

**Maternal and Child  
Health Services Title V  
Block Grant**

**Pennsylvania**

**FY 2018 Application/  
FY 2016 Annual Report**

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## I. General Requirements

### I.A. Letter of Transmittal



July 14, 2017

Ms. Michele H. Lawler, M.S., R.D.  
Director  
Division of State and Community Health  
Maternal and Child Health Bureau  
Health Resources and Services Administration  
Room 5C-26, Parklawn Building  
5600 Fishers Lane  
Rockville, MD 20857

Dear Ms. Lawler:

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 Services Block Grant in Federal Fiscal Year 2018. As directed, Pennsylvania's 2016 Annual Report and 2018 Application have been submitted electronically via EHB, HRSA's electronic handbook.

I look forward to your final approval of our request. Please contact Sara Thuma, MCH Block Grant Coordinator, at [sthuma@pa.gov](mailto:sthuma@pa.gov) with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Cass', written over a horizontal line.

Carolyn S. Cass  
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.

A handwritten signature in black ink, appearing to read 'Lori Stubbs', written over a horizontal line.

Lori Stubbs  
Chief Financial Officer

**I.B. Face Sheet**

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

**I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## **I.E. Application/Annual Report Executive Summary**

The Bureau of Family Health (BFH) as the Title V administrator in Pennsylvania (PA) served an estimated 2.4 million individuals of the maternal and child health (MCH) population in 2016 through the Title V grant and related state and federal funding.

The Title V story in PA is not just about the people reached with needed gap-filling services but also about the evolving culture within the BFH and the Department of Health (DOH) as a whole. The BFH is committed to strengthening its workforce around data usage and the necessity of data driven decision-making; creating a baseline knowledge of public health concepts and the resulting real world application; the significance of working towards health equity; the role of quality improvement in daily work; and importance of enhancing stakeholder and consumer involvement in all aspects of program development and implementation. This cultural shift is further reinforced by the DOH's investment in becoming an accredited health department by the Public Health Accreditation Board and the DOH's strategic plan which also emphasizes a culture of data driven decision-making, evidence-based action, and the incorporation of continuous quality improvement. All these forces are uniting to ensure that the right work is provided in the right way to the most vulnerable populations to have the maximum impact on the health of Pennsylvanians.

The following paragraphs highlight the BFH's successes and challenges of implementing PA's state action plan in 2016. Many of the programs within the purview of the BFH are meeting or exceeding their 2017 goals in 2016. These successes in combination with a dedicated effort to strengthen its workforce put the BFH in a position to make a significant impact on moving the needle for the MCH population in PA in the coming years.

The BFH priority for the women/maternal domain is adolescents and women of childbearing age have access to and participate in preconception and interconception health care and support. This priority is linked to National Performance Measure (NPM) 1: percent of women with a past year preventive medical visit. The BFH has defined two objectives and five Evidence-based Strategy Measures (ESMs) for this priority. In 2016, nearly 1,600 women were served through the county/municipal health departments (CMHDs) home visiting programs which already exceeds the 2017 goal of serving 1,500 women. The BFH also met its 2017 goal in 2016 with 300 women receiving prenatal care through a Centering Pregnancy Program (CPP). While only partial data are available, 87 percent of adolescents and women being served through the CMHDs home visiting program and CPP are engaged in family planning after delivery with over 94 percent having talked to a health care professional about birth spacing/birth control methods. These numbers exceed the BFH's 2017 goal of 80 percent for both measures.

The perinatal/infant domain encompasses work on three priorities: families are equipped with the education and resources they need to initiate and continue breastfeeding their infants; safe sleep practices are consistently implemented for all infants; and appropriate health and health related services, screenings and information are available to the MCH population.

The breastfeeding priority is linked to NPM 4: percent of infants who are ever breastfed and percent of infants breastfed exclusively through 6 months. The approach to increasing breastfeeding rates is multifaceted with four distinct objectives defined for this work, each with an ESM. In 2016, there were 85 out of 100 PA birthing facilities participating in the Keystone 10 initiative which is based on the Baby-Friendly® Hospital Initiative. Of these 85 participating facilities, 46 percent had implemented at least one of the ten evidence-based steps to breastfeeding. Part of the BFH's multifaceted approach to increasing breastfeeding rates involves forming collaborations and exploring media messaging opportunities. The BFH increased from a 2015 baseline of zero to three established collaborations in 2016 and from a 2016 baseline of zero media opportunities, the BFH is on track to exceed its goal

of one media opportunity in 2017.

The safe sleep priority is linked to NPM 5: percent of infants placed to sleep on their backs. There are two objectives identified for this priority aimed at changing sleep behaviors. A new hospital based model program with a social marketing component has begun and four ESMs have been defined to track progress on model implementation and provision of education to parents. Although there were delays in executing the grant agreement in 2016, the BFH met its 2017 goal of recruiting two hospitals with maternity units to implement the model safe sleep program. As this is a new program, there were no other measures with reportable data.

The appropriate health and health related services priority is linked to a State Performance Measure (SPM): percent of newborn screening dried blood spot (DBS) filter papers received at the contracted lab within 48 hours after collection. While the SPM is specifically designed to track progress on the timeliness objective, a second objective focuses on implementing a system change to ensure all newborns are screened for all conditions on the Recommended Uniform Screening Panel (RUSP). There has been steady improvement seen on this SPM with 39.7 percent of DBS filter papers received at the lab within 48 hours in 2014 and 48 percent received in 2016, just shy of the 2017 goal of 49 percent. To aid in timeliness improvement, the BFH applied for and was awarded a \$80,000 grant from New STEPs 360 to apply quality improvement techniques to newborn screening timeliness.

There is one priority for the child health domain: MCH populations reside in a safe and healthy environment. This priority is linked to NPM 7: percent of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescent ages 10 through 19. One objective for this domain is to increase the number of home assessments and safety interventions. Three ESMs will track progress on service provision, hazard identification, and interventions performed. In 2016, the final year of the Lead and Healthy Homes Program (LHHP), 1,300 families were served and over 24,000 supplies were distributed. The Safe and Healthy Homes Program, which has replaced the LHHP, was delayed and is not currently on track to meet 2017 ESM goals based on the first two quarters of home assessment data. However, the estimates projected for the number of hazards identified per home assessment and the number of interventions performed will allow for BFH to meet ESM goals in the next year.

Also within the child health domain is an interim SPM: Percentage of Title V programming with interpersonal violence reduction components. The goal for BFH's CoIIN work is to implement at least one new strategy to address interpersonal violence by 2020. Through participation in the Child Safety CoIIN in Cohort 1 and now into Cohort 2, the BFH is examining the potential for expanding cross-cutting work in interpersonal violence prevention and the first step is to quantify Title V programming within the lens of interpersonal violence reduction strategies. At this time, two programs funded by Title V screen for intimate partner violence within their programming.

The children with special health care needs (CSHCN) domain is linked to the priority: Appropriate health and health related services, screenings and information are available to the MCH population. For the CSHCN domain, this priority is linked with NPM 11: percent of children with and without special health care needs having a medical home. Three objectives, each with a respective ESM, are focused on medical home growth. The BFH met the goal of forming one new medical home collaboration in 2016 and 198 Parent Partners were involved in the PA Medical Home Initiative, which was a slight decrease from 204 in 2015, and was just short of the goal of 200. Approximately 507 providers participated in a learning collaborative, education, or technical assistance regarding the medical home approach. Services provided to CSHCN and their families by the Special Kids Network (SKN) also has two dedicated objectives and ESMs within this priority. The SKN served 1,597 families in 2016, an increase over 2015, and exceeds the 2017 goal. The SKN also formed four new collaborations meeting the goal for this ESM.

The adolescent health domain includes two priorities: protective factors are established for adolescents and young adults prior to and during critical life stages; and adolescents and women of child-bearing age have access to and

participate in preconception and interconception health care and support.

The protective factors priority is linked to NPM 9: percent of adolescents, ages 12 through 17, who are bullied or who bully others. The protective factors priority encompasses a total of seven objectives and ESMS across a variety of work not all related to NPM 9. In 2016, 76 percent of adolescent health vendors received LGBTQ cultural competency training. Additional work related to this priority resulted in suicide prevention programming reaching 135 youth, 338 percent more than the anticipated 40 youth while 20 organizations were certified as safe space providers for LGBTQ youth.

A SPM has been developed to track the progress of the BFH's new mentoring programming: percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50 percent. This SPM was selected to measure how well youth in the mentoring program receive skills, experiences, relationships, and behaviors to help them increase their developmental assets. Objectives for this SPM are currently being met by the Healthy Youth PA program which served 1,038 youth in 2016 through a mentoring program spread across five program locations. This was an increase over the 320 served in the start-up year of 2015. The BFH is in the process of expanding mentoring programming related to this SPM.

The preconception and interconception care priority is linked to NPM 10: percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. The Health Resource Centers (HRCs) provided services to 3,766 youth, short of the 4,500 goal. There are currently HRCs in nine counties which exceeded the 2016 goal. Drop-in medical services were provided to 3,537 youth in 2016 exceeding the goal of 300 youth by 1,179 percent. In 2016, the BFH did not meet the goal of providing reproductive health counseling to 11,817 youth and only served 7,557 youth. After the BFH reviewed data collection procedures, it was discovered there were discrepancies and reporting will be adjusted to ensure more uniform collection and appropriate service targets. The BFH will also increase the grant payment limits in the coming year to enable more youth to be served.

The BFH has worked across several priorities within the cross-cutting domain for the current reporting cycle: women receiving prenatal care are screened for behavioral health and referred for assessment if warranted; MCH populations are able to obtain, process, and understand basic health information needed to make appropriate health decisions (health literacy); Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs (data priority); and appropriate health and health related services, screenings and information are available to the MCH population.

The behavioral health screening priority is linked to NPM 14: A) percent of women who smoke during pregnancy and B) percent of children living in households where someone smokes. The CMHDs are expanding smoking cessation programming with 30 percent currently offering programs. Partial data for 2016 showed that 13 percent of women smoked following a confirmed pregnancy. Work related to this priority also involves training home visitors in motivational interviewing and on the use of the Integrated Screening Tool (5P's). Training is beginning in 2017.

An SPM was created to track work on the health literacy priority: percentage of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable. The BFH plans to establish requirements for grantees to review their disseminated health information and to ensure each grantee creates and maintains a policy and process to review information provided to patients to make sure it is clear and can be understood by all populations served. The BFH has also set objectives for disseminating simple and clear messages about basic health information and increasing the reach of the BrainSTEPS program. In 2016, the BFH

disseminated at least one clear and simple message about health in the re-designed newborn screening brochure to make it easier to read and understand. This brochure and a new rack card specific to lysosomal storage disorders (LSDs) were provided to all hospitals, birthing centers, and midwives and are available in English, Spanish, Chinese, Russian, French, Portuguese, and Vietnamese. The BrainSTEPS program had 603 referrals in 2016 exceeding the goal of 500.

The BFH is making a conscious effort to bring discussion around health disparities and health equity to the forefront both internally and externally. As part of the effort, the BFH began integrating health disparities language into grant agreements as the agreements have come up for renewal throughout the year as part of work on the appropriate health and health related services priority.

The data priority has a defined SPM: percent of Title V staff who analyze and use data to steer program decision-making. The 2016 baseline for this SPM is 29 percent of staff and the goal for 2017 is 32 percent of staff. There are four objectives defined to help the BFH make changes in procedures and processes to institutionalize best practices for a successful future.

While the BFH made good initial progress on the work within the state action plan, it is important to sustain this progress. The continued impact of the opioid epidemic, Zika, lead and potential changes in the healthcare landscape, both at the federal and state levels, will impact the MCH populations and the systems of care in which they receive services. The BFH must be prepared to not only continue to invest in current programming but also plan to provide additional gap-filling services to vulnerable populations as needed. The BFH is committed to investing in its workforce capacity to ensure the implementation of meaningful programming is delivered efficiently and effectively across all the population domains.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

Understanding the needs of the MCH population in Pennsylvania (PA) first requires knowledge of the geographical, political, social and economic characteristics of the Keystone state and its residents. Located in the Northeast, PA is home to over 12.8 million people and is the sixth most populous state. The Appalachian Mountains run through the center of the state creating a large swath of rural forest area dividing the state in half. Additionally, several major interstates crisscross the state making it not only a destination but an important transitory point for those traveling throughout the Northeast and beyond.

The urban counties anchor the state around Pittsburgh in the west and Philadelphia in the east. Urban counties are those with a population density higher than the state population density, while rural are lower. Harrisburg, the capital and headquarters for the Department of Health (DOH), is situated in the southcentral part of the state. Seven of the nation's 100 largest metropolitan areas are located in PA. Sixteen metro areas contain 84 percent of the state's population, 87 percent of the job share and 92 percent of the state's gross domestic product. Further, the top six metropolitan areas—Philadelphia, Pittsburgh, Harrisburg/Carlisle, the Lehigh Valley, Scranton/Wilkes-Barre/Hazleton, and Lancaster—alone generate the bulk of the state's innovation, contain over three-quarters of the state's educated workforce and serve as transport hubs. With the sixth largest economy in the nation, PA has an unemployment rate lower than the national average. The health care, social assistance, manufacturing and real estate sectors are major contributors to the economy.

In 2014, the 157 general acute care hospitals, including 13 Critical Access Hospitals, with over 35,000 licensed beds handled almost 1.5 million admissions. An additional 90 federal and specialty hospitals handled over 180,000 admissions. Trauma centers are primarily located in the 19 urban counties, and are accessible by almost all residents within 60 minutes via air or ground transportation. However, access drops dramatically without the use of helicopters. Supplementing the hospitals are over 250 Federally Qualified Health Centers or Rural Health Centers providing primary care services in 48 counties with 40 percent in rural counties. Act 315, PA's Local Health Administration Law, mandates DOH to provide funding for MCH services in the six county and four municipal health departments.

The delivery of health care services is significantly impacted by the distinctive rural and urban characteristics across the state. While the majority of the 67 counties are rural, over 87 percent of the population, including the greatest density of ethnic minorities, live in metropolitan areas. In rural counties, there is one physician for every 586 residents compared to one physician for every 266 residents in urban counties. In addition to a general lack of healthcare resources, rural areas have other challenges: an aging population; a growing young minority population with higher rates of poverty and unemployment; and a lack of resources or training to meet the language and cultural needs of the growing immigrant populations.

Intersecting with the disparities created by geography are the varied backgrounds of the people that bring a unique combination of cultural norms, life experiences and perceptions to their interaction with the health care system. With the total minority population projected to double between 1990 and 2025, the responsibility and challenge of the Title V program is to have an understanding of these backgrounds and how they shape interactions with services and programming in order for Title V to meet immediate needs and reduce health disparities over the long-term.

African Americans have the highest overall mortality rates compared to all other racial groups following the national

trend. They are more likely to live in urban areas with food deserts, high fast food concentrations and high crime areas with little access to parks and recreational areas. While the uninsured rate has fallen for all racial and ethnic groups as a result of the Affordable Care Act (ACA), non-elderly African Americans are still more likely than whites to be uninsured as of 2015. African Americans are disproportionately underrepresented in the medical community; the majority of licensed physicians in PA are white. An inability to speak with a professional from one's own community creates additional barriers to improving health. White doctors are unlikely to counsel black patients on weight and exercise often due to negative perceptions and a lack of sensitivity to their health challenges. Cultural constructs surrounding body image and attractiveness also define how and when this community interfaces with the health care system with regard to obesity and related illnesses. These barriers, combined with pre-existing low levels of trust in the healthcare system, may continue to contribute to racial disparities in health outcomes.

Despite living under similar socioeconomic conditions, and having similar cultural attitudes with regard to body image, Hispanics have lower overall death rates than blacks. Nearly three-quarters of a million people comprise the Hispanic population which is becoming increasingly diverse in heritage. Some obstacles Hispanics encounter when obtaining health care are cost, language barriers and issues surrounding the stigma of seeking help from a mental health professional.

Increases in immigration and high fertility rates in certain communities are changing the face of health care consumers. In the last decade, the Pacific Islander population doubled and the Asian population increased almost 60 percent with this trend projected to continue. As this population is largely defined, it is important to examine the potential for disparities and differences within groups including different generational attitudes towards death, family duty, information disclosure, decision-making and use of mental health services. Religious traditions, cultural barriers, fear of stigma and deeply held healthcare beliefs shape the relationship of Asian American populations and the health care system. Fear of deportation, waiting periods for Medicaid eligibility, limited English language proficiency and previous maternal and pediatric health challenges before entering the U.S. also contribute to the use of available services.

Undocumented immigrants entering with the possibility of undetected contagious diseases, increases the burden on the health care system which can create a significant impact on the economic and physical health of the state. Refugee admissions into the state have been increasing with over three thousand arriving in 2011 from 57 different countries. Refugees are being forced from their homes and have little choice as to when and where they resettle. Major obstacles for this population include finding employment due to language barriers and housing due to lack of options. For refugees and immigrants, accessing health care services is hindered by language, cultural barriers, potential stigma, low health literacy and the myriad of stressors associated with pre-and post-migration. The degree of acculturation can positively or negatively affect health outcomes. Second-generation immigrants, generally more acculturated than first-generation immigrants, have a greater risk for substance abuse and poor birth outcomes yet are more likely to use preventive and clinical health care.

Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) residents face ongoing health inequities in terms of their absence in statewide surveillance systems, discrimination by healthcare providers, in the workplace and in social situations. Over half of LGBTQ individuals have reported discrimination at some point based solely on sexual orientation, which remains legal in PA. There are few laws protecting LGBTQ families with regard to insurance coverage, hospital visitation rights and powers of attorney. Members of LGBTQ groups have health needs both regular and specific to their sexual and gender orientation that often go unmet.

In response to a range of discriminatory laws being passed in other states, Governor Wolf signed executive orders in April 2016 stating "no agency under the governor's jurisdiction shall discriminate on the basis of sexual orientation, gender expression, and identity, among other areas." These orders pertain to Commonwealth employees,

overlapping a previous executive order, and to the Commonwealth grants and procurement process. These orders are an important signal to the legislature to pass non-discrimination legislation to create clear standards for protecting people across the state. Over 40 municipalities have passed separate ordinances to prohibit discrimination on the basis of sexual orientation and gender identity.

Threatening situations including unsafe school environments and intimate partner violence are constant realities for LGBTQ individuals and can contribute to other risky behaviors. LGBTQ teenagers are significantly more likely to engage in skipping school for fear of personal safety; attempt suicide; make a suicide plan; use tobacco, alcohol and other drugs; engage in unsafe sexual behaviors; and manage weight in an unhealthy way. As many as 25 percent of LGBTQ teenagers who come out are rejected by their families and find themselves homeless, increasing their likelihood of experiencing violence either on the street or in the shelter system.

Large disparities exist in the incarcerated population in three main ways: incarceration rates are much higher for people of color; mental illness impacts a significantly higher proportion of the incarcerated population than the general population; and female prisoners have not only a higher overall rate of mental illness but suffer more adverse consequences. Moreover, all incarcerated individuals are at increased risk for a variety of infections, yet have little access to appropriate health care, including the reproductive care needed by the 25 percent of women who are pregnant or postpartum when they enter prison. The majority of women in jail are mothers, usually the primary caretaker or wage-earner, extending the adverse effects of incarceration to the health of the children of these women.

Mental illness encompasses a wide range of disorders and can be as disabling as cancer or other chronic diseases. Prevalence of mental health issues in children has been increasing though this may be related to more accurate diagnosis. Mental illness is particularly difficult from a policy standpoint as mental illness presents differently between individuals, may lack a precise definition and cuts across policy and service areas, which requires multi-faceted solutions and coordination across agencies and providers.

People with disabilities may have multiple barriers to performing daily life functions including finding physical pathways to community locations and the need for eating and dressing accommodations. Individuals with physical disabilities often have higher levels of poverty and unemployment while those with mental illness are more likely to abuse illicit drugs and/or alcohol and constitute a large portion of the homeless population; all barriers to accessing and using health care services. It is often hard for individuals with disabilities to find a therapist who has cultural competence and experience with their disability. Access to treatment is particularly hard for those with mental illness with issues related to how to get to treatment, treatment plan compliance, the burden of stigmatization and cost.

Overlapping the aforementioned disparities are familial, educational and economic characteristics of the population that further define their interaction with the health care system. With counties varying in median age from 33 to 51 years old, the median age of PA residents is 40.5 years old, three years older than the national median age. The state population is aging and ranks fourth in the U.S. by percentage of the population age 65 and older and by number and percent of population age 85 and older. It is estimated that by 2030, the population of those 60 and older will be almost 30 percent of the state population. Factors and behaviors beginning in the childhood years often influence the chronic diseases present in the aging population. Improving the health of today's children will directly impact the care and resources needed for future elder care.

Of the approximately 5 million households in the state, only about 26 percent have one or more people under the age of 18. Over 3.2 million of these households are defined as families with an average size of 3.1 members. Families are categorized by the U.S. Census Bureau into three types: married-couple families, male householder (no wife present) and female householder (no husband present). While married families are the majority, almost three-

quarters of non-married families are female led. These households have slightly larger family sizes and are more likely to have one or more members less than 18 years of age.

According to the Williams Institute analysis of Census Bureau data, there are 22,340 same-sex couples in PA (sixth nationally) compared to 646,500 in the U.S with almost 16 percent of these couples in PA raising children. The majority of same-sex couples in PA are women (56 percent) and the overwhelming majority are white (81 percent) followed by black (10 percent) and Hispanic (6 percent) couples. The mean income for same-sex couples is slightly higher than that of different-sex couples, \$52,000 versus \$46,000, while over 50 percent have a college education as compared to only 33 percent of different-sex couples. Ninety percent of same-sex couples have health insurance.

Using a Gallup Daily tracking survey, the Williams Institute asks “Do you, personally, identify as lesbian, gay, bisexual or transgender?” The count includes singles and couples in order to get a glimpse of the characteristics of the LGBT community. In PA, three percent of people identify as LGBT with 27 percent raising children. Numbers for the U.S. are similar with four percent of people identifying as LGBT with 29 percent raising children. The percentage of LGBT population is almost evenly split between men and women with men numbering only slightly more at 51 percent. As with same-sex couples, the majority of the LGBT population is white (72 percent) followed by black (11 percent) and Hispanic (8 percent). The average age of the LGBT population is 41.7 years as compared to the non-LGBT population at 49.5 years. PA ranks 38<sup>th</sup> in percentage of LGBT individuals. Over a quarter (28 percent) of LGBT individuals have an income less than \$24,000 as compared to non-LGBT individuals (21 percent). More non-LGBT (90 percent) individuals have health insurance than LGBT individuals (86 percent). The percentage of non-LGBT and LGBT individuals having a college education is nearly equal.

The population of children under age 18 is fairly evenly distributed across age groups for each family type. Of the 2.7 million children in the state, almost 1.7 million live in a married family; over 214,000 children live in male led families; and 707,000 children live in female led families. Not only do more children reside in female led families as compared to male, but these households are half as likely as male led families to have an unmarried partner present.

The racial distribution greatly varies between types of households with children. While almost 84 percent of children in married families are identified as white, 70 percent of children in male led families and a little more than 50 percent of children in female led families identify as white. Female led families have the greatest percentage of children identifying as black or Hispanic as compared to all other households. Female-led have almost twice the percentage of grandchildren in their households as compared to other households.

The median income varies by county from \$36,600-\$86,000 with the median income for families with children within this range at \$70,403. However, when stratified by family type, the numbers are very different with the median income for married families at over \$90,000, approximately \$44,000 for male led families and \$25,000 for female led families. Although female led families are slightly larger than the other types, their median income is nearly half the next highest median income. This income gap is exacerbated by the wage gap. Women in PA are earning slightly less (79 cents) than the national average of (80 cents) for every dollar a man makes. The wage gap is even greater if the woman is a minority.

An understanding of the state’s educational attainment gives a glimpse of the potential earning status of current and future residents. Of the approximately 1.21 million of 18 to 24 year olds, 33 percent have graduated high school; 43 percent are enrolled in college or graduate school and 12 percent have a bachelor’s degree or higher. Males in this age group are enrolled in college or graduate school at a slightly lower rate than females.

For the 8.9 million people aged 25 years and over, over 89 percent are high school graduates or higher although this varies a bit by county, and almost 30 percent have a bachelor’s degree or higher. For this same population, for whom

poverty status is determined, the rate of poverty for those with less than a high school diploma is 25 percent and decreases with educational attainment. The median income for those aged 25 years and older is \$38,000 and ranges from almost \$22,000 for those with less than a high school diploma or equivalency to just over \$66,000 for graduate or professional degree holders.

Of the approximately 1.4 million families with related children under 18 years in 2015, 16 percent were living below the poverty level during the previous year. The poverty rate in both urban and rural PA was 13 percent, slightly lower than the national average. Blacks and Hispanics almost three times as likely to be living in poverty than whites. The highest proportion of families living below the poverty level was the female led families; more than twice the state poverty rate. For all categories of families, those with a householder having less than a high school education had the highest rates of poverty. However, at all levels of educational attainment, the percentage of female led families living below the poverty level was almost three times that of the state. The greater the number of children and number of people in a family, the higher the proportion of families living below the poverty level. In contrast, the more workers there are in the family the lower the proportion of families living below the poverty level. The greatest economic obstacles and burdens fall on female led families as they have lower incomes, higher rates of poverty despite educational attainment, and have larger family units not appearing to include unmarried partners. When looking at women in PA, 13 percent of women live in poverty, slightly better than the national average of 13.4 percent. While 39.2 percent of single mothers live in poverty compared to 36.5 percent nationally.

An important sub-population within the MCH population is adolescents (15 to 19 years) who number an estimated 844,000 with almost 90 percent enrolled in school. The percentage in school varies by race with Hispanic adolescents having the lowest enrollment at 86 percent. Almost 3 percent of black and 4 percent of Hispanic adolescents had a birth in the past 12 months compared to one percent of whites. Almost 61 percent of black adolescents and 45 percent of Hispanics live in female led families compared to only 19 percent of whites. The percentage in the labor force ranges from 35 percent for black adolescents to 44 percent for whites. Health insurance is a key criterion for healthcare access. In 2015, approximately 6 percent of the 12.6 million civilian noninstitutionalized population in PA were uninsured. Approximately 7 percent of men were uninsured compared to 5 percent of women. Only about 6 percent of whites were uninsured compared to almost 10 percent of blacks and 14 percent of Hispanics. The 25-35 year olds had the greatest percentage of uninsured at slightly over 12 percent.

The Affordable Care Act (ACA) has brought some insurance relief with the introduction of the federal Marketplace. While the uninsured rate varies across counties, those that are uninsured are primarily working families with an income below 400 percent of the federal poverty level (FPL) and white. As of February 2017, more than 426,000 Pennsylvanians had selected a Marketplace plan with over 75 percent eligible for subsidies. Over 700,000 individuals receive coverage through the Medicaid expansion. The expansion in PA resulted in a reduction in uncompensated care of approximately \$280 million in 2016 expansion, almost 12,000 individuals were saved from catastrophic out of pocket medical costs, and about 37,000 individuals did not have to borrow or skip payments.

For families with incomes above the Medicaid eligibility levels, children can be covered through PA's CHIP program. A survey by Kaiser Family Foundation found over half of Pennsylvanians reported it was very or somewhat difficult for their family to afford health care compared to a little over 40 percent nationally. While premiums vary across the state, they are lower than the national average.

It is estimated that a repeal of the premium tax credits and Medicaid expansion would result in 137,000 jobs lost in PA in 2019, with the number of uninsured projected to double. An ACA repeal is estimated to result in almost \$36 billion less in federal funding for healthcare to PA and \$7.8 billion more in state spending.

Of increasing concern is a growing provider shortage identified through the 156 defined Medically Underserved Areas/Populations, the 159 primary care Health Professional Shortage Areas (HPSA), the 122 mental health and the 164 dental HPSAs resulting in unmet needs for care. While the state ranks 5<sup>th</sup> in the nation for the ratio of medical residents per 100,000 population, the state ranks 38<sup>th</sup> in percentage of physicians completing graduate medical education in the state and then remaining to practice. In 2016, there were 192.9 primary care physicians per 100,000 population and 60.7 dentists per 100,000 population. Additionally, from 2004 to 2014, PA lost 28 obstetric units. In some parts of PA, there isn't one in a 50-mile radius. While legislation had been proposed to expand the autonomy of nurse practitioners, full practice autonomy has yet to be realized.

Like other states, the epidemic of prescription drug and heroin use is another priority drawing much attention. Addressing this problem has taken precedence since the new administration began in 2015. According to the 2015 PA Coroner's Association Report, there were 3,505 deaths resulting from drug poisoning, a 30 percent increase over the previous year. The number of drug-related deaths is expected to be even higher in 2016. The report indicates ten people die every day in PA from drug related causes, an increase over the seven per day in 2014. While there is a broad range of ages for these deaths, the typical decedent is a single, male, between 30-49 years old.

Attempts to combat the drug problem are multi-faceted and range from improving prescribing practices to providing better and more widely available addiction treatment services. The DOH has implemented the Prescription Drug Monitoring Program (PDMP), which requires prescribers and dispensers to report all prescriptions for Schedule II-V controlled substances. The new PDMP will be used to better inform health care providers about their patients' prescriptions or help patients get needed treatment. In addition, the PA Physician General signed a standing order for Naloxone in February 2016, intended to ensure that residents who are at risk of experiencing an opioid-related overdose, or are in a position to assist a person at risk, are able to obtain Naloxone. The Department of Human Services and Department of Drug and Alcohol Programs are also stepping up efforts to improve availability and access to appropriate treatment when needed.

The DOH in partnership with a broad representation of public health system stakeholders developed a State Health Improvement Plan (SHIP) for 2015-2020. The results of this process could illuminate hidden issues and avenues of service relevant to the MCH population. The SHIP priorities are: 1) obesity, physical inactivity, and nutrition; 2) primary care and preventive services; and 3) mental health and substance abuse. Through the process of defining the SHIP priorities, five cross-cutting themes were also identified: health literacy, public health systems, health equity, social determinants of health and integration of primary care and mental health. The DOH has submitted a letter of intent to the Public Health Accreditation Board to apply for accreditation. Both of these processes 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 DOH has recently released its 2016-2019 Strategic Plan. Identified in this plan are the following four key strategies: 1) Enable local, evidence-based action to improve public health and wellbeing of all Pennsylvanians; 2) Implement an evidence-based, data driven decision-making practice throughout the department to advance public health; 3) Maintain and enhance emergency services and public health preparedness; and 4) Transform PADOH culture to be focused on continuous quality improvement in its approach to public health. These department strategies closely align with the work of Title V in PA and the BFH 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.

Part of Governor Wolf's 2017-2018 budget is a proposal to consolidate the Departments of Health, Human Services,

Aging, and Drug and Alcohol Programs into a Department of Health and Human Services. The purpose of this consolidation is to “encourage more effective collaboration and service delivery, enhance program effectiveness, reduce administrative costs and eliminate duplicate positions. The consolidation has the potential to break down barriers between Title V programming and Medicaid potentially increasing collaborative work and data sharing. There is also the potential for a re-organization of programming to eliminate duplication which may impact the BFH.

The BFH, as the Title V administrator, is facing several potential changes. The potential changes associated with the repeal of the ACA and the associated unknowns surrounding the status of healthcare at the national and state level emphasize the need for the BFH to be prepared to adjust work to continue to provide necessary gap filling services to the MCH population. The consolidation could improve collaboration with Medicaid but cause shifts in programming administered by the BFH. However, it is also imperative the BFH continue to efficiently and effectively implement new and existing programming and remain focused on its commitment to respond not only to the current health needs of the Title V population, but anticipate potential new areas of need created by changing external environments while also addressing the less noticeable underlying structures and determinants shaping the lives of the Title V population in PA.

## **II.B. Five Year Needs Assessment Summary and Updates**

### **FY 2018 Application/FY 2016 Annual Report Update**

#### **II.B.I. Process**

For the interim needs assessment, an electronic survey was developed to gather feedback from stakeholders and service populations on important MCH topics. Beginning in January 2017, Bureau of Family Health (BFH) staff were asked to list top issues or concerns by population domain with the refined lists inserted into the survey to be ranked by respondents from most to least important. The survey included several open-ended questions for respondents to explain their rankings and which of the issues they would want to receive support and why. Respondents were additionally asked to identify as a consumer or a service provider; their county of residence, population served and to provide feedback on the survey itself. The survey was constructed in Survey Monkey by the Bureau of Informatics and Information Technology (BIIT) and sent out via email from the Title V resource account to over 100 contacts representing Title V internal and external stakeholders. Stakeholders were asked to have one to two representatives of their organization and three to five consumers complete the survey. The survey was open for three weeks in April resulting in 54 responses, three of which identified as consumers.

BFH staff sorted the survey results by top issues in each domain, what issue people would fund and if there were any strengths or barriers that appeared in the text responses. Staff will continue to analyze the data to complete a summary report for release both internally and externally over the summer. A summary of the findings is below.

Going forward, the BFH will evaluate this approach to soliciting feedback, including the survey length, finding different ways to reach consumers and building in more time for testing and follow-up.

#### **II.B.2.a. MCH Population Needs**

The survey used by the BFH to collect the following information can be found as an attachment to this report as Supporting Document 1.

For the women/maternal domain, respondents ranked six issues resulting in the following top three:

- Home visiting/community health resources to help manage and improve health
- Ability to find and see a doctor when you need to or get financial assistance for basic needs such as groceries and housing
- Treatment for substance use, such as drug or alcohol counseling

Respondents supported funding home visiting/community health and access to health and social services. Lack of flexibility, lack of transportation and poverty were mentioned as potential barriers to obtaining services. Home visiting was recognized as being associated with positive outcomes, and is a way to build trust and support. Ensuring doctor or healthcare access was viewed as a fundamental need important to all other aspects of living a healthy life, mitigating disparities. Substance use treatment is needed as communities struggle with the impacts of the opioid epidemic.

For the infant domain, respondents ranked 10 issues resulting in the following top three:

- Testing and support services for babies who have developmental delays
- Education and services to help prevent and care for premature babies
- Trying to understand and prevent the death of newborns

Respondents supported funding newborn screening and early intervention, noting early detection and treatment allows children to thrive, decreases costs to society and demonstrates a strong cost/benefit ratio. Barriers to obtaining services were lack of insurance coverage, lack of providers or services within a reasonable distance and opioid epidemic creating new challenges.

For the child domain, respondents ranked six issues resulting in the following top three:

- Information and support about healthy eating options and how to address food insecurity
- Collaboration between home visiting programs and PCPs
- Trying to understand and prevent injury and death due to accidents or other preventable events

Respondents supported funding health promotion activities related to nutrition/food security and injury prevention. While no barriers were identified, nutrition was viewed as a gateway to improved overall health.

For the adolescent domain, respondents ranked 14 issues resulting in the following top three:

- Helping youth develop skills for social and emotional competence, including healthy coping skills
- Supporting individuals, families and communities to make changes that will help youth be healthy and successful
- Helping teenagers/young adults learn to cope with the effects of violence, abuse and other difficulties from their childhood (adverse childhood events/toxic stress/trauma including generational trauma/violence and safety)

Respondents supported funding helping teenagers/young adults learn to cope with the effects of violence, abuse and other difficulties from their childhood as well as supporting individuals, families and communities to help youth be healthy and successful. Noted barriers to positive outcomes for adolescents were drug abuse, trauma, suicide and adverse childhood experiences.

For the CSHCN domain, respondents ranked 11 issues resulting in the following top three:

- Support individuals, families and communities to make changes that help youth be healthy and successful
- Identification and use of community resources
- Transportation

Respondents supported funding the top issue and transportation. Barriers noted were that systems for both obtaining and maintaining services are ineffective, inefficient, and complicated for families to navigate.

For the Cross-cutting domain, respondents ranked 14 issues resulting in the following top three:

- Screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues
- Health disparities resulting from systematic obstacles to health based on race, ethnic group, religion, sexual orientation, gender identity, disability or geographic location
- Affordable and safe housing

Respondents supported funding screening and treatment. As many of the issues listed in this population domain cross populations, service provider respondents were asked to identify in which of the population domains this might be more of an issue. The respondents answered low income, minority, rural and individuals with disabilities. There were no frequently mentioned barriers or strengths noted in this domain.

## **II.B.2.b. Title V Program Capacity**

### **II.B.2.b.ii Agency Capacity**

Over the last two years, the Department of Health (DOH) has undergone preparations to apply for accreditation by the Public Health Accreditation Board in 2018. The accreditation process will help strengthen the DOH, enabling it to better serve Pennsylvanians.

In addition to implementing new programs in 2016, the BFH ended some programs and shifted the focus of others.

While the Lead and Healthy Homes program came to a successful end in 2016, the lessons learned were applied to the Safe and Healthy Homes Program (SHHP), a second iteration of holistic healthy homes programming, which began in July 2016.

In September 2016, the Children's Home Ventilator Program (non-Title V) ended and was replaced with an expanded program providing similar services, the Technology Assisted Children's Home Program.

With new grant guidance from HRSA, the newborn hearing screening program will be moving in a new direction focused on engaging family and health care providers in learning communities to assure participants in the Early Hearing Detection and Intervention system have the information they need and expanding the program's partnership with early intervention to ensure children diagnosed with a hearing loss are enrolled timely.

In early 2016, a new newborn screening filter paper was introduced which allows for reporting of critical congenital heart defects (CCHD) information for all infants born in PA. In April 2016, Mucopolysaccharidosis Type 1 (MPS I) and X-linked Adrenoleukodystrophy (X-ALD) were placed on the mandatory screening panel which became effective for MPS I on February 1, 2017 and for X-ALD on April 1, 2017. Lastly, in July 2016 the program began using a new case management data system (iCMS) which allows staff to provide follow-up services for dried blood spot cases, CCHD cases and hearing cases in one data system.

### **II.B.2.b.iii. Workforce Capacity**

The BFH has had some changes to its senior staff. Cindy Dundas was appointed in November 2016 to fill the director of the Division of Community Systems Development and Outreach (CSDO) vacancy left by Michelle Connors. Ms. Dundas has worked in the BFH for fifteen years and has over twenty years of public health experience, in addition to ten years of experience in the mental health/intellectual disability field. She holds a Bachelor's Degree in psychology and is the parent of a CSHCN.

Erin McCarty was named the director for the Division of Bureau Operations (DBO) in April 2017. Ms. McCarty began working for BFH in January 2017 and has over 10 years of public health experience. She holds a Master's of Public Health degree.

Sara Thuma was named the CSHCN director.

Increasing training for internal and external staff is an ongoing focus for BFH.

The BFH worked with the county and municipal health departments (CMHDs) to provide technical assistance on topics related to the MCH State Action Plan. These sessions allow the BFH to ensure the CMHDs understand the strategies being used to improve the health of residents and assist the CMHDs to execute them locally.

SHHP grantees have both initial training requirements as well as annual professional development training requirements, intended to cover healthy homes technical topics as well as soft skills training, such as motivational interviewing (MI). BFH made MI training available for grantees, including CMHDs and SHHP during 2016.

Adolescent health program staff and grantees participated in topical training for adolescent pregnancy prevention and healthy sexuality, enhancing youth-adult partnerships in programming, and supporting safe and welcoming organizational climates for serving LGBTQ staff and clients.

In late 2016, the breastfeeding program administrator earned lactation counselor certification. Having an in-house expert will allow BFH to more easily develop and implement related programming and information.

In 2016, the Bureau of Family Health restructured the DBO. Programs that were moved to the DBO include administration of the Title V Block Grant, administration of the State Systems Development Initiative Grant (SSDI), Child Death Review (CDR), administration of the Sudden Unexpected Infant Death (SUID) Case Registry grant, PRAMS and the BFH workforce development initiative. The BFH is in the process of fully staffing the DBO.

In 2016, the Division of Newborn Screening and Genetic (DNSG) had several staff changes. The entire DNSG participated in teambuilding activities which included the DiSC Classic, Discovering DiSC. Various staff participated in the following training opportunities: the annual Early Hearing Detection and Intervention Meeting, the Association of Public Health Laboratories Newborn Screening and Genetics Testing Symposium, the Cystic Fibrosis Quality Improvement Initiative In-Person Meeting, the Congenital Cytomegalovirus Public Health and Policy Conference, the Hunter's Hope Medical Symposium, the Short Term Follow-up Stakeholders Meeting which was jointly sponsored by NewSTEPS and the Cystic Fibrosis Foundation and multiple topical webinars. In addition, the Director of the DNSG was selected for and participated in the AMCHP Leadership Lab Next Gen Leaders Cohort.

The DNSG provided TA to hospitals, birthing centers, and midwives regarding proper completion and submission of the DBS filter paper and reporting requirements for CCHD screening and newborn hearing screening. The TA was provided via site visits, conference calls, and "Newborn Screening 101" webinar. The DNSG presented an overview of its screening programs at a midwife workshop held by the Clinic for Special Children in April 2016. Finally, the DNSG provided pulse oximetry machines and machine related training to a group of midwives in October 2016 to increase the number of midwives screening and reporting of CCHDs.

### **II.B.2.c. Partnerships, Collaborations and Coordination**

The Title V Director represents the DOH on a Substance Exposed Infants Workgroup with the Departments of Human Services and Drug and Alcohol Programs to collaboratively improve outcomes for infants and their families who are affected by substance use during pregnancy.

BFH supports the Healthy Homes and Lead Partnership, a group of statewide health and housing advocates that meet regularly to address lead poisoning prevention, healthy home environments and related concerns.

The Pennsylvania Perinatal Partnership represents the collaborative efforts of PA's Healthy Start Projects and MCH programs and is collaborating with AccessMatters to provide trainings for home visiting staff.

The newborn hearing screening program will expand its partnerships with early intervention services through PA Training and Technical Assistance Network (PaTTAN) in the Department of Education. PaTTAN will administer the Guide By Your Side program and provide training to early intervention service coordinators on services available for children who are deaf or hard of hearing.

Partnerships resumed with the Philadelphia Special Needs Consortium and DOH's Office of Health Equity as a new director is in place. New partnerships were formed with the Division of Tobacco Control and Prevention and Bureau of Health Promotion and Risk Reduction.

The BFH collaborated with the state Medicaid program through a National Governor's Association TA grant on the development of recommendations for the Patient-Centered Medical Home Program. This collaboration also worked with three regional Telephonic Psychiatric Consultation Services contractors to raise awareness and to educate medical home providers on this service.

The BFH began directly managing the CDR program at the end of 2016, ending the funding partnership with the Pennsylvania Chapter of the American Academy of Pediatrics (PAAAP). PAAAP remains a collaborating partner for MCH programming.

## **FY 2017 Application/FY 2015 Annual Report Update**

### **II.B.1. Process**

The needs assessment in the current year mainly focused on internal workforce capacity with regard to data usage and analysis; workforce understanding of public health concepts and block grant transformation; and exploring the integration of a MCH Epidemiologist into the Bureau of Family Health (BFH). Other needs assessment work focused on re-emerging issues taking center stage in the public and political arenas such as childhood lead poisoning and neonatal abstinence syndrome (NAS). The BFH also took steps to ensure the PA Behavioral Risk Factor Surveillance System (BRFSS) was funded to produce the sample size needed to support data analysis through direct Title V funding and through reallocation of funds from the State Systems Development Initiative (SSDI). This monetary support enables the BFH to not only have a continued source of data for NPM 1, but also enables other health programs in the state to continue to rely on the BRFSS for data. The BFH applied and was approved to have three modules included in the 2016 survey: Adverse Childhood Experiences (ACE); Health Care Access; and Sexual Orientation/Gender Identity.

The BFH is beginning to explore using electronic surveys to get feedback from stakeholders and populations served during the interim years of the block grant cycle to supplement data collection.

### **II.B.2.a. MCH Population Needs:**

County Municipal Health Departments (CMHDs) are doing great work by streamlining and enhancing home visiting services for women. Centering Pregnancy, a comprehensive group model of prenatal care, is increasing participation from Hispanic women while still experiencing resistance from black women. This resistance stems from a perception of Centering Pregnancy care being lesser care than clinic care. This illuminates the need to continue to analyze the varied barriers for women receiving care.

Coinciding with the epidemic of opioid abuse is a growing concern over the number of babies born in PA diagnosed with NAS. While approaches to determining the scope of the issue in PA are still under discussion, some preliminary numbers are available. From 2012 to 2014, there were 5,829 live hospital births with a diagnosis of NAS. The majority of these hospital live births with a diagnosis of NAS were white, non-Hispanic, and using Medicaid as the primary payer. Dialogue started regarding surveillance needs; what combination of primary, secondary, and tertiary prevention methods will best reduce the incidence of NAS in PA; and what interagency coordination of efforts will look like.

The national attention to the public health issue of lead poisoning led to it re-emerging as a public health concern in PA. While much of the national focus is on lead in water, PA Department of Health (DOH) efforts have been geared towards lead dust from deteriorating lead paint in older homes. PA has one of the highest percentages of homes built before 1978 and 1950 among all states, and all current data suggests the most common source of exposure to lead for PA children is lead dust from deteriorating lead paint.

Securing resources has been and continues to be a challenge to preventing lead poisoning and the issues surrounding lead. In recent years, funding for lead programming has declined resulting in limited programming. Programming limitations have created difficulty in responding to public needs for training, information, and abatement--the only known evidence-based method for preventing exposure. One need that has been met is testing and although Governor Wolf and his administration support universal testing as does the Bureau of Family Health, there is no law in PA that accomplishes this. However, the CMHDs have noted there are system issues with multiple steps needed for testing and result reading as well as out-of-date provider testing guidelines and medical assistance reimbursement.

With the Governor and the Secretary responding to public inquiries and coverage regarding lead, information and data have become a political priority. The Pennsylvania Legislature has drafted legislation addressing concepts such as a lead task force, universal testing, and the provision of a housing unit's lead history to prospective tenants. In contrast, the CMHDs note a need to hold

landlords accountable for failing to address lead issues in rental units. The lack of statewide ordinances and consistent enforcement is a great concern. While increased attention to lead may be helpful for future efforts in securing funding for lead programming, the political factor may add to the complexity of the problem.

Through programming activities and participation in the Child Safety CoIIN, the BFH is focusing on injury and violence reduction.

<b>PA 2015 Youth Risk Behavior Survey of high school students</b>		
<b>YRBS Behaviors</b>	<b>PA</b>	<b>US</b>
Did not go to school because they felt unsafe on way to or from	7.6%	5.6%
Were in a physical fight	21.7%	22.6%
Were electronically bullied	14.3%	15.5%
Were bullied on school property	19.9%	20.2%
Experienced physical dating violence	7.2%	9.6%
Experienced sexual dating violence	9.3%	10.6%
Seriously considered attempting suicide	15.7%	17.7%
Attempted suicide	7.5%	8.6%

While there is a general need for updated national and state data encompassing the strengths and needs for CSHCN and their families, the BFH is currently exploring the magnitude of stress for caregivers of CSHCN.

<b>Impact of CSHCNs Conditions on Families (2009-10)</b>	
Cause family financial problems	17%
Families spent 11 or more hours/week providing or coordinating care	12%
Caused a cut back or stop in work	24%
Parents avoided changing jobs to keep health insurance	16%

In a 2009 survey, over 45 percent of respondents caring for CSHCN said they needed more information or help managing their emotional/physical stress and finding time for themselves. In a 2011 summary of the status of CSHCN by HRSA, it was noted that CSHCN are more than twice as likely to have a parent reporting “usually or always” feeling stressed.

Discussions with the CMHDs noted a need for more education for home visiting providers regarding opioid abuse and also more mental health services for those assessed and in need of referrals. The BFH recognizes a need to more actively address health disparities and work toward health equity; a sentiment shared by the CMHDs as their work is already moving in that direction.

The BFH has decided to look deeper into ACEs as they have emerged in discussions addressing the social determinants of health and violence reduction. ACEs have a dose-response relationship and can affect health, behaviors, and life potential over the lifespan. The PA BRFSS collected data from the ACE module in 2010 and 2014 and will collect this module again in the 2016 cycle.

BRFSS Reported ACEs		
	2010	2014
One or more ACEs	53%	47%
Four or more ACEs	13%	11%
Some form of child abuse	36%	29%
Emotional abuse	31%	32%
Witnessed domestic violence at least once.	15%	15%

For both years, black adults were more likely to have experienced an ACE as compared to white adults. PA’s findings were similar to the combined prevalence for the ten states and the District of Columbia in 2010.

### **II.B.2.b. Title V Program Capacity**

#### **II.B.2.b.ii Agency Capacity**

While some program funding ended, several of the programs within the BFH expanded their reach of service over the past year.

In December 2015, the Newborn Screening and Follow-up Technical Advisory Board voted to place Pompe on the mandatory screening panel and five other lysosomal storage disorders (Krabbe, Fabry, Niemann-Pick, Gaucher, and Hurler Syndrome) on the mandatory follow-up panel. The BFH moved forward with the recommendation and these changes were effective February 5, 2016 increasing the number of mandated conditions to seven and increasing the number of conditions on the follow-up panel to 28.

The Health Resource Center (HRC) Program expanded reproductive health services currently provided to high school students in Philadelphia and Delaware counties to five additional counties (Allegheny, Berks, Dauphin, Lackawanna and Lycoming) with high rates of teen pregnancy, STIs and school dropouts.

The BFH began tracking Pennsylvania data for the CDC’s National SUID Case Registry in September 2015. These comprehensive data from the multidisciplinary child death review team meetings capture the circumstances surrounding each SUID death. This information is used for the development of targeted SUID reduction and prevention activities at both the state and local levels.

The Special Kids Network hired a Regional Coordinator Supervisor and two additional Regional Coordinators, all a parents or guardians of a CSHCN, bringing the total to eight for PA.

#### **II.B.2.b.iii. Workforce Capacity**

The BFH has undergone some leadership changes in the last year. Carolyn Cass was appointed BFH director in February 2016. Tara Landis was appointed in April 2016 to fill the director of the Division of Child and Adult Health Services (CAHS) vacancy left by Ms. Cass. Ms. Landis has worked in the BFH for over eight years and has nearly twelve years of public health experience. She has earned a Bachelor’s Degree from Messiah College and is currently working toward a Master’s degree in Health Education from Penn State University.

Kelly Holland was appointed as acting division director of Newborn Screening and Genetics (NSG) in May 2015 and was appointed as the new division director in August 2015. Michelle Connors is leaving her long-held position of director of the division of Community Systems and Developmental Outreach (CSDO) in July 2016.

In the fall of 2015, Ms. Holland was selected to participate in the Association of Maternal and Child Health Programs (AMCHP) Leadership Lab Next Gen Leaders Cohort. Jane Marsteller, BFH’s Family Advisor and PA Family Delegate for AMCHP, was

selected to participate in the Leadership Lab Family Leaders Cohort. These 10-month programs allow Title V staff from across the workforce to learn from each other and role-based peers.

Several BFH staff have participated in leadership skill building opportunities within the DOH. Additional training for BFH staff included attendance at several trainings and conferences including: the Personal Responsibility Education Program (PREP) In-Person Topical Training “Meeting Youth Where They Are: Understanding the Adolescent Experience”; the 2015 North American Cystic Fibrosis Conference; and the Pennsylvania Community on Transition Conference. Twenty staff attended a training from the Pennsylvania Coalition Against Domestic Violence (PCADV) on Adolescent Relationship Abuse (ARA).

Two staff from the Adolescent Health Services (AHS) program, the Healthy Youth PA grantees, and one CSDO staff person attended the Search Institute’s annual Essentials of Asset Building for Trainers and Facilitators workshop. All staff from the Lead and Healthy Homes Program completed at least one professional development course on healthy homes materials.

BFH grantees attended conferences and trainings including: a Lead and Healthy Homes conference; the National Environmental Health Association Annual Education Conference; 101 trainings and “train the trainer” sessions covering issues regarding Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) cultural competency and identifying and addressing ARA.

Two webinars directed at primary care providers in PA were conducted by grantees and offered Continuing Medical Education credits and American Nurses Credentialing Center approved credits: “Lead Poisoning: Why Some Children are Still at High Risk and What You Can Do About It” and “Keeping Kids Safe at Home, at Play and On the Way.”

In 2015, the Cultural and Linguistic (CLC) initiative was developed to improve the quality of health care provided to families, including those with CSHCN, by promoting and assuring access to and the provision of CLC services for all families. The CLC initiative involves approximately 25 stakeholder representatives. The CLC developed a five-year plan through the formation of workgroups, completion of a Requirements Analysis (a collection of perspectives from state agencies regarding CLC gaps and considerations), and researched other state’s activities on cultural competence.

BFH staff participated in discussions on evidence-based strategies led by the block grant coordinator in preparation for the 2015 Annual Report/2017 Application submission. As a result of the transformation of the block grant and subsequent work on the 2014 Annual Report/2016 Application, it became apparent staff need additional education translating public health concepts into the day to day administering of Title V programming. Additionally, the BFH recognizes the impact of the continued lack of a MCH Epidemiologist on the ability to conduct program evaluation, in-depth analysis of surveillance systems like PRAMS, and on-going block grant needs assessment.

After identifying a data priority, the BFH formed a dedicated workgroup which began by holding discussions with BFH Title V staff in an effort to better understand current programmatic capacity to collect and analyze data. To date, more than half of the discussions have been held with a number of common themes across programs:

- Data are being collected and stored for all Title V programs.
- Staff are attempting to analyze data even in a limited capacity. Many want to collect and utilize data more extensively to improve programs and services delivered, and be efficient and effective in funding use.
- Most of the BFH programs contract with vendors to collect basic, programmatic data related to services provided. BFH provides little direction on establishing specific goals and objectives associated with that data collection, analysis and reporting.
- Staff were unaware of the extent their programs are limited by lack of data.
- All staff were interested in receiving data analysis training if offered, and some were interested in having access to either more tools or dedicated staff experts.

### **II.B.2.c. Partnerships, Collaboration, and Coordination**

While many partnerships and collaborations continued from the previous reporting year, there were some expansions while other funding partnerships ended.

- In 2015, DOH ended the funding partnership with Cribs for Kids. Cribs for Kids will remain a collaborating partner for MCH programming.
- Funding for the Department's Lead Hazard Control Program ended in 2015. As a result of the grant, the Department completed 269 inspections/risk assessments of housing units and made 157 homes lead-safe.
- The BFH collaborates with the asthma section of the Division of Obesity, Physical Activity and Nutrition.
- BFH partners with the Department of Drug and Alcohol programs to educate and develop a plan to address Fetal Alcohol Spectrum Disorder (FASD).
- The BFH partners with Persad Center to provide LGBTQ cultural competency assessments and trainings to HRC grantees. Persad also provides LGBTQ cultural competency consultant services to HRC grantees, in addition to the services provided to the PREP grantees.
- The BFH partners with PCADV to provide training and materials to support program delivery and implementation for the HRC grantees. PCADV provides resources for HRCs to conduct intimate partner violence screenings and referrals to youth seeking services at HRCs.
- Due to the vacancy of the Director of the Office of Health Equity in 2015, this partnership was suspended. It is hoped that work will resume in 2016 with a new director in place.
- The Core Leadership partnership grew in 2015 with participation of additional families of CSHCN.

## **Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)**

### **II.B.1. Process**

Pennsylvania (PA) conducted a State Health Assessment (SHA) in 2013 to assess and report on the health status of the population. This assessment, published in March 2014, is part of a department-wide process to apply for national accreditation by the Public Health Accreditation Board. The SHA is the basis for the creation of the state health improvement plan currently in the final stages of development. The SHA was a collaborative process of collecting and analyzing data and information to develop priorities and policies, garner resources and plan actions to improve the population's health. It was conducted in partnership with 50 outside organizations and includes data and information on demographics; socioeconomic characteristics; quality of life; behavioral factors; the environment; morbidity and mortality; and other determinants of health.

A core committee made up of Department of Health (DOH) staff performed the majority of the work to carry out the assessment with planning and assistance from a consultant firm. An advisory committee, consisting of 125 members representing a broad array of state public health systems including various state agencies, colleges and universities, and organizations/associations was created. In addition to the committees, individual bureaus and programs within the DOH furthered the inclusion of other stakeholders in the process. The SHA circulated for public comment from Sept. 3-Oct. 11, 2013 via the DOH website, through advisory committee distribution, Health Improvement partners and the DOH Health Statistics Bulletin.

The BFH chose to use the SHA as the backbone of the 2015 Title V Needs Assessment to assess the broad needs and capacity of the state and then gather primary data from focus groups to specifically assess MCH population stakeholder needs and capacity with regard to Title V service delivery. Existing partnerships and collaborations were also summarized. The most recent available state and national secondary quantitative data specific to the MCH population were analyzed including:

- PA Bureau of Health Statistics and Research
- PA Community Health Assessment Reports
- Healthy People 2020
- US Census Bureau, American Community Survey
- PA Child Death Review Reports
- Childhood Lead Surveillance Reports
- PA Pregnancy Risk Assessment Monitoring System (PRAMS)

The SHA was the major source of secondary quantitative and qualitative data. Ten broad topic areas were covered by the SHA: the context of health in the state, general health status, major risk and protective factors, occupational health and safety, infectious diseases, injury and violence, maternal and child health, environmental health, healthcare services and chronic diseases. Both local and national data including literature review were used as sources for the SHA. Below are some of the key sources for the creation of the SHA:

- CDC sources such as Youth Risk Behavior Survey & National Notifiable Disease Surveillance System
- Medicaid Statistical Information System

PA Behavioral Risk Factor Surveillance System

PA Cancer Registry

PA Department of Human Services, Office of Medical Assistance Programs

Pennsylvania Health Care Cost Containment Council

The BFH director, division directors, program managers and the Title V project coordinator comprise the Title V Block Grant committee and facilitated fifteen focus groups with various internal and external organizational/program representatives from September to December 2014. The focus groups were asked 12 questions developed internally by BFH staff with regard to the provision of Title V services. Stakeholders who were not able to participate in focus groups were invited to provide written responses to the questions. Focus group data were summarized, themes identified and then divided by population domain. Stakeholder groups were then asked via email for additional feedback on the focus group themes and requested to submit any evidence-based strategies for addressing the themes and/or the new NPMs.

Information from all the data sources was reviewed by the BFH Block Grant Committee individually and collectively. The state's chosen priority needs evolved after careful review of the SHA, subsequent data related to the MCH population, focus group responses, and BFH capacity to impact population needs. Executive staff reviewed and provided additional guidance for the priorities based on overall DOH initiatives and goals. The final priorities reflect an approach to address current population needs in light of the changing health care environment, the transformation of the Title V performance measure framework, and the mission of the DOH. Of the nine priorities selected for the population, four are broader visions of previous state priorities, and the remaining five are new visions to address the needs of the MCH population of PA.

## **II.B.2. Findings**

### **II.B.2.a. MCH Population Needs**

#### **Women/Maternal**

In 2013, there were over 6 million women living in Pennsylvania (PA) with various characteristics detailed in the table below.

2013 Pennsylvania Women	
<b>Race</b>	
83%	White
12%	Black
5%	Other
6%	Hispanic
<b>Unintended Pregnancies (2011)</b>	
38%	Mothers with an unintended pregnancy
<b>Poverty Level</b>	
14%	Below poverty level
<b>Health Insurance</b>	
12%	Uninsured
88%	Insured
<b>Educational Attainment</b>	
3%	< 9 <sup>th</sup> Grade
7%	9–12 Grade
35%	High School Graduate/GED
19%	Some College
8%	Associate Degree
17%	Bachelor's Degree
10%	Graduate or Professional Degree
<b>Employment</b>	
69%	Employed
<b>Smoking (2009-2011)</b>	
29%	Smoked cigarettes in the past two years

In 2013, 68 percent of women had a preventive medical visit in the past year with little variance seen between subgroups, with the exception the uninsured.

In 2013, there were more than 138,000 births and 73 percent of pregnant women received prenatal care beginning in the first trimester which is below the 77.9 percent Healthy People 2020 Objective. The lowest rate of prenatal care access was among uninsured women at 33 percent and it is anticipated that the Affordable Care Act (ACA) will positively impact those numbers going forward. Adequate access to prenatal care is further complicated in certain regions of the state, namely the southeast, where the hospital obstetrical capacity has declined dramatically over the last decade.

Despite the fact that rates of women receiving early and adequate prenatal care have been steadily improving, racial disparities remain with black, Hispanic and Asian and Pacific Islander women having a higher percentage of those who did not receive prenatal care. The table below shows the rates of prenatal care in recent years.

Prenatal Care	
<b>Adequate Prenatal Care (2011)</b>	
73%	White
57%	Black
59%	Hispanic
<b>Prenatal Care in the First Trimester (2010-2012)</b>	
77%	White
56%	Black
57%	Hispanic
<b>No Prenatal Care (2010-2012)</b>	
1%	White
4%	Black
2%	Hispanic

The BFH has begun to address these issues of disparity by implementing creative initiatives, namely Centering Pregnancy, in an area of Philadelphia with historically poor birth outcomes. In 2012, the percentage of low birth weight babies enrolled in the program was slightly lower than the county average and the breastfeeding initiation rate was slightly higher. Over the long term, larger differences in positive birth outcomes are expected. The Lancaster Centering Pregnancy program also saw success with breastfeeding initiation rates at 90 percent, above the countywide rate. With this success, the BFH will continue implementing Centering Pregnancy programs.

Historically, poor birth outcomes such as the infant mortality rate, maternal mortality rate and low birth weight have been higher among blacks. From 2008 to 2012, the rate of severe maternal morbidity per 10,000 delivery hospitalizations increased from 102.1 to 128.1 with the highest rates among Medicaid and non-Hispanic blacks. Additionally, a recent report released by the Philadelphia medical examiner's office revealed a pregnancy-related mortality rate in Philadelphia of 27.4 per 100,000 live births for 2010-2012 compared to the national average of 17.8. These stark figures are a reminder to address the immediate health needs of at-risk populations and the social determinants of health prior to pregnancy.

Stakeholders identified Title V home visiting programs as a strength and an important safety net for at-risk women who would otherwise go unserved or underserved to receive vital and timely prenatal and postpartum services. The importance of addressing non-health related issues of housing, education, employment and domestic violence was identified as a need and speaks to the importance of addressing physical health as well as the social and emotional aspects of the lives of women of child-bearing age.

While current home visiting programs provide postpartum education to new mothers on a variety of topics including birth spacing, healthy infant development, nutrition, mother's health and the importance of immunization, the BFH is looking to expand these programs and for avenues to integrate innovative interconception initiatives to address the social and emotional needs of women.

The BFH continues to work with local health departments to identify pregnant women and improving access to prenatal care. Additionally, the BFH will continue to use PRAMS data to inform program and policy development to emphasize the importance of data driven, evidence based initiatives.

### **Perinatal/Infants**

In 2012 there were 140,873 births in PA making the total number of infants in the state 145,394. Over a third of babies born were to women enrolled in either WIC or Medicaid programs. The table below details demographic details of the infants.

2012 Pennsylvania Infants	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
78%	White
15%	Black
7%	Other
10%	Hispanic

PA requires that all infants be screened for six genetic disorders at no cost and encourage parents to have their infant screened for an additional 23 disorders which may be covered by insurance and results are reported to DOH. Hearing and heart conditions are also screened for at birth and hospitals may screen for additional disorders. Of the births, 97 percent received a blood spot screen to detect metabolic defects with less than half a percent referred for diagnostic confirmatory testing. The top three genetic disorders found in PA are hearing loss, primary congenital hypothyroidism and cystic fibrosis.

The BFH's Newborn Screening program is strong including established contracts with treatment centers to assure babies with a presumptive positive screen are followed through to diagnosis. An integrated newborn metabolic screening tracking system is under development to increase efficiency to reduce programming costs as mandatory screening expands. Lysosomal Storage Disorders are the most recent additions to the mandatory panel of newborn screening tests.

The health of infants can be an indication of the nation's health and as we have seen with other populations in PA, racial disparities persist. These disparities are influenced not only by health related factors but social factors such as poverty and access to care. In 2012, the infant mortality rate for the state was 7.0 however; the rate for black infants (14.3) was nearly double the rate for Hispanic infants (7.9) and nearly triple the rate for white infants (5.2). The leading causes of infant mortality are birth defects, prematurity and low birth weight and sudden unexpected infant death (SUID).

In 2012, 10.8 percent of PA babies were born prematurely, which surpasses the Healthy People 2020 goal of 11.4 percent. The percentage of low birth weight babies was 8.1 with disparities again when stratifying the rate by race: black (12.9), Hispanic (8.5), white (7.0). Only the rate for white babies surpasses the Healthy People 2020 goal of 7.8 percent.

In 2013, the sleep related SUID rate per 100,000 live births was 83.7, a significant improvement from 88.4 in 2012. The safest place for an infant to sleep is alone in a crib on their back and in 2011, 78 percent of infants were placed on their backs to sleep.

In 2014, PA continued to fall below the national breastfeeding rates in six categories as detailed in the table below.

<b>Breastfeeding Rates</b>		
	<b>Pennsylvania</b>	<b>Nation</b>
Ever breastfed	73%	79%
Breastfeeding at 6 months	46%	49%
Breastfeeding at 12 months	26%	27%
Exclusive breastfeeding at 3 months	34%	41%
Exclusive breastfeeding at 6 months	15%	19%

While PA breastfeeding rates are increasing, there is still more work to be done including disparities between counties and sub-populations. Over the past year, 651 primary care and OB-GYN professionals received training on how to support and promote breastfeeding within their patient population with positive changes seen in provider behavior. The BFH is focused on expanding current baby-friendly hospital initiatives to support breastfeeding and integrating breastfeeding messages into other programming supported BFH and DOH.

Stakeholders identified several needs such as providing a cross systems approach including nutrition, housing and education services for the Title V population. Additional suggestions included focusing on continuity of care with a PCP; enhancing and strengthening home visiting programs; parental education related to the health and safety of infants during the prenatal and postpartum periods; and better communication between hospitals, providers and parents. The BFH is looking to address some of these concerns with more integrated and innovative programming especially during the first year of life with a focus on safe sleep.

The BFH is working on numerous initiatives to reduce infant mortality as it is related to safe sleep. Currently, the Cribs for Kids program provides portable cribs, safety education and a home safety check to families unable to afford a safe sleep environment for their infants and conducts trainings for police and emergency personnel to capitalize on their position and presence in the community.

The BFH is working to maintain and expand collaborations through safe sleep summits and ongoing 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. Going forward the BFH will continue to emphasize safe sleep promotion initiatives and support evidence based or informed programming aimed at decreasing the incidence of infant death due to unsafe sleep practices.

## **Child**

In 2013, there were 3,081,171 children ages 0-19 in PA, 24 percent of the population, and their demographic distribution is detailed in the table below:

2013 Pennsylvania Children (ages 0-19)	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
78%	White
15%	Black
4%	Asian/Pacific Islander
4%	Multi-Race
10%	Hispanic
Rural/Urban	
26%	Rural
74%	Urban
Under Poverty Level	
19%	Children under 18

Child injury and mortality are key indicators of children's health. In 2012, the rate of hospitalization for non-fatal injury for children ages 0 through 9 was 189.7 per 100,000. The rate is higher for children ages 1-4, non-Hispanic blacks and males. Of specified causes of injuries resulting in hospitalization, falls and poisonings were in the top three leading causes for those under age 25. Hot objects were the second leading specified cause of injury hospitalizations for children under age 5. The table below details falls and poisonings as causes of injury for children up to age 25.

Hospitalizations for Injuries								
Type of Injury	Under 5		Ages 5 to 14		Ages 15-24		All Ages	
	Number	Percentage of Age Group Total	Number	Percentage of Age Group Total	Number	Percentage of Age Group Total	Number	Percentage
All Injuries	2,186	100%	2,898	100%	10,134	100%	141,130	100%
Falls	610	28%	810	28%	1,017	10%	63,477	45%
Poisoning	215	10%	241	8%	2,389	24%	15,954	11%

The child mortality rate for children ages 1-9 in was 15.5 per 100,000 in 2013 with higher rates for children ages 1-4 years, non-Hispanic blacks, males, and those living in rural areas. There is a clear disparity with regards to both injury and mortality for black children. Black children comprised 14 percent of children ages 1-17, but represented 21 percent of total child deaths and died at 1.6 times the rate of white children. Black children had higher rates of non-fatal injury (ages 0-9), child mortality (ages 1-9), and asthma prevalence (age under 18).

From 2009-2011, males accounted for 75 percent of injury related deaths in children ages 1-21 and males exceeded the number of female deaths in every subcategory of injury related death, including poisoning, overdose or acute intoxication, and for both unintentional and intentional injury. White children comprised nearly all deaths from drowning and poisoning overdose or acute intoxication.

A number of needs were identified by stakeholders: prevention services for asthma and injury, environmental health, school-based services, confidential services, and mental health. While the BFH administers programs that address some of these needs, other needs are addressed by other bureaus and agencies. The Immunization Program and Asthma Control Program reside in other bureaus, school-based services are located within the Department of Education and mental health programs are primarily housed within the Department of Human Services (DHS).

Because these needs are addressed by programs in other areas, the BFH will focus on safe and healthy living environments for children, and programs aimed at reducing child hospitalization and mortality rates. Given the disparities that exist for black children, and for males, future programs or initiatives could address these specific populations.

The proportion of old homes in Pennsylvania presents a challenge to maintaining safe and healthy living environments. In 2010, Pennsylvania was fifth among states in the percentage of homes built before 1950 (36 percent), and as well as those built before 1978 (70 percent). In addition to presenting a risk factor in lead poisoning, an older home also has a greater probability of having a degraded structure. Structural deficiencies can lead to injury, increase the possibility of pest infestation, and contribute to an unsafe, unhealthy living environment. In 2011/12, 19 percent of PA children aged 0-17 lived in a poorly kept home, higher than the national average (16.2).

BFH has successfully implemented the Lead and Healthy Homes Program (LHHP), a primary prevention and education program that seeks to provide education on healthy homes to high risk individuals or families and provide intervention supplies to reduce hazards and promote healthy homes. BFH plans to continue the LHHP with a greater focus on injury prevention through education and interventions to parents about home issues that may present hazards to health and safety.

All of PA's 67 counties are represented by one of the state's 63 local (CDR) teams. Based on findings from child death reviews conducted by local CDR Teams, prevention measures were developed and implemented in the communities across the state addressing motor vehicle safety, suicide prevention, safe sleep and farm safety. The DCAHS will continue to administer the CDR Program and work toward expanding preventive measures and targeted programming. The DCAHS will also collaborate with the Violence and Injury Prevention Program and participate on the Injury and Violence Prevention Network, which endeavors to develop a comprehensive and coordinated injury prevention effort, to further address injury related hospitalization and death.

#### **CSHCN**

CSHCN are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition and also require health and related services of a type or amount beyond that required by children in general. In 2009/2010, CSHCN accounted for 17 percent of PA children, an increase from 15 percent in 2005/2006. Over 245,000 PA children and adults live with a disability and special health care needs due to Traumatic Brain Injury (TBI) with an additional 8,600 sustaining long term disabilities as a result of a TBI annually.

2009/2010 Pennsylvania Children with Special Health Care Needs	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
73%	White
13%	Black
6%	Other
8%	Hispanic
Poverty Level	
38%	< 200%
17%	200-299%
14%	300-399%
30%	≥ 400%
Insurance Coverage	
44%	Private only
36%	Public only
19%	Both private and public
2%	Uninsured

The BFH compares state performance to national performance on outcomes for CSHCN to determine areas of success and need. In all six core areas, PA is performing equal to or above the national outcomes as detailed in the table below.

Measure	PA (2009/2010)	Nation (2009/2010)
CSHCN who received care in a medical home	48%	43%
CSHCN who received adequate and appropriate transition services	40%	40%
Families of CSHCN who stated they were a partner in decision making at all levels	73%	70%
Families of CSHCN who found community-based services are organized and easy to use	69%	65%
Families of CSHCN who said their children were screened when needed	86%	79%
Families of CSHCN with adequate private or public insurance to pay for treatment rendered	69%	61%

While PA is performing better than the national average on the six core performance measures for CSHCN, stakeholders continue to voice the: need for more information on programs and services combined with the assistance of a navigator to walk families through the system; families' ability to determine what services are covered by Medicaid; lack of materials written in a language and at a level that families can understand; affordable and accessible transportation arrangements; and locating respite services for caregivers.

CSHCN face more barriers than other children in fulfilling aspirations related to independent living, employment, relationships and recreation. Issues involving insurance, finding doctors, managing personal health records, navigating the

health care system and understanding their medical conditions. Information about services and self-advocacy skills can go a long way in helping youth be more independent in managing their health care.

Families of CSHCN have also expressed the need for programming specific to bullying. While bullying is a concern for all children, CSHCN report being bullied at a rate of 60 percent compared to 25 percent of the general population. Children with attention deficit hyperactivity disorder are not only more likely to be bullied, but are more likely to bully others. CSHCN face additional challenges such as the victim's ability to recognize, address, and report the bullying as well as the ability of the family to detect and address bullying situations.

The BFH is already working to address these concerns through specific programming and collaboration building. Over 200,000 hours of respite care were provided to families of CSHCN by 19 trained organizations. The Special Kids Network and Medical Home Initiative (MHI) provide families of CSHCN with information to access necessary and appropriate community based services as well as connecting families of CSHCN to each other for support. The BFH offers services to all school districts to consult with school teams and families in the development and delivery of educational services for students who have experienced any type of acquired brain injury through the BrainSTEPS Program. The TBI community, through an advisory board, provides valuable expertise and unique insight to the BFH and assists with policies and procedures related to TBI.

Going forward, the MHI will be greatly enhanced to provide both CSHCN and non-CSHCN with appropriate health and health related services, screenings and information.

The BFH will continue to strengthen partnerships with advocacy organizations such as Parent to Parent, the Parent Education and Advocacy Leadership (PEAL) Center, the PA Youth Leadership Network, and the Children's Hospital Advisory Network for Guidance and Empowerment (CHANGE) to understand and meet the needs of CSHCN.

**Adolescents**

In 2013, PA's 1,759,480 adolescents were distributed by gender and race/ethnicity as shown in the table below.

<b>2013 Pennsylvania Adolescents (ages 10-19)</b>	
<b>Gender</b>	
51%	Male
49%	Female
<b>Race/Ethnicity</b>	
72%	White
13%	Black
3%	Asian
3%	Multi-race
8%	Hispanic

There are significant disparities in outcomes among racial and ethnic groups. In general, adolescents who are black, American Indian, or Hispanic, especially those who are living in poverty, experience worse outcomes in a variety of areas such as obesity, teen pregnancy, tooth decay and educational achievement compared to adolescents who are white. Sexually transmitted infection rates among adolescents 15-17 years of age also show a disparity by race/ethnicity, similar to teen pregnancy rates. The rates for chlamydia and gonorrhea are detailed in the table below.

<b>2012 Chlamydia and Gonorrhea Rates for Adolescents per 100,000 population (15-17 years of age)</b>	
Chlamydia	
340.4	White
890.4	Hispanic
4,791.2	Black
Gonorrhea	
46.8	White
92.6	Hispanic
1,397	Black

In the 2013-2014 school year there were 819,838 students PA schools with 13,945 dropouts. The distribution of these dropouts is detailed in the table below.

<b>2013-2014 School Year Dropouts</b>	
Gender	
58%	Male
42%	Female
Race/Ethnicity	
45%	White
32%	Black
4%	Other
19%	Hispanic

There were 28,957 delinquency-related dispositions in PA during 2013 which represent a 7 percent decrease from 2012 and a 30 percent decrease since 2009. In 2013, 17 year olds accounted for 26 percent of all dispositions, followed 16 year olds (21%) and 15 year olds (17%). White non-Hispanics were involved in 44 percent of delinquency dispositions, followed by black non-Hispanics and Hispanics. Statewide secure detention admissions have declined 17 percent since 2012 and 33 percent since 2009. Statewide, delinquency placements have declined each year since 2009, resulting in a 28 percent decrease.

For 2009-2013, 9 percent of PA adolescents reported using illicit drugs within the month prior to being surveyed which was slightly lower than the national rate. Also for 2009-2013, 18 percent of PA 12-20 year olds reported binge alcohol use within the month prior to being surveyed and higher than the national rate. In 2012-2013, 61 percent of PA adolescents perceived no great risk from drinking five or more drinks once or twice a week, similar to the national rate.

Between 2013 and 2014, PA had a 17 percent increase, the third-largest in the nation, in the number of unaccompanied adolescents who are homeless. In PA, the number of adolescents who are unsheltered increased by nearly a third at a time when the total population of unsheltered homeless decreased in the state and nation.

There are increasing rates for bullying and suicide among adolescents, with increased rates among Lesbian, Gay, Bisexual, Transgender and Questioning/Queer (LGBTQ) adolescents. During the three year period from 2009-2011, intentional self-harm (suicide) was the second leading cause of death among 10 to 17 year olds. For PA's black adolescents, the rate of death due to suicide was approximately twice the rate in black children nationally.

According to the Pennsylvania Youth Survey data from 2013, 93 percent of the survey respondents indicated they think it is wrong or very wrong to bully, however, one in five students indicated they had been bullied at school in the past year. Additionally, 14 percent of respondents indicated they had been electronically bullied in the past year.

The rates of LGBTQ adolescents bullied are even higher. According to the national GLSEN school climate survey, 56 percent of adolescents felt unsafe at school because of their sexual orientation and 38 percent because of their gender expression. In addition, 30 percent of LGBTQ students missed at least one day of school in the past month because they felt they were unsafe or were uncomfortable at school. Among LGBTQ adolescents in the past year 74 percent were verbally harassed, 36 percent were physically harassed, and 17 percent were physically assaulted due to their sexual orientation. Additionally, among LGBTQ adolescents in the past year 55 percent were verbally harassed, 23 percent were physically harassed, and 11 percent were physically assaulted because of their gender expression. The GLSEN survey also found that 62 percent of students who reported an incident of harassment or assault said that the school staff did nothing in response.

The BFH has had success in providing services to high-risk youth, including providing over 13,000 adolescents with reproductive health services, approximately 1,500 adolescents with teen pregnancy prevention programming, providing nearly 1,500 adolescents with services through a Health Resource Center (HRC), and providing over 6,000 safer sex materials (female and male condoms and dental dams) to adolescents through a HRC.

To continue with the strides made in decreasing the teen pregnancy rate and to account for the trends of bullying and suicides the BFH will focus adolescent programming on the areas of preconception and interconception health care and support and, establishing protective factors for adolescents and young adults prior to and during critical life stages. Preconception health care can improve reproductive health outcomes by promoting the health of women of reproductive age before conception therefore improving pregnancy related outcomes. Preconceptive care can significantly reduce birth defects and disorders caused by preterm birth. The goal of interconception care is to improve the outcome for the next pregnancy and reduce the health risk to future babies. These priorities will address major health issues, such as bullying, access to services for LGBTQ youth, suicide prevention, increasing protective factors for youth and preventative medical visits for youth.

### **Life Course**

While the individual components and characteristics of the MCH population are important, the social determinants of health such as access to health care services, transportation options, job availability, social supports, exposure to violence, cultural norms and economic status play a significant role in shaping the health of individuals and populations. The greater the disparity caused by these social determinants, the greater the challenges faced.

PA continues to grow with each generation becoming more diverse than the one before. With diversity comes a richness of culture and differing values which challenge people and systems to think and evolve to meet the changing needs. Growing diversity is not without its challenges however. For those who speak a language other than English at home, the disparities are great with 23 percent living below the poverty level compared to 13 percent of the total population. Expanding diversity demands new approaches and interpretations of how to provide appropriate and needed services to the MCH population.

Despite being a major transportation hub, rural areas lack transportation options and have large travel distances to health services. While urban areas have more transportation options, barriers are still common for those with disabilities and those with limited financial resources. Transportation-related barriers exist across agencies creating ongoing obstacles for accessing services beyond those imposed by insurance status. Uninsured rates, particularly among children are very low and PA ranks significantly below the national average of uninsured. The overall health and dental health status of children continues to be better than the national average. Partnerships with Medicaid and CHIP have resulted in health insurance coverage for the MCH population. The Healthy Baby line assists women in finding both prenatal care and health insurance for themselves and their children. Additionally, the ACA has played a large role in expanding the insurance coverage of the MCH population.

The BFH is also able to capitalize on collaborations with the Medicaid dental program, the PA Dental Association, American Academy of Pediatrics and coalitions to assure that oral health care is accessible, and special efforts focus on the dental needs of CSHCN. Only 10 percent of adults in the country have the skills necessary to find, understand and process health information to make healthy decisions. Health literacy is a broad and multi-faceted need that continues to impact health in PA. Accessing and understanding services and information was identified as a need across all domains and also amongst providers themselves. Stakeholders were consistently vocal regarding the need to use technology to provide information on available resources to both stakeholders and the MCH population through effective routes and messaging. They suggested that social media and texting be used to provide information about specific conditions, initiatives, services, resources and general MCH/Title V knowledge. The BFH has lagged in developing an online presence on social media; however, the BFH will take advantage of DOH's social media accounts to better disseminate information to consumers and stakeholders. Additionally, DOH has started a health literacy coalition providing an opportunity for the BFH to jointly address health literacy across the state.

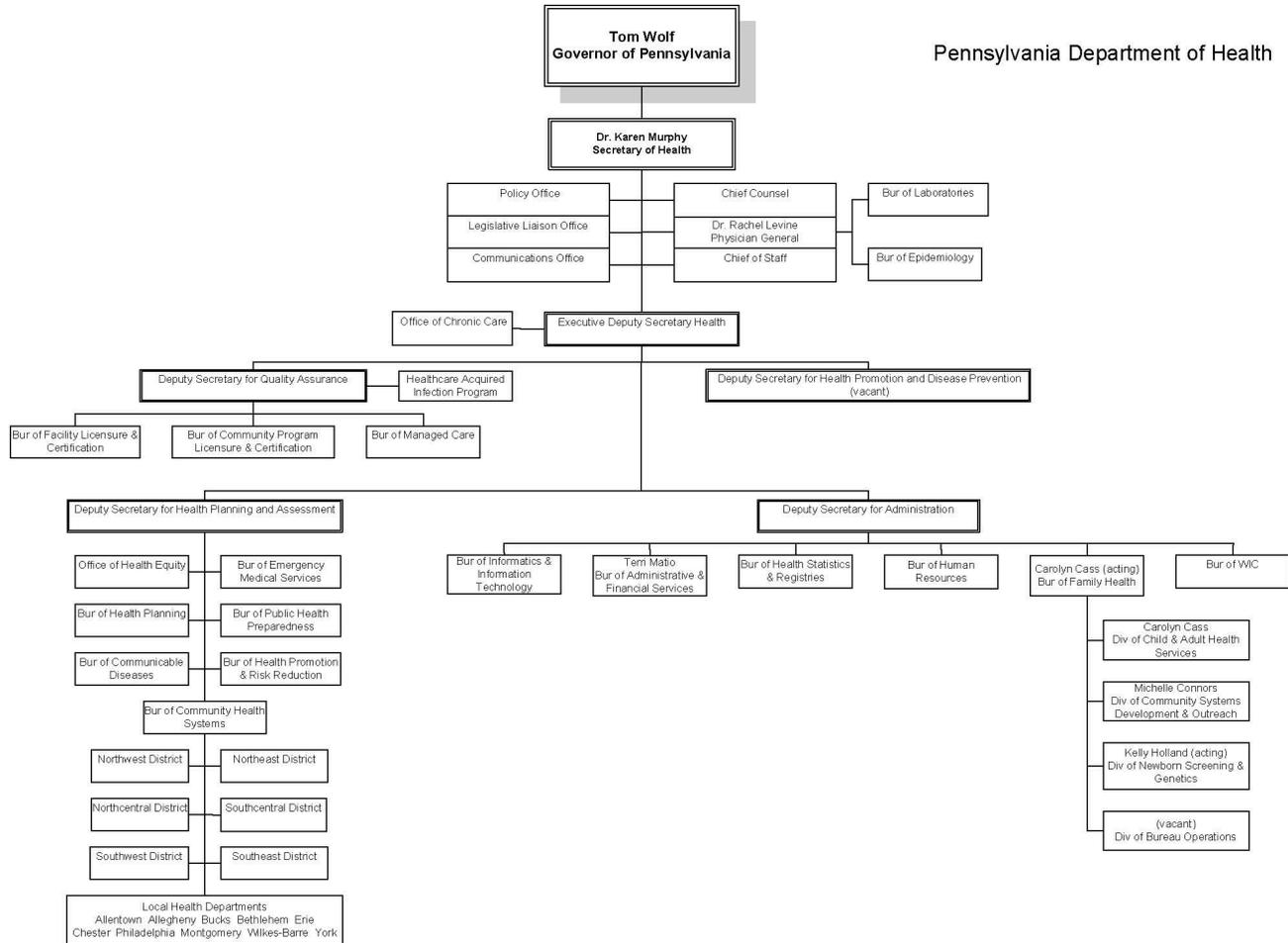
Smoking continues to have an impact on maternal and child health, despite cessation efforts. In 2013, 21 percent of the adults smoked with higher rates seen for those with less than high school education, among non-Hispanic blacks, and with incomes less than \$15,000. In 2013, 14 percent of women smoked during pregnancy a decrease from 17 percent in 2009. Higher rates were seen among women with only a high school education; who were unmarried received Medicaid; were ages 20-24 years; and who participated in WIC. In 2011-2012, 29 percent of children lived in a household where someone smoked and higher rates were found in households with CSHCN and those living below the poverty level.

Exposure to tobacco is a risk factor for the development of asthma and can trigger asthma episodes. The BFH sees a need to more directly address smoking, especially in the home, with more emphasis on screening and providing effective referrals to the 24 hour/7 day a week toll free helpline, the PA Free Quitline which provides smoking cessation information, resources and additional referrals.

The BFH is cognizant of the importance of involving nontraditional MCH organizations when addressing cross cutting and life course issues. Increasing collaborations across populations will encourage better information sharing, greater diversity of messaging, and broaden platforms needed to address the social determinants of health.

## **II.B.2.b Title V Program Capacity**

### **II.B.2.b.i. Organizational Structure**



Tom Wolf was inaugurated as the Commonwealth of Pennsylvania's 47<sup>th</sup> Governor on January 20, 2015. The Governor serves as Chief Executive of the nation's 6<sup>th</sup> most populous state. The Governor's Cabinet is comprised of the directors of various state agencies who are appointed by the Governor and confirmed by the Senate. All Cabinet members are responsible for advising the Governor on subjects related to their respective agencies.

Both Dr. Karen M. Murphy, PhD., RN, Secretary of Health, and Dr. Rachel Levine, Physician General, serve as Cabinet members. Dr. Murphy serves as the chief executive officer of the Department of Health (DOH); she sets overall policy and direction, defines the DOH's mission, establishes strategic goals and outlines specific objectives. Dr. Levine advises the Governor and the Secretary of Health on health policy and participates in the decision-making process of the DOH on policies relating to all medical and public health-related issues.

The DOH's Bureau of Family Health (BFH), as the State Title V Agency in Pennsylvania (PA), is responsible for administering a variety of MCH and CSHCN programs. The BFH's Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO) and Newborn Screening and Genetics (NSG) exercise their capacity to improve the health and well-being of PA's mothers, infants, children and youth, including CSHCN, and their families.

The BFH operates 28 programs using Title V funds and administers a number of other programs using other federal and state funds. Collectively, these programs carry out the mission of the Title V Program by establishing and supporting public health services and systems, promoting and providing primary and preventive care services and ensuring access to direct health care services to MCH populations. These programs encompass direct reimbursable services such as the Newborn Screening and Follow-up Program, non-reimbursable primary and preventative care services such as the Breastfeeding Awareness and Support Program and public health services and systems such as the Child Death Review Program. Tables

**Table 1: Title V Supported Programs**

Program / Service	Function(s)
Reproductive Health Services	Provides family planning services, including routine gynecological care, pregnancy testing, contraceptives, cervical cancer exam, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.
Child Death Review Program	Act 87 codified the Child Death Review (CDR) Program which is designed to promote the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. The CDR Program facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies.
Shaken Baby Syndrome (SBS) Prevention and Awareness Program (Act 176 of 2002)	The SBS program is a prevention program with the goal of reducing the incidence of abusive head trauma in the Commonwealth. This program provides training, education, technical assistance and support to staff at maternity wards and neonatal intensive care units across the Commonwealth.
Local Title V Programs	Ten county municipal health departments provide a variety of services aimed at improving maternal, infant and child health across the Commonwealth. These health departments are located in Allegheny County, Allentown, Bethlehem, Bucks County, Chester County, Erie County, Montgomery County, Philadelphia, Wilkes Barre and York City. Programs provided through these health departments include: maternal home visiting, obesity prevention and education, breastfeeding education and support, health education, prenatal care, perinatal depression screening, infant and child health education and training, direct oral health services, smoking cessation.
Traumatic Brain Injury School Re-Entry	A Statewide school re-entry program aimed at assisting schools with the re-entry issues of children and adolescents who have sustained a Traumatic Brain Injury (TBI). This program ensures that schools are educated on the issue of TBI so that children are accurately identified and

	as such receive the appropriate interventions to succeed.
Teen Pregnancy Prevention Special Initiatives	Two family planning councils in the Commonwealth address teen birth and pregnancy rates through reproductive health services to high school students and two evidence-based teen pregnancy prevention interventions to middle and high school students.
Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Program	Services to LGBTQ youth through Persad Center's Safe Spaces Project, which include suicide prevention training to youth, and engages in coalition building activities with known ally organizations and new partners to help the organizations become Safe Space certified. The Mazzone Center provides a drop-in health center for youth to obtain a variety of health care and social services.
Sudden Cardiac Arrest (Act 59 of 2012)	Primary components of the law include the requirement that parents of student athletes in the public school system must review and sign an information sheet about the warning signs and conditions of sudden cardiac arrest, training requirements for coaches, removal of a player from competition that exhibit symptoms of sudden cardiac arrest, and the requirement that the player may not return until cleared by a licensed medical professional.
Safety in Youth Sports Act (Act 101 of 2011)	The law is intended to protect student athletes from head injuries. As coaches are often the first line of defense in recognizing a concussion in athletes, the law offers tips and guidelines for recognizing and managing these injuries. Key components include establishing standards for managing concussions, removal from activity of an athlete that is suspected of suffering from a head injury, guidelines for returning an athlete to play once medical clearance is received, and required training for coaches.
Infant Death Program	The Pennsylvania Infant Death Program addresses the impact of an infant death on affected families and aims to reduce the incidence of Sudden Infant Death Syndrome (SIDS), suffocation and strangulation through public education. Key components include distribution of educational and instructional materials regarding SIDS and Sudden Unexplained Infant Death Syndrome (SUID) and an acknowledgment statement signed by those receiving the materials.

	those receiving the materials.
Centering Pregnancy Programs	Group prenatal care model used to reduce healthcare disparities, promote healthy behaviors, provide peer support, improve pregnancy outcomes and reduce infant mortality.
Lead and Healthy Homes Program	The Lead and Healthy Homes Program (LHHP) is a holistic healthy homes primary prevention program. The primary activities of the LHHP are to conduct home assessments to identify factors that could contribute to injuries or illness, provide education and interventions to reduce risk factors, and develop partnerships to integrate safe and healthy housing activities with other housing and health programs. Additionally, environmental inspections are performed in homes of children with elevated blood lead levels.
Childhood Lead Surveillance	The Childhood Lead Surveillance Program monitors childhood lead testing and results through the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS), a web-based application system that receives all lead reports submitted by laboratories. Surveillance data are used to identify possible high risk areas, areas of under-testing, and other potential service gaps. In addition to regular reporting of lead data and responses to requests, the program publishes a comprehensive annual report on lead data that includes lead testing, housing, and population data.
PA Medical Home Program (PMH)	Based on the Educating Physicians in their Communities (EPIC) model, the PMH is a statewide education and quality improvement program, using office-based change as the key to improving the care provided to Children and Youth with Special Health Care Needs (CYSHCN). The program also includes a transition component, which works to identify and place pediatric patients with special needs into adult primary care practices.
Epilepsy Support Program	Provides support services for children, youth and adults diagnosed with epilepsy/seizure disorders and their families.
Special Kids Network	Provides information and resources for Children and Youth with Special Health Care Needs (CYSHCN) and their families through 3 primary components: a toll-free helpline; in-home service coordination by an Elks Nurse; and community engagement through Regional Coordinators, who

	are parents of CYSHCN.
<b>Tourette Syndrome Support Program</b>	Provides guidance and counseling to people with Tourette Syndrome and their families. Services include information and referral, and training for providers, parents, teachers, and other professionals.
<b>Cystic Fibrosis Program</b>	Hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Cystic Fibrosis. Breathe PA is funded under this appropriation.
<b>Sickle Cell Program</b>	Select hospitals provide services to diagnosed patients and include diagnostic testing, transitional services, assessment, care, counseling, support, education and preventative therapeutic interventions. Community based organizations across the state provide community based services, education, and psychosocial services to patients. Services include outreach, case management, transition issues, community awareness and family support.
<b>Children's Home Ventilator Program</b>	Provides comprehensive care, including respite care and counseling to ventilator dependent children and families.
<b>Child Rehabilitation Program</b>	Hospitals and one community based organization provide comprehensive, multidisciplinary team care to clients with neuromuscular and orthopedic disorders.
<b>Hemophilia Program</b>	Select hospitals across the state provide multi-disciplinary team care to children and adult patients with a diagnosis of Hemophilia.
<b>Cooley's Anemia Program</b>	Provides comprehensive, care coordinated, multi-disciplinary team services to people of all ages with Cooley's Anemia . Services include transfusion therapy, evaluation of organ damage, specialized therapy, genetic testing, genetic counseling, chelation therapy, education and support groups.
<b>Spina Bifida Program</b>	Select hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Spina Bifida.
<b>Charcot-Marie-Tooth Program</b>	Outreach and education about Charcot-Marie-Tooth disease.
<b>Breastfeeding Awareness and</b>	Breastfeeding education to primary care practices and other healthcare providers across the state (EPIC BEST) and a quality improvement

Support Program	initiative with hospitals (Keystone 10)
Newborn Metabolic Screening and Follow-up Program	<p>This program assures screening and follow-up for 6 mandated conditions and 23 “follow-up” ensuring that blood spot specimen collection occurs as required by law, point of care testing occurs and screening results are reported for follow up through diagnosis. Follow-up services are provided on all infants with abnormal results. Newborns are referred to the appropriate treatment center to receive proper medical evaluation, confirmatory testing, diagnosis and treatment. The program contracts with treatment centers to provide newborn screening evaluations and medical services. The program manages a statewide pharmacy metabolic formula distribution system that supplies formula to diagnosed Pennsylvanians up to the age of 22 months. The program has an advisory committee comprised of subject matter experts who advise the program on best practices and also help develop follow-up protocols when new conditions are added to the screening panels.</p>

Newborn Hearing Screening and Follow-up Program	<p>Assures that all newborns are screened for hearing loss within the first 30 days, are diagnosed within three months, and receive prescribed treatment or intervention services within six months of birth. Newborns receive an initial hearing screening while still in the hospital. Infants who do not pass the initial screen receive follow-up re-screening at the hospital, often as an outpatient. The Department of Health performs follow-up and tracking of infants not passing their follow-up re-screening. Department staff determines whether appropriate assessment and evaluation is completed in a timely fashion and that infants receive the prescribed treatment and intervention. Infants identified as being at risk of delayed onset hearing loss receive continued monitoring as appropriate. The department also administers infant hearing screening educational outreach and training workshops for nurses, audiologists, physicians, early intervention staff, and other concerned professionals. The program has an advisory committee comprised of subject matter experts who advise the program on best practices and also help develop follow up protocols when new conditions are added to the screening panels.</p>
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Table 2: New Title V Programs

**Table 2: Non-Title V Programs**

<b>Program / Service</b>	<b>Function(s)</b>
Head Injury Program	The Head Injury Program provides services to individuals who have sustained a Traumatic Brain Injury (TBI). Services include short term rehabilitation services including cognitive and physical therapy as well as therapeutic recreation and work skills training. Additional services include pre-enrollment assistance, case management and transition services.
Traumatic Brain Injury (TBI) Grant	Through this grant the Department provides training and education to non-traditional personnel that come into contact with individuals who have sustained a TBI. These groups include mental health and drug and alcohol staff, police officers, emergency medical staff and school personnel. Through this training and education, the Department ensures that appropriate supports are in place to assist Pennsylvania residents living with TBI.
Lead Hazard Control Program (LHCP)	The LHCP utilizes certified lead abatement firms to perform lead inspection/risk assessments and lead hazard abatement on housing units of low-income families with children under age six; performs lead outreach and education; and trains contractors in lead-certified disciplines to increase the pool of certified contractors.
Pregnancy and Risk Assessment Monitoring System (PRAMS)	Mail and telephone survey concerning behaviors and attitudes of women around the time of pregnancy; Participate in the analysis of collected data; Act as a liaison with the Centers for Disease Control and Prevention on the PRAMS project.
Chronic Renal Disease	1) Provides dialysis for end stage renal disease patients who

Program	are enrolled in the Chronic Renal Disease Program (CRDP); 2) Provides transportation for end stage renal disease patients enrolled in the CRDP; 3) Provides prescription pharmacy drug benefit through PACE program for end stage renal disease patients enrolled in the CRDP.
Abstinence Education Program - Healthy Youth PA	The Abstinence Program (Healthy Youth PA) utilizes an approach of mentoring, counseling and adult supervision as a means of promoting abstinence from sexual activity.
Personal Responsibility Education Program (PREP)	PREP educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs) including HIV/AIDS, and at least three adulthood preparation subjects including: healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills.
Lead Training Program	The Lead Training Program is conducted with a grant from the EPA. A contracted accredited trainer provides classes in disciplines related to inspection and abatement of lead-based paint. Students are non-profit or government employees and are not charged for classes. Upon completion of the training, students are eligible to apply for certification from the Department of Labor and Industry.

**II.B.2.b.ii. Agency Capacity**

At the state level, the BFH maintains infrastructure to support essential public health services and systems. BFH works with local Title V agencies and selects additional community based partners throughout the state, using approved procurement policies, to provide enabling or direct services to the MCH population in their communities. BFH uses population and public health data to target geographical areas for interventions, and then selects qualified grantees for the project. For all grant agreements, BFH staff develop objectives, work statements and budgets, and provide oversight and monitoring of grantee progress toward the stated goals.

## **Women/Maternal Health**

Pennsylvania's (PA) Title V program serves as an important safety net for pregnant women and women of child-bearing age. This safety net includes a variety of resources such as the training and education of MCH nurses, assisting transient mothers and their children access insurance and health care, screening new mothers for perinatal depression, providing prenatal and postpartum care and educating women on a range of topics such as birth control, substance abuse, domestic violence and healthy birth spacing. Women and mothers accessing Title V services are an inherently at-risk population by virtue of the neighborhoods in which they live, their economic situations or their medical conditions. Title V attempts to meet the needs of these women in the communities in which they reside either in partnership with local/county/municipal health departments or other community or hospital based providers.

BFH collaborates with the 10 local health departments to provide home visiting services to women who do not fit the criteria for the traditional home visiting services. Home visiting services provide education and support on health, nutrition and positive lifestyle changes for women during the prenatal and postpartum period. With realignment of funding to support the new priorities, the BFH expects to expand Nurse Family Partnership into some of the more rural counties of the state, as well as leveraging existing partnerships to provide services to more first time mothers. Additionally, Lancaster General Hospital and Albert Einstein Healthcare Network in Philadelphia, in conjunction with the BFH, offer Centering Pregnancy, a group prenatal care program shown to increase appointment compliance and knowledge of pregnancy and infant health. These programs educate women on the importance of birth spacing and interconception care.

Augmenting and supporting these collaborations is the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system designed to identify maternal experiences and behaviors that occur before and during pregnancy and during early infancy via a stratified sample of women delivering a live birth. PRAMS data are used by BFH to develop strategies for improving maternal and birth outcomes.

The BFH through contracted referral relationships with treatment centers for metabolic and genetic abnormalities, families who have an infant with a presumptive positive test for an abnormality have access to comprehensive genetic services including an explanation of the disorder(s), education and examination of genetic history for families.

## **Perinatal/Infant Health**

Many of the services focused on perinatal/infant health are provided through collaborative work between the BFH and hospital facilities, using a combination of state and federal funds. BFH supports newborn screening tests by paying for the filter paper and laboratory analysis required for six mandatory infant screening tests and filter paper for the additional 22 recommended screenings. The BFH's Newborn Screening and Follow-up Program (NSFP) perform all testing follow-up for these screenings, hearing tests and screenings for Congenital Heart Disease and Severe Combined Immunodeficiency Disease. BFH staff are currently integrating processes with the labs to support new mandatory Lysosomal storage disorder screening. All infants with abnormal/inconclusive test results are referred to one of the BFH contracted treatment centers across the state for diagnostic evaluation and medical case management. The nursing services consultants from the BFH assist birthing facilities with quality assurance issues related to the NSFP such as state regulations and procedures and policies.

Two other BFH programs coordinate efforts through hospitals. The Shaken Baby Syndrome Prevention Program provides supplies, guidance and nursing in-service training to all birthing and children's hospitals in order to ensure that every parent or caregiver of a child born in PA receives shaken baby syndrome education. Keystone 10 is an initiative working with birthing facilities on the adoption and implementation of ten evidence-based steps to baby friendly facilities using education and regional learning collaboratives.

The BFH operates the Healthy Baby hotline as a mechanism for pregnant and new mothers to access information and resources on insurance coverage, obtaining prenatal care and referrals to local healthcare providers and breastfeeding professionals.

The BFH home visiting programs also provide education services on infant care and development once the baby is born. The Cribs for Kids program promotes safe sleep practices aimed at reducing the incidence of infant death due to SIDS and accidental suffocation and strangulation. The program fosters statewide collaboration by working with community partners in order to reach those most in need, and partnering with Graco to supply pack and plays and other infant safety products.

The BFH is part of the PA Perinatal Partnership a collaboration of the Healthy Start projects in PA as well as the local Title V agencies that is interested in working with the BFH to better understand how the Life Course model is being implemented throughout MCH programming.

### **Child Health**

The provision of child health programs by the BFH are more community based.

The BFH provides services for children in numerous programs across PA. In 2013, 5 percent of children were without health insurance coverage and 34 percent of children are covered by Medicaid or the Children's Health Insurance Program (CHIP). Title V nurses in the 10 local health departments staff clinics which are offered to children who have no insurance due to a gap in coverage between providers or insurances or for children who are uninsured or uninsurable. Assessments and basic health services such as growth and development, oral health, lead screenings and immunizations are offered as well as referrals for issues nursing staff is unable to treat. Title V nurses also staff dedicated immunization clinics in numerous locations throughout the state to ensure vaccinations are accessible for all families. These services are provided to offer a safety-net for the Title V population.

The PDPH offers a clinic specifically designed for youth aimed toward improving their health and knowledge about health related issues. Staff assesses psychosocial and reproductive needs and offers referrals to clinical, social and behavioral health services as well as engaging teens in reproductive life planning.

The Allentown City Bureau of Health, Montgomery County Health Department (MCHD) and Wilkes-Barre City Health Department provide dental services to children, through the age of 21, who are uninsured, underinsured or uninsurable. Essential services such as routine examinations, cleanings, extractions and fillings are combined with oral health care education. In 2014, 545 individuals received dental services through these programs. The BFH has supported local Title V agencies in providing dental services and increasing the number of children receiving these services.

The BFH administers the Public Health Child Death Review (CDR) Program, which requires 63 child death review teams covering 67 counties to discuss the circumstances surrounding the deaths of all children 21 years of age and under, and to make recommendations to the State CDR Team and the DOH to promote the safety and well-being of children and reduce child fatalities. The local teams are comprised of community professionals and conduct a multi-disciplinary review of a child's death with a focus on risk factors and prevention recommendations.

The BFH, through regional grantees, provides primary prevention of home-related injuries and illness to families across the state through a home visit with follow-up, education on healthy homes concepts and interventions to address potential hazards. These grantees also conduct inspections of homes where children with elevated blood lead levels reside in order to identify lead exposure sources. Education and technical assistance is provided to clinicians and partners regarding healthy homes concepts.

The BFH oversees the Childhood Lead Surveillance Program, which monitors childhood lead testing and results through the Pennsylvania National Electronic Disease Surveillance System, a web-based application system that receives all lead reports submitted by laboratories. Surveillance data is used to identify possible high risk areas and other potential service gaps.

### **CSHCN**

Due to the broad range of care and coordination needed to meet the needs of the CSHCN population, the BFH supports a variety of direct, support and referral services across the state including those provided by the local health departments to support CSHCN in their communities.

The Title V Family Advisor is used as a liaison between families with CSHCN and the BFH to ensure appropriate representation in program planning and policy making in addition to facilitating a partnership with the Department of Human Services (DHS) to address systematic issues and coordination of care.

The Special Kids Network reaches statewide with in-home service coordination provided by community partners, eight regional coordinators trouble-shooting service challenges from their experience as parents of CSHCN and a toll-free helpline to link families with services.

The BFH provides comprehensive, multi-disciplinary health related services to individuals with certain conditions through the Comprehensive Specialty Care Program including care coordination and information and education provided by hospitals and community organizations.

The PA Medical Home Initiative (MHI) is comprised of 74 medical homes serving 505,555 children including 29,959 CSHCN in practices across the state. The MHI also currently uses 197 parents in the role of Parent Partner to assist practices in enhancing their service from the viewpoint of a parent.

The BFH partners with the DHS for Project LAUNCH, a federal grant that promotes the wellness of young children from birth to 8 years of age by addressing the physical, social, emotional, cognitive and behavioral aspects of their development.

BrainSTEPS is a Child and Adolescent Brain Injury School Re-Entry Program which ensures that those who provide educational support to children with acquired brain injuries understand brain injury and the resulting challenges.

The BFH's memorandum of understanding with the Department of Aging (PDA) allows the BFH to use PDA's Pharmaceutical Assistance Contracts for the Elderly program's claims processing and administrative functions to provide metabolic formula for CSHCNs, including Spina Bifida, Cystic fibrosis and PKU. The MOU allows the BFH to expand the number of accessible pharmacies and consolidate claims processing through a single administrative agency.

The BFH partners with the PA Chapter of the American Academy of Pediatrics and Tuscarora Intermediate Unit to provide referral and follow-up services to infants who fail a hearing screening. BFH staff works with these partners to educate clinicians and parents on the importance of screening and early intervention for better hearing outcomes.

### **Adolescent Health**

The BFH's Adolescent Health programs include the Personal Responsibility Education Program (PREP), Teen Pregnancy Prevention, Reproductive Health Services, Healthy Youth PA and the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Program.

PREP supports programs to delay sexual activity, increase condom or contraceptive use and reduce pregnancy.

Health Resource Centers operate in Philadelphia and Bucks county schools as part of Teen Pregnancy Prevention. The BFH is currently working with AccessMatters to expand to high risk areas across the state. Adagio Health operates three teen pregnancy prevention programs in twelve counties.

The LGBTQ Youth Program provides services to LGBTQ youth to include suicide prevention training and engages in coalition building activities with ally organizations to help them become Safe Space certified. The program also provides a drop-in health center for youth to obtain health care and social services. Training is provided to medical, behavioral health and social service providers on a variety of topics including health disparities, appropriate standards of care for LGBTQ individuals and LGBTQ cultural competency.

Healthy Youth PA is targeted to counties with the highest rate of teenage pregnancy for youth under the age of 15 and youth ages 15 to 17 and incorporates a combination of mentoring and adult-led group discussions for youth ages 9-14 as a means of promoting abstinence from sexual activity. A parenting education component is included for parents or caregivers of the youth participants.

The BFH provides Reproductive Health Services including pregnancy testing, contraceptives, cervical cancer exams, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.

### **Life Course**

Epidemiologic studies have effectively identified causal links between diseases and risk factors. However, a more subtle, nuanced approach involves understanding the link between social factors and health outcomes. Understanding this nuance is vital for Title V programs given the social risk factors inherent in the population served. These social risk factors include

race, gender and socioeconomic status as well as the risk factors associated with stressful life events such as loss of employment, crime victimization or incarceration of a family member, friend or partner. Understanding and implementing the life course perspective means accounting for the risk and protective factors of populations served by Title V. Over time, these risk factors result in the weathering of certain populations; a physiological consequence of repeated and chronic stress which ultimately may impact the health and health outcomes of an individual. The life course perspective means understanding the need to increase protective factors throughout the life span for at-risk populations in order to make a positive impact on their health.

The BFH has engaged in training its own Title V and non-Title V staff about the impact of stressors, allostatic load and the research behind this model of understanding differences in maternal and infant mortality. The BFH used the HRSA and CityMatch toolbox to strengthen understanding.

The PDPH conducted a Life Course Perspective training program to increase knowledge of the life course perspective, improve understanding of racial, ethnic and socioeconomic-based health disparities and to enable participants to implement life course perspective in their respective field.

#### **II.B.2.b.iii. MCH Workforce Development and Capacity**

The Bureau of Family Health (BFH) in conjunction with local Title V staff has a robust MCH/CSHCN as detailed in the chart below.

PA Department of Health Title V Funded Staff Positions		
Program	Number of Funded Positions	Location
Bureau of Family Health Bureau Office	2	Harrisburg, PA
Bureau of Family Health Bureau Operations	3	Harrisburg, PA
Bureau of Family Health Child and Adult Health Services	16 (+2 non TV staff)	Harrisburg, PA
Bureau of Family Health Community Systems Development and Outreach	14	Harrisburg, PA
Bureau of Family Health Newborn Screening and Genetics	13	Harrisburg, PA
Bureau of Community Health Systems School Health	2	Harrisburg, PA
Bureau of Laboratories	1	Lionville, PA
Bureau of Informatics and Information Technology	1	Harrisburg, PA
Office of Legal Council	1	Harrisburg, PA
Policy Office	1	Harrisburg, PA
Office of Physician General	1	Harrisburg, PA
Local Title V staff – MCH	91	Statewide
Local Title V staff – CSHCN	42	Statewide
<b>Total</b>	<b>188</b>	

The BFH has two staff members and nine contracted staff members who are parents of CSCHN. There are 10 MCH consumers and 40 family members of MCH consumers are volunteers on advisory boards that represent the diverse MCH population.

Most staff previously worked outside the BFH in various fields and organizations with ties to the Pennsylvania (PA) MCH population. This diversity of experience combined with pre-established program relationships both within and outside the Department of Health (DOH) provides invaluable knowledge to help further Title V endeavors. The recently appointed Physician General Dr. Rachel Levine will be a valuable advocate for MCH programs at the executive level due to her experience and specialization in child and adolescent health, including the complex care of teens with medical and psychological problems, eating disorders and transgender medicine.

The vacancy in the State Public Health Dentist position, while not directly impacting the BFH, represents a void of expertise regarding oral health within the DOH. BFH has experienced management staff, but lacks incentives for staff growth, thus leading to areas of high turnover. This has been an issue with the MCH coordinator position, which is currently filled but has historically been difficult to retain. BFH Title V staff and their contractors continually seek additional training on the MCH populations served in PA as well as evolving national trends and initiatives.

The BFH's Director, Division Directors and Title V Block Grant Coordinator serve as the lead MCH-related positions that contribute to planning, evaluation and data analysis capabilities. Below are the names and qualifications of the current staff. The Division Directors have over 50 years of collective MCH experience. Many of the BFH's Program Managers, also considered senior staff, have served in their positions between 5 and 10 years.

Director of the Division of Child and Adult Health Services: Carolyn S. Cass

Ms. Cass has worked in the field of Public Health since 1997. Before joining the BFH she worked in the field of behavioral health for over 15 years, primarily providing drug and alcohol treatment services for adolescents and adults in the state hospital system. Since 1994 Ms. Cass has served as adjunct faculty at West Chester University and has served on the faculty at Temple University as well. Ms. Cass has a Master's Degree in Sociology and a PhD in Criminal Justice. Ms. Cass has served as the Acting Director for the BFH effective February 2015.

Director of the Division of Community Systems Development and Outreach: Michelle Connors

Ms. Connors has served in the field of Public Health for over 20 years. She came to the DOH in 1989 and has served as the state's Title V Children with Special Health Care Needs Director since 2002. Ms. Connors holds a Bachelor's Degree from Pennsylvania State University. Her division manages a variety of programs that focus on children with disabilities.

Title V Block Grant Coordinator: Sara Thuma, MPH

Ms. Thuma holds a Master's of Public Health from Johns Hopkins University and a Bachelor's Degree from the University of Colorado. Ms. Thuma came to the DOH this year and is tasked with spearheading efforts for planning, evaluation and data analysis within the BFH. In collaboration with program staff Ms. Thuma works to collect, analyze and interpret data to make recommendations that will enhance program delivery to the MCH population.

Acting Director of the Division of Newborn Screening and Genetics: Kelly Holland

Ms. Holland has served in the field of Public Health for over 10 years. She came to the DOH in 2005 and has held several roles related to maternal and child health including: genetics program administrator, state adolescent health coordinator/adolescent health program administrator and public health program manager. Ms. Holland holds a Bachelor's Degree from the University of Pittsburgh.

The DOH is committed to ensuring that services provided directly and through contracts and grants are performed in a culturally competent manner from the planning stages to final implementation.

The DOH's Bureau of Health Statistics and Research collects and analyzes a wide array of primary and secondary data that is used by the BFH to inform program development and service delivery. Data are collected and analyzed to take into account cultural groups and other disparity factors. Primary data collected by the DOH includes the Pregnancy Risk Assessment Monitoring System (PRAMS), birth certificates, death certificates, PA Immunization Information System (PA-SIIS) and PA's National Electronic Disease Surveillance System (PA NEDSS). The BFH also uses data from the National Child Death Review Case Reporting System, US Census and American Community Survey, National Center for Health Statistics and Healthy People.

The DOH ensures ongoing training for staff, family leaders, volunteers, contractors and subcontractors in the area of cultural and linguistic competence. The following examples are some of the ways in which the DOH provides this training.

The DOH's Office of Health Equity (OHE) hosted a Health Equity Conference in August 2014. More than 300 health professionals, community leaders and stakeholders attended to discuss ways to address health disparities and the effect of chronic diseases in Pennsylvania. Means to improve these conditions included health literacy approaches that can help to reduce health disparities, the role of culturally and linguistically appropriate services standards, cultural competence of clinicians and the impact on limited English proficient patients and mental and behavioral health.

The DOH's Cultural Competence Taskforce is comprised of employees who represent the diverse populations of PA and develop training courses related to cultural competence, cultural sensitivity, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), health literacy, diversity, poverty and other social determinants of health faced by populations served by the DOH. These face to face and online courses will be offered to employees highlighting how the healthcare workforce can communicate effectively with diverse populations.

The DOH partnered with the National Center for Cultural Competence (NCCC) to provide professional development for PA stakeholders on cultural and linguistic competence and their importance in serving CSHCN.

The DOH collaborates with community leaders/groups and families of culturally diverse groups in needs/assets assessments, program planning, service delivery and evaluation/monitoring/quality improvement activities as part of our standard business practices.

The OHE has an advisory committee with representatives of various stakeholder organizations that developed a tactical plan outlining a five-year strategic direction that will be implemented through an organized and collaborative effort of OHE and its partners, including public, private and nonprofit stakeholder organizations.

In December 2014, the DOH endorsed and adopted the CLAS standards. The DOH expects all staff, grantees, stakeholders, contractors or service providers, outreach initiatives, health services and health care practices to adhere to and follow these principles and standards in the pursuit of advancing health equity, improving quality and helping to eliminate health care disparities in PA. The adoption of CLAS means that all members of an organization, regardless of size, are encouraged to apply them at every point of contact.

The Commonwealth and the DOH have policies and procedures to ensure that employees conduct and behavior creates an environment of inclusion, free from discrimination. The Standard General Terms and Conditions of DOH contracts and grants include a provision that all services available to the public shall not be denied or restricted due to race, creed, color, religion, sex, sexual preference, age, handicap or national origin including limited English proficiency.

**II.B.2.c. Partnerships, Collaboration, and Coordination**

The Bureau of Family Health (BFH) is one of many agencies and organizations that serve the MCH population in Pennsylvania (PA). It is through partnerships, collaboration, and coordination with other agencies and organizations that the BFH has been able to not only measure improvements in the health and well-being of PA’s mothers, infants, children and youth, including CSHCN and their families, but examine the reach and effectiveness of its programming for the MCH population. The chart below details these important BFH relationships.

Other MCHB investments	
State Systems Development Initiative (SSDI)	BFH administers the HRSA grant that will be used to build and expand state MCH data capacity to support Title V program efforts. This will expand data driven decision making in MCH programs by strategically managing and integrating existing health information systems. Data will include sources from DOH as well as stakeholders and partners.
Other Federal investments	
CDC 1305 Grant: State Public Health Actions to Prevent and Control	

Diabetes, Heart Disease, Obesity and Associated Risk Factors, and Promote School Health	Through collaboration with the DOH's Bureau of Health Promotion and Risk Reduction, who was awarded this grant, the BFH is pursuing the establishment of breastfeeding friendly employers.
Child Death Review Teams (CDR)	DOH is responsible for administering the Child Death Review (CDR) Program and works closely with the Department of Human Services and the Pennsylvania Chapter of the American Academy of Pediatrics. The goal of CDR is to reduce the incidence of preventable child deaths by combining multi-agency and multi-disciplinary reviews of these deaths with the implementation of targeted prevention efforts aimed at Pennsylvania's most vulnerable populations.
School Re-Entry Program	BFH represents DOH not only as a founding partner, but current leading partner for the BrainSTEPS (Strategies Teaching Educators, Parents and Students) Program. BrainSTEPS works to ensure that those who provide educational support to children with brain injury have an understanding of brain injury, its resulting challenges, and the supports and interventions that will help these students achieve optimal educational success through graduation.
Shaken Baby Syndrome Program (SBS)	DOH collaborates with Penn State Hershey Medical Center and Dr. Mark Dias, a nationally recognized expert in the field of Shaken Baby Syndrome (SBS), to provide information and education to parents aimed at preventing abusive head trauma to a child after birth. All birthing hospitals in Pennsylvania participate in this important program providing parents with alternative behavioral responses to infant crying.
Cribs for Kids	DOH partners and provides funding for this safe-sleep education program for low-income families aimed at reducing the risk of injury and death of infants due to unsafe sleep environments.
	DOH administers PREP, which provides evidence-based teen pregnancy

Personal Responsibility Education Program (PREP)

prevention programs, education on healthy relationships, adolescent development, and healthy life skills. DOH partners with Persad Center, Inc. to provide lesbian, gay, bi-sexual, transgender and questioning (LGTBQ) cultural competency services to PREP implementation sites. Services include an assessment of organizational LGBTQ cultural competency, LGBTQ 101 and advanced trainings for staff as well as ongoing technical assistance.

The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS)

PA PRAMS is a research and surveillance system that serves the maternal and infant community. It is managed within the BFH. It produces a rich dataset of maternal behaviors and experiences captured through a survey process. Data is analyzed and shared in an effort to inform programs both within the DOH and with outside partners and stakeholders.

Lead Hazard Control Program (LHCP)

DOH administers the LHCP in targeted areas of Pennsylvania and partners with other LHCPs in Pennsylvania to create lead-safe home environments for low-income families with children under age 6.

WIC

BFH partners with WIC to jointly develop breastfeeding education materials and to ensure that community based breastfeeding initiatives involve collaboration with local WIC agencies and populations. Additionally, electronic records are routinely shared between the PA PRAMS program and WIC in an effort to identify telephone numbers for sampled and surveyed mothers. This collaborative relationship serves to elevate the PA PRAMS survey response rate. Lastly, BFH partners with WIC to ensure PKU formula is provided for CSHCN through five years of age.

Other HRSA programs

Federally Qualified Health

The PA Medical Home Program, administered by BFH, collaborates with

Federally Qualified Health Centers	The PA Medical Home Program, administered by BFH, collaborates with FQHCs as a means to reach CSHCN in underserved areas.
Newborn Hearing Screening Program	DOH, through the BFH, provides universal newborn hearing screening and intervention through a HRSA grant. In July 2011, the Hands and Voices Guide by Your Side (GBYS) of PA program was launched in all areas of the state to provide parent guides to families. These guides have experience in a variety of communication options and knowledge of diverse hearing loss through diagnoses of their own children. Matches between parent guides and families have been based not only upon geographic proximity, but also upon similarity of diagnoses, hearing levels, communications strategies and technology choices such as cochlear implants or hearing aids. The provision of direct referrals to GBYS became a more formalized and consistent process in January 2014, and this has resulted in services being provided to families with children with hearing loss at a much younger age.
Traumatic Brain Injury Implementation grant	DOH is the lead agency in a number of initiatives aimed at increasing awareness regarding brain injury. These activities consist of training to increase awareness of and screening for TBI in athletes of all ages including youth in intramural athletics which are not affiliated with a school district; screening youth in juvenile justice facilities in order to identify individuals with TBI and assure the provision of appropriate services; technical assistance to juvenile justice facilities and youth athletic associations; and issuance of Continuing Medical Education credits to physicians completing concussion training.
State and Local MCH programs	
Philadelphia Special	The BFH partners with the PSNC, operated through the Philadelphia Public Health Department, to provide programs and resources for CYSHCN and

Needs Consortium (PSNC) | their families.

County Municipal Health Departments	The Department provides funding to the ten county municipal health departments to deliver health services to low income Pennsylvania citizens. The county municipal health departments work to offer health services to women, infants and children who are underinsured, uninsured or uninsurable. The maternal and child health nursing staff assist the newborn screening program by providing filter papers and lancets to those in need in emergency situations. Clients are also provided with referral information to newborn screening metabolic treatment centers.
Other programs within the State Department of Health	
Bureau of Public Health Preparedness (BPHP)	The BFH Family Advisor collaborates with the BPHP on emergency preparedness planning for CSHCN.
Office of Health Equity (OHE)	The BFH collaborates with OHE on initiatives related to ensuring that cultural and linguistic competence standards are met across the DOH and within BFH programming.
Division of Obesity, Physical Activity and Nutrition	The BFH partners with the Division of Obesity, Physical Activity and Nutrition to provide information and assistance regarding breastfeeding across Pennsylvania.
Violence and Injury Prevention Program (IVPN)	DOH administers the Violence and Injury Prevention Program and oversees the Injury and Violence Prevention Network (IVPN). The BFH provides funding and collaborates with the IVPN endeavors to develop a comprehensive and coordinated injury prevention effort.

The Pennsylvania Dept. of

<p>Health's Bureau of Health Statistics and Research (BHSR), Division of Vital Statistics</p>	<p>An ongoing collaboration between the CDR program and BHSR facilitates the generation and sharing of birth and death records. These records are shared with local review teams and serve as the primary reports to determine which reviews are initiated.</p>
<p>Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS)</p>	<p>PA-NEDSS is a statewide, web-based surveillance system that receives and stores reports for all diseases reportable to the Department of Health. Data stored within PA-NEDSS can be used to identify high-risk areas, analyze service gaps, and inform programmatic decisions. The ongoing maintenance of PA-NEDSS is a collaborative effort between DOH's Bureau of Informatics and Information Technology (BIIT) and a number of programs within DOH including those in the BFH.</p>
<p>Environmental Public Health Tracking Network (EPHTN)</p>	<p>The Pennsylvania EPHTN is an effort to collect, analyze, document, and provide information on suspected links between environmental hazards and their impact on the health of citizens. BFH regularly participates in planning and development efforts and annually delivers a childhood lead dataset for inclusion in the EPHTN database and website.</p>
<p>Bureau of Community Health Systems (BCHS)</p>	<p>The BFH collaborated with the district community health nurses to assist the newborn screening program in the following ways: to obtain an initial or repeat filter paper, assist with PKU monitors, educate, support and make referrals to newborn screening metabolic treatment centers as needed.</p>
	<p>BFH provides funding for a chemist at BOL who collaborates with the newborn screening program in the following ways: attends site visits to contracted laboratories; reviews all laboratory processes related to filter papers, provides technical expertise when adding new conditions to the</p>

Bureau of Laboratories (BOL)	screening panel, provides expertise in regard to the Clinical Laboratory Improvement Amendments (CLIA) and assists the program with the technical portion of program evaluation.
Other governmental agencies	
Department of Education (PDE)	<p>PDE is an important partner with the BFH for programs for CSHCN. They are a resource and referral source for families with concerns related to Individual Education Plans (IEPs) and 504 Plans. In addition, BFH works closely with the Pennsylvania Training and Technical Assistance Network (PaTTAN) operated through the Department of Education. PaTTAN coordinates the Transition State Leadership Team, as well as the Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW) groups on the topic of transition of YSHCN to adulthood. Additionally, BFH partners with PDE to develop school age TBI services such as the School Re-Entry program.</p>
Department of Labor & Industry	The BFH works with the Office of Vocational Rehabilitation (OVR) through Labor and Industry on the transition of CSHCN to adulthood.
	<p>The BFH partners and collaborates with several different offices of DHS to meet the needs of families of CSHCN, including the Office of Medical Assistance Programs (OMAP), Office of Mental Health and Substance Abuse Services (OMHSAS), the Medical Assistance Transportation Program (MATP), and the Office of Child Development and Early Learning (OCDEL), which is an office operated jointly by the Departments of Education and Human Services. Additionally, callers to the Healthy Baby Helpline are often referred to the online COMPASS program where individuals can apply for medical assistance and other benefits. Further, the BFH</p>

Department of Human Services (DHS)	collaborates with DHS on a childhood lead data match project. On a quarterly basis, claims data for Medical Assistance (MA) children are matched against BFH data on children who were tested for lead poisoning. Additionally, MA pays for newborn screening costs associated with the filter paper blood specimen and PKU monitoring.
Department of Drug and Alcohol Programs	BFH staff partner with the Department of Drug and Alcohol programs to identify cases and educate on Fetal Alcohol Spectrum Disorder (FASD).
The Pennsylvania Department of Transportation (PENNDOT)	A collaborative relationship between the DOH's Child Death Review (CDR) Program and PENNDOT serves to enhance child death review capacity. In securing traffic death information, the CDR program is able to provide local teams with critical information surrounding traffic fatalities.
Healthy Homes and Lead Partnership (HHLP)	BFH supports and convenes the HHLP, a partnership of health and housing advocates from across Pennsylvania that meet regularly to address lead poisoning prevention, healthy home environments, and related concerns.
PA Early Childhood Education Healthy & Green Initiative	BFH partners with PDE, Department of Environmental Protection, and others to impact the environmental health of preschools, day care centers, and day care homes, so that vulnerable children are not exposed to health and safety hazards.
Public health and health professional education programs and universities	
Albert Einstein Healthcare Network (AEHN)	The BFH collaborates with AEHN to provide a centering pregnancy program (group prenatal care) to Philadelphia women.
Lancaster General	The BFH collaborates with LGH to provide a centering pregnancy program

Hospital (LGH)	(group prenatal care) to Lancaster City women.
The Bloustein Center for Survey Research (BCSR) at Rutgers University	BFH collaborates with the BCSR to administer Pennsylvania's Pregnancy Risk Assessment Monitoring System (PRAMS) survey operations.
Temple University	The BFH's programs for CSHCN partner with Temple University's Institute on Disabilities on the TakeFIVE Respite Care Program which provides respite services for caregivers and siblings of CSHCN.
Comprehensive Specialty Care Program	BFH administers a number of grants providing services to individuals with a variety of conditions (sickle cell, hemophilia, ventilator dependent, cystic fibrosis, spina bifida and orthopedic and neuromuscular conditions). There is a large amount of state funds incorporated in these programs; however, the BFH ensures that the grantees conduct their activities in line with the tenets of the federal MCH funded programs. Partnerships between these state funded programs and MCH funded programs continue to be strengthened via information sharing and inclusion in planning and program activities.
Temple University Harrisburg Campus	Temple University Harrisburg is the backbone organization for the PA Partnership for Healthy Youth: A Collaborative on Adolescent Sexual Health. The mission of the collaborative is to improve the health of Pennsylvania's youth by increasing the coordination and quality of initiatives that impact adolescent sexual health. Collaborative members include staff from: several program areas in the Department of Health (including the BFH), the Department of Education, the Department of Human Services, the family planning councils in the Commonwealth, Planned Parenthood, Penn State University, school districts, LGBT centers, and adolescent medicine practitioners.
Family/consumer partnerships and	

leadership programs	
Traumatic Brain Injury Advisory Board (TBI)	The BFH supports the TBI Advisory Board which is comprised of an ethnically and culturally diverse group of individuals who have a commitment to serving those with brain injuries. Advisory Board members include individuals living with TBI, family members of individuals with TBI, representatives from a number of government agencies, and community-based organizations in TBI service provision and advocacy.
The Pennsylvania Perinatal Partnership (PPP)	The Pennsylvania Perinatal Partnership represents the collaborative efforts of Pennsylvania's Healthy Start Projects and Maternal and Child Health Programs. There is an ongoing collaboration between PA PRAMS, administered by the BFH, and the Pennsylvania Perinatal Partnership (PPP).
Renal Disease Advisory Committee (RDAC)	The BFH supports the RDAC which is comprised of eleven members representing various interest groups including hospitals and medical schools which establish dialysis centers, volunteer agencies interested in kidney disease, local public health agencies, physicians/medical personnel interested in kidney disease, and the general public.
Newborn Screening Technical Advisory Board/Newborn Hearing Screening Technical Advisory Committee	The BFH supports both the Technical Advisory Board and the Technical Advisory Committee to provide expertise, medical advice on medications, and guidance on program improvement. The Board deals with issues related to the metabolic portion of the Newborn Screening Program and the Committee deals with issues related to the hearing portion of the program.

The BFH considers family and consumer partnerships (FCP) a central tenet of serving the MCH population and employs a full-time Family Advisor who conveys the family perspective for program and priority planning. The PA Medical Home Initiative (MHI) utilizes 260 families and consumers as Parent Partners, Parent Advisors, Education Specialists, a Social Media Intern and a member on the Advisory Committee. The Special Kids Network (SKN) employs eight parents of CSHCN as Regional Coordinators and one Regional Coordinator Supervisor. BFH initiatives on Cultural and Linguistic Competence, Core Leadership and Project LAUNCH include 29 individuals from FCP. The Epilepsy Foundations and Tourette Syndrome grantees are operated by parents.

FCP are made up of a diverse group of members with various types of disabilities, racial and ethnic backgrounds and geographical areas. FCP engagement ranges from full-time employment to volunteers on workgroups. FCP who are not employed by the state or grantee are reimbursed for travel and childcare costs and all receive training on Title V. For example, the TBI Advisory Board includes a requirement that at least one-third of all board members must be an individual with a brain injury or a family member. Although positions on the board are not compensated, the BFH provides for transportation, lodging and subsistence. Additionally the TBI Advisory Board participated in focus groups to assist in the

selection of block grant priorities.

Issues of importance to families and consumers are conveyed to the BFH through many mechanisms. In 2014, the SKN facilitated 148 family gatherings, meetings, and Parent Youth Professional Forums. Elks nurses provided 4,228 in-home service coordination visits. The MHI conducts semi-annual Parent Panels.

Title V funds and other resources have been combined to expand FCP involvement resulting in growth in the number and strength of BFH relationships with other programs and organizations.

## II.C. State Selected Priorities

No.	Priority Need
1	MCH populations reside in a safe and healthy living environment.
2	Appropriate health and health related services, screenings and information are available to the MCH populations.
3	MCH populations are able to obtain, process and understand basic health information needed to make health decisions.
4	Protective factors are established for adolescents and young adults prior to and during critical life stages.
5	Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.
6	Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.
7	Safe sleep practices are consistently implemented for all infants.
8	Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.
9	Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.

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

A safe and healthy living environment encompasses the physical structure of the house as well as the behavioral and emotional factors within a home or neighborhood. Families and communities with financial insecurity or instability across the United States suffer disproportionately from the negative health effects of poorly constructed, unsafe and substandard housing. A number of research studies have documented these negative effects, which include asthma and other respiratory illnesses, cardiovascular health problems, increased stress, and adverse overall physical and mental health status. Additionally, social or behavioral factors within families such as domestic violence, familial substance abuse, or housing insecurity all have potential health implications.

This priority replaces the prior state priority to expand injury prevention activities for infants, children and adolescents. The replacement priority more broadly addresses the entire MCH population while more narrowly focusing on the living environment which the Bureau of Family Health (BFH) is able to affect with Title V resources.

**Priority: Appropriate health and health related services, screening and information are available to the MCH populations.**

Access to health and health related services is crucial to securing necessary screening, care and treatment. If the services that are received are not appropriate, at best they are ineffective and at worst they cause injury and death. Due to varying needs such as medical complexity and language or cognitive limitations the MCH population requires providers to address them as individuals and tailor services, screenings and information to suit the individual consumer. Appropriate services also include timely diagnosis and follow-up.

This priority replaces the prior state priority to increase awareness of and access to comprehensive information about services and programs for CSHCN. The replacement priority more broadly focuses on the entire MCH population and that the services, screening and information are appropriate for the individual and their needs.

**Priority: MCH populations are able to obtain, process and understand basic health information needed to make health decisions.**

Health literacy is the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Nearly 9 out of 10 adults have difficulty using the everyday health information that is routinely available in health care facilities, retail outlets, media and communities. Limited health literacy is associated with poorer health outcomes and higher health care costs. Improving health communication and utilizing health technologies are essential to promoting individual and population health.

This priority is new and was strongly influenced by feedback from stakeholders that information is not making its way into the hands of the MCH population and when it reaches them, it is not presented in a manner that is understandable or useful. Health literacy impacts all of the population health domains and is important in the types of service delivery as well.

**Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages.**

Efforts to improve child and adolescent health have typically addressed specific health risk behaviors, such as early initiation of sexual intercourse, tobacco use or violence. However, results from a growing number of studies suggest that greater health impact might be achieved by also enhancing protective factors that help children and adolescents

develop the life skills and assets they need to avoid multiple behaviors that place them at risk for adverse health and educational outcomes.

Protective factors are individual or environmental characteristics, conditions or behaviors that reduce the effects of stressful life events. These factors also increase an individual's ability to avoid risks or hazards and promote social and emotional competence to thrive in all aspects of life, now and in the future. During the needs assessment process, stakeholders reported to the BFH that many adolescents and children do not have a strong foundation of parental or adult support to help them succeed in school, health and social circumstances, which leads to long-term difficulty. An increase of protective factors during adolescence is especially important for some vulnerable populations, such as lesbian, gay, bisexual, transgender and questioning (LGBTQ) adolescents.

This priority replaces the prior state priorities to decrease teen pregnancy through comprehensive sex education and to expand access to physical and behavioral health services for high risk youth such as LGBTQ runaway/homeless by expanding the focus to all adolescents and protective factors at large. Statewide teen pregnancy rates have improved so that a narrow focus is no longer needed. The expanded focus of the priority will allow the BFH to provide programming that meets the needs of specific subpopulations of adolescents to mitigate life stressors for improved outcomes as adults and in future generations.

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

Protecting, promoting and supporting breastfeeding, with its many known benefits for infants, children and mothers, are key strategies to accomplish improving the health of mothers and their children. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first six months, continued breastfeeding for the first year and then for as long as mutually desired by mother and child. For mothers to have success with breastfeeding they require the support of their family. In 2014, Pennsylvania continued to fall below the national breastfeeding rates for ever breastfed, breastfeeding at six months, breastfeeding at 12 months, exclusive breastfeeding at three month and exclusive breastfeeding at six months.

This priority is new and was a clear choice based upon the current breastfeeding rates and feedback from stakeholders. The BFH has a unique position to support families and systems to improve the initiation and continuation of breastfeeding. The BFH will seek to implement initiatives that not only focus on the mother and healthcare provider, but also include the father or partner and extended family to address barriers that may traditionally prevent a mother from initiating or continuing breastfeeding.

**Priority: Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.**

Maternal behaviors known to be related to poor birth outcomes include tobacco use, alcohol use and failure to consume adequate folic acid through multivitamins or diet. Evidence suggests that successful interventions targeting these behaviors prior to pregnancy are associated with improved health of the woman and her infant. Other conditions associated with poor pregnancy outcomes include having an unintended pregnancy, experiencing physical abuse and experiencing high levels of stress. Certain maternal health conditions (e.g., diabetes, hypertension and obesity), if uncontrolled, can lead to poor infant outcomes and have a long-term negative impact on a woman's health. Because a woman might have a subsequent pregnancy, services in the postpartum period (e.g., a postpartum check-up, screening for postpartum depression, counseling about birth control and accessing services such as WIC) are all opportunities to help women maintain or regain good health.

This priority replaces the prior state priority to decrease barriers for prenatal care for at-risk/uninsured women through implementation of best practices. By shifting the focus of the priority to preconception and inter-conception care and support, the BFH will be able to provide preventive care and support to address behaviors and risk factors before they have a negative effect on the mothers and infants.

**Priority: Safe sleep practices are consistently implemented for all infants.**

It is commonly recognized that babies not placed on their backs to sleep are at greater risk for SIDS. According to the AAP Task force on Infant Sleep Position and Sudden Infant Death Syndrome, belly-sleep has up to 12.9 times the risk of death as back-sleep. Despite a nationwide reduction in the incidence of SIDS since 1992 when the AAP issued recommendations regarding back to sleep, the decline has plateaued in recent years. Furthermore, according to the AAP, concurrently, other causes of SUID that occur during sleep (including suffocation, asphyxia and entrapment) and ill-defined or unspecified causes of death have increased in incidence. Consequently, in 2011, the AAP expanded the recommendations from focusing only on back-sleeping to focusing on a safe sleep environment to reduce the risk of sleep-related infant death. A cornerstone of the AAP expanded recommendations is room-sharing without bed-sharing, which evidence shows decreases the risk of SIDS by as much as 50 percent.

In 2013, the Department of Health (DOH) issued a policy statement on safe sleep that is closely aligned with the recommendations made by AAP. This policy statement provides the weight of DOH support for encouraging practices that reduce the risk of death due to SIDS and unsafe sleep practices and represents the first time the DOH has taken a formal position on safe sleep.

This priority is new; however, was part of prior state priority to expand injury prevention activities for infants, children and adolescents. As a new and standalone priority, safe sleep for infants will be able to receive the focus and resources needed to effect safe sleep practices for all infants.

**Priority: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.**

All BFH programs collect data on program activities and participants; however, all of the sources of data have not been used to the full capacity to effectively inform decision-making and evaluate population and programmatic needs. The increasing demands to provide results by using evidence-based and informed practices have allowed the BFH to see missed opportunities in current practices and the potential to improve practices around the identification, collection and use of data. Many stakeholders and partner agencies expressed that as there are insufficient resources to address all of the population needs, there is an increasing need for using data to target resources.

This priority is new and will ensure steps are taken to improve capabilities within the BFH. By focusing on data for this grant cycle, the BFH will make changes in procedures and processes to institutionalize best practices for a successful future.

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

Women's health and the health and wellbeing of their children can be affected by many life stressors including emotional issues, alcohol, tobacco, other drug use and intimate partner violence. Without mitigation, these stressors

continue across the life span leading to generational transmission during critical periods. In Pennsylvania, there is a significant problem with opioid abuse, addiction, prescription drug abuse and neonatal abstinence syndrome. While screening alone will not ameliorate the complex problem of opioid and other drug addiction it will provide the opportunity for women to be referred for assistance and treatment to establish healthy life goals and potentially decrease the harmful effects of these stressors on their children.

This priority replaces the prior state priority to increase behavioral health screening, diagnosis and treatment for pregnant women and mothers (including postpartum depression). The replacement priority continues to address behavioral health with a narrower focus on specific services that the BFH will be more directly able to affect with Title V resources.

When selecting priority needs the BFH considered several factors to determine the extent of the need and whether it was within the scope of the BFH's capacity to affect change. The main factors contributing to the selection of priorities included:

- the severity of the problem, specifically in relation to the severity nationally;
- the scope of the need as a statewide concern;
- alignment with the current vision and mission of the Department; and
- the ability of the BFH to impact the problem without duplicating existing efforts.

As a result of this review process, local or regional issues for which the BFH and Title V funds are not the best mechanism to impact change were not selected. Statewide issues were not selected if the BFH either does not have the capacity to address or the need is specifically addressed by another bureau within the DOH or other state agencies. Whenever possible, narrowly focused needs were included as part of a broader priority that included either multiple population domains or more than one specific need. The following topics were identified during the needs assessment but were not selected as priorities.

Oral health: Though this was a concern voiced by some stakeholders, the BFH determined that a designated priority for oral or dental health services was not warranted. Almost 80 percent of PA children have had a preventive dental visit in the past year (11-12) compared to 78 percent nationally. The DOH does not currently have a public health dentist to champion efforts of increasing availability of oral health services for children, but has provided funding for dental clinics via Primary Care grants.

Support services such as transportation, childcare, education and nutrition: BFH did not prioritize needs that would duplicate services with existing widespread infrastructure through other agencies. BFH addresses these issues within specific initiatives and programs, but the BFH does not have the appropriate capacity to address these as standalone priorities without duplicating services. The BFH will continue efforts to partner with the other agencies and bureaus to promote the needs of MCH populations and offer avenues to better reach and serve the MCH population.

Transition: BFH had a prior state priority to improve the transition of CSHCN from child to adult health, educational and social services. BFH staff and stakeholders believe that transition is not exclusive to CSHCN and there are benefits to addressing transition for all adolescents. Increasing protective factors for adolescents is one way to begin to expand transition activities to all adolescents. Transition services may be considered as a future objective or strategy within the scope of the new priorities.

## II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

## **II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures**

Based on the priority needs selected by the BFH for the five-year reporting period, the following eight NPMs were selected to be addressed. MCH population needs and BFH capacity to impact the NPM were leading factors in the process to select the NPMs.

### **NPM 1: Percent of women with a past year preventive medical visit**

Of the two NPMs specific to the women/maternal health domain, the BFH felt NPM 1 was most closely related to its chosen priority focusing on access and participation in preconception and interconception care. The BFH envisions a shift to more holistic care for women through the childbearing years, not just during pregnancy. Moreover, when considering the aspects of the BFH's capacity, it was determined the BFH had a much higher likelihood of impacting this NPM based on existing infrastructure and capacity to implement pertinent strategies.

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

While the PA breastfeeding rate is increasing, PA still lags far behind many other states and the nation in the percent of infants who are ever breastfed. There are also tremendous disparities in rates of breastfeeding between counties and racial and ethnic groups within the state. The BFH has chosen to make breastfeeding a priority in order to address not only breastfeeding across the state, but also target programming to areas with the greatest disparities. Moreover, through the information collected by the Bureau of Health Statistics and Research (BHSR), PA PRAMS and other national breastfeeding tracking systems, the BFH has a fairly large capacity to track breastfeeding behaviors and refine programming to address the issue within the state. The selection of NPM 4 is then a logical choice.

### **NPM 5: Percent of infants placed to sleep on their backs**

With safe sleep practices being chosen as a priority for PA, NPM 5 is another logical choice for the BFH. PA has legislation requiring all parents receive safe sleep education before leaving the hospital. Sudden infant death syndrome (SIDS) is one of the top five causes of death for those under the age of one in PA. The American Academy of Pediatrics (AAP) has also issued a recommendation for safe sleep in 2011 and DOH issued a policy statement closely aligned with the AAP recommendations in 2013. BFH has vast data resources regarding specific safe sleep and related behaviors including information from BHSR, PA PRAMS and the Child Death Review (CDR) Program that can be leveraged for policy and program formation and expansion.

### **NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19**

The BFH has chosen a priority focused on creating a safe and healthy living environment for the MCH population and selected NPM 7 for the child health domain. Despite the fact that the DOH has other sections working toward injury prevention, the BFH concluded this NPM, of the three related to the child domain, was where there was capacity to make the most impact by building on existing home visiting models and expanding emphasis on potential injury hazards in the home environment. Because of the effectiveness of the existing CDR Program, the BFH is also interested in using CDR data and recommendations to implement initiatives that closely reflect the needs of the child population.

### **NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

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

The adolescent population is of particular importance to the BFH so both NPMs specific to this population were chosen as measures to align with two different priorities defined by the BFH. The NPM related to bullying is most

closely related to the BFH priority surrounding the establishment of protective factors for adolescents and young adults during critical life stages. The NPM related to a preventive medical visit for adolescents is most closely aligned with the BFH priority focusing on preconception and interconception care. The BFH is particularly concerned with the lack of resources and protections for the LGBTQ youth community especially with regard to bullying and medical care and is looking to develop and expand programming and data capacity to support this underserved and marginalized community. Bullying of CSHCN will also be a focus for the BFH.

**NPM 11: Percent of children with and without special health care needs having a medical home**

The BFH has prioritized appropriate health and health related services for the MCH population and the NPM regarding medical home was determined to most closely fit with this priority. There is a large and growing need for the coordination of services within a medical home for all children, but especially for CSHCN. PA has a strong medical home program with 74 practices established and the BFH has chosen to expand on this pre-established capacity. An additional benefit is that medical homes are not limited to CSHCN or the MCH population so that all residents have the potential for improved health care delivery. The BFH also feels the NPM regarding transition is important and will seek to incorporate it during the grant cycle as a state performance measure.

**NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

Of the three cross-cutting/life course NPMs, the BFH decided it had the capacity to make the greatest impact with NPM 14. The BFH can draw on information from PA PRAMS and BHSR and integrate smoking-cessation messages into other programming, especially home visiting models. The Pennsylvania Comprehensive Tobacco Prevention and Control Program is housed within another bureau of the DOH, but the BFH identified this NPM as a way to coordinate and align programming with the available services provided by the DOH. Moreover, this NPM most closely aligns with the BFH priorities regarding MCH populations residing in safe and healthy living environments and women being screened for behavioral health issues. As a cross-cutting topic, successfully impacting this NPM will provide for benefits to mothers regarding maternal morbidity; infants regarding low birth rates, preterm birth rates, mortality and SUIDs; and children regarding overall health.

## **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

- SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.
- SPM 2 - Percent of Title V programming with interpersonal violence reduction components.
- SPM 3 - Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.
- SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.
- SPM 5 - Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%

## **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

The Bureau of Family Health (BFH) identified three priorities that did not have a direct link to any of the chosen national performance measures. Therefore, three state performance measures (SPMs) were developed to capture outcomes for activities within these priority areas. Additionally, two SPMs were developed to capture some of the new and emerging activities and programming being undertaken by the BFH over the five year cycle.

### **SPM: Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.**

This SPM addresses the priority “Appropriate health and health related services, screenings and information are available to the MCH populations” within the perinatal/infant health domain. Timeliness throughout the newborn screening process is not only a national priority but one for the BFH as well. Treatment for many newborn screening conditions is time sensitive. Better long-term health outcomes are seen for these infants with faster detection and treatment of their condition. While the BFH is working with submitters (hospitals, birthing facilities, and midwives) to improve timeliness at all points in the newborn screening process, the collection to receipt time at the lab is a critical point in the process that has a far reaching downstream impact. By tracking the collection to receipt time at the lab, the newborn screening program can determine which submitters need additional education and technical assistance to identify causes of delays and develop solutions to remedy the delays. Improvements in the collection to receipt time at the lab will then promote the overarching goal to enable more timely follow-up and referral for identified conditions.

### **SPM: Percent of Title V programming with interpersonal violence reduction components.**

This SPM addresses the priority “MCH populations reside in a safe and healthy living environment” within the child health domain. This measure is considered interim until it can be determined how to best measure interpersonal violence in PA. Internal and external stakeholders have expressed a need to look more closely at violence prevention especially in regards to intimate partner violence. Through participation in the Child Safety Collaborative Innovation and Improvement Network (CollIN) topic area of interpersonal violence, the BFH is examining the potential for expanding violence prevention programming with particular attention to cross-cutting approaches. As many forms of violence are interconnected, sharing both risk and protective factors, the BFH is looking to create upstream programming that will lead to reductions in multiple forms of violence. This may take the form of small component additions to current programming or may develop into new programming.

### **SPM: Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%.**

This SPM addresses the priority “Protective factors are established for adolescents and young adults prior to and during critical life stages”. This performance measure was chosen to track new programmatic work being undertaken within the adolescent health domain and is related to several Healthy People 2020 objectives. By offering mentoring programs for youth both with and without special health care needs, the BFH is providing opportunities for youth to increase the number of protective factors or decrease the number of risk factors influencing their development and health outcomes. The BFH initially intended to utilize the Search Institute’s 40 Developmental Assets framework to guide the development of the youth mentoring programs. This framework includes 20 external assets organized under the following four categories: support, empowerment, boundaries and expectations and constructive use of time; and 20 internal assets organized under these four categories: commitment to learning, positive values, social competencies and positive identity. Instead, the BFH will utilize a general framework for

positive youth development to guide programs in implementing mentoring activities and to ensure more youth are provided with the building blocks to become healthy, caring, and responsible young adults. This change allows mentoring programs to choose which evidence-based mentoring model they wish to implement based upon the unique circumstances of their target population, including but not limited to the Search Institute's 40 Developmental Assets framework. Youth participating in mentoring activities will be assessed through pre and post assessments to determine changes in risk and protective factors as well as developmental assets and outcomes. By tracking the youth who increase assets by 50 percent, the BFH can observe how well youth in the mentoring programs are provided with the skills, experiences, relationships and behaviors necessary to help them grow into health, caring, and responsible young adults.

**SPM: Percentage of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.**

This SPM addresses the priority "MCH populations are able to obtain, process, and understand basic health information needed to make decisions" within the cross-cutting/life course domain and is related to a Healthy People 2020 objective. The 2015 Needs and Capacity Assessment highlighted the obstacles faced by those with poor health literacy which led to the development of this priority. By tracking this measure, the BFH intends to stimulate grantee action to improve the accessibility and readability of materials used by the MCH populations they serve. The long term goal is an increase in health knowledge, appropriate service usage and behavior change as a result of health information that is accurate and understandable.

**SPM: Percent of Title V staff who analyze and use data to steer programmatic decision-making.**

This SPM addresses the priority "Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs" within the cross-cutting/life course domain. This priority is internally focused but has implications for all aspects of the BFH's MCH programming work. Through internal assessment of all program data collection strengths and needs, the BFH aims to increase the capacity of all staff to not only improve the quality of data received from grantees but incorporate relevant data into programmatic decision-making. The BFH plans to improve leveraging of current surveillance systems and maximizing the use of grantee submitted data in order to work toward the capacity to conduct program evaluation and capture accomplishments on medium to long term outcomes of programming work.

## II.F. Five Year State Action Plan

### II.F.1 State Action Plan and Strategies by MCH Population Domain

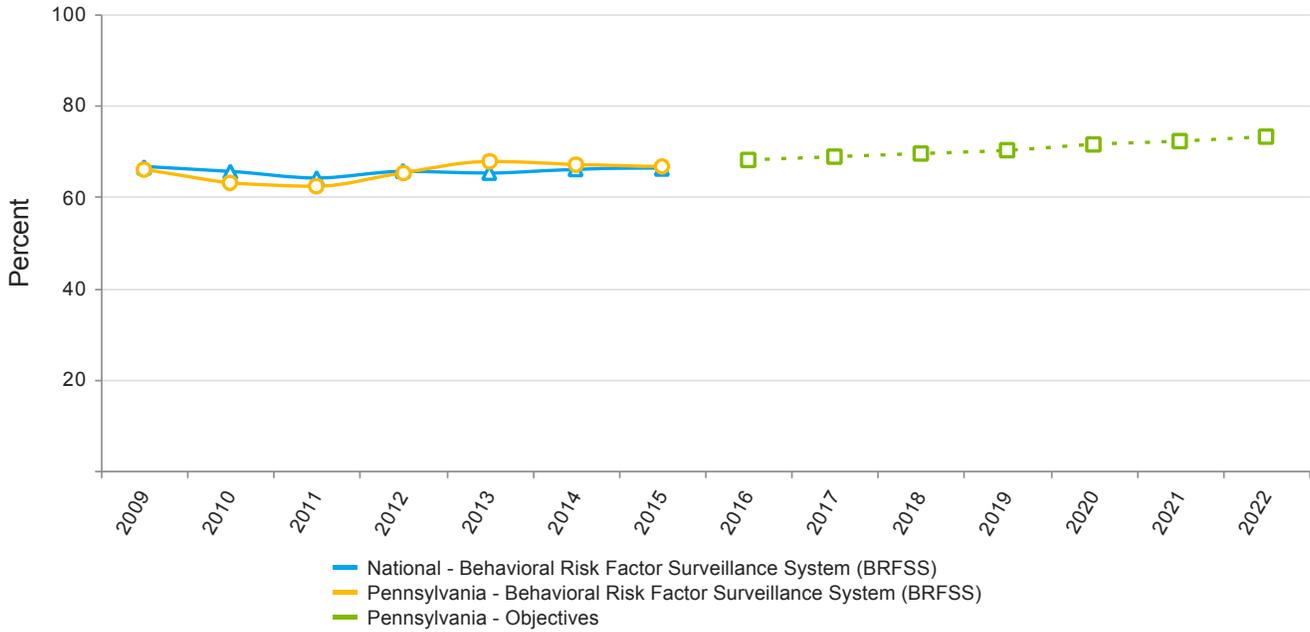
#### Women/Maternal Health

##### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	144.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.2 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.8 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.4 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.6 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	22.2 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.9	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.0	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	248.1	NPM 1

National Performance Measures

NPM 1 - Percent of women with a past year preventive medical visit  
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	68
Annual Indicator	66.5
Numerator	1,427,642
Denominator	2,148,194
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	68.7	69.4	70.1	71.4	72.1	73.1

**Evidence-Based or –Informed Strategy Measures**

**ESM 1.1 - Number of families served through Centering Pregnancy Programs.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	310
Numerator	
Denominator	
Data Source	Quarterly reports from the Centering Pregnancy Pro
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	300.0	305.0	310.0	315.0	320.0	320.0

**ESM 1.2 - Percent of adolescents and women engaged in family planning after delivery.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	87
Numerator	
Denominator	
Data Source	Quarterly reports from the County Municipal Health
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	80.0	82.0	83.0	84.0	85.0	87.0

**ESM 1.3 - Percent of adolescents and women who talked with a health care professional about birth spacing and birth control methods.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	94
Numerator	
Denominator	
Data Source	Quarterly reports from the IMPLICIT Programs
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	80.0	82.0	83.0	84.0	85.0	87.0

**ESM 1.4 - Percent of individuals trained on motivational interviewing.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	50.0	60.0	62.0	64.0	66.0	70.0

**ESM 1.5 - Number of women served through evidence based or informed home visiting programs.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	1,585
Numerator	
Denominator	
Data Source	Quarterly reports from the County/Municipal Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,500.0	1,510.0	1,525.0	1,540.0	1,600.0	1,600.0

**State Action Plan Table**

State Action Plan Table (Pennsylvania) - Women/Maternal Health - Entry 1

Priority Need

Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.

NPM

Percent of women with a past year preventive medical visit

Objectives

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

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

Strategies

Implement evidence based or informed home visiting services (ex. Nurse Family Partnership, Bright Futures, Partners for a Healthy Baby)

Implement Centering Pregnancy Programs

Implement innovative interconception care initiatives for women

Utilize motivational interviewing techniques

ESMs

Status

ESM 1.1 - Number of families served through Centering Pregnancy Programs. Active

ESM 1.2 - Percent of adolescents and women engaged in family planning after delivery. Active

ESM 1.3 - Percent of adolescents and women who talked with a health care professional about birth spacing and birth control methods. Active

ESM 1.4 - Percent of individuals trained on motivational interviewing. Active

ESM 1.5 - Number of women served through evidence based or informed home visiting programs. Active

## NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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NOM 3 - Maternal mortality rate per 100,000 live births

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NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

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NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

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NOM 5.1 - Percent of preterm births (<37 weeks)

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NOM 5.2 - Percent of early preterm births (<34 weeks)

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NOM 5.3 - Percent of late preterm births (34-36 weeks)

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NOM 6 - Percent of early term births (37, 38 weeks)

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NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

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

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NOM 9.2 - Neonatal mortality rate per 1,000 live births

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

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NOM 9.4 - Preterm-related mortality rate per 100,000 live births

**Women/Maternal Health - Plan for the Application Year**

**Domain: Women/Maternal Health**

**2018 Application:**

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

**NPM 1: Percent of women with a past year preventive medical visit.**

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

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

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

**ESM: Number of families served through Centering Pregnancy Program.**

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

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

**ESM: Number of individuals trained in motivational interviewing.**

Unhealthy birth outcomes, such as low birth weight and preterm birth, are influenced by many factors both before and during pregnancy. Preconception care allows women 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 a number of outcomes. Studies have shown that unintended pregnancies are associated with an array of negative health, economic, social, and psychological outcomes for women and children. By implementing interconception and preconception care initiatives, the Bureau of Family Health (BFH) intends to positively influence birth outcomes.

In Pennsylvania in 2014, 76.6 percent of white women, 57.2 percent of black women, 62.3 percent of multi-race women and 60.8 percent of Hispanic women received prenatal care starting in the first trimester. However, racial disparities continue with 1.1 percent of white women and 4.1 percent, 2.6 percent and 2.2 percent of black, multi-race and Hispanic women, respectively, receiving no prenatal care. The BFH is working to address racial disparities by requiring all vendors who serve Title V populations to develop and implement a plan to identify, address and eliminate health disparities in their communities.

The BFH has been working with the County Municipal Health Departments (CMHDs) to ensure screening among pregnant and postpartum women for behavioral health, substance abuse and interpersonal violence. Each of the CMHDs will be required to utilize the Institute of Health and Recovery's 5Ps screening tool to screen women during

home visits. Online trainings on the use of the 5Ps tool have been developed and became available for the CMHD staff as well as other Title V staff in March 2017. This screening will allow the identification of women in need of support and referral for behavioral health services, substance abuse assessment and interpersonal violence counseling. This screening, when performed in the postpartum period, provides home visitors with the opportunity to assess women's behavioral health status and provide referrals as necessary to improve health in this critical interconception period. It also presents a time to introduce or continue a discussion about birth spacing and birth control methods. The BFH has chosen to measure women discussing and engaged in family planning due to its important health, social, financial, environmental and economic benefits. Access to contraception helps people avoid unintended pregnancies, and to plan and space pregnancies to maximize positive health outcomes. It also leads to better interconception care which allows women to improve their health before becoming pregnant, ultimately improving the health of their children.

Home visiting programs have achieved positive outcomes in reducing the incidence of low birth weight babies and repeat pregnancies. They have also resulted in improved child development and increased rates of immunizations. In Pennsylvania, the Office of Child Development and Early Learning (OCDEL) is the lead agency for the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). Many of the home visiting models offered through MIECHV have specific requirements beyond poverty level and need such as prenatal enrollment and first pregnancy. The BFH is an active participant in collaborating with the MIECHV Program by participating as a stakeholder on a statewide home visiting stakeholders committee, which is convened by OCDEL's MIECHV Program. Additionally, OCDEL's MIECHV Program is currently drafting a joint Memorandum of Understanding with the BFH to establish a formal framework of collaboration with regards to home visiting programming. This framework will provide for data sharing, access to trainings and other professional development opportunities, and other opportunities to allow better coordination of home visiting programs in Pennsylvania.

Home Visiting programs through Title V provided by the CMHDs utilize the Bright Futures or Partners for a Healthy Baby home visiting curriculum. Both curricula allow the home visitors to plan and address key topics at necessary intervals for families receiving services. The flexibility inherent in these home visiting programs facilitates participation for those who would not otherwise be eligible for alternate home visiting programs, such as the MIECHV programs. Title V home visiting programs deliver necessary services to those who have had repeat pregnancies or delayed enrollment in a home visiting program. Ideally, home visitors connect with women in the prenatal period; however, not all women seek assistance during this time period. Many home visiting programs within the BFH allow women to obtain services up to a year after the birth of their children. This provides the opportunity for home visitors to develop a relationship with the family and begin educating on child development, safety issues, parenting, immunizations, birth control and interconception care. This education aims to improve birth outcomes moving forward and delay time in between pregnancies.

Home visitors have regular contact with families which allows for comprehensive, family-centered care. This care puts home visitors in the position to identify any developmental delays children may be experiencing. Many of the CMHDs utilize the Ages and Stages developmental screening tool for identifying developmental delays.

As part of the Title V home visiting programs, the BFH is providing training on motivational interviewing techniques. Training on motivational interviewing techniques began in March of 2017. Motivational interviewing is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to understand the need for change. The BFH has chosen to track those trained in this technique to improve behavioral changes among women enrolled in our programs.

The BFH will continue to collaborate with the Lancaster General Hospital (LGH) and Albert Einstein Healthcare Network (AEHN) Centering Pregnancy Programs (CPP). The BFH is also providing training for an obstetrical

practice in Norristown to begin offering Centering Pregnancy in their practice. Quantitative studies have shown that women who receive prenatal care through the Centering Pregnancy model compared to traditional prenatal care have: a reduced number of low birth weight babies, a reduced number of preterm births, and a higher number of prenatal visits and increased breastfeeding rates. The CPP curriculum covers birth control and birth spacing at numerous points throughout the pregnancy and postpartum periods.

Women enrolled in home visiting and CPP have pre-established relationships with their provider that foster future visits with healthcare professionals. These relationships help to increase the number of women seeking care between pregnancies and increase the percent of women having obtained a preventive medical visit within the past year. Therefore, the BFH has chosen to document and track the number of women served by these programs.

The BFH will also continue to work with the Shadyside Hospital Foundation on the IMPLICIT Interconception Care (ICC) project. This project serves as a well-woman visit in that it works to improve overall health by screening women for four behavioral risk factors at well-child visits: (1) smoking status, (2) depression, (3) birth control, and (4) multivitamin with folic acid use. Through implementation of this innovative model, the BFH seeks to identify whether receiving screening and advice from a medical professional during their child's well-visit will increase the likelihood that women will be more likely to participate in regular and ongoing consultation with their own providers.

## Women/Maternal Health - Annual Report

### Domain: Women/Maternal Health

#### 2016 Annual Report:

In 2016, the BFH continued its partnership with the CMHDs to provide local services to residents in their communities. The CMHDs provide preconception care, home visiting, prenatal care and smoking cessation programs among others to improve the health of families. In 2016, nearly 1600 women were served through CMHDs home visiting programs. Home visitors have regular contact with families which facilitates comprehensive, family-centered care. This care puts the home visitor in an ideal position to identify any developmental delays children may be experiencing as well as issues within the home such as intimate partner violence (IPV), substance abuse or social or financial problems. The BFH exceeded its 2017 goal of serving 1500 women through home visiting programs. CMHD home visiting programs consistently work to tweak their programs to achieve the best outcomes. In the past year, numerous CMHD have made the transition from having general nurses to MCH specific nurses. This change has allowed more efficiency within the program and in turn more women are being served annually.

Numerous CMHDs implemented the One Key Question® initiative developed by the Oregon Foundation for Reproductive Health. One Key Question® is a pregnancy intention screening tool used to decrease unintended pregnancies and improve the health of wanted pregnancies. It was designed to proactively address some of the root causes of poor birth outcomes and disparities in maternal and infant health and is used to talk with patients to identify pregnancy intention within the next year. With half of all pregnancies being unintended this initiative allows the CMHDs to educate and develop a reproductive health plan with the women they serve. This allows women to choose when they are ready to begin or expand their family. Additionally, developing a plan allows women to obtain optimal health before pregnancy, leading to healthier birth outcomes. This initiative helps the BFH to meet the objectives around family planning and birth control. With the partial data available, 117 women have been asked One Key Question to begin the conversation about pregnancy intention and birth control.

LGH located in Lancaster city and AEHN located in Philadelphia County both struggle with high proportions of low birth weight babies, as well as racial disparities. In Lancaster city in 2014, 9.5 percent of babies were born with a low birthweight. In 2014 in Philadelphia County, 10.7 percent of babies were born with a low birth weight. Among Lancaster's black population, 11.7 percent are born with a low birth weight, and among Philadelphia's black population, 13.7 percent were born with a low birth weight. The CPPs in these areas aim to improve birth outcomes as well as improve the knowledge base of the participants related to pregnancy and parenting. The BFH continues to work with LGH and AEHN to offer CPPs. Additionally, Philadelphia Department of Public Health and the Montgomery County Health Department began offering CPPs. In 2016, more than 300 women received their prenatal care through a CPP, thus meeting the BFH's 2017 goal of 300. AEHN offers an introductory session for pregnant women so they can get a feel for what prenatal care through the CPP model would be like. In LGH, a comparison among patients who received prenatal care through a CPP and those who received traditional prenatal care revealed that the percentage of women enrolled in the CPP delivering low birth weight babies was 6 percent versus 7 percent through the traditional prenatal care model. Breastfeeding initiating rates were 90 percent through CPP versus traditional prenatal care initiation rate of 80 percent. Furthermore, women breastfeeding at 8 weeks postpartum was 93 percent to 49 percent respectively.

The CMHDs and CPPs have submitted partial data related to family planning and birth spacing. Currently, 87 percent of adolescents and women being served through these programs are engaged in family planning after delivery. Additionally, 94 percent of adolescents and women talked with a healthcare professional about birth

spacing/birth control methods. The BFH has exceeded its goal for 2017 which is 80 percent for both objectives. Delaying pregnancy allows adolescents and women in Pennsylvania the opportunity to choose when they are ready to begin or expand their families. It also affords them the opportunity to improve their own health and habits prior to becoming pregnant.

The BFH continues to work with the IMPLICIT Interconception Care (ICC) Program wherein maternal screenings are conducted at well-child visits. This interconception care project works with children's scheduled well visits to check on the health of their mothers. Each visit addresses four behavioral risk factors to assess women's health: (1) smoking status, (2) depression, (3) birth control, and (4) folic acid. Women are counseled and referred for services as necessary. This initiative is focused on increasing the number of women who see their medical providers and on changing maternal behaviors to improve overall family health and birth outcomes in subsequent pregnancies. In the first year of this program 1,186 women were screened for ICC behavioral risk factors at 6 sites across Pennsylvania. Women screened positive for ICC risk factors at 72.9 percent of visits. Women reported smoking 21.3 percent of visits, screened positive for depression 11.6 percent of visits, not using contraception at 23.1 percent of visits and not taking folic acid at 59.3 percent of visits. Interventions were received at 83.2 percent, 94.6 percent, 82 percent and 51 percent respectively.

## Perinatal/Infant Health

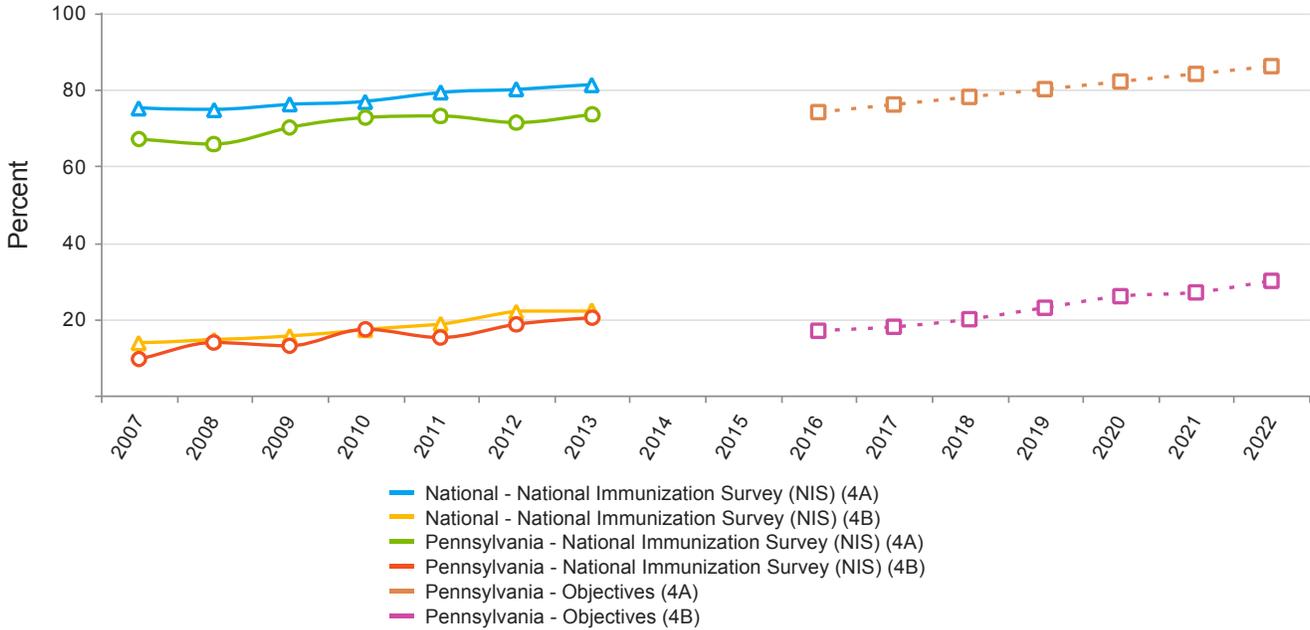
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.9	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	76.6	NPM 4 NPM 5

**National Performance Measures**

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

**Baseline Indicators and Annual Objectives**



**NPM 4 - A) Percent of infants who are ever breastfed**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	74
Annual Indicator	73.3
Numerator	99,273
Denominator	135,367
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	76.0	78.0	80.0	82.0	84.0	86.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	17
Annual Indicator	20.5
Numerator	27,408
Denominator	133,488
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	18.0	20.0	23.0	26.0	27.0	30.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 4.1 - Percent of individual facilities increasing the number of Keystone 10 steps completed each fiscal year.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	46
Numerator	
Denominator	
Data Source	Vendor reports and enrollment numbers
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	25.0	30.0	35.0	40.0	50.0	60.0

**ESM 4.2 - Percent of counties with breastfeeding initiation rates below 73% implementing evidence based strategies**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Vendor reports and PA Health Stats
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	20.0	25.0	30.0	35.0	40.0

**ESM 4.3 - Number of collaborations developed between the breastfeeding program and other programming for cross-messaging.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	BFH internal collection
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	2.0	3.0	3.0	4.0

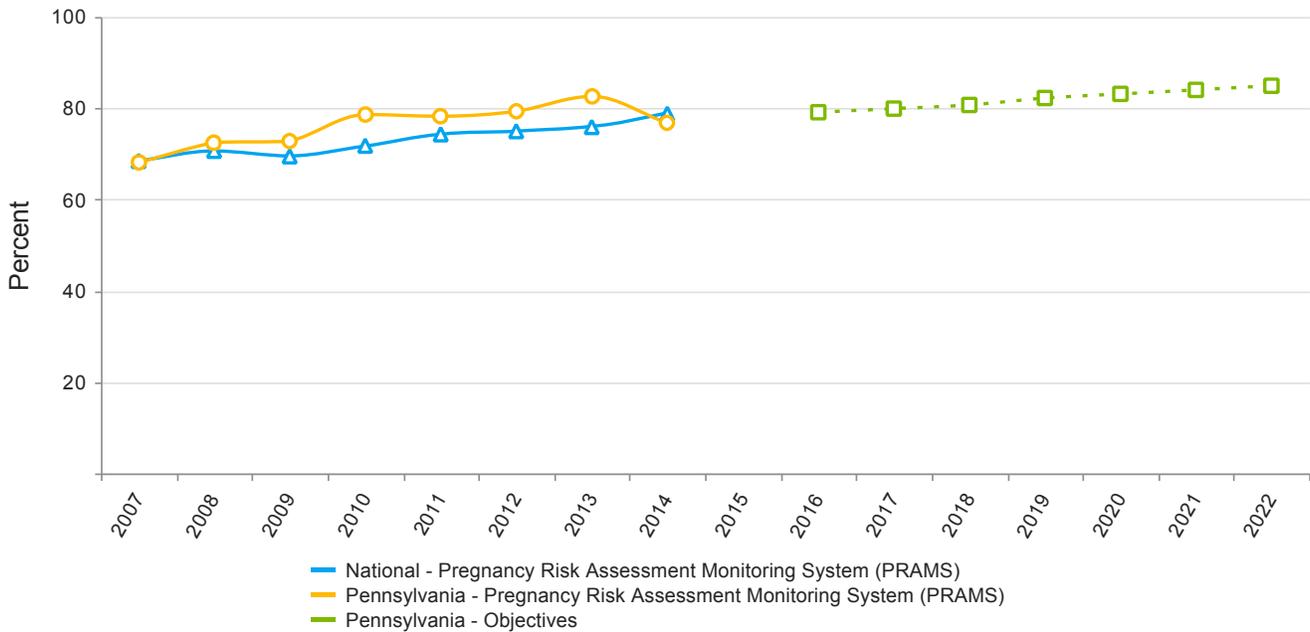
**ESM 4.4 - Number of media opportunities implemented promoting breastfeeding**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	BFH internal collection
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	2.0	3.0	3.0	4.0

**NPM 5 - Percent of infants placed to sleep on their backs  
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	79
Annual Indicator	76.7
Numerator	101,695
Denominator	132,585
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	79.8	80.6	82.1	83.0	83.9	84.8

**Evidence-Based or –Informed Strategy Measures**

**ESM 5.1 - Number of hospitals recruited to implement the model safe sleep program.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	2.0	3.0	3.0	0.0	0.0	0.0

**ESM 5.2 - Percentage of infants born whose parents were educated on safe sleep practices through the model program.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	8.0	9.0	18.0	0.0	0.0

**ESM 5.3 - Percentage of hospitals with maternity units implementing the model program.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	2.0	4.0	8.0	0.0	0.0

**ESM 5.4 - Number of social marketing messages disseminated.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	160.0	337.0	389.0	0.0	0.0	0.0

**State Performance Measures**

**SPM 3 - Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	48
Numerator	
Denominator	
Data Source	Newborn Screening Data System
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	49.0	54.0	59.0	64.0	69.0	74.0

## State Action Plan Table

### State Action Plan Table (Pennsylvania) - Perinatal/Infant Health - Entry 1

#### Priority Need

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

#### NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

#### Objectives

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

Starting with reporting year 2015, annually increase the rate of newborns being breastfed in counties with a 2012 rate below 73%.

Annually develop a minimum of one collaborative opportunity with programs serving MCH populations.

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

#### Strategies

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

Target specified counties to implement the evidence based strategies of peer counseling; partner/family support; or media/social marketing.

Identify programs with which to collaborate throughout the Department and other Commonwealth agencies that serve maternal and child health populations and provide and promote the sharing of breastfeeding information and messages in those programs.

Develop specific messaging that can be utilized across media and implement messaging through identified media opportunities.

ESMs	Status
ESM 4.1 - Percent of individual facilities increasing the number of Keystone 10 steps completed each fiscal year.	Active
ESM 4.2 - Percent of counties with breastfeeding initiation rates below 73% implementing evidence based strategies	Active
ESM 4.3 - Number of collaborations developed between the breastfeeding program and other programming for cross-messaging.	Active
ESM 4.4 - Number of media opportunities implemented promoting breastfeeding	Active

NOMs
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

Priority Need

Safe sleep practices are consistently implemented for all infants.

NPM

Percent of infants placed to sleep on their backs

Objectives

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

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

Strategies

Develop a hospital based model safe sleep program.

Implement a hospital based model safe sleep program.

Implement a social marketing plan to increase population awareness of safe sleep practices.

Participation in the SUID Case Registry.

ESMs

Status

ESM 5.1 - Number of hospitals recruited to implement the model safe sleep program. Active

ESM 5.2 - Percentage of infants born whose parents were educated on safe sleep practices through the model program. Active

ESM 5.3 - Percentage of hospitals with maternity units implementing the model program. Active

ESM 5.4 - Number of social marketing messages disseminated. Active

## NOMs

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

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

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

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

### Priority Need

Appropriate health and health related services, screenings and information are available to the MCH populations.

### SPM

Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.

### Objectives

By 2020, increase the annual percentage of Dried Blood Spot (DBS) samples with a transit time to the contracted lab of less than 48 hours by 5% each year to expedite diagnosis and treatment.

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

### Strategies

Review and analyze data from the Newborn Screening (NBS) system to identify submitters with collection to receipt times greater than the state average and provide these submitters with technical assistance and information on best practices to improve their collection to receipt times.

Review and analyze data from the NBS system to identify submitters with collection times greater than 48 hours and provide these submitters with technical assistance and information on best practices to improve their collection to receipt times.

Work with the contracted NBS laboratory to explore options for weekend pick-up of specimens.

Develop a strategy for identifying and implementing a revised payment system for Newborn Screening.

Develop a process for adding conditions to the mandatory screening panel after conditions are added to the RUSP.

## Perinatal/Infant Health - Plan for the Application Year

### Perinatal/Infant Domain:

#### 2018 Application:

**Priority: Safe sleep practices are consistently implemented for all infants.**

#### **NPM 5: Percent of infants placed to sleep on their backs**

Even after providing programs that recommend and reinforce behaviors to promote a healthy delivery and other positive outcomes for a newborn, not all babies achieve adulthood. As a result, Pennsylvania places great emphasis on reducing infant mortality rates.

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

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

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

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

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

**ESM: Percent of hospitals with maternity units implementing the model program.**

**ESM: Number of social marketing messages disseminated.**

The BFH will continue to support a three-year infant safe sleep grant (7/1/16 to 6/30/19) to develop and implement a hospital based model program with a supporting social marketing approach. The hospital based model program will 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 for this approach as there is more time for observation, correction and reinforcement of safe sleep practices during the hospital stay.

During state fiscal year 17-18, the hospital based model program will be implemented in at least four hospitals in Philadelphia. During state fiscal year 18-19, the hospital based model program will be implemented in at least six hospitals and expand outside of the city of Philadelphia. The BFH will continue to track the number of hospitals that are recruited and those that request to implement the model safe sleep program to determine interest in future programming. As hospitals implement the model safe sleep program, the BFH will track the number of infants whose parents were educated on safe sleep practices to determine the percentage of all infants born in Pennsylvania who are educated on safe sleep practices through the model program. Additionally, the BFH will calculate the percentage

of hospitals with maternity units that implement the model safe program. These measures will allow the BFH to determine the actual reach of the model safe sleep program in comparison to all births in the state. To account for education provided beyond the parents of infants born in hospitals with maternity units, the BFH will track the number of social marketing messages disseminated beginning in the second half of state fiscal year 16-17. This will demonstrate the reach of the program to family, friends, other caregivers, and parents or caregivers of infants born outside the maternity units.

**Priority: Appropriate health and health related services, screenings and information are available to the MCH population.**

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

**Objective 1: By 2020, increase the annual percentage of Dried Blood Spot (DBS) samples with a transit time to the contracted lab of less than 48 hours by 5% each year to expedite diagnosis and treatment.**

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

The Division of Newborn Screening and Genetics (DNSG) will continue quality assurance tasks to ensure timely collection to receipt of the DBS. Activities include monitoring data, providing technical assistance to submitters not meeting the timeliness standard of receipt at the lab within 48 hours of collection, and developing a quarterly newsletter, which showcases a hospital with an average collection to receipt less than 48 hours. Technical assistance efforts will focus on the benefits of timely shipping: best practices for packaging, pickup times and shipping method. A review of the submitter's current protocol will also be conducted to streamline the process. Technical assistance will be provided through phone calls, webinars and on-site visits to submitters.

The DNSG will utilize funds received from the NewSTEPs 360 grant to support education regarding the importance of a timely collection to receipt timeframe. Pennsylvania's NewSTEPs 360 team will generate a submitter self-assessment tool, dried blood spot coordinator manual, a midwife workgroup and offer continuing education units for developed educational sessions. The midwife workgroup will focus on submission of specimens for out of hospital births. These submitters (midwives and birthing facilities) typically mail DBS specimens using the U.S. Postal Service as a result of working in remote locations and with a lack of access to technology. These factors increase collection to receipt times at the laboratory. The newborn screening program will work with the contracted laboratory to provide birthing facilities and midwives additional information on shipping options and will offer additional technical assistance to this group of submitters. With funds from the NewSTEPs 360 grant, the team will collaborate with the contracted laboratory to create an HL7 interface between the laboratory and 8 birthing hospitals. Utilizing a HL7 interface will positively affect newborn screening timeliness by decreasing transcription errors, allowing for better tracking of specimens, providing early notification of lost specimens and improving efficiency by using automatic download processes instead of manual data entry.

The contracted laboratory, Perkin Elmer Genetics, will continue to generate and transmit a monthly newborn screening timeliness report to the dried blood spot coordinators at each birthing facility.

The DNSG will continue to work towards the objective of ensuring that all newborns born in Pennsylvania will be screened for all conditions listed on the RUSP. The RUSP is a national guideline created by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. The DNSG will continue a partnership with the

Newborn Screening and Follow-up Technical Advisory Board (NSFTAB) to implement the screening for all new conditions that may be added to the RUSP. In 2017, the DNSG will initiate screening for X-ALD and MPS 1, the two newest disorders added to the RUSP.

A disparity within Pennsylvania's dried blood spot program is the use of two separate screening panels, a mandated screening panel and a mandated follow-up panel. At this time, only 8 diseases listed on the RUSP are listed on the mandated screening panel. If a submitter chooses to only screen for the diseases listed on the mandated screening panel, the newborn will not be screened for 24 of the 32 diseases listed on the RUSP. In January 2017, the NSFTAB recommended that the two panels be merged, contingent on a new funding structure being developed for newborn screening in Pennsylvania. The DNSG and the NSFTAB will continue efforts to eliminate the inequality.

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

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

The Pennsylvania Breastfeeding Awareness and Support Program will continue to work toward four objectives aimed at increasing the percent of families who initiate and continue breastfeeding their infants. These objectives evolved from educating health care professionals through the EPIC BEST (Educating Physicians in Community Breastfeeding Education, Support and Training) program as well as from feedback from mothers, lactation consultants and the PA Women, Infants and Children (WIC) program. Feedback revealed that many healthcare providers had minimal breastfeeding management training and women indicated their personal decision to breastfeed was not always supported by healthcare professionals. Based on this information, it is apparent that work with healthcare providers needs to continue.

The BFH has determined some community level and community led initiatives are necessary to tackle the persistently low breastfeeding rates, prioritizing counties with low rates. These initiatives will focus on factors in the community, workplaces and within families that support or discourage breastfeeding. Stakeholders will have an opportunity to discuss the issues, develop and implement recommendations. The BFH will utilize pilot projects to test the effectiveness of an intervention, then replicate these efforts in other low-performing parts of the state.

Data from PA birth certificates, the Centers for Disease Control and Prevention's (CDC) Breastfeeding Report Card, and the state's aggregate score from CDC's Maternity Practices in Infant Nutrition and Care (mPINC) will be used to monitor performance. The 2016 Breastfeeding Report Card listed the state's breastfeeding initiation rate at 73.3 percent and the six-month exclusive breastfeeding rate at 20.5 percent. Healthy People 2020 goals, MICH-21.1 and MICH-21.5 (81.9 percent ever breastfed (initiation) and 25.5 percent six-month exclusive, respectively) will be used as the program goals.

**Objective 1: Increase the proportion of PA birthing facilities providing recommended care for breastfeeding mothers and their babies.**

**ESM: Percent of individual facilities increasing the number of Keystone 10 steps completed 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, PA has implemented its Keystone 10 Initiative (K-10) in 86 of PA's 100 birthing facilities.

This voluntary initiative focuses on the adoption and implementation of the ten evidence-based steps to successful breastfeeding. A regionally based learning collaborative model is being utilized to facilitate group discussion with focus on specific steps and barriers to success. In between collaborative meetings, K-10 facilities are assigned “homework” and facilitators provide individualized technical assistance as well. Professionals in participating facilities can partake in limited free educational sessions and facilities are provided with other resources for potential coursework and are encouraged to utilize an employee trainer to provide continuing education within their facility.

The K-10 initiative is looking to expand its reach to Neonatal Intensive Care Units (NICU). Studies have shown preterm infants have lower breastfeeding initiation and duration rates compared to healthy full-term infants. NICU staff have indicated that they do not feel able to meet the current K-10 ten steps due to the nature of care in a NICU. Because this vulnerable population of infants has much to gain from breastmilk, the program is working to modify the K-10 to the needs of NICU infants. Half of current K-10 participants have a NICU and there is significant interest in this expansion. K-10 has provided educational sessions to engage and initiate conversation with facility leadership regarding program expansion. As a pilot endeavor, one NICU has worked with the program to complete modified K-10 steps and received K-10 designation. The modified steps will be further analyzed and tested in a variety of birthing facility settings (academic/teaching, rural, urban). This approach will provide feedback based on varied depths of clinical procedure, safety review and administrative approval allowing the department to develop a more universal approach.

Quality improvement data are generated from a variety of sources. The BFH, vendor and several experts are partnering to provide technical assistance and approve applications for K-10 step certification. The program tracks facilities’ implementation of each of the ten steps and posts that information on the program’s webpage. Within each collaborative, individual facility data are tracked from a baseline point established within the first three months of the start of the collaborative. The data will be analyzed to determine the number and percentage of hospitals completing at least one additional step during each fiscal year. External data will be gathered from the CDC Breastfeeding Report Card and the state’s mPINC score to identify longer term outcomes. K-10 will offer intensive technical assistance to participating facilities that have not yet implemented at least one of the ten steps.

**Objective 2: Starting with reporting year 2015, annually increase the rate of newborns being breastfed in counties with a 2012 rate below 73%.**

**ESM: Percent of counties with breastfeeding rates below 73% implementing evidence-based strategies.**

This objective focuses on working with targeted counties to implement evidence-based strategies. Counties targeted are those with breastfeeding initiation rates below the state’s 2012 average of 73 percent. The 2012 data were the most recent available when this initiative was planned. Breastfeeding rates are determined from data collected from PA birth certificates and are stratified by county, maternal race/ethnicity, maternal age and baby’s birth weight. The counties targeted are in the northeast and southwest regions, because data indicates these counties consistently have low breastfeeding rates. By focusing on raising rates in these counties, the BFH anticipates an increase in the state’s overall breastfeeding rate over time.

Because breastfeeding rates are dependent on a multitude of factors, a community approach is being used to improve breastfeeding rates in struggling areas of the state. The BFH has established open lines of communication (email and telephonic) with maternal and child health organizations to facilitate their involvement. This approach will ensure a community perspective on various issues, enable expanded program focus, and allow for large scale problem solving.

A breastfeeding summit was held in the northeast and attendees identified four areas in need of additional support: family, community, work/school and healthcare. The BFH is working with partners to establish evidence-based frameworks and strategies. Resources and assets will be assessed and strategies implemented to support normalization of breastfeeding in the community, work and school environments and promote support structures within families. Initiatives will initially be tested in a pilot area. Initiatives determined to be successful through project specific measurable outcomes and demonstrated sustainability will be expanded. Plans for expansion will consider community resources, capabilities, potential barriers and competing needs.

Promotion of breastfeeding in birthing facilities is critical to achieving positive infant-feeding outcomes. However, there is often a sharp decline in exclusive breastfeeding in the months following birth. K-10 is working to address this through the community support component. Facilities build relationships with community support services and are encouraged to establish breastfeeding support groups on-site and within the community. Resources are provided to families at discharge. Fostering community networks is critical to reducing premature weaning.

Pennsylvania has the third largest rural population of any state, which can present challenges for families to find local resources. To enhance these resources, the BFH will provide education to healthcare personnel in Federally Qualified Health Centers and Rural Health Clinics in counties with low breastfeeding rates. Education will include breastfeeding management training and certification of lactation consultants.

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

**ESM: Number of new collaborations developed.**

The third objective focuses on building collaborations with other maternal and child health programs to promote breastfeeding. This effort will promote shared messaging to maternal and child health populations and providers. An example is combining safe sleep messaging with the promotion of breastfeeding. Evidence shows that when education is repeated throughout the duration of care there is significant behavioral integration. Safe sleep education will be included in the EPIC-BEST and K-10 programs, on the BFH's breastfeeding webpage, and social media. Safe sleep images used will be consistent with guidelines such as no blankets, pillows or soft toys.

As K-10 facilities implement changes to support newborn and family bonding through breastfeeding, rooming-in and skin to skin contact, there is increased focus on maintaining infant safety. The BFH has coordinated with Pennsylvania Patient Safety Authority to provide patient safety webinars and infant safety education information to K-10 facilities and WIC counselors.

Ongoing collaborations with WIC have promoted consistent messaging to families. The BFH and WIC utilize some of the same breastfeeding education materials and collaborate to update materials. K-10 is aware that some facilities have misconceptions about WIC's role in nutrition and breastfeeding support. A webinar was offered to educate clinical staff about WIC and regional WIC offices attend K-10 collaboratives to share information and resources.

The BFH will collaborate with the Bureau of Health Promotion and Risk Reduction's (BHPRR) CDC 1305 nutrition and physical activity grant, because exclusive breastfeeding reduces the risk of obesity. Leveraged funding from BHPRR will be used to train Certified Lactation Consultants (CLCs) and provide breastfeeding management training to healthcare personnel. Traditionally, medical schools provide minimal breastfeeding education to students. BFH and BHPRR will pilot an initiative to train medical school students in breastfeeding management or as CLCs.

Performance on this objective will be measured by the number of programs identified for collaborative opportunities and the subsequent number of programs that develop into collaborations.

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

**ESM: Number of new media opportunities implemented.**

The fourth objective promotes breastfeeding through the use of media. Messages will be varied across race and ethnic populations, targeting mothers and families including young mothers, which statistics indicate have lower rates of breastfeeding than their older counterparts. The public currently accesses the PA DOH website to obtain breastfeeding information. Links to breastfeeding legislation, parental guidance and county specific resources in the form of a referral guide are provided. In addition to the website, the BFH will continue utilizing Facebook and Twitter to promote the federal Text4Baby service and the Breastfeeding Referral Guide. In support of the district offices' workplace outreach, a campaign promoting the federal Break Time for Nursing Mother's law will be created. This will aid in educating the public about women's rights and employer requirements under the law. Research is currently underway to find the most beneficial messaging to support family involvement with breastfeeding. The number of implemented media opportunities will be tracked.

## Perinatal/Infant Health - Annual Report

### Perinatal/Infant Domain:

#### 2016 Report:

During state fiscal year 15-16, the BFH discontinued funding for the Cribs for Kids program. Cribs for Kids continues to provide their valuable services directly to the public and providers. The BFH and Cribs for Kids remain supportive of each other and work as partners on infant safety initiatives as the need arises.

Through partnerships with home visiting and safety programs, the BFH provides portable cribs to families unable to afford a safe sleep environment. When cribs are delivered, education on safe sleep, injury prevention and other safety measures are discussed.

After being awarded CDC funding for the creation of Pennsylvania's SUID Case Registry, the BFH hired a staff person as coordinator in January 2016. Additionally, due to staffing changes with current partners and within the BFH, the BFH began to directly manage the Child Death Review (CDR) program in 2016. Ultimately, this change has enhanced and strengthened the CDR program. The same staff person coordinates both the SUID Case Registry and CDR programs.

The SUID Registry has been integrated, operationally, into the CDR Program. The PA CDR program serves as the platform on which standardized SUID case registry information is captured. Strategies for improving SUID case identification timeliness and standardization have been accomplished through monthly vital record imports, coordinated information exchange with coroners and medical examiners, statewide education and outreach and expedited report dissemination. The registry has produced enhanced SUID case information within the web-based, National Child Death Review Case Reporting System. This has also expanded infant death data collection, analysis and reporting capabilities. The project has engaged the CDR program's statewide network of multidisciplinary CDR teams, coroners and medical examiners around the issue of SUID. The project has already shown signs of improving Pennsylvania's capacity to develop and monitor a profile of unexplained infant deaths, which has led to improved prevention recommendations, programmatic strategizing and targeted interventions at both the local and state levels.

A three-year grant with the Trustees of the University of Pennsylvania for the infant safe sleep initiative began July 1, 2016. While the grantee began work immediately, a delay in fully executing the grant slowed the progress as the grantee was not able to announce the grant award publicly.

During the first half of the 16-17 fiscal year, the grantee made great strides in pulling together experts to begin development of the hospital based model safe sleep program. The grantee was able to achieve success with the 2017 ESM goal of recruiting two hospitals with maternity units to implement the model safe sleep program, as well as pilot new aspects of the program. Having access to a real-world test environment will allow the grantee to develop an effective model program before full implementation begins.

A day long training for subject matter experts in the two recruited hospitals was conducted which included an overview of SUID, evidence-based best practices for risk reduction interventions to support the 2016 AAP safe sleep recommendations, as well as teach-back and crucial conversations techniques. An online training is also being developed for floor nurses who work on maternity units to teach them evidence-based and best practices for safe sleep with healthy newborns.

The DNSG continues to show progress in improving the timeliness of DBS screening. The current Title V Block Grant

objective is to decrease the timeframe between the collection of the DBS sample to the receipt at the contracted laboratory. To measure success, the DNSG has set a goal of increasing the annual percentage of samples with a transit time of less than 48 hours by 5 percent each year. In 2014, 39.7 percent of the filter papers collected were received at the contracted laboratory within 48 hours of collection. That percentage increased to 45 percent in 2015 and 48 percent in 2016. The DNSG did meet the goal in 2015, however, was shy of the goal in 2016 by 2 percent. The factor likely contributing to this unmet goal was a vacancy in the nursing services consultant position whose primary responsibility is quality assurance with a focus on timeliness of newborn screening. This position was filled in April 2016.

During the state fiscal year 2015-2016, the DNSG provided education to all Pennsylvania submitters regarding the DBS timeliness goals of the DNSG. Monthly collection to receipt averages were tracked and technical assistance was provided to hospitals with an average time from collection to receipt at the laboratory greater than 48 hours. Means of technical assistance included emails, conference calls and site visits. Technical assistance focused on best packaging practices, specimen pick-up schedules and method of shipping. The success of the technical assistance was evident by the increase in Saturday shipping and improved collection to receipt averages. The DNSG created quarterly submitter reports which provided the submitter with their timeliness data compared to the state average. The contracted laboratory assumed the responsibility of the submitter reports in October, 2016. The release of the reports also increased to a monthly receipt.

The DNSG was awarded an \$80,000 grant from NewSTEPs 360. NewSTEPs 360 is the result of a competitive funding opportunity that sought one source to support state newborn screening programs to improve timeliness of newborn screening. A Pennsylvania NewSTEPs 360 team was created and consists of members from the DNSG, the contracted laboratory, and birthing hospital staff. In November 2016, the team traveled to Bethesda, Maryland for the kick-off meeting and has since begun grant activities.

In February 2016, the DNSG added Pompe to Pennsylvania's mandatory newborn screening panel and five other lysosomal disorders to the follow-up screening panel. Pompe is a condition listed on the RUSP.

The process to explore the inclusion of universal newborn screening for congenital cytomegalovirus (CMV) on the RUSP has been initiated by an advocacy group of concerned families of children born with congenital CMV and interested CMV experts. DNSG staff attended a CMV conference in September 2016 to receive education regarding the disease and the possible implementation of CMV screening. The DNSG will continue to monitor CMV's addition to the RUSP and, if added, will work with the NSFTAB to determine if it is appropriate for the Department to add CMV to the mandatory screening panel.

Through an agreement with the PA Chapter of the American Academy of Pediatrics, breastfeeding promotion activities focus on increasing breastfeeding knowledge in community based healthcare settings so these settings can become a source of information and support for pregnant and new mothers. The EPIC BEST (Educating Physicians in Communities-Breastfeeding Education, Support and Training) program is conducted in primary care, OB-GYN, family practices and other locations. In 2016, EPIC BEST trained 299 healthcare and related professionals. Pre-and post-surveys distributed to each practice measured practice and policy changes, such as developing a breastfeeding policy or recommending exclusive breastfeeding to all pregnant women. Results of the survey indicated an increase in practice sites that developed written breastfeeding policies, created breastfeeding supportive office environments and hired lactation consultants. Based on pre- and post-surveys it was concluded policy changes occurred at significantly higher rates after completion of the education.

The K-10 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 2016, the program recruited an additional 17

facilities, bringing the number to 86 of the state's 100 birthing facilities. Of those facilities, one was already certified under the Baby-Friendly® Hospital Initiative (BF) as having completed the ten steps. In November 2015, the step completion applications were released to the K-10 facilities. Within 13 months of the release, 39 facilities (46 percent of the 85 non-BF participants) had implemented between one and 10 evidence based steps to breastfeeding. Facilities have been grouped into five regional collaboratives that meet in person twice annually and participate on subject specific webinars twice a year. Facilities are assigned tasks designed to help them successfully implement the ten steps. A web-based project management tool, Base Camp, is utilized to allow regional collaboratives to share information, best practices and pose discussion questions. All participants are offered a 15-hour breastfeeding management course that meets K-10 education requirements. In the second year of the program, 1,202 clinicians attended courses and 23 facilities completed a train-the-trainer class. The group cohort style of K-10 provides support when facilities feel they have reached barriers. In addition, there are currently six BF certified facilities taking part as subject matter experts to offer guidance. Each facility has champions which understand the importance of breastfeeding to both maternal and infant health and the driving force of those champions has a strong influence on each facility's momentum. The most common barriers noted are lack of administrative support for staff implementing K-10 and the length of time required to approve and implement the quality improvements. K-10 regional facilitators provide on-site technical assistance to facilities reporting lack of administrative support. Technical assistance addresses the natural flow of clinical change and resulting fluctuation in patient satisfaction surveys, provision of positive feedback to staff and communication of administrative expectations to all facility staff, not just maternity care staff. Participating facilities have varying administrative structures responsible for approving changes to clinical care and procedures; therefore, it is difficult to standardize the amount of time required to implement specific steps.

In 2016, discussions began about how NICUs could benefit from participation in K-10. Research was conducted to determine necessary adaptations to K-10 for NICUs. The BFH continues to encourage K-10 facilities to provide breastmilk to NICU infants. Often these infants require formula supplementation due to medical necessity; however, this has a negative impact on exclusive breastfeeding rates. Provision of human donor milk, rather than formula, to infants will help maintain exclusivity rates at the state's birthing facilities. The Three Rivers Milk Bank in Pittsburgh attended K-10 collaboratives to present information. As a result, facilities are promoting pumping breastmilk for NICU infants and providing education to patients on the benefits of breastmilk for critically ill infants. The only NICU to receive K-10 designation presented a webinar on supporting the NICU infant with breastmilk, discussed how the original step initiative was modified for NICU use and highlighted strategies for educating parents on the importance of breastmilk.

Annually, the BFH identifies counties with breastfeeding initiation rates below the 2012 state average of 73 percent. In 2016, BFH began identifying low performing counties to receive targeted evidence based support efforts aimed at improving breastfeeding rates. The first of these were six counties in northeast Pennsylvania: Bradford, Lackawanna, Luzern, Schuylkill, Susquehanna and Wyoming. To gain a comprehensive view of barriers faced by these counties, BFH reached out to maternal and child organizations in those counties. The Geisinger Commonwealth School of Medicine and Maternal Family Health Services expressed interest in partnering with the program to hold a northeast breastfeeding summit to identify issues; which was held on August 25, 2016. Attendees represented 24 organizations specializing in maternal infant health, breastfeeding support, education and insurance. Participants identified four broad categories of concern: family, community, work/school and healthcare. Support strategies were developed and potential community-based champions were identified. As a result, the BFH initiated discussions on a teen parenting pilot project in Schuylkill County aimed at graduating teen parents from high school, supporting breastfeeding, building family structure and teaching coping skills. Partners have also come forward from Luzerne County to discuss implementing a public awareness campaign to promote and normalize breastfeeding. In 2017, projections are for 15 percent of the counties identified as low performing in 2012 to implement evidence based

breastfeeding strategies (which equates to five counties). Baseline rates were zero and BFH is not currently positioned to meet the 2017 goal as activities are only being discussed with two counties. A critical part of implementing county-level improvements is the presence of local champions who will agree to lead improvement activities. Email updates on the counties' activities will be provided to attendees of the northeast breastfeeding summit to keep them engaged and promote future champions to come forth. The BFH has supported breastfeeding education for healthcare professionals in the northeast by targeted marketing of the EPIC-BEST. Physician offices were offered free training along with a gram sensitive pediatric scale. Unfortunately, only one office responded to the offer by the deadline date. The BFH is investigating providing breastfeeding training to students at the Geisinger Commonwealth School of Medicine. Minimal breastfeeding training is provided in medical school and the belief is students who are taught breastfeeding management will continue to support breastfeeding in their practice. Two medical students have been chosen to participate in BFH sponsored CLC training in 2017.

BFH supports collaboration defined as efforts to promote shared messaging and education with various programming areas. In 2015, the baseline number of collaborations was zero. Three collaborations were developed in 2016. The first resulted from misinformation about the issue of women breastfeeding while still smoking, often resulting in early weaning or no initiation of breastfeeding. With this in mind, the BFH incorporated correct messaging within its EPIC-BEST and K-10 programs. An opportunity for collaboration emerged with the Department's Division of Tobacco Prevention and Control (TPC). During the five regional K-10 collaborative meetings in November 2016, TPC gave presentations to K-10 facilities on available no-cost smoking cessation programs and how to refer patients. The intent is to more fully integrate cessation activities in K-10 hospitals. The second resulted from clinical care practice changes in the K-10 initiative. Implementation of skin-to-skin care and infant rooming-in in the maternity care setting brought forth concerns about infant safety. The BFH collaborated with the Pennsylvania Patient Safety Authority to provide webinar based information to K-10 facilities. Pennsylvania data on infant injuries during hospital stays was presented as well as education on preventing injuries in the labor and delivery and postnatal wards. Due to the high level of interest in the subject, a second webinar was presented by Dr. Michael H. Goodstein, Neonatologist at York Hospital, on balancing best practices, skin to skin care, breastfeeding and infant sleep safety.

The third collaboration was with the Bureau of Health Promotion and Risk Reduction's (BHPRR) CDC 1305 grant to promote systems change and increase access to breastfeeding friendly environments. A 2016 collaboration with BHPRR resulted in the purchase of patient education materials, web-based and in-person 15-hour breastfeeding management clinical training modules, gram sensitive pediatric scales, NICU breast pumps, EPIC-BEST trainings and CLC training/text books/exams. Combining departmental efforts will enable efficient use of resources and reduction of duplicative efforts. Based on positive outcomes of the three collaborations, BFH is planning to meet or exceed 2017 projections for one new collaboration.

The BFH enhanced the PA DOH Breastfeeding Awareness and Support web pages. Public access to the pages should increase as social media campaigns are implemented in the coming years. In May 2015, BFH was notified the Department was approved to use social media platforms Facebook and Twitter. There was some delay in provision of guidance for use of the platforms, but in late 2016 the BFH developed Facebook and Twitter campaigns to promote the federal Text4Baby service and the Department's Breastfeeding Referral Guide which provides comprehensive listings of breastfeeding support services organized by county. Approval of the campaigns was received in late 2016 and posts will take place in 2017. Baseline numbers for 2016 were zero and BFH is on target to exceed its 2017 goal of one media opportunity to promote breastfeeding.

## Child Health

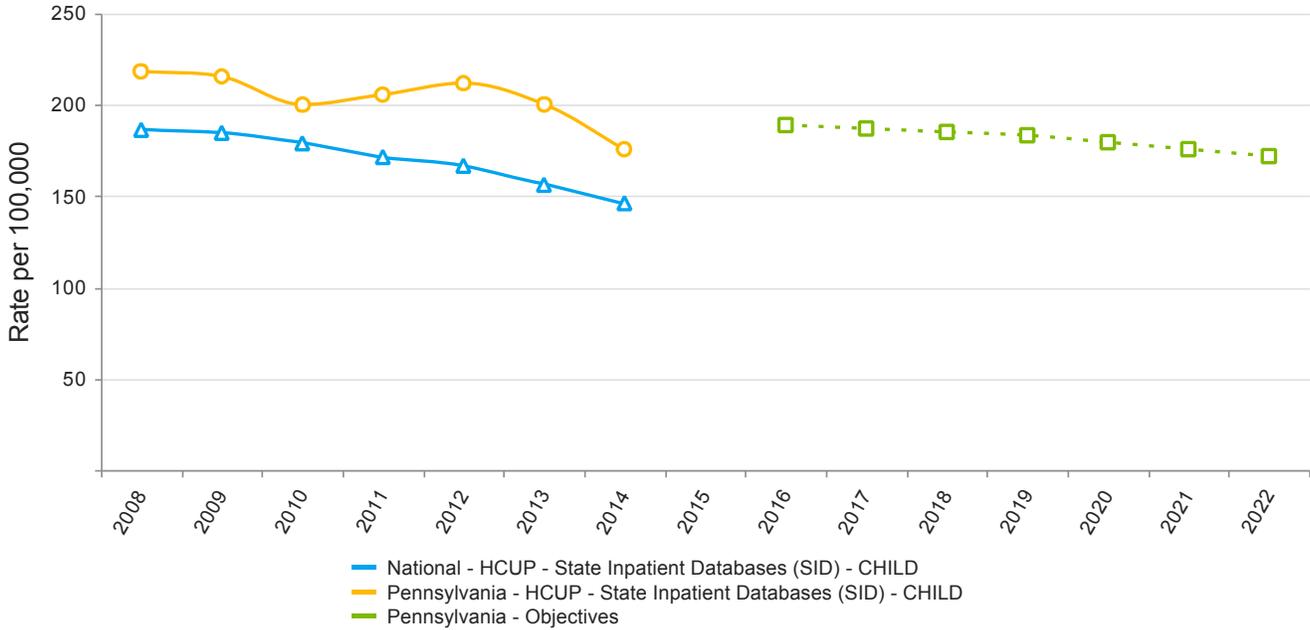
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	15.6	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	31.1	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	10.1	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	7.8	NPM 7

**National Performance Measures**

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

**Baseline Indicators and Annual Objectives**



**NPM 7 - Child Health**

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	188.7
Annual Indicator	175.4
Numerator	2,553
Denominator	1,455,450
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	186.8	184.9	183.1	179.3	175.5	171.7

**Evidence-Based or –Informed Strategy Measures**

**ESM 7.1 - Number of comprehensive home assessments completed.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	97
Numerator	
Denominator	
Data Source	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	875.0	900.0	920.0	920.0	920.0	920.0

**ESM 7.2 - Number of health and safety hazards identified through comprehensive home assessments.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	936
Numerator	
Denominator	
Data Source	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	7,000.0	7,200.0	7,360.0	7,360.0	7,360.0	7,360.0

**ESM 7.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	468
Numerator	
Denominator	
Data Source	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	4,375.0	4,500.0	4,600.0	4,600.0	4,600.0	4,600.0

**State Performance Measures**

**SPM 2 - Percent of Title V programming with interpersonal violence reduction components.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	List of BFH Title V programs
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	14.0	14.0	14.0	18.0	21.0	21.0

**State Action Plan Table**

State Action Plan Table (Pennsylvania) - Child Health - Entry 1

Priority Need

MCH populations reside in a safe and healthy living environment.

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

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

Strategies

- Provide comprehensive home assessments to identify potential home health and safety hazards.

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

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- Continue to provide the Shaken Baby Program

ESMs	Status
ESM 7.1 - Number of comprehensive home assessments completed.	Active
ESM 7.2 - Number of health and safety hazards identified through comprehensive home assessments.	Active
ESM 7.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.	Active

## NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

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NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

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

Priority Need

MCH populations reside in a safe and healthy living environment.

SPM

Percent of Title V programming with interpersonal violence reduction components.

Objectives

As a result of the Child Safety CoIIN, implement at least one new strategy to address interpersonal violence in PA by 2020.

Strategies

Participate in the Child Safety CoIIN with a focus on falls prevention and interpersonal violence reduction.

## Child Health - Plan for the Application Year

### Domain: Child Health

#### 2018 Application:

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

#### NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 19

As a result of the 2015 MCH Needs and Capacity Assessment, the BFH identified the following priority: MCH populations reside in a safe and healthy living environment. The living environment encompasses not only the physical structure of the home, but also the behavioral and emotional factors that apply within a living environment or neighborhood. Low-income people and communities across the United States suffer disproportionately from the negative health effects of poorly constructed, unsafe and substandard housing. A number of research studies have documented these negative effects, which include asthma and other respiratory illnesses, cardiovascular health problems, increased stress, and adverse overall physical and mental health status. In addition to affecting the quality of life for low-income people, these health problems also place a significant burden on the health care system.

Children who are exposed to physical hazards such as contaminants, pests, and moisture issues are at risk for injuries or illnesses. Children may also be exposed to drug use, violence, and domestic abuse in their home and neighborhood environments. By beginning to address factors contributing to injuries during childhood that happen in or around the home, the BFH anticipates a reduction in the child mortality rate and the rate of hospitalization for non-fatal injuries.

Pennsylvania's Child Death Review program (CDRP) was developed to promote the safety and well-being of children by reducing preventable childhood fatalities as a result of review and exploration of the factors contributing to these fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. The CDRP facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies. The BFH uses these data and team recommendations to inform program goals and interventions. In 2018, the BFH will continue to enhance and strengthen the CDRP through data analysis for both SUID and CDRP cases. The BFH is also developing a State CDRP Team who will be tasked with developing policies, training and recommendations for the BFH and local CDRP teams.

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

**ESM: Number of comprehensive home assessments completed.**

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

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

In 2013 the BFH implemented the Lead and Healthy Homes Program (LHHP), using the evidence-informed models of home assessment, education, housing rehabilitation and integrated pest management (IPM) to establish an evidence-informed home assessment and education program to identify and improve the health and safety of homes

and their residents. The healthy homes approach is a coordinated, comprehensive, and holistic approach to preventing diseases and injuries that result from housing-related hazards and deficiencies. In addition to issues related to the structure of homes the LHHP has highlighted the need for education and teaching on practices and behaviors that lead to safe and healthy homes.

This first iteration of evidence-informed healthy homes programming filled a void by addressing health and safety for children in the environment in which they spend the most time. The BFH used the results of LHHP analysis and the MCH needs assessment to reinvent the healthy homes programming to shift the main focus to injury prevention supported with healthy homes concepts. Following a competitive bidding process the Safe and Healthy Homes Program (SHHP) began July 1, 2016 and will run through June 30, 2019. The SHHP targets five regions across the state with the highest injury rates and incorporates American Academy of Pediatrics guidance and interventions to reduce the risks of injuries, and continue to provide limited housing rehabilitation and education to address safe and healthy home issues. Falls, poisoning and hot objects are the leading causes of injuries resulting in hospitalizations in Pennsylvania, especially in the MCH population. Interventions aimed at reducing these hazards in order to prevent injuries are supported by research that ranges from proven to promising and will be offered to families who participate in the SHHP. In addition, the SHHP will use CDRP data and recommendations whenever it is practicable to improve interventions that may be specific to a region or population.

Falls are the leading cause of injuries that result in hospitalization in Pennsylvania particularly for children under age 15. Falls can be the result of structural issues as well as unsafe practices and behaviors. Studies demonstrate that home modification does reduce hazards and is therefore promising as a way to reduce falls and fall injuries. Home modification may include installing window guards and repairing faulty stairs or floor surfaces.

Poisoning causes one out of every ten injuries that require hospitalization in Pennsylvania and rises to almost a quarter of the injuries for people ages 15-24. Poisoning occurs when products or medicines are used in the wrong way, in the wrong amount or by the wrong person. Every 10 seconds, a poison control center in the United States answers a call about a possible poisoning with more than 90 percent of these exposures occurring in the home and 80 percent being unintentional. Half of poisonings occurring in children under age six are from cosmetics and personal care products, which are completely preventable.

Carbon monoxide (CO) is a colorless, odorless gas that is created by the burning of fuel that can be deadly to people. Because CO cannot be seen or smelled, it can only be detected if a working CO detector is properly installed. Despite CO poisoning being preventable, more than 400 Americans die from unintentional CO poisoning not linked to fires, more than 20,000 visit the emergency room, and more than 4,000 are hospitalized.

Burns from hot objects or substances are the second leading cause of injury hospitalization for children under age five in Pennsylvania and, nationally, scalds are the leading cause of burn injuries to children under age four. Reducing water heater temperature to 120°F is one of the easiest interventions to reduce the risk of hot water burns. Educational efforts alone and education paired with safety equipment have been shown to be effective for children of various ages, genders, races, and ethnicities. Such efforts have demonstrated effects for children in single parent and two-parent households, children living in rental units, and children in family-owned homes.

Pesticides are used in about three out of four U.S. homes to prevent or kill bugs or rodents yet they are poisonous to people. Pesticides are often used in large quantities in low income, urban areas. Integrated Pest Management (IPM) includes a broad range of methods to control pests that also minimizes potential hazards to people, property, and the environment. Individually tailored IPM plans can be cost-effective, with costs that are often equal to or lower than traditional chemical pest control. IPM begins with the least risky approaches (e.g., mechanical controls such as

trapping) and moves to targeted pesticide use only if other measures are not successful to control pests. This reduces pesticide exposure and improves health outcomes and housing conditions. When used in low income urban areas, IPM strategies can reduce disparities in pesticide exposure and related health risks, especially for children.

Lead exposure remains a concern for children with 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 in the paint which becomes a problem when it deteriorates or is destabilized during renovations.

Narrowing the geographic area from a statewide program, LHHP, to a regional program, SHHP, based on highest need was a necessary change. In an effort to balance priorities and to see marked improvements in outcome measures, directing funds to the areas with the highest injury rates will ensure that BFH is maximizing our investment. Focusing on low-cost evidence-informed interventions that reduce injuries and provide for healthier homes such as smoke alarms, CO alarms, and IPM will allow more hazards to be addressed in each home. Shifting focus from a reactive approach for larger health and safety interventions with LHHP to a truly preventive approach with SHHP provides more opportunities to move the dial on outcome measures. This was done by limiting interventions to a specific list of evidence based and evidence informed interventions that are implemented before hazards injure the residents of the home.

Due to inherent challenges in tracking success for prevention programs, the BFH will focus on tracking objective measures of the activities that were performed. The BFH seeks to increase the number of services provided and will measure this by tracking the number of comprehensive home assessments completed. One of the measurable outcomes of the assessments is to track the number of health and safety hazards that are identified. In addition to identifying the hazards, the SHHP will continue to implement health and safety interventions that will be tracked to reduce the hazards posing an injury risk. The BFH will consider SHHP successful if identified health and safety hazards are not only identified, but also remediated.

#### **SPM: Percentage of Title V programming with interpersonal violence reduction components.**

#### **Objective 2: As a result of participation in the Child Safety CollIN, implement at least one new strategy to address interpersonal violence in PA by 2020.**

Pennsylvania (PA) applied for and was selected to join the Child Safety Collaborative Improvement and Innovation Network (CS CollIN) as part of their commitment to serving the maternal and child health populations through the Title V MCH Services Block Grant. The priorities identified through the 2015 Needs and Capacity Assessment lend themselves to the development of strategies to address bullying; adolescent suicide in the LGBTQ community; child injury in the home; safe sleep; and intimate partner violence screening. Joining the CS CollIN also enables PA to foster more interstate and intradepartmental/silo-crossing collaboration to reduce the impact of childhood injury in the state. The state was eager to take advantage of an opportunity to participate in fast-paced quality improvement learning and the integration of evidence based practices and strategies to drive systems change. The CS CollIN identified five topic areas on which to focus efforts: teen driver safety; child passenger safety; suicide and self-harm prevention; interpersonal violence prevention; falls prevention. Participating states were required to pick at least two topic areas. PA has chosen interpersonal violence and falls prevention. For the purposes of the CS CollIN, interpersonal violence is inclusive of assault, bullying, child maltreatment, homicide and sexual assault. Many states are looking for cross-cutting upstream approaches to simultaneously address multiple forms of violence.

As a result of participation in the CollIN process, PA aims to identify and implement at least one new strategy to address interpersonal violence. Recent approaches to addressing interpersonal violence are taking a cross-cutting

approach as multiple forms of violence are strongly interconnected, sharing risk and protective factors. The BFH is currently examining the potential for expanding cross-cutting work in interpersonal violence prevention. As a first step and interim measure towards reducing interpersonal violence and overall rates of injury in children and adolescents, the BFH plans to quantify Title V programming within the lens of interpersonal violence reduction strategies. The above stated measure will cross the child and adolescent domains as work through the CollN is focused on reducing child and adolescent deaths, hospitalizations, and Emergency Department (ED) visits.

The CS CollN is continuing into a second cohort and PA applied and was approved to continue their work in Cohort 2 in February of 2017. The goal is take some of the developmental tests already being completed by both the Falls Prevention and Interpersonal Violence Prevention teams and push for small tests of change that will result in the spread of current programming or the piloting of new programming or initiatives.

## Child Health - Annual Report

### Domain: Child Health

#### 2016 Report:

The Lead and Healthy Homes Program (LHHP) staff worked with families to identify and address potential home hazards to prevent injuries and illness. LHHP often worked in conjunction with other home visiting or early education programs and conducts home assessments to identify factors that could contribute to injuries or illness, and provide education and interventions to reduce risk factors. Additionally, environmental inspections were performed in homes of children with elevated blood lead levels. LHHP staff members developed partnerships to integrate safe and healthy housing activities at the local level with other housing and health programs. Many home hazards were remedied by low-cost interventions or simple behavioral changes, but without the appropriate assistance, families may be unable to identify or remediate hazards on their own. The BFH oversaw grants with regional grantees to provide services across the state. LHHP was fully implemented July 1, 2013 in four of the six state health districts. By July 1, 2014, the program was implemented throughout the state. In 2016, over 1,300 families were served and over 24,000 supplies were distributed, including low-cost safety devices, pest control, and non-toxic cleaning supplies. As the LHHP ended the BFH was able to reflect on the success of implementing healthy homes programming as well as use lessons learned to shift the programming to the Safe and Healthy Homes Program (SHHP). The flexibility afforded by the MCH funds was invaluable to the BFH to hone programming to meet the needs of Pennsylvania.

The SHHP was designed to target seven regions across Pennsylvania with the highest injury rates. Applications in response to the issuance of a Request for Applications (RFA) for the Safe and Healthy Homes Program resulted in applications for only six of the regions. Awards were issued to applicants in only five regions after applications for the sixth region would have required excessive changes that would have compromised the integrity of the competitive process. The SHHP began July 1, 2016, with a delay in the execution of grant agreements; however, programmatic activities began several months later. Due to the start-up delays, the SHHP is not on track to meet the 2017 ESMs using the first two quarters of data. Evaluating the progress to date, most grantees are not on track to meet their portion of the annual home assessment ESM goals. At this point there is not concern as the two quarters of data were not representative of the grantees capacity due to the issues previously mentioned. The first quarter of 2017 will be key to determine if changes are needed or if it truly was startup delays. As this is the first year and baseline year for data, the BFH is taking a wait and see approach before making changes. If the number of home assessments can get on track there will be no issues with the other ESMs related to the SHHP. The estimates of identifying eight hazards per home that have a completed comprehensive home assessment is in line with the rate to date of nine hazards identified as well as our estimate of performing five interventions being equal with the rate to date of performing five interventions for each comprehensive home assessment.

One of the largest challenges for this year was the continued attention brought to Pennsylvania stemming from several national newspaper articles comparing children with elevated blood lead levels in Pennsylvania to those in Flint, Michigan. While it was challenging, in the end the public's attention was brought to a topic that typically is overlooked. Over the course of the year attention to water testing increased. Several incidences of water testing above the EPA action level were identified across the state with the state Department of Environmental Protection working to reduce the lead levels to those below the EPA action level. Over the past year there were no legislative policy changes made at the state level regarding lead, including a requirement for universal blood lead testing of children. Additionally, the BFH is working to ensure access to information and resources regarding prevention of lead poisoning is available to all families in Pennsylvania.

The BFH serves as a statewide resource on healthy homes to provide information and referrals to appropriate

organizations. Additionally, the BFH operates a toll-free Lead Information Line to provide information and resources on prevention, screening, abatement and regulatory issues on lead for the citizens of Pennsylvania.

Current work in the BFH addresses injury prevention from a variety of angles. The BFH, in partnership with the Department of Human Services and the PA Chapter of the American Academy of Pediatrics oversees the Child Death Review Program (CDRP) throughout the state. The CDRP was developed to promote the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children under the age of 21. All 67 Pennsylvania counties are represented on local CDRP teams. The CDRP facilitates the death review process, provides training and technical assistance to local teams and makes recommendations regarding prevention programs and policies.

There were 1,931 deaths of children 21 years of age and under in 2013. Of the total deaths, 1,453 were reviewed. Close to half (48.7 percent) of all deaths were infant deaths. There were 452 deaths in children 1 through 17 years of age and 539 deaths in children 18 through 21 years of age in 2013. The rate of death in black children continues to exceed the rate of death in white children. For the three-year period 2011-2013, accidents (unintentional injuries) were the leading cause of death among all children 1 through 21 years of age. They comprised approximately 40 percent of all deaths in that age range. Over three-quarters (75.1 percent) of deaths in Pennsylvania's children 18 through 21 years of age occurred in males. The racial disparity in Pennsylvania's rate of death by homicide in children 1 through 17 years of age remains greater than the national disparity. For the three-year period 2011 through 2013, the rate of death by homicide, nationally, among black children was 4.5 times greater than the rate among white children (black 5.0; white 1.1 per 100,000 population).

Development and implementation of prevention measures vary according to the community and the findings of the local CDRP Team. Some of the prevention measures that have been implemented focus on motor vehicle safety, suicide prevention, safe sleep and farm safety. The intent is that prevention measures will reduce the death rate of children. BFH staff collaborate with the Violence and Injury Prevention Program and participate on the Injury and Violence Prevention Network, which works to develop a comprehensive and coordinated injury prevention effort.

PA's Child Safety Collaborative Improvement and Innovation Network (CS CollIN) work is on two topic areas: falls prevention and interpersonal violence. PA chose to focus on seven change ideas within the falls topic area covering work on concussion assessment; return to learn accommodations for those with TBIs; use of a home safety checklist with home visitors; health care providers giving anticipatory guidance on falls prevention; training various personnel such as home visitors, EMTs and firefighters to perform home safety audits and safety device installation; and safety device distribution and installation. Within the interpersonal violence topic area, PA chose to focus on nine change ideas covering work on training, education, support, and parenting skills development through home visits; implementing evidence-based parenting programs; training in non-violent skill resolution; in-school and after-school programs for youth development and mentoring; service provider training on identification, assessment, and referral for mental health problems, trauma, and risk of interpersonal violence; increasing the use of StopBullying.gov; national awareness campaigns participation; making culturally appropriate resources about trauma available; and changing social norms.

Participation in the CS CollIN process has been a steep learning curve for PA. PA, like other states, has been struggling conceptually with how to implement the quality improvement techniques with small tests of change from the state level. Moreover, the majority of the change ideas within the interpersonal violence driver diagram are large program pieces or entire programs making small tests of change difficult from the state level without funding or stakeholder willingness to test some changes on a small scale.

PA did have success in the falls prevention topic area. In 2016, BFH began the first implementation test as part of the

CS CollN to increase installation of window guards by firefighters. BFH modified this change idea to remove the provision of conducting a home safety audit and installation of stair guards. BFH found two fire companies who were interested in testing the increased installation of window guards in their respective jurisdictions. BFH will work to implement the installation process as well as collect and review data. BFH selected this change idea to complement the SHHP.

The goal for PA's CollN work is to implement at least one new strategy to address interpersonal violence by 2020. PA is using the change ideas as a gauge of the current and future interpersonal violence work being conducted by Title V funded programs. At this time, two programs funded by Title V (7%), home visiting and the Health Resource Centers (HRCs) have screening for intimate partner violence within their programming. Several programs had delays in implementation and it is anticipated one or two more programs will be implemented in the coming year as interpersonal violence reduction programs or have a related component.

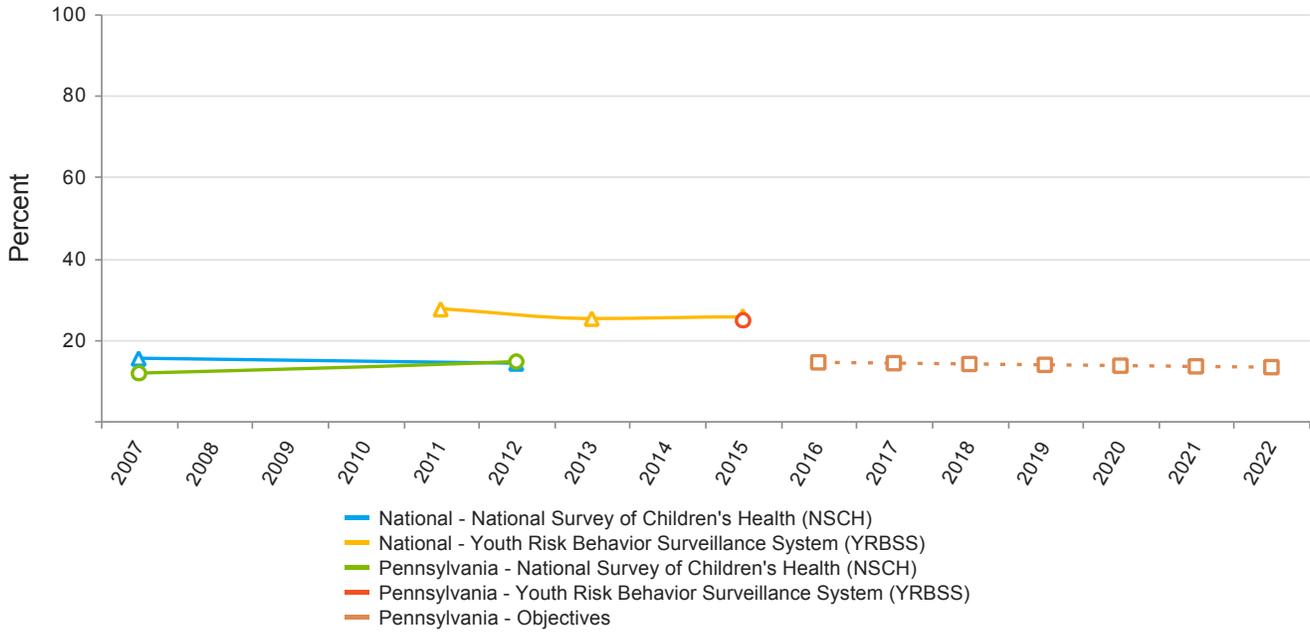
## Adolescent Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	31.1	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	10.1	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	7.8	NPM 9 NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	69.1 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.3 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	26.5 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	27.8 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	29.8 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	60.5 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	62.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	55.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	91.7 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	94.8 %	NPM 10

**National Performance Measures**

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others  
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	14.5
Annual Indicator	14.6
Numerator	139,426
Denominator	958,378
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	14.5
Annual Indicator	24.7
Numerator	122,928
Denominator	497,526
Data Source	YRBSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	14.3	14.1	13.9	13.7	13.5	13.3

**Evidence-Based or –Informed Strategy Measures**

**ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	76
Numerator	
Denominator	
Data Source	quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	80.0	90.0	100.0	100.0	100.0	100.0

**ESM 9.2 - The percent of adolescent serving vendors with a comprehensive anti-bullying/harassment policy.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	25.0	30.0	40.0	55.0	75.0	85.0

**ESM 9.3 - The number of sites participating in bullying prevention efforts.**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	None
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	3.0	4.0	5.0	5.0

**ESM 9.4 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
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<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	740.0	750.0	770.0	790.0	840.0	

**ESM 9.5 - Number of evidence-based mentoring, counseling or adult supervision programs implemented in high risk areas of PA.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	7.0	9.0	11.0	13.0	15.0

**ESM 9.6 - The number of organizations certified as a safe space provider.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	40.0	60.0	80.0	100.0	120.0	140.0

**ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	135
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	150.0	175.0	200.0	230.0	270.0	410.0

**ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program**

<b>Measure Status:</b>	<b>Active</b>
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<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	15.0	30.0	30.0	45.0	45.0

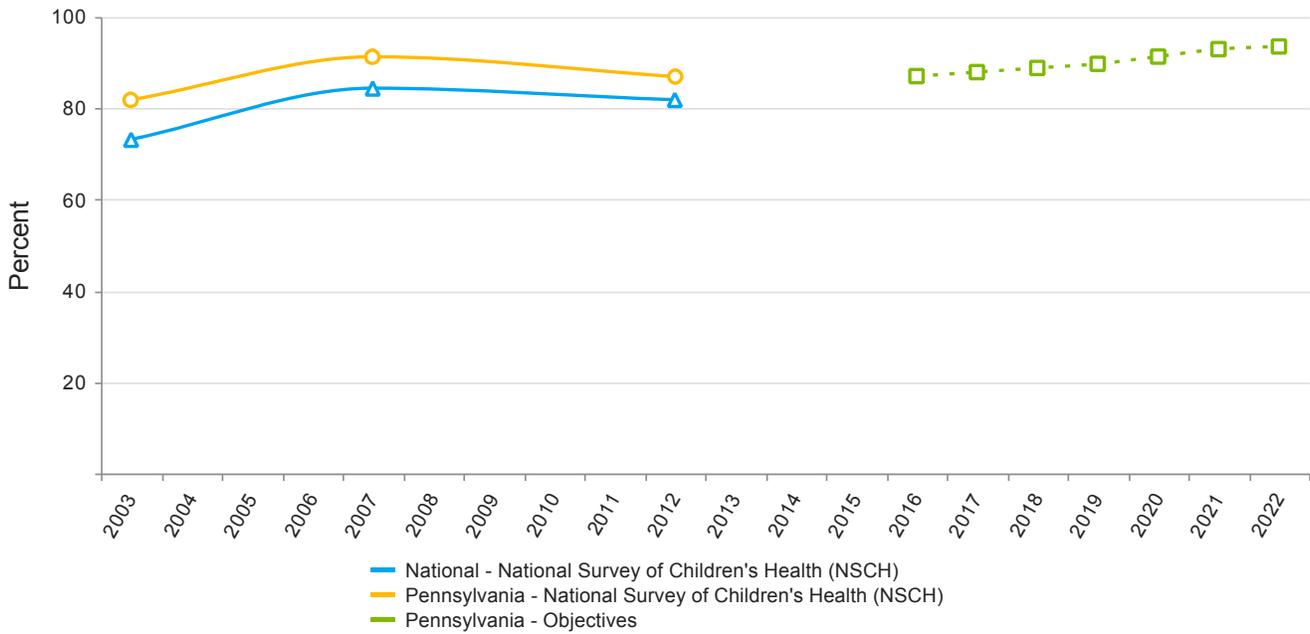
**ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs**

<b>Measure Status:</b>	<b>Active</b>
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**Annual Objectives**

	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	250.0	425.0	475.0	525.0	575.0	625.0

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	86.9
Annual Indicator	86.9
Numerator	836,935
Denominator	962,711
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	87.8	88.7	89.6	91.2	92.8	93.4

**Evidence-Based or –Informed Strategy Measures**

**ESM 10.1 - The number of counties with a Health Resource Center (HRC) available to youth ages 12-17.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	10.0	10.0	11.0	11.0	11.0	11.0

**ESM 10.2 - Number of youth receiving services at a Health Resource Center (HRC).**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	3,288
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	3,500.0	4,000.0	4,500.0	4,500.0	4,500.0	4,500.0

**ESM 10.3 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	18.0	21.0	25.0	30.0	33.0

**ESM 10.4 - Number of youth receiving services at a drop-in site funded by the Bureau of Family Health (BFH).**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	3,537
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	3,800.0	4,000.0	4,200.0	4,500.0	4,900.0	5,200.0

**ESM 10.5 - Number of youth receiving health education and counseling services from a reproductive health provider.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	7,557
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	11,817.0	15,275.0	15,375.0	15,475.0	15,575.0	16,375.0

**State Performance Measures**

**SPM 2 - Percent of Title V programming with interpersonal violence reduction components.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	List of BFH Title V programs
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	14.0	14.0	14.0	18.0	21.0	21.0

**SPM 5 - Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	25.0	50.0	55.0	60.0	65.0

## State Action Plan Table

### State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 1

#### Priority Need

Protective factors are established for adolescents and young adults prior to and during critical life stages.

#### NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

#### Objectives

Increase the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.

Annually increase the number of BFH vendors serving adolescents that adopt and implement comprehensive anti-bullying/harassment policies that specifically enumerate sexual orientation, gender identity, and gender expression as protected categories with clear and effective systems for reporting and addressing incidents that youth experience.

Increase the number of adolescents with and without special health care needs participating in a bullying awareness and prevention program.

#### Strategies

Provide evidence-informed LGBTQ cultural competency training to BFH vendors who serve adolescents.

All vendors serving adolescents through a BFH grant will be required to adopt and implement comprehensive anti-bullying/harassment policies.

Select and implement evidence based strategies from models such as Olweus.

ESMs	Status
ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training.	Active
ESM 9.2 - The percent of adolescent serving vendors with a comprehensive anti-bullying/harassment policy.	Active
ESM 9.3 - The number of sites participating in bullying prevention efforts.	Inactive
ESM 9.4 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.	Inactive
ESM 9.5 - Number of evidence-based mentoring, counseling or adult supervision programs implemented in high risk areas of PA.	Active
ESM 9.6 - The number of organizations certified as a safe space provider.	Active
ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming.	Active
ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program	Active
ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

## State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 2

### Priority Need

Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.

### NPM

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

### Objectives

In the first year of the grant cycle, BFH will increase from baseline SFY 2014-2015 data, the number of counties with a Health Resource Center (HRC) available to youth ages 12-17 either in a school or community based setting.

Beginning in the second year of the grant cycle, the BFH will annually increase the number of youth ages 12-17 utilizing HRC services.

For the duration of the grant cycle, the BFH will increase from baseline SFY 2014-2015 data, the number of LGBTQ youth with a medical visit in the past year.

Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit.

### Strategies

Expand the evidence-informed HRC model to nine additional counties.

Expand to a second service site in each of the nine counties identified in year one and work with the HRC sites to increase the number of youth receiving services.

Utilize LGBTQ organizations to provide drop-in services, for high-risk and LGBTQ youth. The services shall include primary medical care and support services.

Make available office visits and counseling/health education to youth as part of a reproductive health visit at a family planning provider.

ESMs	Status
ESM 10.1 - The number of counties with a Health Resource Center (HRC) available to youth ages 12-17.	Active
ESM 10.2 - Number of youth receiving services at a Health Resource Center (HRC).	Active
ESM 10.3 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services.	Active
ESM 10.4 - Number of youth receiving services at a drop-in site funded by the Bureau of Family Health (BFH).	Active
ESM 10.5 - Number of youth receiving health education and counseling services from a reproductive health provider.	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
NOM 22.2 - Percent of children 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

## State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 3

### Priority Need

Protective factors are established for adolescents and young adults prior to and during critical life stages.

### SPM

Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%

### Objectives

Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs.

Annually increase the number of evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages 8 - 18.

### Strategies

Implement evidence based or evidence-informed mentoring, counseling, and adult supervision programs for youth with and without special health care needs ages 8 - 18.

State Action Plan Table (Pennsylvania) - Adolescent Health - Entry 4

Priority Need

Protective factors are established for adolescents and young adults prior to and during critical life stages.

Objectives

Annually increase the number of LGBTQ sensitive organizations which provide services to youth.

Annually increase the number of LGBTQ youth who have access to suicide prevention services.

Strategies

Implement an evidence-informed approach to train youth-serving organizations to become a safe space for LGBTQ youth.

Implement an evidence-based suicide prevention training for LGBTQ youth.

## Adolescent Health - Plan for the Application Year

### Domain: Adolescent Health

#### 2018 Application:

**Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages**

#### **NPM 9: Percent of adolescents, ages 12 – 17, who are bullied or who bully others.**

Lesbian, Gay, Bisexual, Transgender and Questioning/Queer (LGBTQ) youth experience higher rates of bullying and harassment than their non-LGBTQ peers. In a 2013 report, a majority of Pennsylvania's LGBTQ youth regularly heard anti-LGBTQ remarks at school, had been victimized at school, and did not have access to in-school resources and supports. Due to the lack of support for these youth, 57 percent of students who were bullied never reported it to school staff. Among those students who did report bullying to staff, only 37 percent said reporting resulted in effective intervention by staff. In 2015, these percentages were 53 and 24 respectively; indicating, while there was a seven percent decrease in the percentage of students who were bullied but never reported it to school staff, there was also a 35 percent decrease in the number of students reporting an effective intervention by staff. While these statistics are specific to youth attending school, youth in placement experience bullying and harassment at even higher rates. A study found 78 percent of LGBTQ youth were removed or ran away from their placements as a result of hostility toward their sexual orientation or gender identity.

**Objective 1: For the duration of the grant cycle, BFH will annually increase the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.**

**Objective 2: For the duration of the grant cycle, BFH will annually increase the number of adolescent health vendors that adopt and implement comprehensive anti-bullying/harassment policies that specifically enumerate sexual orientation, gender identity, and gender expression as protected categories with clear and effective systems for reporting and addressing incidents that youth experience.**

**ESM: Percent of adolescent health vendors receiving LGBTQ cultural competency training.**

**ESM: Percent of adolescent serving vendors with a comprehensive anti-bullying/harassment policy.**

The BFH has prioritized the need for protective factors to be established for adolescents and young adults by focusing on evidence-informed recommendations made by the Gay, Lesbian and Straight Education Network (GLSEN) in their 2013 National School Climate Survey. These recommendations include providing professional development for staff on LGBTQ youth issues and implementing comprehensive anti-bullying and harassment policies.

In the upcoming grant cycle, the BFH will collaborate with a LGBTQ service organization to provide evidence-informed cultural competency training to all BFH vendors serving adolescents. Currently, all Personal Responsibility Education Program (PREP) and Healthy Youth PA (Title V Abstinence Education Grant Program) grantees receive cultural competency training for their staff, ranging from an introductory "101" training to a more in-depth topic training, including bullying and health disparities. The BFH contracts with a variety of youth-serving organizations

including family planning councils, partial/outpatient drug and alcohol programs, and residential facilities serving delinquent youth. The BFH aims to have staff at all adolescent-serving organizations attend LGBTQ cultural competency training with a focus on bullying and harassment prevention and intervention.

The BFH will require all adolescent health vendors to implement comprehensive anti-bullying and harassment policies. Policies will be required to specifically enumerate sexual orientation, gender identity, and gender expression as protected categories. The BFH has developed language to be included in all grant agreements with adolescent health vendors, mandating the development of anti-bullying policies. When appropriate, this language will be added to work statements as grants are renewed, modified, or as new grantees begin work. Grantees are required to develop and maintain clear and effective systems for reporting and addressing incidents that youth experience, and will report to the BFH the number of bullying incidents reported and resolved. By working together with adolescent health grantees, the BFH intends to decrease the percent of adolescents, including LGBTQ youth, who bully or are bullied.

The BFH will track the percentage of adolescent health vendors receiving LGBTQ cultural competency training as a measure of the proportion of vendors providing adolescent health services able to respond to and prevent bullying. The BFH will also measure the percentage of adolescent serving vendors with a comprehensive anti-bullying/harassment policy that specifically enumerates sexual orientation, gender identity and gender expression as protected categories to gauge systematic changes by vendors.

**Objective 3: Increase the number of adolescents participating in a bullying awareness and prevention program.**

**REMOVED: ESM: Number of sites participating in bullying prevention efforts.**

**NEW ESM: Number of trainers trained in the Olweus Bullying Prevention Program.**

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 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: friends who bully; and friends who have positive attitudes about violence. Additionally, some aggressive children who take on high status roles may use bullying to enhance their social power and protect their prestige with peers. Conversely, some children with low social status may use bullying to deflect taunting and aggression that is directed towards them, or to enhance their social position with higher status peers.

The BFH will work in collaboration with Clemson University to determine how to best utilize Olweus trainers to improve the bullying prevention infrastructure throughout the Commonwealth. The Olweus model is an evidence-based approach currently being used by school districts across the state. The BFH plans to supplement current Olweus activities by connecting with statewide task forces, providing regional trainings to reach more schools, expanding networks statewide through existing infrastructure, and/or educating the community through collaboration with non-profit and for-profit agencies and organizations.

**Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages**

**Objective 1: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ sensitive organizations which provide services to youth.**

**ESM: Number of organizations certified as a safe space provider.**

For the duration of the grant cycle, the BFH will support Persad Center's, a LGBTQ-focused human service organization, engagement in coalition building activities with known ally organizations and new partners to become Safe Space certified. A Safe Space organization or individual is defined as an ally who can provide support and information to LGBTQ individuals. Persad Center staff provide technical assistance and training to organizations and conducts assessments to determine if the organization meets the certification requirements, as determined by the Persad Center. Safe Spaces focus on youth 14-21 years old and trains organizations on a number of topics, including how to create inclusive programs, how to address harassment, and how to meet the needs of LGBTQ youth of color and transgender youth. The BFH intends to provide places of support and acceptance for LGBTQ youth.

Cultural Competency and Clinical Competency Training provides education to medical, behavioral health, and social service providers. The training includes information on health disparities related to sexual orientation, gender identity, and standards of care for LGBTQ individuals. The BFH will support Mazzoni Center's, a health care provider located in Philadelphia who serves the LGBTQ community, endeavors to provide cultural competency and clinical competency training to organizations to increase provider knowledge of the above issues.

The BFH has chosen to measure the number of safe space organizations that have been certified to track progress on this objective. This data is currently being reported to the BFH and informs the BFH of the reach of the Safe Space training.

**Objective 2: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ youth who have access to suicide prevention interventions.**

**ESM: Number of LGBTQ youth receiving evidence--informed suicide prevention programming.**

Suicide is the second leading cause of death among adolescents ages 10 to 24, and suicide attempt rates are greater for LGBTQ youth. Numerous studies reveal suicide ideation and attempts were three to seven times higher among gay and lesbian youth than heterosexual youth. 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. Based on odds ratios, lesbian, gay, and bisexual young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, compared with peers from families that reported no or low levels of family rejection. Factors contributing to higher rates of suicide include depression, substance abuse, and victimization. The BFH intends to establish protective factors for LGBTQ youth through a partnership with Persad Center.

Persad Center will implement the Yellow Ribbon Suicide Prevention program through support from the BFH for the duration of the grant cycle. This evidence-informed approach has three components: personnel are trained to be gatekeepers and respond effectively in a suicidal crisis; parents, grandparents and guardians are educated on how

to respond effectively to their child's depression and suicidal ideation; the student body is trained to understand the causes of suicidal despair, recognize warning signs and risk factors, and intervene appropriately with an at-risk friend. The Yellow Ribbon Suicide Prevention program will be implemented at the Persad Center's after school program at the Gay and Lesbian Community Center in Pittsburgh, Pennsylvania and within the Erie County School District.

The BFH has chosen to measure the number of youth who are receiving the evidenced-informed suicide prevention programming. The BFH can readily capture this data, which speaks to the saturation of the programming in the targeted areas.

**Priority: Protective factors are established for adolescents and young adults prior to and during critical life stages**

**SPM: Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%.**

MENTOR: The National Mentoring Partnership, Inc., recognizes that mentoring as a youth development strategy is not only a proven foundational asset for a young person's successful path to adulthood, but is a cost-effective prevention and early intervention strategy. Research on evidence-based mentoring has indicated children and youth benefit greatly from a caring, sustained relationship with a mentor. In particular, mentoring may positively impact social-emotional development, behavioral/risk-related behavior, and academic performance. By utilizing mentoring programs to support positive youth development among youth particularly at risk for poor developmental and health outcomes, BFH intends to provide youth with the building blocks to become healthy, caring and responsible young adults. Youth participating in mentoring activities will be assessed through pre and post assessments to determine changes in developmental assets and outcomes.

This performance measure was selected to evaluate how well youth in the mentoring program are provided with skills, experiences, relationships, and behaviors to help them improve their developmental assets and outcomes. Improving developmental assets and outcomes by decreasing risk factors and increasing protective factors will give youth a better chance of succeeding in school and becoming contributing members of their communities.

**Objective 1: Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs.**

The BFH initially intended to utilize the Search Institute's 40 Developmental Assets framework to guide the development of the youth mentoring programs. This framework includes 20 external assets organized under the following four categories: support, empowerment, boundaries and expectations and constructive use of time; and 20 internal assets organized under these four categories: commitment to learning, positive values, social competencies and positive identity. Instead, the BFH will utilize a general framework for positive youth development to guide programs in implementing mentoring activities and to ensure more youth are provided with the building blocks to become healthy, caring, and responsible young adults. This change allows mentoring programs to choose which evidence-based mentoring model they wish to implement based upon the unique circumstances of their target population, including but not limited to the Search Institute's 40 Developmental Assets framework. Youth participating in mentoring activities will be assessed through pre and post assessments to determine changes in risk and protective factors as well as developmental assets and outcomes.

**ESM: Number of youth participating in evidence-based or evidence informed mentoring, counseling or**

## **adult supervision programs.**

Engaging youth to participate in evidence-based or evidence-informed mentoring, counseling or adult supervision programs will support the BFH in reaching its state performance measure of helping youth increase protective factors or decrease risk factors influencing positive youth development and health outcomes by 50 percent. The BFH will measure how well youth participating in mentoring activities are provided with the skills, experiences, relationships and behaviors to help them increase their developmental assets and outcomes. Increasing developmental assets will give youth a better chance of becoming healthy and responsible young adults.

## **ESM: Number of evidence-based programs implemented in high risk areas of Pennsylvania.**

Selecting programs in high risk areas will support the BFH in reaching its state performance measure of helping youth increase protective factors or decrease risk factors influencing positive youth development and health outcomes by 50 percent. Programming will be statewide, with an emphasis on high risk areas in which youth are most likely to engage in risk behaviors and have a greater need for programming.

## **Objective 2: For the duration of the grant cycle, the BFH will annually increase the number of evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages 8-18.**

The BFH will be issuing one statewide Request for Applications (RFA) for agencies to implement mentoring programs in 2017. This RFA process is a competitive bid method to ensure the most qualified agencies are selected to provide high-quality programming that aligns with this State Performance Measure (SPM). The goal is to have grant agreements in place with the organizations selected to provide services through the RFA and to conclude start-up activities by the end of calendar year 2017.

The Youth Mentoring Program will use evidence-based mentoring approaches as a means to provide opportunities for youth ages eight to eighteen to increase protective factors. By utilizing frameworks promoting positive youth development, youth will be provided with building blocks for healthy development to help them grow into healthy, caring and responsible young adults.

The developmental assets fostered through youth mentoring serve as protective factors to help youth avoid negative risky behaviors. The positive effects of these protective factors increase as the number of assets a youth has increases. Enhancing the developmental assets of youth and adolescents promotes positive youth development outcomes and provides an opportunity for youth to transition into healthy young adults who are able to realize their individual potential around critical developmental tasks.

The Youth Mentoring Program will require organizations selected for funding through the RFA process to follow an evidence-based model and utilize guidelines for creating and sustaining quality youth mentoring programs and, consequently, impactful mentoring relationships.

In addition to the new youth mentoring program being constructed in 2017, the BFH will continue to implement Healthy Youth PA, which is funded through the Title V State Abstinence Education Grant Program. Healthy Youth PA uses an approach of evidence-based or evidenced-informed programming that combines mentoring, adult-supervised activities, adult-led group discussions, and parenting education as a means to increase the protective factors of youth ages nine to fourteen.

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

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

**Objective 1: In the first year of the grant cycle, BFH will annually increase the number of counties with a HRC available to youth ages 12-17 either in a school or community based setting.**

**ESM: Number of counties with an HRC available to youth ages 12-17.**

**Objective 2: Beginning in the second year of the grant cycle, the BFH will annually increase the number of youth ages 12-17 utilizing HRC services.**

**ESM: Number of youth receiving services at an HRC.**

**ESM: In schools with an HRC, the percent of youth within that school utilizing the HRC services.**

Adolescents encounter many barriers when attempting to get needed health care, including fear of lack of confidentiality, transportation issues, and inconvenient appointment times and costs. The BFH aims to address and eliminate these barriers through the Health Resource Center (HRC) model. HRCs are located in high schools and community-based organizations so services are easily accessible. The following core services will be provided to HRC clients:

- sexual and reproductive health education
- confidential, individual-level counseling
- screening for chlamydia, gonorrhea and pregnancy
- referrals and direct linkages to core family planning services
- dissemination of condoms and other risk reduction tools

The BFH, in partnership with AccessMatters, will continue the expansion of the HRC model to high-need areas across the Commonwealth. Five expansion sites were selected in calendar year 2015, and two additional sites opened in 2016, for a total of seven expansion sites currently implementing the HRC model. In the coming year, AccessMatters will continue to attract and foster additional partnerships. High-need areas were determined by their high rates of teen pregnancy, gonorrhea, chlamydia, high-school dropouts and binge drinking and therefore are being targeted for expansion HRC locations. The impact of the HRC expansion will be measured by the number of counties with an HRC available to youth ages 12 to 17, the number of youth receiving services at an HRC, and, in schools with an HRC, the percent of youth within the school utilizing the HRC services.

**Objective 3: For the duration of the grant cycle, the BFH will annually increase the number of LGBTQ youth with a medical visit in the past year.**

**ESM: Number of youth receiving services at a drop-in site funded by the BFH.**

In general, LGBTQ youth experience the same range of health challenges as heterosexual youth, but when seeking care, insecurities may arise due to social stigma and biased medical providers. Medical providers may assume clients are heterosexual, and LGBTQ youth often are afraid to disclose their sexual orientation or gender identity to health care providers.

For the duration of the grant cycle, the BFH will partner with the Mazzone Center, to provide culturally competent drop-in services for high-risk and LGBTQ youth at the Mazzone Center's medical center. In addition to primary medical care, support services and basic necessities (food, public transportation tokens, etc.) will be provided.

The BFH will measure the number of youth receiving drop-in medical services. The BFH receives this data from the Mazzone Center. This information is important to determine whether or not this type of service should be offered in other parts of the state and to determine the reach of services at the current location.

**Objective 4: Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit.**

**ESM: Number of youth receiving health education and counseling services from a reproductive health provider.**

The BFH will partner with the four Title X family planning councils in the Commonwealth to provide adolescents age 17 years and younger with health education and counseling services during a reproductive health visit. Per the Quality Family Planning Guidelines (Guidelines) issued jointly by the CDC and the Office of Population Affairs, adolescents are to be provided with additional counseling on how to prevent a pregnancy and communicate with parents/guardians. Counseling should be presented in a teen-friendly environment. To meet these guidelines, providers need to spend additional time counseling youth beyond the standard office visit. Therefore, the BFH will fund office visit and counseling codes to allow providers to spend additional time with adolescents during a reproductive health care visit. The Guidelines also acknowledge, in many cases, a reproductive health visit is the only usual health care adolescents and women are receiving; therefore, it is critical that providers have additional time to spend with adolescents to make sure all of their healthcare needs are being addressed. The BFH will track the number of youth receiving health education and counseling services from a reproductive health provider as an indicator of the percentage of adolescents with a preventive medical visit in the past year.

## Adolescent Health - Annual Report

### Domain: Adolescent Health

#### 2016 Annual Report:

The BFH provides programming on abstinence and contraception to prevent pregnancy and sexually transmitted infections, and three adulthood preparation subjects (healthy relationships, adolescent development, and healthy life skills) through Personal Responsibility Education Program (PREP) funding. PREP is authorized and funded by Section 513 of the Social Security Act and is administered by the Family and Youth Services Bureau. During calendar year 2016, 1,156 at-risk youth completed an evidence-based program at a PREP facility (for this reporting period, the following curriculum were used: Sisters, Informing, Healing, Living and Empowering (SiHLE), Street Smart, Rikers Health Advocacy Program, Making Proud Choices, Becoming a Responsible Teen, All 4 You!, Be Proud! Be Responsible! or Be Proud! Be Responsible! Be Protective!). To address struggles with recruitment and retention, the BFH issued a Request for Applications (RFA) and selected 17 PREP grantees to begin services October 1, 2015. By permitting a wider range of facility types to apply for funds, and by expanding the number of evidence-based programs grantees could use from two to 20, PREP grantees were able to significantly increase the number of youth reached. Compared to the previous year, approximately 82 percent more youth received PREP programming and 89 percent more youth completed at least 75 percent of the curriculum.

In response to NPM 10 (percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year), the BFH supports teen pregnancy prevention services through AccessMatters, who uses these 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 located in high schools or clinics near a school, and are open during hours that are convenient to youth. AccessMatters operates HRCs in fourteen Philadelphia area schools, as well as seven additional locations across the Commonwealth. The seven expansion site HRCs operate in areas with high rates of teen pregnancies, STIs and school drop-outs. Five of these sites began services in late 2015; the remaining two sites began implementation in 2016.

In state fiscal year 2015 (July 2015-June 2016), the HRCs provided services to 3,766 youth. The program also provided 41,136 condoms (internal and external) to eligible students during the same time frame. AccessMatters' goal was to provide services to 4,500 students each state fiscal year, as well as 50,000 condoms to eligible students. These goals were not reached primarily due to a late start because of the state budget impasse. Currently, there are HRCs available in nine counties, which exceeds the goal set for ESM 10.1: the number of counties with a HRC available to youth ages 12-17. AccessMatters' current grant agreement ends June 2016. AccessMatters and BFH staff will review past years' accomplishments and challenges to create new goals for the HRC program. ESM 10.3 (in schools with a HRC, the percent of youth within that school utilizing HRC services) may also be revised, due to the location and population reached by the expansion sites. Many expansion sites are community-based, so the ESM may change, or another ESM may be created to address the expansion of the program.

While working with AccessMatters on the expansion of the HRC program to additional sites, the BFH saw an opportunity to improve the HRC model by incorporating teen dating violence screening and LGBTQ cultural competency training. Teen dating violence screening is addressed through a grant with the Pennsylvania Coalition to Prevent Domestic Violence (PCADV). PCADV provides HRC staff with training and materials to utilize the "Hanging Out or Hooking Up" safety card, developed by Futures Without Violence. This safety card is distributed to all youth visiting an HRC, and includes information on healthy and respectful relationships, digital dating abuse, and national

teen hotline numbers. LGBTQ cultural competency training is provided to HRC staff through a grant with Persad Center. The BFH, in partnership with Persad Center, aims to create a welcoming environment for LGBTQ youth visiting the HRCs, and to educate HRC staff on the specific risks and health disparities experienced by LGBTQ youth. To increase visibility and youth-friendliness of the HRCs, the seven expansion sites were given additional funding to form Youth Advisory Boards. All expansion sites have begun recruiting members, and were provided with membership applications and training modules. The BFH and AccessMatters look to expand the HRC model to additional high-need areas in 2017. In order to expand HRC services in all identified counties, AccessMatters continues to work with existing HRC sub-recipients, youth-serving agencies, and schools to find opportunities to open HRCs in these counties.

The BFH continued to support programming with five separate agencies to implement evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages nine to fourteen in calendar year 2016. This program is directly related to both Objective 1 and 2 within the SPM of percent of youth ages 8 to 18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50 percent. Objective 1 refers to annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs. Similarly, Objective 2 refers to annually increase the number of evidence-based or evidence-informed mentoring, counseling and adult supervision programs available to youth eight to eighteen.

Both Objectives are realized through Healthy Youth PA, which is funded through the Title V State Abstinence Education Grant Program. The initial five Healthy Youth PA agencies continue to represent the most qualified agencies to provide high-quality programming that aligns with this SPM. The areas in which the agencies implement programming represent areas of Pennsylvania in which youth are most likely to engage in risky behaviors such as unsafe sexual activity. These areas include Philadelphia, Dauphin, Allegheny, and Lawrence Counties.

Most of calendar year 2015 involved start-up activities for Healthy Youth PA programming, which resulted in lower numbers of youth served than anticipated. A total of 320 youth between the five programs began receiving programming in calendar year 2015. In calendar year 2016 the agencies were able to focus on program delivery and provision of services to the target population. Throughout the year over 15,000 service hours were provided to 1,038 youth ages 9 to 14 years of age, as well as 627 of their parents/caregivers. Over 79 percent of participant youth and caregivers completed more than 75 percent of programming offered.

An overall increase of 224 percent in the number of youth served by the program from year one to two is due in part to a delay in service provision by the agencies as most of calendar year 2015 involved start-up activities for programming. Recruitment of youth and their families, getting staff in place at the individual program locations, and ordering supplies are some examples of start-up activities that occurred. However, in year two, programs were able to actively begin program delivery and were able to surpass the goal of serving 407 youth, and reach 1,038 youth 9 to 14 years of age.

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. As Healthy Youth PA programming continues, the BFH will be in a better position to realize these, and other, benefits.

Healthy Youth PA, HRC and PREP grantees are required to attend LGBTQ cultural competency training. PREP

grantees are also mandated to 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, transgender youth, to health disparities. In 2016, 76 percent of adolescent health vendors received LGBTQ cultural competency training. With new adolescent health programs starting July 2017, the BFH will continue to exceed their ESM 9.1 annual goal (the percent of adolescent health vendors receiving LGBTQ cultural competency training), and have new vendors trained within the first year of the grant agreements.

While beginning implementation of the Healthy Youth PA program, the BFH determined there were at risk populations of youth within the Commonwealth who would not be served by Healthy Youth PA, but who could benefit from youth mentoring. Therefore, additional programming was needed to fully address the SPM of increasing the percent of youth ages 8 to 18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50 percent. In 2015, a workgroup comprised of BFH staff met to review positive youth development best practices and develop a plan for increasing the number of youth mentoring programs targeting at risk youth throughout the Commonwealth. The BFH drafted a Request for Applications (RFA) for agencies to implement mentoring programs and the RFA will be released in 2017. The RFA competitive bid process will ensure the most qualified agencies are selected to provide high-quality programming that aligns with this SPM.

In response to NPM 10, Objective 4 (number of youth receiving health education and counseling services during a reproductive health visit), the BFH supported the four family planning councils in the Commonwealth to provide reproductive health services to adolescents 17 years and younger. To meet the Guidelines issued jointly by the Centers for Disease Control and Prevention and the Office of Population Affairs, the BFH began funding office visit and counseling codes on July 1, 2015. The Guidelines state that adolescents are to be provided with additional counseling on how to prevent a pregnancy and communicate with parents/guardians, in a teen-friendly environment. To meet these guidelines, providers need to spend additional time counseling youth beyond the standard office visit. The Guidelines also acknowledge, in many cases, a reproductive health visit is the only usual health care adolescents and women are receiving; therefore, it is critical that providers have additional time to spend with adolescents to make sure all of their healthcare needs are being addressed.

In calendar years 2015 and 2016, the goal associated with this objective was to provide reproductive health counseling services to 11,817 youth per year. In calendar year 2015, BFH met this goal, providing reproductive health counseling services to 21,252 adolescents. However, in calendar year 2016, BFH did not meet this goal, providing reproductive health counseling services to 7,557 adolescents, a 67% decrease from the previous year. After the BFH reviewed data collection procedures, it was discovered the family planning councils were not using uniform procedures for reporting the number of clients served each year and that calendar year 2015 data included some duplicated client counts, producing an artificially high client count. In calendar year 2016, the BFH began providing technical assistance around data collection and reporting to the family planning councils and is in the process of revising data reporting forms to ensure uniform data collection and reporting. Additionally, in calendar year 2016, the BFH determined grant payment levels were not sufficient to provide counseling services to 11,817 clients per year. In fiscal year 2017/2018, the BFH will increase the grant payment limits to allow the family planning councils to serve more clients and will work with the family planning councils to establish appropriate service targets.

When examining the death rates for the three-year period of 2011-2013 from Child Death Review (CDR) teams, suicide ranked third in the causes of death in children 1-21 years of age, comprising 12 percent of deaths. Closer examination revealed children 15 through 17 years of age had the highest rate of deaths due to suicide. Local CDR teams recognized the need to focus on suicide prevention activities including: the Yellow Ribbon Campaign, presentations in schools, sub-review groups to specifically look at suicide prevention, developing a suicide

prevention taskforce, and establishing a local chapter of the American Foundation for Suicide Prevention, and supporting Student Assistance Programs.

As a result of CDR recommendations, the BFH provided funding to Persad Center to implement the Yellow Ribbon Suicide Prevention Program six times, which reached 135 youth in calendar year 2016. This is 338 percent more than the anticipated 40 youth that were to be reached. Persad Center implements the Yellow Ribbon Suicide Prevention Program within their Signs of Suicide program, an evidence-informed intervention that is modified to be LGBTQ inclusive. The Signs of Suicide program includes screening and education and aims to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes towards suicide and depression, and increase help-seeking behavior among youth. Persad Center utilizes this program in their After-School Program at the Gay and Lesbian Community Center in Pittsburgh and in the Erie County School District. The program is also used to raise awareness of suicide prevention in the community. Signs of Suicide has been shown to significantly lower rates of suicide attempts and increase youths' knowledge of depression and suicide. The program demonstrates significant reductions in self-reported suicide attempts.

The BFH continues to support Persad Center and Mazzoni Center to provide services to LGBTQ youth. Persad Center implements the Safe Spaces Project, which provides suicide prevention training to youth, and engages in coalition building activities with known ally organizations and new partners to help the organizations become Safe Space certified. To address ESM 9.6 (the number of organizations certified as a safe space provider) in calendar year 2016, Persad Center provided 20 organizations (or 650 individuals) with training to become Safe Space certified. There were 571 youth that took advantage of the Safe Spaces provided by Persad Center. By focusing on Allegheny and Erie counties for the Safe Spaces project, Persad Center is extending its reach to the largest metropolitan areas in Western Pennsylvania to address the absence of safe spaces and ally organizations for LGBTQ youth.

Mazzoni Center provides a drop-in health center for youth to obtain a variety of health care and social services. Mazzoni Center also provides training on health disparities related to sexual orientation, gender identity and appropriate standards of care for LGBTQ individuals and LGBTQ cultural competency training to medical, behavioral health and social service providers. Mazzoni Center provided 3,537 youth with medical services at their drop-in health center in calendar year 2016. Mazzoni Center surpassed their goal of 300 youth served by 1,179 percent. Moreover, 3,215 youth received case management visits, and 1,904 youth received at least one service. Despite this accomplishment with their drop-in health center, Mazzoni Center reports their challenges with providing LGBTQ cultural competency training include not having the staffing capacity to meet all training requests, and a recent uptick in homophobic and transphobic responses from audience members. Regarding the negative responses received on evaluation forms, the Mazzoni Center continues to develop ways to respond that reiterate to these audience members that their personal beliefs can remain but their jobs and the law require them to provide culturally competent services.

The BFH reached out to the LGBT Center of Central Pennsylvania and Alder Health Services in Harrisburg, with the goal of offering similar services to LGBTQ youth in Central Pennsylvania. Both agencies are significantly smaller than the Persad Center and Mazzoni Center, and do not offer the wide range of services needed to support BFH objectives and strategies. BFH will continue to explore offering programming in the Central Pennsylvania region, so LGBTQ youth living there can have access to services that are currently only offered in Philadelphia and Pittsburgh.

The BFH aims to support LGBTQ youth through a variety of programs, but saw a need in youth ages 17 to 24 years old who experience skill and opportunity barriers to launch successfully into adulthood. LGBTQ youth of this age may have overcome bullying, discrimination, and family conflicts, but are often lacking supportive adult help and the skills they need to become independent. The BFH will partner with the Persad Center to implement the Youth Opportunity

Program. Services will begin in July 2017, and the Persad Center will provide youth with “Opportunity Coaches” to help participants reach their goals, including increased financial and social literacy, improved confidence, stable housing, and improved financial condition.

A workgroup comprised of BFH staff was formed in 2016 to focus on improving health outcomes for youth through the prevention of bullying. The workgroup explored the idea of incorporating the Olweus bullying curriculum into BFH’s programs. Positive Behavior Intervention and Supports (PBIS), including the Expect Respect handbook, was another evidence based approach that the workgroup considered. Contact was made with the Pennsylvania Department of Education (PDE) to identify current work being done throughout the Commonwealth. PDE prepared a plan to identify needs and provide recommendations that would best support efforts to reduce bullying behavior in schools and to support the implementation, sustainability and fidelity of research based and/or evidence-based bullying prevention efforts in Pennsylvania’s schools. It was noted that Olweus was the most commonly used bullying prevention program in Pennsylvania. In addition, it was determined that Pennsylvania has the largest cadre of Olweus 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, the workgroup met with Clemson University and PDE staff in early 2017 to determine how the BFH can best support implementation of Olweus and its trainers and address Objective 3: increase the number of adolescents participating in a bullying awareness and prevention program. In 2017, the BFH will work collaboratively with Clemson University to support Olweus trainers across the Commonwealth to improve and expand the bullying prevention infrastructure.

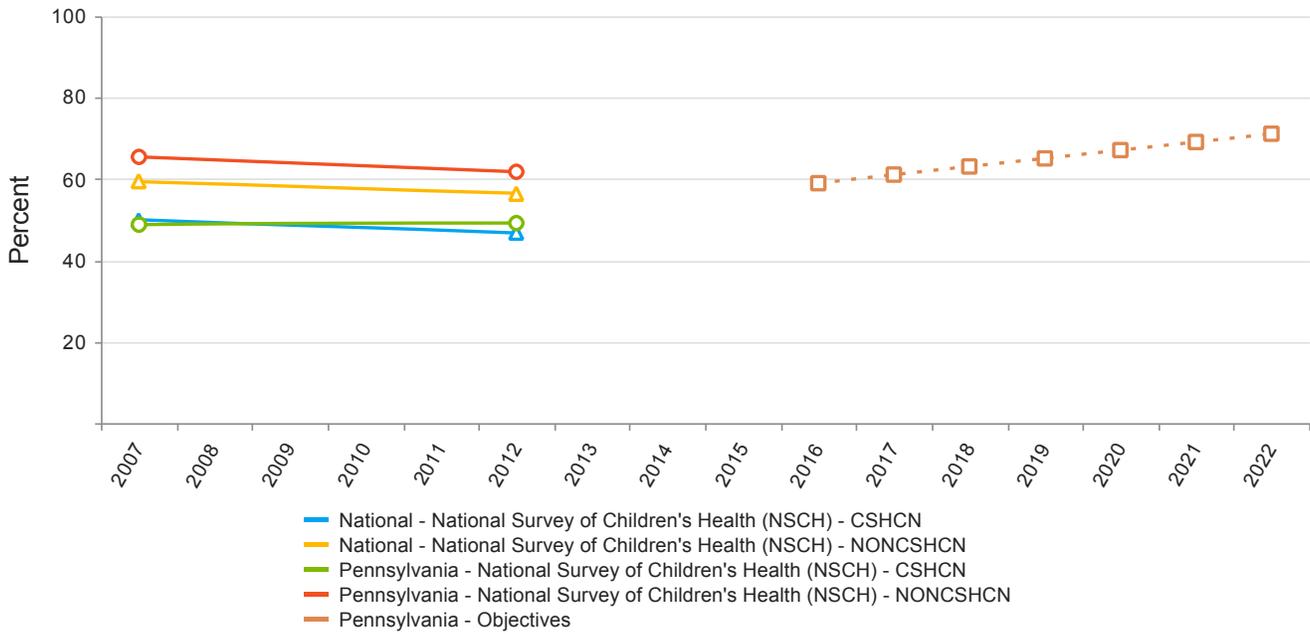
## Children with Special Health Care Needs

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	21.4 %	NPM 11
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.3 %	NPM 11
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	72.8 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	60.5 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	62.2 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	55.9 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	91.7 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	94.8 %	NPM 11

**National Performance Measures**

**NPM 11 - Percent of children with and without special health care needs having a medical home  
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	58.9
Annual Indicator	49.2
Numerator	289,813
Denominator	589,111
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	61.0	63.0	65.0	67.0	69.0	71.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 11.1 - Number of families who received services through the evidence based or evidence informed strategies of the SKN.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	1,597
Numerator	
Denominator	
Data Source	Monthly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,500.0	1,525.0	1,550.0	1,575.0	1,600.0	1,625.0

**ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	BFH internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	4.0	4.0	4.0	5.0	5.0	3.0

**ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	507
Numerator	
Denominator	
Data Source	Quarterly reports and internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	500.0	520.0	540.0	560.0	580.0	600.0

**ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	196
Numerator	
Denominator	
Data Source	Quarterly reports and internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	200.0	225.0	240.0	260.0	280.0	300.0

**ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	BFH internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	2.0	3.0	3.0	4.0

**State Performance Measures**

**SPM 5 - Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	25.0	50.0	55.0	60.0	65.0

## State Action Plan Table

### State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Appropriate health and health related services, screenings and information are available to the MCH populations.

#### NPM

Percent of children with and without special health care needs having a medical home

#### Objectives

Starting with reporting year 2015, annually increase the number of pediatric providers engaged in efforts to adopt medical home principles and practices for their population.

Starting with reporting year 2016, increase the number of youth/young adults and parents/caregivers who are trained, engaged, supported and involved at all levels of program planning and implementation of medical home activities.

Annually develop a minimum of two collaborations with oral or behavioral health entities that involves them in the provision of medical home services.

#### Strategies

Expand provider access to medical home concepts and tools through learning collaboratives, education and statewide technical assistance, with special attention on health care systems and medical training programs.

Facilitate the involvement of youth/young adults and parents/caregivers in aspects of medical homes such as program planning, practice recruitment, practice partners, and patient care navigation/coordination.

Identify and develop collaborations with oral and behavioral health entities to support integration of services with medical homes.

ESMs	Status
ESM 11.1 - Number of families who received services through the evidence based or evidence informed strategies of the SKN.	Active
ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN.	Active
ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance	Active
ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.	Active
ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)
NOM 22.2 - Percent of children 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

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 2

Priority Need

Appropriate health and health related services, screenings and information are available to the MCH populations.

Objectives

Annually increase the number of CSHCN served by SKN.

Annually increase the number of collaborations between systems of care serving CSHCN.

Strategies

Utilize evidence based or evidence informed strategies including the use of Community Health Workers (CHWs) model by providing service coordination, resources and information to families of CSHCN.

Identify and develop collaborations between systems of care serving CSHCN.

## **Children with Special Health Care Needs - Plan for the Application Year**

### **Domain: Children with special health care needs**

#### **2018 Application:**

The mission of the Bureau of Family Health (BFH) is to improve the health and well-being of all mothers, children and families in Pennsylvania. Not only are children with special health care needs (CSHCN) a priority within the Title V work carried out by the BFH, but nearly two million dollars in state funding is allocated to serve children with the following conditions: Cooley's anemia, Cystic Fibrosis, Sickle Cell, Spina Bifida, Orthopedic and Neuromuscular Conditions, Hemophilia and services for children who are technology dependent.

**Priority: Appropriate health and health related services, screening and information are available to the MCH population.**

**NPM: Percent of children with and without special health care needs having a medical home.**

The Pennsylvania Medical Home Initiative (PMHI), funded through Title V, will be evaluated and restructured beginning in 2018. On January 1, 2017, the Department of Human Services (DHS), the agency responsible for the administration of Medical Assistance (MA) in the state, launched its Patient-Centered Medical Home (PCMH) program. The PCMH program will increase access to medical homes for certain high-utilization MA primary care practices (PCP) and their patients by paying these PCPs a per member/per month reimbursement if they are medical homes. The PCMH model will introduce the medical home approach to more PCPs and the managed care organizations that fund them. Plans for how PMHI will collaborate with DHS are still being finalized. The BFH will conduct an evaluation of PMHI to determine the impact the program is having on improving the health and wellbeing of Title V clients, including CSHCN. Outcomes associated with clients receiving services from PCPs participating in the PMHI will be compared to the outcomes of clients receiving services from PCPs who are not participating in the PMHI. The evaluation will also determine if there are disparities in outcomes among subpopulations served by the PCPs participating in the PMHI. The findings of the program evaluation will be used to inform how Title V funding is used to support PMHI and PCMH in the future.

**Objective 1: Starting with reporting year 2015, annually increase the number of pediatric primary care providers (PCPs) engaged in efforts to adopt medical home principles and practices for their populations.**

**ESM: Number of PCPs participating in a learning collaborative, education and/or statewide technical assistance.**

For the first half of 2018, the PMHI's structure will remain essentially the same as in the previous years. PCPs will be invited to participate in learning activities, such as regional collaboratives, webinars and conferences. There is at least one learning activity planned for each month of the fiscal year.

Boston Children's Hospital's National Center for Care Coordination pediatric care coordination curriculum will be utilized to enhance care coordination activities. Consultants will provide resources, education and training on care coordination. The Philadelphia Health Federation will administer several 'medical interpreter' trainings that educate PCPs on cultural and linguistic competencies. A collaboration between the Health Care Improvement Foundation, the Health Care Council of Western Pennsylvania and the Health Literacy Coalition will offer health literacy and youth health care transition trainings. It is anticipated that work will continue with the UPMC Spina Bifida Adult Clinic on new transition protocols to link PCPs and this specialty clinic. The intent is to roll out the protocols to other spina

bifida clinics in the state, and possibly to clinics serving individuals with other conditions as well.

**Objective 2: Starting with reporting year 2016, increase the number of youth/young adults, and parents/caregivers who are trained, engaged, supported and involved at all levels of medical home program planning and implementation.**

**ESM: Number of youth/young adults and parents/caregivers involved in aspects of medical home activities**

The PMHI will increase the involvement of youth and caregivers in a number of ways. Caregivers will continue to be recruited to become Parent Partners within local medical home teams. The PMHI is considering expanding the roles of Parent Partners to include facilitation of group meetings among patients, caregivers and the PCP staff as well as coordination of communication among those same parties. Caregivers will be invited to assume a more involved role in the PMHI program planning and implementation. Transition to adult primary care will continue to be a focus of activities.

One strategy for increasing youth adult involvement will focus on increasing discussions about the medical home approach on social media. A consultant specializing in both youth involvement and social media use will be utilized to provide suggestions for incorporation. Previous opportunities to incorporate youth within educational opportunities, like conferences, have proven very informative and will continue.

Transition to adult primary care will continue to be a focus of youth and caregiver engagement. In order assess health care practice transition readiness, PCPs will be offered the state's Transition Implementation Guide and will also be encouraged to use tools produced by Got Transition. Additionally, it is anticipated collaborative efforts to envelope adult practitioners in transition efforts will be expanded through the PMHI restructuring as these PCPs will be included in the marketing research and as part of medical "homeness" education and technical assistance. The PMHI will make webinars and course offerings available to PCPs via the online Learning Library.

Partnerships with family advocacy organizations, such as the Parent Education, Advocacy, and Leadership (PEAL) Center, which is Pennsylvania's Family to Family Health Information Center and regionally-based organizations, will be strengthened and opportunities for collaborations will be pursued. Specific outreach to minority-serving family organizations will be a focus. Projects to be developed include utilizing these organizations to educate families on the medical home approach and involving the organizations in the statewide education of Parent Partners.

**Objective 3: Annually develop a minimum of one collaboration with a child-serving system that involves them in the provision of medical home services.**

**ESM: Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations.**

For the purposes of this ESM, collaborations are defined as partnerships between the PMHI and organizations which carry out unpaid tasks which share certain medical home objectives with the PMHI. The PMHI has established strong connections with both the oral health and behavioral health communities in the state and it is anticipated that those connections will continue to grow in 2018. Opportunities for outreach and collaboration between local and regional providers as well as with statewide associations will continue to be identified and developed. The PMHI will work closely with DHS on the PCMH program as integration of services is a component of that program. Collaborations may include onsite collaborative services or the use of technology to connect to patients remotely.

Evaluation measures will be developed to rate improved service provision as well as improved health outcomes.

Collaborations with entities like Head Start, the Pennsylvania Coalition on Oral Health and others will continue. There is also an opportunity to take advantage of planned growth in oral health services through the DHS MA program. PCPs will continue to be supported in efforts to provide basic oral health care during patient visits.

The BFH is monitoring the implementation and progress of a Medical Home Community Team being administered by the Philadelphia Department of Public Health for possible expansion to other parts of the state. This project partners home visitors with the medical homes in Philadelphia to assist in addressing patient and PCP concerns outside of the practice walls.

Behavioral health collaborations will be in the forefront in 2018. The PMHI will continue its relationship with the Rehabilitation and Community Providers Association, a founding member of the Pennsylvania Physical Health/Behavioral Health Learning Community, in support of integrated whole person health care and whole person health care policy. By 2018, Project Launch, an early childhood mental health collaboration, should be expanding its integrative work statewide.

**Priority: Appropriate health and health related services, screening and information are available to the MCH population.**

**Objective 1: Annually increase the number of families of children with special health care needs (CSHCN) served by the Special Kids Network (SKN).**

**ESM: Number of families who receive services through the SKN.**

The SKN uses a three-pronged approach to assist CSHCN and their families thrive in their community: use of a toll-free helpline; provision of in-home service coordination; and focus on systemic change at the community and regional levels. Families calling the toll-free helpline are triaged through a standard assessment and referral protocol to receive resources and information. Many families have their needs met through phone consultation with the nurse answering the helpline. For those needing more assistance, families are referred to a nurse or social worker employed by the SKN vendor for service coordination, or to other sources for assistance as the situation dictates. Families are provided with care coordination to address needs as well as learn how to navigate service systems independently in order to increase self-sufficiency. The focus on systemic change is conducted through the work of eight Regional Coordinators (RCs), who are all parents or caregivers of CSHCN. The RCs work with children, youth, families, organizations and providers on a community and regional basis to identify and resolve service related barriers within systems. In 2018, the SKN will transition to an evidence-based home visiting program for CSHCN.

The SKN works to serve the maximum number of families by offering trainings, holding meetings, promoting the helpline, and strengthening collaborations. Trainings are held by the RCs in each of the eight regions. Planned trainings include "Team Up for Families (TUFF)" in partnership with the DHS PA System of Care. TUFF is a peer-led training for parents and caregivers of CSHCN to increase their ability to navigate the system of care and coordinate their own child's care. Building proficiency in this area decreases the amount of service coordination parents may need and builds a network of enabled and empowered families. Another planned training is "Supporting Families throughout the Lifespan" in partnership with DHS' PA Families Network. This training assists families in maximizing their capacity to best support their child or youth in achieving their goals. RCs facilitate SKN meetings that respond to issues that are systemic in nature and engage community members who are committed to resolving and improving service issues and challenges. SKN also continues to promote the help-line that provides information and resources to families and professionals. In 2018, the helpline will transition to BFH staff.

Another area frequently identified as a need of families of CSHCN as well as other at-risk MCH populations is the need for access to reliable transportation. The Division of Community Systems Development and Outreach (CSDO) has been working on this issue through a stakeholder workgroup, but the BFH will be addressing this need on a larger scale in 2018 as transportation is cited as a need by much of the MCH population.

**Objective 2: Annually increase the number of collaborations between systems of care with CSHCN.**  
**ESM: Number of new formal collaborations developed between systems of care serving CSHCN.**

Children and families function best when the systems with which they interact function well, collaborate, and do not duplicate services. It is recognized that different collaborations are needed as children move through the life span. A collaboration is defined as a partnership between SKN and an organization that results in assisting families with obtaining information or providing support. While collaborations are currently in place with the Pennsylvania Department of Education, the Medical Assistance program, the local Intermediate Units, school districts, and transportation providers, there is still work to be done. The SKN will continue to work to develop collaborations with organizations to meet the unmet needs of families of CSHCN. Specifically, collaborations will be sought that can further parenting skills and empower parents to provide the families' own coordinated care.

The BFH, through the SKN and other programs, will strengthen current and develop new partnerships and collaborations serving and supporting families of CSHCN. Collaborations will be strengthened with the PA Link to Aging and Disability Resources through the Department of Aging, and with the PEAL Center. The BFH has maintained a positive working partnership with the PEAL Center for many years, and will be working to formulate a more formal collaboration. The PA Family Network, through the DHS, will be holding regional collaborations for families, and the SKN will pursue opportunities for the RCs to be involved. A new collaboration the BFH will pursue is with the PA Statewide Adoption & Permanency Network to investigate opportunities to provide adoptive and foster families with training on navigating the system of care. Pennsylvania currently has two HRSA funded LEND centers (Leadership Education in Neurodevelopmental and Related Disorders); one at Children's Hospital of Philadelphia, and one at Children's Hospital of Pittsburgh. LEND programs train future leaders in a variety of disciplines to improve the health of children who have or are at risk of developing neurodevelopmental disabilities or other similar conditions such as autism and intellectual disabilities. The Director of the DCSDO has recently joined the Philadelphia LEND's Community Advisory Board, and will utilize the collaboration gained from this involvement to inform activities within the BFH for CSHCN. The SKN will contact Pittsburgh's LEND to collaborate on trainings being provided to family members of CSHCN. On a regional level, the Tri-County Community Action agency serving Cumberland, Dauphin and Perry Counties offers parenting classes and the SKN will pursue a collaboration regarding adding classes for parents and caregivers of CSHCN. In all current and planned collaborations, efforts will be made to ensure families' unmet needs are identified and addressed, and that services are not duplicated among agencies and organizations.

## Children with Special Health Care Needs - Annual Report

### Domain: Children with special health care needs

#### 2016 Report:

The BFH regularly met with partners such as Parent to Parent, PEAL Center, the State Interagency Coordinating Council for Early Intervention and the PA Developmental Disabilities Council. Collaborative meetings were held with leadership and advocacy organizations, family advisory boards, and parents/caregivers to discuss concerns regarding CSHCN. The Department of Health updated its website to better organize information about programs.

The PMHI developed new collaborative relationships with five organizations: the Center for Assistive Technology, the Pediatric Palliative Care Coalition, the University of Pittsburgh School of Medicine, the Epilepsy Foundation of Western/Central PA and the Center for Public Health Readiness & Communication. These unpaid partnerships, which brought together people with similar objectives related to CSHCN, helped the PMHI meet the goals of providing two webinars to PCPs, hosting two statewide conferences and running four learning collaboratives in 2016. These learning events supported PCPs in the process of adopting a medical home approach to care and integrating with behavioral and oral health services. The collaboration with the University of Pittsburgh School of Medicine to recruit pediatric PCPs for a study on mental health integrative care met the 2016 goal of one new collaboration with behavioral or oral health entities.

In 2016, the PMHI had just over 6,500 encounters (i.e. education, technical assistance, meetings, and electronic communications) with PCPs participating in the PMHI and those being recruited for participation. It is estimated 507 providers participated in these encounters. These encounters included 347 educational events, exceeding the 2016 goal of 125 educational encounters with PCPs. Over 491,000 children, including CSHCN, were served by 126 PCPs providing data to the program.

The PMHI offered participating PCPs 12 learning opportunities virtually and in-person on topics such as care mapping, family/professional partnership building and physical/behavioral health integration. The DHS' new TiPS (Telephonic Psychiatric Consultation Services) program, designed to link behavioral health professional support to physical health care professionals, was the topic of one session. Another webinar focused on real life applications of cultural and linguistic issues and included direct messaging to be implemented immediately in the practice setting. Additionally, the PMHI continues to use the Medical Home Cultural Competency Checklist, part of the Medical Home Implementation Guide, to continue to incorporate the tenants of cultural and linguistic competency into all facets of medical home and transition work. Eight PCPs received care coordination stipends for meeting the following criteria: establishing a medical home advisory team, identifying CSHCN and creating patient registries, reporting required data to the PMHI and participating in practice-based quality improvement activities, including care plan development.

Two conferences were held in 2016. One focused on Fetal Alcohol Spectrum Disorders, and the other on Adolescent Health with approximately 100 individuals participating in each. Eighty-seven percent of respondents completing a post-Adolescent Health conference survey indicated the content was very highly or highly relevant to practice activities and 65 percent indicated plans to implement changes in practice protocols.

Practice Coordinators and Parent Advisors offered onsite education, support and technical assistance to PCPs. One Practice Coordinator was content-certified by the National Committee for Quality Assurance, the organization responsible for certifying medical homes, and offered support to PCPs who wanted to build on PMHI experiences

and achieve national accreditation as a medical home. The staff facilitated parental involvement through PMHI's Parent Partner program, in which parents assist the PCPs in the adoption and implementation of the medical home approach. At the end of 2016, 198 Parent Partners were involved in PMHI, which was a slight decrease from 204 in 2015, and which did not meet the goal of 200. Parents/caregivers had many other demands on their time, which negatively impacted the growth rate, and which in turn impacted the ability of local PCP advisory boards to get consistent input and insights from parents/caregivers.

PMHI continued its social media presence with two active Facebook pages, one for the public (361 active members) and the second for a closed group of families/caregivers (220 active members) of CSHCN. Both pages were routinely updated with relevant and timely information, resources and community events for families/caregivers. A blog was created to enhance further communications. Work to reinvigorate youth participation via social media was halted during the year due to the untimely death of the young adult serving as the youth social media consultant, and efforts had to be refocused in new directions.

Boston Children's Hospital's National Center for Care Coordination conducted presentations on care coordination and provided input for future learning collaboratives, particularly on physical/behavioral health integration and training for care coordinators. The PMHI partnered with the statewide Rehabilitation and Community Providers Association on its Physical Health/Mental Health Learning Community, supporting integrated whole person health care and health care policy, leading to participation in a Physical/Mental Health Learning Collaborative, co-hosting a learning collaborative on integrative care with Project LAUNCH (an early childhood/mental health initiative) and monthly calls discussing future policy and programming directions. A partnership with the Epilepsy Foundation Western/Central Pennsylvania and the Pennsylvania Association of Family Practitioners gave insights into specific needs of transitioning youth with epilepsy to assist in shaping policies and practices. The UPMC Spina Bifida Adult Clinic, which specializes in the unique medical needs of adults with spina bifida, utilized input from PMHI PCPs in the development of new transition protocols.

Several PCPs were recruited to join University of Pittsburgh School of Medicine and Western Psychiatric Institute on an integrated behavioral health grant focused on the integration of behavioral health within pediatric primary care. The PMHI also supported the Early Autism Spectrum Disorder Detection and Services study, worked closely with partners to build oral health resources in the state, and educated over 520 medical professionals in basic preventive oral health services such as fluoride varnish application/oral health risk evaluation.

The DHS' MA office continued to develop the PCMH program, focusing on high-volume medical assistance PCPs, both pediatric and adult, adopting and implementing specific criteria leading to improved health of patients. The plan was for PCPs to receive an additional per member per month reimbursement for meeting criteria. The BFH utilized a technical assistance grant from the National Governor's Association to assist Pennsylvania in implementing PCMH, and the Pennsylvania team included staff from the Department of Health, DHS and the PMHI Medical Director, who works for PA AAP. The grant ended in September 2016. DHS' implementation of the program in Pennsylvania was delayed into 2017.

The Special Kids Network (SKN) utilizes Title V funds to support, sustain, and improve statewide services to Pennsylvania's CSHCN. The SKN served 1,597 families in 2016 which is an increase from last year and met the goal for 2016 of reaching 1,500 families through evidence-based or evidence-informed strategies. The number includes calls to the SKN helpline and the number of referrals that came from other sources. Overall in 2016, SKN reached over 28,903 people through presentations, home visits and meetings with organizations and providers. The SKN works to continually increase the number of families served through meetings, trainings, presentations, partnership with Elks nurses who provide service coordination and collaborations with state agencies and other organizations. Increasing the number of families who learn to navigate the system and equipping them with skills to

advocate without assistance results in an enabled and empowered population of parents/caregivers. It also allows SKN staff to utilize their time and resources on new families.

Partnerships with other organizations are being strengthened to ensure families are served by the proper entity and all children get the care that is needed. In last year's report, it was referenced that SKN would explore replicating components of the CaCoon program from Oregon; however, it was decided to continue to with current programming and transition the program to a new model in 2018. A questionnaire was sent out to organizations throughout PA to gather data on services being provided and determine what the unmet needs are for families.

During 2016, SKN developed collaborations with four organizations. A collaboration is defined as a partnership between SKN and an organization that results in assisting families with obtaining information or providing support. The goal was to develop four new collaborations and the goal was achieved.

The first was with the PA System of Care Partnership through the DHS, to provide training for families to better manage the care of their CSHCN. The training was coordinated in 2016 and is to occur in early 2017. The training is "Team Up for Families (TUFF)", a six-hour peer-led and family centered training to teach families to effectively communicate needs and concerns with providers, gain skills to navigate service systems and decipher unfamiliar terminology. Families learn to track treatment progress in daily life and build a circle of support to meet ongoing challenges.

The second collaboration involved PA Family Network, which is an initiative of the Office of Developmental Programs (ODP) of DHS. The RCs provided training entitled "Supporting Families Throughout the Lifespan". This workshop training teaches families and stakeholders the importance of exploring community resources and encouraging family participation. The workshop offers life course tools to develop strong visions for everyday lives, and provides information about service systems encountered throughout the lifespan. In 2016, one RC held this training in their region with an exceptional turnout.

The third collaboration addressed the need for after school care for youth with special needs. SKN partnered with the PA Statewide Afterschool/Youth Development Network to plan a webinar to assist after school providers with integrating youth with special needs into their programs. The collaboration began in late 2016 with the webinar planned for the spring of 2017. A survey will be sent to afterschool providers to gather information on their needs and how they currently include CSHCN in afterschool programs. Once the information is gathered, the webinar will be created.

The fourth collaboration has recently been established with PA Link to Aging and Disability Resources, an initiative through the Department of Aging. A project is being organized to raise awareness of the needs of caregivers of those with disabilities and the importance of life course planning. The project will entail offering nine viewing events of the documentary film "Mimi and Dona", which is relevant to families of people with disabilities and the elderly. The film illustrates the importance of planning for the future of individuals with disabilities and the elderly population. Discussions will be held and resources provided as part of each film viewing event.

In addition to these four new collaborations, the BFH maintained other, previously developed collaborations. The BFH had a collaboration with the DHS Office of Income Maintenance to have staff from County Assistance Offices (CAO) attend SKN Gathering meetings. This facilitated contact between families and the CAO so that families understand the CAO is there to assist them with questions related to Medical Assistance. Another collaboration was with the DHS Office of Medical Assistance Programs (OMAP). OMAP operates Special Needs Units to assist families of CSHCN. By collaborating with OMAP, the BFH and SKN can ensure services and efforts are not

duplicated.

## Cross-Cutting/Life Course

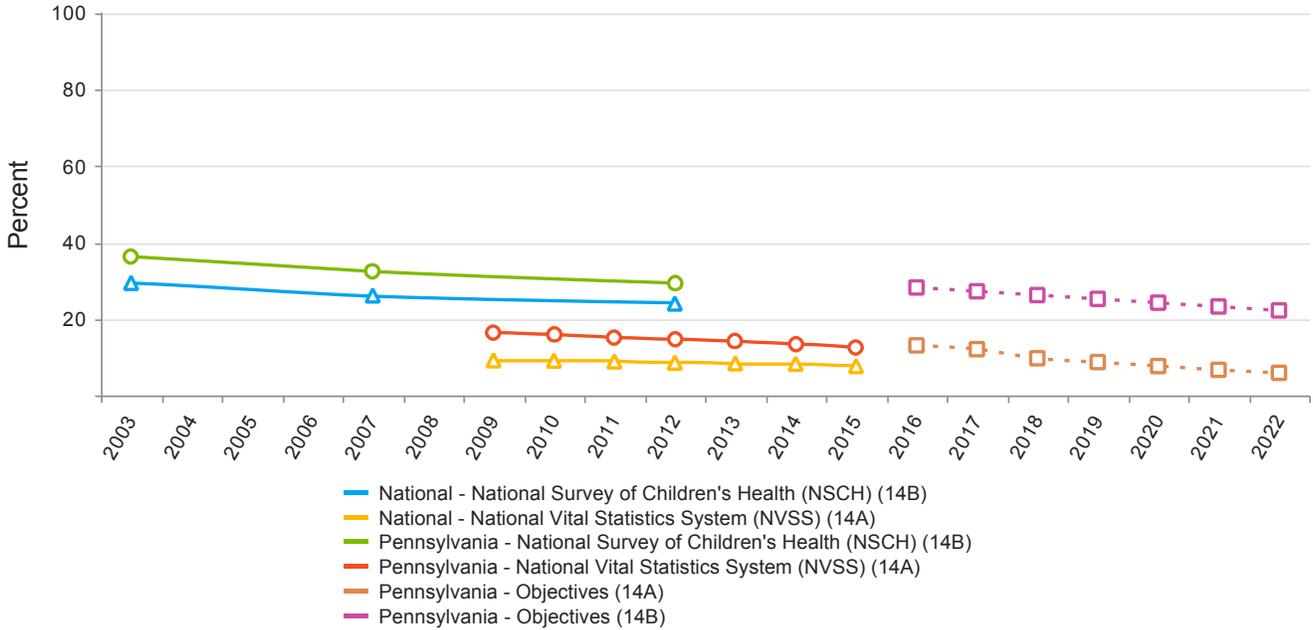
### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	144.6	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.2 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.8 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.4 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	6.6 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	22.2 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.2	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.9	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	4.0	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.9	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	248.1	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	76.6	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	87.3 %	NPM 14

**National Performance Measures**

**NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

**Baseline Indicators and Annual Objectives**



**NPM 14 - A) Percent of women who smoke during pregnancy**

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	13.2
Annual Indicator	12.5
Numerator	17,295
Denominator	138,426
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12.2	9.8	8.8	7.8	6.8	6.0

**NPM 14 - B) Percent of children who live in households where someone smokes**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	28.3
Annual Indicator	29.3
Numerator	792,368
Denominator	2,702,962
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27.3	26.3	25.3	24.3	23.3	22.3

**Evidence-Based or –Informed Strategy Measures**

**ESM 14.1 - Number of Title V funded women who are screened for behavioral health.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,000.0	1,100.0	1,200.0	1,300.0	1,400.0	1,500.0

**ESM 14.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV).**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	75.0	80.0	85.0	90.0	90.0	90.0

**ESM 14.3 - Percent of women who report smoking after confirmation of pregnancy.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	30.0	28.0	26.0	25.0	24.0	23.0

**ESM 14.4 - Percent of women who report smoking after pregnancy.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2011
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	11.0	10.8	10.6	10.4	10.0	9.8

**ESM 14.5 - Percent of Grantees who implement evidence based or evidence informed tobacco free programs.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	20.0	40.0	60.0	80.0	80.0	80.0

**ESM 14.6 - Percent of individuals trained on motivational interviewing.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	50.0	60.0	62.0	64.0	66.0	70.0

**State Performance Measures**

**SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	20.0	38.0	56.0	75.0	78.0

**SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	29
Numerator	
Denominator	
Data Source	BFH internal data collection
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	32.0	42.0	55.0	66.0	76.0	78.0

## State Action Plan Table

### State Action Plan Table (Pennsylvania) - Cross-Cutting/Life Course - Entry 1

#### Priority Need

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

#### NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

#### Objectives

Annually decrease the percentage of women who report smoking during pregnancy.

Annually decrease the percentage of women who report smoking after pregnancy.

#### Strategies

Utilize the Integrated Screening Tool (5Ps)-Institute for Health and Recovery

Utilize Motivational Interviewing

#### ESMs

#### Status

ESM 14.1 - Number of Title V funded women who are screened for behavioral health. Active

ESM 14.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV). Active

ESM 14.3 - Percent of women who report smoking after confirmation of pregnancy. Active

ESM 14.4 - Percent of women who report smoking after pregnancy. Active

ESM 14.5 - Percent of Grantees who implement evidence based or evidence informed tobacco free programs. Active

ESM 14.6 - Percent of individuals trained on motivational interviewing. Active

## NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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NOM 3 - Maternal mortality rate per 100,000 live births

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NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

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NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

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NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

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NOM 5.1 - Percent of preterm births (<37 weeks)

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NOM 5.2 - Percent of early preterm births (<34 weeks)

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NOM 5.3 - Percent of late preterm births (34-36 weeks)

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NOM 6 - Percent of early term births (37, 38 weeks)

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NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

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

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NOM 9.2 - Neonatal mortality rate per 1,000 live births

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

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NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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

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NOM 19 - Percent of children in excellent or very good health

Priority Need

MCH populations are able to obtain, process and understand basic health information needed to make health decisions.

SPM

Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.

Objectives

Beginning in the first year of the grant cycle, disseminate at least one simple and clear messages about basic health information.

Annually increase the number of students with brain injury who are receiving BrainSTEPS and/or CMT services.

Strategies

Review and evaluate available social media platforms that can be used for messaging of basic health information.

Explore the feasibility of using a text messaging or smart phone app outreach program to provide basic health information.

BrainSTEPS program.

Establish requirements for grantees to review their disseminated health information.

#### Priority Need

Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.

#### SPM

Percent of Title V staff who analyze and use data to steer programmatic decision-making.

#### Objectives

Annually identify at least one area for improvement in collecting or using data for each BFH program.

Staff from each BFH program will conduct analysis to develop actionable goals annually.

Staff from each BFH program with actionable findings will develop and implement at least one programmatic strategy based upon the findings during the project period.

Existing data collection programs will increase the dissemination of data to improve public health outcomes.

#### Strategies

Review program activities and goals to determine programmatic needs.

Identify and utilize at least one staff resource to conduct analysis, interpret results, and develop actionable reports.

Develop program strategies based on actionable findings.

Staff will use PA PRAMS and CDR findings to inform, develop, modify and evaluate public health programs and policies in Pennsylvania.

Staff will conduct analyses of childhood lead data to inform public health programs and policies.

State Action Plan Table (Pennsylvania) - Cross-Cutting/Life Course - Entry 4

Priority Need

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

Objectives

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

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

Strategies

Utilize the Integrated Screening Tool (5Ps)-Institute for Health and Recovery

Utilize Motivational Interviewing

State Action Plan Table (Pennsylvania) - Cross-Cutting/Life Course - Entry 5

Priority Need

Appropriate health and health related services, screenings and information are available to the MCH populations.

Objectives

By the end of the grant cycle, all Title V vendors will have developed a plan to identify and address health disparities in the population they serve.

Strategies

Inclusion of health disparities language in all BFH grant agreements.

## **Cross-Cutting/Life Course - Plan for the Application Year**

### **Domain: Cross-Cutting or Life Course**

#### **2018 Application**

There are a number of factors that contribute to poor maternal and infant outcomes and particularly disparate outcomes for African American women and babies. These factors include mental health, smoking and other substance abuse, intimate partner violence, poor housing, unsafe neighborhoods, institutional racism and stress. During the preconception and interconception periods are times when women having access to a trusted health care practitioner is valuable, and opportunities for important conversations about the concerns identified above exist. Data analyzed through PRAMS surveys suggests that when women have had a health care practitioner talk to them about these issues, there is recognition and value in these conversations as preventative measures or interventions.

The Bureau of Family Health (BFH) is planning strategies and activities on several cross-cutting and life course issues that are contributing to negative health conditions in the state as well as those which, when improved, will lead to overall health improvements for residents of Pennsylvania. The state priorities that are addressed in the life course domain are MCH populations are able to obtain, process and understand basic health information needed to make appropriate health conditions; women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted; and appropriate health and health related services, screenings and information are available to the MCH populations.

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

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

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

**ESM: Number of home visitors trained in motivational interviewing.**

The BFH recognizes that prescription drug abuse or misuse impacts MCH populations at all stages, but will be incorporating strategies into Title V programming beginning with the pregnant/maternal population. By assessing behavioral health issues during the prenatal period, the BFH aims to identify and address potentially risky behaviors or circumstances in order to improve pregnancy outcomes, as well as improve health for children and families in the same household. Although prescription drug abuse is a major problem, the BFH will not be solely focusing on prescription drugs. Instead, the BFH will incorporate the use of an evidence-informed screening tool – the Integrated Screening Tool (5P's), to screen for behavioral health issues. The Integrated Screening Tool is a non-threatening and quick conversational tool that assesses risk for alcohol, substance abuse, violence, and depression based on 5 P's: Parents, Peers, Partner, Pregnancy, and Past. The tool guides health professionals to make referrals or recommendations based on responses. The Integrated Screening Tool asks questions about drug or alcohol use by parents or peers as a way to open up the conversation about substance abuse. Women, especially during pregnancy, may be hesitant to talk about their own drug use habits, but are willing to share about the habits of their parents or peers.

Through grant agreements with local agencies who provide either prenatal care or home visiting services, the BFH will include the use of the Integrated Screening Tool with other grant activities. For agencies or staff who have not

used the Integrated Screening Tool, the BFH will provide training and also support the local MCH workforce to identify appropriate referral sources for further assessment and treatment as needed. Online trainings on the use of the 5P's tool have been developed and were available starting in April 2017. The BFH has chosen to measure the number of Title V women who are screened for behavioral health in order to expand the number of opportunities for support and referral for women and improve the health of families in Pennsylvania.

In addition to the Integrated Screening Tool, the BFH will train home visiting program staff to use motivational interviewing techniques, which have been proven to be effective in instilling behavior change. Motivational interviewing is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to understand the need for change. Trainings on motivational interviewing techniques began in March 2017. The BFH chose to track those trained in this technique to gauge the reach of the potential for behavioral changes among women enrolled in our programs.

Home visiting program nurses have the unique advantage of being trusted enough to spend time with women in their homes and with their families. By integrating proven tools into the work that is done in the home, the BFH anticipates an improvement in the number of women who are screened for behavioral health issues and the likelihood that they will receive needed follow-up services.

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

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

Changing the picture of IPV necessitates recognizing all its characteristics and focusing on changing attitudes, particularly among those key population groups that see higher rates of such violence. The BFH will use existing programs to begin assessing IPV and assisting vulnerable individuals with resources they need to avoid being harmed in their relationships. Home visitors are in a position to address IPV and begin a conversation. A simple conversation could save or improve the life and health of a family by removing the stigma surrounding women and children living in unhealthy relationships. The BFH chose to measure the number of women who talk with a home visitor about IPV in order to measure the amount of IPV in the population served and possibly develop programming to address the issue.

The Integrated Screening Tool includes a question about feeling unsafe in one's relationship. The BFH home visiting programs will adapt their curricula or models in order to include the Integrated Screening Tool and appropriate follow-up recommendations and referrals. The BFH anticipates using its MCH Home visiting program and Safe and Healthy Homes Program as the initial pathways for conducting the Integrated Screening Tool. The BFH will also explore the feasibility of adding the tool to programs for adolescents or parents of CSHCN, whether services are provided in homes or not, and expanding ways to address IPV in vulnerable groups.

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

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

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

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

Smoking in pregnancy has many potentially harmful consequences for both mother and fetus, including premature birth, low birth weight, the potential for certain birth defects and serves as a risk factor for Sudden Infant Death Syndrome. Approximately 10 percent of women reported smoking during the last three months of pregnancy, and, although many tried to quit, four in 10 relapsed within six months after delivery. The BFH has chosen to measure the percent of women who report smoking after confirmation of pregnancy in order to better understand women's decisions with regard to smoking and pregnancy. Knowing what percentage of women did not change their behavior upon confirmation of pregnancy will allow us to better understand those who are in need of smoking cessation resources.

The BFH has opportunities to impact women during the prenatal period through Home Visiting and prenatal care programs. In the coming year, BFH will require local Title V agencies, or other funded partners who provide these services, to attend training on the Integrated Screening Tool and Motivational Interviewing, and incorporate screening and referrals into their programs. Home visiting programs, Safe and Healthy Homes Program, and Centering Pregnancy Programs currently perform different kinds of assessment, referrals, or education to women about smoking during pregnancy. By using a consistent and reliable tool and techniques, BFH expects improvements in the number of women who smoke during pregnancy.

The Department of Health's Tobacco Prevention and Control Program (TPCP) has continued to operate the PA Free Quitline with a specialized protocol for pregnant and post-partum users. TPCP provided targeted education and informational outreach to the Department of Human Services Managed Care Organizations to increase the number of referrals of pregnant women to the PA Free Quitline, especially in underserved areas. Additionally, numerous CMHDs offer evidenced-based or evidence-informed smoking programs aimed at pregnant and postpartum women.

Erie County Department of Health (ECDH) is in the process of implementing Baby and Me Tobacco Free which has received the "Model Practice Award" by the National Association of City and County Health Officials (NACCHO). The published results indicate a 60 percent quit rate of women enrolled in the program, six-months postpartum. ECDH has chosen five sites which will be used for enrollment and monitoring of the program. The program addresses the high prevalence of smoking among young women during pregnancy. It provides counseling, support and resources to pregnant women to help them quit smoking and maintain smoking cessation throughout the postpartum period and beyond. The program is successful in helping women quit smoking and abstain from smoking, resulting in improved birth outcomes and long-term positive outcomes for women, children, and their families. The BFH plans to measure the percent of grantees who implement evidence-informed tobacco free programs to track the expansion of programs like the Baby and Me Tobacco Free across the state.

#### **NPM 14: B) Percent of children living in households where someone smokes**

**Objective: Annually decrease the percent of women who report smoking after pregnancy.**

#### **ESM: Percent of women who smoke after pregnancy.**

Exposure to environmental tobacco smoke (ETS) causes disease and premature death among nonsmokers. Specific health consequences for infants and children include more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS). While true for all populations, and especially for growing and developing children, there is no safe level of exposure to ETS. Nearly three out of every 10 children live in a household with a smoker; the rates are higher for CSHCN and those under the poverty level. The BFH chose to measure the percent of women who report smoking after pregnancy in order to assess the number of children living in households where someone smokes.

The BFH will leverage the array of MCH programs, most notably home visiting programs, to more comprehensively integrate education on the effects of ETS. Specifically, the BFH will review program materials and procedures for opportunities to include or enhance referrals for the PA Free Quitline, Pennsylvania's primary smoking cessation resource. The BFH will provide training to home visiting programs regarding motivational interviewing in order to effect behavior change. The BFH will use the Integrated Screening Tool and will use motivational interviewing practices to make and follow-up on referrals.

**Priority: MCH populations are able to obtain, process, and understand basic health information needed to make appropriate health decisions.**

**SPM: Percentage of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.**

Health literacy is the capacity an individual has to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Health literacy impacts an individual's ability to: navigate the healthcare system, share their health history with providers, and engage in self-care and disease management. In order to be health literate, an individual must have basic literacy skills, have basic mathematical skills, have a knowledge of health topics that are relevant to them, and understand the nature and causes of diseases or conditions that impact their health. For individuals from different cultural backgrounds, one's beliefs, communication styles, and ability to comprehend and respond, may impact their ability to understand health related information. Poor health literacy is a stronger predictor of a person's health than age, income, employment status, education level, and race. Therefore, it is imperative that programs, providers, and patients work together to improve health literacy.

As part of an effort to improve health literacy in PA, the BFH plans to establish requirements related to health literacy for the BFH and grantee developed materials to ensure all materials that are disseminated are easy to read and are able to be understood by the populations served. Grantees will be encouraged to use the following resources: National Action Plan to Improve Health Literacy, U.S. Department of Health and Human Services, 2010; The Center for Disease Control and Preventions "Simply Put"; and the U.S. National Library of Medicine's website "How to Write Easy-to Read Health Materials."

**Objective 1: Beginning in the first year of the grant cycle, disseminate at least one simple and clear message about basic health information.**

The Division of Bureau Operations will be working on developing a process to review materials created by the BFH or BFH grantee materials for health literacy prior to dissemination. As part of this review process, the BFH will be able to track the number of health messages being distributed, and how many of those messages met the health literacy guidelines. The BFH will also be reviewing program webpages on the Department of Health website to be sure the messages being presented are clear, concise, and easy to understand. The BFH will also track the number of health messages that are available in multiple languages.

In addition, the BFH will continue to explore whether it is possible to utilize social media and mobile messaging to convey health and prevention information. While the Department of Health has a Facebook page and Twitter account, there are no social media accounts specific to the BFH. According to the 2015 article published by the Pew Research Center on Mobile Messaging and Social Media, the percentage of Google searches using a mobile device is now greater than the number of searches on a desktop computer. Eighty percent of internet users have a smartphone and 47 percent use a tablet to search the internet. Sixty-two percent use their smartphone to search for

additional information about their health conditions.

**Objective 2: Annually increase the number of students with brain injury who are receiving BrainSTEPS and/or Concussion Management Team services.**

Through a grant agreement with the Department of Health and in partnership with the Department of Education, the Brain Injury Association of Pennsylvania implemented a Child and Adolescent Brain Injury School Re-entry Program called BrainSTEPS (Strategies, Teaching Educators, Parents and Students). BrainSTEPS is a program designed to provide services to any student who has experienced an acquired brain injury. The program provides assistance to students with a brain injury or with a prior injury which is still impacting student performance. Once referred for services, the student receives program monitoring from the point of referral through school graduation.

BrainSTEPS will continue to provide students, families, school teams, and medical providers with consultation to assist the student with transition back into the classroom setting. A focus on outreach efforts to the hospital and the medical rehabilitation community will occur. This will occur through promotion, advertisement, and networking. Individual BrainSTEPS Teams have established team goals, one of which is to increase outreach in the hospitals and the medical rehabilitation community. The aim is to further promote and encourage consistency in referrals when a child is discharged from a hospital or medical rehabilitation setting. The student should be referred to the BrainSTEPS program. The BrainSTEPS program model has developed a Concussion "Return to Learn" protocol for individual school districts. The idea is for individual schools to take ownership and implement in-house school Concussion Management Teams (CMT). BrainSTEPS personnel provide the CMTs concussion training. Proper training and preparation is essential in the identification of and monitoring of the injury. BrainSTEPS personnel provide training and technical assistance to each school district that is participating in the Concussion "Return to Learn" protocols. The aim is for further outreach to the education community to increase individual school districts participation in Concussion "Return to Learn" protocols. Outreach is conducted through trainings, presentations, advertising and networking. Expansive outreach will have a positive impact on the desired objective. Utilization of programmatic data will help measure the population served, pinpoint areas for outreach, and assist in evaluation of the existing training curriculum.

**Priority: Appropriate health and health related services, screenings and information are available to the MCH population.**

**Objective: By the end of the grant cycle, all Title V vendors will have developed a plan to identify and address health disparities in the population they serve.**

Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

The BFH is making a commitment to address and combat health disparities in all MCH populations by inserting language into all grant agreements requiring grantees to do the following:

- Develop a plan to identify, address and eliminate health disparities in the populations served by Title V.
- Align their work plan with the goals and strategies of the *National Stakeholder Strategy for Achieving Health Equity*.

Grantees are required to submit a summary of their health disparities work plan in their reports to the BFH from which the BFH can begin building long term goals and additional strategies to address health disparities within the MCH populations of PA.

Grantees will continue to receive technical assistance as the health disparities language is incorporated into the grant agreements as grant agreements are renewed.

**Priority: MCH populations reside in safe and healthy living environments.**

Caregiver stress is an important issue noted by focus groups during the 2015 needs assessment process. Caregivers, particularly those who have children with special health care needs (CSHCN), often provide care to the detriment of their own health and well-being. They deal with physical and emotional strain, financial issues, marriage strain and stress. Often they have little or no support. This lack of support-emotional, financial and physical-for family caregivers of CSHCN, affects the entire family including the CSHCN and the non-CSHCN siblings.

Because of these issues, the BFH began exploring the possibility of developing a program that would address these needs and resulting caregiver stress for all children and families with a focus on families of CSHCN.

In 2016, after further research and in order to begin to address reducing caregiver stress, the BFH began to develop a respite care program. While in the final development stages, it is anticipated this program will provide at risk families in Pennsylvania with financial assistance to obtain respite services in order to reduce caregiver stress in Pennsylvania's Title V population. The main objectives of the program are defined as follows: (1) Provide financial assistance PA's Title V population to obtain respite services; (2) Create and maintain a central listing of respite providers for the families in PA; (3) Provide or refer families to other resources to reduce caregiver stress. The overall goal of this program is to promote safe and healthy living environments by reducing the high burden of stress for caregivers and families. In keeping with the same model as other programs within the Bureau, the respite program will operate as a payer of last resort with a financial eligibility requirement for respite services. There will be minimal additional eligibility requirements in order for the program to be available to as many people as possible. The anticipated start date is January 1, 2018. The program will offer services to caregivers in each of the six regions in Pennsylvania. Services will be provided on a first come, first served basis through an application process and families may only apply once per year.

**Priority: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.**

**SPM: Percent of Title V staff who analyze and use data to steer program decision-making.**

Pennsylvania has selected a state priority to build capacity of Title V staff and programs to collect, analyze, and use data. By building this capacity, the Bureau of Family Health (BFH) anticipates a positive impact across all of the population health domains. While the BFH has several programs that are strong in collecting and using data for program evaluation and decisions, the 2015 Needs and Capacity Assessment revealed that there are not consistent practices in place across the BFH and in the local MCH workforce. To systematically address this, the BFH has developed objectives and strategies to build capacity in an intentional manner, similar to the way objectives and strategies are created to serve population needs. By investing in this capacity, the BFH will be better equipped to understand the needs of the MCH population and make informed decisions about programmatic investments.

The State Performance Measure defined for this priority is the percent of Title V staff who analyze and use data to steer programmatic decision-making. This will be calculated by dividing the number of Title V staff who analyzed and used data at least once during the reporting year by the number of Title V staff. This SPM was chosen because improved data collection and analysis will result in better decision making by staff and lead to improved health outcomes for families in Pennsylvania.

The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS) is an ongoing population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy, and during the child's early infancy. It is a good example of a program that collects and uses data to increase understanding of maternal behaviors and experiences. PA PRAMS data is analyzed and translated into usable information for planning and evaluation of public health programs and policies. PA PRAMS is operated as a collaborative project designed to inform services and interventions statewide, driven primarily by the findings revealed. As such, analysis priorities and plans are informed by the programs and groups impacted. It remains an aim of PA PRAMS to increase visibility and recognition as an ideal source of maternal and infant health information and data. It remains a significant contributor in ongoing efforts to build state capacity for collecting, analyzing and translating data to address MCH issues.

Staff currently conduct descriptive analyses on PA PRAMS data to improve understanding of maternal health behaviors and prevent adverse health events. In the coming year, staff will identify opportunities to disseminate PA PRAMS findings to key stakeholders and increase analytic capability in order to inform, develop, modify and evaluate public health programs and policies in Pennsylvania.

The Childhood Lead Surveillance Program is another example of an existing data collection program, but one that focuses on a single public health issue. Childhood lead data are reported to the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS), a statewide surveillance database that stores patient, test, and provider information for all reportable diseases in Pennsylvania. Staff uses the lead surveillance data to assess blood lead testing activity, blood lead levels, and to identify at risk areas for targeted interventions.

The Pennsylvania Child Death Review (CDR) program is another public health program that relies heavily on high quality data collection. The mission of the CDR Program is to promote the safety and well-being of children and reduce preventable child fatalities. The child death review process includes gathering available information related to the child's life and death. This includes, among others, information derived from death certificates, traffic and law enforcement reports and hospital records. Pennsylvania engages a well-organized, multidisciplinary child death review process that facilitates accurate and consistent reporting. In previous years, technical assistance for local CDR teams was administered through a contract with the Pennsylvania chapter of the American Academy of Pediatrics. As of December 31, 2016, this contract was concluded and the CDR program operations will be fully integrated into the Division of Bureau Operations (DBO).

Currently, all 67 counties in Pennsylvania are covered by one of the 63 local CDR teams. Local team members are comprised of community leaders who represent organizations and agencies that serve and protect children within their respective counties. Diverse organizational representation includes Department of Health agencies and others. CDR teams analyze data in order to develop the most effective prevention strategies to reduce preventable child deaths in Pennsylvania. Teams design prevention education, trainings, and recommendations for legislation and public policy. A statewide multidisciplinary team, comprised of local professionals and representatives of state agencies, review data submitted by local teams and develop protocols and prevention strategies for child death review.

The BFH plans to maximize the use of the CDR data and recommendations as it moves forward with current and

future program planning to address the highest priority needs of the Maternal and Child Health population. The CDR data will specifically be used to guide the targeting of programming and services related to safe sleep practices.

**Objective 1: Annually identify at least one area for improvement in collecting or using data for each BFH program.**

Part of this process will be for staff to review their program activities and goals to determine programmatic needs. After needs are identified, staff can then research what data sources are available to meet programmatic needs. To start the process of transforming data into programmatic strategies, staff will annually identify at least one area for improvement in collecting or using data for each program. Staff were interviewed to determine how each program is currently collecting or using data. Utilizing the interview process and the information gathered during staff interviews, each of the programs within the BFH has begun identifying the data resources available.

**Objective 2: Staff from each BFH program will conduct analysis to develop actionable goals annually.**

Once compiled, the data needs to be analyzed, interpreted and transformed into useful findings. To this end, staff will conduct analysis of the data and develop actionable goals on an annual basis. Since data analysis capability varies across programs, a resource must first be identified and engaged in order to conduct the routine analysis. The DBO has been charged with the initial analysis and goal development for the MCH Block Grant funded programs within the BFH. This will be concurrent with a training regime targeted to aid BFH staff in expanding their abilities to conduct this analysis and goal development in a more independent way in future years; allowing the DBO to move into a support and quality review role as staff expand their capabilities.

In the work plan being developed by the DBO, there is a strong focus on the concurrent data analysis and goal development for programs paired with training for BFH staff. It is anticipated that by the close of 2017 the BFH will have finalized a workplan with identified clear, measurable goals for both staff development and individual program data analysis and goal development.

**Objective 3: Staff from each BFH program with actionable findings will develop and implement at least one programmatic strategy based upon the findings during the project period.**

Since programs will have varying data sources and types, actionable reports will be tailored to specific programmatic needs. The objective will be to develop and integrate at least one programmatic strategy based upon relevant information and findings. Program staff will first have to review potential strategies related to the compilation of actionable findings. The next step will be to prioritize strategies, and decide which ones to pursue.

As program staff are trained and goals developed each program will begin, with the support of the DBO, to prioritize and implement strategies. Since the applicable population for this objective includes Title V program staff and program vendors, staff will consider whether to implement the strategy as a part of program administration at the central office, or to integrate the strategy into vendor activities.

**Objective 4: Existing data collection programs will increase the dissemination of data to improve public health outcomes.**

As each program evolves the use of actionable findings and the development of programmatic strategies, the program will work with the DBO to plan for the release of this data through appropriate outlets. This could be through reports, publications, data briefs, fact sheets, poster presentations, and conference presentations. Those programs

that have vendor involvement will include the vendor in planning how best to disseminate findings and strategy outcomes.

## Cross-Cutting/Life Course - Annual Report

### Domain: Cross-Cutting or Life Course

#### 2016 Report:

In 2016, the Division of Newborn Screening and Genetics (DNSG) re-designed the program's newborn screening brochure to make it easier to read and understand. In addition, the DNSG developed a rack card specific to lysosomal storage disorders (LSDs). The new rack card and the redesigned brochure encourages parents to talk to their healthcare provider about what newborn screens their baby would receive and the results of the screens to increase their knowledge about their baby's health. Both the brochure and rack card are provided to all hospitals, birthing centers, and midwives and are available in English, Spanish, Chinese, Russian, French, Portuguese, and Vietnamese.

The BFH has begun to integrate the health disparities language into grant agreements as the agreements have come up for renewal throughout the year. The Safe and Health Homes Program grantees have already received technical assistance on the integration of the *National Stakeholder Strategy for Achieving Health Equity*. These grantees have already begun to submit draft plans to the program administrator for review and feedback.

The BrainSTEPS program currently operates across Pennsylvania through all 29 Intermediate Units (IU). The IUs link with school districts to provide individualized support services for students in need. BrainSTEPS Teams prepare the student and family for return to school post injury. The teams consist of education professionals, medical professionals, and family members who have received program training. The teams provide a link between medical and school personnel. There are currently 266 active BrainSTEPS teams in place. With coverage across Pennsylvania, annual student referrals to the program have shown an increase. The program has served a total of 3,697 referrals since program inception in 2007. There were 603 new referrals last year. The program is to provide service for at least a minimum of 500 referrals per year.

The Concussion "Return to Learn" component has entered its fourth year. CMTs support both student athletes and non-athletes at the local and district level, who are returning to the demands of school while promoting recovery. Pennsylvania is the first state in the nation to systematically roll out a program and facilitate "Return to Learn" CMTs. The State of Colorado has adopted the BrainSTEPS model into their educational practice. The BrainSTEPS program is currently undergoing an evaluation process conducted by the Centers for Disease Control and Prevention's (CDC) Evaluability Assessment of the "Return to Learn" program model. The CDC plans to disseminate results of the evaluation process at the end of the project in 2017.

The goal of BrainSTEPS is to further enhance the spread of CMTs based within school districts across Pennsylvania. The results thus far have been positive. There are now over 1,110 CMTs providing a level of support for the student and family. This was an increase of 230 from the prior year. The BrainSTEPS program developed a sample protocol for schools to follow regarding concussions. The guide is titled; "A Teacher's Desk Reference Guide". BrainSTEPS Teams are available to schools to provide more intensive student concussion support, consultation, and training, for concussed students who are still symptomatic after four weeks or if they have not returned to their academic baseline. BrainSTEPS teams are available to consult with CMTs at any time.

The BrainSTEPS program continued outreach to increase public awareness of the program. The BrainSTEPS program focused on utilization of existing program data for program evaluation. The program developed a database which encompasses program contents such as referral, geographic locations, type of consultation, type of planning

support implemented, along with satisfaction surveys. The program continued to evaluate existing education and training curriculum to ensure the materials are current.

The BFH has included in all grant agreements with the County Municipal Health Departments (CMHD) a requirement to utilize the integrated 5P's screening tool. Training on the screening tool as well as motivational interviewing will be provided by the BFH beginning in March 2017. The BFH will also be providing training to partners who offer Centering Pregnancy Programs. The BFH has also offered training to the CMHD on Intimate Partner Violence (IPV). The Pennsylvania Coalition Against Domestic Violence (PCADV) was tasked with providing training to the CMHD on IPV topics relevant to the populations they serve.

Due to a delay in training on Motivational Interviewing and the Integrated Screening Tool, data for the number of Title V women screened for behavioral health, the number of home visitors trained on Motivational Interviewing and the number of women who talk with a home visitor about intimate partner violence is unavailable. This information will be available within the next year.

Three of the ten CMHD offer evidence based or evidence informed smoking cessation programs. CMHDs also provide education related to the risks of smoking around infants and children during home visits. Wilkes-Barre City Health Department offered smoking cessation services to more than 200 pregnant and parenting women. Fifty-eight percent of women remained smoke free after three months, 32 percent after six months and 23 percent after twelve months meeting their goals for three and six months but falling short of 25 percent at one year. Erie County Department of Health and Allegheny County Health Department have both begun implementation of evidence based or informed smoking cessation programs. Partial data for 2016 showed that 13 percent of women smoked following a confirmed pregnancy.

In 2016, during a meeting with the CMHDs, the TPCP staff participated in roundtable discussions related smoking cessation services offered through the Department. BFH staff hoped to reiterate to the CMHDs what resources are available within the Department to assist pregnant and parenting women in quitting smoking.

At the outset of 2016, the established data workgroup continued to progress on the work plan created in 2015. Over the course of 2016 the workgroup completed interviews with program administrators to determine each staff's ability and confidence in identification of, as well as the analysis of data related to the program. The interviews also assessed what types of data were collected along with potential other sources of data within each program. The work group completed the interviews in January 2017. Following the completion of the interviews, the workgroup began collating the collected information and the development of a summary report and work plan to address the MCH Block Grant goals while addressing the strengths and weaknesses of the BFH.

A baseline for the SPM, percentage of Title V staff who analyze and use data to steer program decision-making, was developed by interviewing Title V staff to determine the extent to which their programs were using data to steer decision making. Fourteen staff were interviewed at the time a baseline was needed, and of those fourteen it was determined that four were actively using data to direct programmatic decision-making, creating a baseline of 29 percent.

Support from senior management was essential to the success achieved thus far; the BFH recently completed the restructure of the Division of Bureau Operations (DBO) to include data utilization and program evaluation as primary components of the work of the division. This Division is dedicated to increasing the BFH's data analytic capacities as a whole and on a programmatic level. The staff identified to form the data workgroup have been incorporated into the DBO and new staff have been acquired. The data workgroup's previous work is being folded into the duties of the DBO. Next year, the DBO will continue to increase support to BFH staff to grow their data analysis and program

decision-making capabilities.

As data availability and collection varied greatly between programs, the DBO is incorporating the development of a data catalogue for use within the BFH as part of the work plan being developed. This will identify each piece of data readily available within the BFH and which program houses it, as well as identifying external data sources and how those sources are accessed. The development of a data library is also being considered as a means of warehousing forms of external data (such as research studies, operational reports from related programs, and other external sources) for ongoing use and access. The data available can then be compared to the data needed, and where there are gaps, other activities can be pursued to address them.

In 2017, the Childhood Lead Surveillance Program will be transitioning from the BFH to the Department's Bureau of Epidemiology. The Bureau of Epidemiology will track childhood blood lead testing and analyze this data to support related programming within the BFH. The BFH will continue to use the lead surveillance data to identify at risk areas for targeted interventions and inform decision-making for the purpose of improving public health outcomes.

## **Other Programmatic Activities**

### **Other Programmatic Activities:**

The Bureau of Family Health (BFH) supports other critical partnerships with MCHB programs such as the Maternal, Infant, Early Childhood Home Visiting (MIECHV) grant, administered by the Pennsylvania Office of Child Development and Early Learning. BFH staff participate on the MIECHV home visiting stakeholder group to share best practices and collaborate on home visiting initiatives. While the goals for MIECHV and Title V are slightly different, there is mutual benefit in sharing resources and information about successes, challenges, and population needs.

The BFH also currently manages the Comprehensive Specialty Care Program. This program combines state and federal funding for services to children and adults with specific conditions: Cooley's anemia, Cystic Fibrosis, Sickle Cell, Spina Bifida, Orthopedic and Neuromuscular Conditions, Hemophilia and services for children who are technology dependent. The majority of services are provided in hospital settings through multidisciplinary teams and clinic formats, yet there are also several community based entities funded to provide outside support services. In each of these formats, services include care coordination, mental health screenings and referrals; and availability of a patient assistance fund to provide ancillary and support services that reduce barriers to adherence to treatment protocols and lead to improved health outcomes.

The BFH is also expanding the reach of its data surveillance. The PA PRAMS data collection staff began collecting data from two Healthy Start sites in Pennsylvania in June 2017. Through this initiative, survey response data will be available to assess Healthy Start performance and effectiveness regarding expected outcomes/impacts among the target, maternal population. PA PRAMS data collection for this project is planned for June 2017 through March 2018 (10 months).

Pennsylvania has been identified by the CDC as a high-risk state for potential Zika outbreak. Therefore, PA PRAMS is participating in a Zika 12-question supplement project to assess maternal behaviors and experiences related to Zika virus exposure among recently pregnant women who deliver a live-born infant within the state. The current PRAMS process will be modified to include the Zika supplement questions. Data from the Zika supplement will be identified and processed through an accelerated method to provide weighted response data as quickly as possible to the CDC and Commonwealth. PA PRAMS data collection for the Zika supplement is planned for February 2017 through March 2018 (14 months).

Additionally, PA PRAMS is participating in a 12-question supplement pertaining to marijuana and prescription drug use. Maternal drug use is a concern due to potential negative consequences to the mother and infant. The CDC has developed a PRAMS supplement of 12 questions related to marijuana and prescription drug use (including prevalence of use before and during pregnancy, frequency and mode of use, and reason for use). These questions are adapted from existing PRAMS questions and those used by the National Survey on Drug Use and Health. The questions included in the supplement were cognitively tested by CDC's National Center for Health Statistics in the spring of 2016, and field tested in the summer of 2016. Use of these standardized PRAMS supplement questions can provide comparable state-based surveillance estimates to monitor and evaluate policies and programs. PA PRAMS data collection for the marijuana and prescription drug use supplement is planned for April 2017 through March 2018 (12 months).

## II.F.2 MCH Workforce Development and Capacity

### II.F.2 Workforce Development and Capacity

As the Bureau of Family Health (BFH) has adapted to the transformed Title V block grant structure and reporting requirements, it has become apparent that workforce development needs to move beyond program and discipline specific trainings for BFH staff and grantees. Moving forward, the BFH will be augmenting the types of trainings discussed below with bureau-wide trainings to enhance staff understanding of public health concepts and their application to program provision.

In 2018, the Division of Newborn Screening and Genetics (DNSG) staff will attend the annual Early Hearing Detection and Intervention (EHDI) meeting, the Association of Public Health Laboratories (APHL) Genetics Testing Symposium and other topical conferences and webinars that arise. The DNSG rotates the staff that attend these different trainings so all staff can participate in learning opportunities. With funding received from NewSTEPS 360, the DNSG will be working on developing training materials and training webinars for hospitals, birthing centers and midwives, on timeliness in newborn screening which will be available in 2018. In addition, the newborn hearing screening program will take on the role of providing technical assistance education to providers, both hospitals and primary care physicians, on best practices related to newborn hearing screening, instead of utilizing a contractor for these activities.

The Division of Child and Adult Health Services (CAHS) will have four staff representing the Personal Responsibility Education Program (PREP) and Healthy Youth PA programs attending the Family and Youth Services Bureau (FYSB) Adolescent Pregnancy Prevention Grantee Conference, *Strategies for Success: A Holistic Approach to Adolescent Pregnancy Prevention*. The Adolescent Health Section will additionally provide PREP grantees with three regional trainings held across the Commonwealth. The topic of the trainings will be Healthy Sexuality 101, and will explore current data around key adolescent sexual health issues as well as increase participants' comfort when communicating and teaching about sexuality. Two staff from CAHS also attended the bi-annual National Cribs for Kids Conference focusing on infant mortality in the context of safe sleep practices. The theme of this conference was to focus on community collaborations to achieve greater successes than messaging alone.

The BFH is in the process of training all home visitors and Centering Pregnancy program providers on the use of the Institute for Health and Recovery's Integrated 5P's screening tool in conjunction with Motivational Interviewing. Using motivational interviewing with its non-judgmental, non-confrontational and non-adversarial approach aligns with the purpose of the screening tool which will assist home visitors and providers in identifying potential problems. This will allow providers to deliver counseling on some of the consequences experienced and risks faced as a result of the behavior in question. This may help clients envision a better future and become motivated to achieve it. The strategy seeks to help clients think differently about their behavior and ultimately to consider what might be gained through change.

Division of Community Systems Development and Outreach (CSDO) staff who oversee the Traumatic Brain Injury Programs will attend the National Association of State Head Injury Administrators annual conference and the Brain Injury Association of Pennsylvania annual conference in 2018. The conferences will promote increased knowledge of brain injury and best practices in prevention and treatment.

The Division of Bureau Operations (DBO) manages Child Death Review (CDR) and the Sudden Unexpected Infant Death (SUID) Case Registry in Pennsylvania. To accomplish this, DBO staff provided and will continue to provide a variety of trainings and technical assistance to local CDR teams throughout the year. Currently, DBO provides three

regional meetings divided across the state and one statewide meeting occurring in Harrisburg. Additionally, technical assistance is and will continue to be provided to local CDR teams throughout the year as requested. Technical assistance includes aiding teams in building/restructuring new teams; strengthening current teams; identifying partners for collaboration; crafting recommendations; and developing prevention efforts. Technical assistance is also provided specific to the CDR Case Reporting System to help local teams enter data more efficiently, manage the data they have entered and analyze that data to support recommendations and prevention efforts.

The DBO will support workforce development activities throughout the BFH. As a result of the work around the priority, "Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs," the DBO is currently drafting a workforce development plan. This plan, anticipated to begin implementation in 2018, will include training for BFH staff and grantees on topics related to program decision-making and implementation, such as public health problem solving concepts, data use, evidence-based practices and the use of quality improvement and program evaluation. The BFH also plans to research training options around promoting health equity in order to increase understanding of the social determinants that greatly influence the health of populations. The BFH currently has two Master of Public Health interns who are dedicating their time to reviewing qualitative data from the aforementioned priority work, developing introductory presentations for BFH staff on public health concepts, data use, evidence-based practices and health marketing strategies. Two summary reports about BFH data use and health marketing strategies with recommendations will also be developed by the interns and integrated into the BFH workforce development plan. The BFH aims to integrate the collection of more outcome and evaluation measures into its grant agreements and, in order for everyone to understand the need and benefit of these changes to effectively serve the MCH population, must begin training staff and grantees around how to collect data and use it to inform program decisions.

### **II.F.3. Family Consumer Partnership**

### **II.F. 3 Family Consumer Partnership**

Family and consumer partnerships (FCPs) are essential components of improving the health status of MCH populations over the life span. The Bureau of Family Health (BFH) recognizes the value of FCPs and has established multiple means of incorporating families and consumers into the Title V decision-making process. While the BFH recognizes the value and importance of family and consumer partnerships, and there are many active partnerships, it has never developed a strategic plan to address ways to more fully engage partners in planning, program development, and resource allocation. Beginning in federal fiscal year 18, the BFH will begin developing a five-year strategic plan with the active involvement of consumers and family members. This will also be a focus of the newly convening MCH Steering Committee.

Pennsylvania's FCPs are diverse and include mothers, fathers, grandparents, self-advocates and caregivers of CSHCN and those children and youth who may lack necessities such as food, clothing, shelter, safety, parental support, healthcare and education needed for healthy childhood development. Representing many different types of disabilities, FCP representatives include various racial and ethnic groups and are from urban, rural, and suburban regions. Since the BFH utilizes FCPs in different capacities, the degree of engagement ranges from full-time employment to serving on workgroups. Family and consumer partners who are not employed by the Commonwealth or a grantee are reimbursed for their travel, lodging and childcare costs.

The BFH convenes several advisory boards and committees which include consumers and family members. For example, the Traumatic Brain Injury (TBI) Advisory Board includes a requirement that at least one-third of board members must be an individual with a brain injury or a family member of 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 family members on the TBI Advisory Board. The Infant Hearing Screening Advisory Committee has one parent representative who is a volunteer. The Newborn Screening and Follow-up Technical Advisory Board has one parent representative who is a volunteer. Represented on the Medical Home Initiative Advisory Council are one family member, two youth consumers and three family members who are also professionals. The State Interagency Coordinating Council for Early Intervention (SICC) on which the BFH participates has four family members of individuals with disabilities who serve as SICC board members. The BFH collaborates with the Department of Human Services on Project Launch. For this initiative, of the 27 members on the state council, six are consumers/family members, and of the 37 members on the local council, seven are consumers/family members.

The BFH employs a Family Advisor who serves as Pennsylvania's delegate to the Association of Maternal and Child Health Programs (AMCHP) representing families of CSHCN. Currently, the Family Advisor is a member of AMCHP's Best Practices Committee which assists in the review, evaluation and recognition of programs submitted to AMCHP. This involvement by the Family Advisor with AMCHP provides the BFH with resources and information about other states' activities, enables engagement in MCH programming at a national level and ensures family delegates are serving on AMCHP committees.

The Special Kids Network (SKN) employs nine family members as full time employees: eight regional coordinators (RC) and a RC supervisor. SKN offers a language line and has brochures in four different languages (English, Spanish, Arabic and Indonesian) so that more families can read and understand available information. RCs facilitate SKN Meetings and SKN Gatherings, formally known as Parent Youth Professional Forums to hear issues that are impacting the MCH population. Recent topics of discussion at the SKN Gatherings include emergency preparedness, assistive technology, bullying prevention and navigating the lifespan.

The BFH, through its administration of the Pennsylvania Medical Home Initiative (PMHI), conducts Advisory Committee meetings twice annually and employs two Parent Advisors, an Education Specialist, a youth Social Media Intern and a youth on the Advisory Committee. The PMHI consistently has around 200 families and consumers serving as Parent Partners to assist with planning and advocacy at the community level. The Parent Partners also provide the caregiver perspective to the medical home practice teams. Parent Partners are reimbursed for the costs of time, child care and travel to serve in this capacity.

To improve access and attendance for family/consumer engagement activities, the BFH ensures that buildings and accommodations where meetings are held are accessible; meetings are held throughout the state in rural, urban and suburban settings; and interpreters or translated documents are provided when needed.

#### **II.F.4. Health Reform**

#### **II.F.4. Health Reform**

In April of 2015, under the Department of Human Services, Pennsylvania implemented HealthChoices as a Medicaid expansion plan. By June 2017, over 715,000 Pennsylvanians were newly enrolled as a result of the Medicaid expansion, including citizens from ages 18-64 in all 67 counties. Of those who were enrolled in a newly eligible category, 124,170 people had a substance use disorder diagnosis at some point in 2016. In addition to member enrollment, Medicaid provider enrollment increased by 4,442 physicians, 601 dentists, and 444 certified registered nurse practitioners between 2015 and 2017. By increasing the availability of providers for primary care, dental, and behavioral health, the Department of Human Services aims to increase both access to health care coverage, as well as access to care.

The uninsured rate in Pennsylvania has dropped from 14 percent in 2013 to eight percent in 2017. Results of economic modeling suggest that Medicaid expansion expenditures led to 15,500 jobs, an increase in economic output by \$2.2 billion, and an additional \$53.4 million in state tax revenue. After a steady rise over 15 years in costs associated with uncompensated care by Pennsylvania's general acute care hospitals, there was a decrease in costs of nearly 9% in the first year that Medicaid expansion was implemented.

Pennsylvania's Governor Tom Wolf has fully supported the implementation of Medicaid expansion and remains committed to government reforms that increase efficiency and reduce waste. In support of increased efficiency, in 2017 his budget proposal for the coming year included a plan to unify four state agencies – Department of Health, Department of Human Services, Department of Aging, and Department of Drug and Alcohol Programs – into one consolidated Department of Health and Human Services (DHHS). The creation of the DHHS is intended to eliminate duplication of effort and streamline service provision for providers, consumers and families, especially seniors and individuals with physical disabilities, who often seek services from multiple departments. The unification plan was proposed to be implemented beginning in the 17-18 fiscal year, pending approval by the legislature. Title V programs and many of the Department of Health's grant-funded programs were proposed to be moved into a newly created Office of Public Health. At the time of this report, the unification has not been approved for implementation under the 17-18 state fiscal year budget; however, the negotiations for a unified agency are continuing.

As with many states, Pennsylvania government and healthcare advocates are closely watching proposals at the federal level to repeal the Affordable Care Act, as well as proposed cuts to the Medicaid program overall. Pennsylvania Medicaid is crucial to the care of more than 1.1 million children, including children with special health care needs, and 730,000 individuals with disabilities. On average, in rural counties about 45 percent of children are enrolled in Medicaid. Changes to the Affordable Care Act and Medicaid expansion could have significant detrimental impacts, not only on the individuals who are currently covered and may lose their coverage, but on the hospitals and provider networks, especially in large swaths of rural Pennsylvania, that may have difficulties in sustaining services.

In order to effectively plan and implement appropriate services, the Bureau of Family Health (BFH) is considering carefully how potential changes in the healthcare landscape, both at the federal and state levels will impact the MCH populations and the systems of care in which they receive services. The BFH continues to strive to increase investments in enabling services and public health systems and to monitor programming to assure that direct services are funded only as a last resort. BFH will continue to provide safety net services for vulnerable populations who are unable to access the services they need through traditional payment mechanisms.

The Pennsylvania Department of Health (PA DOH) registered with the Public Health Accreditation Board and submitted an application for public health accreditation in April 2017. As a prerequisite for submitting the application, the PA DOH updated the state health assessment and published the State Health Improvement Plan (SHIP). The SHIP outlines strategies and measures for the PA DOH priority areas: obesity, physical inactivity, and nutrition; primary care and preventive services; and mental health and substance use. The strategies of the SHIP and the MCH State Action Plan are not duplicative of each other, but may be mutually beneficial to address systems of care, health inequities, and health improvement. In preparation and pursuit of public health accreditation, there have been many opportunities for PA DOH to examine and improve processes and service delivery, which will ultimately have a benefit on Title V programming as well.

Direct services are provided by local Title V agencies for children and pregnant women who are uninsured, underinsured, or uninsurable. Services include early pregnancy testing to encourage early entry into prenatal care or home visiting programs and depression screenings to all prenatal and postpartum women receiving services. Referrals are provided as needed to improve the health of women and their families.

Direct services are also targeted for specific community needs in other areas of the state. Erie County Health Department and the Philadelphia Department of Public Health (PDPH) offer health clinics to individuals who have no insurance due to a gap in coverage between providers or insurances or for individuals who are uninsurable. Basic health services such as well visits, immunizations, referral services etc., are provided to offer a safety-net for the Title V population. Montgomery County Health Department (MCHD), PDPH, Albert Einstein Hospital Network (AEHN) and Lancaster General Hospital (LGH) offer prenatal services. MCHD and PDPH provide prenatal care to uninsurable women who would not otherwise be able to afford prenatal care throughout their pregnancy. AEHN and LGH offer prenatal care through Centering Pregnancy programs. The Division of Newborn Screening and Genetics provides safety net pharmaceutical services for patients with medical confirmation of Cystic Fibrosis, Spina Bifida, and Phenylketonuria (PKU). To be eligible for services, patients meet all of the following criteria: U.S. citizenship, Pennsylvania residency, lack of monetary resources or health insurance. Depending on income, some families may be required to contribute to the cost of their prescriptions. If the eligible individual has prescription coverage, it must be used first.

Many adolescents avoid needed healthcare because they are insured under their parents' health plans and concerned about their parents' reactions if they obtain sexual or reproductive health services. To overcome this barrier, the BFH works with local providers for the adolescent health programs described below to provide confidential services. Title V is the payor of last resort for all programs.

Four family planning councils provide reproductive health services to youth 17 and younger. Services provided include: routine gynecological care, pregnancy testing, contraceptives, cervical cancer screening tests, screening and treatment for sexually transmitted diseases, education and counseling, and general health screening services.

AccessMatters provides reproductive health services to high school students through the Health Resource Center (HRC) program. Reproductive health services include: counseling and education, information about reproductive health and relationships, decision making and sexuality, STI screening and pregnancy testing, and referrals to school and community based resources and family planning network for free or low-cost sexual and reproductive health care. AccessMatters operates HRCs in 14 Philadelphia area schools, as well as seven additional locations across the Commonwealth with high rates of teen pregnancy, STIs and school dropouts.

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



## II.F.5. Emerging Issues

### II.F.5. Emerging Issues

Though not a new issue, the PA DOH has continued its efforts to address the opioid epidemic in Pennsylvania. Heroin overdose and deaths have continued to climb, even while the availability and use of naloxone has increased. In August of 2016, PA DOH launched the Prescription Drug Monitoring Program (PDMP), which requires prescribers and dispensers to report all prescriptions for Schedule II-V controlled substances. Since being implemented, over 90,000 prescribers have registered with the PDMP, and over seven million queries have been completed. The Department of Human Services has also implemented and increased the amount of funding available for Centers of Excellence, designed to treat substance use disorders as well as underlying behavioral or physical health issues that are often interconnected. Through home visiting programs, the BFH continues to support efforts to provide screening and referrals for behavioral health and substance use in general, and is available to collaborate on additional interventions when identified by PA DOH.

Another of the unintended consequences of the opioid epidemic is the associated increase in infants born with neonatal abstinence syndrome (NAS). The Departments of Health, Human Services, and Drug and Alcohol Programs are being assisted with guidance and technical assistance from the SAMHSA 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families and Caregivers regarding the Child Abuse Prevention and Treatment Act (CAPTA) reporting and intervention requirements. These agencies are looking beyond CAPTA to implement reporting of infants diagnosed with NAS and appropriate prevention and intervention measures using a public health approach. One prong of this approach is to support universal screening of both pregnant women and infants. PA does not have real-time reporting of NAS at this time and is looking to implement it through regulatory change. While the state agencies have work to do to count and respond to the increase in NAS; the medical community and local child welfare agencies are invested in treatment and ensuring safe home environments for these infants. Several PA hospitals are national leaders in treatment of pregnant women and their babies as well as in researching appropriate medical treatment protocols for infants. The BFH will be allocated funding to support the implementation of surveillance measures.

The PA DOH is continuing to address zika prevention and surveillance through the Bureau of Epidemiology and the Bureau of Public Health Preparedness. PA DOH has distributed over 4,000 zika prevention kits and provided education to women and travelers about zika risks and pathways for exposure. Zika prevention kits containing insect repellants, condoms, and standing water treatment tabs are available for free at local health departments and federally qualified health centers. PA DOH has also provided guidance to healthcare providers about testing for zika, and continues to conduct surveillance of confirmed disease and infection cases of zika.

In April 2016, Pennsylvania passed a bill legalizing the use of medical marijuana for patients under the care of a physician for a serious medical condition. The creation and passage of this law was the result of a grassroots effort led by parents and family advocates and activists, including parents of children with autism, epilepsy, and intractable seizures. DOH will be the regulatory authority for the Medical Marijuana Program and anticipates that full implementation will occur by April 2018. In the interim, DOH is issuing temporary regulations for laboratories, growers, dispensers, physicians, caregivers, and patients while the formal regulations are being developed. Prior to full implementation, caregivers for Pennsylvania children under age 18 with qualifying medical conditions may apply for a "Safe Harbor Letter" to obtain and administer medical marijuana prior to full implementation of the program. As of April 2017, 231 Safe Harbor Letter applications were approved. In June 2017, DOH issued twelve permits to medical marijuana growers/processors, and 27 permits to dispensaries in Pennsylvania. Permittees have six months to become operational before they can begin growing or dispensing medical marijuana. DOH has also

developed a Medical Marijuana Physician Workgroup consisting of physicians, hospital administrators, and addiction specialists to make recommendations for implementing a successful program. The Medical Marijuana Program will also promote high quality research into the effectiveness and efficacy of medical marijuana in treating a patient's serious medical condition.

Also garnering consistent attention is the issue of childhood lead exposure in Pennsylvania. The BFH has applied for and was awarded funding for lead hazard abatement activities as well as lead poisoning prevention and education. PA DOH has been working collaboratively with the Department of Human Services to identify strengths and opportunities in childhood lead testing and follow-up in the Medicaid and CHIP populations. Going forward, the PA DOH is developing strategies to prevent and address lead poisoning from several avenues, including education and information to the public, legislative actions to mandate universal childhood lead testing, education to pediatricians and health care providers, and addressing obstacles to safe and healthy housing.

## **II.F.6. Public Input**

### **II.F.6 Public Input:**

After submission of the 2015 Annual Report/2017 Application and the in-person review with HRSA staff, the Bureau of Family Health (BFH) posted the full application, new executive summary, and state action plan to the BFH website. Visitors to the website can still view the 2014 Annual Report/2016 Application. The website also links visitors to the other state action plans through the TVIS website as well as to general information about the Title V block grant and the transformation. The BFH still maintains a resource email account on the website specific to the Title V block grant to enable people to send comments or input at any time.

As part of on-going public input, the BFH is scheduling quarterly recurring meetings with the County/Municipal Health Departments (CMHDs). The CMHDs are critical stakeholders in the administration of the Title V Maternal and Health Services Block Grant 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. The meetings are designed to not only bring the CMHDs together with the BFH to continue to promote better relationships, but also to have in-depth discussions on individual sections of the Title V Action Plan and provide ongoing technical assistance to local health departments about the application of relevant research, evidence-based and/or promising practices. The BFH will be leveraging the feedback from the CMHDs to improve programming support for the CMHDs, and inform long-term program planning and annual block grant reporting.

In October of 2016, staff from the BFH as well as staff from the Division of Tobacco Prevention and Control met with representatives from the CMHDs. The BFH provided technical assistance on four topics for this meeting: preconception/interconception care; adolescent health; tobacco cessation; and breastfeeding. Participants were given a review of the block grant transformation performance measure logic model and then shown the specific performance measure logic model for each of the four topics to ensure the CMHDs have a clear understanding of what the BFH is tracking and reporting on for the Title V block grant and why. The majority of the meeting was spent in four small groups led by BFH and Division of Tobacco Prevention and Control subject matter experts. The topic area subject matter experts were tasked with discussing trends and performance, evidence-based or informed strategies, and encouraging discussion and feedback regarding barriers, successes, opportunities, and on-going needs.

During the meeting held on March 8, 2017, the BFH provided technical assistance on three topics: Child Health, the Institute for Health and Recovery 5P's Screening Tool and Health Disparities. BFH staff provided an overview of the performance measurement framework for the Block Grant, and included specific examples of how program strategies fit into the Maternal and Child Health State Action Plan. Additionally, BFH staff provided an overview of DOH's Collaborative Improvement and Innovation Network (CollIN) activities. In addition to discussing the three topics in a small group format, there was also a large group discussion regarding data needs and challenges encountered by the CMHDs. CMHDs noted the need for city-level data not just county-level for indicators like birth outcomes. Another issue noted was how to define and count Neonatal Abstinence Syndrome (NAS) as well as the number of pregnant women with drug and alcohol issues.

Over the next year, the BFH plans to form a MCH Steering Committee representing a variety of stakeholders and family members to provide input on the evolution of future Title V Annual Reports/Applications and to guide the formation and structure of focus groups and other forms of stakeholder and family/consumer engagement activities. Through this committee, the BFH plans to build consistent avenues of public input throughout the Title V reporting process as well as increase and expand consumer engagement in program development, implementation and

evaluation.

After submission of the 2016 Annual Report/2018 Application and in-person HRSA review, the BFH will post the full report, state action plan and executive summary to the BFH website. A summary of the findings from the interim needs assessment survey will be produced as a stand-alone document and posted to the website as well for stakeholders to review and provide additional feedback.

#### **II.F.7. Technical Assistance**

The Bureau of Family Health does not need technical assistance at this time and will request technical assistance if the need arises during the year.

### III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$24,147,277	\$23,442,305	\$23,296,703	\$23,527,801
<b>Unobligated Balance</b>	\$0	\$0	\$0	\$0
<b>State Funds</b>	\$57,775,000	\$44,636,906	\$57,510,000	\$44,898,657
<b>Local Funds</b>	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$0	\$0	\$0	\$0
<b>Program Funds</b>	\$0	\$0	\$0	\$0
<b>SubTotal</b>	\$81,922,277	\$68,079,211	\$80,806,703	\$68,426,458
<b>Other Federal Funds</b>	\$214,421,400		\$226,007,691	\$3,964,517
<b>Total</b>	\$296,343,677	\$68,079,211	\$306,814,394	\$72,390,975

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$23,442,305	\$23,491,258	\$23,527,801	
<b>Unobligated Balance</b>	\$0	\$0	\$0	
<b>State Funds</b>	\$47,298,000	\$44,131,488	\$47,153,000	
<b>Local Funds</b>	\$0	\$0	\$0	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$0	\$0	\$0	
<b>SubTotal</b>	\$70,740,305	\$67,622,746	\$70,680,801	
<b>Other Federal Funds</b>	\$4,350,997	\$1,853,304	\$5,170,360	
<b>Total</b>	\$75,091,302	\$69,476,050	\$75,851,161	

	2018	
	Budgeted	Expended
<b>Federal Allocation</b>	\$23,491,258	
<b>Unobligated Balance</b>	\$0	
<b>State Funds</b>	\$46,514,800	
<b>Local Funds</b>	\$0	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$0	
<b>SubTotal</b>	\$70,006,058	
<b>Other Federal Funds</b>	\$5,902,230	
<b>Total</b>	\$75,908,288	

### **III.A. Expenditures**

#### **Expenditures:**

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. All direct service expenditures reported on form 3b reflect services that were not covered or reimbursed through another provider. Title V is the payer of last resort for all direct services.

Expenditures of Title V funds are in compliance with the legislative requirements that a minimum of 30 percent of funds are allocated for the support of preventive and primary services for children; a minimum of 30 percent of funds are allocated for services for children with special health care needs; and a maximum of 10 percent of funds are allocated as administrative costs.

The total state funds budgeted in 2015 included state funding for the Chronic Renal Disease Program (CRDP) and the Head Injury Program (HIP). Both of these state-funded programs are administered in the Bureau of Family Health (BFH) and have previously been included in the total state funds under the control of the Title V agency. Beginning in reporting year 2015, BFH began omitting the CRDP and HIP expenditures as the programs do not provide services for MCH populations. Therefore, there is a significant discrepancy between the amount of non-federal funds budgeted for 2015 and the expenditures for 2015. All non-federal funds reported as expenditures for 2015 provide services for MCH populations.

### **III.B. Budget**

#### **Budget:**

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 2018 that is level with the FFY 2016 award.

Pennsylvania's proposed budget for FFY 2018 is in full compliance with the federally mandated threshold requirements. Of Pennsylvania's proposed federal grant award for 2017, \$13,309,375 (56.6% of the total budget) is designated for the support of preventive and primary services for children, and \$7,865,646 (33.4% of total budget) is designated for the support of services for children with special health care needs. Administrative costs are budgeted at \$2,352,780, which is 10 percent of the grant award. Administrative Costs include all personnel and operating costs that are not directly or indirectly incurred for the provision of prevention, education, intervention, or treatment services.

Pennsylvania bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations. Pennsylvania's maintenance of effort amount from 1989 is \$20,065,575. Non-federal funds that contribute to the maintenance of effort amount include state appropriations for School Health Services, and Maternal and Child Health Services. Additional state funds that are under the control of the BFH and serve the MCH population include appropriations for special conditions such as Sickle Cell, Cystic Fibrosis, Hemophilia, Cooley's Anemia, Tourette Syndrome, Services for Children with Special Needs, Epilepsy, and Newborn Screening. Total state funds contributed to the MCH services in 2017 are \$47,153,000. The total state funds budgeted for 2017 do not include funding for the Chronic Renal Disease Program (CRDP) and the Head Injury Program (HIP), which were both included until 2015 in the total state funds under the control of the Title V agency. Beginning with budgeted projections for FFY 2016, BFH is omitting the CRDP and HIP expenditures as the programs do not provide services for the MCH population.

The BFH is the recipient of several other federally funded projects that impact the MCH population, including: Abstinence Education Grant and Personal Responsibility Education Program from the Administration for Children and Families; Pregnancy Risk Assessment Monitoring System and Sudden Unexpected Infant Death Case Registry from CDC; State Systems Development Initiative, Traumatic Brain Injury, and Universal Newborn Hearing Screening and Intervention from HRSA. The total funding from all other federal projects for 2016 is \$5,170,360.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [MOU.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [BFH Interim Needs Assessment 2017.pdf](#)

## VI. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

**State: Pennsylvania**

	<b>FY18 Application Budgeted</b>	
<b>1. FEDERAL ALLOCATION</b> (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 23,491,258	
A. Preventive and Primary Care for Children	\$ 12,682,429	(53.9%)
B. Children with Special Health Care Needs	\$ 8,459,704	(36%)
C. Title V Administrative Costs	\$ 2,349,125	(10%)
<b>2. UNOBLIGATED BALANCE</b> (Item 18b of SF-424)	\$ 0	
<b>3. STATE MCH FUNDS</b> (Item 18c of SF-424)	\$ 46,514,800	
<b>4. LOCAL MCH FUNDS</b> (Item 18d of SF-424)	\$ 0	
<b>5. OTHER FUNDS</b> (Item 18e of SF-424)	\$ 0	
<b>6. PROGRAM INCOME</b> (Item 18f of SF-424)	\$ 0	
<b>7. TOTAL STATE MATCH</b> (Lines 3 through 6)	\$ 46,514,800	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 20,065,575		
<b>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</b> (Same as item 18g of SF-424)	\$ 70,006,058	
<b>9. OTHER FEDERAL FUNDS</b> Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
<b>10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)</b>	\$ 5,902,230	
<b>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</b> (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 75,908,288	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 180,938
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 111,127
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	\$ 250,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 2,316,829
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,819,324
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 143,825
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control	\$ 966,667
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	\$ 113,520

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 23,442,305		\$ 23,491,258	
A. Preventive and Primary Care for Children	\$ 12,616,373	(53.8%)	\$ 13,050,291	(55.5%)
B. Children with Special Health Care Needs	\$ 8,481,702	(36.2%)	\$ 8,091,842	(34.4%)
C. Title V Administrative Costs	\$ 2,344,230	(10%)	\$ 2,349,125	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 47,298,000		\$ 44,131,488	
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)	\$ 47,298,000		\$ 44,131,488	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 20,065,575				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 70,740,305		\$ 67,622,746	
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)	\$ 4,350,997		\$ 1,853,304	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 75,091,302		\$ 69,476,050	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 1,552,455	\$ 481,532
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,979,932	\$ 835,634
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 134,828	\$ 965
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 13,949
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	\$ 241,630	\$ 205,888
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 163,633
US Environmental Protection Agency > Office of Pollution Prevention and Toxics (OPPT) > Lead Abatement	\$ 96,778	\$ 1,233
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control		\$ 30,331
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program		\$ 120,139

**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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	\$ 2,318,601	\$ 2,398,346
2. Infants < 1 year	\$ 1,717,670	\$ 1,947,004
3. Children 1-22 years	\$ 9,546,074	\$ 8,330,171
4. CSHCN	\$ 7,559,788	\$ 8,360,244
5. All Others	\$ 0	\$ 106,368
Federal Total of Individuals Served	\$ 21,142,133	\$ 21,142,133

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	\$ 0	\$ 0
2. Infants < 1 year	\$ 7,714,240	\$ 4,826,985
3. Children 1-22 years	\$ 36,620,000	\$ 34,178,356
4. CSHCN	\$ 1,761,346	\$ 2,870,037
5. All Others	\$ 419,214	\$ 2,256,110
Non Federal Total of Individuals Served	\$ 46,514,800	\$ 44,131,488
Federal State MCH Block Grant Partnership Total	\$ 67,656,933	\$ 65,273,621

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	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.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	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.

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Pennsylvania**

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 4,784,260	\$ 4,389,083
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,558,138	\$ 1,495,097
B. Preventive and Primary Care Services for Children	\$ 2,493,217	\$ 2,190,642
C. Services for CSHCN	\$ 732,905	\$ 703,344
2. Enabling Services	\$ 5,431,300	\$ 4,559,064
3. Public Health Services and Systems	\$ 13,275,698	\$ 14,543,111
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		\$ 586,509
Physician/Office Services		\$ 3,684,041
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 118,533
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 4,389,083
<b>Federal Total</b>	<b>\$ 23,491,258</b>	<b>\$ 23,491,258</b>

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 7,971,800	\$ 4,976,441
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 7,714,240	\$ 4,826,985
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 257,560	\$ 149,456
2. Enabling Services	\$ 0	\$ 684,285
3. Public Health Services and Systems	\$ 38,543,000	\$ 38,470,762
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		\$ 995,288
Physician/Office Services		\$ 845,833
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 3,135,320
Direct Services Line 4 Expended Total		\$ 4,976,441
<b>Non-Federal Total</b>	\$ 46,514,800	\$ 44,131,488

**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: 140,146**

**1. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	138,622 (98.9%)	298	107	107 (100.0%)

Program Name(s)				
Maple syrup urine disease	Classic phenylketonuria	Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)
Classic galactosemia				

**2. Other Newborn Screening Tests**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic Acidemia	137,323 (98.0%)	51	3	3 (100.0%)
Methylmalonic Acidemia (methylmalonyl-CoA mutase)	137,323 (98.0%)	51	0	0 (0%)
Methylmalonic Acidemia (Cobalamin disorders)	137,323 (98.0%)	51	0	0 (0%)
Isovaleric Acidemia	137,323 (98.0%)	51	0	0 (0%)
3-Methylcrotonyl-CoA Carboxylase Deficiency	137,323 (98.0%)	51	5	5 (100.0%)
3-Hydroxy-3-Methylglutaric Aciduria	137,323 (98.0%)	51	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Holocarboxylase Synthase Deficiency	137,323 (98.0%)	51	0	0 (0%)
β-Ketothiolase Deficiency	137,323 (98.0%)	51	0	0 (0%)
Glutaric Acidemia Type I	137,323 (98.0%)	51	4	4 (100.0%)
Carnitine Uptake Defect/Carnitine Transport Defect	137,323 (98.0%)	51	0	0 (0%)
Medium-chain Acyl-CoA Dehydrogenase Deficiency	137,323 (98.0%)	51	16	16 (100.0%)
Very Long-chain Acyl-CoA Dehydrogenase Deficiency	137,323 (98.0%)	51	1	1 (100.0%)
Long-chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency	137,323 (98.0%)	51	0	0 (0%)
Trifunctional Protein Deficiency	137,323 (98.0%)	51	1	1 (100.0%)
Argininosuccinic Aciduria	137,323 (98.0%)	30	0	0 (0%)
Citrullinemia, Type I	137,323 (98.0%)	30	0	0 (0%)
Homocystinuria	137,323 (98.0%)	30	0	0 (0%)
Tyrosinemia, Type I	137,323 (98.0%)	30	0	0 (0%)
S, βeta-Thalassemia	138,621 (98.9%)	88	8	8 (100.0%)
S,C Disease	138,621 (98.9%)	88	22	22 (100.0%)
Biotinidase Deficiency	137,312 (98.0%)	21	17	17 (100.0%)
Critical Congenital Heart Disease	118,626 (84.6%)	170	25	25 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Cystic Fibrosis	137,210 (97.9%)	204	33	33 (100.0%)
Hearing loss	133,744 (95.4%)	935	210	122 (58.1%)
Severe combined immunodeficiencies	119,434 (85.2%)	14	0	0 (0%)
Hurler Syndrome (MPS I)	1,854 (1.3%)	1	0	0 (0%)
Globoid Cell Leukodystrophy (Krabbe)	1,859 (1.3%)	0	0	0 (0%)
Fabry	1,855 (1.3%)	0	0	0 (0%)
Niemann-Pick	1,854 (1.3%)	0	0	0 (0%)
Gaucher	1,854 (1.3%)	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:**

"Data Notes: All AC, AA, and HGB conditions are reported by the lab as a group, so there is not a specific pre-pos number per disorder for AC and AA conditions.

SCID number screened is less as it is up to the submitter if they screen for this condition or not.

GAA - was added to the mandatory screening panel on 2/5/16

The 5 LSDs in section 2 were added to the supplemental panel on 2/5/16, one hospital began screening for these conditions on 3/8/16 and there were a few other requests for Krabbe and Fabry.

CH is a lower number as it is not run on samples less than 24 hours."

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Total Births by Occurrence</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total Births by Occurrence Notes</b>
	<b>Field Note:</b>	This is for 2015. The most recent year available.
2.	<b>Field Name:</b>	<b>Core RUSP Conditions - Receiving At Lease One Screen</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Glycogen Storage Disease Type II (Pompe) is also included in this count.
3.	<b>Field Name:</b>	<b>Hearing loss - Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	This is the number of referrals with confirmed enrollment in early intervention services.

**Data Alerts: None**

**Form 5a  
Unduplicated Count of Individuals Served under Title V**

**State: Pennsylvania**

**Reporting Year 2016**

		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	3,599	54.5	1.6	6.7	19.8	17.4
2. Infants < 1 Year of Age	138,343	32.8	0.0	62.4	4.8	0.0
3. Children 1 to 22 Years of Age	58,068	1.0	0.0	0.1	1.1	97.8
4. Children with Special Health Care Needs	33,613	18.9	0.1	10.9	0.7	69.4
5. Others	27,394	4.5	0.0	5.4	0.2	89.9
Total	261,017					

**Form Notes for Form 5a:**

Form Note: The Bureau does not have the capability to unduplicate numbers between the various divisions or their programs. Three divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the division's "Total" for each of the categories and some counts are estimates due data collection limits. 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. The Bureau has only chosen to use the state insurance coverage estimates for the infant population. The Bureau chose not to use the insurance estimates for the other populations. 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 state estimates.

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This domain includes: Lead and Healthy Homes Program (nothing to report as SFY 15/16 was used last year and was the end of the grant period), Safe and Healthy Homes Program (CY2016, 10), CPP (CY16, 310), Prenatal Care (CY16, 231), Early Pregnancy Testing (CY16, 64), Smoking Cessation (CY16, 230), Dental (CY16, 225), Breastfeeding (CY16, 630), CMHV (CY16, 1389), BCHS (CY16, 492), Healthy baby (CY16, 18)
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This is the number of infants receiving at least one newborn screen. This includes 131 infants who are being served by the metabolic treatment centers, 31 infants served by the CF treatment centers, 64 infants served by the HBG treatment centers, and 19 infants enrolled in the PKU formula program. The state insurance percentages were also used for this domain. Infants are served by the following programs: Safe and Healthy Homes Program (CY2016, 19), CMHV (CY16, 590)Shaken Baby Syndrome (CY16, 127,843)
3.	<b>Field Name:</b>	<b>Children 1 to 22 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This domain includes: Safe and Healthy Homes Program (CY2016, 157), LGBTQ (CY16, 1497), Reproductive Health grants (SFY15-16, 7819), Teen Special Intiatives/HRCs (CY16, 4184), Dental (CY16, 60), CMHH (CY16, 13), Health Needs Assessment (CY16, 719), Youth Care Coordinator (CY16, 136), Nutrition Education and Counseling (CY16, 179), CMHV (CY16, 216), BCHS (CY16, 37866), Brain Steps (CY16, 623), Epilepsy (CY16, 3671), Juvenile Justice (SFY15/16, 260), Tourette's (CY16, 668)
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This domain includes: Safe and Healthy Homes Program (CY 2016, 74), PDPH HIP (CY16, 172), Cleft Palate Clinic (CY16, 14), Case Management (CY16, 40), CMHV (CY16, 49), BCHS (CY16, 4809), PKU formula program (194), CF pharmacy program (1), CMT (CY16, 37), CF (CY16, 3171), Cooley's (CY16, 193), Child Rehab, (CY16, 3450) Hemo (CY16, 1675), Home Vent (CY16, 484), Respite (CY16, 1435), Spina (CY16, 1060), SKN (CY16, 9093), Sickle (CY16, 7103), Tourette's (CY16, 559)
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This domain includes:LGBTQ grants (CY16, 1493), 19 served by the PKU formula program, 8 in the CF pharmacy program, and 4 in the spina bifida pharmacy program, CMT (CY16, 128), Cooley's (CY16, 45), CF (CY16, 557) Healthy Baby (CY16, 129), Hemo (CY16, 1781), Home Vent (CY16, 3), Sickle (CY16, 3874), SKN (CY16, 18117), Spina (CY16, 411) Tourette's (CY16, 825)



**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**

**State: Pennsylvania**

**Reporting Year 2016**

Types Of Individuals Served	Total Served
1. Pregnant Women	120,714
2. Infants < 1 Year of Age	138,343
3. Children 1 to 22 Years of Age	1,721,632
4. Children with Special Health Care Needs	446,160
5. Others	43,743
<b>Total</b>	<b>2,470,592</b>

**Form Notes for Form 5b:**

Form Note: The Bureau does not have the capability to unduplicate numbers between the various divisions or their programs. Three divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the division's "Total" for each of the categories and some counts are estimates due data collection limits. 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. The infant domain and the children domain are unduplicated counts on this form.

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This domain includes: Lead and Healthy Homes Program (nothing to report as SFY 15/16 was used last year and was the end of the grant period), Safe and Healthy Homes Program (CY2016, 10), CPP (CY16, 310), Prenatal Care (CY16, 231), Early Pregnancy Testing (CY16, 64), Smoking Cessation (CY16, 230), Dental (CY16, 225), Breastfeeding (CY16, 630), CMHV (CY16, 1389), BCHS (CY16, 492), healthy baby (CY16, 18), Keystone 10 breastfeeding (CY16, 117,115)
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This is an unduplicated count. This is the number of infants receiving at least one newborn screen. This includes 131 infants who are being served by the metabolic treatment centers, 31 infants served by the CF treatment centers, 64 infants served by the HBG treatment centers, and 19 infants enrolled in the PKU formula program. Infants are served by following programs: Safe and Healthy Homes Program (CY2016, 19), CMHV (CY16, 590)Shaken Baby Syndrome (CY16, 127,843)
3.	<b>Field Name:</b>	<b>Children 1 to 22 Year of Age</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	This is an unduplicated count. This is the school health grow screening total (1,721,632). The total of all other programming for this domain was 963,549 and includes the following programs: Safe and Healthy Homes Program (CY2016, 157), LGBTQ (CY16, 2203), Abstinence (CY16, 1806), PREP (CY16, 1557), Reproductive Health grants (SFY15-16, 7819), Teen Special Initiatives/HRC (CY16, 4184), Dental (CY16, 60), CMHH (CY16, 13), Health Needs Assessment (CY16, 719), Youth Care Coordinator (CY16, 136), Nutrition Education and Counseling (CY16, 179), CMHV (CY16, 216), Youth Tobacco education (CY16, 1160), Youth Bullying education (CY16, 531), BCHS (CY16, 37866), Epilepsy (CY16, 3671), Medical Home, includes children with and without special health care needs (CY16, 899,721), Brain Steps (CY16, 623) Juvenile Justice (SFY 15/16, 260) Tourette's (CY16, 668)
4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2016</b>

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**Field Note:**

This domain includes: Safe and Healthy Homes Program (CY 2016, 74), PDPH HIP (CY16, 172), Cleft Palate Clinic (CY16, 14), Case Management (CY16, 40), CMHV (CY16, 49), School Health (12-13, 412234), BCHS (CY16, 4809), 313 Served by the federal hearing grant through the GBYS program, 194 in the PKU formula program, and 1 in the CF pharmacy program, CMT (CY16, 37) CF (CY16, 3171) Cooley's (CY16, 193), Child Rehab (CY16, 3450), Hemo (CY16, 1675), Home Vent (CY16, 484), Respite (CY16, 1435), Spina (CY16, 1060), SKN (CY16, 9093), Sickle (CY16, 7103), Tourette's (CY16, 559)

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5. **Field Name:** **Others**

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**Fiscal Year:** **2016**

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**Field Note:**

This domain includes: LGBTQ grants (CY16, 1493), PREP (CY16, 81), PREP training (CY16, 372), LGBTQ grants training (CY16, 3393), Teen Special Initiatives/HRCs training (CY16, 57), 19 served by the PKU formula program, 8 in the CF pharmacy program, and 4 in the spina bifida pharmacy program, Brain Steps presentations (CY16, 4226), Epilepsy presentations (CY16, 4271), CMT (CY16, 128), Cooley's (CY16, 45), CF (CY16, 557), EPIC BEST(BF presentations) (CY16, 299), Healthy Baby (CY16, 129), Hemo (CY16, 1781), Home Vent (CY16, 3), Sickle (CY16, 3874), SKN (CY16, 18117), Spina (CY16, 411), Juvenile Justice presentations (SFY15-16, 933), PATS presentations (SFY 15-16, 910), Shaken Baby presentations (CY16, 1807), Tourette's (CY16, 825)

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Pennsylvania**

**Reporting Year 2016**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	140,146	98,670	19,524	133	5,943	137	4,640	11,099
Title V Served	2,541	1,094	639	6	105	3	67	627
Eligible for Title XIX	57,017	30,186	15,072	115	1,849	37	0	9,758
2. Total Infants in State	143,731	110,765	19,456	0	6,213	0	6,604	693
Title V Served	693	352	202	3	67	0	30	39
Eligible for Title XIX	76,616	40,433	17,723	115	2,049	17	0	16,279

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	123,592	14,951	1,603	140,146
Title V Served	1,412	1,083	46	2,541
Eligible for Title XIX	46,744	10,242	31	57,017
2. Total Infants in State	129,285	14,446	0	143,731
Title V Served	489	201	3	693
Eligible for Title XIX	63,589	12,967	60	76,616

**Form Notes for Form 6:**

The Department of Human Services and Title V are reporting 2016 data. The Bureau of Informatics and Information Technology is reporting 2015 data.

**Field Level Notes for Form 6:**

None

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

**State: Pennsylvania**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2018 Application Year</b>	<b>2016 Reporting Year</b>
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"	Kelli Sebastian	Kelli Sebastian
4. Contact Person's Telephone Number	(717) 772-2763	(717) 772-2763
5. Number of Calls Received on the State MCH "Hotline"		147

<b>B. Other Appropriate Methods</b>	<b>2018 Application Year</b>	<b>2016 Reporting Year</b>
1. Other Toll-Free "Hotline" Names	Special Kids Network	Special Kids Network
2. Number of Calls on Other Toll-Free "Hotlines"		1,371
3. State Title V Program Website Address	<a href="http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Bureaus/Pages/Family-Health.aspx#.WRHX6qPD_X5">http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Bureaus/Pages/Family-Health.aspx#.WRHX6qPD_X5</a>	<a href="http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Bureaus/Pages/Family-Health.aspx#.WRHX6qPD_X5">http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Bureaus/Pages/Family-Health.aspx#.WRHX6qPD_X5</a>
4. Number of Hits to the State Title V Program Website		1,373
5. State Title V Social Media Websites	<a href="https://twitter.com/PAHealthDept">https://twitter.com/PAHealthDept</a> ; <a href="https://www.facebook.com/pennsylvaniadepartmentofhealth">https://www.facebook.com/pennsylvaniadepartmentofhealth</a>	<a href="https://twitter.com/PAHealthDept">https://twitter.com/PAHealthDept</a> ; <a href="https://www.facebook.com/pennsylvaniadepartmentofhealth">https://www.facebook.com/pennsylvaniadepartmentofhealth</a>
6. Number of Hits to the State Title V Program Social Media Websites		47,707

**Form Notes for Form 7:**

Line B4: The Bureau is now able to collect the number of pageviews to the site. B6: This entry is the number of profile visits for the DOH Twitter account for Jan-Dec 2016. The Bureau does not have an individualized social media profile. No data from Facebook was available for 2016.

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Pennsylvania**

**1. Title V Maternal and Child Health (MCH) Director**

Name	Carolyn Cass
Title	Director, Bureau of Family Health
Address 1	625 Forster Street, Health and Welfare Building
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17110
Telephone	(717) 346-3000
Extension	
Email	ccass@pa.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Sara Thuma
Title	Program Administrator
Address 1	625 Forster Street, Health and Welfare Building
Address 2	7th Floor East
City/State/Zip	Harrisburg / PA / 17110
Telephone	(717) 346-3000
Extension	
Email	sthuma@pa.gov

### 3. State Family or 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 2018**

No.	Priority Need
1.	MCH populations reside in a safe and healthy living environment.
2.	Appropriate health and health related services, screenings and information are available to the MCH populations.
3.	MCH populations are able to obtain, process and understand basic health information needed to make health decisions.
4.	Protective factors are established for adolescents and young adults prior to and during critical life stages.
5.	Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.
6.	Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.
7.	Safe sleep practices are consistently implemented for all infants.
8.	Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.
9.	Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	MCH populations reside in a safe and healthy living environment.	Replaced	
2.	Appropriate health and health related services, screenings and information are available to the MCH populations.	Replaced	
3.	MCH populations are able to obtain, process and understand basic health information needed to make health decisions.	New	
4.	Protective factors are established for adolescents and young adults prior to and during critical life stages.	Replaced	
5.	Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.	New	
6.	Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.	Replaced	
7.	Safe sleep practices are consistently implemented for all infants.	New	
8.	Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.	New	This priority will supplement the capacity to achieve all other priorities using data driven decisions to support evidence based measures.
9.	Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	Replaced	

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10a  
National Outcome Measures (NOMs)**

**State: Pennsylvania**

**Form Notes for Form 10a 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
2015	75.3 %	0.1 %	101,914	135,324
2014	75.6 %	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%, 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
2014	144.6	3.3 %	1,926	133,203
2013	128.9	3.2 %	1,696	131,576
2012	127.8	3.1 %	1,703	133,247
2011	118.6	3.0 %	1,600	134,872
2010	108.2	2.8 %	1,463	135,194
2009	110.5	2.8 %	1,525	138,044
2008	101.8	2.7 %	1,405	137,973

**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**

**FAD Not Available for this measure.**

State Provided Data	
	2016
<b>Annual Indicator</b>	13.4
<b>Numerator</b>	19
<b>Denominator</b>	142,113
<b>Data Source</b>	Pennsylvania Report of Maternal Deaths, Pennsylvania Live Births
<b>Data Source Year</b>	2014

**NOM 3 - Notes:**

None

**Data Alerts: None**

**NOM 4.1 - 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
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	8.4 %	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%, or >10% missing data and should be interpreted with caution

**NOM 4.1 - Notes:**

None

**Data Alerts: None**

**NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.4 %	0.0 %	1,997	140,109
2014	1.4 %	0.0 %	2,006	141,638
2013	1.4 %	0.0 %	2,006	140,081
2012	1.5 %	0.0 %	2,137	141,805
2011	1.5 %	0.0 %	2,151	142,786
2010	1.6 %	0.0 %	2,309	143,006
2009	1.6 %	0.0 %	2,347	146,040

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.2 - Notes:**

None

**Data Alerts: None**

**NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.8 %	0.1 %	9,456	140,109
2014	6.9 %	0.1 %	9,707	141,638
2013	6.6 %	0.1 %	9,213	140,081
2012	6.6 %	0.1 %	9,355	141,805
2011	6.7 %	0.1 %	9,511	142,786
2010	6.7 %	0.1 %	9,632	143,006
2009	6.7 %	0.1 %	9,840	146,040

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 4.3 - Notes:**

None

**Data Alerts: None**

**NOM 5.1 - Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.4 %	0.1 %	13,224	140,800
2014	9.4 %	0.1 %	13,291	142,051
2013	9.4 %	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%, or >10% missing data and should be interpreted with caution

**NOM 5.1 - Notes:**

None

**Data Alerts: None**

**NOM 5.2 - Percent of early preterm births (<34 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.8 %	0.0 %	3,984	140,800
2014	2.8 %	0.0 %	4,023	142,051
2013	2.9 %	0.1 %	4,095	139,775
2012	3.0 %	0.1 %	4,245	141,341
2011	3.0 %	0.1 %	4,237	142,053
2010	3.0 %	0.1 %	4,311	142,174
2009	3.0 %	0.1 %	4,408	144,968

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.2 - Notes:**

None

**Data Alerts: None**

**NOM 5.3 - Percent of late preterm births (34-36 weeks)**

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.6 %	0.1 %	9,240	140,800
2014	6.5 %	0.1 %	9,268	142,051
2013	6.4 %	0.1 %	8,971	139,775
2012	6.5 %	0.1 %	9,162	141,341
2011	6.6 %	0.1 %	9,338	142,053
2010	6.9 %	0.1 %	9,749	142,174
2009	7.0 %	0.1 %	10,184	144,968

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

**NOM 5.3 - 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
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	22.3 %	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%, 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
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

**Legends:**  
■ Indicator results were based on a shorter time period than required for reporting

**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
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	7.3	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
2014	5.9	0.2 %	838	142,268
2013	6.7	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
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
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
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 - Sleep-related 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
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 - The percent of infants born with fetal alcohol exposure 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
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 has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations**

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	20.0	0.4 %	2,685	134,203
2013	18.6	0.4 %	2,455	132,296
2012	16.5	0.4 %	2,199	133,249
2011	13.6	0.3 %	1,827	134,872
2010	11.2	0.3 %	1,519	135,194
2009	9.6	0.3 %	1,324	138,044
2008	8.2	0.2 %	1,132	137,974

**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)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**FAD Not Available for this measure.**

**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 12 months**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.7 %	1.6 %	517,530	2,624,270

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% 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
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
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
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
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**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	22.3 %	1.5 %	614,207	2,752,138
2007	20.9 %	1.6 %	583,332	2,794,078
2003	18.9 %	1.0 %	533,166	2,815,445

**Legends:**

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system**

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	21.4 %	2.0 %	93,556	436,844

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children 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
2011_2012	2.3 %	0.5 %	53,554	2,324,035
2007	1.8 %	0.7 %	42,832	2,347,841

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children 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
2011_2012	9.2 %	1.2 %	213,543	2,315,341
2007	7.4 %	1.2 %	174,425	2,346,984

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children 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
2011_2012	69.1 % ⚡	5.5 % ⚡	193,172 ⚡	279,708 ⚡
2007	81.3 %	4.7 %	217,274	267,200
2003	76.4 %	3.7 %	148,118	193,991

**Legends:**

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children 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
2011_2012	87.3 %	1.3 %	2,400,525	2,749,015
2007	88.7 %	1.2 %	2,478,407	2,794,078
2003	87.4 %	0.9 %	2,460,765	2,815,445

**Legends:**

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.5 %	2.3 %	321,906	1,215,876
2007	29.7 %	2.4 %	376,361	1,268,280
2003	29.3 %	1.7 %	390,055	1,332,616

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

**Data Source: WIC**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	27.8 %	0.2 %	23,640	84,996
2012	28.3 %	0.2 %	26,366	93,009
2010	27.9 %	0.1 %	26,995	96,762
2008	25.3 %	0.2 %	21,631	85,595

**Legends:**

- Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	29.8 %	1.2 %	143,728	482,751
2009	27.5 %	1.1 %	154,056	559,897

**Legends:**

 Indicator has an unweighted denominator <100 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

**NOM 21 - Percent of children without health insurance**

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	72.8 %	3.0 %	149,132	204,792
2014	78.6 %	2.5 %	162,535	206,860
2013	75.5 %	2.7 %	157,582	208,695
2012	68.3 %	3.0 %	143,464	210,027
2011	69.7 %	2.5 %	148,434	212,970
2010	61.3 %	2.7 %	132,844	216,692
2009	38.8 %	3.1 %	84,163	217,080

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

**NOM 22.2 - Percent of children 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
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 95% confidence interval half-width/estimate > 0.6
- ⚡ 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 (Female)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	62.2 %	3.9 %	236,916	380,957
2014	66.9 %	3.8 %	256,713	384,018
2013	59.5 %	4.1 %	229,756	386,058
2012	57.4 %	4.1 %	223,164	388,522
2011	51.9 %	4.1 %	204,680	394,084
2010	52.3 %	3.9 %	211,177	404,115
2009	53.2 %	4.8 %	215,713	405,598

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	55.9 %	3.6 %	223,967	400,572
2014	47.4 %	4.0 %	191,294	403,552
2013	44.1 %	4.0 %	179,131	406,034
2012	21.9 %	3.1 %	89,702	409,792
2011	8.5 %	1.9 %	35,326	415,205

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Pennsylvania**

**NPM 1 - Percent of women with a past year preventive medical visit**

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	68
Annual Indicator	66.5
Numerator	1,427,642
Denominator	2,148,194
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	68.7	69.4	70.1	71.4	72.1	73.1

**Field Level Notes for Form 10a NPMs:**

None

**NPM 4 - A) Percent of infants who are ever breastfed**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	74
Annual Indicator	73.3
Numerator	99,273
Denominator	135,367
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	76.0	78.0	80.0	82.0	84.0	86.0

**Field Level Notes for Form 10a NPMs:**

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	17
Annual Indicator	20.5
Numerator	27,408
Denominator	133,488
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	18.0	20.0	23.0	26.0	27.0	30.0

**Field Level Notes for Form 10a NPMs:**

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	79
Annual Indicator	76.7
Numerator	101,695
Denominator	132,585
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	79.8	80.6	82.1	83.0	83.9	84.8

**Field Level Notes for Form 10a NPMs:**

None

**NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Child Health)**

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	188.7
Annual Indicator	175.4
Numerator	2,553
Denominator	1,455,450
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	186.8	184.9	183.1	179.3	175.5	171.7

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Not changing the projection as the 175.4 doesn't seem to conform with the general trend.

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	14.5
Annual Indicator	14.6
Numerator	139,426
Denominator	958,378
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	14.5
Annual Indicator	24.7
Numerator	122,928
Denominator	497,526
Data Source	YRBSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	14.3	14.1	13.9	13.7	13.5	13.3

**Field Level Notes for Form 10a NPMs:**

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	86.9
Annual Indicator	86.9
Numerator	836,935
Denominator	962,711
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	87.8	88.7	89.6	91.2	92.8	93.4

**Field Level Notes for Form 10a NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs having a medical home**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	58.9
Annual Indicator	49.2
Numerator	289,813
Denominator	589,111
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	61.0	63.0	65.0	67.0	69.0	71.0

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Edited numbers based upon the National Survey of Children's Health (combined statistic).

**NPM 14 - A) Percent of women who smoke during pregnancy**

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	13.2
Annual Indicator	12.5
Numerator	17,295
Denominator	138,426
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12.2	9.8	8.8	7.8	6.8	6.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 14 - B) Percent of children who live in households where someone smokes**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	28.3
Annual Indicator	29.3
Numerator	792,368
Denominator	2,702,962
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	27.3	26.3	25.3	24.3	23.3	22.3

**Field Level Notes for Form 10a NPMs:**

None

**Form 10a  
State Performance Measures (SPMs)**

State: Pennsylvania

**SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.**

<b>Measure Status:</b>	<b>Active</b>
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<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	20.0	38.0	56.0	75.0	78.0

**Field Level Notes for Form 10a SPMs:**

None

**SPM 2 - Percent of Title V programming with interpersonal violence reduction components.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	List of BFH Title V programs
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	14.0	14.0	14.0	18.0	21.0	21.0

**Field Level Notes for Form 10a SPMs:**

None

**SPM 3 - Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	48
Numerator	
Denominator	
Data Source	Newborn Screening Data System
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	49.0	54.0	59.0	64.0	69.0	74.0

**Field Level Notes for Form 10a SPMs:**

None

**SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	29
Numerator	
Denominator	
Data Source	BFH internal data collection
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	32.0	42.0	55.0	66.0	76.0	78.0

**Field Level Notes for Form 10a SPMs:**

None

**SPM 5 - Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	N/A
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	25.0	50.0	55.0	60.0	65.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Revised this objective since are not requiring grantees to use the development assets framework. Will revise detail sheet.

**Form 10a**  
**Evidence-Based or –Informed Strategy Measures (ESMs)**  
**State: Pennsylvania**

**ESM 1.1 - Number of families served through Centering Pregnancy Programs.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	310
Numerator	
Denominator	
Data Source	Quarterly reports from the Centering Pregnancy Pro
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	300.0	305.0	310.0	315.0	320.0	320.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Number of women in LGH, AEHN and PDPH CPP

**ESM 1.2 - Percent of adolescents and women engaged in family planning after delivery.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	87
Numerator	
Denominator	
Data Source	Quarterly reports from the County Municipal Health
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	80.0	82.0	83.0	84.0	85.0	87.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Partial data

**ESM 1.3 - Percent of adolescents and women who talked with a health care professional about birth spacing and birth control methods.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	94
Numerator	
Denominator	
Data Source	Quarterly reports from the IMPLICIT Programs
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	80.0	82.0	83.0	84.0	85.0	87.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Partial data

**ESM 1.4 - Percent of individuals trained on motivational interviewing.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	50.0	60.0	62.0	64.0	66.0	70.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Due to a delay in the implementation of the Grant Agreement, MI training did not begin until 2017. Additionally, changes are needed to the goals originally laid out. Most of the vendor trainings will occur in 2017 and 2018 and the numbers have been edited to reflect that.

**ESM 1.5 - Number of women served through evidence based or informed home visiting programs.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	1,585
Numerator	
Denominator	
Data Source	Quarterly reports from the County/Municipal Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,500.0	1,510.0	1,525.0	1,540.0	1,600.0	1,600.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
number of women in prenatal and postpartum CMHD HV programs

**ESM 4.1 - Percent of individual facilities increasing the number of Keystone 10 steps completed each fiscal year.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	46
Numerator	
Denominator	
Data Source	Vendor reports and enrollment numbers
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	25.0	30.0	35.0	40.0	50.0	60.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 4.2 - Percent of counties with breastfeeding initiation rates below 73% implementing evidence based strategies**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Vendor reports and PA Health Stats
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	20.0	25.0	30.0	35.0	40.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
 planning activities began in mid summer 2016 so no counties implemented evidence based strategies during that year

**ESM 4.3 - Number of collaborations developed between the breastfeeding program and other programming for cross-messaging.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	BFH internal collection
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	2.0	3.0	3.0	4.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 4.4 - Number of media opportunities implemented promoting breastfeeding**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	BFH internal collection
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	2.0	3.0	3.0	4.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 5.1 - Number of hospitals recruited to implement the model safe sleep program.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	2.0	3.0	3.0	0.0	0.0	0.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2016 . Objective projections have only been made for the three year grant period.

**ESM 5.2 - Percentage of infants born whose parents were educated on safe sleep practices through the model program.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	8.0	9.0	18.0	0.0	0.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Grant period is 7/1/16 to 6/30/19. Model program was under development 7/1/16 to 6/30/17 and implementation begins 7/1/17. Objective projections have only been made for the three year grant period.

**ESM 5.3 - Percentage of hospitals with maternity units implementing the model program.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	2.0	4.0	8.0	0.0	0.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Grant period is 7/1/16 to 6/30/19. Model program was under development 7/1/16 to 6/30/17 and implementation begins 7/1/17. Objective projections have only been made for the three year grant period.

**ESM 5.4 - Number of social marketing messages disseminated.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	160.0	337.0	389.0	0.0	0.0	0.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Grant period is 7/1/16 to 6/30/19. Implementation begins 7/1/17. Objective projections have only been made for the three year grant period.

**ESM 7.1 - Number of comprehensive home assessments completed.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	97
Numerator	
Denominator	
Data Source	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	875.0	900.0	920.0	920.0	920.0	920.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.

**ESM 7.2 - Number of health and safety hazards identified through comprehensive home assessments.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	936
Numerator	
Denominator	
Data Source	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	7,000.0	7,200.0	7,360.0	7,360.0	7,360.0	7,360.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.

**ESM 7.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	468
Numerator	
Denominator	
Data Source	Quarterly reports from Pennsylvania Safe and Heat
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	4,375.0	4,500.0	4,600.0	4,600.0	4,600.0	4,600.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.

**ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	76
Numerator	
Denominator	
Data Source	quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	80.0	90.0	100.0	100.0	100.0	100.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
Increased numbers to reflect current status.

**ESM 9.2 - The percent of adolescent serving vendors with a comprehensive anti-bullying/harassment policy.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	25.0	30.0	40.0	55.0	75.0	85.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.3 - The number of sites participating in bullying prevention efforts.**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
------------------------	----------------------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	None
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	3.0	4.0	5.0	5.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

There was no activity on this measure in 2016. The bullying program is going in a different direction and a new ESM has been created.

**ESM 9.4 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.**

<b>Measure Status:</b>	<b>Inactive - Replaced</b>
------------------------	----------------------------

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	740.0	750.0	770.0	790.0	840.0	

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.5 - Number of evidence-based mentoring, counseling or adult supervision programs implemented in high risk areas of PA.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	7.0	9.0	11.0	13.0	15.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.6 - The number of organizations certified as a safe space provider.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	40.0	60.0	80.0	100.0	120.0	140.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
Updated numbers to match work statements.

**ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	135
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	150.0	175.0	200.0	230.0	270.0	410.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	15.0	30.0	30.0	45.0	45.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	250.0	425.0	475.0	525.0	575.0	625.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Revised numbers to better match expectations of mentoring program (to begin January 2018).

**ESM 10.1 - The number of counties with a Health Resource Center (HRC) available to youth ages 12-17.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	10.0	10.0	11.0	11.0	11.0	11.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
Updated numbers to reflect current program status/goals.

**ESM 10.2 - Number of youth receiving services at a Health Resource Center (HRC).**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	3,288
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	3,500.0	4,000.0	4,500.0	4,500.0	4,500.0	4,500.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

SFY 2016 number does not include the last quarter (report due end of July). Previous numbers were extremely low - updated to reflect current numbers and work statements.

**ESM 10.3 - In schools with a Health Resource Center (HRC), the percent of youth within that school utilizing HRC services.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	15.0	18.0	21.0	25.0	30.0	33.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
 SFY 2016 number does not include the last quarter (report due end of July).

**ESM 10.4 - Number of youth receiving services at a drop-in site funded by the Bureau of Family Health (BFH).**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	3,537
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	3,800.0	4,000.0	4,200.0	4,500.0	4,900.0	5,200.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 10.5 - Number of youth receiving health education and counseling services from a reproductive health provider.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	7,557
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	11,817.0	15,275.0	15,375.0	15,475.0	15,575.0	16,375.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Previous numbers were way too high, had issues with site counts. Technical assistance provided and reporting issues fixed. Numbers were updated.

**ESM 11.1 - Number of families who received services through the evidence based or evidence informed strategies of the SKN.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	1,597
Numerator	
Denominator	
Data Source	Monthly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,500.0	1,525.0	1,550.0	1,575.0	1,600.0	1,625.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	4
Numerator	
Denominator	
Data Source	BFH internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	4.0	4.0	4.0	5.0	5.0	3.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	507
Numerator	
Denominator	
Data Source	Quarterly reports and internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	500.0	520.0	540.0	560.0	580.0	600.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Projections were adjusted. Once final numbers were collected for 2016, it was determined that projections were too low when initially completed. This is a duplicated count across activities.

**ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	196
Numerator	
Denominator	
Data Source	Quarterly reports and internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	200.0	225.0	240.0	260.0	280.0	300.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	BFH internal reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1.0	2.0	2.0	3.0	3.0	4.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 14.1 - Number of Title V funded women who are screened for behavioral health.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	1,000.0	1,100.0	1,200.0	1,300.0	1,400.0	1,500.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year

**ESM 14.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV).**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	75.0	80.0	85.0	90.0	90.0	90.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year. Training on the required screening tool did not begin until 2017.

**ESM 14.3 - Percent of women who report smoking after confirmation of pregnancy.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	30.0	28.0	26.0	25.0	24.0	23.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Partial data

**ESM 14.4 - Percent of women who report smoking after pregnancy.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	13
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2011
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	11.0	10.8	10.6	10.4	10.0	9.8

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**  
PRAMS 2011, % answering 3 of cigs same/more from pregnancy to postpartum

**ESM 14.5 - Percent of Grantees who implement evidence based or evidence informed tobacco free programs.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	20.0	40.0	60.0	80.0	80.0	80.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Two of 10 CMHD have smoking cessation programs up an running in 2016

**ESM 14.6 - Percent of individuals trained on motivational interviewing.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Quarterly reports
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	50.0	60.0	62.0	64.0	66.0	70.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Due to a delay in the implementation of the Grant Agreement, MI training did not begin until 2017. Additionally, changes are needed to the goals originally laid out. Most of the vendor trainings will occur in 2017 and 2018 and the numbers have been edited to reflect that.

**Form 10b**  
**State Performance Measure (SPM) Detail Sheets**

**State: Pennsylvania**

**SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.**

**Population Domain(s) – Cross-Cutting/Life Course**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To ensure that each grantee establishes and maintains a policy and process to review information provided to patients and ensure it is clear and can be understood.								
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>The number of grantees who have updated or developed new materials that are accurate and can be understood by the patient population.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The total number of Title V grantees.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The number of grantees who have updated or developed new materials that are accurate and can be understood by the patient population.	<b>Denominator:</b>	The total number of Title V grantees.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The number of grantees who have updated or developed new materials that are accurate and can be understood by the patient population.								
<b>Denominator:</b>	The total number of Title V grantees.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	(AHS-6.1): Reduce the proportion of persons who are unable to obtain or understand the need to receive necessary medical care, dental care, or prescription medicines.								
<b>Data Sources and Data Issues:</b>	Grantee reporting and/or site visits. National Action Plan to Improve Health Literacy, U.S. Department of Health and Human Services, 2010; The Center for Disease Control and Preventions “Simply Put”; and the U.S. National Library of Medicine’s website “How to Write Easy-to Read Health Materials.” In order to develop materials that can be used and understood by individuals: identify the target audience; the issue that needs to be addressed; invite the intended audience to determine needs and evaluate their level of understanding; determine and design messaging based on feedback provided; and design, pretest, edit, publish, and evaluate.								
<b>Significance:</b>	According to Healthy People 2020, 10% of all individuals were unable to obtain care or medicines in 2007. The target set is 9%. When families do not have an understanding of the health care information provided to them, this places the patient at risk for failing to follow through on medical recommendations, adhering to recommended behaviors like safe sleep and breastfeeding. Without prevention and timely intervention, patients frequently need more care and face a difficult rehabilitative process. If materials provided to families is written and presented in a manner that it can be understood, this will result in increased knowledge and/or a change in behavior.								

**SPM 2 - Percent of Title V programming with interpersonal violence reduction components.**  
**Population Domain(s) – Child Health, Adolescent Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of Title V programs with interpersonal violence reduction components.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of Title V programs with interpersonal violence reduction components.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of Title V programs.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of Title V programs with interpersonal violence reduction components.	<b>Denominator:</b>	Total number of Title V programs.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of Title V programs with interpersonal violence reduction components.								
<b>Denominator:</b>	Total number of Title V programs.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	Not applicable.								
<b>Data Sources and Data Issues:</b>	Data will come from an assessment of current Title V programming and new programming addressing interpersonal violence reduction in accordance with the evidence-based driver diagram from Child Safety CoIIN participation and CDC definitions of risk and protective factors for interpersonal violence. A potential issue is the number of total Title V programs can fluctuate and the definition of component will need to be clear.								
<b>Significance:</b>	Recent approaches to addressing interpersonal violence are taking a cross-cutting approach as multiple forms of violence are strongly interconnected. As a participant in the Child Safety CoIIN, PA has chosen Interpersonal Violence Prevention as a topic area on which to focus as some current Title V programming occurs in this topic area and the Bureau of Family Health, as the Title V administrator, is examining the potential for expanding cross-cutting work in interpersonal violence prevention. The Bureau of Family Health plans to leverage work done within the Child Safety CoIIN framework to quantify and increase the number of interpersonal violence prevention programs and/or program components within Title V programming. This measure is considered interim until it can be determined how to best measure interpersonal violence in PA.								

**SPM 3 - Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.**

**Population Domain(s) – Perinatal/Infant Health**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	By tracking this measure the DOH will be able to identify submitters (hospitals, birthing facilities, and midwives) that are not meeting the standard for collection to receipt times. The DOH will provide technical assistance to these submitters to im								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The number of dried blood spot filter papers received at the lab within 48 hours after collection.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The total number of dried blood spot filter papers received by the lab.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The number of dried blood spot filter papers received at the lab within 48 hours after collection.	<b>Denominator:</b>	The total number of dried blood spot filter papers received by the lab.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The number of dried blood spot filter papers received at the lab within 48 hours after collection.								
<b>Denominator:</b>	The total number of dried blood spot filter papers received by the lab.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	Not applicable.								
<b>Data Sources and Data Issues:</b>	Newborn screening data system. No data collection issues or limitations.								
<b>Significance:</b>	By receiving the newborn screening dried blood spot filter papers within 48 hours of collection, the contracted laboratory will be able to report out critical results to DOH within five days of life, the industry standard. This allows DOH staff to begin the follow-up process earlier in the newborn’s life, leading to a quicker referral turnaround, diagnosis and treatment. Many newborn screening conditions are time sensitive, the sooner they are detected and acted on the better the outcome is for the long-term health of the newborn and the family.								

**SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.**  
**Population Domain(s) – Cross-Cutting/Life Course**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percentage of Title V staff who analyze and use data to steer programmatic decision-making.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of Title V staff who analyzed and used data at least once during the reporting year.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of Title V staff.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of Title V staff who analyzed and used data at least once during the reporting year.	<b>Denominator:</b>	Number of Title V staff.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of Title V staff who analyzed and used data at least once during the reporting year.								
<b>Denominator:</b>	Number of Title V staff.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	Not applicable.								
<b>Data Sources and Data Issues:</b>	Counts for the numerator will be obtained from Bureau of Family Health (BFH) internal data collection performed by the Priority 8 workgroup. This workgroup is responsible for all matters pertaining to the data priority. Counts for the denominator will be determined by BFH personnel records.								
<b>Significance:</b>	As the Title V block grant administrator, the BFH has purposely chosen a state priority related to data collection and analysis. Through internal assessment of all program data collection strengths and needs, the BFH aims to increase the capacity of all staff to incorporate relevant data into programmatic decision-making.								

**SPM 5 - Percent of youth ages 8-18 participating in mentoring programs who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%**  
**Population Domain(s) – Adolescent Health, Children with Special Health Care Needs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To annually increase the number of youth ages 8-18 participating in mentoring programs who increase their protective factors or decrease their risk factors influencing positive youth development and health outcomes by 50%.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of youth participating in programming who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of youth participating in programming.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of youth participating in programming who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%	<b>Denominator:</b>	Number of youth participating in programming.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of youth participating in programming who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%								
<b>Denominator:</b>	Number of youth participating in programming.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	<p>AH-3 Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver.</p> <p>AH-3.1 Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems.</p> <p>AH-4 Increase the proportion of adolescents who transition to self-sufficiency from foster care.</p> <p>AH-4.1 Increase the proportion of adolescents in foster care who exhibit positive early indicators of readiness for transition to adulthood.</p> <p>AH-5 Increase educational achievement of adolescents and young adults.</p> <p>AH-5.1 Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade.</p> <p>AH-5.2 Increase the proportion of students who are served under the Individuals with Disabilities Education Act who graduate high school with a diploma.</p> <p>AH-11 Reduce adolescent and young adult perpetration of, and victimization by, crimes.</p>								
<b>Data Sources and Data Issues:</b>	Programs will utilize pre and post assessments to measure changes in protective factors and risk factors of youth participating in programming.								
<b>Significance:</b>	Adolescent Health programming is a part of the Bureau of Family Health. This particular performance measure was selected to measure how well youth in the evidence-based or evidence-informed mentoring programs are provided with skills, experiences, relationships, and behaviors to help them increase their protective factors and decrease their risk factors. This will, in turn, give the youth a better chance of succeeding in school and becoming contributing members of their communities.								

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Pennsylvania**

No State Outcome Measures were created by the State.

**Form 10c**  
**Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**

**State: Pennsylvania**

**ESM 1.1 - Number of families served through Centering Pregnancy Programs.**

**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	Annually increase the number of families served through Centering Pregnancy Programs.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>The numerator is the number of families enrolled in Centering Pregnancy programs.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>500</td> </tr> </table>		<b>Numerator:</b>	The numerator is the number of families enrolled in Centering Pregnancy programs.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	500
<b>Numerator:</b>	The numerator is the number of families enrolled in Centering Pregnancy programs.									
<b>Denominator:</b>	Not applicable.									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	500									
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the Centering Pregnancy Programs.									
<b>Significance:</b>	Quantitative studies of Centering Pregnancy Programs have shown that women who receive prenatal care through the Centering Pregnancy model compared to traditional prenatal care have a reduced number of low birth weight babies and preterm births, a higher number or prenatal visits and increased breastfeeding rates. These factors will improve the health of families in Pennsylvania.									

**ESM 1.2 - Percent of adolescents and women engaged in family planning after delivery.**  
**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of adolescents and women engaged in family planning after delivery.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number of women engaged in family planning after delivery.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of women engaged in family planning after delivery.	<b>Denominator:</b>	The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
	<b>Numerator:</b>	The numerator is the number of women engaged in family planning after delivery.							
	<b>Denominator:</b>	The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants.							
	<b>Unit Type:</b>	Percentage							
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the County Municipal Health Departments.								
<b>Significance:</b>	Family planning services have important health, social, financial, environmental and economic benefits. Access to contraception helps people to avoid pregnancies they do not want, and to plan and space the pregnancies they do want. Interconception care allows women to improve their health before becoming pregnant ultimately improving the health of their children.								

**ESM 1.3 - Percent of adolescents and women who talked with a health care professional about birth spacing and birth control methods.**

**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of adolescents and women who talked with a health care professional about birth spacing and birth control methods.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number of women served through the IMPLICIT program who talked with a health care professional about birth spacing or birth control methods.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The denominator is the number of women who are served through the IMPLICIT Programs.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of women served through the IMPLICIT program who talked with a health care professional about birth spacing or birth control methods.	<b>Denominator:</b>	The denominator is the number of women who are served through the IMPLICIT Programs.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator is the number of women served through the IMPLICIT program who talked with a health care professional about birth spacing or birth control methods.								
<b>Denominator:</b>	The denominator is the number of women who are served through the IMPLICIT Programs.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the IMPLICIT Programs.								
<b>Significance:</b>	Annually increasing the number of women who are discussing birth control and birth spacing with a health professional will likely improve women’s interconception health and ultimately the health of their children. The IMPLICIT program works on the schedule of children’s well visits to screen mothers for four risk factors: smoking, depression, contraception and multivitamin use. Increasing the number of health care professionals discussing birth control methods will in turn increase the number of women utilizing birth control.								

**ESM 1.4 - Percent of individuals trained on motivational interviewing.**  
**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of Title V home visitors trained on motivational interviewing in order to elicit behavior change.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number of Title V home visitors trained on motivational interviewing techniques.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The denominator is the number of Title V home visitors.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.	<b>Denominator:</b>	The denominator is the number of Title V home visitors.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.								
<b>Denominator:</b>	The denominator is the number of Title V home visitors.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the County Municipal Health Departments and Nurse Family Partnership (NFP) Programs. At this time we are unsure of whether we will be able to require that the NFP utilize motivational interviewing techniques.								
<b>Significance:</b>	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Increasing the number of home visitors who are trained on motivational interviewing should increase the number of women who are discussing birth control, birth spacing, family planning, IPV and other behavioral health with a health professional and will motivate the women to be more active in their interconception health and ultimately the health of their children.								

**ESM 1.5 - Number of women served through evidence based or informed home visiting programs.**  
**NPM 1 – Percent of women with a past year preventive medical visit**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of women served by evidence-based or informed home visiting programs.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The number of women enrolled in home visiting programs.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>	<b>Numerator:</b>	The number of women enrolled in home visiting programs.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	The number of women enrolled in home visiting programs.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	5,000								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the County/Municipal Health Departments and Nurse Family Partnership.								
<b>Significance:</b>	Evidence based home visiting programs have achieved positive outcomes in reducing the incidence of low birth weight babies, fewer repeat pregnancies, improved child development and increased rates of immunizations. All of these factors together will likely improve the health of women and their children.								

**ESM 4.1 - Percent of individual facilities increasing the number of Keystone 10 steps completed each fiscal year. NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percentage of facilities completing additional steps.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of facilities enrolled in initiative which have completed at least one additional step by the end of the fiscal year than when they started the fiscal year.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of facilities enrolled in initiative at the beginning of the fiscal year.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of facilities enrolled in initiative which have completed at least one additional step by the end of the fiscal year than when they started the fiscal year.	<b>Denominator:</b>	Number of facilities enrolled in initiative at the beginning of the fiscal year.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of facilities enrolled in initiative which have completed at least one additional step by the end of the fiscal year than when they started the fiscal year.								
<b>Denominator:</b>	Number of facilities enrolled in initiative at the beginning of the fiscal year.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data for the numerator will be gleaned both from the vendor reports as well as from the DOH website on which the listing of hospitals achieving steps is provided. The denominator is the total number of facilities enrolled in the initiative at the beginning of the fiscal year. The denominator will change as new facilities are added to the initiative (funding dependent).								
<b>Significance:</b>	The BFH is currently funding an initiative, called the Keystone 10 Initiative, in which a vendor is facilitating the adoption and implementation of the ten evidence based steps, commonly known as the Ten Steps to Baby Friendly Hospitals, within Pennsylvania birthing facilities. Evidence demonstrates that breastfeeding rates at facilities increase as those facilities implement the evidence based steps. Monitoring the increase in the number of steps will ensure movement by these facilities towards increasing breastfeeding rates.								

**ESM 4.2 - Percent of counties with breastfeeding initiation rates below 73% implementing evidence based strategies**

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

<b>Measure Status:</b>	Active									
<b>Goal:</b>	Increase breastfeeding initiation rates in counties with a 2012 breastfeeding initiation rate below 73% by implementing evidence based strategies within those counties.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of counties with a 2012 breastfeeding initiation rate below 73% which implement evidence based strategies.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>All counties with a 2012 breastfeeding initiation rate below 73%.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	Number of counties with a 2012 breastfeeding initiation rate below 73% which implement evidence based strategies.	<b>Denominator:</b>	All counties with a 2012 breastfeeding initiation rate below 73%.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of counties with a 2012 breastfeeding initiation rate below 73% which implement evidence based strategies.									
<b>Denominator:</b>	All counties with a 2012 breastfeeding initiation rate below 73%.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Data Sources and Data Issues:</b>	The numerator will indicate the number of counties in which the BFH has successfully implemented evidence based strategies and the denominator is a fixed number of counties falling within those parameters (2012 was used as the baseline data for this initiative as that was the most recent data available at the time the initiative was developed). Data will come from vendor reports and PA Health Stats.									
<b>Significance:</b>	The BFH is currently undertaking initiatives to work with targeted counties to assist in the implementation of evidence based strategies. Implementation of evidence based strategies, like peer counseling, providing partner/family support, and conducting media or social marketing have been shown to increase breastfeeding initiation and duration rates among women. The counties targeted for these activities are those consistently having lower breastfeeding rates than the overall Pennsylvania rate since this type of data started to be recorded in 2003.									

**ESM 4.3 - Number of collaborations developed between the breastfeeding program and other programming for cross-messaging.**

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

<b>Measure Status:</b>	Active									
<b>Goal:</b>	Annually develop a minimum of one collaborative opportunity with programs serving the MCH population.									
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of collaborations developed.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>10</td> </tr> </table>		<b>Numerator:</b>	Number of collaborations developed.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10
<b>Numerator:</b>	Number of collaborations developed.									
<b>Denominator:</b>	Not applicable.									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	10									
<b>Data Sources and Data Issues:</b>	Numerator will be the number of collaborative opportunities developed, meaning that a focus on breastfeeding is incorporated into other programs as applicable. This information will be collected by the breastfeeding program staff.									
<b>Significance:</b>	<p>The BFH is currently pursuing collaborative opportunities within the Department of Health and with outside entities with the intent of incorporating breastfeeding awareness, support, education, materials and messaging within the work of other programs. The BFH will also incorporate applicable education, materials and messaging from other programs within their breastfeeding work. Building collaborative relationships helps ensure that women and families receive consistent, public health focused messaging on particular topics and better ensures that the professionals that interact with these populations are educated and also have a point of contact for questions and additional information. Anecdotally we have often been told that it is the conflicting or incomplete messages that women/families receive that impact their decisions to breastfeed and they often do not know where to turn for assistance. It is therefore important for others serving those populations to have an effective understanding of breastfeeding.</p>									

**ESM 4.4 - Number of media opportunities implemented promoting breastfeeding**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually implement a minimum of one media opportunity promoting breastfeeding as the infant feeding norm for the state.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of media opportunities implemented.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10</td> </tr> </table>	<b>Numerator:</b>	Number of media opportunities implemented.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10
<b>Numerator:</b>	Number of media opportunities implemented.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10								
<b>Data Sources and Data Issues:</b>	The Numerator will capture the number of media opportunities implemented by the breastfeeding program staff.								
<b>Significance:</b>	The use of media to promote breastfeeding is an evidence based strategy that has been shown to increase breastfeeding rates. The BFH is currently exploring media opportunities available to promote breastfeeding. Media ‘encompasses’ the range of opportunities available from traditional print materials to advertising to a web presence and current social media platforms. This range is being utilized both to reach a diverse segment of the population and also to allow some flexibility in implementation as opportunities are often funding dependent and funding is not always available.								

**ESM 5.1 - Number of hospitals recruited to implement the model safe sleep program.**  
**NPM 5 – Percent of infants placed to sleep on their backs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of hospitals that have been recruited to implement the model safe sleep program.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The number of hospitals that have committed to implementing the model safe sleep program within the next year.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The number of hospitals that have committed to implementing the model safe sleep program within the next year.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100
<b>Numerator:</b>	The number of hospitals that have committed to implementing the model safe sleep program within the next year.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected from quarterly reports from the Infant Safe Sleep Initiative. An applicant has been selected; however, a grant agreement is pending for programming that will begin July 1, 2016. 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.								
<b>Significance:</b>	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 5.2 - Percentage of infants born whose parents were educated on safe sleep practices through the model program.**

**NPM 5 – Percent of infants placed to sleep on their backs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of infants born whose parents were educated on safe sleep practices through the model program.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></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 style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Denominator is the number of infants who were born in Pennsylvania during the year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Numerator is the number of infants whose parents were educated on safe sleep practices through the model program for a year.	<b>Denominator:</b>	Denominator is the number of infants who were born in Pennsylvania during the year.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Numerator is the number of infants whose parents were educated on safe sleep practices through the model program for a year.								
<b>Denominator:</b>	Denominator is the number of infants who were born in Pennsylvania during the year.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	<p>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. An applicant has been selected; however, a grant agreement is pending for programming that will begin July 1, 2016. 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.</p>								
<b>Significance:</b>	<p>This will show the reach of the hospital based model program in comparison to all births. Education has a history of success as seen through the Back to Sleep campaign in the 1990’s that saw a drastic decline in SIDS rates. The hospital based model program not only will address SIDS, but further reach to provide education on accidental strangulation and suffocation.</p>								

**ESM 5.3 - Percentage of hospitals with maternity units implementing the model program.**  
**NPM 5 – Percent of infants placed to sleep on their backs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of infants born whose parents were educated on safe sleep practices through the model program.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Numerator is the number of hospitals that have implemented the model program.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Denominator is the number hospitals in Pennsylvania with a maternity unit. Unit is a percentage.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Numerator is the number of hospitals that have implemented the model program.	<b>Denominator:</b>	Denominator is the number hospitals in Pennsylvania with a maternity unit. Unit is a percentage.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Numerator is the number of hospitals that have implemented the model program.								
<b>Denominator:</b>	Denominator is the number hospitals in Pennsylvania with a maternity unit. Unit is a percentage.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Quarterly annual reports from the Infant Safe Sleep Initiative will provide the numerator. Data from the Division of Newborn Screening and Genetics will identify the number of hospitals in Pennsylvania with a maternity unit. An applicant has been selected; however, a grant agreement is pending for programming that will begin July 1, 2016. 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.								
<b>Significance:</b>	This will show the reach of the hospital based model program in all hospitals eligible to implement the model program. Nearly all births in Pennsylvania occur in a hospital. Using a hospital based model program will allow for growth to provide this life saving education to the parents of 97 percent of births.								

**ESM 5.4 - Number of social marketing messages disseminated.**  
**NPM 5 – Percent of infants placed to sleep on their backs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of social marketing messages disseminated to increase population awareness of safe sleep practices.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>The number of social marketing messages disseminated. The type of message will be counted, if multiple methods are used.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>1,000</td> </tr> </table>	<b>Numerator:</b>	The number of social marketing messages disseminated. The type of message will be counted, if multiple methods are used.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000
<b>Numerator:</b>	The number of social marketing messages disseminated. The type of message will be counted, if multiple methods are used.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Data Sources and Data Issues:</b>	<p>Quarterly annual reports from the Infant Safe Sleep Initiative will provide the number and type of social marketing messages disseminated. An applicant has been selected; however, a grant agreement is pending for programming that will begin July 1, 2016. At this time only the general types of social marketing that will be implemented is known. The grantee anticipates planning for social marketing will be a 6 month process and will then be able to better estimate the number of messages to be disseminated. The BFH would prefer to hold off on projecting the number of social marketing messages to be disseminated until the planning has at least begun. Due to the Infant Safe Sleep Initiative being a three year grant, projections are not being made past the grant period as future programming is undetermined at this time.</p>								
<b>Significance:</b>	<p>This will show the quantity of safe sleep messages that are disseminated to the public. Educating the public at large will provide safe sleep messages not only to parents, but allow for a consistent message to reach family, friends and other caretakers. Conflicting messages from family and friends can influence parents to not implement the life-saving safe sleep education provided through the hospital based model and other messaging. Additionally, this will allow the parents of infants not born in a hospital to receive safe sleep messages.</p>								

**ESM 7.1 - Number of comprehensive home assessments completed.**

**NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of comprehensive home assessments completed.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>	<b>Numerator:</b>	The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	5,000								
<b>Data Sources and Data Issues:</b>	Quarterly reports from Pennsylvania Safe and Healthy Homes Program will provide this information. The grant agreements for the Pennsylvania Safe and Healthy Homes Program have not yet been fully executed. While no issues have been identified to delay program implementation, it is behind schedule. This objective is the number of assessments grantees are expected to complete each year with 920 being the goal required by the grant agreements.								
<b>Significance:</b>	This number identifies the number of homes that have been evaluated for health and safety hazards that could cause injury to children and adolescents ages 0-19. The holistic approach of a comprehensive home assessment has been demonstrated to be less expensive than conducting separate assessments and subsequent intervention of individual hazards. The Pennsylvania Safe and Healthy Homes Program will focus on hazards that are leading causes of injuries that lead to hospitalizations. The regions of the Pennsylvania Safe and Healthy Homes Program have a total injury rate higher than the state rate, both a fatal and nonfatal injury rate higher than the state rate or a fatal injury rate more than two times the state rate for individuals under age 25.								

**ESM 7.2 - Number of health and safety hazards identified through comprehensive home assessments.**  
**NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of health and safety hazards identified.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The number of health and safety hazards identified through comprehensive home assessments performed through the Pennsylvania Safe and Healthy Homes Program.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>20,000</td> </tr> </table>	<b>Numerator:</b>	The number of health and safety hazards identified through comprehensive home assessments performed through the Pennsylvania Safe and Healthy Homes Program.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20,000
<b>Numerator:</b>	The number of health and safety hazards identified through comprehensive home assessments performed through the Pennsylvania Safe and Healthy Homes Program.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	20,000								
<b>Data Sources and Data Issues:</b>	Quarterly reports from Pennsylvania Safe and Healthy Homes Program will provide this information. The grant agreements for the Pennsylvania Safe and Healthy Homes Program have not yet been fully executed. While no issues have been identified to delay program implementation, it is behind schedule. The projected objectives are calculated by multiplying the number of home assessments completed by the average number of hazards identified in each home. It is estimated there will be an average of 8 hazards identified in each home that an assessment is completed in.								
<b>Significance:</b>	This number identifies the number of health and safety hazards that have been identified in homes that have been evaluated for health and safety hazards that could cause injury to children and adolescents ages 0-19. The holistic approach of a comprehensive home assessment has been demonstrated to be less expensive than conducting separate assessments and subsequent intervention of individual hazards. The Pennsylvania Safe and Healthy Homes Program will focus on hazards that are leading causes of injuries that lead to hospitalizations. The regions of the Pennsylvania Safe and Healthy Homes Program have a total injury rate higher than the state rate; both a fatal and nonfatal injury rate higher than the state rate; or a fatal injury rate more than two times the state rate for individuals under age 25.								

**ESM 7.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.**

**NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of health and safety interventions performed.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Numerator:</b></td> <td>Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments through the Pennsylvania Safe and Healthy Homes Program.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Number:</b></td> <td>10,000</td> </tr> </table>	<b>Numerator:</b>	Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments through the Pennsylvania Safe and Healthy Homes Program.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000
<b>Numerator:</b>	Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments through the Pennsylvania Safe and Healthy Homes Program.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Data Sources and Data Issues:</b>	Quarterly reports from Pennsylvania Safe and Healthy Homes Program will provide this information. The grant agreements for the Pennsylvania Safe and Healthy Homes Program have not yet been fully executed. While no issues have been identified to delay program implementation, it is behind schedule. It is estimated that grantees will provide an average of 5 interventions (give items to residents) per home assessed. The number of interventions does not equal the number of hazards found as not all hazards require a countable item intervention.								
<b>Significance:</b>	This number identifies the number of health and safety interventions that have been performed to reduce the leading causes of injuries to children and adolescents ages 0-19. All allowable interventions are evidence based or evidence informed and have a direct connection to the prevention of injuries that often lead to hospitalization. The families targeted with the Pennsylvania Safe and Healthy Homes Program frequently do not have the education to understand the need for these interventions and more importantly do not have the available resources to otherwise implement the interventions.								

**ESM 9.1 - The percent of adolescent health vendors receiving lesbian, gay, bisexual, transgender and questioning (LGBTQ) cultural competency training.**

**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Numerator:</b></td> <td>Number of adolescent health vendors receiving LGBTQ cultural competency training.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Denominator:</b></td> <td>Number of adolescent health vendors.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of adolescent health vendors receiving LGBTQ cultural competency training.	<b>Denominator:</b>	Number of adolescent health vendors.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of adolescent health vendors receiving LGBTQ cultural competency training.								
<b>Denominator:</b>	Number of adolescent health vendors.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data collection and analysis will be performed by the adolescent health vendors. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
<b>Significance:</b>	<p>According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17 percent of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others.</p> <p>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.</p> <p>LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.</p> <p>Bias based on gender; social/socio-economic class and privilege; gender orientation, sexual preference, and gender identity; mental, physical and emotional ability/disability; physical appearance (most notably obesity); and religion are frequently at the center of bullying and discrimination in schools. Improving knowledge and competency in these areas can help programs more effectively prevent bullying and more appropriately react to bullying when it happens.</p>								

**ESM 9.2 - The percent of adolescent serving vendors with a comprehensive anti-bullying/harassment policy.**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To annually increase the percentage of BFH vendors serving adolescents that adopt and implement comprehensive anti-bullying/harassment policies that specifically enumerate sexual orientation, gender identity, and gender expression.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of adolescent health vendors with a comprehensive anti-bullying/harassment policy.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of adolescent health vendors.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of adolescent health vendors with a comprehensive anti-bullying/harassment policy.	<b>Denominator:</b>	Number of adolescent health vendors.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of adolescent health vendors with a comprehensive anti-bullying/harassment policy.								
<b>Denominator:</b>	Number of adolescent health vendors.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data collection and analysis will be performed by the BFH vendor serving adolescents. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
<b>Significance:</b>	<p>According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17 percent of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others.</p> <p>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.</p> <p>Youth who bully others are more likely to experience alcohol and drug abuse in adolescence. This serious health problem can persist long after adolescence.</p> <p>LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.</p>								

**ESM 9.3 - The number of sites participating in bullying prevention efforts.**

**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Inactive - Replaced								
<b>Goal:</b>	Increase the number of adolescents participating in a bullying awareness and prevention program.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #1f4e79; color: white;"><b>Numerator:</b></td> <td>Number of sites participating in bullying prevention efforts.</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;"><b>Unit Number:</b></td> <td>25</td> </tr> </table>	<b>Numerator:</b>	Number of sites participating in bullying prevention efforts.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	25
<b>Numerator:</b>	Number of sites participating in bullying prevention efforts.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	25								
<b>Data Sources and Data Issues:</b>	Data collection and analysis will be performed by the vendor(s) selected by DOH to carry out the activities of the bullying program. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
<b>Significance:</b>	<p>According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17 percent of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others.</p> <p>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.</p> <p>Youth who bully others are more likely to experience alcohol and drug abuse in adolescence. This serious health problem can persist long after adolescence.</p> <p>Bullying prevention efforts can create settings where all youth, including youth with special health care needs, can feel safe and increase their chances of experiencing positive health outcomes.</p>								

**ESM 9.4 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.**

**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Inactive - Replaced								
<b>Goal:</b>	Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>10,000</td> </tr> </table>	<b>Numerator:</b>	A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.	<b>Denominator:</b>	Not applicable	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000
<b>Numerator:</b>	A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.								
<b>Denominator:</b>	Not applicable								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Data Sources and Data Issues:</b>	Data will be collected from organizations implementing programming. The data will include a count of youth being served.								
<b>Significance:</b>	<p>Engaging youth to participate in evidence-based or evidence informed mentoring, counseling, or adult supervision programs will support the Bureau of Family Health in reaching its State Performance Measure of helping youth increase their assets by 50%. This particular performance measure was selected to measure how well youth in the mentoring program are provided with skills, experiences, relationships, and behaviors to help them increase their developmental assets. Increasing developmental assets, in turn, will give the youth a better chance of succeeding in school and becoming contributing members of their communities.</p> <p>Providing opportunities for youth to increase the number of developmental assets they have is the primary organizing concept of this approach. By utilizing the Search Institute’s 40 Developmental Assets framework, youth will be provided with building blocks for healthy development to help them grow into healthy, caring and responsible young adults. The Search Institute’s developmental assets framework includes 20 external assets organized under the following four categories: support, empowerment, boundaries and expectations, and constructive use of time; and 20 internal assets organized under these four categories: commitment to learning, positive values, social competencies, and positive identity.</p> <p>This ESM is not directly linked to NPM 9, but is linked to the following SPM: Percent of youth ages 8-18 participating in a mentoring program who increased assets by 50%.</p>								

**ESM 9.5 - Number of evidence-based mentoring, counseling or adult supervision programs implemented in high risk areas of PA.**

**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of evidence-based or evidence-informed mentoring, counseling and adult supervision programs available to youth ages 8 -18.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>The measure of this strategy will be a count of evidence-based programs being implemented. We anticipate funding up to 4 separate programs throughout Pennsylvania.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>20</td> </tr> </table>	<b>Numerator:</b>	The measure of this strategy will be a count of evidence-based programs being implemented. We anticipate funding up to 4 separate programs throughout Pennsylvania.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20
<b>Numerator:</b>	The measure of this strategy will be a count of evidence-based programs being implemented. We anticipate funding up to 4 separate programs throughout Pennsylvania.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	20								
<b>Data Sources and Data Issues:</b>	Data will be based on how many programs are selected by the Bureau of Family Health to implement programming. Additionally, those programs will report to the Bureau on any additional programs they may contract with to provide the same services. Programs will be implemented statewide, with an emphasis on high risk areas in which youth are most likely to engage in risky behaviors such as unsafe sexual activity.								
<b>Significance:</b>	<p>Selecting programs in high risk areas will support the Bureau of Family Health in reaching its State Performance Measure of helping youth increase their assets by 50%. Programming will be implemented statewide, with an emphasis on high risk areas in which youth are most likely to engage in risky behaviors and provide a greater need for programming. For example, Healthy Youth PA is a program funded by the Title V State Abstinence Education Grant Program and uses a combined approach of mentoring, adult supervision, and counseling to increase assets of youth. Healthy Youth PA targets 10 counties in Pennsylvania that have the highest pregnancy rates of females age 15-17. A similar approach will be taken with the newly developed programs, although programming will be implemented statewide as programming will not just focus on reducing teenage pregnancy rates.</p> <p>This ESM is not directly linked to NPM 9, but it is linked to the following SPM: Percent of youth ages 8-18 participating in a mentoring program who increased assets by 50%.</p>								

**ESM 9.6 - The number of organizations certified as a safe space provider.**

**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To annually increase the number of Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) sensitive organizations which provide services to youth.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Numerator:</b></td> <td>Number of LGBTQ sensitive organizations that provide services to youth.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Number:</b></td> <td>500</td> </tr> </table>	<b>Numerator:</b>	Number of LGBTQ sensitive organizations that provide services to youth.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	500
<b>Numerator:</b>	Number of LGBTQ sensitive organizations that provide services to youth.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	500								
<b>Data Sources and Data Issues:</b>	<p>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.</p> <p>This ESM is not directly linked to NPM 9, but is linked to the following priority: Protective factors are established for adolescents and young adults prior to and during critical life stages.</p>								
<b>Significance:</b>	<p>Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face a variety of challenges, both environmental and individual, that shape how they view themselves as well as their perception of how they view others. LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide</p> <p>LGBTQ youth suffer alarmingly high rates of bullying and violence in schools, alcohol and drug use, sexually transmitted infections (including HIV/AIDS), suicide and homelessness. Some statistics include:</p> <ul style="list-style-type: none"> <li>o 84.6 percent of LGBTQ students reported being verbally harassed, 40.1 percent reported being physically harassed and 18.8 percent reported being physically assaulted at school in the past year because of their sexual orientation.</li> <li>o Nearly two-thirds (61.1 percent) of students reported that they felt unsafe in school because of their sexual orientation.</li> <li>o 38.4 percent of LGBTQ youth drank alcohol before age 13, compared with 21.3 percent of heterosexual youth.</li> <li>o LGBTQ youth report rates of suicide attempts from 20 to 40 percent and lifetime prevalence suicide attempt rates ranging from 7 to 20 percent as adults.</li> <li>o LGBTQ youth are also more likely to engage in behaviors that may result in unintended pregnancy:</li> </ul> <p>To help LGBTQ youth better manage their life experiences, support from adults is essential and, in some cases, life changing. Parents and caregivers play an important role in the self-esteem of any child; receiving support from their parents and/or caregivers is integral to the positive physical, mental and emotional health of LGB youth. While some LGBTQ youth may not receive support and positive reinforcement from parents and/or caregivers, the support they receive from one staff person</p>								



**ESM 9.7 - Number of LGBTQ youth receiving evidence-informed suicide prevention programming.  
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To annually increase the number of LGBTQ youth who have access to suicide prevention services.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of LGBTQ youth who have access to suicide prevention services.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>1,000</td> </tr> </table>	<b>Numerator:</b>	Number of LGBTQ youth who have access to suicide prevention services.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000
<b>Numerator:</b>	Number of LGBTQ youth who have access to suicide prevention services.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Data Sources and Data Issues:</b>	<p>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.</p> <p>This ESM is not directly linked to NPM 9, but is linked to the following priority: Protective factors are established for adolescents and young adults prior to and during critical life stages.</p>								
<b>Significance:</b>	<p>LGBTQ youth face a variety of challenges, both environmental and individual, that shape how they view themselves as well as their perception of how they view others. LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide. LGBTQ youth suffer alarmingly high rates of bullying and violence in schools, alcohol and drug use, sexually transmitted infections (including HIV/AIDS), suicide and homelessness.</p> <p>Some statistics include:</p> <ul style="list-style-type: none"> <li>o 84.6 percent of LGBTQ students reported being verbally harassed, 40.1 percent reported being physically harassed and 18.8 percent reported being physically assaulted at school in the past year because of their sexual orientation.</li> <li>o Nearly two-thirds (61.1 percent) of students reported that they felt unsafe in school because of their sexual orientation.</li> <li>o 38.4 percent of LGBTQ youth drank alcohol before age 13, compared with 21.3 percent of heterosexual youth.</li> <li>o LGBTQ youth report rates of suicide attempts from 20 to 40 percent and lifetime prevalence suicide attempt rates ranging from 7 to 20 percent as adults.</li> </ul> <p>To help LGBTQ youth better manage their life experiences, support from adults is essential and, in some cases, life changing. Parents and caregivers play an important role in the self-esteem of any child; receiving support from their parents and/or caregivers is integral to the positive physical, mental and emotional health of LGBTQ youth. While some LGBTQ youth may not receive support and positive reinforcement from parents and/or caregivers, the support they receive from one staff person at a local agency (possibly a manager, facilitator or program director) can positively affect their outcomes.</p>								

**ESM 9.8 - Number of trainers trained in the Olweus Bullying Prevention Program**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the number of community-based organizations participating in a bullying awareness and prevention program								
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>Number of trainers trained in the Olweus Bullying Prevention Program</td> </tr> <tr> <td><b>Denominator:</b></td> <td>None</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of trainers trained in the Olweus Bullying Prevention Program	<b>Denominator:</b>	None	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of trainers trained in the Olweus Bullying Prevention Program								
<b>Denominator:</b>	None								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data collection and analysis will be performed by the vendor(s) selected by DOH to carry out the activities of the bullying program. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
<b>Significance:</b>	<p>According to the Bullying in US Schools 2014 Status Report using data from the Olweus Bullying Questionnaire, 17% of all students were involved in bullying by either being bullied, bullying others or both being bullied and bullying others.</p> <p>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.</p> <p>Youth who bully others are more likely to experience alcohol and drug abuse in adolescence. This serious health problem can persist long after adolescence.</p> <p>LGBTQ youth and those perceived as LGBTQ are at an increased risk of being bullied. Bullied LGBTQ youth, or youth perceived as LGBTQ are more likely to skip school, smoke, use alcohol and drugs, or engage in other risky behaviors. Lesbian, gay or bisexual youth are more than twice as likely as their peers to be depressed and think about or attempt suicide.</p>								

**ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs**

**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Numerator:</b></td> <td>A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Denominator:</b></td> <td>N/A. This measure was inappropriately inactivated.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>	<b>Numerator:</b>	A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs	<b>Denominator:</b>	N/A. This measure was inappropriately inactivated.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs								
<b>Denominator:</b>	N/A. This measure was inappropriately inactivated.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	5,000								
<b>Data Sources and Data Issues:</b>	Data will be collected from organizations implementing programming. The data will include a count of youth being served								
<b>Significance:</b>	<p>Engaging youth to participate in evidence-based or evidence informed mentoring, counseling, or adult supervision programs will support the Bureau of Family Health in reaching its State Performance Measure of helping youth increase their assets by 50%. This particular performance measure was selected to measure how well youth in the mentoring program are provided with skills, experiences, relationships, and behaviors to help them increase their developmental assets. Increasing developmental assets, in turn, will give the youth a better chance of succeeding in school and becoming contributing members of their communities.</p> <p>Providing opportunities for youth to increase the number of developmental assets they have is the primary organizing concept of this approach. By utilizing the Search Institute’s 40 Developmental Assets framework, youth will be provided with building blocks for healthy development to help them grow into healthy, caring and responsible young adults. The Search Institute’s developmental assets framework includes 20 external assets organized under the following four categories: support, empowerment, boundaries and expectations, and constructive use of time; and 20 internal assets organized under these four categories: commitment to learning, positive values, social competencies, and positive identity.</p>								

**ESM 10.1 - The number of counties with a Health Resource Center (HRC) available to youth ages 12-17.  
 NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of counties with an HRC available to youth ages 12-17 either in a school or community based setting								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of HRCs available to youth ages 12-17</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>20</td> </tr> </table>	<b>Numerator:</b>	Number of HRCs available to youth ages 12-17	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	20
<b>Numerator:</b>	Number of HRCs available to youth ages 12-17								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	20								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” The HRCs fill this primary care gap by being available and accessible in the schools youth attend and in the communities where they reside. Expanding the number of HRCs in the state will expand availability of vital health services for youth. Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed.								

**ESM 10.2 - Number of youth receiving services at a Health Resource Center (HRC).**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number annually of youth ages 12-17 utilizing HRC services.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of youth ages 12-17 receiving services at an HRC.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> </table>	<b>Numerator:</b>	Number of youth ages 12-17 receiving services at an HRC.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000
<b>Numerator:</b>	Number of youth ages 12-17 receiving services at an HRC.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” The HRCs fill this primary care gap by being available and accessible in the schools youth attend and in the communities where they reside. Expanding the number of HRCs in the state will expand availability of vital health services for youth. Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed.								

**ESM 10.3 - 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.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percentage of adolescents who utilize a HRC within their school.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of youth ages 12-17 receiving services at an HRC.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Number of youth ages 12-17 attending school with a HRC.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of youth ages 12-17 receiving services at an HRC.	<b>Denominator:</b>	Number of youth ages 12-17 attending school with a HRC.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of youth ages 12-17 receiving services at an HRC.								
<b>Denominator:</b>	Number of youth ages 12-17 attending school with a HRC.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	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.								
<b>Significance:</b>	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” The HRCs fill this primary care gap by being available and accessible in the schools youth attend and in the communities where they reside. Expanding the number of HRCs in the state will expand availability of vital health services for youth. Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed.								

**ESM 10.4 - Number of youth receiving services at a drop-in site funded by the Bureau of Family Health (BFH).  
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of adolescents and young adults who identify as Lesbian, Gay, Bisexual, Transgender, and/or Questioning (LGBTQ) with a medical visit in the past year.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of youth ages 14-24 receiving services at a BFH-funded drop-in center.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10,000</td> </tr> </table>	<b>Numerator:</b>	Number of youth ages 14-24 receiving services at a BFH-funded drop-in center.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10,000
<b>Numerator:</b>	Number of youth ages 14-24 receiving services at a BFH-funded drop-in center.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10,000								
<b>Data Sources and Data Issues:</b>	Data will be collected from the Grantee that provides a drop-in center for LGBTQ individuals ages 14-24. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
<b>Significance:</b>	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed. Drop-in centers provide an access point for LGBTQ youth to receive services that is accessible and sensitive to the barriers they may face.								

**ESM 10.5 - Number of youth receiving health education and counseling services from a reproductive health provider.**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of adolescents receiving health education and counseling services during a reproductive health visit.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of adolescents.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>50,000</td> </tr> </table>	<b>Numerator:</b>	Number of adolescents.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	50,000
<b>Numerator:</b>	Number of adolescents.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	50,000								
<b>Data Sources and Data Issues:</b>	Data will be collected from the four family planning providers. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
<b>Significance:</b>	<p>Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed. As one of the access points for youth to receive health care services, the reproductive health visit provides an opportunity for youth to receive health education and counseling, including education and counseling about STIs, HIV/AIDS, pregnancy prevention, general wellness, reducing risky behaviors, and healthy relationships.</p>								

**ESM 11.1 - Number of families who received services through the evidence based or evidence informed strategies of the SKN.**

**NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of families of children and youth with special health care needs served by SKN.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number of families who received services through the evidence based or evidence informed strategies.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of families who received services through the evidence based or evidence informed strategies.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	The numerator is the number of families who received services through the evidence based or evidence informed strategies.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	5,000								
<b>Data Sources and Data Issues:</b>	Data will be collected through monthly reports from the Pennsylvania Elks Major Projects, Inc.								
<b>Significance:</b>	<p>Community Health Workers (CHWs) have been shown to be valuable for community programs that aim to improve health. Many times CHWs are members of the communities in which they serve and are able to develop a trusting, one-on-one relationship with consumers and providers. CHW programs are designed to improve access to care, increase knowledge, prevent disease and improve select health outcomes. There are several CHW program models that have been designed to improve outcomes of patient health. More than one model can be combined into a program to ensure that the program effectively meets the needs of the target population. The Care Coordinator/Manager Model and the Outreach and Enrollment Agent Model are the evidence based models that are currently being utilized by the service coordinators, and the Community Organizer and Capacity Builder Model is the evidence based model that is utilized by the RCs. The combination of these models of service provision will likely improve access to information and help families to navigate the health care system for CSHCN.</p> <p>This ESM is not directly linked to NPM 11, but is linked to the following priority: Appropriate health and health related services, screenings and information are available to the MCH populations.</p>								

**ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN.  
 NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of collaborations between systems of care serving CSHCN.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number of collaborations developed between BFH and other organizations with a vested interest in CSHCN.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of collaborations developed between BFH and other organizations with a vested interest in CSHCN.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator is the number of collaborations developed between BFH and other organizations with a vested interest in CSHCN.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected using a spreadsheet that will be developed, when a collaboration is made.								
<b>Significance:</b>	<p>Families of children and youth with special health care needs require more assistance than families of typical children, and need additional support. As children move through the life span, different needs are identified, so accessing information and resources can be an ongoing need for caregivers. No organization can assist families alone and by establishing a working relationship with other organizations families of CSHCN will benefit from a better system of care.</p> <p>This ESM is not directly linked to NPM 11, but is linked to the following priority: Appropriate health and health related services, screenings and information are available to the MCH populations.</p>								

**ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance**

**NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of pediatric providers participating in a learning collaborative, education and/or statewide technical assistance.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>1,000</td> </tr> </table>	<b>Numerator:</b>	Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1,000
<b>Numerator:</b>	Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1,000								
<b>Data Sources and Data Issues:</b>	Numerator will be compiled from several data sources each fiscal year. The BFH funds a vendor to implement the PA Medical Home Initiative which focuses on building the number of medical homes available to children and youth with special health care needs. The vendor will report quarterly and annually the number of pediatric providers participating in any of the mentioned activities as an unduplicated number. Additionally, the Medical Home Program Project Officer will report on practices involved in these activities aside from those provided by the vendor as an unduplicated number.								
<b>Significance:</b>	<p>The medical home concept was introduced by the American Academy of Pediatrics almost 40 years ago with focus on the location of a child’s medical record, particularly a child with a special health care need. Since that time, medical home has expanded to be more of a home base for care delivered through a partnership between a healthcare provider and the child/family being served and has grown to encompass adult care as well. The original guidelines have been updated on several occasions and continue to stress care that must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Evidence continues to build that demonstrates the medical home approach to care shows associations pediatric medical homes and improved health outcomes, increase in family satisfaction with care provided and decreased healthcare costs.</p> <p>The NPM focuses on the number of children having a medical home and the best way to ensure that children have access to providers practicing the components of medical homes is to focus on training, education and provision of technical assistance, with particular attention paid to providers within health care systems and medical training programs.</p>								

**ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.  
NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase involvement of youth/young adults and parents/caregivers in BFH medical home activities.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>500</td> </tr> </table>	<b>Numerator:</b>	Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	500
<b>Numerator:</b>	Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	500								
<b>Data Sources and Data Issues:</b>	Focus is on increasing the number of youth/young adults and parents/caregivers involved in the medical home activities being implemented by the BFH. Unduplicated numbers will be collected from the vendor implementing the PA Medical Home Initiative for the BFH at the end of each fiscal year. Additionally, unduplicated numbers will also be tabulated by the Medical Home Project Officer that capture non-vendor activities each fiscal year.								
<b>Significance:</b>	Family involvement serves as a key component of all Title V work involving children and youth with special health care needs and family centered care is a cornerstone of medical home activities as it recognizes that families are the primary caregivers of their children. It is equally important that youth and young adults are enabled to be partners in their own care to the extent possible. Individuals will be given the opportunities to participate in a number of facets of medical home activities, ranging from directly helping families of other children, to helping practices address issues of concerns of families to helping plan the direction of medical home activities overall.								

**ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations**

**NPM 11 – Percent of children with and without special health care needs having a medical home**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually develop a minimum of two collaborations with oral or behavioral entities that involves them in the provision of medical home services.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of collaborations developed.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>10</td> </tr> </table>	<b>Numerator:</b>	Number of collaborations developed.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	10
<b>Numerator:</b>	Number of collaborations developed.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	10								
<b>Data Sources and Data Issues:</b>	The BFH's PA Medical Home Program is currently pursuing collaborative opportunities within the Department of Health and with outside entities with the intent of integrating oral and behavioral health services within medical homes. Collaborations will be deemed developed if a mutual agreement between entities is reached and provides for movement towards a definitive goal, in this case, integration of services. Numerator will be the number of collaborative opportunities developed.								
<b>Significance:</b>	<p>Good oral health has a positive impact on overall health and conversely, poor oral health can have negative effects on overall health. Children with special health care needs are often not able to perform activities of daily living, like those needed to keep their gum, teeth and the like healthy with consistency and effectiveness, therefore are likely to suffer from poor oral health. Treatments for special needs, like certain medications for instance, can also negatively impact oral health. Additionally, access to dental health continues to be a concern in many parts of the state, and access to a pediatric dentist able to effectively treat children with special needs is even harder to find.</p> <p>Behavioral health is another issue of concern for families of children with special health care needs. A disability can mask an underlying behavioral health concern or can worsen a child's mental state and create behavioral health issues. As with oral health, the lack of access to providers and/or long waiting lists are concerns in most parts of the state, particularly providers that are able to treat children with one or more conditions.</p> <p>An opportunity to serve children's oral and behavioral health needs more effectively, therefore, lies in integrating that care with their sources of physical health, their medical home. Integration can take many forms: providing joint onsite care; having another provider in close proximity and making appointments before the family leaves; providing telehealth services, and perhaps even providing some cross training (pediatrician providing a behavioral health screenings, an oral health professionals referring a child to a pediatrician).</p>								

**ESM 14.1 - Number of Title V funded women who are screened for behavioral health.**

**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health risk factors.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Numerator:</b></td> <td>The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT program who are screened for behavioral health risk factors.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Denominator:</b></td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;"><b>Unit Number:</b></td> <td>5,000</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT program who are screened for behavioral health risk factors.	<b>Denominator:</b>	Not applicable.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	5,000
<b>Numerator:</b>	The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT program who are screened for behavioral health risk factors.								
<b>Denominator:</b>	Not applicable.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	5,000								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.								
<b>Significance:</b>	<p>Moving forward the Department is including in Title V Grant Agreements with the County Municipal Health Departments that Grantees conduct behavioral health screenings for women in prenatal and home visiting programs using the 5Ps. The IMPLICIT program was created around behavioral health screenings in the postpartum period. Increasing the number of women enrolled in these programs will allow more women to be screened and possibly identified as needing behavioral health interventions and in turn lead to healthier women and children as help is received.</p> <p>This ESM is not directly linked to NPM 14, but is linked the following priority: Women receiving prenatal care or home visiting are screened for behavioral health concerns and referred for assessment if warranted.</p>								

**ESM 14.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV).  
 NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of women with a home visitor who have a conversation about IPV.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>The numerator will consist of the number women in home visiting programs who have a conversation about IPV.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>The denominator will consist of the number of women in home visiting programs.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator will consist of the number women in home visiting programs who have a conversation about IPV.	<b>Denominator:</b>	The denominator will consist of the number of women in home visiting programs.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator will consist of the number women in home visiting programs who have a conversation about IPV.								
<b>Denominator:</b>	The denominator will consist of the number of women in home visiting programs.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the home visiting programs.								
<b>Significance:</b>	<p>IPV happens in every community. Home visitors are in a position to address IPV and begin a conversation. A simple conversation could save or improve the life and health of a family by removing the stigma surrounding women and children living in unhealthy relationships. The Institute for Health and Recovery’s 5P’s tool screening, which the DCAHS is requiring all home visitors be trained on and utilize, allows for the identification of women in need of support and referrals for mental health, substance abuse assessment and IPV. Incorporating IPV screening into the home visiting curriculum will allow us to gain an understanding of the prevalence of IPV in the population served.</p> <p>This ESM is not directly related to NPM 14, but it is related to the following priority: Women receiving prenatal care or home visiting are screened for behavioral health concerns and referred for assessment if warranted.</p>								

**ESM 14.3 - Percent of women who report smoking after confirmation of pregnancy.**

**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually decrease the percentage of women who report smoking during pregnancy.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number women in home visiting and centering pregnancy programs who report smoking after confirmation of pregnancy.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The denominator is the number of pregnant women in home visiting and centering pregnancy programs.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number women in home visiting and centering pregnancy programs who report smoking after confirmation of pregnancy.	<b>Denominator:</b>	The denominator is the number of pregnant women in home visiting and centering pregnancy programs.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator is the number women in home visiting and centering pregnancy programs who report smoking after confirmation of pregnancy.								
<b>Denominator:</b>	The denominator is the number of pregnant women in home visiting and centering pregnancy programs.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.								
<b>Significance:</b>	Decreasing the number of women who report smoking after pregnancy confirmation will decrease the number of preterm births, low birth rate, respiratory problems and SIDS and increase the health of babies before and after birth. The DCAHS chose to focus on smoking after confirmation of pregnancy due to the fact that nearly 50% of pregnancies are unintended and it is a better indication of behavioral changes and overall health throughout the pregnancy.								

**ESM 14.4 - Percent of women who report smoking after pregnancy.**

**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually decrease the percentage of women who report smoking after pregnancy.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT programs who report smoking after pregnancy.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The denominator is the number of women in home visiting, centering pregnancy and the IMPLICIT programs.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT programs who report smoking after pregnancy.	<b>Denominator:</b>	The denominator is the number of women in home visiting, centering pregnancy and the IMPLICIT programs.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
	<b>Numerator:</b>	The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT programs who report smoking after pregnancy.							
	<b>Denominator:</b>	The denominator is the number of women in home visiting, centering pregnancy and the IMPLICIT programs.							
	<b>Unit Type:</b>	Percentage							
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.								
<b>Significance:</b>	Decreasing the number of women who report smoking after pregnancy will decrease the possibility of respiratory and other health problems among children and increase the health of everyone living in the household.								

**ESM 14.5 - Percent of Grantees who implement evidence based or evidence informed tobacco free programs.  
 NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually decrease the percentage of women who report smoking before, during and after pregnancy.								
<b>Definition:</b>	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;"><b>Numerator:</b></td> <td>The numerator is the number of vendors implementing evidence based or evidence informed tobacco free programs.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Denominator:</b></td> <td>The denominator will consist of the number of vendors.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;"><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of vendors implementing evidence based or evidence informed tobacco free programs.	<b>Denominator:</b>	The denominator will consist of the number of vendors.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator is the number of vendors implementing evidence based or evidence informed tobacco free programs.								
<b>Denominator:</b>	The denominator will consist of the number of vendors.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through vendor reporting.								
<b>Significance:</b>	Increasing the number of evidence based or evidence informed tobacco free programs will help to decrease the number of women who report smoking before, during and after pregnancy. Women who smoking before pregnancy have more difficulty becoming pregnant. Women who smoke during pregnancy are more likely to deliver preterm babies, low birth weight babies and babies who are more likely to die from Sudden Infant Death Syndrome (SIDS). Women who smoke after pregnancy have babies with weaker lungs increasing risk factors for other health problems.								

**ESM 14.6 - Percent of individuals trained on motivational interviewing.**

**NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Annually increase the percentage of Title V home visitors trained on motivational interviewing in order to elicit behavior change.								
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>The numerator is the number of Title V home visitors trained on motivational interviewing techniques.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>The denominator is the number of Title V home visitors.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.	<b>Denominator:</b>	The denominator is the number of Title V home visitors.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.								
<b>Denominator:</b>	The denominator is the number of Title V home visitors.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Data will be collected through Quarterly reports from the County Municipal Health Departments and Nurse Family Partnership (NFP) Programs. At this time we are unsure of whether we will be able to require that the NFP utilize motivational interviewing techniques.								
<b>Significance:</b>	Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Increasing the number of home visitors who are trained on motivational interviewing should increase the number of women who are discussing birth control, birth spacing, family planning, IPV and other behavioral health with a health professional and will motivate the women to be more active in their interconception health and ultimately the health of their children.								

**Form 11**  
**Other State Data**  
**State: Pennsylvania**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

## 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](#)

## Abbreviated State Action Plan Table

State: Pennsylvania

### Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2 ESM 1.3 ESM 1.4 ESM 1.5	

### Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants.	NPM 4 - Breastfeeding	ESM 4.1 ESM 4.2 ESM 4.3 ESM 4.4	
Safe sleep practices are consistently implemented for all infants.	NPM 5 - Safe Sleep	ESM 5.1 ESM 5.2 ESM 5.3 ESM 5.4	
Appropriate health and health related services, screenings and information are available to the MCH populations.			SPM 3

### Child Health

State Priority Needs	NPMs	ESMs	SPMs
MCH populations reside in a safe and healthy living environment.	NPM 7 - Injury Hospitalization	ESM 7.1 ESM 7.2 ESM 7.3	
MCH populations reside in a safe and healthy living environment.			SPM 2

## Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Protective factors are established for adolescents and young adults prior to and during critical life stages.	NPM 9 - Bullying	ESM 9.1 ESM 9.2 ESM 9.3 <i>Inactive</i> ESM 9.4 <i>Inactive</i> ESM 9.5 ESM 9.6 ESM 9.7 ESM 9.8 ESM 9.9	
Protective factors are established for adolescents and young adults prior to and during critical life stages.			
Protective factors are established for adolescents and young adults prior to and during critical life stages.			SPM 5
Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support.	NPM 10 - Adolescent Well-Visit	ESM 10.1 ESM 10.2 ESM 10.3 ESM 10.4 ESM 10.5	

## Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Appropriate health and health related services, screenings and information are available to the MCH populations.	NPM 11 - Medical Home	ESM 11.1 ESM 11.2 ESM 11.3 ESM 11.4 ESM 11.5	
Appropriate health and health related services, screenings and information are available to the MCH populations.			

**Cross-Cutting/Life Course**

State Priority Needs	NPMs	ESMs	SPMs
MCH populations are able to obtain, process and understand basic health information needed to make health decisions.			SPM 1
Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	NPM 14 - Smoking	ESM 14.1 ESM 14.2 ESM 14.3 ESM 14.4 ESM 14.5 ESM 14.6	
Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.			
Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.			SPM 4
Appropriate health and health related services, screenings and information are available to the MCH populations.			