting year. The Grantee anticipates having their doulas fully trained by early 2023. The BFH looks forward to providing an update regarding implementation and progress of the Healthy Start community-based doula program in the 2023 Title V Report.

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 OUD is 84.9%, significantly more than the national average of 45%. Further, according to the DOH's "Neonatal Abstinence Syndrome: 2020 Report", 1,825 newborns were diagnosed with opioid-related NAS, compared to 1,608 the year before. The incidence of NAS per 1,000 live births in 2020 was 14.0, an increase from the rate of 11.9 in 2019.

In 2022, the BFH continued and completed its partnership with the Alliance of Pennsylvania Councils, Inc. (Alliance) in an initiative to reduce the rate of unplanned pregnancies, increase access to family planning care, and improve detection and treatment access for women and birthing people with OUD. This multifaceted initiative built linkages between family planning organizations and behavioral health/substance use treatment centers between 2018 and 2022.

At the beginning of this project, each family planning council belonging to the Alliance 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 SUDs, including OUD.

In 2022, the Alliance trained seven behavioral health providers to assess for pregnancy intention as part of their routine intake and counseling. Albeit this is higher than the number of providers trained in 2021 (two), it did not meet the objective to increase the number of behavioral health providers trained in pregnancy intention assessment. The low number of provider trainings and the absence of new partnerships with SUD treatment facilities was due to the natural project trajectory, as 2022 was the final year of the grant and the Alliance's focus was instead on maintaining and strengthening existing partnerships.

In 2022, the Alliance provided services to improve the preconception health of and reduce unintended pregnancy rates for 5,243 individuals, including 3,804 people with an SUD, 3,076 individuals with OUD, 1,477 women with OUD, and 12 youth. Due to the subsiding of COVID-19 pandemic-related barriers and restrictions in 2022, the Alliance was able to refer more individuals to contraceptive care and conduct more counseling and group education sessions than in 2021. In 2022, 704 individuals participated in 86 group education sessions on sexual and reproductive health.

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 BIPOC, the majority (73.9%) of individuals served by this program in 2022 were white; however, the percentage of white clients varies between the pilot projects, depending in part on the demographics of the geographic area served. Overall, the population served by the program was slightly less majority-white than the state of Pa. (73.9% compared to 81%). The program also served more Hispanic/Latinx clients than the state population (17.2% compared to 7.8%). The overall racial and ethnic composition of the clients served did not shift substantially from 2021 to 2022, despite the continued disproportionate burden on people of color and the agencies that serve them.

This grant initiative ended in 2022. By increasing access to integrated sexual and reproductive health services for groups that are disproportionately affected by SUD, the BFH hoped to reduce the incidence of unintended pregnancy and improve health outcomes for birthing people with OUD and their babies. If the BFH selects to replicate elements of the pilot projects in future partnerships, a focus on serving communities of color will be key to addressing racial maternal and infant health disparities through this work.

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

Objective: Increase the percent of women and birthing people 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 and birthing people 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 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 CMHD 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 based 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. Going forward, as new grant agreements are executed, the BFH is asking partners to utilize evidence-based tools for depression screenings in lieu of the 5Ps tool which is not considered an evidence-based tool as it lacks published, peer-reviewed research studies.

The IMPLICIT ICC Program, mentioned earlier in this report, includes maternal depression screenings at 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 2022, 2,331 birthing people received a depression screening at their child's WCV; of these, 471 had positive screenings, and interventions were documented for 453, or 96.2% 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 the participant will follow through with the appointment. In 2022, 90.4.3% 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 postpartum 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.

Pa., 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 focused on extending Medicaid access to postpartum services; 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 and birthing people to receive care in the early postpartum period

Objective: Increase the percent of women and birthing people 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

ESM: Percent of women and birthing people who attend a postpartum visit within 28 days of delivery, through the 4th trimester pilot program

Maternal mortality (MM) and morbidity, and the pervasive disparities between racial and ethnic groups, continues to be a strong area of focus. According to the CDC, there was a 40% increase in MM nationwide in 2021, with a rate of 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. In 2021, 1,205 individuals died of maternal causes in the U.S., compared to 861 in 2020 and 754 in 2019.

Racial disparities in health outcomes persist. In 2021, non-Hispanic Black/African American birthing people experienced a MM rate 2.6 times higher than that of white birthing people; 69.9 Black/African American women and birthing people per 100,000 died from maternal causes in 2021, versus 26.6 of their white counterparts. The MM rate continued to climb for Black/African American individuals; the rate for this population was 55.3 per 1000,000 live births in 2020, 44.0 in 2019 and 37.3 in 2018.

In addition to racial disparities in MM rates, birthing people continue to experience disparities in MM based on age. In 2021, MM rates for individuals aged 40 and older were 6.8 times higher than the rate for women under 25. There were 20.4 deaths per 100,000 live births for birthing people under age 25, versus 31.3 for people aged 25-39, and 138.5 for individuals aged 40 and older.

Nationwide, the leading underlying causes of maternal mortality are cardiovascular conditions (more than 33%), infection (12.5%), and obstetric hemorrhage (11.2%). Based on CDC Maternal Mortality Review Committee (MMRC) Data from 36 states, over 80% of all pregnancy-related deaths are preventable. The leading underlying causes of pregnancy-related death among Black/African American birthing people are cardiac and coronary conditions, and over 50% of postpartum strokes occur within 10 days of delivery. Early postpartum care decreases mortality risk for people with hypertensive disorders and other chronic conditions.

Pregnancy care has traditionally been organized into three trimesters, with a single postpartum visit at approximately six weeks postpartum. The timing of this visit contradicts the evidence that shows over 50% of pregnancy-related deaths occur after the birth of the infant, and 40% of these deaths occur by six weeks postpartum. In addition, as many of 40% of individuals do not see their maternity provider at all after discharge from the hospital or birth center, with rates even lower among Black/African American people.

The “fourth trimester (4TM)” generally refers to, at least, the first three months postpartum up to a year 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, preexisting 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 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 after pregnancy. As a result of the ACOG recommendations, the IMPLICIT Network, with support from BFH, developed and began implementation of an innovative 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.

The IMPLICIT 4TM model aims to identify high risk patients, who may have mood concerns, obesity or wound

concerns, thyroid disorders, hypertensive disorders, endocrine disorders, renal disease, or substance use disorders. 4TM providers create a postpartum registry of anyone who received prenatal care at the practice, or delivered with providers in the practice, and prioritizes getting patients back into the office to see their providers between 7 and 21 days after delivery. Ideally, providers develop a plan for the early postpartum visit when the patient is between 28 weeks gestation and delivery.

4TM providers collect patient data from multiple encounters, including at prenatal visits, immediately after delivery, and during the early postpartum visit. At the early postpartum visit, 4TM connects patients with any needed psychosocial, biomedical, and other wraparound services or referrals. 4TM screening assesses for biomedical risk (hypertension, preeclampsia, cardiovascular, diabetes, and postpartum hemorrhage) and psychosocial risk (depression, tobacco use, and substance use). In order to reduce fragmentation of care across providers and settings, providers establish a care team, which may include a primary care provider, specialty physician, lactation consultant, mental and behavioral health providers, and a case manager. Initially, the IMPLICIT Network planned to use baseline data from eight 4TM pilot sites established in 2021. The goal of establishing baseline data was to demonstrate the efficacy of the model, while expanding to new sites in 2022. However, due to COVID-19-related staffing limitations, the pilot project experienced significant barriers to establishing timely, consistent, and accurate data collection, reporting, and analysis, resulting in an extension of the pilot period.

In 2022, the IMPLICIT Network completed the pilot stage and fully implemented the 4TM model at three sites (Lancaster General Family Medicine Residency (FMR), UPMC Williamsport FMR, and University of Pennsylvania Philadelphia-FMR). By the end of 2022, two of these sites were sharing early postpartum visit and 4TM questionnaire data, and the third site was sharing early postpartum visit data, while collecting questionnaire data. The baseline data for the ESM was established in 2022, with 58.2% (336) of 577 eligible birthing people among the three sites having received an early postpartum visit through the 4TM program. In addition, the two sites currently sharing 4TM screening questionnaire data indicated that of the 426 birthing people who were eligible for 4TM screening at their sites, 318 (74.6%) received any 4TM screening and 219 (57.5%) received the full 4TM screening.

The IMPLICIT Network has continued to experience challenges in collecting, sharing, and analyzing data from the 4TM project. The data sharing process has so far largely relied on manual data entry, a labor-intensive and time-consuming process. In addition, unforeseen complications with utilizing and updating electronic health records and creating common workflows delayed progress of this initiative. Additionally, initial baseline data revealed issues related to data validity and clarity within the 4TM questionnaires, which have since been updated. In 2023, the IMPLICIT Network will continue to support 4TM 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

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 Pennsylvania Maternal Mortality Review Committee (PA MMRC), a requirement of Pa.'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 requirements, PA MMRC membership includes obstetricians, maternal fetal medicine specialists, certified nurse-midwives, addiction medicine specialists,

specialized gynecologic psychiatrists, social workers, coroners, emergency medicine physicians, and community voices. In addition to clinical guidance, PA 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.

The PA MMRC reviews all pregnancy-associated deaths, defined as a death during pregnancy or one year following the end of pregnancy regardless of outcome, in Pa. with the exception of pregnancy-associated deaths that occur in Philadelphia County. Philadelphia has administered a local MMRC for more than a decade. PA MMRC and Philadelphia MMRC collaborate to collectively review all deaths in Pa.

The PA MMRC's first report highlighting maternal death cases from 2018, 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.

In 2022, the PA MMRC reviewed 2020 pregnancy-associated deaths. In 2020 there were 87 cases verified as pregnancy associated. During this time the committee reviewed a total of 54 of the 87 verified cases or 62% of cases. Of those reviewed, 32 deaths were accidental deaths, including poisoning/overdose, with 23 of the 32 related to substance use. There were seven homicides, two suicides, and 13 natural deaths. The committee determined that 15 of the cases reviewed were pregnancy-related, defined as a death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

Maternal Mortality Review Program (MMRP) staff continued to strengthen partnerships with internal and 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. Internally, staff met with the Bureau of Health Statistics and Registries as well as other program areas who review deaths to improve the quality of data acquired for the MMRP.

In 2021, Philadelphia MMRC implemented recommendations around four topic areas: Early Warning Signs Training Initiative, Obstetrics and Cardiology Taskforce, Transforming Philadelphia's Response to Intimate Partner Violence in Acute Obstetrical Settings, and Community Investment. While no new recommendations were implemented in 2022, Philadelphia MMRC continues to work to implement programming and initiatives around these topics.

In 2022, the PA PQC worked with 55 hospitals representing 81% of live births in Pa. to implement the following initiatives: an expanded focus on maternal OUD (39 hospitals), NAS (43 hospitals), and contraceptive care, including access to immediate postpartum long-acting reversible contraception (LARC) (19 hospitals); Moving on Maternal Depression (MOMD) to improve prenatal and postpartum depression screening and follow-up rates and reduce associated racial/ethnic disparities (23 hospitals); and the PA AIM initiative to adopt the PA AIM Bundle to improve severe hypertension in pregnancy treatment and reduce associated racial/ethnic disparities (24 hospitals). 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)

Effective collaboration and coordination are important to create a high-quality system of support for birthing people and families in Pa. Collaboration across agencies and programs ensures better coordinated services and reduces the duplication of services across agencies. BFH staff met the goal of convening with DHS and MIECHV quarterly in the 2022 calendar year. The intent of these meetings is collaboration among agencies to understand the programs and initiatives offered through the systems of care for the people in Pa. This knowledge and understanding aids in the development of gap filling programs offered through Title V.

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, 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. However, in the budget for state fiscal year 2023, $2.3 million in state funds were allocated to expand existing maternal health programming and prevention strategies aimed at reducing Pa.'s maternal mortality rate. Other federal funds from the Centers for Disease Control and Prevention (CDC) are used to support the MMRC. Taking into consideration the overall population needs, 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.

Additionally, 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. The evaluation findings will be used by the BFH to help strengthen and inform decision-making regarding adolescent and maternal health programming, specifically group prenatal care, and to serve as a prototype for evaluating other group prenatal health care models utilized by the

DOH.

III. Priorities

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

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

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

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

The County Municipal Health Departments (CMHD) offer home visiting services to pregnant and birthing people, infants, children, and CSHCN. CMHD 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. CMHD 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 CMHD home visiting programs allow birthing people to obtain services up to a year after the birth of their children. All these factors enable home visitors to develop a relationship with and begin supporting the family exactly where they are, assist in acquiring needed services, and improve the overall health and wellbeing of Pa. families.

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 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 CMHD to provide home visiting services to the Title V population. BFH staff will continue to assess whether Title V home visiting services should be a core service by continuing to work and meet with staff from DHS. DHS oversees the Medical Assistance (MA) Managed Care Organizations (MCOs), who 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 as well as the evidence-based Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). The CMHD HV program is very small in comparison to the MIECHV or MA HV programs. BFH staff is working to determine a way to transfer HV services from the CMHD to the Medicaid program, which many participants are a part of, as to not duplicate services. However, until the MA HV program is situated and understood by DHS, the MCOs and BFH, staff is hesitant to suspend these gap filling 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 established to ensure participants not covered by MA continue to receive home visiting services.

Strategy: Increase the percent of adolescents, women and birthing people 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, women and birthing people who talked with a health care professional about birth spacing or birth control methods by 1%

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

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. Since the service areas of the two CPP locations are limited, the total number of persons served by the CPP is small. Additionally, the programs are working to address a specific need in the communities where the programs reside. These factors make it difficult to measure whether this strategy is addressing the disparities identified in the statewide data. However, the populations identified and served by AEHN and WellSpan York stand to benefit from the focused services provided. Barriers and access to care are considered when developing strategies to increase positive health and birth outcomes. Transportation to and from medical appointments, culturally appropriate care, providing behavioral health screenings and warm referrals, including in-home therapy may positively impact the patients served by these programs.

Strategy: Implement care models that include preconception and interconception care

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

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

Poor maternal health contributes to excess rates of preterm birth and infant mortality, and a healthy pregnancy begins long before conception. Preconception and interconception care improve the health of women and birthing people before and between pregnancies. 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 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 the birthing person and their infant.

Individuals who are impacted by mental health, substance use, and chronic health conditions, and who experience an unintended pregnancy, are at higher risk of experiencing adverse pregnancy outcomes. Studies indicate that unintended pregnancies are associated with adverse physical health, psychological, economic, and social outcomes, particularly for individuals with pre-existing behavioral and physical health concerns. Screening and intervention for family planning, depression, tobacco use, and multivitamin with folic acid use can address these risk factors prior to pregnancy. In addition, ICC that includes contraceptive counseling can reduce rates of unintended pregnancies.

As birthing people who receive ICC tend to have healthier pregnancies and lower-risk births, this strategy may help lower rates of maternal morbidity and mortality, particularly where there are disparities. ICC is particularly critical for Black/African American birthing people, who have the highest infant and maternal mortality rates of any racial group in the United States, including in Pa. Due largely to the nation's history of racism and marginalization, Black/African American pregnant people are significantly more likely to have pre-existing health conditions than their white counterparts. The rate of maternal mortality is at least twice as high for non-Hispanic Black/African American birthing

people than for non-Hispanic white birthing people. In addition, the rate of severe maternal morbidity is 2.3 times higher among Black/African American birthing people than among their white counterparts, affecting over 1,000 births per year in Pa. ICC has the capacity to reduce these persistent racial disparities in birth outcomes by reducing unintended pregnancies and by helping birthing people enter pregnancy in optimum health.

Despite broad consensus on the importance of ICC, this care is still not routinely provided, and there is not widely accepted, evidence-based model for delivering ICC. To help address this gap, the Interventions to Minimize Preterm and Low Birthweight Infants using Continuous Improvement Techniques (IMPLICIT) Network developed, piloted, and implemented a model for ICC in Pennsylvania in 2012.

The IMPLICIT Network is a multi-state, family medicine, maternal-child health learning collaborative focused on improving birth outcomes and promoting the health of women, birthing people, infants, and families through evidence-based interventions, innovative models of care, quality improvement, and professional development for current and future physicians. Through the IMPLICIT Network participating providers have the ability to establish evidence for ICC. It is also a forum for professional collaboration, development, and continuing education.

Often, due to lack of transportation, paid time off, or childcare, parents do not attend routine provider visits for themselves, but instead prioritize attendance at well-child visits (WCVs) for their infant or child. By offering biomedical, psychosocial, and behavioral interventions for risk factors prior to pregnancy the risk of adverse pregnancy outcomes, such as preterm birth, can be minimized. The IMPLICIT ICC model works to change maternal behaviors and improve birth outcomes by screening birthing people for four behavioral risk factors at their child's WCVs: smoking status, depression, contraception, and multivitamin with folic acid use. Individuals with positive screens are provided with brief interventions or referrals. This model of care has been shown to effectively identify modifiable maternal risks and show maternal behavior change that are associated with improved health outcomes.

The IMPLICIT ICC model is adaptable to a variety of settings, including family medicine practices, pediatric care, health departments, community health centers, and public health programs. Because no two clinical sites are identical, each practice can tailor this innovative model to meet its needs and those of the population it serves. Providers may utilize this model even if they do not wish to participate in the IMPLICIT Network's collaborative processes (such as data collection and quality improvement efforts).

The IMPLICIT Network has been working to advance principles of health equity within its programs and operations, to better address racial disparities in maternal health. Disaggregating data by race/ethnicity and meaningful community engagement are two priority areas of focus for the IMPLICIT Network in the coming year. The Network is actively building community partnerships, through partnership agreements, on the local, state, and national level, and is establishing a community advisory board to generate feedback and suggestions for improvement. In addition, the IMPLICIT Network will begin providing ICC program data regarding screening and intervention rates, disaggregated by race/ethnicity, in its regular reports. This will help the BFH to better understand how well this strategy is serving Black/African American birthing people and other priority populations during the interconception period.

In 2024, the IMPLICIT Network will continue to work with family medicine providers in Pa. to strengthen existing ICC programs and expand this model of care to new sites. Through continued implementation of the IMPLICIT ICC model of care at participating IMPLICIT Network sites, the BFH seeks to demonstrate that the model can effectively identify modifiable maternal risks and result in 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 priority 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.

Community-based doula programs provide perinatal 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.

If implemented with a focus on equitable access, community-based doula support can reduce persistent and pervasive racial disparities in maternal health outcomes. Within local communities, doulas often serve as trusted sources of information, advocacy and navigation throughout the perinatal period. By providing culturally concordant, continuous support and evidence-based information across the entire pregnancy, doulas can contribute to improved maternal and infant outcomes and experiences by reducing stress, anxiety, and pain, and by promoting self-efficacy and confidence. According to a U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief, individuals' labor and delivery that were supported by doula care had lower cesarean and preterm birth rates and improved rates of breastfeeding initiation. By supporting clients in advocating for their personal care preferences, doulas can help reduce the detrimental effects of racism and implicit bias and prevent unwarranted and undesired clinical interventions.

In addition to improving clinical care practices, community-based doulas can help address social determinants of health that impact maternal health, such as transportation issues, language and cultural gaps, food and housing insecurity, and maternal mental health conditions. Depending on the situation, doulas may provide screening, referral, and navigation assistance for necessary services. This may be particularly helpful for Black/African American women and birthing people, as generations of structural racism has resulted in inequities. The BFH is invested in helping to ensure that birthing people in Pa. have access to culturally and racially concordant doula care during the perinatal period. The BFH is interested in helping to grow the MCH workforce at the local level and increase access to sustainable employment opportunities for community-based doulas. As such, the BFH is supporting the development of community-based doula programs that are primarily focused on addressing racial maternal health disparities; increasing the number of community-based doulas that are certified through the Pennsylvania Certification Board; and providing community-based doula support to priority communities. 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.

Currently, the BFH supports two community-based doula program grants using Title V funds: one serving individuals affected by opioid use disorder (OUD), through the Philadelphia Department of Public Health (PDPH), and one providing doula care to individuals within the Healthy Start Pittsburgh service area.

The PDPH developed a Doula Support Program tailored to the needs of birthing people with SUD. The program uses 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.

Healthy Start Pittsburgh (Allegheny and Westmoreland counties) is implementing a community-based doula program in areas with high rates of racial disparities in preterm birth and infant mortality. The program is utilizing the HealthConnect One model. The BFH looks forward to working with Healthy Start over the coming year as they continue to implement this program.

Additionally, Delaware County Health Department (DCHD), which was established in 2022, intends to implement a doula program. DCHD will partner with established community-based doula programs to hire and train new doulas as well as provide doula services to the community. Doulas serving birthing people with SUD/OUD and mental health concerns will be given additional training on substance use, NAS, trauma-informed care, and mental health. Montgomery County Health Department (MCHD) will continue to support the training of community-based doulas through a partnership with Maternity Care Coalition. MCHD's Perinatal Periods of Risk (PPOR) study indicated that, to reduce infant mortality rates and increase birth equity, doulas are needed in communities to serve Black/African American and brown birthing people.

The state has made significant strides in recent years to make quality doula care more accessible and affordable for all birthing people. Over the past few years, the Pennsylvania Doula Commission, PA Department of Human Services, and the Pennsylvania Certification Board (PCB) developed and began implementing a state-level Certified Perinatal Doula (CPD) credentialing process. In addition, the state has begun taking steps toward making doula services reimbursable under Pa.'s MA program, to provide a pathway for low-income individuals to access doula care, and for those doulas to receive compensation for their services. However, MA reimbursement will not begin until sufficient doulas have been certified by the PCB in all regions of the state. Unfortunately, there have not been concerted efforts to recruit, train, and certify community-based doulas, and, as a result, there are fewer than 10 doulas certified through the PCB.

The BFH is invested in helping to grow the perinatal doula workforce throughout Pa. and helping to ensure that pregnant and birthing people – particularly those who identify as Black, Indigenous, and People of Color (BIPOC) -- have access to culturally and racially concordant doula care. The four community-based doula programs mentioned in this section are, by the nature of their limited-service areas, incapable of significantly impacting statewide rates of maternal mortality and related health disparities. The BFH is currently exploring ways to partner with community-based maternal health organizations throughout Pa. to train, certify, and mentor community-based doulas and increase public and provider awareness of both the doula credential and service.

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

Objective: Increase the percent of women and birthing people 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 and birthing people 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 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 (parents, peers, partner, pregnancy, past) 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 identifying pregnant, birthing, and postpartum people in need of support and referral for mental health services, SUD assessment, and intimate partner (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 birthweight, and fetal growth restriction. In the postpartum period, maternal depression may result in issues with breastfeeding/chestfeeding, difficulties in relationships, or increased substance use. The risk of maternal depression is 1.6 times higher for Black/African American individuals than their white counterparts; unfortunately, mental health symptoms are often overlooked and under addressed among Black/African American pregnant and birthing people.

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 the implementation of new grant agreements in 2023, the CMHDs are required to use a validated screening tool to screen participants for depression. The majority have chosen either the Edinburgh Depression Scale or Patient Health Questionnaire-9 as their preferred screening tools. Participants are screened, at minimum, once in both prenatal and postpartum periods. CMHDs are encouraged to make warm referrals to behavioral health services following a positive screen. Race and ethnicity data are not collected as part of this measure, making it difficult to gauge whether it is addressing the disparities found in referral rates for behavioral health services.

With BFH and Title V support, 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 Pa.

Although screenings of this kind are completed irrespective of participants' race or ethnicity, efforts of this nature enable more birthing people to be assessed and connected to treatment or resources when necessary. This has the potential to impact racial disparities in rates of maternal depression in the service area of participating providers. Replication and expansion of this model of care throughout the state could result in a statewide reduction of maternal morbidity and mortality due to unidentified and untreated behavioral health concerns, particularly where there are disparities.

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 be required to use evidence based IPV screening tools. The selected tools include the Hurt, Insult, Threaten, Scream (HITS) and the Humiliation, Afraid, Rape, Kick (HARK) screenings which address both emotional and physical abuse. 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 percentage of behavioral health services referrals made because of the positive screens.

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

Objective: Increase the percent of women and birthing people 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 and birthing people who attend a postpartum visit within 28 days of delivery through the 4th trimester pilot program

Early postpartum care decreases mortality risk, particularly among birthing people who have chronic medical conditions like hypertensive disorders. Following 2018 recommendations from the American College of Obstetricians and Gynecologists, the IMPLICIT Network developed a 4th trimester (4TM) model of care initiative to address gaps in postpartum care and decrease rates of maternal mortality in the early postpartum period. With this model, 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. Title V funds are supporting the development and implementation of the IMPLICIT 4TM model of postpartum care in Pa.

Through implementation of the IMPLICIT 4TM model, birthing people identified as high risk for postpartum complications are scheduled for a postpartum visit between 7 and 21 days after birth. At this early visit, participating sites provide counseling, interventions, and/or referrals for birthing people that screen positive for one or more risk factors. By helping patients recognize warning signs, get an accurate and timely diagnosis, and have access to quality care, the 4TM model of postpartum care decreases their risk of maternal morbidity and mortality.

The 4TM model is currently being implemented at four sites in Pa., with plans for further replication. In the next year, the IMPLICIT Network will continue to support, strengthen, and expand the 4TM program in Pa. and to standardize, collect, share, and analyze data regarding the people that receive screening, referrals, and follow-up care in the first month postpartum. By implementing this model of care, the BFH seeks to decrease rates of maternal morbidity and mortality in the early postpartum period, particularly where there are disparities. Although the 4TM model has the potential for reducing racial disparities in maternal mortality rates by addressing cardiovascular health earlier in the postpartum period, it is too early in the model's implementation to understand its true reach or impact on the overall maternal population or on the Black/African American maternal population. However, this strategy aims to directly address the priority need and, if successful, could drive improvement for the National Outcome Measures on maternal morbidity and mortality, and decrease racial health disparities for birthing people in Pa.

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. MMRCs thoroughly review cases of pregnancy-associated death, which is any death during pregnancy or within one year of the end of pregnancy, and develop recommendations. These reviews allow state level data and trends to be identified and focused interventions to be implemented to decrease the number of preventable deaths. Data from MMRCs from 2017-2019 determined that the underlying causes of pregnancy-related deaths, or deaths that would not have occurred if the person was not pregnant, vary by race. Cardiac and coronary conditions were the leading underlying cause of death among non-Hispanic Black persons. Mental health conditions were the leading underlying cause of death among Hispanic and non-Hispanic white persons.

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 Pa. builds infrastructure to identify and support pregnant and postpartum individuals who have mental health concerns, use substances, and/or have a history of IPV. In addition, the MMRC recommended that Pa. provide more comprehensive medical care for all pregnant and postpartum individuals.

Healthcare-related recommendations were shared with the Pennsylvania Perinatal Quality Collaborative (PA PQC). The PA PQC is implementing quality improvement initiatives related to severe hypertension in pregnancy, maternal OUD, NAS, contraceptive care and depression. The PA PQC works with 63 hospitals across the state representing 82.5% of live births in Pa. Implementing recommendations through the PA PQC has the potential to positively impact the health of birthing people in Pa. Further, BFH staff are working with the Jewish Healthcare Foundation to implement programming to expand the reach of existing e-consults or telephonic/video consultation for SUD and MH perinatal follow-up/treatment. Other recommendations will require support from, and coordination with, other internal and external stakeholders.

Review of pregnancy-associated deaths from 2020 will be completed in 2023. Once all data has been analyzed, program staff will work to publish a second legislative report identifying and addressing disparities among this population. In 2024, the BFH will work to identify partners to assist with implementing MMRC 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

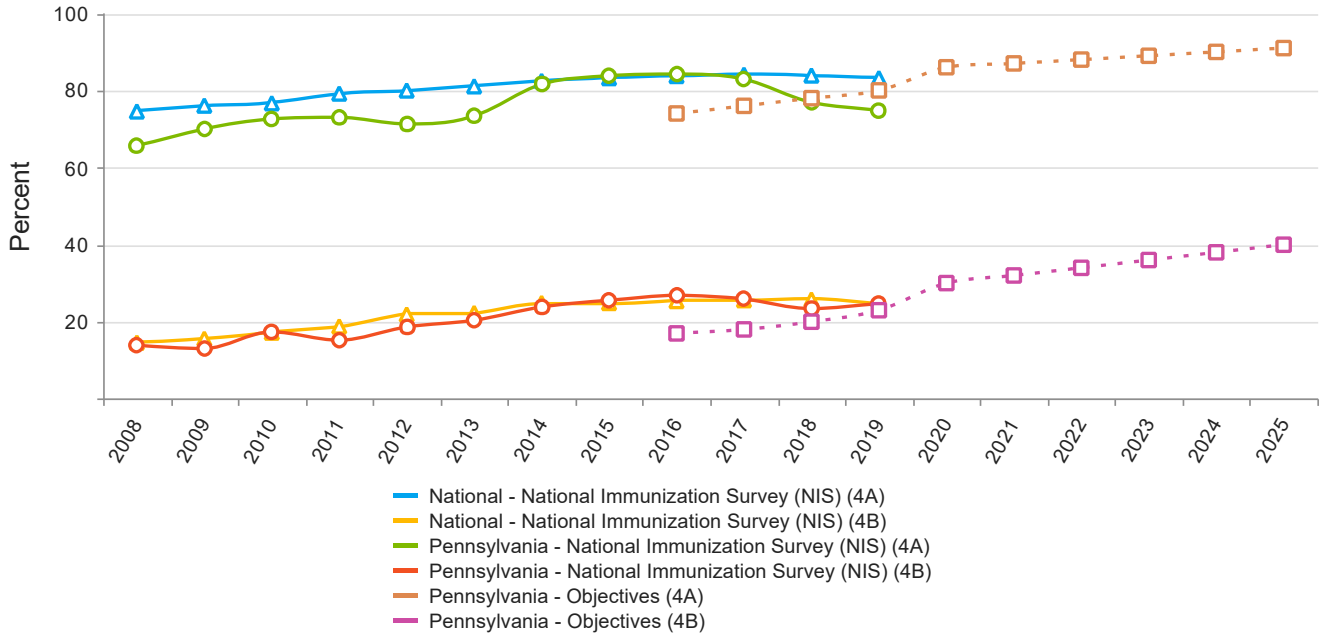
Effective collaboration and coordination are important to create a high-quality system of support for birthing people and families in Pa. Collaboration can increase service utilization through effective referral processes. Further, agencies that communicate with one another and share information can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

Convening quarterly with other state agencies and programs helps strengthen a shared understanding of initiatives for families, with the goal of reducing silos across agencies and better serving pregnant and parenting people in Pa. With continued meetings, the BFH will be able to determine what gap filling services are needed to improve the health of Pa. residents and address the disparities identified in the data. In the next year, the BFH will continue quarterly meetings with the DOH, DHS, and the 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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	78	80	86	87	88
Annual Indicator	83.8	84.2	82.9	76.9	74.8
Numerator	111,838	113,497	105,668	95,850	97,967
Denominator	133,410	134,782	127,530	124,715	131,013
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	20	23	30	32	34
Annual Indicator	25.6	26.9	25.9	23.6	24.6
Numerator	32,912	35,760	32,327	28,555	31,220
Denominator	128,398	132,966	124,942	121,059	126,762
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

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

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of Keystone 10 (K10) facilities that progressed by one or more steps each fiscal year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			60	60
Annual Indicator			41.2	21.3
Numerator			21	10
Denominator			51	47
Data Source			K10 program	K10 program
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			4	4
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			10
Annual Indicator		10	10
Numerator			
Denominator			
Data Source		agenda and meeting minutes	agenda and meeting minutes
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

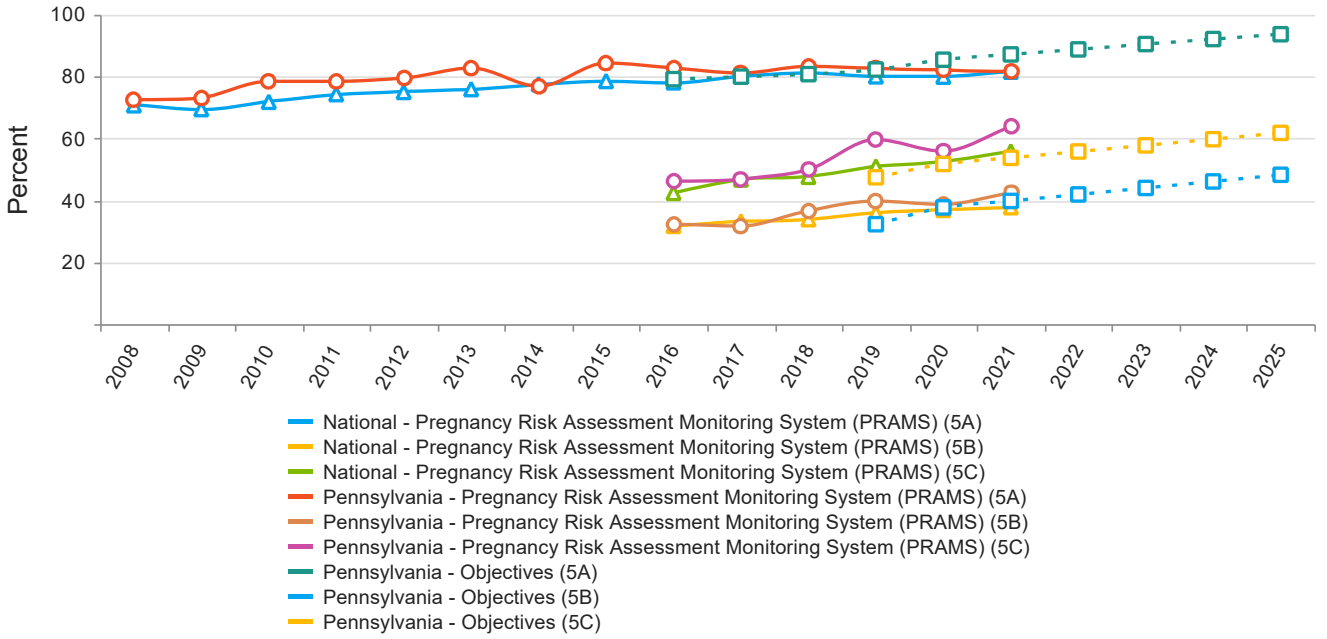
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	10.0	10.0	10.0

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

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			15
Annual Indicator		15	15
Numerator			
Denominator			
Data Source		quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.6	82.1	85.3	87	88.6
Annual Indicator	81.2	83.1	82.4	81.8	81.6
Numerator	103,722	104,542	101,724	98,852	99,193
Denominator	127,773	125,760	123,405	120,823	121,571
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	80.6	82.1	85.3	87	88.6
Annual Indicator	81.2	83.1			
Numerator					
Denominator					
Data Source	PRAMS	PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective		32.3	37.7	39.8	41.9
Annual Indicator	31.5	36.6	39.8	38.8	42.6
Numerator	38,141	44,262	46,940	45,339	50,575
Denominator	121,226	120,893	118,085	116,778	118,589
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		32.3	37.7	39.8	41.9
Annual Indicator	31.5				
Numerator					
Denominator					
Data Source	PRAMS				
Data Source Year	2016-2017				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective		47.4	51.7	53.7	55.7
Annual Indicator	46.9	50.1	59.5	56.0	64.0
Numerator	56,601	60,875	70,513	65,435	75,742
Denominator	120,631	121,402	118,424	116,863	118,331
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		47.4	51.7	53.7	55.7
Annual Indicator	46.9				
Numerator					
Denominator					
Data Source	PRAMS				
Data Source Year	2016-2017				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			infant program that implements recommendations	Infant Program that implements recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	3	3	0	0	6
Annual Indicator	6	6	0	5	1
Numerator					
Denominator					
Data Source	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	Grantee quarterly reports
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	8	9	18	9	37
Annual Indicator	8.6	17.4	0	36.1	41.2
Numerator	11,639	23,337		47,314	53,068
Denominator	135,498	134,091		131,006	128,959
Data Source	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	grantee quarterly reports and annual birthing data
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	2	4	8	8	24
Annual Indicator	1.9	8.9	0	32.5	33.3
Numerator	2	9		27	28
Denominator	107	101		83	84
Data Source	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	grantee quarterly reports, birthing hospital count
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	38.0	40.0	0.0

ESM 5.5 - Number of targeted prevention initiatives or interventions implemented using Perinatal Periods of Risk (PPOR) data

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			1
Annual Indicator		0	17
Numerator			
Denominator			
Data Source		PPOR vendors quarterly and annual reports	PPOR vendors quarterly and annual reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			70.5	71
Annual Indicator			64.6	58.1
Numerator			197	18
Denominator			305	31
Data Source			Pennsylvania newborn screening data system	Pennsylvania newborn screening data system
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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 (K10) 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 Perinatal Periods of Risk (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. 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 matching funds are used 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) multiyear 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 2022 with 92 birthing hospitals/free standing birthing centers and 125 midwives performing deliveries. Based on newborn screening data, 133,512 infants were born in Pa. in 2022, with 95.6% of births occurring in hospitals and free-standing birth centers, and 4.4% 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 2022, the DNSG's contracted laboratory, PerkinElmer Genetics, performed 132,981 (99.6%) initial dried blood spot screenings. The number of infants receiving a hearing screening in 2022 was slightly less at 127,327 (95,4%). In addition, 129,372 (96.9%) 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 2022, 547, or 0.4% 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. was 5.6 per 1,000 live births in 2020. The rate for Black/African American infants was 10.9 per 1,000 live births in 2020, more than two times the Healthy People 2030 goal of 5.0 per 1,000 live births. The rate for Black/African American infants was higher than the rate for Latinx infants (5.6), which also did not meet the Healthy People 2030 goal, and more than double the rate for white infants (4.5). In 2020, 9.6% of Pa. babies were born prematurely. The percent of low birthweight babies was 8.3. Health disparities persist again when stratifying low birthweight by race and ethnicity: Asian/Pacific Islander (9.2%) Black/African American (14.5%), Latinx (8.5%), white (6.8%), and multi-race (10.1%)

More than a third of the 2020 deaths (most recent year complete data is available) reviewed by local Child Death Review (CDR) teams were deaths among infants. There were 314 total infant deaths reviewed, representing 39.2% of all cases reviewed. Prematurity remains the leading cause of death for infants. Of the total 314 infants' deaths reviewed, 148 (47.1%) were due to prematurity. An examination of Pa.'s reviewed infant deaths for 2020 revealed that 59 (18.8%) of the 314 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 2020 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 2022, the BFH participated in 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 continue to be 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 2022, 84 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 2022. This goal was not met, as only 21% (10 of 47 eligible facilities) completed at least one step. Much of this is because many birthing facilities have already completed all 10 steps and ongoing issues with COVID-19 mitigation efforts and staffing shortages meant that other birthing facilities had challenges finding the resources to complete more K10 steps. As the program begins to sunset K10, the focus has turned to ongoing sustainability efforts to ensure that the program's effects continue long after funding has ceased. These efforts include having K10 certified hospitals complete sustainability plans which were submitted to PA AAP for review and performing existing step reviews to ensure continued fidelity to the K10 program.

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 eighth 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 2022 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, Basecamp, 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.

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

As noted above, the BFH houses both the DNSG and 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 rate.

The PA Breastfeeding Awareness and Support Program and the Safe Sleep Program met quarterly during 2022 to discuss and implement possible collaborative and educational efforts between the programs. Collaborative and cross educational actions taken during 2022 included: continuing to share safe sleep resources to First Food's breastfeeding community partners via their monthly newsletter and social media platform, sharing the updated 2022 Safe Sleep guidelines with grantees through Basecamp, social media and the newsletter, and continuing to create and share cross educational materials on preventing SIDS through the intersection of safe sleep practice and breastfeeding to both programs' grantees.

The PA Breastfeeding Awareness and Support Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) collaborate all year through an annual Breastfeeding Referral guide which is jointly updated and hosted on the breastfeeding website, updates from local WIC offices at each regional biannual collaborative, and ongoing meetings with program representatives.

Additionally, in 2022, the PA Breastfeeding Awareness and Support Program began a data collaboration with Pennsylvania's Pregnancy Risk Assessment Monitoring System (PRAMS) program. The breastfeeding program will use PRAMs data to assess ongoing breastfeeding support needs throughout the state and to plan for future programming that centers health equity.

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, PA AAP was awarded grant funding by the BFH through a Request for Applications to administer a program to increase breastfeeding support and awareness. In 2021 and 2022, 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 2022. 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. Topics discussed during the spring 2022 collaboratives included defining the landscape of lactation support within each region, identifying ways to build capacity for lactation support within different communities as well as breakout sessions with updates from regional WIC offices, continuing education on bridge and donor milk, and assisting clients with breast pumps. Topics discussed during fall 2022 included Empower Best Practices for breastfeeding, a mini grant panel to discuss the mini grant awardees for this fiscal year, and a review of First Food's social media campaign which shared breastfeeding photos and stories during National Breastfeeding Month.

PA AAP also provided breastfeeding educational opportunities to community partners in 2022. These opportunities included a statewide breastfeeding outreach event for Father's Day, a webinar addressing the formula shortage and re-lactation, a webinar on LGBTQIA+ gender inclusivity and lactation support, and a webinar series geared toward ensuring that childcare centers are breastfeeding friendly. PA AAP conducted a social media campaign in honor of National Breastfeeding Month which highlighted personal breastfeeding stories via narrative and photo entries which were featured on First Food's social media pages. Additionally, PA AAP created a series of library story kits to be distributed throughout the state. These story kits focus on both providing education to library staff members on public libraries as safe spaces for breastfeeding parents and as an educational resource on breastfeeding for children and their families. PA AAP also created a 'Breastfeeding Welcome Here' toolkit and guide for breastfeeding in the workplace and a guide for childcare centers to ensure that they are breastfeeding friendly.

Lastly, PA AAP awarded 15 mini grants to community partners to provide breastfeeding support and education based on the demographic needs of underserved populations in communities with low breastfeeding rates. 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 School District of Philadelphia to support breastfeeding and pumping for students while they continue to attend classes, a mini grant in Cameron County to create baby baskets to support breastfeeding for babies with neonatal abstinence syndrome, and a mini grant through the Lancaster City YMCA to provide breastfeeding education and support to low-income families.

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 or lead prevention strategies or are already involved in developing or implementing similar prevention strategies.

Internally, 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 2022, the process was unable to identify an actionable recommendation for the infant health domain. 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, including recommendations from local CDR teams. 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. The internal process for sharing local CDR team recommendations will be revisited once the assessment and plan are complete.

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 second grant period (July 1, 2021, to June 30, 2024) with the Trustees of the University of Pennsylvania for the infant safe sleep initiative continued during 2022. The grantee was fully engaged in recruitment and implementation in 2022 and efforts extended throughout 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 2022, despite the ongoing pandemic, safe sleep work continued. The grantee continued to offer a monthly live Subject Matter Expert (SME) training. The consistent training schedule assists with the ongoing challenges associated with the nursing shortage and staff turnover. As the hospital-based model program marked the sixth year of implementation, the need for new SMEs at fully implemented hospitals increased. In addition to eliminating the need for all staff at a hospital to attend a single onsite live session, it has enriched the learning environment with participants from multiple hospitals. The grantee continued to report positive outcomes as participants were able to engage in peer-to-peer learning from hospitals at different levels of implementation.

By the end of 2022, the hospital-based model safe sleep program was fully implemented in 28 of the 84 (33%) birthing hospitals which narrowly missed the ESM goal of 34% of birthing hospitals with implementation. While the ESM goal was not achieved, it is crucial to note that during 2022, one hospital stopped the implementation process due the pending closure of the birthing unit and two fully implemented hospitals closed a birthing unit and the acute care general hospital. Over 53,000 infants or 41% of the births in 2022 had parents who received safe sleep education through the model program exceeding the 37% ESM goal.

It is important to note that since the ESMs were developed until 2022, both the number of birthing hospitals and annual births were declining. While annual births continued to decline, it was encouraging that the decline in the number of birthing hospitals began to reverse.

The ESM goal for the number of hospitals with maternity units recruited to implement the model safe sleep program in the next year was six for 2022 as it was a full grant year. The grantee ended 2022 with one hospital recruited to implement the model safe sleep program in the next year. While the grantee was far from the ESM goal, there was no delay for recruited hospitals to begin implementing the hospital-based model program as in prior years. At the close of 2022, seven hospitals were in the process of implementing the hospital-based model program. Due to improvements to create a more dynamic implementation process, the ESM for the number of recruited hospitals no longer provides the predictive data it did when it was established in 2016.

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

The Perinatal Periods of Risk (PPOR) is a comprehensive approach to help communities use data to reduce infant mortality rates and disparities in those rates. 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 provides an analytic framework and steps for investigating and addressing the specific local causes of high fetal and infant mortality rates and disparities. All six stages of the PPOR process (readiness, data analysis, planning, implementation, evaluation, and reinvestment) contribute to making data a powerful agent for systems change, but at the core of PPOR are its analytic methods.

While the national infant mortality rate has declined over time, the Black-white gap in infant mortality has continued to increase. Prematurity, low birth weight, and preterm-related causes are generally understood to be the largest contributors to this persistent disparity. However, communities are often not uniformly aware of their root causes of infant mortality or aligned in how to best respond. Because of this, actions to reduce these disparities can be less impactful. Through the PPOR process, local communities determine the period(s) of risk with the most disparity in deaths to focus efforts. PPOR fosters greater cooperation in improving maternal child health (MCH) through more effective data use, strengthened data capacity, and greater shared understanding of complex infant mortality issues. 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 increases the use of relevant data to inform decision-making and evaluate population and programmatic needs at the community level.

Using Title V funds, the Montgomery County Health Department (MCHD) completed the first two phases of the PPOR in 2020. Results indicated disparities among Black/African American birthing people and their infants compared to white birthing people and their infants, with the greatest disparity being the death rate for very low birthweight Black/African American infants. In 2022, after working through delays caused by COVID-19, MCHD focused on the implementing a strategic plan aimed at lowering disparities and improving birth outcomes for Black/African American infants. Throughout the PPOR process the stakeholders group identified three areas of need in Montgomery County: increased numbers of allied health workers, reduction of provider bias, and access to resources.

While much needs to be done to solidify initiatives for the strategic plan, there has been some work completed to date. Community focus groups were formed and provided valuable input on community needs. The groups determined that the county needed more allied health workers, including doulas and Perinatal Community Health Workers (PCHW), to serve people of color (POC) in Montgomery County. In an attempt to increase the workforce and ensure that the community is equally and accurately represented, doula and PCHW trainings were, and continue to be, offered with priority given to POC.

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 and implement community action plans in their local communities.

Although each organization began the PPOR process in January 2021, they are operating under timelines and

facing challenges unique to their plans and circumstances. The first two stages of the PPOR process are focused on analyzing linked vital records 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. PDPH and ACHD completed these two stages in 2021. Due to delays they experienced in receiving vital records data from the Pennsylvania Department of Health's Bureau of Health Statistics and Registries, MCHC was unable to complete the first two stages of the PPOR process until December 2022. Ultimately, all three PPOR analyses 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 proportion of very low birthweight infants would help reduce overall infant mortality rates and disparities for these communities.

After completing the data analyses, each grantee began working with their PPOR community stakeholder groups to select and/or develop initiatives and interventions for inclusion in their community action plan. The purpose of these action plans is 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 and the 12-point plan as described by Dr. Michael Lu et al. in their 2010 article, "Closing the Black-White gap in birth outcomes; a life-course approach", which is to:

1. Provide interconception care to women with prior adverse pregnancy outcomes
2. Increase access to preconception care to African American women
3. Improve the quality of prenatal care
4. Expand healthcare access over the life course
5. Strengthen father involvement in African American families
6. Enhance coordination and integration of family support services
7. Create reproductive social capital in African American communities
8. Invest in community building and urban renewal
9. Close the education gap
10. Reduce poverty among African American families
11. Support working mothers and families
12. Undo racism.

PDPH and ACHD received approval to move forward with implementing their community action plans in 2022. To date, 17 initiatives and interventions have been implemented by these grantees using PPOR data, meeting the ESM goal. These projects are primarily focused on reducing racial disparities in maternal and infant health outcomes and include public campaigns, peer support programs, expansion of healthcare and family support services, and expansion of the local workforce for Black community-based doulas.

The PPOR process is, at its core, community-based, led and supported by stakeholders outside of the contracting agency. The scope of what each grantee is able to accomplish with regards to their community action plan is largely dependent on the collaborations and relationships they have with the organizations, networks, and groups supporting their local communities. Well-connected and well-funded agencies conducting PPOR studies are better positioned to implement a higher quantity and quality of initiatives that can ultimately impact birthing people in their communities more broadly.

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 obtaining requested repeat filter papers as a concern. In 2022 96.5% (8301 of 8602) of the requested repeat filter papers were collected, meeting the established goal of 94%. 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 community health nurse (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 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. Due to staffing turnover and continued submitter inquiry, this document was redistributed via email to all hospitals and birth centers and mailed to all midwives again in 2022. 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 DNSG partnered with NewSTEPs in 2020 to do a continuous quality improvement project aimed at improving birth to report timeliness. Six Pa. hospitals received funding from NewSTEPs for implementation of an HL7 interface. As a result of this project, which terminated on August 31, 2022, all six hospitals demonstrated improved timeliness in birth to reporting of all conditions. Unanticipated project successes included increased awareness of birth to report timeliness, increased awareness of proper completion of filter papers, and a decrease in birth to referral days to treatment centers for presumptive positive specimens.

The BFH developed a state performance measure (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 this 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. Data review of 2022 initial report out timeframes for an abnormal result indicates 58% (18 of 31) time-critical conditions were called out on or before the

infant's fifth day of life, and the average report out time for all conditions was within six days of life. There is an opportunity for improvement in reporting out time-critical conditions if Pa. is to meet HRSA's recommendation.

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. Documentation review of 2022 data demonstrates 100% documented report out dates for pre-positive results.

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 measures the percent of newborns born in Pa. receiving a DBS 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 2022, 0.4% 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.

An online newborn screening education module, with a focus on timeliness, is available to all providers and partners on the TRAIN PA website. This module, previously funded by NewSTEPs, was originally completed by the University of Pittsburgh via an intergovernmental agreement with the DNSG in 2019 and revised in 2021. The module continued to be shared with new staff and hospitals in 2022.

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, DBS, and NAS 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 initially 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. In 2019, the match produced 55 records. A review of the cases indicated all the CDR cases had, in fact, passed their CCHD screening or were appropriately excluded from the screening because their birth weight was less than 1500 grams.

In 2020, the match produced 52 records. The DNSG and DBO planned to expand the data comparison to include DBS and NAS data in addition to CCHD screening data for 2020 records. The DNSG reviewed the 52 cases, and all again had a passing CCHD screening result or were appropriately excluded from screening due to prematurity and birth weight of less than 1500 grams. All 52 cases also had a timely DBS collection, and the screening results indicated the babies had within normal limit findings for all Pennsylvania mandated conditions. One of the matching cases was confirmed as having NAS. The program plans to continue to analyze correlations between NAS diagnosed infants reported as SUID cases to determine if any policy changes or educational materials may serve to help eliminate SUID related demise in the NAS population.

The DNSG and DBO were not able to complete a data match and review of the 2021 CDR cases due to the 2021 CDR data not being finalized at the time of this report. To date, the 2019 and 2020 data matches did not identify any correlation between CDR cases and not performed CCHD and DBS newborn screenings. The match has not led to actionable programmatic changes through our review of the 2019 and 2020 data.

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 2022 due to COVID-19, impeding the ability to meet this ESM. Of the deaths occurring in 2020 (most recent year available), local CDR teams reviewed and entered 148 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 the inability to secure access to a virtual training platform that is easily accessible for partners without Microsoft Teams. The delivery method for this training needs reevaluated. Training objectives and a presenter to facilitate have been identified and the training will be scheduled in fiscal year 2023. 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.

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.

Sleep related sudden unexpected infant deaths (SUIDs) remain highly racially disparate, especially for Black infants as compared to white infants, and present an arena for highly targeted safe sleep work. Following collaboration with the National Maternal Child Health Workforce Development Center, the BFH is planning thoughtful, informed community engagement sessions with Black families to gather input to identify effective and appropriate strategies to increase safe sleep for infants through increased use of risk reduction strategies and interventions.

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

Breastfeeding is an important factor in combating infant mortality. Improving breastfeeding initiation and duration rates is critical to reducing some causes of 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%.

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

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, 2025. The program will work with the PA AAP to 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 used 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.

As many facilities are already fully Keystone 10 designated and thus cannot complete any more K10 steps, the focus in 2024 will be supporting all K10 facilities in sustainability efforts as the K10 program begins to sunset. PA AAP will support facilities' sustainability efforts by completing reviews on existing steps to ensure continued compliance, asking that facilities complete sustainability plans, and continuing to support K10 facilities by providing technical assistance and support through this transitional phase.

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 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. Action steps moving forward include adding a representative from the Department's Neonatal Abstinence Syndrome program to these meetings in order to ensure greater collaboration between all populations that need support with both safe sleep and breastfeeding and continuing to provide educational information and resources through First Food outreach via the First Food newsletter, social media platforms, and Basecamp.

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 marketing 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. These efforts will continue to include collaboration with WIC program representatives on the annual statewide breastfeeding referral guide which is hosted on the Department's web page and contains county specific- individuals and organizations that can provide breastfeeding awareness, support, and assistance. The guide includes information on lactation specialists, community programs, support/mother groups, community coalitions, breast pump rentals and local, state, and national help lines.

Additionally, in 2024 the breastfeeding program will continue an annual data collaboration with Pa's Pregnancy Risk Assessment Monitoring System (PRAMS) program. The breastfeeding program will utilize PRAMS data to assess ongoing breastfeeding support needs throughout the state and to plan for future programming that centers health equality and equity by analyzing the PRAMS phase 8 questions 'Are you currently breastfeeding or feeding pumped milk to your new baby' and 'Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources?' stratified by the variable for maternal race/ethnicity.

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 summer 2020 to administer a program to increase breastfeeding support and awareness statewide and the program officially started in October 2020. In 2024, 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.

The Surgeon General's Call to Action to Support Breastfeeding recommends using community-based organizations to both support and promote breastfeeding. PA AAP will collaborate with community-based organizations and partners by distributing mini-grants that are focused on improving initiation and duration breastfeeding rates in areas of need based on target population demographics. Additionally, PA AAP will collaborate with community-based organizations and partners by hosting regional collaborative meetings for birthing facilities and community partners. Pre- and post-surveys will be used to assess knowledge gained, barriers to education and services, and determine the ongoing needs of the region.

PA AAP conducts 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 also provides

at least three breastfeeding educational opportunities to community partners each year. 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. 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 focusing on marginalized populations such as women of color, LGBTQ+ individuals, mothers 24 years of age or younger, or low-income individuals/women. 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 a viable area of intervention. As such, the BFH recognizes the importance of providing education and outreach to increase safe sleep practices across the state 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 sleep. These efforts include maintaining and expanding collaborations through the Safe Sleep Initiative and the ongoing Pa. Child Death Review (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 Case Registry provides data to inform prevention recommendations and 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 2024, the BFH will continue to utilize 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.

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. Recommendations for deaths determined to be preventable will be reported to the BFH and implemented as appropriate, with a particular focus on prevention strategies that address identified social, economic, environmental, and structural factors influencing mortality rates, acknowledge the life course, and promote health equity. The goal is to increase sharing of data and findings with state and local partners to inform infant fatality prevention and health promotion strategies, enhance policies and practices of systems serving infants and families and promote support for concrete services and policies that help families thrive and expand community awareness of factors associated with fatalities.

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 at least 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.

The hospital-based model program serves as a free and supported baseline improvement on the legal requirements of Act 73 of 2010 the SIDS and Infant Safe Sleep Act. Act 73 requires caregivers to receive safe sleep education prior to discharge from the hospital. The hospital-based model program, while not directly targeting areas or groups of greater need, seeks to elevate the floor of safe sleep risk reduction practices statewide.

During 2024, the hospital-based model program will continue to be implemented in birthing hospitals throughout the state. The pandemic and smaller pool of hospitals in which to implement the hospital-based model program seem to be impacting the statewide expansion. Subsequently, the ambitiously 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 will be reevaluated for implementation beyond 2024. 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.

The subject matter expert (SME) training will continue to be offered monthly online in a live format to accommodate

implementing hospitals as well as new SMEs at fully implemented hospitals. The blending of staff from different hospitals and different levels of implementation with the hospital-based model program has created a rich environment for learning. Prior to the pandemic, each hospital completed SME training onsite and in a rather isolated environment. Now, a diversity of experience is brought together during the live online training to create an engaging opportunity to connect with and learn from peers.

The hospital-based model program will continue implementation in hospitals that serve infants but do not have a postpartum unit, following demand from such hospitals. These hospitals include both transfer hospitals from the birthing hospital or those admitting infants for an acute care stay later in the first year of life. This will provide a consistent message of 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 Pa. Preterm birth and low birth weight are two primary causes of infant mortality; Pa.'s infant mortality rate for Black/African American infants reflects the racial disparity evident in these other markers. As the Title V program works to prevent infant mortality and transform systems of inequality, the PPOR framework can be utilized by communities to assess root causes, identify strategies for action, and contribute to meaningful change among the populations most impacted.

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 birth weight 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.
The PPOR process enables communities to collaboratively address the underlying disparities that are identified in data. At the national level, very low birth weight and prematurity have been identified in data as the leading underlying causes of preventable infant death. Via the PPOR process, communities use local data to identify or confirm primary causes of disparities; typically, very low birth weight and prematurity are also the drivers of preventable infant mortality at the local level.

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. Further, adjoining or similar communities to those who have already completed the PPOR process may be able to utilize lessons learned, complete their own PPOR analyses, and/or adapt selected initiatives to meet their populations' specific needs and capabilities.

PPOR studies conducted at the local level can improve infant mortality rates and decrease racial disparities in those rates, in the selected community. Due to the delayed impact of health promotion initiatives on birth outcomes, particularly those with a life course or upstream focus, immediate reductions in infant mortality rates are not likely to result from PPOR. To determine if implementing this strategy is sufficient to impact the population health measure, follow-up PPOR analyses, utilizing each communities' infant mortality data from the years following full

implementation, would need to be conducted. The data from the initial and follow-up PPOR analyses could then be compared to identify if, and by how much, rates of infant mortality (especially where there is inequity) were reduced over that time span. However, given the myriad other factors that could impact infant mortality rates during that period, it would be difficult to state with confidence that the PPOR initiatives alone were responsible for the decrease.

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 address specific, local drivers of feto-infant mortality, using the PPOR framework. Each program will continue to implement, evaluate, and expand upon their selected initiatives and interventions in 2024.

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 now able 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 identified the lack of requested repeat filter papers as a concern. 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 children with special health care needs. 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 (CHNs) 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 CHNs will reach out to the submitter and/or the primary care provider (PCP) and the family to notify them that a repeat filter paper is requested. The CHNs will continue to notify families and by providing the parents with a letter and a disorder fact sheet via mail or email which includes next steps after an abnormal screening result.

The CHNs 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 assigned 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.

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 measures the percent of newborns born in the state of Pa. receiving a DBS 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 CHNs 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 all infant/early childhood deaths 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 CHNs 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 2022 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 an infant/early childhood deaths to CCHD quarterly data match, the programs also plan on matching 2022 DBS results and NAS cases to this data set. 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 CHNs 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 infant/early childhood reported case was associated with a DBS screening parent refusal. Parents in Pa. have the right to refuse dried blood spot screening if the screening conflicts with their religious beliefs or practices. The BFH will conduct technical assistance with the birth hospital, birth center, or home birth midwife as the parent education they provide can be influential in the parent's decision on whether to proceed with future DBS screening. The 2022 infant/early childhood deaths will be matched to 2022 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 314infant deaths reviewed in 2020 (the most recent data available), 148(47.1%) were related to prematurity. This is consistent with previous years' CDR data. In 84.1% 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.

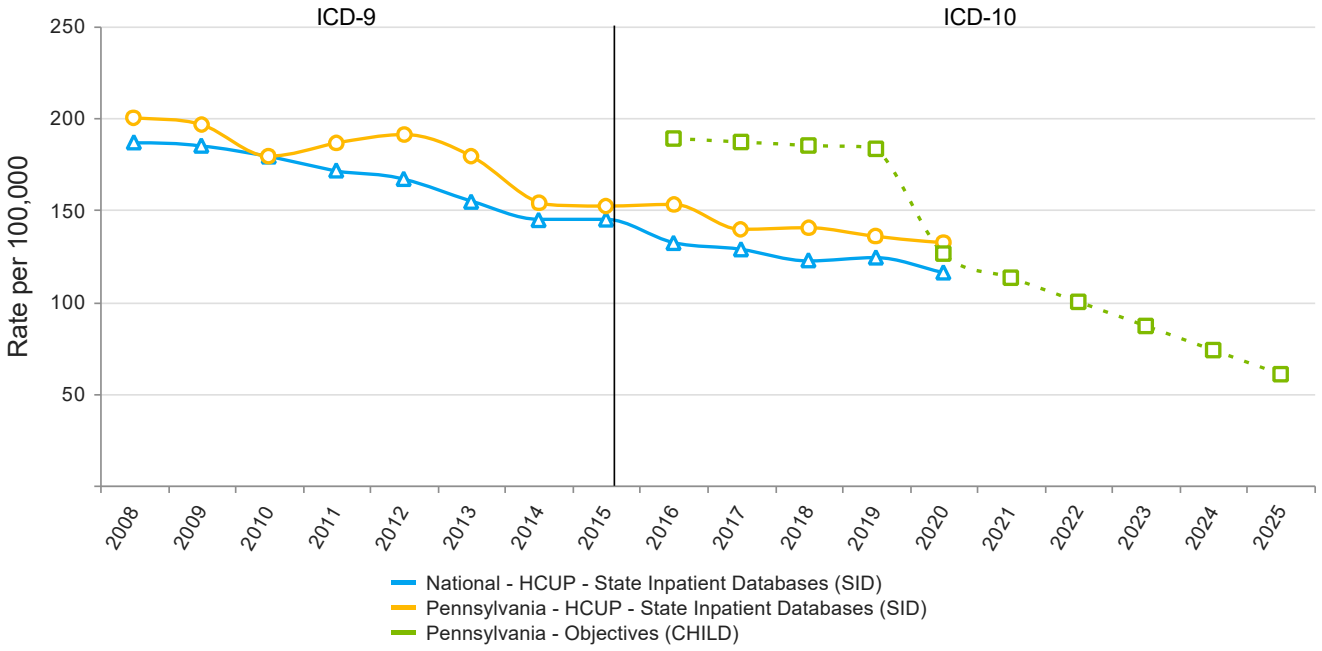
To strengthen local CDR teams' ability to identify the underlying causes of infant deaths due to prematurity, the BFH will develop guidelines to assist local CDR teams in their reviews of these cases. Annually, the BFH will provide training on the guidelines to local CDR teams. Training can be delivered 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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	184.9	183.1	126.2	113.1	100
Annual Indicator	152.5	139.4	139.8	135.4	132.5
Numerator	2,201	2,004	1,997	1,928	1,875
Denominator	1,443,388	1,437,802	1,428,611	1,423,977	1,414,571
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			child program areas implementing recommendations	child program areas implementing recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			30	32
Annual Indicator			15	36
Numerator				
Denominator				
Data Source			quarterly grantee reports	quarterly grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	34.0	36.0	38.0

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		73
Numerator		
Denominator		
Data Source		grantee reports
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	180.0	90.0	0.0

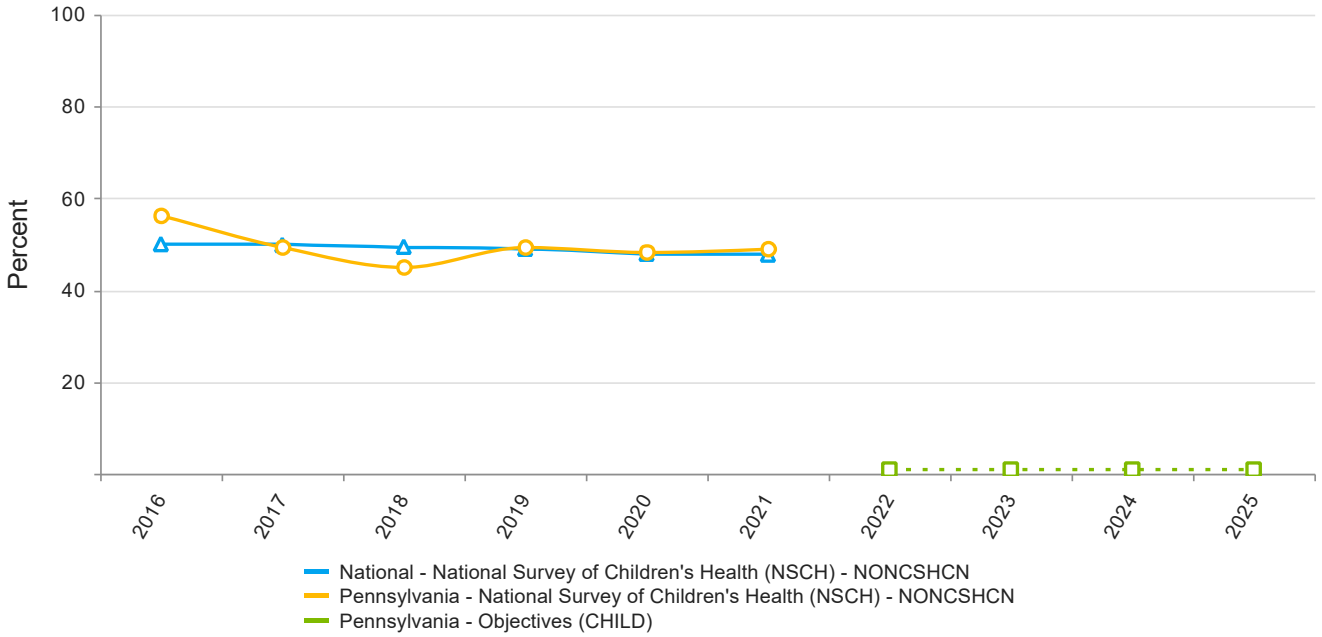
ESM 7.1.4 - Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits.

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		713
Numerator		
Denominator		
Data Source		Grantee reports
Data Source Year		2022
Provisional or Final ?		Final

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**	**2022**
Annual Objective			1
Annual Indicator	49.3	48.3	48.8
Numerator	1,027,215	985,573	986,512
Denominator	2,085,050	2,039,338	2,021,161
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			2	3
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			CSHCN programs implementing recommendations	CSHCN programs implementing recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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	2022
Annual Objective			475	498
Annual Indicator			302	654
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	523.0	549.0	576.0

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

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	52
Annual Indicator			20	17
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

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	2022
Annual Objective			8	8
Annual Indicator			22	12
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			40	43
Annual Indicator			0	3.7
Numerator				7
Denominator				190
Data Source			Philadelphia Department of Public Health	Philadelphia Department of Public Health
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			6	5
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			50	110
Annual Indicator			103	134
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	115.0	120.0	125.0

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			500	515
Annual Indicator			315	463
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	530.0	545.0	560.0

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	2022
Annual Objective			8	8
Annual Indicator			43	10
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			40	44
Annual Indicator			137	76
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			15	19
Annual Indicator			11	13
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	23.0	27.0	31.0

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

Measure Status:	Inactive - Completed		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			quarterly reports
Data Source Year			2022
Provisional or Final ?			Final

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**	**2022**
Annual Objective			20
Annual Indicator		11.2	22.8
Numerator		3,592	7,116
Denominator		31,964	31,156
Data Source		quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	22.0	24.0	26.0

ESM 11.15 - Percent of families reporting through surveys that they were partners in decision making.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	**2025**
Annual Objective	80.0	80.0

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)	Inactive
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	Inactive
ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems	Active
ESM 11.15 - Percent of families reporting through surveys that they were partners in decision making.	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 62 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.

Of the 1,664 deaths occurring in 2020, 801 (48.1%) were reviewed and entered in the National Fatality Review-Case Reporting System (NCFRP-CRS) by local CDR teams. Many teams were unable to complete a review of all children's deaths occurring in 2020 due to continued COVID-19 related efforts which impacted the teams' ability to meet, and some key team members' capability to devote time and resources to CDR. More than a third (39.2%) of all deaths reviewed were infant deaths. Children 18 through 21 years of age accounted for 34.3% of child deaths reviewed. Combined, these two age groups represented 74.0% of all child deaths reviewed in Pa. in 2020.

Deaths of Black/African American children, including infants, occur at a higher rate than those of other races. Both the national rate and the Pa. rate of Black/African American children's deaths saw an increase from 2019 to 2020. In Pa., the rate increased from 91.7 per 100,000 population in 2019 to 105.0 per 100,000 population in 2020. Nationally, for the same time period, the rate increased for Black/African American children from 90.2 per 100,000 to 97.1 per 100,000. Black/African American children continue to die at a rate twice that of white children.

While the Pa. rate of death for white children saw a slight decrease in 2020, the national rate saw a slight increase. The Pa. rate was 44.8 per 100,000 population in 2019 compared to 43.9 per 100,000 population in 2020. In 2019, the national rate was 46.1 per 100,000 population and in 2020, the rate was 48.1 per 100,000 population.

The rate of death for Asian/Pacific Islander children residing in Pa. decreased from 31.0 per 100,000 population in 2019 to 28.7 per 100,000 population in 2020. The national rate decreased in 2019 from 31.9 per 100,000 population to 28.5 per 100,000 population in 2020.

Of the 94 reviews conducted on deaths occurring in children aged 1 through 9 years, the most frequent cause of death was cancer, which was identified in 10 cases (10.6%). Of the 118 reviews conducted on deaths occurring in children aged 10 through 17 years, the most frequent cause of death was due to bodily force or weapon, identified in 42 cases (35.6%). Of the 275 reviews conducted on deaths of youth aged 18 through 21 years, the most frequently occurring cause of death was bodily force or weapon, identified in 121 cases (44.0%).

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.

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 2022, 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 2022, the LHCP held a total of 45 events educating the public about lead exposure and lead poisoning as well as the LHCP and its benefits to families and the community. Thirty-five units were evaluated for LHCP services; of those evaluated, 11 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 400 working hours of training and employment to persons 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 (CDC) for a five-year grant (September 2021 through September 2026), the CLPPP partnered with local health departments to implement strategies and activities to ensure blood lead testing and reporting, enhance blood lead surveillance, and improve linkages of lead-exposed children to recommended services. On January 1, 2022, in response to the CDC’s updated blood lead reference value (BLRV) from 5 µg/dL to 3.5 µg/dL, the Department adopted the new lower BLRV and encouraged all county and municipal health departments (CMHDs), lead prevention partners, and health care providers to use the lowered BLRV to determine the blood lead level required for case management and environmental investigation. Additionally, ongoing efforts to support childhood blood lead poisoning prevention work continued with the passage of Act 150 of 2022 “the Childhood Blood Lead Test Act (act)” on November 3, 2022. Requirements of the act, which took effect on January 2, 2023, are anticipated to result in increased blood lead testing rates and reporting. 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 testing and referral rates, allocate state funding for remediation services, and engage the public to eliminate lead poisoning in children across the state. In the past year, the group has been committed to the development and implementation of several initiatives. In addition to the creation of a screening guide for Pa. primary care providers and a resource guide to help municipalities protect children from lead paint poisoning and improve property values, the Lead-Free Promise Project (LFPP), a coalition of more than 50 organizations, was established. The coalition's goals are to have all children tested twice for lead at ages one and two and ensure all poisoned children are referred to Early Intervention Services. In the past year, the LFPP advocated for the passage of Senate bill 522 (Act 150 of 2022) which increases the availability and coverage of lead testing for Pa.'s children. Additionally, the LFPP secured 10 million in funds from the American Recovery Plan Act (ARPA) which will be used for lead hazard control, lead training and capacity building for lead programs in Pa.

Additionally, using Title V funding, the BFH supports a variety of child health focused programs implemented by the 11 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 2022, the HFA program enrolled and served over 85 families. The Philadelphia Department of Public Health (PDPH) offers a clinic specifically designed for youth aimed toward improving their health and increasing their knowledge about health-related issues. Staff assess psychological and reproductive health needs and offer referrals to clinical, social, and behavioral health services as well as engage teens in reproductive life planning. In 2022, PDPH served 88 youth through this program.

Through the Preventive Health and Health Services (PHHS) Block Grant, the Bureau of Health Promotion and Risk Reduction (BHPRR) provided funds to the American Trauma Society of Pennsylvania (ATSPA) for the Safe Kids Pennsylvania statewide coalition as well as to nine CMHDs for Safe and Healthy Communities. This work is also indirectly supported by Title V, which partially funds a DOH position overseeing it.

Nineteen Safe Kids PA Coalitions and Partners have continued to conduct childhood injury prevention activities through education, collaboration, and advocacy throughout Pa. Safe Kids PA provides statewide technical assistance activities to local Safe Kids coalitions and partners through a multi-faceted approach of public awareness, education, public policy, community activities, and safety supplies distribution.
The BPHHR continued to leverage funds from the PHHS Block Grant with nine CMHDs to utilize the following strategies to prevent childhood injuries:

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

Children in Pa. are also increasingly experiencing trauma and adverse childhood experiences (ACES) early in life. As of 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 disproportionately affected 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. OAR was dissolved in 2023, following the start of a new administration. Governor Shapiro has advocated for increased access to mental health services, especially for youth, but what that may look like in practice is forthcoming.

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 SHCs across the state, as well as the number of those children referred to a medical home within six months. From June 2022 through December 2022, a total of 1,439 infants and children ages 0-17 seen in the SHCs were identified as not having a medical home. The Community Health Nurses made medical home referrals for 434 infants under the age of one year and 959 children aged 1-17. Referrals were made for 96.8% of infants and children identified as not having a medical home.

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 Pa. 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 CDR 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 and injuries. Feedback on the white paper for Motor Vehicle Accidents was sought from the State CDR Team during the June 2022 meeting.

In 2022, 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 59 identified cases in 2022, 6 families (10.2%) 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 2022, the program's grantee, The Pennsylvania Athletic Trainers' Society (PATS), had difficulty recruiting and retaining ConcussionWise Instructors. They responded to that difficulty by ensuring that the athletic trainers recruited would dedicate the time necessary to schedule and complete trainings to become ConcussionWise Instructors. A total of 36 trainings, exceeding the goal of 32, were conducted for athletic personnel. The trained athletic personnel then conducted 118 trainings for diverse populations reaching 2,514 individuals. PATS partnered with youth sports organizations and school districts in urban and rural areas when scheduling trainings to help address areas of health inequity.

Strategy: Provide comprehensive 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

Objective: Increase the number of eligible households that receive a home child safety education visit or intervention by 3% by June 30, 2024

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

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

In July 2021, the BFH began the Prevent Injuries in Children (PIC) program. The PIC program is a primary prevention program that combines comprehensive in-home child safety education visits and home safety interventions to increase child safety practices including the use of home safety equipment. The PIC program differs from prior in-home child safety programs, more narrowly focusing on child injury prevention than a broader healthy home perspective. While local organizations have lamented the loss of the broader healthy homes services, BFH strives to provide targeted and evidence-based or evidence-informed strategies to improve child health.

The PIC program is provided in association with other home visiting programs as an additional and separate component that provides education and 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 are provided at no-charge to participating families based on their specific child safety needs.

The PIC program was designed to provide services in counties with the greatest health disparities in child injury and address health equity and serve those most in need without additional work or efforts at the local level. Counties were ranked for priority based on injury, death, race and ethnicity, and emergency department visits using both rates and numbers. Eight categories were used to establish the county prioritization with data calculated for the combined 0-9 age group and all given equal weight in the ranking and prioritization process.

The PIC program was anticipated to operate in 10 counties; however, suitable vendors were only found for four counties. While two of the four counties are meeting expectations the other two are having substantial challenges enrolling participants leading to overall suboptimal outcomes.

In 2022, BFH anticipated completing 180 comprehensive in-home child safety education visits and performing 900 home safety interventions as a result of needs identified through the comprehensive in-home child safety education visits. BFH estimated that each comprehensive in-home child safety education visit would result in five home safety interventions being performed. While the PIC program only produced 73 comprehensive in-home child safety education visits, 713 home safety interventions were performed, or nearly 10 home safety interventions performed per comprehensive in-home child safety education visit.

While the PIC program is not reaching as many children and families as anticipated, it is reaching those most in need. The nearly double rate of home safety interventions performed per comprehensive in-home child safety education visit is a sign of success in the goal of child injury prevention. Another unintended benefit of not achieving the anticipated number of comprehensive in-home child safety education visits is that there is not a wait for families

interested in the PIC program to receive services. The BFH would like to serve a greater number of families, however, the families served to date have received prompt and highly needed services.

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

Child Health - Application Year

I. Overview of Approach to Child Health Domain

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 2024, 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. Ongoing efforts to support childhood lead poisoning prevention work continues following the passage of the Childhood Blood Lead Test Act (Act) on November 3, 2022. Requirements of the Act, which took effect on January 2, 2023, are anticipated increase blood lead testing rates and reporting. Additionally, $10 million in funds from the American Recovery Plan Act (ARPA) have been allocated for lead hazard control, lead training, and to build capacity among current lead programming in Pa. These funds will be administered through vendors who have existing lead hazard control programs in an effort to ensure the work is completed in the two-year period of this funding. Program staff have created flexibilities in program requirements that will enable vendors to serve families that may not be eligible through other funding sources.

The Bureau of Community Health Services (BCHS) oversees the School Health Program, which is the oldest program of public health services in Pa., with responsibilities predating 1895. The program serves all children of school age attending public, private and non-public schools in Pa. and is responsible for providing technical assistance, training and coordination of programs and services to schools, parents and the community at large regarding school health programs and services.

The Bureau of Health Promotion and Risk Reduction (BHPRR) discontinued funding Safe Kids Pennsylvania (Safe Kids PA) from the Preventive Health and Health Services Block Grant (PHHSBG) due to changing priorities in June 2023. The BFH determined that directly funding Safe Kids PA aligns with the Title V Block Grant child health priority and allows for continuity of vital injury prevention efforts throughout the state. Safe Kids PA is the designated Safe Kids organization to serve Safe Kids Coalitions and establish Safe Kids Partnerships throughout the state under an agreement with Safe Kids Worldwide and the American Trauma Systems Foundation Pennsylvania Division (ATSPA) which operated SKPA.

A one-year agreement to determine ongoing strategies is being pursued to allow for SKPA to fulfill their role as the state office for Pa. and BFH to identity strategies to support child injury prevention efforts. In addition to the current activities of the SKPA partner organizations and independent coalitions, support of the CDR program is being evaluated. Historically, the CDR program has faced challenges transforming findings into actionable prevention strategies. SKPA is poised to provide training and technical assistance to the local teams to transform the teams' findings into evidence-based strategies.

BHPRR will continue to support injury prevention work through the PHHSBG. An RFA was released in March 2023 seeking applicants to address unintentional injury prevention services in three focus areas: falls prevention for older adults; reducing Motor Vehicle Occupant Injuries/Deaths in children, adults, and teen; and prevention of adverse childhood experiences.

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 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. Previously, Community Health Nurses located in SHCs documented and reported all referrals of children ages 0-17, who do not have a provider, made to a medical home. As of July 1, 2023, BCHS will no longer report data for purposes of the MCH State Action Plan. Referrals to medical homes will continue in the SHCs as appropriate.

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 years 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. The Philadelphia Medical Examiner's Office has applied directly for the next round of funding from the CDC for the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry. As the Philadelphia Medical Examiner's Office anticipates receiving the funding directly for this project, beginning in 2024, there will no longer be a need to support this work with Title V MCHSBG funds.

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 stalled BFH's plans to facilitate trainings on death scene investigations, including doll reenactments, to improve the quality of death scene investigations for children who die suddenly and unexpectedly; however, the training will be held in June 2023. The response for this training was tremendous, especially from law enforcement. Moving forward, the BFH will work in consultation with leaders in the investigative agencies involved in child death reviews to develop a sustainable and permanent model for delivering death scene investigation and doll reenactment training that may include a train-the-trainer model, an asynchronous online training, or a combination of both. 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 or lead prevention strategies or already be involved in developing or implementing similar prevention strategies. The State CDR Team will develop a minimum of one white paper per cause of death. This process is being evaluated by the BFH and the State CDR Team in 2023. The evaluation will seek to streamline processes, assess effectiveness, and inform recommendations for improving the framework. Additionally, the BFH will continue to seek opportunities to share the CDR recommendations more widely, with a particular focus on prevention strategies that address identified social, economic, environmental, and structural factors influencing mortality rates, acknowledge the life course, and promote health equity. The goal is to increase sharing of data and findings with state and local partners to inform child fatality prevention and health promotion strategies, enhance policies and practices of systems serving children and families and promote support for concrete services and policies that help families thrive and expand community awareness of factors associated with fatalities.

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. Multiple studies show that rural and urban areas suffer from health care disparities and lack of access to care and preventive care. According to the CDC, those living in rural areas are at a greater risk of dying from a TBI compared to people living in urban areas due to greater travel time to emergency medical care, less access to a Level 1 trauma center, and difficulty accessing specialized care. One of the most common ways children get concussions is through sports-related injuries. Contact sports, such as football, soccer and ice hockey, result in nearly twice as many TBI emergency department visits than noncontact sports and four times those associated with recreation-related activities. The program will continue to focus efforts on eliminating health disparities within its target population by ensuring equitable coverage throughout the state by prioritizing urban and rural areas.

In 2024, BFH will explore other options to increase the number of individuals served while reviewing the Department’s responsibilities outlined in the Safety in Youth Sports Act of Nov. 9, 2011, P.L. 411, No. 101.

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 current Prevent Injuries in Children (PIC) program that began in July 2021 is scheduled to end in June 2024. During 2024, the PIC program 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.

The PIC program was designed to provide services in counites with the greatest health disparities in child injury. Counties were ranked for priority based on injury, death, race and ethnicity, and emergency department visits using both rates and numbers. Eight categories were used to establish the county prioritization with data calculated for the combined 0-9 age group and all given equal weight in the ranking and prioritization process. The service area of the PIC programs was designed intentionally to address health equity and serve those most in need without additional work or efforts at the local level.

As a prevention program, 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 with the program seeking to annually increase the number of visits. Additionally, home safety interventions performed due to needs identified during comprehensive in-home child safety education visits represent potential injuries that are prevented.

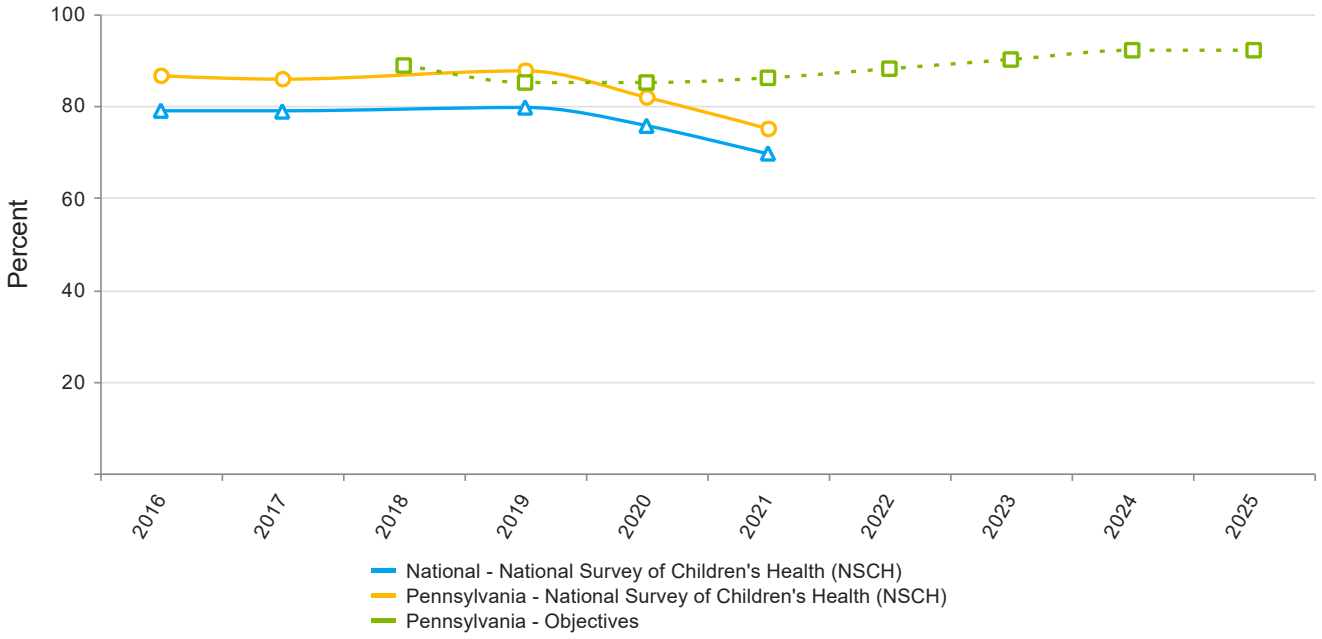
Due to the enrollment challenges faced in several of the counties served by the PIC program, the outcome of the state fiscal year 2022-2023 activities will determine how the PIC program proceeds beyond July 1, 2024. It is likely that only some of the counties currently receiving funding will be renewed to continue providing services. The PIC program was established at the county level to better engage smaller trusted community partners in implementing evidence-informed child injury prevention strategies. The BFH attempted to streamline and simplify the application and implementation processes to support smaller and less resourced organizations. The PIC program has not resulted in the anticipated outcomes and, as such, the BFH is seeking alternative strategies.

As detailed above, the BFH is seeking to support the majority of child injury prevention strategies with SKPA going forward. The reach of SKPA is unparalleled, elevating the potential for long-term reductions in mortality and morbidity through evidence-based strategies. Safe Kids offers a wide array of child injury prevention strategies for children of all ages. Child passenger safety, bicycle safety, and drowning, large contributions to child injury, disability, and death that have typically been out of reach for the BFH strategies will now be possible. SKPA will be able to provide administrative support and technical assistance to smaller and less resourced community partners in harder to reach communities across the state. Collaboration with SKPA offers an opportunity for both statewide reach and with targeted strategies to meet local needs.

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	88.7	85	85	86	88
Annual Indicator	85.7	85.7	87.7	81.8	75.0
Numerator	715,291	715,291	659,147	679,581	678,512
Denominator	834,394	834,394	751,698	830,408	904,738
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	18	21	25	30	33
Annual Indicator	15	12	7	3	4.9
Numerator				2,698	5,698
Denominator				89,993	116,285
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4,500	4,550
Annual Indicator			540	3,573
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			90	90
Annual Indicator			99	94.7
Numerator			4,589	9,477
Denominator			4,635	10,007
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			45	45
Annual Indicator			9	259
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			3,880	3,880
Annual Indicator			4,681	7,039
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4,730.0	4,730.0	4,730.0

ESM 10.6 - The number of users who accessed the SafeTeens.org site

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10,000	11,000
Annual Indicator			49,943	27,102
Numerator				
Denominator				
Data Source			grantee reports	grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			360	360
Annual Indicator			151	34
Numerator				
Denominator				
Data Source			grantee reports	grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			150	160
Annual Indicator			53	207
Numerator				
Denominator				
Data Source			grantee reports	grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
2023	2024	2025	
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			35	39
Annual Indicator			145	645
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			55	55
Annual Indicator		59.5	63.1	62.2
Numerator		13,448	9,536	7,437
Denominator		22,602	15,110	11,955
Data Source		Grantee reports	quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 metho

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			8	8
Annual Indicator		9.4	11.1	12.3
Numerator		2,127	1,677	1,472
Denominator		22,602	15,110	11,955
Data Source		Grantee reports	quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			94	94
Annual Indicator			93.1	90.9
Numerator			1,500,973	1,528,486
Denominator			1,612,808	1,680,853
Data Source			NSCH, Indicator 5.9, Pa. data	NSCH, Indicator 5.9, Pa. data
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 metho	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 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 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

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 metho	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 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 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

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 metho	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 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 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

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

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 2021, the sex and race/ethnicity of Pennsylvania's Adolescent population (n=1,598,703) were distributed as shown in the table below.

2021 Pennsylvania Adolescents (ages 10-19)	
Sex	
51%	Male
49%	Female
Race/Ethnicity	
76%	White
15%	Black
4%	Asian/Pacific Islander
5%	Multi-race
12%	Hispanic

According to 2021 Youth Risk Behavior Surveillance System (YRBSS) data, 32.1% of ninth through 12th grade students in Pennsylvania (Pa.) responded affirmatively that they had, "ever had sexual intercourse." In 2021, 23.1% of 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, 14.5% 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.

2020 Pennsylvania Teen Pregnancy Rates, per 1,000 youth (ages 15-17)	
Race/Ethnicity	
4.4	White
20.3	Black
1.8	Asian/Pacific Islander
15.9	Multi-Race
18.1	Hispanic

The BFH implements several initiatives to address teen pregnancy, including the disparate impact of teen pregnancy on racial and ethnic minority youth. 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 2022, 1,370 youth completed an evidence-based program at a PREP facility. The Bureau has eight subgrantees that provide PREP programming. A Request for Applications (RFA) was issued to recruit additional and new partners in September 2022. New awarded grants resulting from this RFA will begin programming in July 2023.

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 2022, 52% of currently active adolescent health grantees received LGBTQ cultural competency training, a decrease of 12% from the previous year due to the loss of a PREP provider. 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 2020-2021 National Survey of Children’s Health, 15.8% of Pa. children 17 years of age and younger have experienced one ACE, and 24.2% 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 from middle childhood to adolescence. A competitive RFA was released in 2019 and sites were selected in Philadelphia, Allegheny, Fayette, Lawrence, and Mercer Counties. There were 67 TOP Clubs in schools during calendar year 2022, serving a total of 1,107 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 2021 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 one third of LGBTQ students said that their school had an active Gay Student Alliance or similar student club available. 58.9% of LGBTQ youth had experienced LGBTQ related discriminatory policies or practices at school. Due to the lack of support for these youth, 61.5% of LGBTQ students who were harassed or assaulted in school never reported it to school staff, and only 14.5% of students indicated that they reported these incidents to staff regularly. 60.3% of students who did report an incident said the school staff did nothing in response when incidents were reported. A hostile school climate affects students’ academic success and mental health. LGBTQ students who experience victimization and discrimination at school have worse educational outcomes and poorer psychological well-being.

According to the Trevor Project, 28% of LGBTQ youth reported experiencing homelessness or housing instability at some point in their lives and those who did had two to four times the odds of reporting depression, anxiety, self-harm, considering suicide, and attempting suicide compared to those with stable housing. Additionally, 16% of LGBTQ youth reported they slept away from parents or caregivers because they ran away from home, with more than half (55%) reporting they ran away because of mistreatment or fear of mistreatment due to their LGBTQ identity.

According to the 2021 YRBSS,49.6% 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 15.6% 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 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 worked 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, continued 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. During the course of this collaboration, the BFH was able to provide two trainings using funding provided through the CoIIN. The trainings focused on providing LGBTQ specific education for service providers working with adolescents and were attended by over 700 community partners who work with youth. Additionally, the BFH has begun including tasks for mental health screening and referrals in grant agreements as appropriate.

On July 1, 2022, the BFH entered into a grant agreement with Penn State Milton S. Hershey Medical Center 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 YAC held its first meeting in March 2023.

The BFH entered into a grant agreement with the Pennsylvania School-Based Health Alliance (PSBHA) that took effect July 1, 2022. PSBHA is an alliance of 32 school-based health centers (SBHCs) in Pa. tasked with providing behavioral and mental health assessments and services for approximately 4,000 middle and high school students. PSBHA will coordinate services, including universal mental health screenings, cognitive behavioral interventions, trauma-informed care, solution-focused counseling, periodic check-ins with students, referrals to outside services with parental consent, and small group counseling sessions, across all SBHCs. Funding for this initiative comes from the American Rescue Plan Act, passed by the U.S. Congress in 2021.

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 12 Philadelphia area schools and five Philadelphia area community sites. There are an additional 30 sites in nine additional counties across the state. The 30 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, Fayette, Beaver, Lehigh, and Venango Counties. In calendar year 2022, 4.9% of youth attending schools with an HRC used the HRC services, an increase from the 2.6% of youth who used the services in 2021. The rate of youth utilization remains far from the goal of 30%, however, work will continue to promote HRCs in school settings so additional youth can access services provided through HRCs.

There were 3,573 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 2022. Referrals are made for services which fall outside the scope of HRC service delivery. Work will continue to increase the referrals each year so youth are able to continue accessing services beyond what the HRCs can provide.

In calendar year 2022, 94.71% of visits to an HRC included counseling, 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 to develop and maintain Youth Advisory Boards.

The HRC program has also established four strategies to promote health equity within the HRC program. These strategies were developed by using the National Stakeholder Strategy for Achieving Health Equity, put forth by the US Department of Health and Human Services. The four strategies developed are as follows:

- Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.

- Ensure access to quality healthcare for all.
- Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities.
- Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation; encourage financing and reimbursement for health interpreting services.

Work in calendar year 2022 toward meeting these strategies included having the Youth Advisory Boards develop partnerships to help the HRC program increase awareness of health disparities, using a new communication platform to increase awareness of health disparities, conducting outreach activities, ensuring program staff receive cultural competency trainings, and ensuring program materials are translated into all necessary languages of program recipients.

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 community-based organization staff trained in the OBPP

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.
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.

In calendar year 2022, eight new staff, including staff from three additional CYOs, were fully trained and certified in the CYO OBPP. A total of 259 CYO staff were trained in OBPP, and 7,039 youth participated in bullying prevention programming across all CYOs in calendar year 2022, exceeding the goal of 3,880 youth.

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 2022, 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 SafeTeens.org. In 2022, 27,102 individuals spent an average of over a minute and a half 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 2022 there were 34 referrals, not meeting the goal of 360 referrals, for in-person services, including counseling, made because of the text line. This number is down 77% from the previous year. 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, the NEPA Youth Drop In Center and health resource centers in Berks and Lehigh counties. During the pandemic, most of these events were cancelled or went virtual and have not returned to pre-pandemic levels of in person participation, which may account for the continued reduction in texts received and subsequently referred for services.

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 Brain Injury and Opioid Initiative, formerly known as the Acquired Brain Injury (ABI) and Opioid Training Program, in 2019. The Brain Injury and Opioid Initiative was developed to 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. BIAPA conducted a needs assessment survey of clinical centers working with brain injury and individuals with substance use disorder. The results informed the development of a new product that better serves professionals during the trainings. In 2022, BIAPA provided training

to 207 professionals, exceeding the goal of 160.

SPM: Percent of children 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 2022, a total of 11,505 unique youth mentees received evidence-based mentoring from 577 mentors. This did not meet the goal of 15,270 youth outlined in the mentoring grantees' work statements due to 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 ended June 30, 2022.

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: 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 2020, but they did not begin serving youth until January 2021 as time was provided to start up the programming. In state fiscal year 2022, Hugh Lane Wellness Foundation, Inc. provided Mental Health First Aid Screenings to 173 youth. Of those 173 youth screened,

none were at risk of suicide, substance abuse, or mental health crisis and did not require referral services. Hugh Lane also provided AFFIRM, a cognitive-based therapy group for LGBTQ youth to learn stress coping skills and improve well-being, to 55 LGBTQ youth, with 34 youth completing the AFFIRM series. SRPS provided the OUTPace 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 increased its ability to support LGBTQ youth by incorporating awareness and training on health disparities faced by LGBTQ youth in its programming. In state fiscal year 2022, a total of 800 youth mentees received evidence-based mentoring. Of those 800 youth mentees, 251, or 31% of youth identified as LGBTQ.

The BFH tracked the number of LGBTQ-identified youth who increased knowledge of one or more positive coping strategies as demonstrated by pre- and post-surveys. In state fiscal year 2022, 66% of youth who completed the AFFIRM program offered by Hugh Lane Wellness Program increased knowledge of one or more positive coping mechanisms. During the same period, 91% of the 11 LGBTQ youth participants at SRPS who completed both pre- and post-surveys demonstrated an increase in one or more positive coping mechanisms.

Overall, 71% of LGBTQ youth who completed both a pre- and a post-survey demonstrated an increase in one or more positive coping strategies. Although the data is limited due to youth reluctance to complete surveys and strict requirements for survey administration, qualitative data and analysis of survey results across all youth indicate a significant number of additional LGTBQ youth participants also experienced an increase in one or more protective factors. Hugh Lane and SRPS are working to increase the number of LGBTQ youth who complete both pre- and post-surveys in the coming year by revising the survey questions and length and updating the survey administration process.

The objective to increase the percentage of LGBTQ-identified youth participating in an evidence-based or evidence-informed program who report increased positive coping strategies by 0.02% over the course of the program was an error. The correct objective is to increase the percentage by 2% over the course of the program. This will be corrected moving forward.

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 2022.

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 2022, the BFH continued to work with the Ed Snider Youth Hockey Foundation (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 nonviolent relationships with dating partners. The Foundation has provided CBIM to adolescent and young males during their life skills hockey program and 645 individuals were served during 2022, surpassing the goal of 39 individuals served. The Foundation also addressed disparities through other funding via multiple methods to help increase security and reduce inequity for youth and their families. The Foundation distributed more than 11,000 books in partnership with Team First Book Philadelphia, provided COVID-19 vaccine access for low-income communities of color, and connected 89 students and families to their Crisis Management team to help with resources and to cope with needs such as homelessness, food insecurity, and unstable home environments.

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% each year

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 2022, BFH provided 18,905 adolescents with services, exceeding the goal of 15,475 youth served. This was a decrease in reach by 1% 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 were 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 establish reporting requirements consistent with those required by Title X. In state fiscal year 2022, 62% 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, 12% of those adolescents were provided a LARC, exceeding 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 entered into a grant agreement with Penn State Health Milton S. Hershey Medical Center to develop and facilitate a Youth Advisory Council (YAC). 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. The YAC, comprised of three regional councils representing the eastern, central, and western portions of Pa, was developed to provide a forum for youth involvement in community, organization, and program development at both the statewide and regional level utilizing a youth-friendly framework.

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 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 47 HRCs in 10 counties (Philadelphia, Delaware, Berks, Lackawanna, Lycoming, Dauphin, Fayette, Beaver, Lehigh, and Venango) throughout Pa. through funding from Title V. It is anticipated these HRCs will remain operational in 2024 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.

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.

The BFH is currently evaluating the HRC program to assess the program's impact and determine future funding. This process will determine if the program continues as is, or if the program needs altered to achieve more successful outcomes. The evaluation will conclude prior to the end of the current HRC program cycle, which ends in June 2025.

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 (CYOs) to supplement current Olweus activities across Pa. There are currently 8 CYOs, selected through competitive Request for Applications (RFAs), implementing OBPP, including providing staff with ongoing training. These CYOs will continue implementation through calendar year 2024. The ongoing sustainability of the program is being evaluated due to a combination of factors, including significant staff turnover and the disallowance, by Clemson, of subcontracted staff to administer trainings.

The BFH will track the number of community-based organization staff trained in OBPP, 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 funded. An OBPP goal 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.

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 2024, 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 textline, a text-based hotline that fields questions from respondents and provides factual responses and referrals to local community partners as appropriate. To increase usage of the hotline, coordination with local and statewide youth programs will be heightened to establish a more youth led approach to education and advertising. Additionally, the use of social media will be bolstered to promote Safeteens.org to direct youth to the hotline. 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 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 fields 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 two percent 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 continue working with Hugh Lane Wellness Foundation, Inc., and Students Run Philly Style to provide evidence-based or evidence-informed programming to enhance positive behaviors, personal strengths, and interpersonal relationships for LGBTQ youth. Hugh Lane Wellness Foundation Inc. will continue implementing 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 (SRPS) will continue implementing 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 currently make up 31% of youth participants.

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 2024, 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, with a particular focus on prevention strategies that address identified social, economic, environmental, and structural factors influencing mortality rates, acknowledge the life course, and promote health equity**.** The goal is to increase sharing of data and findings with state and local partners to inform child fatality prevention and health promotion strategies, enhance policies and practices of systems serving children and families and promote support for concrete services and policies that help families thrive and expand community awareness of factors associated with fatalities.

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 (MII) focuses on the intimate partner relationship behaviors of young men to increase their knowledge of intimate partner violence, gender equity, and bystander intervention. An RFA was issued in 2023 seeking a grantee to expand the MII program into southcentral Pa. with anticipated implementation beginning in 2024. The new grantee will use the Coaching Boys into Men (CBIM) curriculum and tools to teach young male athletes skills to build respectful and nonviolent relationships with dating partners, and ultimately, prevent sexual assault and adolescent relationship abuse. Data suggests that coach-delivered dating violence prevention programs reduce violence perpetration and negative bystander behaviors condoning dating violence. 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 Grantee will service a minimum of seven schools or organizations with two to three separate sports teams in each school or organization per year.

Priority: Support and effect change at the organizational level and system level by supporting and promoting policies, programs and actions that advance health equity, address the social, environmental, and economic determinants of health, and deconstruct institutionalized systems of oppression

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 each year

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.

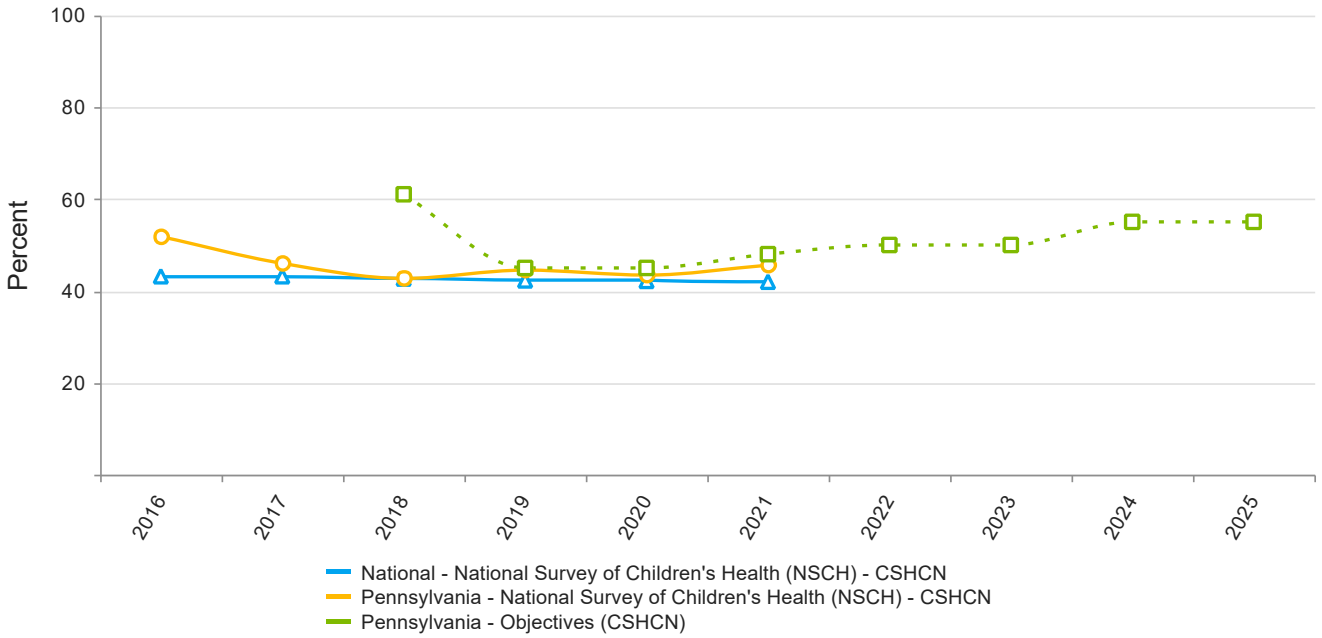
The BFH will track the percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method, as well as the percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who 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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	61	45	45	48	50
Annual Indicator	45.9	42.9	44.5	43.6	45.6
Numerator	234,614	223,990	244,784	255,237	270,075
Denominator	511,324	521,926	549,735	585,504	592,908
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			2	3
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			CSHCN programs implementing recommendations	CSHCN programs implementing recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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	2022
Annual Objective			475	498
Annual Indicator			302	654
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	523.0	549.0	576.0

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

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	52
Annual Indicator			20	17
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

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	2022
Annual Objective			8	8
Annual Indicator			22	12
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			40	43
Annual Indicator			0	3.7
Numerator				7
Denominator				190
Data Source			Philadelphia Department of Public Health	Philadelphia Department of Public Health
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			6	5
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			50	110
Annual Indicator			103	134
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	115.0	120.0	125.0

ESM 11.8 - Number of referrals to BrainSTEPS program

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			500	515
Annual Indicator			315	463
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	530.0	545.0	560.0

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**	**2022**
Annual Objective			8	8
Annual Indicator			43	10
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			40	44
Annual Indicator			137	76
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			15	19
Annual Indicator			11	13
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	23.0	27.0	31.0

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

Measure Status:	Inactive - Completed		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			quarterly reports
Data Source Year			2022
Provisional or Final ?			Final

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**	**2022**
Annual Objective			20
Annual Indicator		11.2	22.8
Numerator		3,592	7,116
Denominator		31,964	31,156
Data Source		quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	22.0	24.0	26.0

ESM 11.15 - Percent of families reporting through surveys that they were partners in decision making.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	**2025**
Annual Objective	80.0	80.0

State Performance Measures

SPM 3 - Increase the percent of hospitals making referrals to Early Intervention (EI)

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			50
Annual Indicator			74.7
Numerator			56
Denominator			75
Data Source			NAS programmatic documentation
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	55.0	60.0	65.0

SPM 4 - Percent of eligible infants with a Plan of Safe Care

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			50
Annual Indicator			64.5
Numerator			790
Denominator			1,225
Data Source			NAS programmatic documentation
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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)	Inactive
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	Inactive
ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems	Active
ESM 11.15 - Percent of families reporting through surveys that they were partners in decision making.	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)	Inactive
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	Inactive
ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems	Active
ESM 11.15 - Percent of families reporting through surveys that they were partners in decision making.	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 - Increase the percent of hospitals making referrals to Early Intervention (EI)

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 2020-2021 National Survey of Children's Health (NSCH), 22.7% (592,908) of children in Pa. have a special health care need, exceeding the national average of 19.5%. Of those CSHCN, only 18% report receiving care in a well-functioning system in Pa., a decrease from 20.5% in the 2019-2020 NSCH. Clearly, there is a significant need for evidence-based programming and services for this population.

The BFH provides services for CSHCN and their families, as well as initiatives to improve the system of care, through a combination of Title V, other federal, and state funding.

Not only are CSHCN a priority within the Title V work carried out by the BFH, but more than five million dollars in state funding in 2022 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 levels to improve health and health related outcomes for individuals and families.

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 helps families connect with community-based services and understand their organizations 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. The BFH utilizes partnerships such as the PEAL Center, 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 participated in numerous in person outreach opportunities in 2022 to bring awareness to the helpline. In 2022, 429 calls were received through the helpline, an increase from the 396 received in 2021.

The Specialty Care Program (SCP) consists of 28 state-funded grants across 13 grantees (11 health 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 increased cross-system collaboration, mental health screenings, 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 other systems, and support to participate in community-based activities. In 2022, the SCP served 7,368 individuals from birth through age 21, and an additional 4,295 individuals aged 22 and older through matching state funds.

In 2022, the SCP continued the requirement that grantees dedicate a certain percentage of funds to a Client Assistance Fund (CAF), addressing critical barriers or needs that affect the client's ability to adhere to treatment or

impact the client's quality of life. The CAF allows grantees to assist clients and their families by providing immediate assistance, 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 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 1,370 first responders, 4,073 school employees, 2,068 secondary students, 87 family members/caregivers, and 958 community members in 2022. 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. PA-TSA provides in-person opportunities for families of children with TS to come together in-person to share experiences and network at a retreat and a summer camp. 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. In 2022, TACHP was administered by the Health Promotion Council of Southeastern Pennsylvania, covering eastern and south-central Pa. In 2021, the vendor covering the western part of the state withdrew from TACHP. Since then, the Health Promotion Council has been fielding inquiries from families in the western part of the state. Maximum program capacity is 150 children, and as of the end of 2022, there were 67 children enrolled.

The BFH's Head Injury Program (HIP), funded through state funds not part of the state match, provided rehabilitative and therapeutic services to individuals aged 18 and older with a Traumatic Brain Injury (TBI). Rehabilitation services are provided in a residential, outpatient or home and community-based setting. In 2022, the HIP added telerehabilitation as a permanent option for Cognitive Rehabilitation Therapy (CRT). CRT via telerehabilitation is offered in individual or group sessions.

The Acquired Brain Injury Program (ABIP), funded by Title V, provided rehabilitative and therapeutic services for individuals between the ages 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. In 2022, the ABIP served four individuals.

The BFH administered the TBI State Partnership Grant, funded by the Administration for Community Living (ACL) through July 31, 2026. The primary goal of this grant is to maximize the health, independence, and overall well-being

of individuals with TBI in Pa. Through the grant, four focus areas were determined: Juvenile Justice, Older Adults, NeuroResource Facilitation, and Intersectionality of Intimate Partner Violence. The BFH in partnership with the grantee, Brain Injury Association of Pennsylvania (BIAPA), provided education, training, and technical assistance services to professionals working within the juvenile justice and older adult populations. Throughout Pa., four juvenile justice trainings were provided to 400 individuals and four older adult trainings were provided to 123 individuals. The BFH also partnered with BIAPA to implement the NeuroResource Facilitation Program (NRFP). This program assists individuals ages 18 and older with a TBI to identify service needs and address them by locating and coordinating appropriate resources. In March 2022, ACL awarded the Department supplemental funding to expand the public health work force. The primary focus of these funds is to expand the NeuroResource Facilitation Program to identify and address the service and support gaps caused by the COVID-19 pandemic. The Department and BIAPA conducted a focus group and identified the following gaps: social isolation, access to quality and timely healthcare, employment, compounding symptoms, and evidence-based and up to date COVID-19 information. The Department, through BIAPA, employed two additional NeuroResource Facilitators to assist with addressing these gaps. In May 2022, BFH received authorization from ACL to expand the NRFP to include individuals with a non-traumatic brain injury (nTBI). The NRFP served 78 participants statewide. The BFH, in partnership with the PA Coalition Against Domestic Violence, began the development of an education curriculum focused on the intersectionality of IPV and brain injury as well as a technical assistance toolkit for professionals working with those who have experienced IPV.

The County Municipal Health Departments (CMHDs), funded by Title V, offer a variety of services aimed toward CSHCN through home visiting programs. CMHDs use the evidence-based Ages and Stages Questionnaires (ASQ) developmental screening tool during home visits and make 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 Chester County Health Department (CCHD) offers a home visiting program specifically for children assessed to be at-risk. At-risk children are defined as children with health issues such as low birth weight, prematurity, congenital conditions, failure to thrive, asthma, hearing deficiencies, metabolic conditions, or complicated medical issues. Additionally, a child may be identified as at-risk if certain maternal issues are present such as drug or alcohol dependence, Children and Youth involvement, mental health issues, children of adolescent mothers, or other issues that could lead to less-than-optimal development. In 2022, CCHD served 51 CSHCN and those at-risk for developmental delays through this program.

The Philadelphia Department of Public Health (PDPH) offered mini-grant project opportunities to community organizations. All funded projects were procured through a Request for Proposals process, were under $3,000, and promoted trainings or collaboration to improve systems that serve CSHCN. Mini grants included the Sunshine Foundation which fulfills dreams and requests for CSHCN ages 3 to 18; equine therapy to help increase social and life skills and foster community while encouraging personal growth; a sibling support group for CSHCN and their siblings to promote social interaction, meaningful relationships with their siblings, and friendship; and home visits for families and children on the autism spectrum to engage families through the use of games and activities.

In 2022, the BFH continued its partnership with PDPH on an initiative to improve the systems in which CSHCN receive care, called the Family Impact Initiative (FII). In 2021, 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 assembling an effective coalition of stakeholders, assessing community systems, 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. In 2021, the BFH, with the support of AMCHP and the North Carolina Department of Health and Human Services, worked with PDPH to build capacity to implement FII; several goals were accomplished that year and FII was fully implemented in 2022. Through Title V, PDPH was awarded $100,000 per year for three years to continue this initiative to address needs in the health care system with the goal of increasing the percentage of CYSHCN who receive care in a well-functioning system. In 2022, the advisory committee established goals and activities to address needs in education, transition, and health care.

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 2022 Child Death Review Annual Report examines child deaths that occurred in 2020. Of the total 801 reviewed deaths occurring in 2020, the medical conditions category represented 363 cases (45.3% of the total deaths reviewed) and 168 children who were determined to have a prior disability or chronic illness. Through obtaining information from annual recommendation reports and quality data from local CDR teams, the BFH examined 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 further reviewed information for feasibility to determine if there were any 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 2022, no recommendations related to CSHCN were referred to Title V staff.

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 Pennsylvania Department of Education and BIAPA, has implemented a brain injury school reentry program called BrainSTEPS (Strategies, Teaching Educators, Parents, and Students) since 2007. BrainSTEPS provides consultation services to any public-school student who has been identified as having an acquired brain injury. An acquired brain injury includes traumatic brain injuries of all severities and non-traumatic brain injuries. BrainSTEPS is comprised of over 230 brain injury educational consultants serving on regional teams. Teams are based in Pa.'s 29 educational Intermediate Units and two school districts. Once referred, the student receives services from the point of referral through secondary school graduation.

To ensure CSHCN receive care in a well-functioning system, BrainSTEPS coordinates and streamlines collaboration between students, their caregivers and the medical, rehabilitation, and education sector through the development and monitoring of person-‑centered care plans. Person-centered plans provide the student and their caregivers the ability to identify the student's needs, barriers to having those needs met, and have an active role in the decision-making process. In 2022, the BFH exceeded the goal of 498 person-centered plans by providing 1,880 consultation hours to develop 654 person-centered plans for both students referred in the current year and those continuing to receive services who were initially referred in previous years. This was achieved primarily by promoting BrainSTEPS teams' consistent use of a Brain Injury Supports Framework (BISF) Online Application tool to create person-centered plans. The BISF was created to guide BrainSTEPS team members, students, their caregivers, and their school team through determining appropriate academic supports, based on presenting signs and symptoms of the student's brain injury. Once the tool is completed, it is embedded into the student's person-centered care plan and disseminated to the student, their caregivers, and the school staff involved in the student's case. BIAPA also provided training, workshops, and technical assistance to team members to support their ability to follow the established program model. Each year, BrainSTEPS Team Leaders are required to establish annual team objectives to promote person-centered thinking and planning for their coverage area. To ensure the BrainSTEPS Team Leaders are actively working on these objectives, a monthly meeting is held to discuss their progress and problem solve any service provision barriers.

In 2022, the BrainSTEPS program continued to participate in the CDC's Systematic Evaluability Assessment of Return to School Programs following a TBI. The evaluation is assessing the BrainSTEPS program and its protocols to determine best practices for optimal student health and learning and will conclude in September 2025. The BrainSTEPS program also partnered with the Children's Hospital of Philadelphia (CHOP) to apply for a research

grant from the Centers for Disease Control and Prevention (CDC) to identify disparities in concussion outcomes in the pediatric population. In November 2022, CHOP was awarded a four-year grant, beginning in January 2023 and ending in December 2027. The study will use the BrainSTEPS database to analyze school re-entry data after concussion to improve education and access to concussion care.

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

The Community to Home (C2H) Program identifies and eliminates systemic issues for CSHCN 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 provide in-home care coordination and education within six rural regions of Pa., encompassing 48 of Pa.'s 67 counties. 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.

The goal of the C2H program is to provide CSHCN and their families with tools for self-sufficiency and connect them to appropriate resources. CHWs engage with families to assess their needs and develop individualized care management plans with measurable goals. CSHCN and their families are active members of the care management plan. The CHWs connect CSHCN and their families to appropriate supports and services to better address their needs and help families learn how to navigate the health and human services systems.

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 CHWs provide 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 2022, 17 family satisfaction surveys were received at the conclusion 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 the care plan and individualized goals. Despite numerous outreach methods encouraging the completion of the satisfaction surveys, the BFH has been unsuccessful in receiving surveys from a greater portion of the 142 families enrolled in the program in 2022. Therefore, the BFH did not meet the goal of 52 families completing surveys. The BFH has provided technical assistance regarding survey collection and is working with grantees to identify new strategies to increase the number of surveys being returned. The objective has been updated in 2023 to align with the program goal of increased survey completion rates. This ESM has also been updated in 2023 to better reflect the satisfaction of clients served with the surveys that are received. The percentage of families who felt like they were partners in decision-making will be measured and reported.

Strategy: CSHCN receive coordinated, ongoing, comprehensive care within the medical system

A quality medical system ensures that children have continuity of care from infancy through transition into adulthood. In addition, the medical system must be supported to provide care coordination services so that each family and the range of professionals serving them work together as an organized team to implement a specific care plan and to address issues as they arise. Collaboration between the primary, specialty, and subspecialty providers to establish shared management plans in partnership with the child and family, and to clearly articulate each other's role, is a key component of a quality medical system. Equally key is the partnership between the primary care provider and the broad range of other community providers and programs serving CSHCN and their families.

Objective: Annually increase the number of collaborative agreements with medical providers through the Sickle Cell Community-Based program by eight per year

ESM: Number of medical provider collaborative agreements established by the Sickle Cell Community-Based program

The goal of the Sickle Cell Community Based Services and Support (CBSS) program 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, systemically remediate disparities, alleviate barriers to care, and ultimately improve health outcomes and the quality of life for those living with SCD.

The CBSS requires the two grantees to identify and develop collaborative agreements with medical care providers across the state. These agreements support increased communication between medical care providers (such as health systems, insurance providers, primary care practices, specialists, mental/behavioral care providers, and pharmaceutical companies) by 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 2022, the CBSS continued plans to annually increase the number of collaborative agreements with medical care providers. In 2022, the CBSS established 12 new agreements with medical providers, exceeding 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 used Title V funds for the Federally Qualified Health Center (FQHC) Program. Through a grant agreement with the Pennsylvania Association of Community Health Centers (PACHC), the FQHC Program pursued two overarching goals: to improve programmatic, clinical, and operational performance within FQHCs related to CSHCN; and, to increase CSHCN access to well-functioning, continuous systems of care. Partnering with PACHC, the largest association of primary care practices in the state, allowed the FQHC Program to access CSHCN through medical home health centers.

The FQHC Program engaged CSHCN and their families in their condition management; screened CSHCN for

mental, behavioral, emotional, and developmental conditions; referred CSHCN to appropriate services immediately upon positive screens; increased access to quality care; and transitioned CSHCN through life stages. Eight FQHCs participated in the program and provided 10,954 services to 7,116 CSHCN. This represented 23% of the 31,156 CSHCN in the participating FQHCs, exceeding the goal of 20% of CSHCN receiving quality care in participating FQHCs in 2022.

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 challenges identified within the community. These interventions along with mechanisms to hold providers accountable for access and quality and to ensure that the voices of those receiving services are heard are crucial to improving health. The Philadelphia Department of Public Health, partnering with Children's Hospital of Philadelphia, trains community health workers on the Room2Breathe (R2B) evidence-based program and provides 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 communicate with 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. To be eligible for R2B, children referred must be between two and 14 years old, a resident of Philadelphia County, and have had two emergency department visits or hospital admissions for asthma-related symptoms. In Philadelphia, asthma disproportionately affects Black/African American and Latinx children in both prevalence and hospital utilization. Accordingly, R2B partners with pediatric clinics that serve patients matching those racial/ethnic backgrounds. The BFH chose to measure the number of children who successfully complete the R2B 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. One hundred and ninety children were served by the program in 2022. Of these participants, 50% identified as Black/African American, 33% as Latinx, and 25% of participants' race data was unknown/not reported. Seven (4%) of the 190 participants completed the program. R2B recognizes it has a high program attrition rate attributed to families dealing with multiple challenges that can lead to a premature exit from the program (moving out of Philadelphia, competing priorities, etc.). R2B will continue to work with families to improve asthma related symptoms.

Strategy: Initiate regular meetings and collaboration between the Department of Health and Department of Human Services

The Department of Health (DOH) and Department of Human Services (DHS) each have an integral role in providing services to the MCH population. As Pa.'s Medical Assistance administrator, DHS oversees many programs serving underserved and under-resourced 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 DHS', 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 contributed to a well-

functioning system.

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 2022. 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 2022, five 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 uses telehealth technology to connect, 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.

Following ADC inclusion on AMCHP's Innovation HUB and the program's continuing success, the Bureau entered into an agreement with Drexel University to evaluate program implementation, data use, outcomes, and replicability; and, pending the evaluation results, develop a model for program replication. The reports and materials created will be used to develop a plan to expand the ADC into additional counties across the state.

In 2022, 134 children were evaluated, exceeding the goal of 55. Of the 134 children evaluated, 118 were diagnosed with autism (88% of those evaluated). Once a child is diagnosed, the ADC provides care coordination services to assist families in enrolling in therapeutic and other services, as well as training families in applied behavior analysis (ABA) principles. In 2022, 57 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.

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 to expand knowledge of the program, the population it serves, and how to access resources. Increased awareness of the BrainSTEPS program, services, and resources contribute to the system of care for CSHCN, by allowing for an earlier referral to the program, identification and treatment of brain injury, and fewer long-term complications. In 2022, BrainSTEPS targeted outreach and program promotion to families with pre-school and school-aged children, rehabilitation facilities, medical professionals working with the pediatric population, and community organizations and agencies that serve primary and secondary school students. BrainSTEPS conducted a total of 32 presentations to a diverse audience of 2,370 participants.

Prior to 2020, the BrainSTEPS program referrals were on an upward trend to consistently fulfill the goal to increase referrals by 15 each year. However, in the aftermath of the COVID-19 pandemic, the number of referrals significantly decreased. The program could not conduct the necessary outreach, program promotion, or service provision to fulfill the pre-pandemic referral goal. In 2022, the BrainSTEPS program continued to experience residual impacts of the pandemic. The program received 463 referrals, which was 90% toward the goal of 515 referrals, and a significant increase from the 315 referrals received in 2021. To continue increasing referrals, BrainSTEPS employed a Regional Facilitator (RF) in Pa.'s central region. The RF assists the 31 BrainSTEPS teams across the state to support each referral received in their respective location. BrainSTEPS developed a promotional program poster to be disseminated in 2023 to all 3,287 public schools in Pa. The poster contains information about the program, eligibility requirements, and a QR code that directs individuals to the referral page allowing them to easily refer a student in an accessible manner.

The BrainSTEPS program continued to implement the Concussion "Return to Learn" Management Team Model. This initiative enabled schools to implement in-house school Concussion Management Teams. These teams systematically improved the program's success by ensuring students with mild TBI received 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 identify and refer a designated number of new students to the program, along with helping additional school districts implement Concussion Management Teams within their school districts.

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 developed partnerships with and between community-based service providers to enhance systems-level supports. Grantees sought out new community-based service providers to establish partnerships and strengthened existing partnerships. These partnerships support education and communication related to sickle cell

disease within multiple settings (such as education, employment, religious worship, and recreation) and support increased integration of CSHCN into community activities. These partnerships are used to identify impactful social determinants of health and 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 2022, the CBSS established 10 new collaborative partnerships with community-based organizations, exceeding the goal of eight collaborations. Also, during 2022, the CBSS held a total of 44 community events including World Sickle Cell Day activities, educational sessions, 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 the PEAL Center (PEAL) to implement the Leadership Development and Training program which provides Parent/Family and Youth Leadership Institutes. The Parent/Family Leadership Institutes address relationships, sexuality, dignity of risk, and supporting self-advocacy. The Youth Leadership Institutes create a network among peers while building leadership and self-advocacy skills. During 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. During 2022, 76 youth with special health care needs attended the Leadership Development and Training Program, significantly surpassing the goal of 44 youth.

In addition, 150 participants attended the Health Matters Conference which included presentations on “Preventing Challenging Behaviors” and “Surviving to Thriving”. The Family Leadership Institutes were provided both virtually and in-person with a total of 115 parents and family members served.

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 subpopulation of CSHCN and face many challenges, including transitioning to the adult health care system. In the C2H program, individuals aged 14 years and older have an individualized care plan that includes a transition plan preparing transition to adult

health care, independent living, post-secondary education, and employment. C2H services support transitioning youth during and after services end through the creation of a comprehensive transition plan. Youth transition plans are reviewed and monitored by the BFH for completeness and thoroughness. The BFH objective for 2022 was that at least 50% of youth 14 years of age and older enrolled in C2H have appropriate transition plans as part of their individualized care plans. In 2022,15 youth enrolled in the C2H program and 13, or 86.6%, of those youth had a complete transition plan as part of their individualized care plan. The ESM was not met as only 15 youth were enrolled, however, the larger objective goal of 50% of youth enrolled having a completed transition plan was met.

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 DOH was authorized to mandate hospitals 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 opioid disaster declaration expired in August 2021, following 15 renewals, when the Pa. General Assembly declined to extend it. 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 responsible for reporting all NAS case data into iCMS. All NAS coordinators receive iCMS training to prepare them for compliance with the mandatory state reporting requirements. The NAS reporting form submitted by hospitals includes detailed information pertaining to the plan of safe care (POSC) 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 technical assistance centered around required reporting data, EI referrals, and statewide assessment of POSC. The NAS consultant organizes and participates in statewide and regional NAS meetings and uses information gathered during these meetings in conjunction with the NAS 2020-2022 data reported in iCMS to develop DNSG follow-up policies and procedures along with helpful tools for POSC 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 were included in

the 2020 Annual NAS Report, which indicated that approximately 25% (449 of 1825) of infants diagnosed with NAS were located in the EI database, confirming a referral to EI services. To date, 75 hospitals have reported NAS cases to the Department for 2022. Of those 75 hospitals, 56 (74.6%) have at least one confirmed referral to EI. 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. On a quarterly basis, the DNSG shares data with BEISFS detailing the percent of NAS infants with a confirmed EI referral broken down by individual county and hospital. This data has been utilized by BEISFS for targeted outreach to county programs with low percentages of referred children in relation to the total number of children identified. The intent was for those programs to build on their relationships with the birthing hospitals in their local area and ensure they are familiar with the referral process. In 2022, staff from the BEISFS presented educational information regarding EI services and referrals to hospitals and providers during an event for Newborn Screening Awareness.

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. Post-discharge information, to include initiation of POSC, is a required section of the electronic NAS report form submitted by hospitals to DOH when an infant is diagnosed with NAS. DHS', OCYF is primarily responsible for monitoring the delivery of services by county and private children and youth social service agencies as well as ChildLine, which is the child abuse reporting system. The OCYF conducts oversight of these programs from a regional level.

Per findings presented in the 2020 Annual NAS Report, a notification to ChildLine was made for 84.49% of newborns with NAS and 56.27% had a POSC initiated. According to 2022 preliminary data extracted from iCMS, a notification to ChildLine was made for 89% of newborns with NAS and 64.5% (790 of 1,225) had a POSC initiated. Given that all newborns with NAS who meet the Department of Health's NAS case definition may also be considered substance affected infants per the DHS definition, these percentages should be higher and may indicate a need for improved provider education on reporting requirements. However, data on ChildLine notifications and POSC are self-reported by the hospital and further validation by the DHS or the OCYF is not currently required. Accordingly, reported data may not accurately reflect notifications received by DHS or involvement of the OCYF.

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. In 2022, OCYF continued the process of analyzing quarterly data through matching of NAS data with the Child Welfare Information Solution (CWIS) system. OCYF reported this task to be difficult and time consuming with the need to develop improved processes for analysis. OCYF was unable to provide definitive findings but did report concerns regarding the percent of NAS infants receiving a Child Line referral and POSC.

In January 2022, another formal data exchange summary was finalized and signed by DNSG and OCYF. The data

exchange summary provides OCYF with the ability to send de-identifiable CWIS data to DNSG on a biannual basis. The first data exchange was executed in October 2022. DNSG was hopeful that the CWIS data received could be matched with NAS data, but the data did not include enough data variables for a match to be possible. The DNSG and OCYF are continuing discussions regarding exchange of data, processes for analysis, and next steps.

In 2022, the DNSG was able to take several steps to address disparities in rural areas relating to NAS. Through NAS reporting, surveillance, and data analysis, the northwest region of Pa. has been identified as having the highest NAS incidence rates within the state. In January 2022, the DNSG announced a new resource for infants and families impacted by NAS. The Neonatal Abstinence Syndrome Family Guide Tool Kit was created by DOH nurses in the northwest district in conjunction with the Northwest Neonatal Abstinence Syndrome Coalition. The toolkit was added to the DOH's webpage for NAS and copies are available to hospitals and providers upon request. The DNSG distributed several hundred copies of the toolkit during events in the northwest specifically aimed at addressing NAS.

Also in 2022, the DNSG convened a grant funded project with a community partner within the NW region (Crawford County Drug and Alcohol) to initiate a pilot project for infants and families impacted by NAS. The pilot project consisted of the development and distribution of an NAS toolkit/booklet and baby basket containing various items identified by neonatal intensive care unit staff as fundamental in caring for infants diagnosed with NAS.

Lastly, the DNSG initiated conversations with the West Virginia Health Department to address concerns relating to Pa. resident births in West Virginia. The DNSG has identified concerns relating to lack of notification of Pa. resident infants diagnosed with NAS and born out of state, raising additional concerns relating to post-discharge referrals and services. To address these concerns, the DNSG contacted West Virginia's Health Department to discuss the possibility of developing a data share agreement, which would provide the DNSG with notification of Pa. resident infants diagnosed with NAS born at a West Virginia facility. The data share agreement was not finalized in 2022 and ongoing conversations continue.

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, community based, and coordinated. As stated in the CSHCN report section, according to the 2020-2021 National Survey of Children's Health, the percent of Pennsylvania's (Pa.) CSHCN has risen to 22.7%, exceeding the national average of 19.5% and, with only 18% 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. The BFH will begin incorporating the principles, strategies, and recommendations of the "Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs". 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 BFH provides services for CSHCN and their families, as well as initiatives to improve the system of care, through a combination of Title V, other federal, and state funding.

The goal of the Specialty Care Program (SCP) is to facilitate improved health outcomes by identifying and removing barriers to care. The SCP includes state match funded programming for individuals with Cooley's Anemia, cystic fibrosis, hemophilia, sickle cell disease, and spina bifida. 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 2024, the Technology Assisted Children's Home Program (TACHP) program vendor will continue to use 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 SCP 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 (DHS) to identify and work toward filling identified gaps in service for programs serving CSHCN.

State match funds will again be used in 2024 to support outreach and education-based grants for individuals diagnosed with epilepsy and Tourette Syndrome. The BFH will continue to collaborate with Pa. 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 when compared to suburban populations. PA-TSA will focus on community outreach and engage in in-person and virtual activities to promote TS awareness within Pa. 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.

The Administration for Community Living (ACL) awarded the BFH the Traumatic Brain Injury (TBI) State Partnership Program Grant, in effect from August 1, 2021, through July 31, 2026. The BFH will maintain and expand the NeuroResource Facilitation Program (NRFP), along with providing TBI education for professionals, caregivers, and family members within the juvenile justice and older adult populations. The NRFP and the education component will be provided by the grantee, Brain Injury Association of Pennsylvania (BIAPA). The BFH will continue funding 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 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 brain injury across the lifespan, their family members, and their support networks. ACL also awarded the BFH supplemental funding to expand the NRFP to identify and address the service and support gaps caused by the COVID-19 pandemic, in effect from April 1, 2022, to September 30, 2024. The BFH, through BIAPA, will continue employing two NeuroResource Facilitators to address the following identified gaps: social isolation, access to quality and timely healthcare, employment, compounding symptoms, and evidence-based and up to date COVID-19 information. The BFH will address these gaps by continuing a support group for individuals with a brain injury that were impacted by the COVID-19 pandemic, develop newsletters containing COVID-19 and public health information specific to the brain injury population, and develop an emergency response plan to assist individuals with a brain injury to navigate services, supports, and resources during a public health emergency.

The BFH's Head Injury Program (HIP), funded through state funds not part of the state match, provides rehabilitative and therapeutic services to individuals with a TBI. To be eligible for the HIP, an individual must be a U.S. citizen, 18 years of age or older, have resided in Pa. at the time of injury and application, and sustained a TBI after July 2, 1985. The HIP's goal is to help individuals with TBI live independently in their homes and communities.

The BFH will continue providing services through the Acquired Brain Injury Program (ABIP) that was implemented in July 2020 with Title V funding. Despite outreach and marketing efforts, the ABIP continues to have very few referrals and participants; subsequently, the ABIP will discontinue services in 2024. The program will continue to provide short term rehabilitation for individuals ages 18 through 25 who sustained an acquired brain injury through May 31, 2024. 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 (CMHDs) 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. New grant agreements, with the 30% budget requirement for CSHCN, were developed for all 11 CMHDs in early 2023. BFH will continue to assist the CMHDs in determining the best means of serving CSHCN in their communities.

New initiatives for the CMHDs include Wilkes-Barre City Health Department's (WBCHD) recreational programs for CSHCN. Partnering with the Challenger baseball league, an adaptive baseball program for CSHCN ages 4 to 18 years, WBCHD will provide registration costs and safety equipment to allow the formation of more teams and increased participation. Additionally, WBCHD will work with their local YMCA to offer swimming lessons to CSHCN and support accommodations needed to make the swim program accessible to all. Chester County Health Department (CCHD) will incorporate trauma informed care and resiliency resources into their home visiting program to help mitigate the effects of adverse childhood experiences.

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 Request for Proposals, 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 years. 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. In 2024, the BFH will continue to utilize Title V funding to support the system change work with PDPH and has implemented the Family Impact Initiative to bring service system 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. This initiative will be expanded to other areas of Pennsylvania in the future.

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, services and how to navigate different systems of care via telephone. Through the SKN helpline, the BFH is helping families connect with community-based services and navigate them 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.

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.

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 2024, the BFH will continue to use data from the local 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. Additionally, the BFH will continue to look for opportunities to share the CDR recommendations more widely, with a particular focus on prevention strategies that address identified social, economic, environmental, and structural factors influencing mortality rates, acknowledge the life course, and promote health equity. The goal is to increase sharing of data and findings with state and local partners to inform child fatality prevention and health promotion strategies, enhance policies and practices of systems serving children, including CSHCN, and families and promote support for concrete services and policies that help families thrive and expand community awareness of factors associated with fatalities.

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. BrainSTEPS provides consultation services to any public-school student who has been identified as having an acquired brain injury. An acquired brain injury includes traumatic brain injuries of all severities and non-traumatic brain injuries (nTBI). BrainSTEPS is comprised of over 230 brain injury educational consultants serving on regional teams. Teams are based in Pa.'s 29 educational Intermediate Units and two school districts. Once referred, the student receives services from the point of referral through secondary school graduation.

In 2024, the BFH, through BrainSTEPS program, will ensure CSHCN receive care in a well-functioning system by continuing to coordinate and streamline collaboration between students, their caregivers and the medical, rehabilitation, and education sectors through the development and monitoring of person-centered care plans. Person-centered plans provide the student and their caregivers the ability to identify the students' needs and barriers to having those needs met and have an active role in the decision-making process. To promote consistency of the BrainSTEPS teams to create person-centered plans, the BFH will continue using the Brain Injury Supports Framework (BISF) Online Application tool. This tool guides BrainSTEPS team members, students, their caregivers, and their school team through determining appropriate academic supports, based on presenting signs and symptoms of the student's brain injury. Once the tool is completed it is embedded into the student's person-centered care plan and disseminated to the student, their caregivers, and the school staff involved in the student's case. The BFH, through BIAPA, will provide training, workshops, and technical assistance to BrainSTEPS team members to ensure they are following the established program model. BrainSTEPS team leaders will continue to establish annual team objectives to promote person-centered thinking and planning for their coverage area. To ensure they are actively working on these objectives, monthly team meetings will be scheduled to discuss their progress and problem solve any service provision barriers they are experiencing.

The BFH recognizes the barriers CSHCN transitioning to adulthood experience in regard to having their needs met. To mitigate these challenges, the BrainSTEPS program will develop a transition toolkit for BrainSTEPS students graduating from secondary education in 2024. This toolkit will contain information and resources on post-secondary education, employment, housing, brain injury treatment, long-term care, advocacy, support groups, and transportation.

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 Centers for Disease Control and Prevention (CDC)’s Systematic Evaluability Assessment of Return to School Programs following a TBI. This evaluation is assessing the BrainSTEPS program and its protocols to determine best practices for optimal student health and learning. The program will also continue to participate in a CDC research grant, administered by Children’s Hospital of Philadelphia (CHOP), to identify disparities in concussion outcomes in the pediatric population. The goal is to improve the outcomes of children with nTBI and reduce the disparities in those outcomes by translating the CDC’s Pediatric nTBI Guideline into standard care. The study will use the BrainSTEPS database to analyze school re-entry data after concussion, to improve education and access to concussion care.

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

The Community to Home (C2H) Program identifies and eliminates systemic issues for CSHCN 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 encompass 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 was revised in 2023 to better depict and measure the work toward making families feel like true partners in decision-making.

In 2024, the BFH will have concluded C2H services under the initial five-year agreement with grantees who have

provided services since 2019. In July 2024, a new grant cycle for the program will be established, which could bring new grantees and partners to the program. C2H services will continue to be provided to families in Pa.'s 48 rural counties. Outreach will continue to be a priority and expanded to reach new community-based partners, along with strengthening existing partnerships to bring quality and comprehensive services and supports to families served in the program. The BFH will support new grantees and does not foresee any disruptions in providing this service to families as their satisfaction, engagement, and need to receive critical services are paramount.

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. To be functional, 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 to and quality of care 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 will continue to identify and develop collaborative agreements with medical care providers. The collaborative agreements will be based upon the needs of those with sickle cell disease and the needs of the care providers. Grantees will be required to support and increase communication between medical care providers to reduce service duplication, streamline referral processes, simplify care plans, and improve information sharing across care providers. Increased collaboration between care providers will result in individuals experiencing coordinated and comprehensive care and allow care providers to improve systems' functionalities through policy and procedural changes across the population.

The CBSS program provides service to the entire state by dividing counties into five regions. This allows the CBSS program to partner with the state-funded Specialty Care Program clinics (who have similar goals and measures) to address broader systemic barriers across served conditions. These partnerships result in system performance impacts beyond sickle cell disease or any single condition and allow for statewide systemic improvement between health systems and community-based providers.

In 2024, the CBSS will continue to implement plans to annually increase the number of collaborative agreements with medical care providers, anticipating meeting or exceeding the goal of eight new partnerships. CBSS Grantees will also be exploring insurance reimbursements for services to increase sustainability for the program.

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 the Federally Qualified Health Center (FQHC) Program through a grant agreement with the Pennsylvania Association of Community Health Centers (PACHC). The FQHC Program will support systemic change, over time, that improves quality of care for CSHCN through changes within unique, funded FQHCs to be shared and replicated across roughly fifty FQHCs and their multiple sites. The FQHC Program will offer funding through 2024 to health centers statewide to reach CSHCN, and the program anticipates meeting or exceeding its goal of 22% of CSHCN receiving quality care in participating FQHCs.

The FQHC program will implement a series of quality improvement changes to increase the effectiveness of selecting, evaluating and replicating projects supported through the program. PACHC will develop a methodology to assess FQHC proposed projects to identify which areas of system function are being addressed and how they will impact CSHCN. PACHC, working with the participating FQHCs, will monitor the projects for impact and success, while preparing appropriate projects for replication. These projects will then be shared (with roughly fifty FQHCs, as well as look-alikes and rural health centers) by PACHC so that additional health systems can replicate the projects and expand the systemic impacts. These approaches will allow individual FQHCs to impact community-level system function through proposed projects, and PACHC to impact statewide systemic function through project sharing and replication.

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 2024, the Philadelphia Department of Public Health, in partnership with CHOP, will continue to train CHWs on the evidence-based Room2Breathe (R2B) Asthma home visiting program. The CHWs will provide home-visiting services to families of children, ages 2 to 14 years, 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 R2B 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 underserved and under-resourced 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. In 2024, the DOH and DHS will continue the use of a shared site to store meeting updates and other resources to ensure access to current information to improve services for CSHCN.

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 2024, the BFH will continue the Autism Diagnostic Clinic (ADC) through the grantee Easterseals Eastern PA as it concludes its five-year grant cycle. This program will maintain its use of telehealth technology to increase access to autism evaluations, diagnosis, parent education, and referral for treatment. The ADC is anticipated to meet or exceed its goal of screening 115 children for autism spectrum disorder.

In 2024, the ADC will conclude a program review through Drexel University at its primary site in Berks County and the five surrounding counties of Lehigh, Northampton, Carbon, Monroe, and Pike. Based on the reports and materials created through Drexel University's review, the Department anticipates future replication of the ADC statewide.

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

In 2024, the BFH will continue to collaborate with the PA Department of Education and BIAPA to conduct BrainSTEPS program outreach and program promotion to expand 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 for an earlier referral to the program, identification and treatment of brain injury, and fewer long-term complications.

To increase referrals through outreach and program promotion, the BrainSTEPS Director and Regional Facilitators will continue assisting the 31 BrainSTEPS teams across the state to provide support for each referral received in their respective location. The BFH, along with partners, will conduct targeted outreach to rehabilitation facilities and hospitals with low program referral rates, and educate others about the program through cross systems collaboration, trainings, and presentations.

The BrainSTEPS program will continue to implement the 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 provide training and technical assistance to Concussion Management Teams on concussion recognition and best practices. This additional support will help to identify and refer a designated number of new students to the program, along with helping additional school districts implement Concussion Management Teams.

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 continue to support and develop partnerships with and between community-based service providers focusing on systems-level changes. Grantees will seek out new and known community-based service providers to establish new and strengthen existing partnerships. 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.

The CBSS program provides service to the entire state by dividing counties into five regions. This allows the CBSS program to partner with the state-funded Specialty Care Program clinics (who have similar goals and measures) to address broader access to care and services for all served conditions. These partnerships result in system performance and equitable care improvements beyond sickle cell disease or any single condition.

In 2024, the CBSS will continue increasing the number of collaborative agreements between the CBSS and community-based providers and is anticipated to meet or exceed the goal of eight new partnerships. CBSS grantees will also be exploring insurance reimbursements for services to improve program sustainability.

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. PEAL is also a Family Voices (FV) state affiliate providing technical assistance, training, and connections to other F2Fs. FV is a national family-led organization which promotes partnerships with families on individual and policy-making levels to improve health care services and policies for CSHCN. The BFH provides Title V funds to PEAL to conduct outreach and training to families and CSHCN. Outreach activities will include kinship care for grandparents and other family members in caregiving roles. 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. PEAL will continue to use interpreting services to reach non-English speaking individuals, translate documents such as newsletters and flyers into Spanish, and provide live Spanish interpretation for webinars and in-person trainings. A Mandarin speaking staff member is also available to provide informal support.

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 subpopulation 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 2024 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

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 Early Intervention

Early Intervention (EI) services in Pa. 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.

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: 2020 Report, published by the Pa. DOH’s Bureau of Epidemiology, there were 1,825 NAS cases reported in 2020 with a statewide incidence rate of 14.0 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 (POSC). The DNSG analyzed NAS data collected during 2020 and plans to share the data with POSC coordinators and other state agencies to develop consistent discharge POSC 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 employs an NAS Nursing Services Consultant that will focus on technical assistance centered around required reporting data, EI referrals, and statewide 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 2020-2022 data reported in iCMS, to develop DNSG follow-up policies and procedures along with helpful tools for POSC coordinators. The DNSG will also provide quarterly key performance measure reports to share with Pa. birthing hospitals that will focus on timeliness of NAS case reporting and percentage of NAS cases receiving EI referrals. The DNSG has a signed memorandum of understanding (MOU) with the Bureau of Early Intervention to share EI enrollment data.

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. The MOU 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)

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 Child Abuse Prevention and Treatment Act (CAPTA) requires that a POSC be offered to every family caring for an 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. Notifications of substance affected infants are made to the Department of Human Services (DHS) OCYF, via Childline, the child abuse reporting system. OCYF is responsible for oversight of the delivery of child welfare services by county and private children and youth social service agencies.

The BFH houses the DNSG, which oversees reporting of NAS cases by all Pa. birthing facilities. Post-discharge information, to include initiation of POSC, is a required section of the electronic NAS report form submitted by hospitals to DOH when an infant is diagnosed with NAS. A signed MOU with the 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.

Through a formal collaboration, the DNSG and OCYF will continue to 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. The 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.

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**	**2022**
Annual Objective			5	3
Annual Indicator			3	2
Numerator				
Denominator				
Data Source			Bureau of Family Health internal documentation	Bureau of Family Health internal documentation
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	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	2022
Annual Objective			9.1	8.9
Annual Indicator			9.4	9.2
Numerator				
Denominator				
Data Source			NVSS	NVSS
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			11.2	10.7
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			HealthyPeople 2030	HealthyPeople 2030
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	25.9	25.9	23.9

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			26.4	25.9
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			NVSS	NVSS
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 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 2022, the BFH continued to use previously developed resources in an effort to improve Title V staff's access to and use of Pennsylvania's (Pa.) maternal and child health data. The 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), has been updated regularly with the most current data since its initial dissemination in 2021. Periodic reminders about its utility are provided to staff to encourage its use to inform programmatic decision-making and reporting. In fall 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. In 2022, updated Title V data briefs were disseminated to staff and the public. The static 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.

Another initiative related to this priority that continued in 2022 was training staff on data disaggregation and steps they could take to assess and break down programmatic data. The BFH developed and delivered two introductory trainings on the concept of data disaggregation and how to disaggregate program data to characterize the population served in 2021. A follow-up training was conducted in June 2022 on how and why to disaggregate program outcome data. The goal of these trainings was to build staff capacity to collect and use program data with intention and consideration of the principles of health equity. These topics will be continually revisited with staff and additional training may be developed in 2023-2024 as improved data collection and utilization continues to be a BFH training priority.

Data from a 2023 survey of staff on 2022 training initiatives suggest improvement in this area since 2021 as over 60% of staff indicated they understand data disaggregation as a concept and why it is important. However, the survey also suggested there are barriers to practical implementation of this concept as only half of all staff respondents indicated they have ever disaggregated their data, and many indicated data currently collected are not easily disaggregated or may not be meaningful due to small numbers. Accordingly, this remains an important training priority.

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

The Division of Bureau Operations (DBO) uses a workflow process in Microsoft Teams for technical assistance requests. While DBO technical assistance is available for 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, time bound, inclusive, and equitable (SMARTIE) 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 form 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 facilitate the data collection process as needed and obtain any data access required.

In 2022, DBO received and completed one technical assistance request, falling short of the ESM goal. DBO received a request for technical support to assist the program evaluation for Easterseals Autism Diagnostic Clinic resulting in a general discussion and review of the resources available to the program administrator.

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

The ESM was met as over 80% of staff were trained on availability of NSCH data and how to access it. A presentation on the NSCH website was made to Bureau staff at a quarterly staff meeting in December 2022. The presentation included a discussion of the oversample, an exploration of the data on the website, and how to access and analyze it. In addition, U.S. Census staff reported in March 2023 that data collection for the 2022 NSCH was completed, including the completion of the anticipated 1,500 to 1,550 interviews in Pa. That data will be available in fall 2023. 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. In July 2022, HRSA approved BFH's request to transfer MCHSBG funds to U.S. Census to cover the cost of the 2023 oversample.

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. In November 2022, the weighted data from this supplement became available. BFH Epidemiology staff is further analyzing this data and PRAMS staff will develop a data brief based on the findings. This data brief will then be made publicly available on the DOH website and shared broadly with interested parties. 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 the Division of Newborn Screening and Genetics to provide breastfeeding data and Government Agency Maternal Mental Health Fellows Program to provide data surrounding depression and determining possible disparities related to maternal mental health. PA PRAMS is currently working with the Bureau of Epidemiology's Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) team in utilizing PRAMS data to determine how the COVID-19 pandemic impacted prenatal care and to gain a better understanding of vaccine hesitancy and adherence to COVID-19 mitigation practices. Additionally, PA PRAMS is working with the Bureau of Health Promotion and Risk Reduction to provide breastfeeding data for their CDC SPAN Cooperative Agreement Application. Externally, PA PRAMS has received requests for data to assist Lehigh Valley Health Network conduct research on various screening and counseling topics that occurred during and after pregnancy. PA PRAMS also provided data on how often birthing people are educated on safe sleep habits to the Pennsylvania Perinatal Quality Collaborative for the development of improved educational opportunities within maternal health care providers.

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 2022 Data to Action #1 reflected on a study, "*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",* pertaining to risk factors associated with postpartum depression conducted utilizing PA PRAMS data from 2012-2015. The 2022 Data to Action #2 reflected on the data brief based on data from the PRAMS COVID-19 Supplement, which ran from May 2020 to December 2020. This supplement collected data to gain an understanding of how the COVID-19 pandemic impacted birthing people. The data brief is publicly available on the DOH website.

Due to a lack of programs or policies created or modified by entities who directly requested PRAMS data from the Bureau, these ESMs have 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 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 decade, the percentage of child deaths reviewed has decreased from a high of 75% for 2013 deaths to 43.2% for 2019 deaths. Deaths occurring in 2020 are the most current data available. Of the 1,664 deaths occurring in 2020, 801 (48.1%) were reviewed and entered in the National Center for Fatality Review and Prevention-Case Reporting System (NCFRP-CRS) by local CDR teams. Many teams were unable to complete

a review of all children's deaths occurring in 2020 due to continued COVID-19 related efforts which impacted the ability of teams to meet and some key team members' capability to devote time and resources to CDR. Attrition has also adversely impacted teams as key team members and team chairs have retired or moved to new positions.

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 has also begun importing information from Vital Statistics into the NCFRP-CRS for all local CDR teams. Importing data from Vital Statistics into the NCFRP-CRS requires less manual entry from the local CDR teams, which BFH expects will lead to improved timeliness and data quality.

The State CDR Team prevention framework has not worked as intended. Meeting participation and engagement are low. The framework will be reassessed to determine how the State CDR team can best meet its statutory obligations in a way that is meaningful.

BFH has leveraged Title V funds to partner with East Stroudsburg University to assess the current Pa. CDR system. The expected outcomes are to: better meet the needs of the local CDR teams; increase the number of case reviews; and increase the quality of those reviews and subsequent data. In 2022, the vendor surveyed team chairs and coroners in addition to observing several team meetings. The vendor has begun meeting with other states' CDR programs to understand the breadth of what is possible. Some preliminary assessment findings include:

- Rural vs urban differences in CDR participation are significant.
- Formal new chair training is limited.
- Limited time and limited information from out-of-county/state deaths are barriers, even among teams that regularly report data.
- Uniformity in how and when CFRP data entries are made is lacking.

The vendor will continue to survey CDR chairs, key stakeholders in areas without functioning teams, and other states' CDR programs before moving onto making recommendations.

The goal to increase the number of child fatality cases reviewed and entered into the case reporting system by local CDR teams by five percent was met this year despite teams being adversely 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.

At the statewide 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 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 grantees to improve the quality of their work with regards to equity and reducing disparities. Training is provided to DOH project officers as well as grantees. 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 DOH Anti-racism and Health Equity Task Force (ARHETF), 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 ARHETF 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 state. In 2022, the DOH Shared Language document containing standard health equity terms and definitions was approved and shared with the Department. Current initiatives include training modules for the terms and definitions, an analysis of Department policies and practices through an equity lens, and an assessment of existing health equity initiatives across the Department. The DOH Health Promotion Program Development Framework, a guiding document for staff responsible for developing and implementing health promotion and health education programs, was also updated.

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. PIHET is currently developing a Racial Equity Strategic Plan. Finally, staff participate in statewide efforts, including an Anti-Racism Book Club, and a Diversity, Equity, and Inclusion Interagency Collaboration Workgroup, formally known as the Human Centeredness

Community.

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 2022, 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 achieve 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. Although the three-year work plan was to conclude in September 2022, the HEC was disbanded early in June 2022. Endeavors, collaborations, and resources, internal and external to the BFH, continue to shape the direction of this complex work.

In January 2023, the BFH entered a new phase, the Health Equity Priority Project, expanding health equity efforts across the Bureau. Staff were charged with revisiting their program strategies, as outlined in the state action plan, by using a set of "guiding questions" to evaluate their existing programs. In revisiting the strategies, staff first examined the MCH problem and the health outcome, whether current strategies were appropriate for the population to be served, if input from communities or populations that are intended to be served is supportive of the strategies, and whether strategy implementation is sufficient to impact population health measures.

Second, staff reexamined programmatic areas where the implementation or reporting measures required adjustments to better respond to the program needs, specifically if there was a need for data disaggregation or the development of evaluation measures. Lastly, staff identified existing gaps where strategies (existing or non-existing)

do not fully address priority needs.

The Health Equity Priority Project is a step in raising awareness of practical application of health equity principles on existing projects and offers an opportunity for staff to practice applying a “health equity lens” to assessing strategies. There is opportunity to build on this initial activity and further incorporate this practice into general operating procedures related to strategy and program development, implementation, and evaluation.

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

In June 2022, the HEC implemented a two-part series of Health Equity Prerequisite trainings with BFH staff, completing this ESM. The trainings’ key focus areas addressed the following competencies, identified through the 2019 BFH Health Equity Assessment, for 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.

At the time of the training, 98% of staff completed the Health Equity Prerequisite trainings. Although the HEC training plan was delayed due to COVID-19 and the HEC training plan has been discontinued with the HEC, efforts to continue trainings on health equity will be explored for the coming year.

Building on the awareness introduced in the Health Equity Prerequisite trainings, trainers from the Governor’s Office of Performance Excellence facilitated a “Continuous Quality Improvement for a Healthier Pennsylvania” training. Held in December 2022, 73% of staff participated in the training. Aligned with principles of health equity, the learning objectives included identifying the connections between bias, social location, and health equity; using continuous quality improvement as a vehicle to improve health equity outcomes; and establishing a continuous quality improvement environment through the Healthy Government Framework. The Healthy Government Framework is comprised of five key principles:

1. Purpose: Clarifying our whys. Why do we exist and why do our customers value what we do.
2. Process: Identifying work creating value for our customers and doing it well.
3. Capability: Ensuring employees have the knowledge, skills, and tools they need to succeed.
4. Management System: Creating visibility into our performance at every level.
5. Human-Centered Mindset and Culture: Putting people, customers, and team members at the cent er of your organization.

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. Analysis of the surveys continued through 2022 to help guide the direction of the Bureau’s health equity work and training needs. A report compiling the findings and recommendations was finalized in January 2023.

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). The committee's long-term goal was 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 sources. 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), State Systems Development Initiative (SSDI) 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) Case Registry 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 2022 report, Title V staff have continually expressed a desire for increased training and assistance in this area.

In 2024, 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 continue to 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. The next update to the data briefs will begin in 2023 with the goal to disseminate in 2024.

BFH will continue to promote the use of specific, measurable, attainable, realistic, time bound, inclusive, and equitable (SMARTIE) 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

In 2024 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 SMARTIE 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 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 MCH 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 will continue to forward the Child and Adolescent Health Measurement Initiative's (CAHMI) notifications about availability of new NSCH data to staff 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 Pa. 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 Pa.'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 Pa. 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, Pa. 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. In 2024, 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 and may update its analysis once Pa.'s NSCH oversample data are available at the end of 2023. In the meantime, the BFH remains 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 2022 birth year, PA PRAMS participated in the Social Determinates of Health Supplement. This weighted data set is anticipated to be disseminated to the PRAMS states with the core PRAMS 2022 data set in fall/winter 2023. The DOH Epidemiology staff will provide descriptive analysis of the datasets which will be disseminated to BFH staff, the PRAMS Committee, and other partners in early 2024. PA PRAMS also participated in the Postpartum Assessment of Women Survey (PAWS), sponsored by Columbia University. This project was implemented to gain a better understanding of the causes of postpartum mortality and morbidity. PAWS data collection ran from January 2021 to March 2022. Data for this project was received by BFH in early 2023. This data will be summarized and shared with partners through the next 12 months. The weighted dataset for the COVID

Vaccine Supplement, which ran during the 2021 birth year, became available in winter 2022. Data briefs will be created specifically for the COVID Vaccine Supplement in 2023. All data briefs, fact sheets, and reports on these projects will be made available on the PA PRAMS 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 future years. PA PRAMS will also explore options for promoting PRAMS across the state. CDC PRAMS has developed and will be implementing a new web option to complete the PRAMS questionnaire. With the implementation of Phase 9 of PA PRAMS, beginning in the 2023 birth year, the BCSR staff will implement the web option as an alternative method for completing the Pa. Questionnaire. Expectations are that this new option will increase the overall response rate, providing more precise data. PRAMS data from the 2023 birth year, including the web option, will be available to PRAMS states in the winter 2024. 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 added an additional stratum of Black and Multi Race individuals in Allegheny County for the 2022 birth year. This data will be available with the PRAMS 2022 data in winter 2023. In addition, PA PRAMS has contracted with Rutgers to conduct a follow-up survey with Allegheny County for respondents who opted into the follow-up survey when they completed the PRAMS survey. Follow-up surveys will continue through January 2024 with the data from this project becoming available in the summer 2024.

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

To address the challenges that local CDR teams have in meeting the obligations of Act 87, the BFH will continue to explore 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 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 will continue to partner with East Stroudsburg University to provide an assessment of the current Pa 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 is assessing the following:

- Local CDR team composition and processes;
- Information gathered at the reviews;
- Quality of data entered; and
- How other states CDR programs operate and function.

The assessment process will soon move into the strategy planning and recommendation phase. Once a final report is completed, key stakeholders including the State CDR team and local CDR teams will assist the BFH in deciding on an incremental plan to implement recommendations and enhance the prevention that comes from the reviews.

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 will maintain its collaboration with epidemiology staff in the Bureau of Epidemiology through the assigned epidemiology research associate and will 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 2023 and throughout 2024.

To further enact systems change, increased workforce capacity to identify training and technical assistance resources for staff and grantees is needed 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 2024, the BFH plans to continue to explore capacity building and the technical assistance needs for both staff and grantees around health equity and the health disparity 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 state 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 DOH's Office of Health Equity, Culturally Linguistically Appropriate Services taskforce, the DOH Anti-racism and Health Equity Task Force and the statewide efforts Diversity, Equity, and Inclusion Interagency Collaboration Workgroup and the Anti-Racism Book Club), as well as the Pennsylvania Interagency Health Equity Team.

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 performance measures which address the other components of the priority. Throughout 2024, through the MCH Workforce Development Grant, BFH will identify and formalize the baseline series of trainings and the measures to establish when the baseline has been obtained. Additionally, the BFH will identify policy and practice for staff to move from learning to application.

Strategy: Increase staff understanding of Health Equity principles

Previously, this strategy was guided by a series of three-year workplans developed by the BFH's HEC which focused 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. Moving forward, in lieu of a formal HEC, the BFH will establish ad hoc committees to address emerging needs. Additionally, the BFH will explore building on the Health Equity Priority Project that began in 2023 to incorporate the critical thinking practice throughout all strategies and program development, implementation, and evaluation.

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 MCH Workforce Development Grant, anticipated to begin in 2023, will incorporate health equity capacity building, starting in 2024. By leveraging the feedback from the 2021 BFH Health Equity Assessment, and health equity work at the Department level, the BFH will work to identify and align training opportunities, increasing health equity expertise and assuring staff have a solid understanding of the issues and potential solutions.

Once staff recognize and implement health equity principles, building on those skills will be essential. BFH will consider the need to develop technical assistance materials to support staff professional development and address the need for staff to provide technical assistance to external partners. Additionally, a mechanism to measure effectiveness of how technical assistance is administered and its quality needs to be developed.

III.F. Public Input

After submission of the 2021 Annual Report/2023 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 Pennsylvania (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 4 state action plan table, and the needs assessment summary update of the 2022 Annual Report/2024 Application were posted to the BFH's Title V site and e-mailed to stakeholders through Pennsylvania's Title V listserv in July of 2023 for public comment. The documents were available for review and comment for a period of three weeks.

In response to request for public comment, BFH received one comment that advocated for oral health and dental care access to be incorporated in Pa.'s Title V work. The need around improving oral health and access to oral health services was not adopted as a Title V priority as there is existing capacity, funding, and programming addressing oral health within the Bureau of Health Promotion and Risk Reduction in the Department. Nonetheless, building and strengthening partnerships, especially those working to improve care access, is important to BFH and the BFH is committed to considering the extent to which the frequently cited needs, including improving oral health, may be addressed through new collaborations and the development and implementation of strategies. However, with the proposed elimination of the preventive dental care national performance measure in the Title V guidance to be published in 2024, it is unlikely oral health will be a funded priority area.
The BFH also 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 nonconforming people who are pregnant or parenting whenever possible, such as in the program descriptions in the action plan narrative.

The comment recommended restructuring an evidence-based measure to not consider the number of long-acting reversible contraceptives used by adolescents a measure of success due to concerns about potentially coercive practices, explicitly including reproductive health as an area of concern in the Children with Special Health Care Needs domain, and expanding the topic of healthy relationships to all youth rather than just young adults and adolescent males. The BFH aims to select topic areas and evaluation measures respectful of the populations being served that target and work to reduce disparities.

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. As referenced in *Needs Assessment Update* supplemental fact sheets on identifying inequities within the selected priority areas were published and released to stakeholders in 2023 as a part of interim needs assessment activities. 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 2022. 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 - Pa. Title V Action Plan 2021-2025_Year 4.pdf

Supporting Document #02 - Visual Exec Summary_Pop.Fact Sheets_Needs Assessment Update.pdf

Supporting Document #03 - Needs Assessment Update.pdf

Supporting Document #04 - Pa. Public Input Survey Theme Tables by Population Pa. Title V Partnerships Collaboration Coordination.pdf

Supporting Document #05 - 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 2023.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Pennsylvania

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 24,213,971	
A. Preventive and Primary Care for Children	$ 10,492,369	(43.3%)
B. Children with Special Health Care Needs	$ 7,711,350	(31.8%)
C. Title V Administrative Costs	$ 2,421,397	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 20,625,116	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 52,971,500	
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)	$ 52,971,500	
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)	$ 77,185,471	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 7,295,387	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 84,480,858	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	$ 1,160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 537,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 176,022
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 239,423
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 110,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 517,499
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 201,778
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,291,409
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 240,875
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,820,881

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 23,928,946 (FY 22 Federal Award: $ 24,213,971)		$ 24,213,971	
A. Preventive and Primary Care for Children	$ 10,381,678	(43.4%)	$ 10,267,208	(42.4%)
B. Children with Special Health Care Needs	$ 7,744,494	(32.4%)	$ 7,983,272	(32.9%)
C. Title V Administrative Costs	$ 2,392,894	(10%)	$ 2,421,397	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 20,519,066		$ 20,671,877	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 47,605,500		$ 48,897,957	
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)	$ 47,605,500		$ 48,897,957	
A. Your State's FY 1989 Maintenance of Effort Amount $ 20,065,575				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 71,534,446		$ 73,111,928	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 7,917,414		$ 3,136,141	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 79,451,860		$ 76,248,069	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 2,094,365	$ 588,660
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 200,000	$ 117,972
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 536,083	$ 431,812
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 232,193	$ 164,452
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 110,000	$ 58,711
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	$ 580,000	$ 139,126
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 515,875	$ 83,037
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	$ 957,000	$ 263,605
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 574,036	$ 381,857
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 2,117,862	$ 906,909

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 3,099,486	$ 2,874,289
2. Infants < 1 year	$ 3,255,923	$ 3,243,313
3. Children 1 through 21 Years	$ 7,400,866	$ 7,023,895
4. CSHCN	$ 7,519,760	$ 7,800,441
5. All Others	$ 516,539	$ 850,636
Federal Total of Individuals Served	$ 21,792,574	$ 21,792,574

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 0	$ 0
2. Infants < 1 year	$ 6,822,800	$ 5,600,245
3. Children 1 through 21 Years	$ 34,649,150	$ 34,647,500
4. CSHCN	$ 5,448,670	$ 4,436,621
5. All Others	$ 6,050,880	$ 4,213,590
Non-Federal Total of Individuals Served	$ 52,971,500	$ 48,897,956
Federal State MCH Block Grant Partnership Total	$ 74,764,074	$ 70,690,530

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:	**2024**
	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:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Services for Children with Special Health Care Needs reported on Form 2, line 1B includes infrastructure and services for 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:	**2022**
	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.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Services for Children with Special Health Care Needs reported on Form 2, Line 1B includes infrastructure and services for family of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.
- CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Pennsylvania

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 1,599,927	$ 446,260
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 10,407	$ 0
B. Preventive and Primary Care Services for Children	$ 1,306,470	$ 6,005
C. Services for CSHCN	$ 283,050	$ 440,255
2. Enabling Services	$ 10,201,353	$ 10,131,890
3. Public Health Services and Systems	$ 12,412,691	$ 13,635,821
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		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 12,010
Other		
Cognitive Therapy Services		$ 434,250
Direct Services Line 4 Expended Total		$ 446,260
Federal Total	$ 24,213,971	$ 24,213,971

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 12,747,750	$ 9,531,462
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 6,822,800	$ 5,600,245
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 5,924,950	$ 3,931,217
2. Enabling Services	$ 5,047,350	$ 4,271,993
3. Public Health Services and Systems	$ 35,176,400	$ 35,094,502
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		$ 1,497,123
Physician/Office Services		$ 1,189,986
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 4,410,259
Other		
Therapeutic Rehab		$ 2,434,094
Direct Services Line 4 Expended Total		$ 9,531,462
Non-Federal Total	$ 52,971,500	$ 48,897,957

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: 133,512 **Data Source Year: 2022**

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	132,981 (99.6%)	844	220	220 (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)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	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 I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
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	7,590 (5.7%)	0	0	0 (0%)
Fabry	7,590 (5.7%)	0	0	0 (0%)
Niemann-Pick	7,590 (5.7%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Pennsylvania Newborn Screening and Follow-up Program (NSFP) provides follow-up services from birth to diagnosis for all Pennsylvania newborns. Long-term follow-up is not performed by the NSFP.

Form Notes for Form 4:

Although not on the Pennsylvania Mandatory or Supplemental Mandatory screening panels, and not followed-up by the Program, four hospitals opt to screen for Gaucher, Fabry, and Niemann-Pick: Jefferson Einstein Hospital, Jefferson Einstein Montgomery Hospital, Penn State Hershey Medical Center, and Penn State Health St. Joseph Medical Center.

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The Data Source Year for Total Births by Occurrence is 2022. The source for total births by occurrence is provisional 2022 data from the Pennsylvania Newborn Screening Internet Case Management System (iCMS) provided by the Bureau of Family Health.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: Data source year for Screening Counts is 2022. Pennsylvania newborn screening includes all 35 CORE and 26 Secondary RUSP conditions, as well as Krabbe disease. 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 2022

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	3,295	18.4	0.0	2.1	10.7	68.8
2. Infants < 1 Year of Age	132,978	23.6	0.0	0.0	0.0	76.4
3. Children 1 through 21 Years of Age	68,433	15.8	0.3	4.9	0.6	78.4
3a. Children with Special Health Care Needs 0 through 21 years of age^	18,776	61.4	1.0	18.5	2.9	16.2
4. Others	27,261	16.1	0.0	14.9	1.2	67.8
Total	231,967					

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	132,622	No	130,003	91.8	119,343	3,295
2. Infants < 1 Year of Age	131,545	No	133,512	99.6	132,978	132,978
3. Children 1 through 21 Years of Age	3,218,766	No	3,218,669	45.2	1,454,838	68,433
3a. Children with Special Health Care Needs 0 through 21 years of age^	759,621	No	760,945	52.9	402,540	18,776
4. Others	9,617,708	No	9,481,872	0.3	28,446	27,261

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: Services/programs represented in the pregnant women served count include the following: Breastfeeding, Centering Pregnancy Program, Community Health, County Municipal Health Department Home Visiting, Doula Support Program Pacify Breastfeeding app, Prevent Injuries in Children	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	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 and municipal Health Department Home Visiting, Infant Safe Sleep Initiative, Prevent Injuries in Children, federally qualified health centers, Community to Home, sickle cell community-based services and supports, and specialty care programs for Cooley's anemia, cystic fibrosis, hemophilia, sickle cell, and spina bifida Systems limitations regarding mathematical rounding prevent reporting the actual number served, 132981.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Services and programs represented in the children served count include the following: Alliance Opioid Project, Bullying Prevention, Community Health, County Municipal Department Home Visiting, Health Resource Centers, LGBTQ behavioral health, Mentoring, Prevent Injuries in Children, Reproductive Health Grants, Youth Care Team, Room2Breathe Program, autism diagnostic clinic, federally-qualified health centers, Safety in Youth Sports, Male Involvement Initiative, epilepsy, Community to Home, BrainSTEPS, Leadership and Development Training Program), Technology Assisted Children’s Home program, Tourette's, metabolic formula program, and specialty care programs for Cooley’s anemia, cystic fibrosis, hemophilia, sickle cell, spina bifida	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
Services and programs represented by in the CSHCN count include the following:Room2Breathe Program, Bullying Prevention, Community Health, county and municipal health department Home Visiting, Prevent Injuries in Children, autism diagnostic clinic, federally-qualified health centers, Community to Home, BrainSTEPS, Leadership and Development Training Program, Technology Assisted Children's Home Program, Tourette's, Guide by Your Side program, Family Connections for Language and Learning program, metabolic formula program, infants served by newborn screening case management including metabolic treatment centers, cystic fibrosis treatment centers, hemoglobin treatment centers, PKU formula program, and specialty care programs for Cooley's anemia, cystic fibrosis, hemophilia, sickle cell, and spina bifida.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
Services and programs represented in the 22+ served count include the following: Alliance Opioid Project, Breastfeeding, county and municipal health department Home Visiting, IMPLICIT ICC, IMPLICIT 4TM, Pacify Breastfeeding app, Acquired Brain Injury Program, Epilepsy, Brain Injury/Opioid , BrainSTEPS, Safety in Youth Sports Program, Tourette's, metabolic formula program, cystic fibrosis pharmacy program, and spina bifida pharmacy program, and specialty care programs for Cooley's anemia, cystic fibrosis, hemophilia, sickle cell, and spina bifida.

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2022**

Field Note:
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 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**

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: Breastfeeding, Centering Pregnancy Program, Community Health, County and Municipal Health Department Home Visiting, Doula Support Program, Pacify Breastfeeding App, Prevent Injuries in Children, PRAMS, and Smoking Cessation

2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**

	Field Note: The true numerator is 119386. Mathematical rounding accounts for the difference between this and the system reported number. The denominator (130003) is from the NVSS Vital Statistics Rapid Release Report, June 2023. Births: Provisional Data for 2022, page 8. . The calculated percentage using these values is 91.8%.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	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 and the PKU formula program. This number represents the best unduplicated estimate of infants served. Other services/programs represented by this count include: County and Municipal Health Department Home Visiting, Infant Safe Sleep Initiative, Prevent Injuries in Children, Cooley's anemia, Cystic Fibrosis, Hemophilia, Sickle Cells Clinics, Sickle Cell CBSS, Spina Bifida, Federally Qualified Health Centers, Community2Home, and Sudden Death in the Young.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: The true numerator is 132981. Mathematical rounding accounts for the difference between this and the system reported number. The denominator (133512) is PA Newborn Screening Internet Case Management System Provisional Data for 2022. The calculated percentage using these values is 99.6%.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: This is the number of children receiving a school growth screen and represents the best unduplicated estimate. Other services represented include: PREP, PREP training, LGBTQ Behavioral Health, Mentoring, Bullying Prevention, Health Resource Centers, Sexual Risk Avoidance Education program/Teen Outreach Program, County and Municipal Health Department Home Visiting, Youth Care Team, Alliance Opioid Project, Reproductive Health Grants, Prevent Injuries in Children, Room2Breathe, Cooley's anemia, Cystic Fibrosis, Hemophilia, Sickle Cell Clinics, Spina Bifida, Sickle Cell CBSS, autism diagnostic clinic, federally qualified health centers, Epilepsy, Safety in Youth Sports, male involvement initiative, Community2Home, BrainSTEPS, Leadership and Development Training Program, Tourette's, Injury Prevention, Community Health, Family Connections for Language and Learning program, metabolic formula program	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: The true numerator is 1,454,539. Mathematical rounding accounts for the difference between this and the system reported number. Denominator (3,218,669) is Pa. civilians aged 1 to 21 from 2021 ACS 1 year estimate for Pennsylvania. The calculated percentage is 45.2%.	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**

	Fiscal Year:	**2022**
	Field Note: Services and programs represented in the CSHCN served count include the following: Bullying Prevention program, Room2Breathe Program, County and Municipal Health Department Home Visiting, Prevent Injuries in Children, Cooley's anemia, Cystic Fibrosis, Hemophilia, Sickle Cell Clinics, Spina Bifida, Sickle Cell CBSS, autism diagnostic clinic, federally qualified health centers, Community2Home, BrainSTEPS, Leadership and Development Training Program, Technology Assisted Children's Home program, Tourette's, Community Health, School Health, Guide By Your Side program, metabolic formula program, newborn screening case management including metabolic treatment centers, cystic fibrosis treatment centers, hemoglobin treatment centers, PKU formula program, CCHD referrals, and the Family Connections for Language and Learning program	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: The true numerator is 402,296. Mathematical rounding accounts for the difference between this and the system reported number. The denominator (760,945) is the product of the NSCH 2020-2021 percentage of children aged 0-17 with special health care needs (22.7%) multiplied by the sum of the total 2021 Pennsylvania child population (age 1-21) from the U.S. Census Bureau source described in the child field note (3218669) and the total 2021 provisional Pennsylvania infant population (133512). The calculated percentage is 52.9%.	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Services represented include: PREP, IMPLICIT ICC, IMPLICIT 4TM, Alliance Opioid Project, County and Municipal Health Department Home Visiting, Breastfeeding, Pacify Breastfeeding app, PREP training, Cooley's anemia, Cystic Fibrosis, Hemophilia, Sickle Cell Clinics, Spina Bifida, Sickle Cell CBSS, Epilepsy, Brain Injury/Opioid, BrainSTEPS, Safety in Youth Sports, Juvenile Justice, Acquired Brain Injury Program, Tourette's, metabolic formula program, cystic fibrosis pharmacy program, spina bifida pharmacy program	
10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2022**
	Field Note: The true numerator is 28,751. Mathematical rounding accounts for the difference between this and the system reported number. The denominator (9481872) is the 2021 ACS 1-Year Estimate for Pa. (12,964,056), less the sum of the counts in the child (3,218,669) infant (133,512), and pregnant women (130,003) field notes. The calculated percentage is.3 %.	

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.
2.	Others, 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 2022

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	119,385	87,868	12,177	10,028	119	4,298	0	4,417	478
Eligible for Title XIX	59,511	19,443	12,653	11,894	98	1,334	42	0	14,047
2. Total Infants in State	133,512	98,265	13,618	11,215	134	4,806	0	4,940	534
Title V Served	132,980	97,874	13,564	11,170	133	4,787	0	4,920	532
Eligible for Title XIX	65,448	21,707	13,833	13,116	107	1,531	82	0	15,072

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: The source for total deliveries in the state (total births by occurrence) is the 2020 Pennsylvania Birth files, provided by the Pennsylvania Office of Administration, Division of Health Informatics. An updated 2021 files was not available before the Title V MCH Block Grant Application/Report deadline. The Non-Hispanic Asian and Non-Hispanic Native Hawaiian or Other Pacific Islander categories are aggregated in the source data.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	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 (2021 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 (119,386) for 2022. Sum of category totals differs due to rounding.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: The race/ethnicity of pregnant women who were eligible for Title XIX services was self-reported. The data is from calendar year 2022.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: The count for total infants in state (133,512) is from calendar year 2022 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 (2021 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:	**2022**
	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 (2021 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 (132981) for 2022. Sum of category totals differs due to rounding.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: The race/ethnicity of infants who were eligible for Title XIX services was self-reported. The data is from calendar year 2022.	

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

State: Pennsylvania

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 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"		140

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	Special Kids Network	Special Kids Network
2. Number of Calls on Other Toll-Free "Hotlines"		429
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		1,337
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		310,523

Form Notes for Form 7:

The number of calls received by the Healthy Baby hotline reported in Annual Report Year 2022 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 2022 Healthy Baby numbers are direct, intentional calls to the hotline.

All calls logged for the 2022 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 page visits to the Department of Health's Facebook page from January to December 2022. The Department also maintains a Twitter account.

Form 8
State MCH and CSHCN Directors Contact Information

State: Pennsylvania

1. Title V Maternal and Child Health (MCH) Director	
Name	Tara Trego
Title	Director, Bureau of Family Health
Address 1	625 Forster Street
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 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 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

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Pennsylvania

Application Year 2024

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
2021	77.8 %	0.1 %	99,405	127,739
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**
2020	89.5	2.7	1,104	123,355
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
2017_2021	15.6	1.5	105	670,963
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**
2021	8.3 %	0.1 %	11,007	132,434
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**
2021	9.8 %	0.1 %	13,006	132,419
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**
2021	26.3 %	0.1 %	34,843	132,419
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**
2021/Q1-2021/Q4	1.0 %			
2020/Q4-2021/Q3	1.0 %			
2020/Q3-2021/Q1	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 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2020	5.7	0.2	748	131,035
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**
2020	5.6	0.2	729	130,693
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
2020	3.8	0.2	497	130,693
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
2020	1.8	0.1	232	130,693
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**
2020	208.9	12.7	273	130,693
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
2020	80.3	7.8	105	130,693
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
2021	5.8 %	0.9 %	7,132	123,699
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
2020	13.0	0.3	1,621	124,596
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
2020_2021	10.0 %	1.1 %	244,652	2,439,741
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**
2021	17.9	1.2	231	1,288,576
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
2021	37.0	1.5	592	1,598,703
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
2019_2021	8.0	0.6	194	2,417,649
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
2019_2021	8.4	0.6	202	2,417,649
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
2020_2021	22.7 %	1.5 %	592,908	2,614,069
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
2020_2021	18.0 %	2.8 %	106,567	592,908
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
2020_2021	4.5 %	0.9 %	97,576	2,167,221
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
2020_2021	9.7 %	1.1 %	210,048	2,160,838
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
2020_2021	55.2 %	4.9 %	193,354	350,140
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
2020_2021	90.2 %	1.1 %	2,348,185	2,603,839
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
2020	13.1 %	0.1 %	7,248	55,283
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 <20 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
2021	17.3 %	1.1 %	82,498	475,679
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
2020_2021	16.0 %	2.2 %	186,082	1,165,910
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**
2021	4.2 %	0.3 %	112,319	2,672,798
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
2018	74.4 %	2.9 %	103,000	138,000
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
2021_2022	64.4 %	1.1 %	1,582,148	2,455,254
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
2021	77.7 %	2.1 %	589,951	759,394
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
2021	91.1 %	1.3 %	692,094	759,394
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
2021	92.8 %	1.3 %	704,855	759,394
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
2021	11.5	0.2	4,643	401,993
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
2021	11.6 %	1.3 %	14,307	122,835
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
2020_2021	2.2 %	0.4 %	57,773	2,592,361
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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			78.2	78.8	79.4
Annual Indicator		77.6	75.2	74.3	71.3
Numerator		1,651,482	1,609,089	1,571,902	1,536,221
Denominator		2,128,688	2,140,534	2,115,148	2,154,160
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2020	2021

Previous NPM-1 BRFSS data for survey year 2017 that was pre-populated under the 2018 Annual Report Year is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	69.4	70.1	78.2	78.8	79.4
Annual Indicator	65.3	77.6			
Numerator					
Denominator					
Data Source	NIS	NIS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	78	80	86	87	88
Annual Indicator	83.8	84.2	82.9	76.9	74.8
Numerator	111,838	113,497	105,668	95,850	97,967
Denominator	133,410	134,782	127,530	124,715	131,013
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	20	23	30	32	34
Annual Indicator	25.6	26.9	25.9	23.6	24.6
Numerator	32,912	35,760	32,327	28,555	31,220
Denominator	128,398	132,966	124,942	121,059	126,762
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.6	82.1	85.3	87	88.6
Annual Indicator	81.2	83.1	82.4	81.8	81.6
Numerator	103,722	104,542	101,724	98,852	99,193
Denominator	127,773	125,760	123,405	120,823	121,571
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.6	82.1	85.3	87	88.6
Annual Indicator	81.2	83.1			
Numerator					
Denominator					
Data Source	PRAMS	PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective		32.3	37.7	39.8	41.9
Annual Indicator	31.5	36.6	39.8	38.8	42.6
Numerator	38,141	44,262	46,940	45,339	50,575
Denominator	121,226	120,893	118,085	116,778	118,589
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		32.3	37.7	39.8	41.9
Annual Indicator	31.5				
Numerator					
Denominator					
Data Source	PRAMS				
Data Source Year	2016-2017				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective		47.4	51.7	53.7	55.7
Annual Indicator	46.9	50.1	59.5	56.0	64.0
Numerator	56,601	60,875	70,513	65,435	75,742
Denominator	120,631	121,402	118,424	116,863	118,331
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		47.4	51.7	53.7	55.7
Annual Indicator	46.9				
Numerator					
Denominator					
Data Source	PRAMS				
Data Source Year	2016-2017				
Provisional or Final ?	Final				

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	184.9	183.1	126.2	113.1	100
Annual Indicator	152.5	139.4	139.8	135.4	132.5
Numerator	2,201	2,004	1,997	1,928	1,875
Denominator	1,443,388	1,437,802	1,428,611	1,423,977	1,414,571
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2016	2017	2018	2019	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	88.7	85	85	86	88
Annual Indicator	85.7	85.7	87.7	81.8	75.0
Numerator	715,291	715,291	659,147	679,581	678,512
Denominator	834,394	834,394	751,698	830,408	904,738
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	61	45	45	48	50
Annual Indicator	45.9	42.9	44.5	43.6	45.6
Numerator	234,614	223,990	244,784	255,237	270,075
Denominator	511,324	521,926	549,735	585,504	592,908
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			1
Annual Indicator	49.3	48.3	48.8
Numerator	1,027,215	985,573	986,512
Denominator	2,085,050	2,039,338	2,021,161
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			70.5	71
Annual Indicator			64.6	58.1
Numerator			197	18
Denominator			305	31
Data Source			Pennsylvania newborn screening data system	Pennsylvania newborn screening data system
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			5	3
Annual Indicator			3	2
Numerator				
Denominator				
Data Source			Bureau of Family Health internal documentation	Bureau of Family Health internal documentation
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	4.0	4.0	5.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Increase the percent of hospitals making referrals to Early Intervention (EI)

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			50
Annual Indicator			74.7
Numerator			56
Denominator			75
Data Source			NAS programmatic documentation
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			50
Annual Indicator			64.5
Numerator			790
Denominator			1,225
Data Source			NAS programmatic documentation
Data Source Year			2022
Provisional or Final ?			Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			94	94
Annual Indicator			93.1	90.9
Numerator			1,500,973	1,528,486
Denominator			1,612,808	1,680,853
Data Source			NSCH, Indicator 5.9, Pa. data	NSCH, Indicator 5.9, Pa. data
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			9.1	8.9
Annual Indicator			9.4	9.2
Numerator				
Denominator				
Data Source			NVSS	NVSS
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

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

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
n 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. 2022 (2021-2022) is an estimate of 9.2 and is based on the 2021 estimate, as updated HP2030 is not available.

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

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			11.2	10.7
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			HealthyPeople 2030	HealthyPeople 2030
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	25.9	25.9	23.9

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.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Health People 2030 changed the parameters of child mortality rates to combine all child mortality rates ages 1-19. Forthcoming reporting for this SPM will utilize data from CDC Wonder to better capture the measures and the actual annual indicators. CDC Wonder is a comparable data source for this measure. Projections for 2023, 2024, and 2025 have been updated to reflect the new data source.	

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

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			26.4	25.9
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			NVSS	NVSS
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
n 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**	**2022**
Annual Objective			24	24.5
Annual Indicator			55.2	45
Numerator			891	618
Denominator			1,615	1,374
Data Source			CMHD final reports	CMHD final reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			85	85.9
Annual Indicator			75.6	89.3
Numerator			198	167
Denominator			262	187
Data Source			CPP quarterly reports	CPP quarterly reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	86.8	87.7	88.6

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Percent of women and birthing people 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**	**2022**
Annual Objective			80	82.4
Annual Indicator			78.3	80.3
Numerator			2,243	2,880
Denominator			2,865	3,587
Data Source			IMPLICIT ICC quarterly and annual reports	IMPLICIT ICC quarterly and annual reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			3	4
Annual Indicator			3	0
Numerator				
Denominator				
Data Source			Philadelphia Department of Public Health	Philadelphia Department of Public Health, Healthy
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
PDPH experienced strong staff retention in 2022 and did not need to hire (or train) additional doulas. Healthy Start hired and began training doulas in Fy22-23, but training was not complete by the end of CY2022.

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			25	27
Annual Indicator			2	7
Numerator				
Denominator				
Data Source			Alliance of PA Inc. quarterly and annual reports	Alliance of PA Inc. quarterly and annual reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 birthing people 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	2022
Annual Objective			80	80.8
Annual Indicator			88	90.4
Numerator			373	433
Denominator			424	479
Data Source			IMPLICIT ICC and CPP quarterly reports CMHD annual	IMPLICIT ICC and CPP quarterly reports CMHD annual
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			3	3
Annual Indicator			0	58.2
Numerator			0	336
Denominator			1	577
Data Source			2021	2022
Data Source Year			IMPLICIT	IMPLICIT
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			3	0
Numerator				
Denominator				
Data Source			Philadelphia MMRC reporting to the Department	Philadelphia MMRC reporting to the Department
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			2	4
Numerator				
Denominator				
Data Source			meetings held	meetings held
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percent of Keystone 10 (K10) facilities that progressed by one or more steps each fiscal year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			60	60
Annual Indicator			41.2	21.3
Numerator			21	10
Denominator			51	47
Data Source			K10 program	K10 program
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			4	4
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			10
Annual Indicator		10	10
Numerator			
Denominator			
Data Source		agenda and meeting minutes	agenda and meeting minutes
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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**	**2022**
Annual Objective			15
Annual Indicator		15	15
Numerator			
Denominator			
Data Source		quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			infant program that implements recommendations	Infant Program that implements recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	3	3	0	0	6
Annual Indicator	6	6	0	5	1
Numerator					
Denominator					
Data Source	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	Grantee quarterly reports
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	8	9	18	9	37
Annual Indicator	8.6	17.4	0	36.1	41.2
Numerator	11,639	23,337		47,314	53,068
Denominator	135,498	134,091		131,006	128,959
Data Source	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	grantee quarterly reports and annual birthing data
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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					
	2018	2019	2020	2021	2022
Annual Objective	2	4	8	8	24
Annual Indicator	1.9	8.9	0	32.5	33.3
Numerator	2	9		27	28
Denominator	107	101		83	84
Data Source	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	grantee quarterly reports, birthing hospital count
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 Perinatal Periods of Risk (PPOR) data

Measure Status:	Active		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			1
Annual Indicator		0	17
Numerator			
Denominator			
Data Source		PPOR vendors quarterly and annual reports	PPOR vendors quarterly and annual reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			child program areas implementing recommendations	child program areas implementing recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			30	32
Annual Indicator			15	36
Numerator				
Denominator				
Data Source			quarterly grantee reports	quarterly grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

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

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		73
Numerator		
Denominator		
Data Source		grantee reports
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	180.0	90.0	0.0

Field Level Notes for Form 10 ESMs:

None

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

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		713
Numerator		
Denominator		
Data Source		Grantee reports
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	900.0	450.0	0.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	18	21	25	30	33
Annual Indicator	15	12	7	3	4.9
Numerator				2,698	5,698
Denominator				89,993	116,285
Data Source	Quarterly reports	Quarterly reports	Quarterly reports	quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4,500	4,550
Annual Indicator			540	3,573
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			90	90
Annual Indicator			99	94.7
Numerator			4,589	9,477
Denominator			4,635	10,007
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			45	45
Annual Indicator			9	259
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	60.0	60.0	60.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
ESM language was changed to measure the number of community-based organizations staff trained after the objective was established in the prior years. This revision occurred to more accurately reflect the program capacity and outcomes.

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**	**2022**
Annual Objective			3,880	3,880
Annual Indicator			4,681	7,039
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	4,730.0	4,730.0	4,730.0

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**	**2022**
Annual Objective			10,000	11,000
Annual Indicator			49,943	27,102
Numerator				
Denominator				
Data Source			grantee reports	grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			360	360
Annual Indicator			151	34
Numerator				
Denominator				
Data Source			grantee reports	grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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**	**2022**
Annual Objective			150	160
Annual Indicator			53	207
Numerator				
Denominator				
Data Source			grantee reports	grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			1	1
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			35	39
Annual Indicator			145	645
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			55	55
Annual Indicator		59.5	63.1	62.2
Numerator		13,448	9,536	7,437
Denominator		22,602	15,110	11,955
Data Source		Grantee reports	quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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 metho

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			8	8
Annual Indicator		9.4	11.1	12.3
Numerator		2,127	1,677	1,472
Denominator		22,602	15,110	11,955
Data Source		Grantee reports	quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			2	3
Annual Indicator			0	0
Numerator				
Denominator				
Data Source			CSHCN programs implementing recommendations	CSHCN programs implementing recommendations
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			475	498
Annual Indicator			302	654
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			50	52
Annual Indicator			20	17
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

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**	**2022**
Annual Objective			8	8
Annual Indicator			22	12
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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	2022
Annual Objective			40	43
Annual Indicator			0	3.7
Numerator				7
Denominator				190
Data Source			Philadelphia Department of Public Health	Philadelphia Department of Public Health
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			4	4
Annual Indicator			6	5
Numerator				
Denominator				
Data Source			agenda and meeting minutes	agenda and meeting minutes
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			50	110
Annual Indicator			103	134
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			500	515
Annual Indicator			315	463
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	530.0	545.0	560.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			8	8
Annual Indicator			43	10
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			40	44
Annual Indicator			137	76
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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	2022
Annual Objective			15	19
Annual Indicator			11	13
Numerator				
Denominator				
Data Source			quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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:	Inactive - Completed		
State Provided Data			
	2020	**2021**	**2022**
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			quarterly reports
Data Source Year			2022
Provisional or Final ?			Final

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**	**2022**
Annual Objective			20
Annual Indicator		11.2	22.8
Numerator		3,592	7,116
Denominator		31,964	31,156
Data Source		quarterly vendor/grantee reports	quarterly vendor/grantee reports
Data Source Year		2021	2022
Provisional or Final ?		Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	22.0	24.0	26.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.15 - Percent of families reporting through surveys that they were partners in decision making.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	80.0	80.0

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. However, 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>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>PHI-R06, Enhance the use and capabilities of informatics in public health, including data-sharing, data exchange, and application to practice and use in decision-making, is currently in research status. This means it is a high-priority public health issue that does not yet have evidence-based interventions developed to address it. It may or may not have reliable baseline data available. If both baseline data and evidence-based interventions become available, this objective may become a core Healthy People 2030 objective.</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.

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: 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</td></tr>
</table>

	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. 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 - Increase the percent of hospitals making referrals to Early Intervention (EI)
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 EI
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 Division of Newborn Screening and Genetics, 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. 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 3 is linked to the following ESM: ESM: Percent of NAS cases within iCMS referred to Early Intervention

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 Division of Newborn Screening and Genetics (DNSG), which oversees reporting of NAS cases by all PA birthing facilities. The data reported to the NAS program includes a Plan of Safe Care status. Tracking the percent of infants receiving a Plan of Safe Care allows the program to collaborate with the Office of Children, Youth, and Families (OCYF), the provider of the Plan of Safe Care, to provide technical assistance to hospital staff referring infants to OCYF. 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 4 is linked to the following ESM: ESM: Frequency data will be shared to enable OCYF and DNSG identify all infants who should have a Plan of Safe Care

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 ESM:

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:	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 are linked to the following ESM: ESM: Percentage of staff trained annually on the principles of Health Equity and the effectiveness of Health Equity plans
Significance:	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.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The goal is to narrow the mortality gap between majority and minority populations as a result of comprehensive programming, policy change and organizational action</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>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)</td></tr>
<tr><td>Denominator:</td><td>Number of live births</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>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)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data source is the 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.</td></tr>
<tr><td>Significance:</td><td>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</td></tr>
</table>

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 are linked to the following ESM:

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

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/birthing people completing evidence-based or -informed home visiting programs
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women/birthing people who complete Title V home visiting programs **Denominator:** Number of women/birthing people enrolled in Title V home visiting programs
Data Sources and Data Issues:	Annual reports from the County Municipal Health Department
Evidence-based/informed strategy:	Increase the percent of women/birthing people who successfully complete evidence-based or informed home visiting programs. Home visiting programs for pregnant and parenting women/people have shown to improve a number of birth outcomes including reduced incidence of preterm birth and low birth weight infants (Tabb, et al., 2022). Title V home visiting offers flexibility in enrollment, meeting the needs of the family where they are at and providing support during the prenatal, postpartum, newborn, and toddler stages, or they can choose to receive services during the entire duration of the program which provides additional support and resources to the family. Home visiting also positively affects the health and well-being of the birthing person. An important component of the Title V home visiting program is screening for maternal depression, both prenatally and postpartum, utilizing validated screening tools. Screenings done throughout the perinatal period have shown to be an equitable intervention for improving access to mental health services and care. Program completion varies by County Municipal Health Department but many offer home visiting services until the child is two years of age. Tabb, K. M., Bentley, B., Pineros-Leano, M., Simonovich, S. D., Nidey, N., Ross, K., Huang, W-H., & Huang, H. (2022). Home Visiting as an Equitable Intervention for Perinatal Depression: A Scoping Review. Frontiers in Psychiatry, 13, [826673]. https://doi.org/10.3389/fpsyt.2022.826673
Significance:	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, home visiting programs provide services such as screenings and connecting participants to resources during this period. Additionally, an important component of home visiting programs is connecting the people to needed services including preventive care.

ESM 1.2 - Percent of adolescents and women enrolled in Centering Pregnancy Programs who talked with a health care professional about birth spacing and birth control methods
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase time between pregnancies among Centering Pregnancy Program participants by increasing the percent of adolescents and women enrolled in Centering Pregnancy programs who talk with a professional about birth spacing or birth control methods</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents and women enrolled in Centering Pregnancy programs who talked with a healthcare professional about birth spacing and birth control methods</td></tr>
<tr><td>Denominator:</td><td>Number of women enrolled in Centering Pregnancy programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will be provided through the CPP grantees’ quarterly and annual reports.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Increase the percent of adolescents, women, and birthing people enrolled in centering pregnancy programs who talk with a health care professional about birth spacing or birth control methods.

Centering Pregnancy leads to better health outcomes including decreased rates of preterm birth and low birth weight infants, and better pregnancy spacing. Centering Pregnancy participants discuss birth spacing or birth control methods multiple times throughout the program. Birth spacing gives the body more time to fully recover from pregnancy. This is important as better birth spacing has shown to reduce adverse health outcomes including preterm birth, low birthweight, neonatal, and maternal mortality (Lonhart, et al., 2019)

Lonhart, J. A., Mayo, J. A., Padula, A. M., Wise, P. H., Stevenson, D. K., & Shaw, G. M. (2019). Short interpregnancy interval as a risk factor for preterm birth in non-Hispanic Black and White women in California. Journal of Perinatology: Official Journal of the California Perinatal Association, 39(9), 1175–1181. https://doi.org/10.1038/s41372-019-0402-1</td></tr>
<tr><td>Significance:</td><td>Conceiving within 12 months of delivery can cause heightened health risks for both mother and infant. The Centering Pregnancy Program (CPP) curriculum covers birth control and birth spacing at numerous points throughout the pregnancy and postpartum periods to encourage women to actively participate in interconception care.</td></tr>
</table>

ESM 1.3 - Percent of women and birthing people 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Change maternal behaviors and improve birth outcomes by screening women for four behavioral risk factors at well-child visits</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 mothers served through the IMPLICIT ICC program screened for four risk factors at a minimum of one well-child visit</td></tr>
<tr><td>Denominator:</td><td>Number of mothers served through the IMPLICIT ICC program in attendance at well-child visits</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from the IMPLICIT Interconception Care Program’s quarterly and annual reporting.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The IMPLICIT (Interventions to Minimize Preterm and Low birthweight Infants through Continuous Improvement Techniques) Network is a multi-state, family medicine, maternal-child health learning collaborative of the Family Medicine Education Consortium. The focus of the collaborative is on improving birth outcomes and promoting the health of women, birthing people, infants, and families through evidence-based interventions, innovative models of care, quality improvement, and professional development for current and future physicians. There are 36 IMPLICIT Network sites across 10 states. Of these, 13 are in Pennsylvania, making it the most represented state in the Network, in terms of both the number of sites and unique patients.

Individuals who are impacted by mental health, substance use, and chronic health conditions, and who experience an unintended pregnancy, are at higher risk of experiencing adverse pregnancy outcomes. Screening and intervention for family planning, depression, tobacco use, and multivitamin with folic acid use can address these risk factors prior to pregnancy.
Interconception care (ICC) is the use of medical and psychological interventions to address individuals’ risk factors between pregnancies, with the aim of improving future maternal and infant health outcomes. Family physicians are ideally positioned to lead health care system change related to ICC; even for those parents that lack providers of their own are likely to take their infants to their pediatric health care visits. Well-child visits in the first 2 years of life occur frequently (at 1 and 2 weeks and at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months), presenting family health providers with regular opportunities to screen for and address maternal risk factors.
The IMPLICIT Network developed an ICC model of care in 2012. Through this model, birthing people who accompany their children to WCVs from birth to 24 months are screened for four risk factors (tobacco use, depression risk, cont</td></tr>
<tr><td>Significance:</td><td>ICC has the capacity to reduce the persistent racial disparities in maternal and fetal birth outcomes. The leading underlying causes of infant mortality, particularly among Black babies, are low birthweight and pre-term birth (factors which are often connected). By offering biomedical, psychosocial, and behavioral interventions prior to pregnancy, the</td></tr>
</table>

influence of risk factors for adverse pregnancy outcomes, such as preterm birth, can be minimized. In addition, interconception care that includes contraceptive counseling can reduce rates of unintended pregnancies. 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 setting of interconception care has taken multiple forms, with people being provided ICC only during annual well-woman visits or at their postpartum checkup(s). However, in a system where most people do not routinely receive early postpartum care, birthing people may not see their maternal care provider until at least 6 weeks postpartum, if at all; many do not, or cannot, attend the six-week postpartum visit, due to time, childcare, work, and transportation constraints. Often, the first appointment a birthing person has with a provider after their baby's birth is with their infant's doctor – not their own -- when they take their newborn or child to their routine well-child visits. Working within the child-well visit framework provides family health providers with an opportunity to address mothers' health during the interconception period.

Despite broad consensus on the importance of preconception and interconception care, this care is still not routinely provided. To help address this gap, the IMPLICIT Network developed, piloted, and implemented a model for ICC in Pennsylvania. Through this model, birthing people are screened for four risk factors that contribute to poor birth outcomes and provide

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.
Evidence-based/informed strategy:	Community-based doulas provide an expanded set of services over conventional private-pay doulas, including connecting individuals with community resources and increasing the number of home visits during pregnancy and the postpartum period. Community-based doulas offer evidence-based, trauma-informed, and holistic emotional, physical, and informational support, education, and counseling to families during the perinatal period. These community care workers provide continuous labor support to individuals and families; conduct in-person and virtual visits throughout pregnancy and the postpartum period; accompany clients to healthcare and social service appointments; provide support related to loss of pregnancy or infant; and connect individuals to community-based, and state/federally funded resources, including those which address need within the social determinants of health. They focus on eliminating health barriers and disparities and promoting healthy bonding between pregnant people and their babies. In contrast to conventional doulas, community-based doulas typically share the same background, culture, and language as the pregnant people they support. They also have additional training in SDOH, trauma, and racial equity that supplements the mainstream doula education curriculum. Doula care improves maternal health outcomes by reducing unnecessary medical procedures that can result in serious short- and long-term complications. A 2017 Cochrane systematic review analyzed data from 26 individual studies involving more than 15,000 women. The review found numerous benefits to continuous labor support, including: • 83% reduction in non-indicated cesarean deliveries, and a 59% reduction in odds of cesarean delivery overall • 15% greater likelihood of a spontaneous vaginal birth (without vacuum or forceps) • 10% reduction in the use of pain medications • Shorter labor by an average of 41 minutes • 31% reduction in reporting a negative birth experience
Significance:	Doula support can improve birth outcomes and has the potential to reduce health disparities and improve health equity. Globally, the United States ranks 60th in maternal mortality, even though it spends more than any other country on maternal care. According to a 2022 brief from the Commonwealth Fund, among birthing people in high-income countries, rates of preventable pregnancy-related deaths are highest in the United States. Importantly, per the CDC's Pregnancy Mortality Surveillance System, significant racial disparities continue to exist nationally, with Black women and birthing people experiencing a maternal mortality rate three times higher than that of those who are White. These disparities are attributed to many

factors, including inequities in housing, environmental conditions, economic opportunity, and access to health care, which have resulted from the nation's history of racism, discrimination, and inequitable policies.

If implemented with a focus on equitable access, and community-based doula support can reduce persistent and pervasive racial disparities in maternal health outcomes. Within local communities, doulas often serve as trusted sources of information, advocacy and navigation throughout the perinatal period. By providing culturally concordant, continuous support and evidence-based information across the entire pregnancy, doulas can contribute to improved maternal and infant outcomes and experiences by reducing stress, anxiety, and pain, and by promoting self-efficacy and confidence. According to this 2022 ASPE Issue Brief, individuals' labor and delivery that were supported by doula care had lower cesarean and preterm birth rates and improved rates of breastfeeding initiation. By supporting clients in advocating for their personal care preferences, doulas can help reduce the detrimental effects of racism and implicit bias and prevent unwarranted and undesired clinical interventions.

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 birthing people 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 birthing people 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 birthing people 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>Evidence-based/informed strategy:</td><td>ICC has the capacity to reduce the persistent racial disparities in maternal and fetal birth outcomes. The leading underlying causes of infant mortality, particularly among Black babies, are low birthweight and pre-term birth (factors which are often connected). By offering biomedical, psychosocial, and behavioral interventions prior to pregnancy, the influence of risk factors for adverse pregnancy outcomes, such as preterm birth, can be minimized. In addition, interconception care that includes contraceptive counseling can reduce rates of unintended pregnancies. 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 setting of interconception care has taken multiple forms, with people being provided ICC only during annual well-woman visits or at their postpartum checkup(s). However, in a system where most people do not routinely receive early postpartum care, birthing people may not see their maternal care provider until at least 6 weeks postpartum, if at all; many do not, or cannot, attend the six-week postpartum visit, due to time, childcare, work, and transportation constraints. Often, the first appointment a birthing person has with a provider after their baby’s birth is with their infant’s doctor – not their own -- when they take their newborn or child to their routine well-child visits. Working within the child-well visit framework provides family health providers with an opportunity to address mothers’ health during the interconception period.

Despite broad consensus on the importance of preconception and interconception care, this care is still not routinely provided. To help address this gap, the IMPLICIT Network developed, piloted, and implemented a model for ICC in Pennsylvania. Through this model, birthing people are screened for four risk factors that contribute to poor birth outcomes and provide</td></tr>
<tr><td>Significance:</td><td>Screening tools can identify the need for services and improve birth outcomes for birthing people and their infants. Additionally, screening provides maternal and family healthcare providers and home visitors with the opportunity to assess birthing parent’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>Evidence-based/informed strategy:</td><td>In 2018, the American College of Obstetricians and Gynecologists called for a new paradigm for postpartum care that addresses the current needs of birthing people, including earlier contact, and protects against morbidity and mortality after pregnancy. In response, and to eliminate gaps in care that people receive during the early postpartum period, the IMPLICIT Network developed a 4th trimester model of care (also known as 4TM).
The 4TM model aims to identify high risk patients, who may have mood concerns, obesity or wound concerns, thyroid disorders, hypertensive disorders, endocrine disorders, renal disease, or substance use disorders. 4TM providers create a postpartum registry of anyone who received prenatal care at the practice starting at 28 weeks gestation, or anyone that delivered by the practice, and prioritizes getting patients back into the office to see their providers between 7 and 21 days after delivery. Providers develop a plan for the early postpartum visit when the patient is between 28 weeks gestation and delivery.
4TM providers collect patient data from multiple encounters, including at prenatal visits, immediately after delivery, and during the early postpartum visit. At the early postpartum visit, 4TM connects patients with any needed psychosocial, biomedical, and other wrap-around services or referrals. To reduce fragmentation of care across providers and settings, providers establish a care team, which may include a primary care provider, specialty physician, lactation consultant, mental and behavioral health providers, and a case manager.

Stumbras, K., Rankin, K., Caskey, R., Haider, S., & Handler, A. (2016). Guidelines and Interventions Related to the Postpartum Visit for Low-Risk Postpartum Women in High and Upper Middle Income Countries. Maternal and child health journal, 20(Suppl 1), 103–116. https://doi.org/10.1007/s10995-016-2053-6

Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: a critical transition per</td></tr>
<tr><td>Significance:</td><td>Pregnancy care has traditionally been organized into three trimesters, with a single</td></tr>
</table>

postpartum visit at approximately six weeks postpartum. The timing of this visit contradicts the evidence that shows over 50% of pregnancy-related deaths occur after the birth of the infant, and 40% of these deaths occur by six weeks postpartum. As many of 40% of individuals don't see their maternity provider at all after discharge from the hospital or birth center, with rates even lower among people who are Black. For those that attend their six-week appointment, it may be too late. By six weeks postpartum, the ability of providers to assist patients with concerns about maternal mental health, birth control and birth spacing, physical recovery from childbirth, substance use, and other issues is reduced significantly. For some patients, this delay in receiving care results in severe morbidity or mortality. An earlier postpartum visit has the potential to reduce preventable deaths, by ensuring birthing people get the care they need before their conditions worsen.

Early postpartum care decreases mortality risk, particularly among birthing people who have chronic medical conditions like hypertensive disorders. With the 4TM model, birthing people that are identified to be high risk for postpartum complications are scheduled for an early postpartum visit, between 7 and 21 days after birth. At this visit, they are connected to psychosocial, biomedical, and other wrap-around services, as needed. By helping patients recognize warning signs, get an accurate and timely diagnosis, and have access to quality care, the 4TM model of postpartum care decreases their risk of maternal morbidity and mortality.

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
Evidence-based/informed strategy:	Maternal Mortality Review Committees identify, review, and characterize pregnancy-related deaths; and identify prevention opportunities, in order to facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and better understand associated disparities; determine what interventions at patient, provider, facility, system, and community levels will have the most effect; and inform the implementation of initiatives in the right places for families and communities who need them most. Through the CDC's standardized tools and technical assistance, MMRCs can collaborate around a shared data framework and initiate discussions around how the data can inform improvement activities. The potential impact of MMRCs on maternal mortality rates, particularly where there are disparities, is significant. Examples of MMRC in the evidence base include the following articles: Callahan, T., Zaharatos, J., St Pierre, A., Merkt, P. T., & Goodman, D. (2021). Enhancing Reviews and Surveillance to Eliminate Maternal Mortality. Journal of women's health (2002), 30(8), 1068–1073. https://doi.org/10.1089/jwh.2021.0357 Kramer, M. R., Strahan, A. E., Preslar, J., Zaharatos, J., St Pierre, A., Grant, J. E., Davis, N. L., Goodman, D. A., & Callaghan, W. M. (2019). Changing the conversation: applying a health equity framework to maternal mortality reviews. American journal of obstetrics and gynecology, 221(6), 609.e1–609.e9. https://doi.org/10.1016/j.ajog.2019.08.057 Report from Maternal Mortality Review Committees: A View into their Critical Role. Building U.S. Capacity to Review and Prevent Maternal Deaths. 2017. https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIAReport.pdf Trost, S. L., Beauregard, J. L., Smoots, A. N., Ko, J. Y., Haight, S. C., Moore Simas, T. A., Byatt, N., Madni, S. A., & Goodman, D. (2021). Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008-17. Health affairs
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 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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)</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>The number of meetings held between the DOH, DHS and DHS' MIECHV Program.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Agendas and meeting minutes will serve as the data source and will be used to determine the number of collaborative meetings held.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The goal of eliminating health disparities cannot be accomplished by a single sector or entity. The causes of health disparities are complex and multifactorial and stem from not only the health care sector but also the social determinants of health (i.e., the conditions in which people are born, grow, live, work, and age). Sustainable partnerships among government agencies, as well as public–private partnerships exemplify the importance of collaborative engagement needed to accomplish this goal (Towe, et al., 2016). Collaboration across sectors can promote efficiency by identifying issues being addressed by multiple agencies and fostering discussion of how agencies can share resources and reduce redundancies, thus potentially decreasing costs and improving performance and outcomes (Rudolph, Caplan, Ben-Moshe, & Dillon , 2013).

Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon , L. (2013). Health in All Policies: A Guide for State and Local Governments . Washington, DC and Oakland, CA: American Public Health Institution and Public Health Institute. Retrieved from https://www.apha.org/-/media/Files/PDF/factsheets/Health_inAll_Policies_Guide_169pages.ashx
Towe, V. L., Leviton, L., Chandra, A., Sloan, J. C., Tait, M., & Orleans, T. (2016). Cross-Sector Collaborations And Partnerships: Essential Ingredients To Help Shape And Well-Being. Health Affairs (Project Hope), 35(11), 1964-1969. Retrieved from https://doi.org/10.1377/hlthaff.2016.0604</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 4.1 - Percent of Keystone 10 (K10) 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 Pa. birthing facilities that have completed one or more steps **Denominator:** Total number of Pa. birthing facilities participating in K10
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.
Evidence-based/informed strategy:	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% (Bartick, Boisvert, Phillip, & Feldman-Winter, 2020). 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 (Baby-Friendly USA, 2018).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. Baby-Friendly USA. (2018). The Ten Steps to Successful Breastfeeding. Bartick, M., Boisvert, M. E., Phillip, B. L., & Feldman-Winter, L. (2020). Trends in Breastfeeding Interventions, Skin-to-Skin Care, and Sudden Infant Death in the First 6 Days After Birth. The Journal of Pediatrics, 218, 11-15. Retrieved from https://doi.org/10.1016/j.peds.2019.09.069
Significance:	Improving breastfeeding initiation and duration rates is necessary to reduce infant mortality, and the completion of Keystone 10 steps leads to better breastfeeding rates within all target populations.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Annually collaborate with the Safe Sleep Program to identify and develop collaborative opportunities</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 collaborative meetings held between the Breastfeeding Program and the Safe Sleep Program</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The number of collaborative meetings held with the Safe Sleep Program will be collected by the breastfeeding program staff.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The American Academy of Pediatrics (AAP) recommends that all babies should sleep on their back on a firm, flat, non-inclined surface. The AAP additionally recommends that parents should sleep in the same room, but not the same bed as a baby. The AAP also states that breastfeeding reduces the risk of sleep-related infant deaths (American Academy of Pediatrics, 2022). It is therefore important for others serving those populations to have an effective understanding of both breastfeeding and safe sleep practices.

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.

American Academy of Pediatrics. (2022). American Academy of Pediatrics Updates Safe Sleep Recommendations Back is Best.</td></tr>
<tr><td>Significance:</td><td>Collaborative opportunities 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 is important, as it provides others serving those target populations an effective understanding of breastfeeding.</td></tr>
</table>

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>Provide breastfeeding education, community outreach and improve breastfeeding initiation and duration rates in target populations.</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>Research shows that mothers are more likely to breastfeed with continued support from their families and communities. The Surgeon General’s Call to Action to Support Breastfeeding recommends that public health professionals work directly with community-based organizations to support breastfeeding (Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women's Health (US), 2011). PA AAP will collaborate with community-based organizations and partners by hosting regional collaborative meetings for birthing facilities and community partners. Pre- and post-surveys will be utilized to assess knowledge gained, barriers to education and services, and determine the ongoing needs of the region.

Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women's Health (US). (2011). The Surgeon General's Call to Action to Support Breastfeeding. Rockville, MD: Office of the Surgeon General. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK52682/</td></tr>
<tr><td>Significance:</td><td>Breastfeeding is an important component to combat infant mortality. The collaborative meetings serve as an opportunity to provide education and resources to all partners, regionally and statewide, and to work with target populations</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:	Provide resources for community partners to provide breastfeeding education, community outreach and improve breastfeeding initiation and duration rates in target populations.
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:	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% (Bartick, Boisvert, Phillip, & Feldman-Winter, 2020). The Surgeon General's Call to Action to Support Breastfeeding, recommends using community-based organizations to both support and promote breastfeeding (Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women's Health (US), 2011). PA AAP will collaborate with community-based organizations and partners by distributing mini-grants that are focused on improving initiation and duration breastfeeding rates in areas of need based on target population demographics. Bartick, M., Boisvert, M. E., Phillip, B. L., & Feldman-Winter, L. (2020). Trends in Breastfeeding Interventions, Skin-to-Skin Care, and Sudden Infant Death in the First 6 Days After Birth. The Journal of Pediatrics, 218, 11-15. Retrieved from https://doi.org/10.1016/j.peds.2019.09.069 Office of the Surgeon General (US); Centers for Disease Control and Prevention (US); Office on Women's Health (US). (2011). The Surgeon General's Call to Action to Support Breastfeeding. Rockville, MD: Office of the Surgeon General. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK52682/
Significance:	Improving breastfeeding initiation and duration rates is necessary to reduce infant mortality. Providing community-based support to low income and minority populations leads to better breastfeeding rates statewide as well as in target populations.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Implement recommendations that are provided from the Child Death Review Team on infant deaths and SUID related deaths in order to inform infant programming</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>The number of recommendations implemented</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data will come from infant program areas that review and implement recommendations.

2020 Child Death Review Annual Report (pa.gov)</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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 are used to make recommendations to inform prevention strategies and programming. Through this program, deaths among Pennsylvania’s children can be better understood and interventions designed to prevent future deaths can be identified (Bureau of Family Health, Division of Bureau Operations, 2022).

Data from CDC WONDER and Bureau of Health Statistics and Registries show that, both nationally and in Pennsylvania, the largest rate of deaths occurring in 2020, by age group, was infants, children less than 1 year old. Over one-third of the 2020 deaths reviewed by local CDR teams were deaths among infants. The majority of infant deaths, 47.1%, were due to prematurity ((Bureau of Family Health, Division of Bureau Operations, 2022, p. 5) and 18.8% were SUID-related cases ((Bureau of Family Health, Division of Bureau Operations, 2022, p. 21). Further, racial disparities in this population persist with CDC WONDER data for Pennsylvania showing that Black or African American infants die of SUID at more than twice the rate of white infants (Bureau of Family Health, Division of Bureau Operations, 2022, p. 21).

Actionable recommendations developed by CDR teams could promote changes to systems of care and aid in the implementation of preventive strategies impacting infant death. However, CDR teams may require guidance in developing recommendations that clearly identify what systems need to do in order to achieve change.

Bureau of Family Health, Division of Bureau Operations. (2022). Child Death Review Annual Reports: Deaths Occurring in 202. PA Department of Health, Harrisburg . Retrieved from https://www.health.pa.gov/topics/Documents/Programs/2022%20CDR%20Annual%20Report.pdf</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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.
Evidence-based/informed strategy:	A bundled intervention of safe sleep risk reduction interventions provided in the hospital at room orientation, rather than discharge, resulted in significantly more infants with safe sleeping practices while in the hospital setting (Mason, Ahlers-Schmidt, & Schunn, 2013). Mason, B., Ahlers-Schmidt, C., & Schunn, C. (2013). Improving Safe Sleep Environments for Well Newborns in the Hospital Setting. Clinical Pediatrics, 52(10), 969-975. doi:https://doi.org/10.1177.0009922813495954
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>Evidence-based/informed strategy:</td><td>A bundled intervention of safe sleep risk reduction interventions provided in the hospital at room orientation, rather than discharge, resulted in significantly more infants with safe sleeping practices while in the hospital setting (Mason, Ahlers-Schmidt, & Schunn, 2013).

Mason, B., Ahlers-Schmidt, C., & Schunn, C. (2013). Improving Safe Sleep Environments for Well Newborns in the Hospital Setting. Clinical Pediatrics, 52(10), 969-975. doi:https://doi.org/10.1177.0009922813495954</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 1990s 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

<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 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>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Quarterly and 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.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>A bundled intervention of safe sleep risk reduction interventions provided in the hospital at room orientation, rather than discharge, resulted in significantly more infants with safe sleeping practices while in the hospital setting (Mason, Ahlers-Schmidt, & Schunn, 2013).

Mason, B., Ahlers-Schmidt, C., & Schunn, C. (2013). Improving Safe Sleep Environments for Well Newborns in the Hospital Setting. Clinical Pediatrics, 52(10), 969-975. doi:https://doi.org/10.1177.0009922813495954</td></tr>
<tr><td>Significance:</td><td>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% of births.</td></tr>
</table>

ESM 5.5 - Number of targeted prevention initiatives or interventions implemented using Perinatal Periods of Risk (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:	PPOR is a comprehensive approach for addressing high infant mortality rates at the community level, and disparities in those rates. PPOR was initially developed between 2000-2004 by CityMatCH and its member health departments with support of the Centers for Disease Control and Prevention and the March of Dimes. It was adapted for U.S. cities from an approach used by the World Health Organization. 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 reinvestment) contribute to making data a powerful agent for systems change, but at the core of PPOR are its analytic methods. Studies supporting the use of the PPOR process to select or develop effective strategies to prevent infant mortality are available in the MCH Library and are listed below: Besculldes, M, & Laraque, F (2005). Racial and ethnic disparities in perinatal mortality: Applying the perinatal periods of risk model to identify areas for intervention. Journal of the National Medical Association, 97(8), 1128-1132. Burns, P (2005). Reducing infant mortality rates using the perinatal periods of risk model. Public Health Nursing, 22(1), 2-7. Chao, SM, Donatoni, G, Bemis, C, Donovan, K, Harding, C, Davenport, D (

Significance:	While the national infant mortality rate has declined over time, the Black-white gap in infant mortality has continued to increase. Prematurity, low birthweight, and preterm-related causes are generally understood to be the largest contributors to this persistent disparity. However, communities are often not uniformly aware of their root causes of infant mortality or aligned in how to best respond. Because of this, actions to reduce these disparities can be less impactful. 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. 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 community-based programming to promote the use of relevant data to inform decision-making, evaluate population and programmatic needs, and implement interventions to reduce infant mortality at the community level. 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. Grantees must address at least three of the 12 points on Dr. Michael Lu's plan to close the Black-White gap in birth outcomes, when selecting initiatives or interventions for inclusion in the PPOR community action plan. As the Pennsylvania Title V program works to prevent infant mortality and transform systems of inequality, PPOR can be utilized by communities to assess root causes, identify strategies for action, and contribute to meaningful change among the populations that are most impacted.

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.
Evidence-based/informed strategy:	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 (Bureau of Family Health, Division of Bureau Operations, 2022). The BFH will review for feasibility and implement prevention-related CDR recommendations in order to reduce child death overall and will track the number of CDR recommendations implemented. Actionable recommendations developed by CDR teams could promote changes to systems of care and aid in the implementation of preventive strategies impacting child death. However, CDR teams may require guidance in developing recommendations that clearly identify what systems need to do in order to achieve change. Bureau of Family Health, Division of Bureau Operations. (2022). Child Death Review Annual Reports: Deaths Occurring in 2020. PA Department of Health, Harrisburg . Retrieved from https://www.health.pa.gov/topics/Documents/Programs/2022%20CDR%20Annual%20Report.pdf
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
ESM Subgroup(s):	Children 0 through 9
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.
Evidence-based/informed strategy:	According to the Children's Safety Network in their 2019 report Evidence-based and Evidence-informed Strategies for Child and Adolescent Injury Prevention, education and training to prevent sports-related injuries was found to be effective in reducing the incidence of injuries. It also stated that while concussions can be caused by many different activities, they are particularly common among children and adolescents who play contact sports. Children's Safety Network. (2019). Evidence-based and Evidence-Informed Strategies for Child and Adolescent Injury Prevention. Retrieved from https://childrenssafetynetwork.org/sites/default/files/Evidence-Based%20Strategies%20FINAL.pdf
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. Children's Safety Network. (2019). Evidence-based and Evidence-Informed Strategies for Child and Adolescent Injury Prevention. Retrieved from https://childrenssafetynetwork.org/sites/default/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.

Children's Safety Network. (2019). Evidence-based and Evidence-Informed Strategies for Child and Adolescent Injury Prevention. Retrieved from https://childrenssafetynetwork.org/sites/default/files/Evidence-Based%20Strategies%20FINAL.pdf</td></tr>
<tr><td>Significance:</td><td>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.</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>Evidence-based/informed strategy:</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 in 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 substance, 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 (Strengthen the Evidence Base for MCH Programs).

Strengthen the Evidence Base for MCH Programs. (n.d.). Evidence Tools: NPM 10 Adolescent Well-Visit. Retrieved July 14, 2023, from MCH Evidence: mchevidence.org/tools/npm/10-adolescent-well-visit.php</td></tr>
<tr><td>Significance:</td><td>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. Transportation barriers are often cited as barriers to healthcare access. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use (Syed, Gerber, & Sharp, 2013). 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.

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: transportation barriers to health care access. . Journal of community health , 38(5), 976-993. Retrieved from https://doi.org/10.1007/s10900-013-9681-1</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.
Evidence-based/informed strategy:	Mental health problems among youth, defined as experiences of emotional or psychological distress that affect daily functioning, are a serious public health issue in the United States. Failure to address mental health problems that emerge in adolescence, even symptoms that do not meet the criteria for a diagnosable disorder, can have severe consequences, including poor relationships, substance use, truancy, school failure, justice system involvement, and suicide. However, most adolescents in need of care never receive it. Pathways to engaging youth in services begin with the identification of a problem, followed by a decision to seek or accept help, and end with selection and receipt of services. Multiple individual, interpersonal, and structural factors are known to influence service pathways. Underserved youth, in particular, racial/ethnic minority youth and youth from low-income households, face additional barriers that make them less likely to receive care (DeFosset, Gase, Ijadi-Maghsoodi, & Kuo, 2017) 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 (AccessMatters, 2019).
Significance:	The National Institutes of Health has noted that research has shown a lack of focus on prevention of behavioral health issues among adolescents such as substance use, sexual risk behaviors, and violence and that involving multiple systems within the community, beyond mental health systems, is necessary (Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine, 2016). HRCs provide a crucial role in referring adolescents to appropriate services to address these, and other, issues. Measuring the number of referrals made each year is important to ensure the number of referrals each year increases. Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. (2016). Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington, DC: National Academies Press (US). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK384915/ doi: 10.17226/23442

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 of 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>Evidence-based/informed strategy:</td><td>Mental health problems among youth, defined as experiences of emotional or psychological distress that affect daily functioning, are a serious public health issue in the United States. Failure to address mental health problems that emerge in adolescence, even symptoms that do not meet the criteria for a diagnosable disorder, can have severe consequences, including poor relationships, substance use, truancy, school failure, justice system involvement, and suicide. However, most adolescents in need of care never receive it. Pathways to engaging youth in services begin with the identification of a problem, followed by a decision to seek or accept help, and end with selection and receipt of services. Multiple individual, interpersonal, and structural factors are known to influence service pathways. Underserved youth, in particular, racial/ethnic minority youth and youth from low-income households, face additional barriers that make them less likely to receive care.

Health Resource Centers (HRCs) support the overall health and well-being of youth (AccessMatters, 2019). HRCs are located in school 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 healthy relationships and behaviors regarding human sexuality and encouraging critical thinking around sexual activity (DeFosset, Gase, Ijadi-Maghsoodi, & Kuo, 2017).

US Department of Health and Human Services . (n.d.). Healthy Relationships in Adolescence. Retrieved July 14, 2023, from Office of Population Affairs: https://opa.hhs.gov/adolescent-health/healthy-relationships-adolescence</td></tr>
<tr><td>Significance:</td><td>Mental health problems among youth, defined as experiences of emotional or psychological distress that affect daily functioning, are a serious public health issue in the United States. Failure to address mental health problems that emerge in adolescence, even symptoms that do not meet the criteria for a diagnosable disorder, can have severe consequences, including poor relationships, substance use, truancy, school failure, justice system involvement, and suicide. However, most adolescents in need of care never receive it. Pathways to engaging youth in services begin with the identification of a problem, followed by a decision to seek or accept help, and end with selection and receipt of services. Multiple individual, interpersonal, and structural factors are known to influence service pathways. Underserved youth, in particular, racial/ethnic minority youth and youth from low-income</td></tr>
</table>

households, face additional barriers that make them less likely to receive care.

Health Resource Centers (HRCs) support the overall health and well-being of youth (AccessMatters, 2019). HRCs are located in school 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 healthy relationships and behaviors regarding human sexuality and encouraging critical thinking around sexual activity (DeFosset, Gase, Ijadi-Maghsoodi, & Kuo, 2017).

US Department of Health and Human Services . (n.d.). Healthy Relationships in Adolescence. Retrieved July 14, 2023, from Office of Population Affairs: https://opa.hhs.gov/adolescent-health/healthy-relationships-adolescence

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.

Measure Status:	Active
Goal:	Increase the number of community-based organizations participating in a bullying awareness and prevention program
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** Number of community-based organization staff trained in the OBPP **Denominator:**
Data Sources and Data Issues:	Data collection and analysis will be performed by the Grantees. It will be a grant deliverable as required by the work statement and reported to the Department of Health via quarterly reports and during site visits. 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 (Centers for Disease Control and Prevention, 2019). Bullied LBGTQ 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 (Stopbullying.gov, n.d.). Centers for Disease Control and Prevention. (2019). Youth Risk Behavior Survey Data. www.cdc.gov/yrbs. Stopbullying.gov. Bullying of LBGT Youth and Those Perceived to Have Different Sexual Orientations [Fact Sheet]. https://www.stopbullying.gov/sites/default/files/2017-09/lgbtyouthtipsheet.pdf
Evidence-based/informed strategy:	The OBPP is an evidence-based program designed to address, prevent, and reduce bullying in school-aged children (Olweus, 1994). In partnership with Clemson University who administered the curriculum, and who trained and certified staff from selected community youth organizations (CYO), this program provides years of research, developmentally appropriate strategies, intervention techniques, environmental support, established surveys, staff engagement, and other practical applications to assist CYOs in implementing anti-bullying practices in order to improve social-emotional outcomes among youth in Pennsylvania. Olweus, D. (1994). Bullying at school: basic facts and effects of a school based intervention program. Journal of child psychology and psychiatry, and allied disciplines, 35(7), 1171-1190. Retrieved from https://doi.org/10.1111/j.1469-7610.1994.tb01229.x
Significance:	According to the Bullying in US Schools 2019 Status Report using data from the Olweus Bullying Questionnaire, 17% of all students were involved in bullying by either being bullied (12%), bullying others (3%), or both being bullied and bullying others (2%) (Luxenberg, Limber, & Olweus, 2019). 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 (National Center for Education Statistics, 2022).

National Center for Education Statistics. (2022). Bullying at School and Electronic Bullying. U.S. Department of Education, Institute of Education Science. Condition of Education.

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 Grantees. It will be a grant deliverable as required by the work statement and reported to the Department of Health via quarterly reports.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The OBPP is an evidence-based program designed to address, prevent, and reduce bullying in school-aged children (Olweus, 1994). In partnership with Clemson University who administered the curriculum and trained and certified staff from selected community youth organizations (CYO), this program provides years of research, developmentally appropriate strategies, intervention techniques, environmental support, established surveys, staff engagement, and other practical applications to assist youth participants improve their social-emotional well-being that result positive behavioral outcomes.

Olweus, D. (1994). Bullying at school: basic facts and effects of a school based intervention program. Journal of child psychology and psychiatry, and allied disciplines, 35(7), 1171-1190. Retrieved from https://doi.org/10.1111/j.1469-7610.1994.tb01229.x</td></tr>
<tr><td>Significance:</td><td>According to the Bullying in US Schools 2019 Status Report using data from the Olweus Bullying Questionnaire, 17% of all students were involved in bullying by either being bullied (12%), bullying others (3%), or both being bullied and bullying others (2%) (Luxenberg, Limber, & Olweus, 2019).
Bullying affects youth in negative 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 (National Center for Education Statistics, 2022).

Luxenberg, H., Limber, S. P., & Olweus, D. (2019). Bullying in U.S. Schools: 2019 Status Report. Hazelden Publishing. Retrieved from https://olweus.sites.clemson.edu/documents/Status%20Report_2019.pdf
National Center for Education Statistics. (2022). Bullying at School and Electronic Bullying. U.S. Department of Education, Institute of Education Science. Condition of Education .</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.
Evidence-based/informed strategy:	Dissemination of medically accurate information is imperative to reducing risk to adolescents (Centers for Disease Control and Prevention). According to the CDC, increasing access to and awareness of an array of health services (sexual, physical, relational) has positive impacts on adolescents. Adolescents require regular health care services in order to reduce risk. Centers for Disease Control and Prevention. (n.d.). Adolescents, Technology and Reducing Risk for HIV, STDs and Pregnancy. Retrieved from https://www.cdc.gov/std/life-stages-populations/Adolescents-white-paper.pdf
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>Evidence-based/informed strategy:</td><td>Dissemination of medically accurate information is imperative in reducing risk to adolescents (Centers for Diseason Control and Prevention). According to the CDC, increasing access to and awareness of an array of health services (sexual, physical, relational) has positive impacts on adolescents. Adolescents require regular health care services in order to reduce risk and make informed decisions regarding their care. Provisional of appropriate referrals is an integral part of reducing risk and informing decisions.

Centers for Diseason Control and Prevention. (n.d.). Adolescents, Technology and Reducing Risk for HIV, STDs and Pregnancy. Retrieved from https://www.cdc.gov/std/life-stages-populations/Adolescents-white-paper.pdf</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.
Evidence-based/informed strategy:	A 2018 report found that people with TBIs have a significantly greater risk for opioid misuse and overdose. In addition, people with TBIs often have difficulty managing these prescriptions due to memory lapses and reduced impulse control (National Institute on Disability, Independent Living, and Rehabilitation Research, 2018). National Institute on Disability, Independent Living, and Rehabilitation Research. (2018). Summary of Responses from a Request for Information: People with Disabilities and Opioid Use Disorder. US Department of Health and Human Services, Administration for Community Living . Retrieved from https://acl.gov/sites/default/files/news%202018-05/20180502NIDILRROpioidRFIFindings.pdf
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.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Implement a minimum of one CDR recommendation annually within Adolescent Health programming</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>The number of CDR recommendations implemented 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 on the number of recommendations reviewed for feasibility and implemented will be collected internally by the Bureau of Family Health.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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 (Bureau of Family Health, Division of Bureau Operations, 2022). 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.

Actionable recommendations developed by CDR teams could promote changes to systems of care and aid in the implementation of preventive strategies impacting adolescent death. However, CDR teams may require guidance in developing recommendations that clearly identify what systems need to do in order to achieve change.

Bureau of Family Health, Division of Bureau Operations. (2022). Child Death Review Annual Reports: Deaths Occurring in 2020. PA Department of Health, Harrisburg . Retrieved from https://www.health.pa.gov/topics/Documents/Programs/2022%20CDR%20Annual%20Report.pdf</td></tr>
<tr><td>Significance:</td><td>Data from CDR can inform providers and systems of care on the need for targeted interventions to reduce the rate of child death.</td></tr>
</table>

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:** 1,000 **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.
Evidence-based/informed strategy:	Through the work of Futures Without Violence, the CDC has recognized the CBIM Curriculum as evidence based. According to Miller et al. (2020), “an athletic coach–delivered program for middle school male athletes is an effective strategy for reducing relationship abuse among younger adolescents.” Miller, E., Jones, K. A., Ripper, L., Paglisotti, T., Mulbah, P., & Abebe, K. Z. (2020). An Athletic Coach-Delivered Middle School Gender Violence Prevention Program: A Cluster Randomized Clinical Trial. JAMA pediatrics, 174(3), 241-249. Retrieved from https://doi.org/10.1001/jamapediatrics.2019.5217
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>Evidence-based/informed strategy:</td><td>Access to most and moderately effective contraception methods, as a tool to reduce unintended pregnancy in adolescents, reduces overall risk to adolescents. Adolescents require regular health care services to receive comprehensive sexual and reproductive health counseling about the importance of delaying the initiation of sexual activity and about their contraceptive options, including counseling on which method would be best for them and on how to use that method correctly and consistently (Centers For Disease Control and Prevention, n.d.).

Centers For Disease Control and Prevention. (n.d.). Health Care Providers and Teen Pregnancy Prevention. Retrieved from Centers for Disease Control and Prevention : https://www.cdc.gov/teenpregnancy/health-care-providers/index.htm</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 (U.S. Department of Health and Human Services, Office of Population Affairs, n.d.).

Centers For Disease Control and Prevention. (n.d.). Health Care Providers and Teen Pregnancy Prevention. Retrieved from Centers for Disease Control and Prevention : https://www.cdc.gov/teenpregnancy/health-care-providers/index.htm</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 metho

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>Evidence-based/informed strategy:</td><td>According to the CDC, increasing access to the use of Long-Acting Reversible Contraception (LARC) can reduce contraceptive non-adherence resulting in fewer unintended pregnancies. When adolescents are not able to take contraceptive medications as directed or use other methods of contraception incorrectly, the risk of pregnancy increases. LARC are the most effective types of birth control for teens. LARC is safe to use, does not require taking a pill each day or doing something each time before having sex, and can prevent pregnancy for 3 to 10 years, depending on the method (Centers for Disease Control and Prevention, 2015). Adolescents require regular health care services to receive comprehensive sexual and reproductive health counseling about the importance of delaying the initiation of sexual activity and about their contraceptive options (Centers For Disease Control and Prevention , n.d.).

Centers for Disease Control and Prevention. (2015, April 7). Preventing Teen Pregnancy. Retrieved from Centers for Disease Control and Prevention : https://www.cdc.gov/vitalsigns/larc/index.html
Centers For Disease Control and Prevention. (n.d.). Health Care Providers and Teen Pregnancy Prevention. Retrieved from Centers for Disease Control and Prevention : https://www.cdc.gov/teenpregnancy/health-care-providers/index.htm</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 (U.S. Department of Health and Human Services, Office of Population Affairs, n.d.).

U.S. Department of Health and Human Services, Office of Population Affairs. (n.d.). Contraceptive Care Measures. Retrieved from HHS Office of Population Affairs : https://opa.hhs.gov/research-evaluation/title-x-services-research/contraceptive-care-measures</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
ESM Subgroup(s):	CSHCN
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 into 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 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 to increase the number of recommendations that CDR teams make during child death reviews https://www.health.pa.gov/topics/Documents/Programs/2021 CDR Annual Report.pdf
Evidence-based/informed strategy:	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 are used to make recommendations to inform prevention strategies and programming (Bureau of Family Health, Division of Bureau Operations, 2022). Through this program, deaths among Pennsylvania's children, and specifically CSHCN, can be better understood and interventions designed to prevent future deaths can be identified. Actionable recommendations developed by CDR teams could promote changes to systems of care and aid in the implementation of preventive strategies impacting CSHCN death. However, CDR teams may require guidance in developing recommendations that clearly identify what systems need to do in order to achieve change. Bureau of Family Health, Division of Bureau Operations. (2022). Child Death Review Annual Reports: Deaths Occurring in 2020. PA Department of Health, Harrisburg . Retrieved from https://www.health.pa.gov/topics/Documents/Programs/2022%20CDR%20Annual%20Report.pdf
Significance:	Data from Child Death Review can inform providers and systems of care on the need for targeted interventions to reduce the rate of death of CSHCN.

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
ESM Subgroup(s):	CSHCN
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.
Evidence-based/informed strategy:	Through person-centered planning, individuals and their families are partners in the decision- making proc (National Quality Forum, 2020). This approach provides individuals the opportunity to take an active role i planning and coordination of their services and supports, based on their unique aspirations, needs, preferences, values, and goals. It fosters social networking, parental connection and participation, and community involvement (Claes, Van Hove, Vandevelde, van Loon, & Schalock, 2010). Individuals are empowered by informed choice, which guides the development, implementation, and maintenance of a flex service plan for services and supports. Claes, C., Van Hove, G., Vandevelde, S., van Loon, J., & Schalock, R. L. (2010). Person-centered planning analysis of research and effectiveness. Intellectual and developmental disabilities, 48(6), 432-453. Retriev from https://doi.org/10.1352/1934-9556-48.6.432 National Quality Forum. (2020). Person-Centered Planning and Practice. Retrieved from https://www.qualityforum.org/Publications/2020/07/Person_Centered_Planning_and_Practice_Final_Repor
Significance:	Person-centered planning has gained wide acceptance as a best practices model for individuals with traun brain injuries (TBI) because of the positive outcomes experienced by survivors and their families when inv 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 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 addressi needs of individuals with TBI because of the highly individualized nature of every brain injury. The utilizatio this type of planning will likely lead to better outcomes for students served by BrainSTEPS than if all stude 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:	Inactive - Replaced
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
ESM Subgroup(s):	CSHCN
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.
Evidence-based/informed strategy:	To improve system function and accessibility of health systems partnerships established through the Sickle Cell Community-Based program. Data demonstrates that CSHCN experience services in well-functioning systems at much lower rates than their peers (HRSA Maternal & Child Health, n.d. - a). To address this the program requires that formal agreements be developed to address barriers to care, improve communication between providers and improve service delivery. These agreements support the medical home components: a model of care that is patient-centered, coordinated, comprehensive, and ongoing; and community-based services are organized so families can use them easily (HRSA Maternal & Child Health, n.d. - b). Across the country, CBOs have long provided social services and care to people of all ages and their families to address community resource needs, promote health and behavior change, improve functional ability, and reduce social isolation. Effective partnerships and contracts between health care organizations and CBOs are an important way to improve the overall health and well-being of the individuals and communities served by each organization (The National Academies of Science, Engineering, and Medicine, 2020).The strategy is also being assessed using the CSHCN Blueprint as a guide for future change (McLellan, Mann, Scott, & Brown , 2022) (Kuo, Rodgers, Beers, McLellan, & Nguyen, 2022) (Warren, McLellan, Mann, Scott, & Brown, 2022). HRSA Maternal & Child Health. (n.d. - a). National Outcomes Measure 17.2 CSHCN Systems of Care PA. Retrieved from HRSA Maternal & Child Health: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures HRSA Maternal & Child Health. (n.d. - b). Children and Youth with Special Health Care Needs (CYSHCN). Retrieved from HRSA Maternal & Child Health: https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn Kuo, D. Z., Rodgers, R. C., Beers, N. S., McLellan, S. E., & Nguyen,
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN and non-CSHCN</td></tr>
<tr><td>Goal:</td><td>Increase the percent of families who successfully complete the Room2Breathe Asthma home visiting 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>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>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Room2Breathe Asthma program is an evidence-based program modeled on Children’s Hospital of Philadelphia’s community asthma prevention program (Children's Hospital of Philadelphia, n.d.). 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.

Children's Hospital of Philadelphia. (n.d.). Community Asthma Prevention Program (CAPP). Retrieved from Children's Hospital of Philadelphia: https://www.chop.edu/centers-programs/community-asthma-prevention-program-capp</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN</td></tr>
<tr><td>Goal:</td><td>To convene regular collaborative meetings between the Department of Health and Department of Human Services to improve services and systems for CSHCN</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>The number of meetings held annually between the Department of Health and the Department of Human Services to discuss services and systems for CSHCN</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data source will be documentation from meetings held between agencies.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Initiate regular meetings and collaboration between DOH and DHS. The goal of eliminating health disparities cannot be accomplished by a single sector or entity. The causes of health disparities are complex and multifactorial and stem from not only the health care sector but also the social determinants of health (i.e., the conditions in which people are born, grow, live, work, and age). Sustainable partnerships among government agencies, as well as public–private partnerships exemplify the importance of collaborative engagement needed to accomplish this goal (Towe, et al., 2016). Collaboration across sectors can promote efficiency by identifying issues being addressed by multiple agencies and fostering discussion of how agencies can share resources and reduce redundancies, thus potentially decreasing costs and improving performance and outcomes (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013).

Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). Health in All Policies: A Guide for State and Local Governments . Washington, DC and Oakland, CA: American Public Health Institution and Public Health Institute. Retrieved from https://www.apha.org/-/media/Files/PDF/factsheets/Health_inAll_Policies_Guide_169pages.ashx
Towe, V. L., Leviton, L., Chandra, A., Sloan, J. C., Tait, M., & Orleans, T. (2016). Cross-Sector Collaborations And Partnerships: Essential Ingredients To Help Shape And Well-Being. Health Affairs (Project Hope), 35(11), 1964-1969. Retrieved from https://doi.org/10.1377/hlthaff.2016.0604</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN</td></tr>
<tr><td>Goal:</td><td>To increase the number of children screened for Autism Spectrum Disorder (ASD) prior to five years of age</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>The numerator is the count of children screened for ASD by the Easterseals of Eastern PA Autism Diagnostic Clinic</td></tr>
<tr><td>Denominator:</td><td></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 Easterseals of Eastern PA Autism Diagnostic Clinic. Data will be self-reported by grantee.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The model provides an in-home, telehealth diagnostic for children screened as potential for having autism spectrum disorder (ASD). The model increases access to care by connecting CSHCN to providers capable of diagnosing ASD that would be geographically limited outside of telehealth delivery (Barbosa, Zhou, Waddell, Myers, & Dorsey, 2021). The model screening methods also allow for a shift in age of diagnosis from early school-aged to daycare/pre-school aged CSHCN. The model incorporates the medical home model components that children and youth are screened early and continuously, and services are organized so families can use them easily (HRSA Maternal & Child Health, n.d. - b). The strategy is supported and assessed by the National Survey of Children’s Health Indicator 2.8d ‘How old was this child when a doctor or other health care provider first told you that he or she had autism, autism spectrum disorder, Asperger’s disorder or pervasive developmental disorder? (Data Resource Center for Child and Adolescent Health , 2022)’ The strategy is also monitored and reviewed using the CSHCN Blueprint (McLellan, Mann, Scott, & Brown, 2022) (Kuo, Rodgers, Beers, McLellan, & Nguyen, 2022).

Barbosa, W., Zhou, K., Waddell, E., Myers, T., & Dorsey, E. R. (2021). Improving Access to Care: Telemedicine Across Medical Domains. Annual review of public health, 463-481. Retrieved from https://doi.org/10.1146/annurev-publhealth-090519-093711
Data Resource Center for Child & Adolescent Heath. (2023, June). Retrieved from Explore the Data/NSCH Interactive Data Query (2016 - Present): https://www.childhealthdata.org/browse/survey/results?q=9350&r=40
Data Resource Center for Child and Adolescent Health . (2022). Child and Family Health Measures Content Map, 2020-2021 National Survey of Children's Health (two years combined) . Child and Family Health Measures Initiative . Retrieved from Data Resource Center for Child & Adult Health : https://www.childhealthdata.org/App_Themes/Main/Conten</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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
ESM Subgroup(s):	CSHCN
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.
Evidence-based/informed strategy:	Effective communication, through outreach and program promotion, increases positive health outcomes for individuals and their families (Cyril, Smith, Possami-Inesedy, & Renzhao, 2015). Families are equipped with the information they need to easily access and navigate community-based services and supports. Cyril, S., Smith, B. J., Possami-Inesedy, A., & Renzhao, A. M. (2015). Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. Global health action, 8, 29842. Retrieved from https://doi.org/10.3402/gha.v8.29842
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 11.10 - 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
ESM Subgroup(s):	CSHCN
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.
Evidence-based/informed strategy:	To improve system function and accessibility of community resources established through the Sickle Cell Community-Based program. Data demonstrates that CSHCN experience services in well-functioning systems at much lower rates than their peers (HRSA Maternal & Child Health, n.d. - a). To address this the program requires that formal agreements be developed to address barriers to care, improve communication between providers and improve service delivery. These agreements support the medical home components: a model of care that is patient-centered, coordinated, comprehensive, and ongoing; and community-based services are organized so families can use them easily (HRSA Maternal & Child Health, n.d. - b). Across the country, CBOs have long provided social services and care to people of all ages and their families to address community resource needs, promote health and behavior change, improve functional ability, and reduce social isolation. Effective partnerships and contracts between health care organizations and CBOs are an important way to improve the overall health and well-being of the individuals and communities served by each organization (The National Academies of Science, Engineering, and Medicine, 2020). The strategy is also being assessed using the CSHCN Blueprint as a guide for future change (McLellan, Mann, Scott, & Brown , 2022) (Kuo, Rodgers, Beers, McLellan, & Nguyen, 2022) (Warren, McLellan, Mann, Scott, & Brown, 2022). HRSA Maternal & Child Health. (n.d. - a). National Outcomes Measure 17.2 CSHCN Systems of Care PA. Retrieved from HRSA Maternal & Child Health: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures HRSA Maternal & Child Health. (n.d. - b). Children and Youth with Special Health Care Needs (CYSHCN). Retrieved from HRSA Maternal & Child Health: https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn Kuo, D. Z., Rodgers, R. C., Beers, N. S., McLellan, S. E., & Nguyen, T. K. (
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>ESM Subgroup(s):</td><td>CSHCN</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>Evidence-based/informed strategy:</td><td>According to the National Survey of Children’s Health, CSHCN are more likely than non-CSHCN to experience unmet health care needs. In 2019-2020, less than a quarter of CSHCN ages 12-17 years received adult health care transition planning (HRSA Maternal & Child Health, 2022). The Parent Education and Leadership Center (PEAL) is the only agency in Pa. that provides training, information, and technical assistance to help CSHCN across the entire state. PEAL is the only designated Parent Training and Information Center and the sole Family Health Information Center in Pa.

HRSA Maternal & Child Health. (2022). Children and Youth with Special Health Care Needs NSCH Data Brief June 2022. Data Brief. Retrieved from https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/nsch-data-brief-children-youth-special-health-care-needs.pdf</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>ESM Subgroup(s):</td><td>CSHCN</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>Evidence-based/informed strategy:</td><td>In 2011, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American
College of Physicians (ACP) jointly published guideline recommendations based on expert opinion and consensus recommendations for transitioning adolescents into adult care. The 2011 report states that “the goal of a planned health care transition is to maximize lifelong functioning and well-being…[thereby] ensuring that high-quality, developmentally appropriate health care
services are available in an uninterrupted manner as the person moves from adolescence to adulthood (American Academy of Pediatrics , et al., 2011).”

Potential barriers to successful transition for CSHCN include a lack of time and resources to address transition issues, inadequate reimbursement, hesitancy of families and providers to dissolve long-standing therapeutic relationships, and gaps in residency training for both transition processes and medical management of adults with childhood-onset chronic diseases. Additionally, CSHCN present broader challenges for transition including issues related to insurance, entitlements, guardianship, and eligibility for adult community-based services.

Community to Home uses Community Health Workers 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. This program helps families to plan for transitions into adulthood and adult health care for youth 14 and over.

American Academy of Pediatrics , American Academy of Family Physicians , American College of Physicians , Transitions Clinicial Report Authoring Group , Cooley, W. C., & Sagerman , P. J. (2011). Supporting the health care transition from adolescence to adulthood in the medical home. Pediatrics, 128(1), 182-200. Retrieved from</td></tr>
</table>

	https://doi.org/10.1542/peds.2011-0969
Significance:	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

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

Measure Status:	Inactive - Completed
Goal:	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
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of children without a provider or insurance that are referred to a medical home **Denominator:** Total number of children that Community Health Nurses see in their State Health Centers without a provider or insurance
Data Sources and Data Issues:	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
Evidence-based/informed strategy:	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).
Significance:	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.

ESM 11.14 - Percentage of CSHCN receiving quality care in participating Federally Qualified Health Center (FQHC) health systems
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Annually increase the percentage of CSHCN receiving quality care through project-funded FQHC health systems.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The numerator is a count of the CSHCN served through the funded programs in the project-funded FQHC programs. **Denominator:** The denominator is a count of the total number of CSHCN receiving care in the project-funded FQHC programs.
Data Sources and Data Issues:	Data source will be the Data Collection and Recording Tool developed for the FQHC program. Data will be self-reported by grantee and verified with copies of written collaborative agreements.
Evidence-based/informed strategy:	To improve system function and accessibility of health systems partnerships established through the Sickle Cell Community-Based program. Data demonstrates that CSHCN experience services in well-functioning systems at much lower rates than their peers (HRSA Maternal & Child Health, n.d. - a). To address this the program requires that formal agreements be developed to address barriers to care, improve communication between providers and improve service delivery. These agreements support the medical home components: a model of care that is patient-centered, coordinated, comprehensive, and ongoing; and community-based services are organized so families can use them easily (HRSA Maternal & Child Health, n.d. - b). Across the country, CBOs have long provided social services and care to people of all ages and their families to address community resource needs, promote health and behavior change, improve functional ability, and reduce social isolation. Effective partnerships and contracts between health care organizations and CBOs are an important way to improve the overall health and well-being of the individuals and communities served by each organization (The National Academies of Science, Engineering, and Medicine, 2020).The strategy is also being assessed using the CSHCN Blueprint as a guide for future change (McLellan, Mann, Scott, & Brown , 2022) (Kuo, Rodgers, Beers, McLellan, & Nguyen, 2022) (Warren, McLellan, Mann, Scott, & Brown, 2022). HRSA Maternal & Child Health. (n.d. - a). National Outcomes Measure 17.2 CSHCN Systems of Care PA. Retrieved from HRSA Maternal & Child Health: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures HRSA Maternal & Child Health. (n.d. - b). Children and Youth with Special Health Care Needs (CYSHCN). Retrieved from HRSA Maternal & Child Health: https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn Kuo, D. Z., Rodgers, R. C., Beers, N. S., McLellan, S. E., & Nguyen,
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 11.15 - Percent of families reporting through surveys that they were partners in decision making.
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>ESM Subgroup(s):</td><td>CSHCN</td></tr>
<tr><td>Goal:</td><td>Annually, a minimum of 80% of families will report that they were partners in decision making through the Community to Home 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>The number of families who report through satisfaction surveys that they were partners in decision making while enrolled in the Community to Home program</td></tr>
<tr><td>Denominator:</td><td>The number of satisfaction surveys received/returned for the Community to Home program</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Grantees will provide families with client satisfaction surveys at the conclusion of services and data collected will be reported within quarterly reports.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Community health workers (CHWs) help to connect community members to available services and resources. They provide benefits to individuals, communities, providers, and payers. Since CHWs are often members of the communities they serve, and rural communities typically have strong community connections, CHWs have an opportunity to:

• Develop trusting, one-on-one relationships with patients
• Act as a liaison between the healthcare system, patients, and families/caregivers
• Gain support from other organizations serving the community
• Strengthen care coordination by connecting patients with available healthcare and social support services
• Extend the reach of healthcare providers and services, which is particularly helpful in areas with shortages of providers
• Deliver services that are appropriate based on the patient's language and culture
• Give back to their communities
Access to healthcare services is critical to good health, yet rural residents face a variety of access barriers. By promoting access to healthcare services, CHWs can help improve health outcomes and quality of life in rural communities. Integrating CHWs as a member of the care delivery team, so they are working alongside physicians, nurses, and other healthcare staff, is an effective strategy for achieving improvements in health outcomes. Incorporating CHWs as a member of the care delivery team also frees up resources and enables rural healthcare professionals to focus on more complex patients and issues (Rural Health Information Hub , 2020).

Community to Home utilizes CHWs to provide care-coordination through home visiting. This evidence-based model of care coordination services 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.</td></tr>
</table>

	Rural Health Information Hub . (2020, July 8). Advantages of Community Health Workers in Rural Programs . Retrieved from Rural Health Information Hub: ht
Significance:	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. 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.

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 2022

	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 • Early Intervention
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	• Early Intervention
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 • Early Intervention
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 • Prescription Drug Monitoring Program records • 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 Pregnancy Risk Assessment Monitoring System (PRAMS), Child Death Review, Sudden Unexpected Infant Death/Sudden Death in the Young (SUID/SDY) registries, Maternal Mortality Review, newborn screening (NBS), and neonatal abstinence syndrome (NAS) 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 are not always provided to the BFH timely per the 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 birth files are not always provided to the BFH timely per the agreed upon schedule.
Data Source Name:	**3) Medicaid**
	Field Note: The BFH receives de-identified, aggregate data from the Department of Human Services, Office of Medical Assistance 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: