

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

Pennsylvania

**FY 2019 Application/
FY 2017 Annual Report**

Created on 9/26/2018
at 10:52 PM

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I. General Requirements

I.A. Letter of Transmittal



July 13, 2018

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
5600 Fishers Lane, Room 18N33
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 2019. As directed, Pennsylvania's 2017 Annual Report and 2019 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 with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Carolyn S. Cass", with a long horizontal line extending to the right.

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.

Christine L. Sowen
for 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 F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Bureau of Family Health (BFH) as the Title V administrator in Pennsylvania (PA) served an estimated 2.6 million individuals of the maternal and child health (MCH) population in 2017 using over \$72 million of Title V grant, state match and other federal funding to support programming, state-level program management, and public health systems development. In partnership with over 50 grantee and key MCH stakeholder groups, the BFH applies a life-course approach to the delivery of programming across the six Title V population domains. An intentional effort is now being made to apply a lens of health equity, not only to improve the health and well-being of the most vulnerable, but to expand the scope of work and the story of Title V in PA to include an examination of a range of social determinants of health, most importantly those systems and policies reinforcing discrimination and increasing the allostatic load of all vulnerable populations.

As part of its systems-building work, the BFH is implementing new infrastructure and processes to maintain a continuous cycle of feedback through interim needs assessment surveys, focus groups, and client satisfaction and client engagement initiatives to ensure all MCH voices, including those of the most vulnerable, are heard. Moreover, the BFH is committed to strengthening its workforce around data usage and the necessity of data driven decision-making and creating a baseline knowledge of public health concepts, including health equity and the social determinants of health, to more effectively implement programs and evaluate program impact.

The following paragraphs highlight the BFH's successes and challenges of implementing PA's state action plan in 2017. Many of the programs within the purview of the BFH are meeting or exceeding their 2017 goals.

The BFH focuses on two priorities within the women/maternal domain: adolescents and women of childbearing age have access to and participate in preconception and interconception health care and support; and women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted. The access to preconception and interconception care 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 2017, nearly 1,900 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 exceeded its 2017 goal with 330 women receiving prenatal care through a Centering Pregnancy Program (CPP). Surpassing the 2017 goal were the 85 percent of adolescents and women being served through the CMHDs home visiting program and CPP are engaged in family planning after delivery with over 83 percent having talked to a health care professional about birth spacing/birth control methods.

Within the behavioral screening priority there are three objectives and five ESMs, some of which are linked to NPM 14.1: Percent of women who smoke during pregnancy. In 2017, 20 percent of women participating in a CMHD home visiting program reported smoking after confirmation of pregnancy. Over 1,300 women enrolled in the CMHD home visiting programs were screened using the Integrated Screening Tool (5P's) far exceeding the 2017 goal. Exceeding its 2017 goal of 75 percent, 89 percent of women enrolled in Title V home visiting programs talked to a home visitor about intimate partner violence.

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 2017, 85 out of 105 PA birthing facilities participated in the Keystone 10 initiative which is based on the Baby-Friendly[®] Hospital Initiative. Of these 85 participating facilities, 28 percent of participants completed more Keystone 10 steps in 2017 than in 2016, exceeding the goal of 25 percent. There are plans for 2018 to target a media campaign in the northeast region of PA as eight of the ten counties had a breastfeeding rate below 73 percent in 2012.

The safe sleep priority is linked to NPM 5: percent of infants placed to sleep on their backs; percent of infants placed to sleep on a separate surface; and percent of infants placed to sleep without soft objects or loose bedding. 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. In 2017, two hospitals have fully implemented the model with six hospitals recruited to implement the model in 2018, exceeding the 2017 goal. Over 4,000 infants or three percent of the births in 2017 had parents who received safe sleep education through the model program.

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 52 percent of samples received at the lab within 48 hours of collection, surpassing the 2017 goal of 49 percent.

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. One objective for this domain is to increase the number of home assessments and safety interventions. Three ESMs track progress on service provision, hazard identification, and interventions performed. In 2017, 1,069 home assessments were completed by the Safe and Healthy Homes Program (SHHP) exceeding the 2017 goal of 875. Of the almost 6,500 health and safety hazards identified through the home assessments, 4,845 health and safety interventions were performed exceeding the 2017 goal of 4,375.

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 Child Safety CoIIN work was to implement at least one new strategy to address interpersonal violence by 2020. By the end of 2017, 7.4 percent of Title V programming had interpersonal violence reduction components. It is anticipated one or two more programs with interpersonal violence reduction components will be implemented in the next year.

The children with special health care needs (CSHCN) domain is linked to two priorities: Appropriate health and health related services, screenings and information are available to the MCH population; and MCH populations are able to obtain, process, and understand basic health information needed to make health decisions (health literacy). A portion of the work is independent from a NPM, however, three objectives, each with a respective ESM focused on medical home growth are linked with NPM 11: percent of children with and without special health care needs having a medical home. The BFH met the goal of forming one new medical home collaboration in 2017 and 214 Parent Partners were involved in the PA Medical Home Initiative, which met the 2017 goal of 200. Over 4,000 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 the appropriate health and health related services priority. The SKN served 1,732 families in 2017, exceeding the 2017 goal. The SKN also formed four new collaborations in 2017 meeting the goal for this ESM. Work within this domain addressing the health literacy priority is focused on increasing the reach of the BrainSTEPS program. With nearly 600 referrals, the BFH exceeded the 2017 goal of 500 new referrals to BrainSTEPS program. Moreover, the BrainSTEPS model was included in a Centers for Disease Control and Prevention (CDC) evaluation of best practices and has also been adopted for implementation by Colorado.

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 2017, 83 percent of adolescent health vendors received LGBTQ cultural competency training. Additional work related to this priority resulted in suicide prevention programming reaching 368 youth, 273 percent more than in 2016 and more than double the goal for 2017, while 10 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 improve 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 funded with other federal funds which served 784 youth in 2017 through a mentoring program spread across five program locations. The BFH is in the process of expanding mentoring programming related to this SPM to three more areas with new Title V-funded programs starting in January of 2018.

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 3,780 youth, exceeding the 2017 goal. Also exceeding the 2017 goal, were 18 percent youth utilizing HRC services in schools with a HRC. Planning is under way to expand HRCs to three additional counties. Drop-in medical services were provided to 3,520 youth in 2017 exceeding the goal of 500 youth. In 2017, the BFH provided 10,599 youth with reproductive health counseling services, not quite meeting the goal of 13,545. It is anticipated the BFH will reach the 2018 goal due to an increase in the grant payment limits beginning in July 2017.

The BFH has work across several priorities within the cross-cutting domain for the current reporting cycle: the health literacy priority; 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.

A 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. In 2017, one grantee (1.3 percent of grantees) has developed and disseminated clear messaging as part of the infant safe sleep initiative. Brochures, palm cards, and posters with simple and consistent messaging for the hospital, bus and subway were developed.

The BFH is making a conscious effort to bring discussion around health disparities and health equity to the forefront both internally, through workforce development initiatives, and externally, through the integration of health disparities

language into grant agreements as part of work on the appropriate health and health related services priority. The BFH also developed the first, of what will be several, technical assistance documents to aid local agencies and stakeholders in utilizing the available evidence base to address various MCH issues in vulnerable populations.

The data priority has a defined SPM: percent of Title V staff who analyze and use data to steer program decision-making. The 2017 goal for this SPM is 32 percent of staff which was not achieved, partially due to an increase in staff. There are four objectives defined to help the BFH make changes in procedures and processes to institutionalize best practices for a successful future. Over the next year, training will be implemented to increase knowledge around data sources, data analysis and the development of program performance measures. New within the data priority is a pilot program, which will examine vital records and Medicaid data, to understand what factors influence consumers and clinicians to access or fail to access 17P, a treatment known to reduce pre-term delivery for women who have previously experienced a pre-term delivery.

While spotlight issues such as the opioid epidemic rightly shape the public health agenda of the PA Department of Health (DOH), the BFH must continue to lead the work of Title V towards the shadows, to look and listen for those bearing an unequitable burden of disease, injury, or mortality as their needs do not dissipate in the face of emergent issues. The inherent flexibility of the Title V funding allows the BFH to adapt to spotlight issues and DOH priorities while still having the ability to address and innovate around ongoing MCH population needs over the long-term, thus giving those most vulnerable populations the best chance at achieving a higher quality of life through improved health and well-being.

III.A.2. How Title V Funds Support State MCH Efforts

The Pennsylvania Department of Health and the Bureau of Family Health (BFH) expends federal and state maternal and child health (MCH) funds in accordance with Title V and other federal and state guidelines with the goal of protecting and promoting the health and wellbeing of women, children, and families. In FFY17, \$23,480,555 federal Title V dollars were expended, \$12,686,325 on preventive and primary care for children, \$8,446,175 on children with special health care needs, and \$2,348,055 on Title V administrative costs. Pennsylvania bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations. Total state and federal Title V expenditures for FFY17 were \$69,744,788. Additionally, the BFH expended \$2,592,423 in other federal funds implementing MCH programming. As outlined on Form 5, federally and non-federally funded Title V programs served 2,572,033 individuals from the MCH population. Title V served 98 percent of infants and 55 percent of children in FFY17. Over time, Pennsylvania has increased its capacity to serve a greater proportion of the MCH population by shifting reimbursable direct service expenditures to the appropriate payors and utilizing federal and non-federal Title V funds for population health programs, such as school health services and NBS.

III.A.3. MCH Success Story

The Division of Newborn Screening and Genetics (DNSG) implemented their internet case management system (iCMS) in July 2016. This system houses demographic information and dried blood spot, critical congenital heart defect, and hearing screening results on all newborns born in or screened in Pennsylvania and provides a means for community health nurses in the DNSG to easily follow-up on any abnormal screening results. Phase two of iCMS was rolled out to all submitters (hospitals, birthing facilities, and midwives) between fall 2017 and spring 2018. Phase two allowed submitters to input individual level hearing screening results directly into iCMS via HL7 messaging, device upload, or manual entry. This allowed the DNSG to implement reporting of individual level hearing screening results, which will greatly improve the quality of hearing screening data. In addition, phase two allowed contracted treatment centers to directly enter diagnostic evaluation results providing for more timely and accurate reporting on diagnosed dried blood spot disorders. iCMS also has significant data reporting capacity including a data warehouse and the ability to build ad-hoc reports utilizing any data field captured in iCMS. The DNSG plans on further expanding the capacity of iCMS to include a data match with vital records and expanding the reporting of diagnostic data to include reporting by non-contracted specialists including cardiologists and audiologists during the second half of 2018.

III.B. Overview of the State

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

PA is anchored by two urban counties – Allegheny in the west and Philadelphia in the east. Urban counties are those with a population density higher than the state population density, while rural have a lower density. Harrisburg, the capital and headquarters for the Department of Health (DOH), is situated in the southcentral part of the state. As of March 2017, PA's 19 large counties (counties where 75,000 or more are employed) accounted for approximately 77 percent of total employment within the commonwealth. All but one of those counties are considered urban. In 2016, slightly over 78 percent of the state GDP was produced by urban counties. PA has the sixth largest economy in the nation, but as of February 2017, had a seasonally-adjusted unemployment rate that was slightly higher than the national average. In 2017, 28 percent of PA's population was low income (under 200 percent FPL), and 43 percent of the state's Medicaid expansion population works full or part time but makes less than the eligibility threshold of 138 percent FPL.

The health care, social assistance, manufacturing and real estate sectors are major contributors to the economy. The industries with the greatest number of employees in PA were health care and social assistance in 2016, growing 6 percent since 2012. Employment in farming increased from 2012-2016, reversing a trend from 2001-2012. While 56 of PA 's 67 counties have at least 500 individuals employed in farming, six of the seven largest pockets of farm employment are along PA's southern border.

The delivery of health care services is significantly impacted by the distinctive rural and urban characteristics across the state. While 48 of PA's 67 counties are considered rural, nearly three-quarters of PA's residents live in urban counties. The concentration has become even more pronounced since 2010, as most of the population growth in PA has occurred in urban counties. In 2014, there was one physician for every 266 residents in urban counties, as compared to one physician for every 586 residents in rural counties. Of the 17 counties without Federally Qualified Health Centers (FQHC), all but one are rural. As of 2014, of the estimated 435,921 residents experiencing a primary care provider (PCP) shortage, 52 percent lived in a rural county. Rural counties also represented all 29 counties where at least 15 percent of the population was experiencing a PCP shortage. In 2014-2015, there were 67 general acute care hospitals, with a total of 7,427 beds, in rural PA. Seven rural counties have no hospitals. On average, there were 2.17 hospital beds for every 1,000 rural residents compared to 2.63 hospital beds for every 1,000 urban residents.

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. On average, rural PA residents are older than urban PA residents. In 2015, 18 percent of the rural population was 65 years old and older compared to 16 percent of the urban population. From 2010 to 2040, the number of senior citizens in rural PA is projected to increase by 54 percent.

Across the state in 2016, the 156 general acute care hospitals (including 15 Critical Access Hospitals) with nearly 35,000 licensed beds handled almost 1.5 million admissions. An additional 93 federal and specialty hospitals handled nearly 170,000 admissions. There are nine children's hospitals in PA, six of which are in either Philadelphia

or Pittsburgh. The other three are in Danville, Erie, and Hershey. Children who live in rural areas or in areas not near these hospitals may not have ready access.

Supplementing the hospitals are over 260 FQHC or rural health centers providing primary care services in 50 counties. FQHCs are an important resource for PA's vulnerable populations; 91 percent of patients are at or below 200 percent FPL, 51 percent are on Medicaid, and 53 percent are members of a racial or ethnic minority.

Critical access hospitals are rural hospitals that provide 24-hour emergency services with an average daily census of 25 patients or less. These hospitals serve as key providers in areas with sparse populations, geographic barriers to care, and significant health professional shortages to address populations who are generally older, sicker, and poorer. Besides anchoring a broad range of health and human services in their communities, many of these hospitals continue to be the top employers in their county and major contributors to local economies. Of concern is that in FY 2016, nine of the critical access hospitals (60 percent) reported negative operating margins.

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

Counties without CMHD have state health centers who provide and support public health programs throughout PA. To organize the state health centers, PA is split into six community health districts, each covering a geographic region of the state. Each health district in turn has a district office that helps coordinate activity throughout the district. Through the utilization of community health assessments and outreach, the centers focus on five core functions:

- Communicable disease investigation and prevention
- Immunizations
- Public health education
- HIV/STD services
- Tuberculosis investigation and treatment.

A key component in the MCH system of care is Medicaid, administered in PA by the Department of Human Services (DHS). Medicaid eligibility is determined by belonging to a particular group such as pregnant women, children, low-income adults, elderly adults, or disabled adults; or by having a special condition, as well as meeting financial and citizenship requirements. Medicaid eligibility levels are highest in PA for children and pregnant women and both are higher in PA than the median U.S. rate.

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

In addition to covering basic Medicaid services, states can choose to cover up to 30 optional benefits. PA covers 24, including prescription drugs, vision, dental, physical therapy, home health, and hospice care. PA's Medicaid expansion coverage includes the Affordable Care Act's (ACA) ten essential health benefits and expanded mental

health and substance use treatment services.

As of March 2017, CHIP and Medicaid combined provided health and long-term care coverage to more than 2.9 million individuals in PA. Medicaid is also a major source of funding for safety-net hospitals and nursing homes, and most Medicaid spending in PA is for the elderly and people with disabilities. Medicaid accounts for 61 percent of all federal funds received by PA and 29 percent of the state general fund.

Children with special health care needs (CSHCN) are served by Special Needs Units (SNU) within Medicaid. SNU are housed within physical health Managed Care Organizations (MCO) and ensure CSHCN receive services and supports in a timely manner. SNU also assist CSHCN with access to services and information, coordinate between physical health and behavioral health and other systems, and staff a dedicated special needs hotline. Each physical health MCO has a full-time SNU coordinator. SNU staff also work in close collaboration with the SNU housed within DHS.

Individuals not eligible for Medicaid may qualify for CHIP, also a part of DHS. CHIP provides free or low-cost health insurance to uninsured children and teens up to age 19 in families with incomes over the Medicaid limit (133 percent FPL). As of November 2016, there were 168,238 children enrolled in CHIP, more than 70 percent of whom received CHIP for free. Another 25 percent received low-cost CHIP.

So, who are the people being served by the MCH system of care in PA? Following a national trend, PA is becoming more racially and ethnically diverse. From 2010-2016, the minority population increased from 36 percent to 39 percent nationally, and from 21 to 23 percent in PA. Minority residents make up more of the population in urban areas (30 percent) than in rural areas (9 percent). The population identifying as Hispanic increased in PA by 25 percent from 2010-2016, increasing by at least 7 percent in every county. From 2000 to 2015, the rural population became more racially diverse, as the non-white or Hispanic rural population increased from 5 percent of the total population, to 9 percent. With the total minority population projected to double between 1990 and 2025, the responsibility and challenge of the Title V program is to understand their diverse backgrounds, and how they shape interactions with services and Title V programming.

Like the US, blacks in PA have the highest overall mortality rates compared to all other racial groups. Their infant mortality rates are three times that of whites. Compared to whites, the percentage of teen (age 15-17) births and teen pregnancy rate are four times that of whites. This is despite teen pregnancy rates for blacks having dropped nearly 60 percent from 2010 – 2016. For blacks, the percentage of births to unmarried mothers is nearly two and a half times that of whites, and the percentage of low birth weight is twice that of whites. Compared to whites, blacks also have significantly higher percentages of no prenatal care, untimely prenatal care, and mothers not breastfeeding. While the uninsured rate has fallen for all racial and ethnic groups because of the ACA, as of 2016 whites are still more likely to be insured than blacks. Approximately 900,000 people comprise an increasingly diverse Hispanic population. Despite living under similar socioeconomic conditions, and having similar cultural attitudes about body image, Hispanics have lower overall death rates than blacks. However, Hispanics still have some disparities when compared to whites. Like blacks, despite a decline in teen pregnancy rates from 2015-2016, both the percentage of teen births and the teen pregnancy rate are nearly four times that of whites. The percentage of births to unmarried mothers for Hispanics is twice that of whites. In addition, the infant mortality rate, percentage of low birth weight, and percentage of untimely or no prenatal care are all significantly higher for Hispanics than for whites.

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 regarding insurance coverage, hospital visitation rights and powers of attorney. Members of LGBTQ groups have health needs both regular and specific to their sexual and gender orientation that often go unmet.

In response to a range of discriminatory laws being passed in other states, Governor Wolf signed executive orders in April 2016 stating “no agency under the governor’s jurisdiction shall discriminate on the basis of sexual orientation, gender expression, and identity, among other areas.” These orders pertain to commonwealth employees, and the commonwealth grants and procurement process. Over 40 municipalities have passed separate ordinances to prohibit discrimination based on sexual orientation and gender identity.

People with disabilities may have multiple barriers to performing daily life functions such as finding physical pathways to community locations and needing 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 have substance use disorders and constitute a large portion of the homeless population; all barriers to accessing and using health care services. Getting to treatment, treatment plan compliance, cost, and the burden of stigmatization all make access to treatment difficult for those with mental illness. In addition, the system of care for CSHCN is a confusing maze of interlocking directories challenging for families to navigate. Overlapping the disparities are familial, educational and economic characteristics of the population that further define their interaction with the MCH system of care. In general, PA is growing older. The median age of PA residents is 40.6 years old, approximately three years older than the US median age. From 2010-2016, PA’s population grew less than 1 percent, the number of young residents (under 18) decreased 4 percent, but the number of residents 65 and older increased 13 percent. In 2040, an estimated 25 percent of the total rural population will be 65 and older. At that time, there will be more senior citizens than children and youth in rural PA. Counties with large elderly populations could face the possibility of diverting resources from MCH populations towards their elderly residents.

Of the approximately 5 million households in the state, nearly 3.2 million of these households are defined as families, with an average size of 3.1 members. The U.S. Census Bureau categorizes families as: married-couple families, male householder (no wife present) and female householder (no husband present). While married families are the majority, over 70 percent of non-married families are female led. These households have slightly larger family sizes, are more likely to have members less than 18 years of age, and are more likely to live in multi-unit structures. Eight percent of all households in PA are single parent households with children under 18 and no spouse present. PA had a lower percentage of households with children (26 percent) than the national figure (29 percent).

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. Most same-sex couples in PA are women (56 percent) and 81 percent are white. The mean income for same-sex couples is higher than that of different-sex couples, \$52,000 versus \$46,000, and over half have a college education as compared to only 33 percent of different-sex couples. Ninety percent of same-sex couples have health insurance. In PA, three percent of people identify as LGBT with 27 percent raising children; the US numbers are four and 29 percent. As with same-sex couples, most of the LGBT population is white (72 percent). PA ranks 38th 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 evenly distributed across age groups for each family type. Of the nearly 2.7 million children in the state, over 1.7 million live in a married family. Over 218,000 children live in male led families; and roughly 690,000 children live in female led families, which are less likely to have an unmarried partner

present.

The racial distribution greatly varies between types of households with children. While more than 82 percent of children in married families are identified as white, 72 percent of children in male led families and 53 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 families are more likely to have grandchildren in their households, and more likely to have a child with a disability in their household when compared to other households.

Median income varies by county from \$36,600-\$89,000; for families with children, it is \$70,063. However, there are stark differences in median income when considering family type. The median income for married families is almost \$94,000, approximately \$41,000 for male led families and \$25,300 for female led families. Although female led families are slightly larger than the other types, their median income is much lower. Women's income is also affected 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.

Future earnings are related to a person's level of educational attainment. Of the approximately 1.19 million 18 to 24 year olds, almost 34 percent have graduated high school; nearly 45 percent are enrolled in college or graduate school and just over 12 percent have a bachelor's degree or higher. Females in this age group are enrolled in college or graduate school at a higher rate than males.

For the 8.92 million people aged 25 years and over, over 90 percent are high school graduates or higher, varying a bit by county, and nearly 31 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 nearly 25 percent and decreases with educational attainment. The median annual income for those aged 25 years and older is approximately \$39,600 and ranges from \$22,800 for those with less than a high school diploma or equivalency to almost \$70,000 for graduate or professional degree holders.

In 2016, a smaller percentage of PA residents (12.9 percent) lived in poverty compared to the national rate (14 percent). However, there are still large swaths of the population living in poverty, as 26.4 percent of PA's black residents and 30 percent of PA's Hispanic residents lived in poverty and both were more than three times as likely to be living in poverty than whites. Of the 1.35 million families with related children under 18, 14.6 percent were living below the poverty level during the previous year. Female led families were more likely than any other to be living below the poverty level, and more than twice as likely as all PA families with children under 18. The highest rates of poverty were for those families with a householder having less than a high school education. However, at all levels of educational attainment, the percentage of female led families living below the poverty line was higher than other families, more than double in most cases.

Adolescents (15 to 19 years) are an important sub- population within the MCH population, numbering nearly 833,000 with almost 89 percent enrolled in school in 2016. School enrollment among adolescents is fairly consistent by race, with Hispanics having the lowest enrollment at 84.5 percent. For Hispanic adolescents, 2.2 percent had a birth in the past 12 months, compared to 1.6 percent for blacks and 0.7 percent for whites. Almost 58 percent of black adolescents and nearly 40 percent of Hispanics live in female led families compared to only 18 percent of whites. White and Hispanic adolescents had comparable percentages in the labor force (between 42 and 43 percent), the percentage for blacks was only 34 percent.

Health insurance is a key factor for health care access. In 2016, 5.6 percent of the nearly 12.6 million civilian

noninstitutionalized population in PA were uninsured. By gender, 6.5 percent of men were uninsured compared to nearly 5 percent of women. Only slightly more than 5 percent of whites were uninsured compared to slightly more than 7 percent of blacks and nearly 14 percent of Hispanics. Nearly 11 percent of 25-34-year-olds were uninsured, the largest proportion of any age group. As educational attainment increased, the percentage insured increased.

The ACA has brought some insurance relief with the introduction of the federal Marketplace. While the uninsured rate varies across counties, the 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 residents had selected a Marketplace plan with over 75 percent eligible for subsidies. The expansion in PA resulted in almost 12,000 individuals being saved from catastrophic out of pocket medical costs, and about 37,000 individuals did not have to borrow or skip payments.

Impacting PA residents, the health care system and the broader landscape of the MCH system of care are several important issues. Like other states, the epidemic of opioid use is now a priority of both the Governor's administration and the DOH. In 2015, PA's mortality rate from opioid deaths was higher than the national rate (11.2 versus 10.4 per 100,000). According to the 2016 PA Coroner's Association Report, there were 4,884 deaths resulting from drug poisoning, a 39 percent increase over the previous year and nearly double the amount from just two years previous. And the number of deaths is expected to increase again in 2017, as the report indicates that 13 people die every day in PA from drug related causes. While there is a broad range of ages for these deaths, the typical decedent is single, male and between 25-34 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. In January 2018, Governor Wolf declared the heroin and opioid epidemic a statewide disaster emergency, a first for a public health emergency. The declaration allowed for the creation of a command center that will track progress and enhance the coordination of health and public safety agencies, helping commonwealth agencies address the opioid epidemic. The command center is stationed at the Pennsylvania Emergency Management Agency and headed by an incident commander.

The recently confirmed Secretary of Health, Dr. Rachel Levine, is working to have the epidemic declared a public health disaster, which is an unprecedented step. The DOH's plan is to focus on the following:

- prevention, through bolstering its programs that work to prevent drug abuse;
- rescue, through a standing order for Naloxone signed by the Secretary when she was the Physician General;
- and treatment (with a focus on medically-assisted treatment), via a warm handoff from the organization where the person first touches the system for treatment.

Dr. Levine has also outlined additional priorities for the DOH as follows:

- Access to medical marijuana in 2018.
- Implement recommendations of the nursing home taskforce and auditor general reports including the development of regulations.
- Implement a rural health initiative with six pilot hospitals in 2018.
- Continue to build capacity to respond to public health threats through preparedness.

Rural hospitals are critical to areas not only because they provide access to care for populations that do not have a lot of options, but are also often the biggest job producers in the area. However, the current payment mechanism puts rural hospitals under significant economic pressure. The DOH has prioritized the protection of access to health care in rural communities using a Rural Health Model, developed in coordination with the Centers for Medicaid

and Medicare Services. Another unique challenge related to PA's status as a largely rural state is Lyme disease. PA has the most reported cases of Lyme disease of any state in the country. As it is a priority, the DOH is forming an inter-bureau workgroup to pull together resources and knowledge to address it.

The Secretary's priorities combined with the State Health Improvement Plan (SHIP) and the DOH's Strategic Plan guide the work of the agency and illuminate areas for Title V to implement work. The DOH is currently in the middle of its SHIP for 2015-2020, developed in partnership with a broad representation of public health system stakeholders. The SHIP priorities are: 1) obesity, physical inactivity, and nutrition; 2) primary care and preventive services; and 3) mental health and substance abuse. Through the process of defining the SHIP priorities, five cross-cutting themes were also identified: health literacy, public health systems, health equity, social determinants of health and integration of primary care and mental health.

The DOH 2016-2019 Strategic Plan consists of 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 PA DOH 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 Bureau of Family Health, as the Title V administrator, will continue to emphasize evidence-based and data driven decision-making within its programming while increasing the integration of quality improvement techniques throughout its work.

In February 2018, the DOH formally submitted the required documents to the Public Health Accreditation Board to apply for public health accreditation. Accreditation ensures that the DOH is meeting national evidence-based standards and providing PA residents with the best programs and services available. Accreditation can help the BFH improve collaborations between staff and stakeholders and further the Title V mission and programming through increased accountability, quality service delivery and institutionalized processes, such as the use of evidence-based practices and integration of quality improvement techniques.

PA's MCH system of care is further augmented by state statutes mandating programs serving the MCH populations and requiring the resources of Title V in both staff and funding. The Newborn Child Testing Act (35 P.S. § 621, et. seq. and amended by Act 36 of 2008) establishes a program providing for the screening tests of newborn children and follow-up services related to case management, referrals, confirmatory testing, assessment and diagnosis of newborn children with abnormal, inconclusive or unacceptable screening tests results. Act 87 of 2008 mandates the Child Death Review (CDR) Program, which provides for statewide and county-based multidisciplinary CDR teams to conduct reviews of all deaths of children aged 21 and under. The Act also requires an annual report on the information, distribution and causes of child deaths in PA and reflects information collected during the CDR process from collaborative processes between the DOH and local CDR teams. The Pennsylvania Code (028 Pa. Code § 27.22 and 028 Pa. Code § 27.34) requires laboratories and providers to report blood lead test results to the DOH. And looking towards the future, Act 24 of 2018 establishes a Maternal Mortality Review committee to conduct multidisciplinary reviews of maternal deaths and develop recommendations for the prevention of future maternal deaths.

PA is a state of contrasts presenting unique challenges to the delivery of services and resources across the MCH system of care. An aging but diverse population will gradually force a system adjustment to meet geographic, programmatic, and cultural needs. Swaths of poverty are inseparable from gender, education, race and ethnicity with women led families bearing an unequal burden. Systems of care are equipped to meet urban needs but not rural needs. This, however, is not as dire as it seems. There is strength in the access to care provided by Medicaid and CHIP, the local work of the CMHD, and DOH development of strategic plans and newer programs to meet current

challenges such as opioid addiction and maternal mortality. Title V resources will have to be nimble and adaptable to meet the changing landscape of MCH service needs in PA.

III.C. Needs Assessment

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Process

Surveying service recipients and providers on an annual basis is now part of the Bureau of Family Health's (BFH) interim needs assessment infrastructure for soliciting feedback from stakeholders. BFH staff developed an electronic survey to explore the strengths and barriers related to the availability of maternal and child health (MCH) resources and services. Building on lessons learned in 2017, this year's survey was less comprehensive to ease completion and result in a larger sample size. The survey (Attachment 1) was constructed in SurveyMonkey by the Bureau of Informatics and Information Technology (BIIT). A hyperlink to the survey was sent to over 100 MCH provider contacts with a request to complete the survey and share it with service recipients. A skip pattern was built into the survey so respondents would get a specific set of questions depending on how they identified themselves. Included in the survey were questions on demographics, the availability of various services, barriers, places people go for health information, discrimination, health equity, and the survey format. For some questions, respondents were asked which populations were affected – women/maternal, perinatal/infant, or children ages 1 – 21 with or without special health care needs. The delineation by population was included to allow for more varied data analysis. The survey was open between March 23, 2018 and April 11, 2018. Survey findings are being used to inform the development of focus groups. Both providers and service recipients indicated access to services and resources was a top barrier experienced by service recipients. The BFH is in the process of setting up focus groups with service recipients to probe for more information around this barrier. All findings will be used to inform programming and will be shared with stakeholders in a full report.

Findings

Responses to the survey were received from 15 service recipients or family members of service recipients (service recipients) and 91 service providers, for a total of 106 responses. Service recipients were asked to identify their county of residence. Because of the limited number of responses from service recipients, only seven of 67 counties were represented. Service recipients were asked to describe themselves or those for whom they provide care out of four population groups. Most service recipients selected the children ages 1-21 and women/mother populations. Three service recipients selected the children with special health care needs (CSHCN) population, and two selected the perinatal/infant population.

Providers were asked to identify the populations their program or organization serves, with the option to select up to four populations. Responses were evenly distributed across all four population groups: 67 responses for children ages 1-21, 62 for women/maternal, 62 for CSHCN, and 56 for perinatal/infant. Geographically, responses were received from every county with Philadelphia and Allegheny counties submitting the most responses.

Thirty-two MCH resources and services were listed and service recipients were asked how often they can get those services and resources if they need them on a scale of not applicable, never, seldom, about half the time, usually, and always. As part of the survey design, responses were given a numerical weighted average. The lower the average, the less often the respondent could get the service. The two most common and the two least common responses were identified based on the weighted averages. The services and resources service recipients could get least often, were the availability of medical homes and services to reduce stress, such as respite. Those service recipients could get most often were well-baby and well-child visits with a pediatrician or family doctor and pre-pregnancy care.

There was not a broad range of responses from providers when asked how often service recipients could get those same services if they need them. The services and resources service recipients were least likely to get included services to reduce stress, such as respite and bullying prevention. The services and resources service recipients were most likely to get included preventing infant deaths and well-baby and well-child visits with a pediatrician or family doctor.

Service recipients were asked to choose barriers they might have experienced that prevented them from receiving services or resources across three population groups. The list of barriers included 21 options in the following categories: access, financial, structure, individual, and other, divided by three population groups. The most common barriers among service recipients were “access to information” and “do not know what services and resources are available”. “Do not know what services and resources are available” was the most common barrier for the women/maternal population and children ages 1-21 population. “Transportation” and “application forms too complicated” were the top barriers for the perinatal/infant population. Receiving incorrect eligibility information from providers was one response to an open-ended question about barriers.

Providers were asked about their perspectives on barriers preventing service recipients from receiving services or resources. For each population, providers selected from the same list of 21 barriers as the service recipients. The most common responses overall were: “do not know what services and resources are available” and “transportation”. “Transportation” was the top barrier for the women/maternal population and the perinatal/infant population. “Transportation” and “do not know what services and resources are available” were tied as the top barrier for the children ages 1-21 population. The main themes in response to an open-ended question about barriers included transportation and financial issues.

Next, service recipients were asked where they physically go in their neighborhood or community for health information or discussion about health issues. Out of 11 options, the most common responses overall were government agencies (women, infants and children [WIC], local health departments, etc.) and health clinics/hospitals. Government agencies was also the most common response for all the population domains. In response to an open-ended question about additional locations, one service recipient indicated there are no resources in their community and another reported they go to other people for health information. From the providers’ perspective, the top places overall where service recipients physically went mirrored the service recipient responses. Open-ended responses by providers noted family and friends as sources of information.

Service recipients were then asked a question related to reasons people may experience or feel like they are experiencing unequal treatment when receiving services and responded to a list of 14 possible reasons. Income level and disability were the most common responses. Additional reasons provided in response to an open-ended question included finding homes other than housing for families with young children and many services are offered only to low-income people.

A question posed only to providers asked them to describe policies, training requirements or initiatives that have been or are being implemented by their organization to address cultural and linguistic humility or health equity. Responses from 37 providers indicated their organizations have attempted to increase culturally and linguistically appropriate materials and staff behaviors. Themes that emerged were training, having access to a language line, providing materials in various languages and hiring of bi-lingual staff. Eight providers reported their organizations included non-binary gender and sexual orientation data on demographic forms or received training on how to collect this data. Five providers shared their organization is working on obtaining a safe space designation or their partnering organizations are designated as safe spaces. Ten responses were received related to developing a plan to address health equity or health disparities. The most common response was the respondent’s organization had at

least one health disparities plan.

When asked how the survey process could be improved, providers reported that some of the questions were unclear, difficult to answer, or could be interpreted in different ways. Themes that emerged in response to an open-ended question about anything providers wanted to add included the need to be more effective in sharing information with families, lack of resources, and various barriers that prevent people from receiving information and services.

A. Capacity

Agency

Within the BFH, the specialty care grants were redesigned with a focus on identifying and addressing barriers to care, supporting access to care and connecting with community supports, and care coordination. Services for LGBTQ youth and the SafeTeens program were expanded. The Newborn Hearing Screening and Follow-up Program expanded its reach under revised federal guidance. The Respite Care Program, CDC Lead Poisoning Prevention program, and Support.Empower.Learn. Parenting Health Initiative are new programming within the BFH.

Workforce

BFH staff and grantees participated in a variety of program-specific and individual skill-building training over the last year to enhance current skill sets as well as introduce new staff and staff in new roles to the relevant subject matter. Multiple staff attended national trainings, regional symposiums, local and national conferences and DOH offered trainings. Examples of these opportunities include:

- LGBTQ training, which was offered to all BFH staff and attended by 23
- the Association for Maternal and Child Health Programs conference, attended by staff from several divisions
- the Sickle Cell Disease Association of America National Convention was attended by the Project Officer for the Sickle Cell Program
- regional trainings for hearing screening providers and contracted treatment centers on the use of the Internet Case Management System (iCMS)
- professional development courses for the Safe and Healthy Homes Program field staff

B. Partnerships

Starting in December 2017, the BFH began collaborating with the Division of Vital Records in BIIT to link the iCMS for newborn screening with the vital records system with support from the State Systems Development Initiative grant.

The Newborn Hearing Screening Program launched the first of six new learning communities, established new or expanded partnerships with Early Intervention, Leadership Education in Neurodevelopmental Disabilities Programs, and Parent Education and Advocacy Leadership Programs, and created a new EHDI Advisory Group comprised of various stakeholders.

The BFH is now partnering with the Department of Human Services (DHS) and the Allegheny County Department of Human Services to create a statewide Project LAUNCH replication guide.

The BFH partnered with the Bureau of Epidemiology to implement the CDC Lead Poisoning Prevention - Childhood Lead Poisoning Prevention Program with the goal of increasing blood lead testing, identifying children with elevated

blood lead levels, and creating linkages to follow-up care.

Some partnerships ended as programs concluded or changed direction, such as the partnerships with Cribs for Kids, the Shaken Baby Syndrome Programs and the Core Leadership Team.

C. Efforts to Operationalize Five Year Needs and Capacity Assessment

The BFH is exploring various options for conducting the Five-Year Needs and Capacity Assessment, including the possibility of contracting with a vendor. A description of potential project deliverables has been drafted and includes both quantitative and qualitative metrics for capturing the strengths and needs of the health status of MCH populations in PA and the BFH's capacity to address those needs.

D. Changes in Organizational Structure and Leadership

There were no senior leadership personnel changes within the BFH, however Erin McCarty is now the CSHCN Director and Tara Trego is now the MCH Director. The administrative and budget functions of the DOH, DHS, the Department of Aging, and the Department of Drug and Alcohol Programs are in the process of being consolidated.

E. Emerging Issues

Governor Tom Wolf and the DOH are committed to addressing the most pressing health issues emerging in PA. Maternal deaths have more than doubled in PA since 1994, a problem even more pronounced for women who are minorities or low-income. PA ranks 21st among states in maternal mortality and was the largest state without a maternal mortality review committee. In 2018, Governor Wolf signed House Bill 1869 calling for the creation of a Maternal Mortality Review Committee to conduct a multidisciplinary review of maternal deaths and identify trends to inform the development of prevention recommendations.

The opioid epidemic has continued to ravage communities in PA. A statewide opioid emergency declaration has been signed to enhance collaboration among state agencies in the fight against the opioid crisis. At DOH, birth certificate fees were waived for people suffering from opioid use disorder to make it easier for them to receive the required identification for treatment facilities. PA's standing order of Naloxone was updated in 2018 to authorize DOH-certified EMS providers or DOH-licensed EMS agencies to leave behind Naloxone with people who are in a position to assist individuals who are experiencing opioid-related overdoses.

In response to limited data on Neonatal Abstinence Syndrome (NAS), NAS was added to the list of PA's reportable conditions. Hospitals and birthing centers are now required to report to DOH information related to infants with NAS born on or after January 10, 2018 to mothers who are residents of PA. This data will be used to identify locations where cases are clustered so resources can be targeted to high-need areas. More than 60 percent of hospitals and birthing centers in the state are now reporting cases of NAS. The BFH and the Bureau of Epidemiology participate in a workgroup to explore the possibility of building a system of surveillance for NAS trends and to inform the development of supportive services for affected mothers.

One new approach to treating patients with serious medical conditions is medical marijuana. The DOH's Medical Marijuana Program moved into its second phase, allowing up to 13 new grower/processor permits and up to 23 new primary dispensary permits. This is the maximum allowed by PA's medical marijuana law. DOH's Medical Marijuana Program is the only program in the country that has a clinical research component. In 2018, DOH approved eight universities as Certified Academic Clinical Research Centers to conduct research on the effectiveness of medical marijuana in the treatment of approved conditions.

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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.

PA 2015 Youth Risk Behavior Survey of high school students		
YRBS Behaviors	PA	US
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.

Impact of CSHCNs Conditions on Families (2009-10)	
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	
Race	
83%	White
12%	Black
5%	Other
6%	Hispanic
Unintended Pregnancies (2011)	
38%	Mothers with an unintended pregnancy
Poverty Level	
14%	Below poverty level
Health Insurance	
12%	Uninsured
88%	Insured
Educational Attainment	
3%	< 9 th 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
Employment	
69%	Employed
Smoking (2009-2011)	
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	
Adequate Prenatal Care (2011)	
73%	White
57%	Black
59%	Hispanic
Prenatal Care in the First Trimester (2010-2012)	
77%	White
56%	Black
57%	Hispanic
No Prenatal Care (2010-2012)	
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.

Breastfeeding Rates		
	Pennsylvania	Nation
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.

2013 Pennsylvania Adolescents (ages 10-19)	
Gender	
51%	Male
49%	Female
Race/Ethnicity	
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.

2012 Chlamydia and Gonorrhea Rates for Adolescents per 100,000 population (15-17 years of age)	
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.

2013-2014 School Year Dropouts	
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.

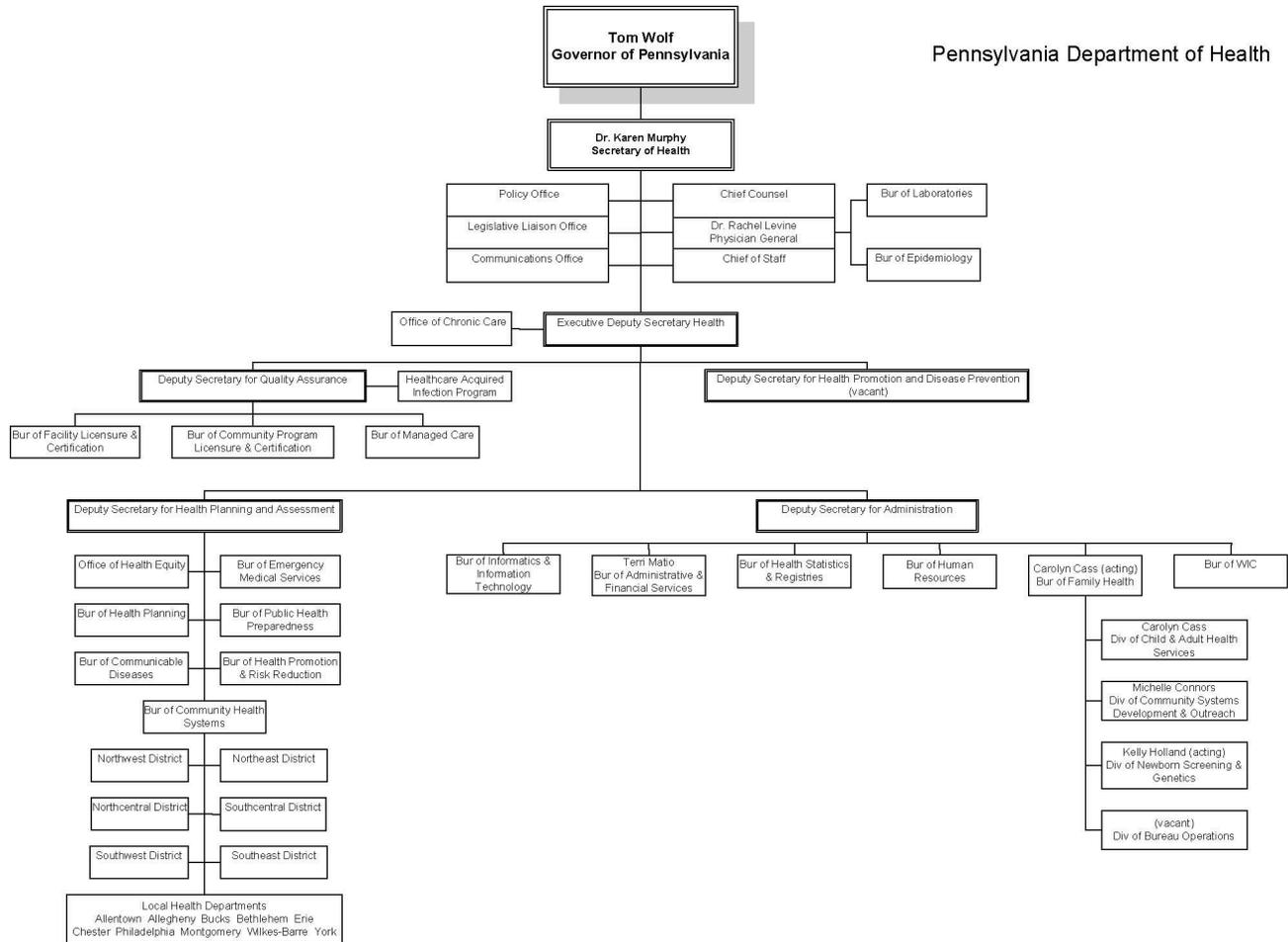
Smoking continues to have an impact on maternal and child health, despite cessation efforts. In 2013, 21 percent of the adults smoked with higher rates seen for those with less than high school education, among non-Hispanic blacks, and with incomes less than \$15,000. In 2013, 14 percent of women smoked 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 47th Governor on January 20, 2015. The Governor serves as Chief Executive of the nation's 6th 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.
Tourette Syndrome Support Program	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.
Cystic Fibrosis Program	Hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Cystic Fibrosis. Breathe PA is funded under this appropriation.
Sickle Cell Program	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.
Children's Home Ventilator Program	Provides comprehensive care, including respite care and counseling to ventilator dependent children and families.
Child Rehabilitation Program	Hospitals and one community based organization provide comprehensive, multidisciplinary team care to clients with neuromuscular and orthopedic disorders.
Hemophilia Program	Select hospitals across the state provide multi-disciplinary team care to children and adult patients with a diagnosis of Hemophilia.
Cooley's Anemia Program	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.
Spina Bifida Program	Select hospitals across the state provide comprehensive, multidisciplinary team care to pediatric and adult patients with Spina Bifida.
Charcot-Marie-Tooth Program	Outreach and education about Charcot-Marie-Tooth disease.
Breastfeeding Awareness and	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: Non Title V Programs

Table 2: Non-Title V Programs

Program / Service	Function(s)
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
Total	188	

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)	<p>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.</p>
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The Pennsylvania Pregnancy Risk Assessment Monitoring System (PA PRAMS)	<p>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.</p>
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Lead Hazard Control Program (LHCP)	<p>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.</p>
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WIC	<p>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.</p>
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Other HRSA programs	
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Federally Qualified Health Centers	The PA Medical Home Program, administered by BFH, collaborates with
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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.

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$23,296,703	\$23,527,801	\$23,442,305	\$23,491,258
State Funds	\$57,510,000	\$44,898,657	\$47,298,000	\$44,131,488
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$80,806,703	\$68,426,458	\$70,740,305	\$67,622,746
Other Federal Funds	\$226,007,691	\$3,964,517	\$4,350,997	\$1,853,304
Total	\$306,814,394	\$72,390,975	\$75,091,302	\$69,476,050

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$23,527,801	\$23,480,555	\$23,491,258	
State Funds	\$47,153,000	\$46,264,233	\$46,514,800	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$70,680,801	\$69,744,788	\$70,006,058	
Other Federal Funds	\$5,170,360	\$2,592,423	\$5,902,230	
Total	\$75,851,161	\$72,337,211	\$75,908,288	

	2019	
	Budgeted	Expended
Federal Allocation	\$23,480,555	
State Funds	\$48,774,500	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$72,255,055	
Other Federal Funds	\$5,231,068	
Total	\$77,486,123	

III.D.1. Expenditures

The Pennsylvania Department of Health and the Bureau of Family Health (BFH) expends federal and state maternal and child health (MCH) funds in accordance with Title V and other federal and state guidelines with the goal of protecting and promoting the health and wellbeing of women, children, and families. Title V FFY17 expenditures, both federal and non-federal, align with Pennsylvania's MCH nine priority needs as identified on Form 9. Priority needs were addressed through the following strategies:

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

as well as home safety interventions, such as integrated pest management and preventive safety devices to address the leading causes of child injury and death, and implement Child Safety Collaborative Innovation and Improvement Network (CollIN) falls prevention and interpersonal violence reduction activities. Other federal funds were expended to enhance childhood blood lead level surveillance and implement lead prevention activities.

- **Protective factors are established for adolescents and young adults prior to and during critical life stages** - Federal Title V funds were expended to provide evidence-informed LGBTQ cultural competency training to BFH vendors who serve adolescents, require all vendors serving adolescents through a BFH grant to adopt and implement comprehensive anti-bullying/harassment policies, identify evidence-based strategies to address bullying, implement an evidence-informed approach to train youth-serving organizations to become a safe space for LGBTQ youth, and implement an evidence-based suicide prevention training for LGBTQ youth. Federal Title V funds and other federal funds were expended to develop evidence-based or evidence-informed mentoring, counseling, and adult supervision programs for children ages 8 to 18 with and without special health care needs.
- **Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted** - Federal Title V funds were expended to promote the utilization of the 5Ps Integrated Screening Tool from the Institute for Health and Recovery and motivational interviewing.
- **MCH populations are able to obtain, process and understand basic health information needed to make health decisions** - Federal Title V funds were expended to review and evaluate available social media platforms for messaging of basic health information, explore the feasibility of using a text messaging or smart phone application outreach program to provide basic health information, and implement the BrainSTEPS program. Other federal funds were expended to provide direct and enabling services through the Traumatic Brain Injury program while federal Title V funds were used to support state-level program management of the Traumatic Brain Injury program and public health systems development.
- **Title V staff and grantees identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs** –Federal Title V funds were expended on staff who reviewed program activities and goals to determine programmatic needs, conducted analysis, interpreted results, developed actionable reports, developed program strategies based on actionable findings, and used PA Pregnancy Risk Assessment Monitoring System (PRAMS) and Child Death Review findings to inform, develop, modify and evaluate public health programs and policies in Pennsylvania. Other federal funds, supplemented with federal Title V funds, were expended to collect, analyze, and report PA PRAMS data as well as to improve the state’s ability to identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs.

Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services) 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.

Federal Title V, nonfederal and other federal funds were expended in FFY17 to support MCH programming throughout the state, improving the health of mothers and children. The program outcomes discussed in the State Action Plan and other sections of the Application/Annual Report could not have been achieved without federal Title V funding.

In FFY17, \$23,480,555 federal Title V dollars were expended, \$12,686,325 on preventive and primary care for children, \$8,446,175 on CSHCN, and \$2,348,055 on Title V administrative costs. Pennsylvania bases maintenance of effort match funds on all non-federal funds that exclusively serve MCH populations. In FFY17, \$46,264,233 state dollars targeting MCH populations were expended, surpassing the state's maintenance of effort amount from 1989, \$20,065,575. Total state and federal Title V expenditures for FFY17 were \$69,744,788. Additionally, the Bureau of Family Health (BFH) expended \$2,592,423 in other federal funds implementing MCH programming. Non-federal funds that contributed to the maintenance of effort amount included state appropriations for School Health Services and Maternal and Child Health Services. Additional state funds under the control of the BFH and serving the MCH population included 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. Non-federal expenditures supported direct, enabling, and public health services and systems targeting infants and children with and without special healthcare needs.

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. There were no significant variations of more than 10 percent in the FFY17 Title V expenditure data reported on Form 2 and Form 3, as compared to the planned budget for FFY17. Expenditures are monitored on a monthly basis to ensure compliance with legislative financial requirements. As outlined on Form 5, federally and non-federally funded Title V programs served 2,572,033 individuals from the MCH population. Title V served 98% percent of infants and 55% of children in FFY17. Over time, Pennsylvania has increased its capacity to serve a greater proportion of the MCH population by shifting reimbursable direct service expenditures to the appropriate payors and utilizing federal and non-federal Title V funds for population health programs, such as school health services and NBS.

III.D.2. Budget

Title V FF19 budget estimates, both federal and non-federal, align with Pennsylvania's MCH nine priority needs as identified on Form 9. Priority needs will be addressed through the following strategies:

- **Adolescents and women of child-bearing age have access to and participate in preconception and inter-conception health care and support** - Federal Title V funds are budgeted to implement evidence-based or informed home visiting programs, Centering Pregnancy programs, and innovative interconception care initiatives for women, expand the evidence-informed HRC program, utilize Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) organizations to provide drop-in services, including primary medical care and support services, for high-risk and LGBTQ youth, make available office visits and counseling/health education to youth as part of a reproductive health visit at a family planning provider and build linkages between family planning and behavioral health and substance abuse treatment centers. Other federal funds are budgeted to provide services through the Personal Responsibility Education Program and Abstinence Education Grant Programs while federal Title V funding is budgeted to support state-level management of these programs as well as related public health systems development activities.
- **Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants** - Federal Title V funds are budgeted to facilitate adoption of evidence-based strategies to support initiation and continuation of breastfeeding, providing and promoting breastfeeding education, developing collaborations and implementing media campaigns.
- **Safe sleep practices are consistently implemented for all infants** - Federal Title V funds are budgeted to develop and implement a hospital-based model safe sleep program, implement a social marketing plan to increase awareness of safe sleep practices, and implement Sudden Unexpected Infant Death (SUID) prevention strategies, including safe sleep promotion, based upon the data reported in the SUID Case Registry. Other federal funds are budgeted to support participation in the SUID Case Registry.
- **Appropriate health and health related services, screenings and information are available to the MCH Populations** - Federal Title V funds are budgeted to review and analyze data from the Newborn Screening (NBS) system to inform quality improvement activities to improve data collection and reporting and develop strategies to address identified weaknesses in NBS data collection and reporting, expand provider access to medical home concepts and tools, facilitate the involvement of youth and caregivers in aspects of medical homes, identify and develop collaborations with oral and behavioral health entities to support integration of services with medical homes, utilize evidence-based or informed strategies to provide service coordination, resources and information to families of children with special health care needs (CSHCN), develop collaborations between systems of care serving CSHCN, and support vendors to address health disparities by including health disparities language in all BFH grant agreements. Non-federal as well as other federal funds are also budgeted to improve the NBS case management system, provide direct, enabling, and public health services to CSHCN through specialty care grants, and provide school health services to children with and without special healthcare needs.
- **MCH populations reside in a safe and healthy living environment** - Federal Title V funds are budgeted to provide comprehensive home assessments to identify potential home health and safety hazards as well as home safety interventions, such as integrated pest management and preventive safety devices to address the leading causes of child injury and death, and implement Child Safety CollN falls prevention and interpersonal violence reduction activities. Other federal funds are budgeted to enhance childhood blood lead level

surveillance and implement lead prevention activities.

- **Protective factors are established for adolescents and young adults prior to and during critical life stages** - Federal Title V funds are budgeted to provide evidence-informed LGBTQ cultural competency training to BFH vendors who serve adolescents, require all vendors serving adolescents through a BFH grant to adopt and implement comprehensive anti-bullying/harassment policies, identify evidence-based strategies to address bullying, implement an evidence-informed approach to train youth-serving organizations to become a safe space for LGBTQ youth, and implement an evidence-based suicide prevention training for LGBTQ youth. Federal Title V funds and other federal funds were expended to develop evidence-based or evidence-informed mentoring, counseling, and adult supervision programs for youth with and without special health care needs for children ages 8 to 18.
- **Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted** - Federal Title V funds are budgeted to promote the utilization of the 5Ps Integrated Screening Tool from the Institute for Health and Recovery and motivational interviewing.
- **MCH populations are able to obtain, process and understand basic health information needed to make health decisions** - Federal Title V funds are budgeted to review and evaluate available social media platforms for messaging of basic health information, explore the feasibility of using a text messaging or smart phone application outreach program to provide basic health information, and implement the BrainSTEPS program. Other federal funds are budgeted to implement the service component of the Traumatic Brain Injury program while federal Title V funds are budgeted for state-level program management and related systems development activities.
- **Title V staff and grantees identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs** - Federal Title V funds are budgeted to review program activities and goals to determine programmatic needs, conduct analysis, interpret results, develop actionable reports, develop program strategies based on actionable findings, and use PA Pregnancy Risk Assessment Monitoring System (PRAMS) and Child Death Review findings to inform, develop, modify and evaluate public health programs and policies in Pennsylvania. Other federal funds are budgeted to collect, analyze, and report PA PRAMS data as well as to improve the state's ability to identify, collect, and use relevant data to inform decision-making and evaluate population and programmatic needs. This federal Title V and other federal funded programming will be used to assess program performance related to targeted MCH outcomes so improvements can be made when weaknesses are identified.

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 2019 that is level with the FFY 2017 award.

Pennsylvania's proposed budget for FFY 2019 is in full compliance with the federally mandated threshold requirements. Of Pennsylvania's proposed federal grant award for 2019, \$10,986,641 (46.8% of the total budget) is designated for the support of preventive and primary services for children, and \$7,923,493 (33.7% of total budget) is designated for the support of services for children with special health care needs. Administrative costs are budgeted at \$2,348,055, 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. Note, beginning in FFY 2019, Pennsylvania is adjusting the reporting methodology for funding designated to preventive and

primary care for children to reflect the population served, rather than the outcome of the service. In previous years, services provided to pregnant women were included in the calculation because the goal of these services was to improve perinatal and infant health outcomes. Services provided to pregnant women will no longer be designated as preventive and primary services for children.

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 MCH 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 NBS. Total state funds contributed to the MCH services in 2019 are \$48,774,500. The federal-state Title V Block Grant partnership subtotal for 2019 is \$72,255,055. Federal Title V and state funds will be monitored on a monthly basis to ensure the match requirements are met for FFY19.

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, Sudden Unexpected Infant Death Case Registry, and Childhood Lead Poisoning Prevention Program from CDC; Support for Expectant and Parenting Teens, Women, Fathers, and their Families from the Office of Adolescent Health; State Systems Development Initiative, Traumatic Brain Injury, and Universal Newborn Hearing Screening and Intervention from HRSA; and Lead-based Hazard Control from HUD. The total funding from all other federal projects for 2019 is \$5,231,068. State MCH budget grand total for 2019 is \$77,486,123.

Budgeted amounts outlined on Form 3b reflect Pennsylvania's intent to spend the majority of its anticipated FFY19 MCH funding from federal Title V, state, and other federal sources on enabling services and public health services and systems. The budgeted amounts for direct services reported on Form 3b are estimates of the cost of direct services not covered or reimbursed through another provider. Title V is the payer of last resort for all direct services. As evidenced by the variety of programming listed within the State Action Plan, Pennsylvania has allocated funding to directly and indirectly supporting the public health essential functions for the three legislatively defined populations, preventive and primary care services for all pregnant women, mothers, and infants up to age one, preventive and primary care services for children, and services for CSHCN. The allocation of funding for enabling services and public health services and systems outlined on Form 3b demonstrates Pennsylvania's continued commitment to expanding systems of care for both MCH and CSHCN populations.

III.E. Five-Year State Action Plan

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

State: Pennsylvania

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

Within the structure of the Pennsylvania (PA) MCH system of care, the Bureau of Family Health (BFH) is uniquely positioned as the leader on MCH public health issues as the administrator of the Title V Maternal and Child Health Services Block Grant (MCHSBG). The BFH is one of the largest bureaus within the PA Department of Health and has a breadth of programming to match. This breadth of programming and related activities enabled the BFH to demonstrate, through the provision of documentation, work across almost all of the Public Health Accreditation Board (PHAB) domains for the PA Department of Health's application for accreditation in 2018. Full integration of evidence-based public health, driven by the transformation of the Title V MCHSBG, has made the BFH a leader within the PA DOH on the use of evidence-based practices, data driven decision-making, continuous quality improvement, and client and family engagement and satisfaction activities. The BFH is comprised of the following four divisions:

- Division of Child and Adult Health Services (DCAHS)

The DCAHS provides evidence-based programming to promote improved health outcomes for maternal, infant, child, and some adult populations. The DCAHS manages federal grants to provide services to vulnerable populations for the Personal Responsibility Education Program, Abstinence Education Program, Support for Expectant and Parenting Teens, Lead-based Paint Hazard Control Program, and Lead Poisoning Prevention Education. The DCAHS also implements strategies from the MCHSBG action plan to address a range of program areas related to adolescent health, infant mortality, child safety, intimate partner violence, LGBTQ services and maternal health.

- Division of Community Systems Development and Outreach (CSDO)

CSDO works in partnership with family/caregivers and stakeholders to create systemic changes to improve health and health related outcomes for at-risk individuals and families. CSDO supports evidence-based programming for children with special health care needs, including the Special Kids Network, Specialty Care Program such as spina bifida, cystic fibrosis, hemophilia, sickle cell, Cooley's Anemia, epilepsy, and metabolic diseases. CSDO serves as the state lead on Traumatic Brain Injury (TBI) programs, BrainSTEPS, and the TBI Federal Grant. CSDO also houses the PA Medical Home Initiative, Project Launch (in partnership with DHS), and programs that teach boys and men to be supportive partners and fathers by demonstrating respect for women.

- Division of Newborn Screening and Genetics (DNSG)

DNSG is responsible for ensuring all newborns born in Pennsylvania receives various newborn screens, which include dried blood spot screening, critical congenital heart defects screening, and hearing screening. DNSG staff perform follow-up activities to ensure any newborn with an abnormal screening result receives a referral for confirmatory testing and diagnosis. DNSG also oversees grant agreements with treatment centers, the Cystic Fibrosis, Spina Bifida, and Metabolic formula program, provides funding for the Guide by Your Side Program, and the Breastfeeding Awareness and Support Program.

- Division of Bureau Operations (DBO)

The DBO provides support to Bureau of Family Health staff by managing the reporting requirements of the

Title V Maternal and MCHSBG. DBO also provides leadership and technical support to the Bureau and grantees on client satisfaction, client engagement, cultural humility and staff development. Additionally, DBO manages several surveillance and grant programs including Child Death Review; Sudden Unexpected Infant Death Case Registry; PA Pregnancy Risk Assessment Monitoring System (PA PRAMS); Technology Assisted Children's Home Program (TACHP) and State Systems Development Initiative (SSDI).

These four divisions work with over 50 partners in the form of grantees, advisory boards, Medicaid bureaus, advisory and advocacy groups to execute programming across the six population domains. The BFH serves as convener and a point of contact for MCH issues across the state as the representative of the Title V MCHSBG work. While key internal DOH partners, such as the Bureau of Women, Infants and Children (WIC) and the Bureau of Health Promotion and Risk Reduction address niche health issues within the MCH population such as nutrition, obesity, physical activity, and breast and cervical cancer screening, the BFH has the singular ability to address the public health issues facing the MCH population from a broad perspective across the life course. As such, the life-course theory is the guiding roadmap for the implementation of programs with the use of Title V, state and other federal funds. Understanding the key risk and protective factors influencing a person's health across the lifespan enables the BFH to design, plan, and implement programming at multiple critical life stages simultaneously thereby giving current and future generations the best chance at improved health.

The adolescent life stage receives specific emphasis with a large portion of programming aimed at mitigating potential negative health outcomes by linking high-need youth with adult role models, teaching resistance skills, and encouraging adolescents to make healthy decisions. By investing now in the health of adolescents, the BFH seeks to establish protective factors and promote lifelong health among PA youth. Adverse childhood experiences and risk factors can have lasting effects on an adolescent's health. Interventions at this vulnerable life stage, including skill building and the presence of quality adult role models, are associated with positive outcomes in overall health, social-emotional development and behavioral/risk-related behavior. These positive outcomes put adolescents on the trajectory to become healthy adults.

Key to the application of life-course theory to MCH population health is an understanding of the services and systems that shape the health of the most vulnerable of the MCH population, particularly the role of Medicaid in the provision of direct service, especially for CSHCN. As the role of Medicaid and insurance expands, the BFH has been able to shift the role of Title V away from direct service provision to focus on the provision of enabling services and the maintenance and enhancement of public health services and systems through a combination of Title V, state and other federal funding streams.

While ensuring access to health insurance and high quality, appropriate, and culturally sensitive care is an important facet of the work of Title V, the BFH is increasingly applying a lens of health equity to expand work to address the social determinants of health throughout the life-course which are linked to maternal and child health outcomes. While the BFH has already taken steps to target evidence-based practices across the action plan to populations at higher-risk of adverse outcomes, such as those with low breastfeeding rates, high infant mortality rates, and LGBTQ youth, an intentional effort is being made to increase workforce development around addressing health disparities and health equity to increase the BFH's capacity to mitigate the impact of a variety of social determinants of health especially the effects of discrimination and racism, sexism, classism, and heterosexism.

III.E.2.b. Supportive Administrative Systems and Processes

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

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 2019, the Division of Newborn Screening and Genetics (DNSG) will continue to provide staff with the opportunity to attend the Early Hearing Detection and Intervention (EHDI) meeting, the Association of Public Health Laboratories (APHL) Newborn Screening Symposium and other topical conferences. In addition, the DNSG will continue to participate in topical webinars hosted by various organizations related to newborn screening, newborn hearing screening, and newborn screening for critical congenital heart defects. The DNSG plans on updating the dried blood spot screening provider manual and the hearing screening guidelines document for hearing screeners in order to provide updated information and technical assistance to all submitters (hospitals, birthing centers, and midwives).

All field staff in the Safe and Healthy Homes Program (SHHP) will complete at least one professional development course during the year. These staff are encouraged to complete training that provides new skills with many registered to complete the motivational interviewing (MI) training. Home visitors will continue to utilize MI techniques and the 5 P's Screening Tool. Women will be referred, as necessary, for mental health services, substance abuse assessment and intimate partner violence counseling. In 2019, the BFH is concluding the training provided on MI, however will continue to support vendors who wish to utilize Title V funding to have their home visitors trained on MI techniques. The BFH will offer trainings to address implicit racial bias in MCH services and systems.

To increase emphasis on promoting positive maternal and family child engagement and interaction, Title V staff will be trained in Partners in Parenting Education (PIPE). The PIPE Curriculum and instructional model focus on the development of healthy parent-child relationships and interactions. Regional trainings are expected to be held in the Spring of 2019.

The 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 2019. The conferences will promote increased knowledge of brain injury and best practices in prevention and treatment. Staff will attend training related to programs that have recently undergone or are undergoing changes, including Medical Home, Special Kids Network, and Specialty Care Program. Staff attendance at pertinent program or related subject matter conferences will occur as appropriate. An area of new program development within CSDO, related to increasing male involvement as an indicator to improve maternal and child health, will result in staff obtaining training in this area.

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 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.

Work has begun on developing a survey, targeted at BFH staff, to determine internal staff capacity and training needs around the aforementioned topics. The goal is to survey staff on an annual basis. Additionally, work has begun on the creation of a resource library to compile literature and other supplemental resources to be used by BFH staff. This will potentially be made available to grantees as well.

Over the long term, the BFH also plans to create opportunities for grantees to engage in learning and sharing their expertise. Several grantees have begun conducting introductory presentations to BFH staff about their respective programming and this will continue over the next year. As a result of the work in 2017 by the BFH's two Master of Public Health interns, four introductory presentations were developed for BFH staff on public health concepts, data use, evidence-based practices and health marketing strategies. These presentations are being delivered throughout 2018. The BFH aims to integrate the collection of more 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 and analyze data, develop enhanced process and impact measures and use these tools to inform program decisions and improve program effectiveness.

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 is planning on convening a committee toward the end of 2018, dedicated to reducing health disparities and promoting health equity in the populations it serves. While it will be up to the committee members to determine the specific activities, timelines, and workplan, there are two main goals for the first year: 1) develop a training plan for internal staff on health disparities and health equity; and 2) develop an approach for internal staff to provide technical assistance to vendors developing plans to address health disparities.

III.E.2.b.ii. Family 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. Over the next year, the BFH will begin developing a five-year strategic plan with the active involvement of consumers and family members.

When looking at the levels of engagement within the multi-dimensional framework for patient and family engagement in the revised Title V guidance, the BFH is engaging in family partnership activities at many points on the continuum. Many of the programs primarily focused on the provision of care for CSHCN emphasize family-centered care at the clinical level. This theory of care emphasizes the inclusive role of the client and family across the continuum of engagement from consultation to involvement to partnership and shared leadership. However, the majority of programs administered through the BFH are not direct services.

The BFH is beginning to build engagement at the organizational design and governance level. Focused effort is beginning on ensuring the collection and creation of standardized reporting of client satisfaction both at the vendor and Title V administration level. New language regarding client satisfaction survey requirements for grant agreements was finalized at the beginning of 2018 and will be integrated into agreements as they are established. Vendors will have the option of using current client satisfaction surveys or creating their own, both requiring project officer approval. For those vendors not currently using a client satisfaction survey, the BFH will be developing a survey template to be tailored to programs requesting technical support.

At the policy level, part of the strategic plan to more actively and intentionally engage clients and families will involve the provision of focus groups, participation on the new MCH Workgroup, as well as maintaining or expanding participation on topic specific advisory boards and committees.

Throughout 2017 and into 2018 the BFH has begun to take steps to improve client and family engagement across programming. In December 2017, the BFH released an electronic survey to their MCH vendor list to designed to gather feedback from vendors on how clients and families are engaged in the design, implementation, and evaluation of their programs. Vendors who respond that they are not actively engaging clients and families will also be asked if they have a plan for engagement, or if not, why not. Survey responses will be tabulated internally and released in a summary for the vendors. The information gathered from the survey will be used to develop a plan that will support and enhance current and future programming around client and family engagement.

As part of interim needs assessment activities, the BFH also plans to pilot several focus groups in an effort to not only gain valuable insights on the strengths and needs of the MCH population but also gauge the impact/reach of MCH services and resources. By applying a quality improvement process to the implementation of focus groups, the BFH will be building a process and infrastructure on which to institute focus groups in a standard way. This will create opportunities to not only gather feedback on MCH population strengths and needs but also gather public input on the development of the Title V MCHSBG Report/Application process, program planning, and workforce needs.

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.

Within some programming, family members have roles beyond serving on a committee. 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. The Pennsylvania Medical Home Initiative (PMHI) 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.

While the BFH and its Title V MCHSBG vendors utilize a variety of methods to solicit guidance from a variety of stakeholders, including families and individuals, current activities are limited to specific topics and do not address all aspects of the Title V MCHSBG Action Plan. In order to create a lasting infrastructure for continued client and family engagement, BFH will establish a MCH Working Group to provide structure for ongoing collaboration with community groups, service providers, system partners, families, and individuals. The MCH Working Group membership will consist of up to 25 individuals representing diverse MCH stakeholders, including but not limited to clients and family members. In order to promote client and family engagement, particularly from vulnerable and medically underserved populations, BFH will offer clients and family members travel reimbursement for MCH Working Group and subcommittee meeting attendance. Additional support, such as reimbursement for childcare while family members attend meetings, may be offered on a case by case basis. BFH plans to hold the first MCH Working Group meeting after the start of State Fiscal Year 2018/2019. Anticipated activities for year one include providing input into the Five Year Needs Assessment, assisting with prioritization of programming for the Title V MCHSBG State Action Plan for Fiscal Years 2020/2021 through 2024/2025, directing client and family engagement activities, and recommending strategies for improving data collection and reporting.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

For the budget periods covering December 1, 2015-November 30, 2017, the State Systems Development Initiative (SSDI) funds were combined with Title V MCHSBG funds to supplement the support for the Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS) to increase the survey sample size to ensure the maintenance of the survey and therefore continued management of public health programs in PA. The BRFSS provides information on the health status, access to health care, behavior constituting risk to health and use of prevention services by PA adults. As the BRFSS is the federally available data source for the Title V MCHSBG National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year, it was critical to support this data source to ensure the impact of programming work within the Women/Maternal domain could be tracked over time. The BFH has also requested supplementary modules be added to the BRFSS survey over the last several years to collect data related to adverse childhood experiences, caregiver burden, and sexual orientation and gender identity.

In the application for the new SSDI grant cycle beginning in December 2017, the BFH defined the following activities to address the three goals of SSDI:

- Goal 1: Build and expand state MCH capacity to support the Title V MCH Services Block Grant program activities and contribute to data driven decision making. To meet Goal 1, the BFH will survey clients and providers and will conduct focus groups with clients and families to determine the current health status of MCH populations, gaps in services, barriers to accessing care, and client and provider satisfaction with services.
- Goal 2: Advance the development and utilization of linked information systems between key MCH datasets. The BFH intends to meet Goal 2, by linking the Internet Case Management System (iCMS), which houses newborn screening data, with the vital records system. The purpose of this project is to use the linked data from vital records to identify infants who have not been screened so these infants can be referred for screening.
- Goal 3: Support program evaluation activities around the National Performance Measures that contribute to building the evidence base for the Title V Maternal and Child Health Services Block Grant. The BFH intends to support the County Municipal Health Departments (CMHDs) in establishing case management systems and evaluating their home visiting programs which are associated with the NPM: percent of women with a past year preventive medical visit to meet Goal 3.

Since the submission of the SSDI application, new and more effective ways to use the SSDI grant were identified which is necessitating a proposal to change the scope of the work. Within Goal 1, the interim needs assessment efforts will continue but as in-kind contributions for the first three years. The Goal 1 work is being expanded to use a portion of the SSDI funds over the first three years of the grant to support data collection regarding 17-alpha-hydroxy progesterone caproate (17P), as part of the BFH's efforts to reduce preterm births. The goal of the project is to reduce preterm births by identifying barriers that prevent women from taking 17P and subsequently identifying strategies to overcome those barriers and improve uptake of 17P for eligible women.

The BFH is proposing to shift the work of Goal 3 away from what was defined in the application to building internal capacity to conduct program evaluation through the development of more refined process and impact measures. As a result, BFH staff will be better able to track and describe programming impact across the Title V MCHSBG State Action Plan. Staff's training needs around identifying data sources, conducting basic data analysis, and the development of process and impact measures will be used to inform the development of technical assistance strategies. The proposed changes to the SSDI scope of work leaves room to incorporate additional data linkage or

related work into years four and five of the grant which may consist of supporting ongoing technical assistance for 17P or supporting enhancements to the iCMS beyond the technical support outlined in the original application.

The work defined and supported through SSDI contributes to Title V MCHSBG data collection and reporting in several ways. Through the support of SSDI funds and in-kind contributions, the BFH is building a process for on-going interim needs assessment with the inclusion of focus groups to not only ensure client and family participation in the BFH's assessment of MCH population strengths and needs but to also create a cycle of feedback to inform Title V MCHSBG programming and decision-making. The aforementioned work around 17P and building internal capacity to conduct program evaluation is tied directly to achieving objectives defined within the cross-cutting/systems building domain of the State Action Plan around the priority: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs. Enhanced program evaluation and data-driven decision-making is limited until internal capacity is strengthened.

The BFH has consistent, annual access to 100 percent of the following MCH data sources: birth vital records, death vital records, Medicaid, WIC, newborn bloodspot screening, newborn hearing screening, hospital discharges and PRAMS. Only 16.7 percent of the data sources are linked to birth vital records. Both the birth and death records are used by the BFH to monitor trends in MCH population health status and determine potential target populations for services. The newborn screening data are used not only for follow-up and referral for services on positive screens but also for continuous quality improvement to achieve national standards of newborn screening timeliness. PRAMS data are used as baseline data for work across the action plan related to preconception and interconception care, safe sleep, smoking during pregnancy, breastfeeding and intimate partner violence. Data from both Medicaid and WIC are used to inform specific projects as needed creating a foundation from which to build enhanced partnerships in the future.

Beyond the scope of SSDI, the BFH is planning to enhance its data capacity efforts through the hiring of a MCH epidemiologist and a statistical analyst and thereby strengthen capacity to monitor trends in MCH population health, analyze data and drive program decision-making across the State Action Plan.

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

With the introduction of the Affordable Care Act (ACA) and related Medicaid expansion, insurance coverage in Pennsylvania has expanded, resulting in 5.6 percent of the nearly 12.6 million civilian noninstitutionalized population in PA being uninsured in 2016. As of February 2017, more than 426,000 residents had selected a Marketplace plan with over 75 percent eligible for subsidies. With a decrease in the need for gap-filling direct service provision, 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. The BFH will continue to provide safety net services for vulnerable populations who are unable to access the services they need through traditional payment mechanisms. However, with the future of the ACA uncertain, the BFH must also be prepared to change programming course in order to support MCH populations in receiving necessary direct service provision throughout the system of care.

The BFH partners with local agencies and multidisciplinary clinics on the provision of direct services for the MCH populations using Title V and state funds. Funded by a combination of state and Title V funds, the Specialty Care Program (SCP), which addresses Child Rehabilitation (serving neuromuscular and orthopedic conditions), Cooley's Anemia, Cystic Fibrosis, Hemophilia, Sickle Cell, and Spina Bifida, is focused on patient centered care through a multidisciplinary team clinic model. The goal of the SCP is to improve patient health outcomes by providing comprehensive care and reducing barriers to adherence to treatment plans.

Other 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.

A key component in the MCH system of care and the primary insurance provider for many of the vulnerable populations in PA is Medicaid, housed with the PA Department of Human Services (DHS). The BFH is currently collaborating with Medicaid in several areas. A new pilot project is using Medicaid data to examine women's and clinicians access to or failure to access 17P. The BFH collaborates with the Office of Child Development and Early Learning (OCDEL), which is the lead agency for the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), by participating as a stakeholder on a statewide home visiting stakeholders committee. Additionally, the BFH has standing bi-monthly meetings with representatives from the Office of Medical Assistance to discuss issues particular to the system of care serving children with special health care needs.

To further solidify the current topic specific collaborations with Medicaid, the BFH has begun working on the development of an updated Memorandum of Understanding (MOU) between the two agencies. In the midst of introductory discussions, the two agencies are identifying potential priority topic areas for further investigation and information sharing. The goal of the MOU is to clearly define areas of collaboration in order to eliminate duplication of services while providing for opportunities to share resources and information regarding the work of both agencies. Each agency would like to determine how to most effectively use available resources to fill gaps in services and improve the provision of quality services across the MCH system of care. Avenues for data sharing, particularly around performance measurement, are also key points for future collaboration.

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

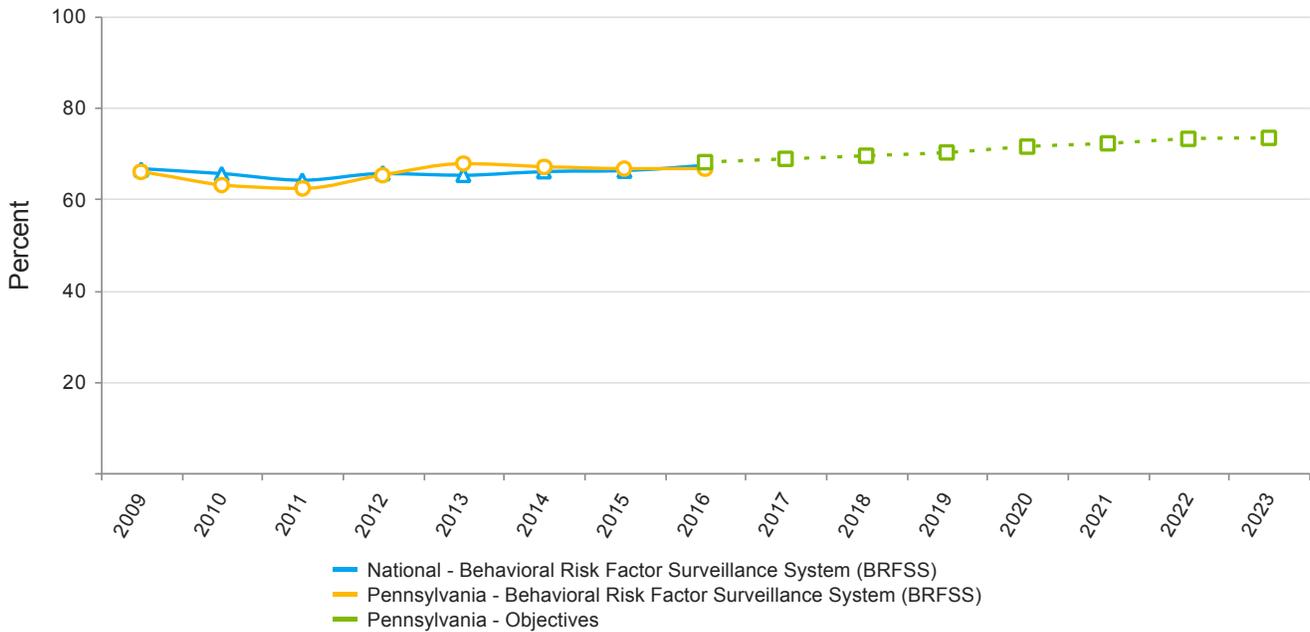
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	114.8	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	18.6	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	8.2 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	9.3 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	22.7 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	6.8	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	6.2	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	4.4	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.7	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	252.4	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	102.8	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	8.0 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	13.1	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.1 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	15.8	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	10.1 %	NPM 1

National Performance Measures

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



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017
Annual Objective	68	68.7
Annual Indicator	66.5	66.4
Numerator	1,427,642	1,417,944
Denominator	2,148,194	2,136,103
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	69.4	70.1	71.4	72.1	73.1	73.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		300
Annual Indicator	310	330
Numerator		
Denominator		
Data Source	Quarterly reports from the Centering Pregnancy Pro	Quarterly reports from the Centering Pregnancy Pro
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	340.0	345.0	350.0	350.0	350.0	350.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	87	85
Numerator		
Denominator		
Data Source	Quarterly reports from the County Municipal Health	Quarterly reports from the County Municipal Health
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	87.0	88.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	94	83
Numerator		
Denominator		
Data Source	Quarterly reports from the IMPLICIT Programs	Quarterly reports from the IMPLICIT Programs
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	87.0	88.0

ESM 1.4 - Number of individuals trained on motivational interviewing.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	50
Numerator		
Denominator		
Data Source	Grantee reports	Grantee reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	0.0	0.0	0.0	0.0	0.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1,500
Annual Indicator	1,585	1,930
Numerator		
Denominator		
Data Source	Quarterly reports from the County/Municipal Health	Quarterly reports from the County/Municipal Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

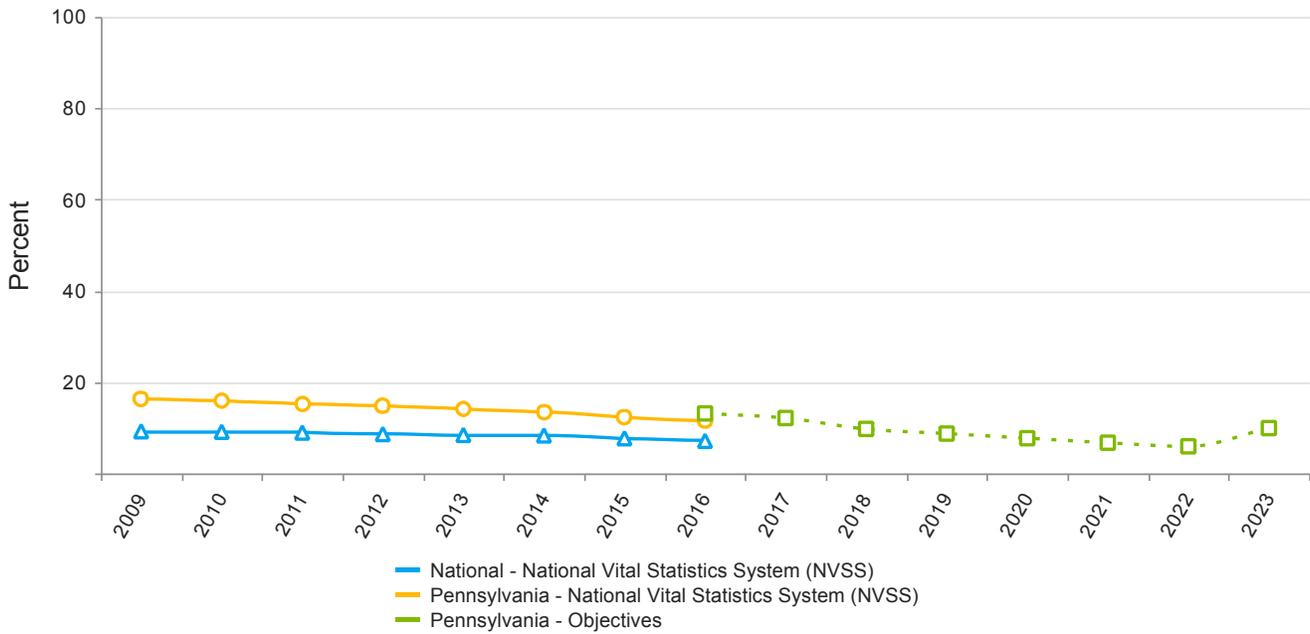
Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,600.0	1,700.0	1,800.0	1,900.0	1,925.0	1,950.0

ESM 1.6 - Percent of eligible women receiving 17-alpha-hydroxy progesterone caproate (17P) treatment compared to baseline data.

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	11.0	12.0	13.0	14.0	15.0

**NPM 14.1 - Percent of women who smoke during pregnancy
Baseline Indicators and Annual Objectives**



Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	2017
Annual Objective	13.2	12.2
Annual Indicator	12.5	11.5
Numerator	17,295	15,875
Denominator	138,426	137,557
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	9.8	8.8	7.8	6.8	6.0	10.0

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1,000
Annual Indicator	0	1,304
Numerator		
Denominator		
Data Source	n/a	n/a
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,400.0	1,500.0	1,550.0	1,600.0	1,650.0	1,700.0

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		75
Annual Indicator	0	89
Numerator		
Denominator		
Data Source	n/a	Grantee Reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.0	85.0	90.0	90.0	90.0	90.0

ESM 14.1.3 - Percent of women who report smoking after confirmation of pregnancy.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		30
Annual Indicator	20	20
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.0	26.0	25.0	24.0	23.0	22.0

ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	30	30
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	40.0	40.0	40.0	40.0	40.0

ESM 14.1.5 - Percent of individuals trained on motivational interviewing.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		50
Annual Indicator	0	50
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	0.0	0.0	0.0	0.0	0.0

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

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

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 - Number of individuals trained on motivational interviewing.	Active
ESM 1.5 - Number of women served through evidence based or informed home visiting programs.	Active
ESM 1.6 - Percent of eligible women receiving 17-alpha-hydroxy progesterone caproate (17P) treatment compared to baseline data.	Active

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

State Action Plan Table (Pennsylvania) - Women/Maternal Health - Entry 2

Priority Need

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

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

Annually decrease the percentage of women who report smoking during pregnancy.

Strategies

Utilize the Integrated Screening Tool (5Ps)-Institute for Health and Recovery
 Utilize Motivational Interviewing

ESMs	Status
ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health.	Active
ESM 14.1.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV).	Active
ESM 14.1.3 - Percent of women who report smoking after confirmation of pregnancy.	Active
ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs.	Active
ESM 14.1.5 - Percent of individuals trained on motivational interviewing.	Active

NOMs

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

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

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Pennsylvania) - Women/Maternal Health - Entry 3

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

Women/Maternal Health - Annual Report

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

In 2016, there were over six million women living in Pennsylvania. The racial composition of this population is 82 percent white, 11 percent black, two percent multi-race and seven percent Hispanic. A number of factors contribute to poor maternal and infant outcomes and particularly disparate outcomes for black women and babies. These factors include mental health, smoking and other substance misuse, intimate partner violence (IPV), substandard housing, unsafe neighborhoods, institutional racism and stress. Mental health, substance abuse and IPV have negative consequences on a family. Nationally, about one in nine women experience symptoms of postpartum depression, about five percent of women use illicit substances and between three and nine percent of women experience IPV during pregnancy. Additionally, experiencing IPV during pregnancy has been shown to increase the incidence of depression and substance use.

The preconception and interconception periods are times when 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 a health care practitioner talk to them about these issues, there is recognition and value in these conversations as preventative measures or interventions. Pregnancy and the postpartum periods present a window of opportunity for home visitors to assess and take steps to improve both the physical and mental health of women and families.

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 negative health outcomes. Unintended pregnancy can have significant negative consequences for women, their families and society. Studies indicate that unintended pregnancies are associated with a plethora of adverse health, psychological, economic and social outcomes. In 2010, 53 percent of all pregnancies in Pennsylvania were unintended with a rate of 47 per 1000 for women age 15 – 44 years. The BFH focuses on preconception and interconception care and uses programming to provide tools and resources to the women and families served by Title V. By implementing interconception and preconception care initiatives, the BFH intends to positively influence birth outcomes.

In Pennsylvania in 2016, 77.5 percent of white women, 63 percent of black women, 65.1 percent of multi-race women and 64.7 percent of Hispanic women received prenatal care starting in the first trimester. However, racial disparities continue with 1 percent of white women and 3.7 percent, 2.5 percent and 2.2 percent of black, multi-race and Hispanic women, respectively, receiving no prenatal care. The BFH consistently ensures that services provided by Title V address the prevalence of disparities among specific at-risk populations which experience social and economic disadvantages related to race, ethnicity, sexual orientation, disability, mental health, immigration status or geographic location. These populations are often linked to discrimination and generally have poorer health outcomes. The BFH is working to address racial disparities by requiring that all vendors who serve Title V populations annually develop and implement a plan to identify, address and eliminate health disparities in their communities.

Home visiting programs have achieved positive outcomes in reducing the incidence of low birth weight babies and repeat pregnancies. These programs 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, unlike the CMHD flexible enrollment requirements. Many of the CMHDs have MIECHV home visiting programs administered out of their offices which allows for easy collaboration and referral. The BFH collaborates with the MIECHV Program by participating as a stakeholder on a statewide home visiting stakeholders' committee, which is convened by OCDEL's MIECHV Program.

In 2017, the BFH supported a state bill aimed at establishing a state Maternal Mortality Review Committee (MMRC). Maternal deaths are a serious public health concern and a formal process is needed to further investigate the cause of deaths in order to develop prevention strategies. There is a need to provide public information and education on the incidence, causes and disparities among maternal deaths to educate providers and the public in order to reduce the risk factors associated with these deaths. Currently, there is no established statewide process in Pennsylvania for investigating maternal deaths. However, the City of Philadelphia has a MMRC which has been active since 2010. In 2016 in Pennsylvania the maternal mortality rate was 16.7 deaths per 100,000 births. While Pennsylvania's rate is lower than the national average of 19.9 maternal deaths per 100,000 live births, there is much room for improvement particularly within the disparities associated with maternal mortality. From 2010 to 2014, Pennsylvania's rate of maternal mortality for white women was 9.5 while the rate for black women was 23.1. This huge disparity shows how dire the need is to investigate and reduce maternal mortality disparities. Healthy People 2020's goal is to lower the maternal mortality rate to 11.4 per 100,000 live births.

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

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

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

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

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

ESM: Number of families served through Centering Pregnancy Program.

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

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

ESM: Number of individuals trained in motivational interviewing.

The BFH continued its partnership with the County Municipal Health Departments (CMHD) to provide local services

to residents in their communities. The 10 County Municipal Health Departments (CMHD) are located in Allegheny County, Allentown City, Bethlehem City, Bucks County, Chester County, Erie County, Montgomery County, Philadelphia County, Wilkes-Barre City and York City. Each of these locations are affected by poverty, racial and health disparities and greatly benefit from the MCH services provided. The CMHD have been longstanding partners for numerous reasons, one of which is direct access to Title V eligible participants at the local level. The CMHD serve this population in many different capacities and it is beneficial to the CMHD as well as the families to provide services across a wide range of health, mental health and social services to improve and enrich the lives of families.

Various evidence-informed programs and best practices have been implemented to improve health outcomes and to reduce health disparities among at-risk and underserved populations served by the CMHDs. The CMHDs provide preconception care, home visiting, prenatal care and smoking cessation programs, among others, to improve the health of families. Over 1,900 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 IPV, substance abuse or social or financial problems. The BFH exceeded its 2017 goal of serving 1,500 women through home visiting programs. In fact, the program has exceeded the 2022 goals and as such the objectives have been re-evaluated to better project actual service numbers.

Each of the 10 CMHD home visiting programs serve prenatal and postpartum women and their infants. Evidence-based or evidence-informed programming and curriculums such as Partners for a Healthy Baby and Bright Futures provide primary and preventative maternal and infant health services as well as education on a variety of health topics including but not limited to substance abuse, healthy homes, safe sleep, fetal development, healthy nutrition for pregnancy, immunizations, birth control and family planning, parenting techniques, and breastfeeding.

Despite continued efforts to keep women knowledgeable about the benefits to their health and the health of their babies by accepting services, there were barriers and challenges to delivering services. Challenges presented included women refusing services, excessive missed appointments, staff transition, and language barriers resulting in longer visits which created workload issues. A continuing challenge in some areas remains need versus capacity with nursing staff at the maximum manageable caseload. Additionally, the families served through the CMHD programs have many challenges related to young age, single parenting, lack of parenting education, lack of family support, social and emotional issues, learning disabilities, and history of drug or alcohol misuse. The CMHD continually work to identify and address these issues among their patients.

Numerous CMHD utilize the One Key Question® initiative developed by the Oregon Foundation for Reproductive Health. One Key Question® is a pregnancy intention screening tool used to decrease unintended pregnancies and improve the health of wanted pregnancies. It was designed to proactively address some of the root causes of poor birth outcomes and disparities in maternal and infant health and is used to open a dialogue with patients to identify pregnancy intention within the next year. As nearly half of all pregnancies are unintended, this initiative allows the CMHD to educate and develop a reproductive health plan with the women they serve. The initiative helps women to choose when they are ready to begin or to expand their family. Additionally, developing plans allows women to obtain optimal health before pregnancy, leading to healthier birth outcomes. This initiative helps the BFH meet the objectives around family planning and birth control. In 2017, 206 women were screened using One Key Question® to begin the conversation about pregnancy intention and birth control.

The BFH continued its partnership with two hospitals, Lancaster General Health (LGH) and Albert Einstein Medical Center (AEHN), as well as the Philadelphia Department of Public Health (PDPH), which provides Centering Pregnancy Programs (CPP). LGH, located in Lancaster City, and AEHN and PDPH, both located in Philadelphia

County, struggle with high proportions of low birth weight babies, as well as racial disparities. In Lancaster City from 2014-2016, 10.5 percent of babies were born with a low birthweight. In Philadelphia County, 10.8 percent of babies were born with a low birth weight. Both rates are higher than the overall percentage for that time period in Pennsylvania (8.2 percent). Among Lancaster City and Philadelphia's black populations, 14.9 and 14 percent respectively of babies were born with a low birth weight compared to the overall rate in Pennsylvania (13.3 percent). 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.

Combined, these programs served over 330 families with a continued emphasis on improving birth outcomes and reducing disparities among at risk populations in Lancaster and Philadelphia Counties. Program outcomes were positive. LGH saw higher than expected rates for full term births with 95 percent of their participants delivering at full term. Breastfeeding rates were also positively affected by the CPPs with 89 percent of participants breastfeeding at birth versus 62 percent of women prior to the implementation of the CPPs. CPP participants were screened for depression and referrals were made to mental health professionals as necessary. The CPPs had high patient satisfaction rates, with LGH reporting that 100% of women that completed their CPPs were satisfied with the experience.

The CMHDs and CPPs have submitted data related to family planning and birth spacing. Currently, 85 percent of adolescents and women of child bearing age being served through these programs are engaged in family planning after delivery. Additionally, 83 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.

Through Title V funds the BFH continued to partner with the Shadyside Hospital Foundation to implement 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 two years of this program, 2,495 women were screened for ICC behavioral risk factors at seven sites across Pennsylvania, with an 81.4 percent screening rate across all sites. Women screened positive for one of the four ICC risk factors at 26.8 percent of visits with interventions provided in 69.9 percent of those cases. Women reported smoking at 21 percent of visits, screened positive for depression at 10.8 percent of visits, reported not using contraception at 24.7 percent of visits and not taking folic acid at 52 percent of visits. Interventions were provided at 83 percent, 95 percent, 82.9 percent and 55.4 percent respectively.

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.

In 2016, the BFH made it a requirement for all Title V-funded County Municipal Health Department (CMHD) home visiting programs to utilize the Institute for Health and Recovery's 5Ps (5Ps) screening tool, which is an evidence-informed screening tool. 2017 was the first full year of this initiative. 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. The 5Ps is a quick, non-threatening conversational tool that assesses risk for alcohol, substance abuse, violence, and depression based on five domains (Parents, Peers, Partner, Pregnancy, and Past). The tool guides health professionals to make referrals or recommendations based on responses. The tool asks questions about drug or alcohol use by parents or peers 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 Title V funded agencies that provide home visiting services, the BFH required the use of the 5Ps with other grant activities. For agencies or staff who have not used the 5Ps tool previously, the BFH provided training as well as resources to Title V vendors in order to identify appropriate referral sources for further assessment and treatment as needed. Online trainings on the use of the 5Ps tool were developed and available starting in April 2017. Any individual attending training on Motivational Interviewing was provided access to the online 5Ps training. Motivational Interviewing (MI) techniques have been proven to be effective in instilling behavior change. MI is a goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to understand the need for change. Trainings on MI techniques began in March 2017. Trainings on the 5Ps and Motivational Interviewing were open to any service provider; however, Title V staff and agencies were given priority. The BFH has chosen to measure the number of women receiving Title V home visiting services who are screened for behavioral health in order to expand the number of opportunities for support and referral for women and also to track the number of staff trained in MI to gauge the reach of the potential for behavioral changes among women enrolled in Title V home visiting programs.

Home visitors 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.

In 2017, 122 health professionals were trained on the use of the 5Ps screening tool and MI techniques, 63 of the 122 health professional trained were Title V staff, meeting the BFH goal of 50% of individuals trained in MI. Of the 122 health professionals trained, 53 CMHD home visitors were trained on MI and are currently utilizing MI as well as the 5Ps to assess substance use, domestic violence, and emotional health issues in an attempt to motivate women to make healthy changes in their lives. In the first year of this initiative, 1,304 women enrolled in the CMHD home visiting programs were screened for behavioral health issues which exceeds the 2020 goal of 1000. The BFH will need to reevaluate these goals.

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

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

The 5Ps includes a question about feeling unsafe in one's relationship. The Title V home visiting programs have

adapted their curricula or models to include the use of the 5Ps and provide appropriate follow-up recommendations and referrals. In 2017, 1,723 out of 1,930, or 89% of women enrolled in Title V home visiting programs talked to a home visitor about intimate partner violence exceeding the goal of 75%.

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

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

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

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

The BFH has opportunities to impact women during the prenatal period through home visiting programs. In the past year, BFH required local Title V agencies, such as the CMHDs, vendors from the Safe and Healthy Homes Program, which provides services in home, and other funded partners to attend training on the 5Ps and MI and to incorporate screening and referrals into their programs.

The Department of Health's Tobacco Prevention and Control Program (TPCP), funded in part through tobacco settlement funding, has continued to operate the PA Free Quitline using a specialized protocol for pregnant and postpartum users. Additionally, three of the CMHD offer evidenced-based or evidence-informed smoking cessation programs aimed at pregnant and postpartum women. The programs included: Baby & Me – Tobacco Free; Smoking Cessation & Reduction in Pregnancy Treatment; and the American Lung Association's Freedom from Smoking Program. The need for smoking cessation programs among those served by the CMHD is great. In 2017, 20 percent of women participating in a CMHD home visiting program reported smoking after confirmation of pregnancy.

Erie County Department of Health (ECDH), one of the CMHD, implemented the Baby & Me Tobacco Free (BMTF) smoking cessation program which has received the "Model Practice Award" by the National Association of City and County Health Officials. The published program results indicate a 60 percent quit rate of women enrolled in the program, six-months postpartum. 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. ECDH experienced some challenges in finding community partners to receive training and to offer the BMTF program. However, in 2017, 51 individuals from seven agencies received training on the curriculum. Garnering interest with local obstetrics practices and local Women, Infants, and Children (WIC) offices continues to be a challenge; however, efforts continue with these organizations. With a delayed start due to the challenges noted above, 23 women were enrolled in the program. Outcomes for those enrolled is not yet available. Additional information on program outcomes will be available in next year's report.

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 living under the poverty level.

The BFH has only partial data from very few home visiting programs that are able to collect this level of reliable data. In 2017, 42 percent of women continued to smoke or started smoking again after the birth of their baby.

While the BFH will continue to provide education to women and families regarding smoking cessation, NPM 14.2, the objectives and ESMs associated with it will be removed from future action plan measures, due to challenges in collecting valid and reliable data.

Women/Maternal Health - Application Year

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

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

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

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

ESM: Number of women served through evidence-based or evidence-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.

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

The BFH will continue its partnership with two hospitals, Lancaster General Health (LGH) and Albert Einstein Medical Center (AEHN), as well as the Philadelphia Department of Public Health, to provide CPP in the next year. Planned activities include the addition of a CPP group for mothers with Substance Use Disorders through LGH. This group will follow the original CPP model with the addition of education focused on pain management without opioids, soothing techniques for babies diagnosed with Neonatal Abstinence Syndrome (NAS), as well as other topics specific to this population. The opioid crisis has caused an immediate need for this group as the number of infants born addicted continues to grow in Pennsylvania. According to the Pennsylvania Health Care Cost Containment Council the number of infants diagnosed with NAS increased nearly 1,100 percent between 2000 and 2017. In that same period, the rate of NAS hospital stays grew from 1.2 per 1,000 newborn stays to 15 per 1,000. In state fiscal years ending in 2016 and 2017, there were 3,289 newborn hospital stays statewide with evidence of maternal substance abuse, including 137 in Lancaster County.

The BFH is exploring the idea of completing a Request for Applications for CPP. In the past, BFH staff had difficulty finding providers willing to implement this program due to factors such as reimbursement for additional time, effort and space as well as challenges with enrollment and retention. The BFH is interested to see if knowledge of the program outcomes will alter providers point of view on program implementation.

Women enrolled in both County Municipal Health Departments (CMHD) 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 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. The factors are: (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 women receiving screening and advice from a medical professional during their children's well-visits will increase the likelihood that they will be more likely to participate in regular and ongoing consultation with their own providers.

Work is under way to develop partnerships with the four regional Family Health Councils to address unintended pregnancy rates among individuals with opioid use disorders statewide. Each Council will develop a pilot project to build linkages between family planning agencies and behavioral health and substance abuse treatment centers, leveraging the partnerships and experience to find the right fit for the communities served by each Council.

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 (MI).

The BFH, with Title V funds, continues its work with the CMHDs to ensure screening among pregnant and postpartum women for risk factors related to behavioral health issues, substance use disorder and interpersonal violence. Each of the CMHDs will continue to be required to utilize the Institute for Health and Recovery's Integrated 5Ps Screening Tool (5Ps) to screen women during home visits. Online trainings on the use of the 5Ps tool have been developed and continue to be available for the CMHDs as well as other staff working with Title V programs that provide home visits. This screening tool assists with the identification of women in need of support and referral for behavioral health services, substance use disorder assessment and interpersonal violence counseling. This screening tool, when used 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. There is also opportunity to introduce or to continue a discussion about birth spacing and birth control methods. The BFH has chosen to measure the number of women discussing and engaging in family planning due to its important health, social, financial, environmental and economic benefits. Access to contraception helps people to avoid unintended pregnancies and space pregnancies through planning 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.

In 2019, the BFH will conclude the training provided on MI. However, the BFH will continue to support vendors who wish to utilize Title V funding to have their home visitors trained on utilizing MI techniques. Additionally, as racism and minority stress have been identified as a root cause of multiple health disparities, including adverse infant and

maternal health outcomes, the BFH, utilizing Title V funds, is working to provide professional development trainings to BFH staff and vendors on the concept of implicit bias and racial microaggressions.

CMHDs' home visiting programs utilize the Bright Futures curriculum or the Partners for a Healthy Baby curriculum. Both curricula allow home visitors to plan and to address key topics at necessary intervals for families receiving services. The flexibility inherent in these home visiting programs facilitates participation from those who would not otherwise be eligible for alternate home visiting programs, such as the MIECHV programs. CMHDs' home visiting programs deliver necessary services to women 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 period. Many CMHDs' home visiting programs allow women to obtain services up to a year after the births of their children. This provides the opportunity for home visitors to develop a relationship with the family and begin educating mothers on child development, safety issues, parenting, immunizations, birth control and interconception care. This education aims to improve the overall health and well-being of the families served as well as improving birth outcomes and delaying time in between pregnancies moving forward.

Home visitors have regular contact with families which allow for comprehensive, family-centered care. This care puts home visitors in the position to identify any possible developmental delays in the children. Many of the CMHDs utilize the Ages and Stages developmental screening tool for identifying developmental delays in children ages one month to five and a half years.

The BFH continually works toward strengthening the CMHDs' home visiting programs. In 2019, the BFH will place more emphasis on promoting maternal-child engagement. Research demonstrates the "protective effect" that positive maternal-child interaction has on an infant's brain development and long-term health amid stressful living conditions and adverse childhood experiences (ACEs). To build capacity, efforts are underway to organize regional trainings for CMHDs' staff on the Partners in Parenting Education (PIPE) curriculum for home visiting nurses and other program staff. The training is a two-day comprehensive, interactive, and experiential training designed to teach and to support parenting educators in using the PIPE curriculum with their clients. The training is expected to be held in the Spring of 2019. The BFH continues to work with the CMHDs to identify and to address MCH disparities among the at-risk populations served and to ensure that the goals and strategies chosen reflect the priorities of the state action plan.

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 for indicators of IPV and assisting vulnerable individuals with resources that they need to avoid being harmed in their relationships. Home visitors are to address IPV and begin a conversation with their clients. 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, violent relationships. The BFH chose to measure the number of women who talk with a home visitor about IPV to measure the incidence of IPV in the population served and possibly develop programming to address the issue.

The 5Ps includes a question about feeling unsafe in one's relationship. The BFH home visiting programs will continue to use their adapted curricula or models to include the 5Ps and offer appropriate follow-up

recommendations and referrals. The BFH anticipates expanding the use of the 5Ps to the Safe and Healthy Homes Program as well as exploring 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.

Home visitors will continue to talk with clients about IPV and the impact it can have on a family if left unaddressed. Public health strategies that promote healthy behaviors in relationships are important in stopping the cycle of IPV. Programs that teach youth skills for dating can prevent violence in dating relationships before it occurs. BFH is currently developing a program in partnership with the Pennsylvania Coalition Against Domestic Violence to address healthy relationships and intimate partner violence among adolescents. It is expected that this program will be fully operational in 2019.

The BFH is also developing a male involvement program that will improve maternal health by addressing healthy relationships and reducing intimate partner violence. The program will involve the creation of a curriculum for young men regarding healthy and respectful behavior towards women. An increase in knowledge around healthy and respectful behavior towards women will foster greater partner support and decrease intimate partner violence. The goal is for women to experience better health outcomes when receiving support from their partners. The BFH is currently exploring evidence-based and evidence-informed strategies to inform the development of this new program.

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 during 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 in PA 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 to better understand women's decisions regarding 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 need smoking cessation resources.

Currently, two of BFH home visiting programs, Safe and Healthy Homes Program and Centering Pregnancy Programs, perform different types of assessments, referrals, or education to women about smoking during pregnancy. The BFH is considering requiring that all programs use the 5Ps assessment tool. By using a consistent and reliable tool and techniques, BFH expects reductions in the number of women who smoke during pregnancy.

In the coming year, Erie County Health Department intends to expand the Baby & Me Tobacco Free (BMTF) program to provide services in Warren County in addition to Erie County. Warren County has a State Health Center with minimal MCH services and will benefit from the program. Additionally, ECHD will offer BMTF services to the partners of enrolled pregnant women with the goal of improving the overall health of the family.

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.

The BFH previously chose to measure the percent of women who reported smoking after pregnancy to assess the number of children living in households where someone smokes. After careful consideration, BFH staff have decided to remove NPM 14: B. Since the BFH home visiting programs vary in the amount of time women are followed after pregnancy, solid data is difficult to obtain on this ESM. The BFH will continue to collaborate with the Tobacco Prevention and Control Program (TPCP), the state's primary smoking cessation resource, to expand opportunities to include or enhance referrals for the TPCP's PA Free Quitline.

The proposed legislation to establish a Maternal Mortality Review Committee (MMRC) was signed into law in May 2018. The BFH will participate on the MMRC and help to develop recommendations regarding the prevention of maternal deaths in Pennsylvania. There is a well-documented need for MMRC's as the rate of maternal mortality in the United States has more than doubled in recent decades. Furthermore, there are more women who survive maternal near deaths but are negatively affected by persistent health related issues. Data collected from a MMRC could potentially save lives as well as improve the quality of lives among women who suffer from pregnancy related complications. The BFH will be responsible to assist in the development and management of the MMRC. The MMRC will consist of health professionals with extensive expertise in maternal health including a maternal fetal medicine specialist, a social worker, an emergency medical services provider, a psychiatrist, and representation from the Pennsylvania Department of Health, among others. Committee members will represent various regions of the commonwealth, including both rural and urban areas. The MMRC will review maternal death cases from various sources such as death certificates and from medical examiners and coroners. Once the MMRC summarizes the causes of maternal death, they will make recommendations for prevention.

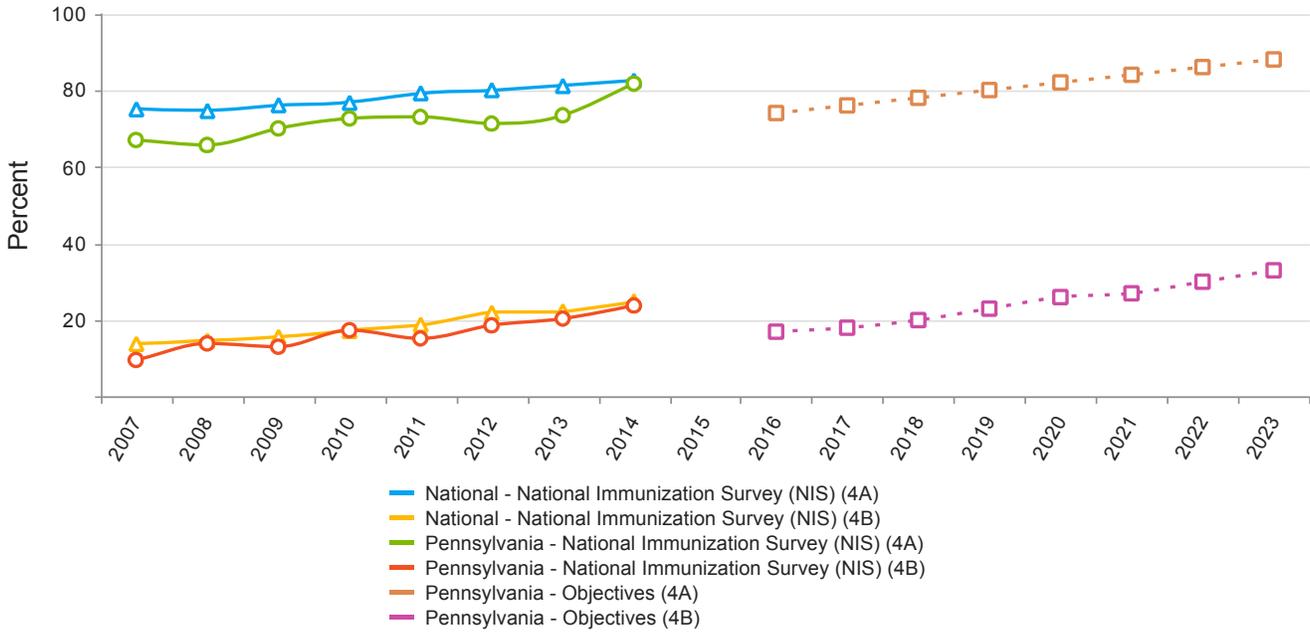
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	6.2	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.7	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	102.8	NPM 4 NPM 5

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	74	76
Annual Indicator	73.3	81.8
Numerator	99,273	108,050
Denominator	135,367	132,020
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	17	18
Annual Indicator	20.5	23.7
Numerator	27,408	30,174
Denominator	133,488	127,300
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	23.0	26.0	27.0	30.0	33.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of facilities designated as a Keystone 10 facility each fiscal year.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	7	12
Numerator		
Denominator		
Data Source	Vendor reports and enrollment numbers	Vendor reports and enrollment numbers
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	17.0	22.0	27.0	32.0	37.0	42.0

ESM 4.2 - Percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	37	45
Numerator		
Denominator		
Data Source	Vendor reports and PA Health Stats	Vendor reports and PA Health Stats
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	47.0	52.0	57.0	62.0	67.0	72.0

ESM 4.3 - Number of new collaborations developed (between breastfeeding program plus other program).

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	3	1
Numerator		
Denominator		
Data Source	BFH internal collection	BFH internal collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

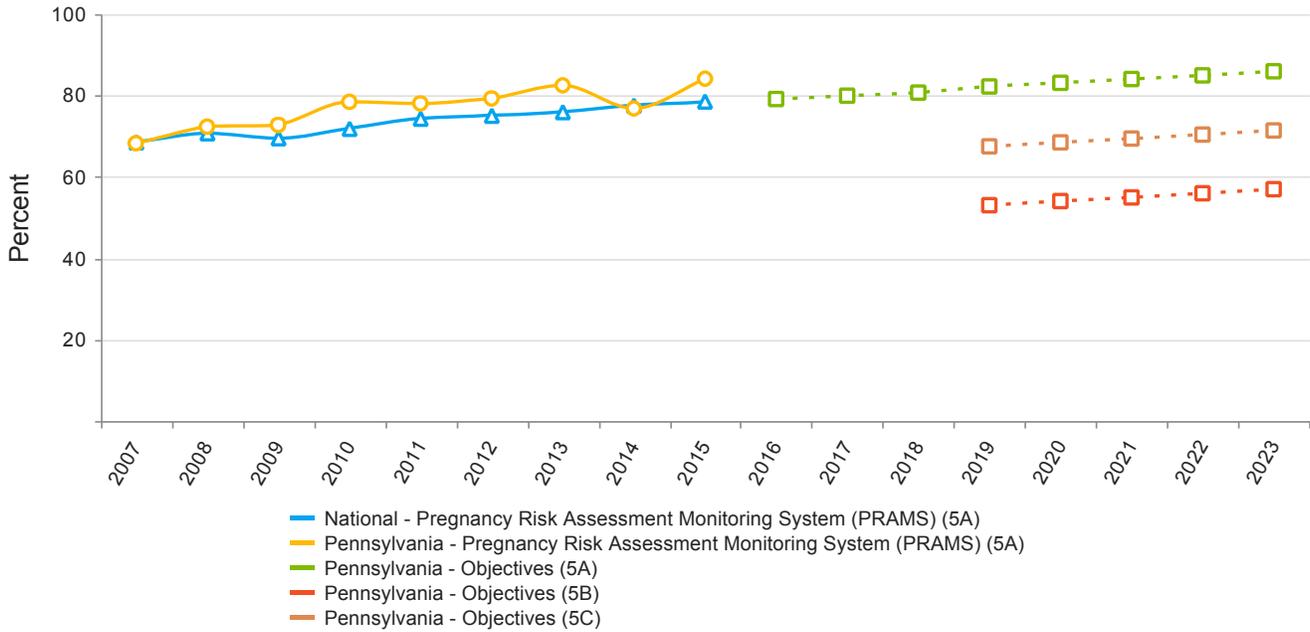
ESM 4.4 - Number of media opportunities implemented promoting breastfeeding per fiscal year.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	BFH internal collection	BFH internal collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

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



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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	79	79.8
Annual Indicator	76.7	84.0
Numerator	101,695	110,308
Denominator	132,585	131,259
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.6	82.1	83.0	83.9	84.8	85.8

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	51
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2012-2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	53.0	54.0	54.9	55.9	56.9

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	65.4
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2012-2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	67.4	68.4	69.3	70.3	71.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	2	6
Numerator		
Denominator		
Data Source	quarterly reports from the Infant Safe Sleep Initi	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	3.0	3.0	0.0	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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	3
Numerator		
Denominator		
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	8.0	9.0	18.0	0.0	0.0	0.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	2
Numerator		
Denominator		
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	4.0	8.0	0.0	0.0	0.0

ESM 5.4 - Number of social marketing messages disseminated.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		160
Annual Indicator	0	42
Numerator		
Denominator		
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	171.0	86.0	0.0	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.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		49
Annual Indicator	48	52
Numerator		
Denominator		
Data Source	Newborn Screening Data System	Newborn Screening Data System
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	54.0	59.0	64.0	69.0	74.0	79.0

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

NPM 4 - A) Percent of infants who are ever breastfed 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 2017, annually increase number of counties with a breastfeeding rate at or above the 2016 statewide average of 81 percent.

Annually identify and 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 in the Department and with other entities that serve maternal and child health populations and develop collaborations with them to promote and support breastfeeding with and within 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 facilities designated as a Keystone 10 facility each fiscal year.	Active
ESM 4.2 - Percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year.	Active
ESM 4.3 - Number of new collaborations developed (between breastfeeding program plus other program).	Active
ESM 4.4 - Number of media opportunities implemented promoting breastfeeding per fiscal year.	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - 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

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

Objectives

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

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 3

Priority Need

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

SPM

SPM 3 - 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 - Annual Report

The BFH provides services to the perinatal/infant domain through a combination of Title V, other federal, and state funding as described below. Within the BFH, programs serving this population domain are split between the Division of Newborn Screening and Genetics (DNSG) and the Division of Child and Adult Health Services (DCAHS). Title V funds the breastfeeding awareness and support program, the safe sleep program, newborn screening program staff, and the newborn screening data system. State funds are utilized for the contract with the contracted newborn screening lab, which includes payment for the disorders on the mandatory screening panel, grant agreements with the treatment centers, and a phenylketonuria (PKU) formula program. In addition, in 2017 the DNSG received HRSA funding for activities related to newborn hearing screening.

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

In PA, there are 105 birthing hospitals/free standing birthing centers and 99 midwives performing deliveries. In 2016 there were 138,661 infants born in PA, with 96.6 percent of births occurring in hospitals, 1.2 percent of births occurring in free-standing birth centers, and 2.2 percent of births occurring in other settings (ex. clinic/doctor's office, home birth). In 2016, the newborn screening program's contracted laboratory, PerkinElmer Genetics, performed 138,451 initial screenings, which is slightly under the number of births in PA. The number of infants receiving a hearing screen is lower, with 132,996 infants receiving a hearing screen in 2016. The newborn screening program is working to ensure all infants receive the required newborn screens, especially newborns born in an out-of-hospital setting.

The infant mortality rate for PA dropped to 6.1 per 1,000 live births in 2016; however, the rate for black infants (14.6) was nearly double the rate for Hispanic infants (7.4) and more than triple the rate for white infants (4.6). In 2016, 9.3 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 8.2 with disparities again when stratifying the rate by race: black (13.9), Hispanic (9.0), white (6.9). Only the rate for white babies surpasses the Healthy People 2020 goal of 7.8 percent.

Prematurity remains the leading cause of death for infants. Of the 629 infant deaths reviewed by Child Death Review teams in 2014, 46.6 percent of the infant deaths reviewed were due to prematurity. PA's review of infant deaths for 2014 revealed that 83 (13.2 percent) of the 629 infant deaths were SUID-related cases. This is the second highest cause of death for infants, behind only prematurity. CDC WONDERS data for PA shows that black infants die of SUID nearly three times more than white infants. Although the rate has seen an overall decline over the past five years, in 2014, the rate for black infants rose slightly higher than the national rate. Meanwhile, the rate for white infants declined in the past year to the lowest rate in five years and was below the national average.

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

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

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

ESM: Percent of 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, the Pennsylvania Breastfeeding Awareness and Support Program (program) has implemented its Keystone 10 Initiative (K-10) in birthing facilities statewide. This voluntary initiative focuses on the adoption and implementation of the ten evidence-based steps to successful breastfeeding. 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 2017, 85 of PA's 105 birthing facilities were engaged in the K-10 initiative. The program exceeded its 2017 goal of 25 percent of birthing facilities increasing the number of K-10 steps completed in each fiscal year, as 28 percent of the participants completed more K-10 steps in 2017 than they completed in 2016.

According to a national study, the effect of maternity-care practices on breastfeeding plays a major role in breastfeeding rates. Mothers in the United States are 13 times more likely to stop breastfeeding before six weeks if they delivered in a hospital not participating in the K-10 initiative in comparison to mothers who delivered at a facility where at least six of the ten steps were followed. After the completion of the second year of the initiative, 12 hospitals have implemented six or more steps and ten hospitals have completed all ten steps of the K-10 initiative.

Facilities participating in the K-10 initiative have been grouped into five regions. Each region has an in-person biennial collaborative. The 2017 collaborative meetings focused on providing training on breastfeeding best practices and reviewing the K-10 application process. Facilities were given the opportunity to share best practices and procedures. Part of the discussion included each facility naming its greatest accomplishment and biggest barrier in the K-10 process. Facilities who have already completed the ten steps gave insight on how their program was able to successfully implement the difficult steps. Overall, the collaboratives provided facilities the opportunity to brainstorm with other facilities and share information on the K-10 process. A web-based project management tool, Base Camp, is utilized to allow the regional collaboratives to share information, best practices, and pose discussion questions. In addition to the collaboratives, the program provided a 15-hour breastfeeding management course to staff members of facilities participating in the K-10 initiative. In 2017, 616 K-10 facility staff members completed the training.

The most common K-10 barriers recognized are the lack of administrative support for staff implementing K-10 and the length of time required to approve and implement the evidence-based steps. Multiple efforts have been implemented to overcome these barriers. Each facility has a designated champion who is aware of the importance of breastfeeding to both maternal and infant health. These champions are the driving force of each facility's momentum. K-10 regional facilitators are available to provide on-site technical assistance to facilities reporting lack of administrative support. In addition, there are currently ten K-10 designated facilities available to offer guidance to the other K-10 facilities.

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.

The program aims to increase breastfeeding rates in counties identified with initiation rates below the state's 2012 average of 73 percent. The 2017 goal was to have 15 percent of the identified counties implement evidence-based

strategies. The program is unable to determine the implementation of evidence-based strategies; however, training was provided to individuals in 20 percent of the identified counties.

The program provided funding to the PA Chapter of the American Academy of Pediatrics (PA AAP) to host a statewide Breastfeeding Summit on May 24, 2017. Two hundred sixty-one clinical and support staff, including representatives from 82 K-10 facilities, attended the summit and learned the latest research from national experts, practical implementation techniques from colleagues and had opportunities to learn how to meet the cultural diversity needs of PA's population. The summit presentation topics included: "Changing the Model of Care: using Quality Improvement" with a focus on the Neonatal Intensive Care Unit (NICU); and "Serving Hispanic Mothers and Families: Identifying and Overcoming Barriers."

The program provided funding to the PA AAP to develop the Educating Physicians in Communities-Breastfeeding Education, Support and Training (EPIC BEST) program. The EPIC BEST program provides breastfeeding promotion activities focused 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. EPIC BEST trainings are conducted in primary care, OB-GYN, family practices and other locations. EPIC BEST trainings include education on breastfeeding best practices, prenatal education for mothers, common problems for breastfeeding mothers, education for mothers going back to work and where to find breastfeeding educational resources. Health practices located in the northeast/northcentral, northwest, and southwest counties, as well as practices in low breastfeeding areas such as north Philadelphia and Chester county, received breastfeeding communications on upcoming EPIC BEST trainings via email, fax, and regular mail. The practices in the northeast counties also received phone calls. K-10 facilities in these counties were also used to promote EPIC-BEST in their communities. One hundred fifty five total practices received information on EPIC BEST. Of these practices, 57 were in the northeast/northcentral area of the state, 29 were in the southwest, 39 were in the northwest, and 30 were in other communities identified as having low breastfeeding rates. As a result of the outreach, EPIC BEST held 38 trainings and trained 468 healthcare professionals. Of the 38 EPIC BEST trainings, 16 trainings were held in seven counties with a 2012 breastfeeding rate lower than 73 percent: Monroe; Lackawanna; Luzerne; Wyoming; Huntington; Allegheny; and, Washington counties. The professionals attending these trainings were encouraged to take education gained back to their practices and apply it to their county and community. Preliminary 2017 breastfeeding statistics show 19 of the 21 counties in the southcentral and southeast regions of PA have a breastfeeding rate above the 2012 average of 73 percent. Collectively, the counties in these two regions have a breastfeeding rate of approximately 85 percent in 2017.

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

ESM: Number of new collaborations developed.

Through a collaboration with the Bureau of Health Promotion and Risk Reduction (BHPRR), the program provided certified lactation counselor (CLC) training to staff members of facilities participating in the K-10 initiative and other health professionals. Counties in the northeast and southwest were identified as target areas in need of breastfeeding outreach as the county data for breastfeeding initiation rates displayed rates around or below the state average. Two trainings, one located in the northeast and a second located in the southwest, were held in June and October of 2017. A total of 138 participants attended the CLC trainings, of those attending the training, 135 of the attendees passed the CLC exam and are now certified lactation counselors. The Bureau of Women, Infants and Children and the Nurse Family Partnership, existing program partners, were invited to the CLC training, and several members from these organizations attended the training.

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

The program did not meet its 2017 goal of one media opportunity to promote breastfeeding. However, in January 2018, the program entered into an agreement with Maternal and Family Health Services to develop and implement a multi-faceted public awareness campaign to promote and normalize breastfeeding; educate the public on the benefits of breastfeeding; and promote locally available breastfeeding support resources. The campaign will begin in the Spring of 2018 in the northeast region of PA as eight of ten counties in this region are below the 2012 breastfeeding average of 73 percent.

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

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

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.

Sleep position and environment are completely controllable factors for infants and can have a direct result in reducing infant mortality. A multitude of challenges must be overcome to change the collective knowledge and practice to achieve safe sleep practices for all infants at all sleeps.

A study showing increased adherence to safe sleep practices in the hospital setting when a bundled intervention was implemented at room orientation rather than hospital discharge prompted the BFH to support development of such a model program. The development and implementation of a hospital based model safe sleep program is supported with a social marketing approach targeting Philadelphia through a three-year infant safe sleep grant (7/1/16 to 6/30/19).

The grant with the Trustees of the University of Pennsylvania continued successfully for the infant safe sleep initiative during 2017. The grantee finalized the hospital based model safe sleep program during the first half of 2017 which includes training modules, patient education materials, implementation forms and guides, and evaluation instruments. All finalized components of the hospital based model safe sleep program are available online at www.pasafesleep.org.

The two previously recruited Philadelphia hospitals fully implemented the hospital based model safe sleep program

during 2017, including achieving near perfect completion of training by required staff members. These hospitals represent two percent of the hospitals with maternity units in the state. Over 4,000 infants or three percent of the births in 2017 had parents who received safe sleep education through the model program. This implementation and education surpassed the 2017 ESMs as implementation was expected later in the year.

The grantee recruited six hospitals with maternity units to implement the model safe sleep program in the next year which surpasses the ESM goal of two for 2017. Four of these hospitals are in the city of Philadelphia with the other two in the surrounding counties in the southeast region of the state.

To support the messaging provided in the hospital setting, the social marketing plan began social media posting and ads, public transit ads, and email blasts. The social media ads engaged the target demographics and drove traffic to the PA Safe Sleep website. The simple and consistent messaging supporting safe sleep practices wraps around families in both the hospital and community settings. Implementation of the social marketing plan began in July and has been highly successful. Shortly following implementation, the grantee determined that the number of planned social media posts was targeted higher than it needed to be to achieve the desired results. Engagement with the early social media posts continued far longer than anticipated. As a result, the grantee determined it would be more effective to allow more organic engagement of the social media posts to occur than adhere to the higher rate of posting. The target ESM of 160 social marketing messages disseminated was not achieved; however, the 42 social marketing messages were quality messages and well received by the public at large.

The grantee also challenged the trained nursing staff to engage in safe sleep activism when unsafe infant sleep images are used in the media. In a newsletter used to keep staff engaged at hospitals that have implemented the model program sample language was provided to use on social media to call out companies using unsafe infant sleep images. This builds on practice by the BFH to ensure that all images used in publications promote diversity, inclusion, and safe practices – especially safe sleep. Previously, the BFH removed images of infants sleeping in an unsafe manner from the newborn screening materials that are provided to all new parents and replaced them with images clearly depicting safe sleep practices. Also, the BFH began distributing materials supporting newborn screening from a national organization developed by another state that had a picture displaying a questionable infant sleep environment. The BFH staff took quick action to bring the image to the attention of the national organization and other state while offering staff to assist in the redesign of the materials. The BFH believes that correct and consistent messaging both with words and images will go a long way to making safe infant sleep the norm.

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

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

The Sudden Unexplained Infant Death (SUID) Registry operates within PA's Child Death Review (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. Title V funds training and technical assistance activities as well as prevention measures while other federal funds are

used to pay for the SUID Coordinator position.

Training on case entry was provided to local CDR teams in 2016 and 2017. Teams were educated on the criteria of what constitutes a completed case in the registry. In addition, BFH continues to provide training to local teams on the decision-making algorithm for assigning SUID case categories. A team of BFH staff reviews and categorizes cases for completeness and timeliness at the state level. The BFH team reviews the categorization entries provided by the local teams and works with the team to correct any potential errors to ensure categorization consistency across the Commonwealth.

Also as part of the quality assurance process, the SUID Coordinator reviews the data in the case reporting system to determine timeliness and completeness of entered cases within 90 days of the case information being entered in to the case reporting system. Based on this review the SUID Coordinator will then determine a team's level of need regarding training and technical assistance. Support and resources are provided to teams who are consistently failing to meet the 30-day mark for entering data after the review is complete.

The project has already shown signs of improving PA'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.

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

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

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

The DNSG has continued to implement efforts to improve the timeliness of DBS newborn screening. With a baseline of 39.7 percent of DBS samples collected in 2014 received by the laboratory within 48 hours of collection, the DNSG has shown steady progress in improving this statistic. In 2017, 52 percent of samples were received at the laboratory within 48 hours of collection, which was above the 2017 goal of 49 percent.

During the 2016-2017 state fiscal year, the DNSG began providing monthly timeliness reports to all hospitals. These reports include the average collection to receipt time, in hours, for all birthing hospitals and ranks hospitals from shortest to longest collection to receipt timeframes. The reports are sent to the DBS coordinator, nursery manager and NICU manager for each birthing hospital. In addition, PerkinElmer Genetics, the contracted laboratory for newborn screening, began providing birthing hospitals monthly reports which include the hospital's average collection to receipt, the state average collection to receipt, and the hospital's percentage of unacceptable DBS samples. Any hospital with a collection to receipt timeframe greater than 52 hours receives technical assistance from staff. The DNSG has received positive feedback and has seen increased hospital efforts due to the sharing of timeliness data.

The DNSG released its first newborn screening newsletter to hospitals on October 3, 2016. Quarterly newsletters, which provide submitters (hospitals, birthing centers, and midwives) with program updates, DBS timeliness improvement methods and highlight a hospital with an improved transit time have continued to be released.

With NewSTEPs 360 funding, the DNSG provided small no-bid grants to five large hospitals to implement an HL7 interface with PerkinElmer Genetics in an effort to decrease the timeframe between collection of the DBS specimen and the release of the screening results. In 2017, the identified hospitals began the planning and building the HL7 interface and will “go live” in 2018. In addition, the DNSG held three regional meetings, inviting DBS coordinators, nursery managers, and NICU managers, to discuss barriers, educational needs, and practices of hospitals with an average collection to receipt time less than 48 hours. The information gathered from the regional meetings will be used to develop online learning modules in 2018.

In December 2017, the first midwife workgroup was held and will continue quarterly. The workgroup focuses on the barriers of newborn screening in an out of hospital setting, with a focus on timely newborn screening. These submitters (midwives and birthing facilities) typically mail DBS specimens using the U.S. Postal Service as a result of working in remote locations leading to an increased collection to receipt timeframe.

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

In PA, there is a two-panel system for newborn screening consisting of a mandatory screening panel and a mandatory follow-up panel. Between the two panels, screening is available for all diseases listed on the RUSP. Infants are screened for the nine mandatory conditions and the submitters (hospitals, birthing centers, and midwives) can elect to screen for 27 other dried blood spot disorders on the mandatory follow-up panel. The newborn screening program pays for the screening of the mandatory conditions utilizing state funds and the submitters are required to pay for the screening of the disorders on the mandatory follow-up panel if they elect to screen for those conditions.

Although submitters can choose what conditions are screened for a majority of babies born in PA are screened for all conditions on the RUSP. In 2017 there were 105 hospitals/birthing centers and 99 midwives performing deliveries in PA. Of these, 60 midwives and one hospital, accounting for 4,312 births, only elected to screen for the mandatory conditions. There were 22 hospitals and 25 midwives who elect to screen for all disorders on the RUSP except for SCID, which accounted for 11,597 births. The remaining 82 hospitals and 14 midwives screened for all conditions listed on the RUSP, accounting for 122,536 births. The percentage of hospitals and birth centers screening for all conditions listed on the RUSP increased from 73% in 2016 to 78% in 2017. This increase can be attributed to the technical assistance provided to each hospital and birth center electing not to include SCID on their screening panel. The quality assurance nurse provided verbal education, on the importance of screening for SCID, to management staff at each facility.

In an effort to maintain consistency with the RUSP, on February 1, 2017, the DNSG added MPS I to the mandatory screening panel and on April 1, 2017 added X-ALD to the mandatory screening panel. Both conditions were added to the RUSP on February 16, 2016.

PA is one of the few states without a newborn screening or filter paper fee. This makes it difficult to add disorders to the mandatory screening panel as the precedence has been set that the program will pay for the screening of disorders on the mandatory panel. Therefore, in order to add a disorder to the mandatory panel the program must request an increase in the state appropriation for newborn screening. In January 2017, the NSFTAB recommended that the two panels be merged, contingent on a new funding structure being developed for newborn screening in PA. On April 7, 2017, HB 1081 was introduced, which would merge the two panels and require a newborn screening fee with funds deposited into a Newborn Child Screening Program Account. The bill has not moved forward, however, the DNSG and the NSFTAB supports the bill. This bill addresses strategies associated with the Title V objectives.

Perinatal/Infant Health - Application Year

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

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

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

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

In previous years, the Pennsylvania Breastfeeding Awareness and Support program (program) measured the success of this objective by tracking the number of facilities that increased the number of Keystone 10 (K-10) steps completed each fiscal year. As the program's goal is to have all participating facilities complete all 10 steps and receive the designation of a K-10 hospital, the program has determined the previous ESM was not an accurate indicator progress. Therefore, the program has changed the ESM to measure the percent of facilities designated as a K-10 facility each fiscal year. The program's new goal is to increase the number of K-10 designated facilities by five percent each fiscal year.

The program will continue funding the PA Chapter of the American Academy of Pediatrics (PA AAP) to administer the K-10 initiative. The program will work with the PA AAP to improve promotion of the K-10 initiative and encourage participants to complete K-10 steps. Education will be given to participants on the positive outcomes breastfeeding has on mothers and their babies, and how completing K-10 steps leads to better breastfeeding rates. The program and PA AAP will continue to provide technical assistance and approve applications for K-10 step completion.

The most common barriers noted from K-10 facilities are the lack of administrative support for staff implementing K-10 and the length of time required to approve and implement the quality improvements. To combat this, the regionally based learning collaborative model will continue to be utilized to facilitate group discussion with focus on specific steps and barriers to success. The collaborative meetings will provide consistent education to all facilities, as well as give facilities an opportunity to share best practices and procedures with other facilities.

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

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

In previous years, this objective was based off a statewide average from 2012 and the success of the objective was measured by tracking the percentage of counties with breastfeeding rates below state average implementing evidence-based strategies. This measurement cannot be accurately calculated and was previously calculated using an assumption that receipt of education ensures the implementation of an evidenced based strategy. Therefore, the program has revised the objective and associated ESM. The objective was updated to be based on baseline data from 2016 and was re-worded for clarity. The ESM now measures the percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year. The program's new goal is to increase the percent of counties with a breastfeeding rate at or above 81 percent by five percent each fiscal year. In 2016, 37

percent (25 of 67 total counties) of PA counties had a breastfeeding rate of 81 percent or higher, while 63 percent (42 of 67 total counties) of PA counties are below the state average.

In state fiscal years 2018-2019 and 2019-2020, the program will be conducting a two-year pilot project designed to document the effectiveness of early intervention methods in breastfeeding. The program will select a community based program to fund, within a county with a low breastfeeding rate, to provide mothers with weekly post-discharge breastfeeding telephone support, of 20–30 minutes in duration, for 4 weeks. The pilot will be analyzed and if found successful, the early intervention methods will be rolled out in other counties with low breastfeeding rates.

In PA, nearly 3.4 million (27 percent) of the state's 12.7 million residents live in a rural county, which can present challenges for families to find local resources. Of the 42 counties with breastfeeding rates below the state average of 81 percent, 34 are rural counties. The program will provide breastfeeding education to Federally Qualified Health Centers (FQHCs) and rural health clinics located in rural counties with low breastfeeding rates.

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

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

State data indicates lower breastfeeding rates in the African-American population. In 2016, 75 percent of African-American women in PA were reported as breastfeeding, compared to 82 percent of all other races. Based on a literature review, the program found that a lack of family and community support for breastfeeding and a historically negative perception of breastfeeding in the community is a major barrier leading to lower breastfeeding rates in the African-American population. Therefore, the program will provide mini-grants to community based organizations with a focus on reaching African-American women to encourage the initiation and continuation of breastfeeding among this population.

The program will continue to collaborate with the Bureau of Health Promotion and Risk Reduction's (BHPRR). Funding from BHPRR will be used to continue the partnership with PA AAP. PA AAP will host the K-10 regional collaborative meetings and provide the breastfeeding management training to healthcare personnel through the Educating Physicians in Communities-Breastfeeding Education, Support and Training (EPIC BEST) program.

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

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

The program will promote a campaign for the federal Break Time for Nursing Mother's law. This federal law requires employers to provide break time and a place for most hourly wage-earning and some salaried employees (nonexempt workers) to express breast milk at work. This will aid in educating the public about women's rights and employer requirements under the law.

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

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

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, PA 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 continue to be implemented in hospitals with maternity units and moves the education regarding safe sleep practices from hospital discharge to room orientation. There are proven improvements 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 2018-2019, the hospital based model-program will be implemented in at least six hospitals and pushing beyond the city of Philadelphia. The number of hospitals and the associated annual births will keep the BFH on track to achieve the targeted ESMs for the number of hospitals recruited to implement the hospital based model program, percentage of infant born whose parents were educated on safe sleep practices, and the percentage of hospitals with maternity units implementing the program.

There has been a great deal of interest from hospitals across the state to implement the model safe sleep program which cannot be achieved during the current grant period. The BFH will engage the grantee upon review of the full second year of the grant to determine they are interested in a continuation of the grant to extend the reach of the model hospital program in other areas with higher disparities and at risk populations.

As a result of the change in the social marketing plan upon implementation, the ESMs have been reduced for the remainder of the grant period. In 2018, 171 social marketing messages are anticipated and 86 in 2019. The decrease in 2019 is due to the current grant period ending June 30, 2019. While the number of social marketing messages to be disseminated is reduced it is a result of higher quality engagement with the lower level of social media posts. The high level of engagement with the social marketing messages will continue the reach of the

lifesaving safe sleep message 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.

The Division of Newborn Screening and Genetics (DNSG) will explore other methods to improve the timeliness of newborn screening. The United Parcel Service (UPS), the newborn screening courier service, does not deliver samples to the screening laboratory on Sundays. In addition, UPS does not pick up specimens from submitters on Sundays. These gaps are large barriers to improving the timeliness of newborn screening. The DNSG and PerkinElmer Genetics, the contracted screening laboratory with the UPS contract, will discuss either improving the UPS schedule or a potential agreement with a different courier for Sunday pick up and delivery. The DNSG will also work with midwives to educate them on the importance of timeliness and encourage them to begin using UPS instead of the U.S. Postal Service for shipping specimens to improve timeliness of collection to receipt for out of hospital births.

The DNSG is utilizing NewSTEPs 360 funding to contract with the University of Pittsburgh to develop a newborn screening online learning module focused on timeliness. The DNSG will promote the module, track its use and capture the number of participants completing the module. This data will be used to compare the completion of the training and the hospital's newborn screening timeliness to evaluate the effectiveness of the training. The DNSG will continue quality assurance tasks to ensure timely collection to receipt of the DBS filter papers. Monthly reports, the publication of newsletters and the midwife workgroup will continue in 2019. Technical assistance will expand to include site visits to low performing hospitals to determine barriers and educate facilities on best practices.

The DNSG will update the Newborn Screening Provider Manual which was last updated in 2009. The manual focuses on best practices for submitters related to all aspects of newborn screening, including timeliness. In addition, the DNSG will revise the PA Department of Health Chapter 28 Screening and Follow-up for the Diseases of the Newborn regulations. The current regulations are out dated and lack provisions related to timeliness. New regulations will support the DNSG while implementing efforts to improve the timeliness of newborn screening.

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 DNSG will continue to work towards the objective of ensuring that all newborns born in PA will be screened for all conditions listed on the RUSP. The DNSG and will continue efforts to encourage submitters not screening for conditions on the mandatory follow-up panel to add the conditions to their screening panels.

On February 8, 2018, the Advisory Committee on Heritable Disorders in Newborns and Children reviewed the evidence for and the implications of adding to the RUSP and voted to recommend the Secretary of Health and Human Services add Spinal Muscular Atrophy (SMA) to the RUSP. Should SMA be added to the RUSP, the DNSG will work with the Newborn Screening and Follow-up Technical Advisory Board (NSFTAB) to explore adding SMA to

the mandatory screening panel in PA. The DNSG will continue to partner with the NSFTAB to implement the screening for all new conditions that may be added to the RUSP.

The use of two separate screening panels, a mandated screening panel and a mandated follow-up panel, continues to leave some PA newborns unscreened for all the conditions listed on the RUSP. The DNSG will continue to support the NSFTAB's recommendation to merge the two panels contingent on a new funding structure and support House Bill 1081 which recommends merging the two panels and requiring a newborn screening fee with funds deposited into a Newborn Child Screening Program Account.

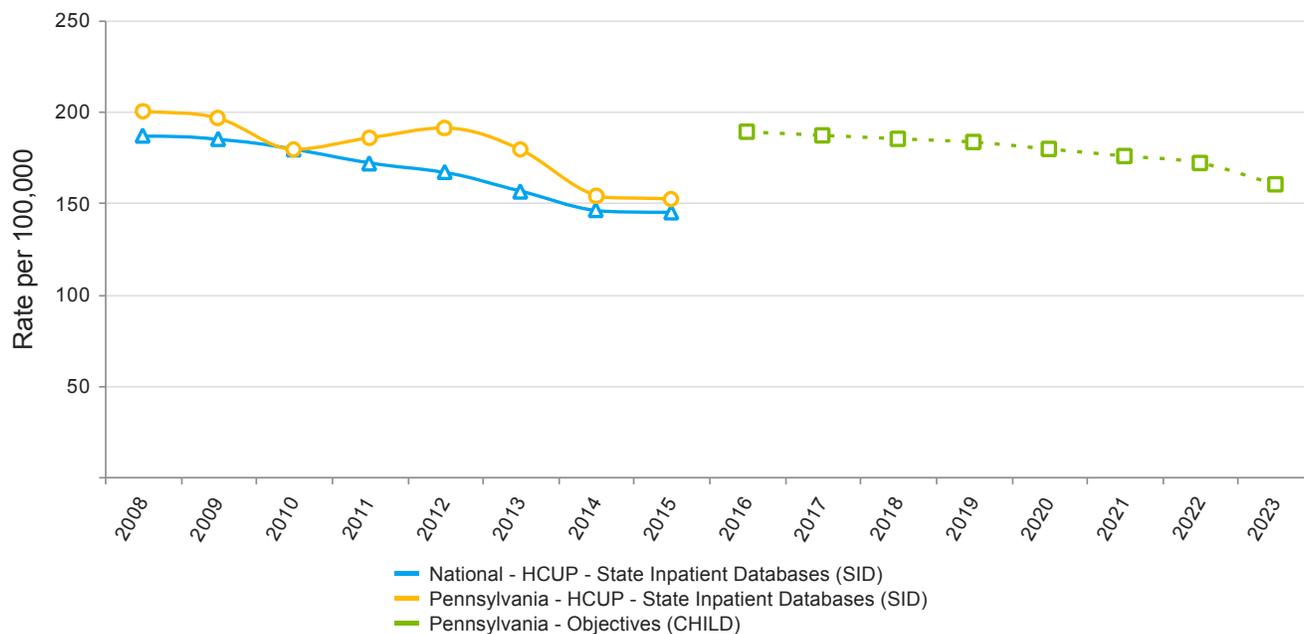
Child Health

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-2016	18.1	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	31.6	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	10.1	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	8.2	NPM 7.1

National Performance Measures

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



Federally Available Data

Data Source: HCUP - State Inpatient Databases (SID)

	2016	2017
Annual Objective	188.7	186.8
Annual Indicator	175.4	152.0
Numerator	2,553	1,654
Denominator	1,455,450	1,088,130
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	184.9	183.1	179.3	175.5	171.7	160.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Number of comprehensive home assessments completed.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		875
Annual Indicator	97	1,069
Numerator		
Denominator		
Data Source	Quarterly reports from Pennsylvania Safe and Health	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	900.0	920.0	920.0	920.0	920.0	0.0

ESM 7.1.2 - Number of health and safety hazards identified through comprehensive home assessments.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		7,000
Annual Indicator	936	6,447
Numerator		
Denominator		
Data Source	Quarterly reports from Pennsylvania Safe and Health	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7,200.0	7,360.0	7,360.0	7,360.0	7,360.0	0.0

ESM 7.1.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		4,375
Annual Indicator	468	4,845
Numerator		
Denominator		
Data Source	Quarterly reports from Pennsylvania Safe and Health	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,500.0	4,600.0	4,600.0	4,600.0	4,600.0	0.0

State Performance Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		14
Annual Indicator	7	7.4
Numerator		
Denominator		
Data Source	List of BFH Title V programs	List of BFH Title V programs
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.0	14.0	18.0	21.0	21.0	22.0

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

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

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.

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

- Continue to provide the Shaken Baby Program.

ESMs	Status
ESM 7.1.1 - Number of comprehensive home assessments completed.	Active
ESM 7.1.2 - Number of health and safety hazards identified through comprehensive home assessments.	Active
ESM 7.1.3 - 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

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

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

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

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

Priority Need

MCH populations reside in a safe and healthy living environment.

SPM

SPM 2 - 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 - Annual Report

Current work in the BFH addresses injury prevention through a variety of programs. The Child Death Review (CDR) program promotes the safety and well-being of children by reducing preventable childhood fatalities. This is accomplished through systemic, multi-agency reviews of the deaths of children up to the age of 21 years. All 67 Pennsylvania counties are represented on 63 local CDR teams. The CDR program through the BFH facilitates the review process, provides training and technical assistance to local teams and ensures data quality. In 2016, the BFH began to transition the CDR program from the Pennsylvania Chapter of the American Academy of Pediatrics to within the Bureau. The transition was complete by the end of 2017 and the CDR program is currently housed within the Bureau. The CDR program is supported through a combination of Title V and other federal funds, with other federal funds being used to fund staff time and Title V funds being used to fund training and technical assistance efforts as well as prevention activities.

There were 1,743 deaths of children 21 years of age and under in 2014. Of the total deaths, 1,258 were reviewed. Close to half (48.7 percent) of all deaths were infant deaths. Children age 18 years up to 22 years of age accounted for 26.3 percent of child deaths reviewed. Combined, these two age groups represent 76.6 percent of all child deaths reviewed in Pennsylvania in 2014 (most recent complete data available).

In Pennsylvania, deaths of African American children occur at a higher rate than those of other races. From 2010-2014, there had been a decline in the rate of death for African American children, reaching a five-year low of 89.8 per 100,000 population in 2014. However, this rate is still higher than the national mortality rate for African American children of 86.2 per 100,000 population.

Of the 137 reviews conducted on deaths occurring in children aged one through nine years, the most frequent cause of death was other medical conditions, identified in 22 cases (16.1 percent). In the 158 reviews conducted regarding deaths occurring in children aged 10 through 17 years, the most frequent cause of death was due to weapons, identified in 31 cases (19.6 percent). An examination of the 331 reviews conducted on children aged 18 through 21 years revealed that the most frequently occurring cause of death was weapon-related which was identified in 81 cases (24.5 percent).

Development and implementation of prevention measures vary according to the community and the findings of the local CDR 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.

The Shaken Baby Syndrome (SBS) Program is an injury prevention program provided by the BFH and in accordance with PA Law 2002-176. The program's goal is to reduce the incidence of abusive head trauma by assisting hospitals in fulfilling the statutory requirement of providing SBS education to parents before discharge from the hospital after the birth of a baby. Until June 30, 2017, the BFH worked through a contractor to provide training, education, and technical assistance to staff at hospitals and birthing centers. The training measures have been achieved and the program is now self-sustaining. The BFH continues to supply educational materials to the hospitals and birthing centers.

The BFH continues to focus on improving the health and safety of the home environment for the MCH population by focusing on the implementation of a holistic home assessment and intervention program which does not fall within typical health or home rehabilitation programming. These home assessments not only identify both safety and environmental hazards in the home, but provide the residents with interventions to decrease or eliminate the hazard. While the living environment is more than the home, that is the area on which BFH can have an immediate impact.

The prevention of injuries through decreased hospitalization for non-fatal injuries is being used to measure these primary prevention methods with improved physical and mental health for the entire family as another expected outcome.

Lead exposure and lead poisoning disproportionately affect minority children and low-income families. The total population of Pennsylvania is less than 11 percent African American but the proportion of African American's living in the areas where this program is targeted is more than three times higher. The primary source of lead exposure in children of Pennsylvania is deteriorating lead based paint (LBP), which is found in homes built before 1978. The majority of Pennsylvania's housing was built before 1980. The BFH receives funding from the U.S. Department of Housing and Urban Development (HUD) for the Lead Hazard Control Program (LHCP) to identify and to remediate lead-based paint hazards in homes of families with children under 6 years of age, children with elevated blood lead levels (BLLs), and pregnant women. The BFH partnered with eight vendors in high-need targeted areas across the state to implement LHCP activities. The LHCP aims to make homes lead safe to provide safe, healthy housing for Pennsylvania's minority and low-income families.

Priority: MCH populations reside in safe and healthy living environments.

One area of Pennsylvania's Child Safety Collaborative Improvement and Innovation Network (CS CollIN) work focuses on falls prevention. The BFH chose to focus on seven change ideas within the falls topic area covering work on concussion assessment; return to learn accommodations for those with traumatic brain injuries (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, emergency medical technicians (EMTs) and firefighters to perform home safety audits and safety device installation; and safety device distribution and installation. In 2017, BFH decided to focus on concussion prevention and management in sports clubs in Pennsylvania. Title V funded the staff who oversaw CS CollIN activities.

Throughout the year BFH has focused on concussion prevention and management training and protocols in sports clubs in Pennsylvania. The goal was to determine how many non-school youth (sports) soccer programs require their coaches to take an approved concussion training course. Two soccer clubs responded to BFH's initial outreach and both had concussion policy in place. Additional discussion occurred with each club to determine if they would be interested in coaches, parents and other individuals participating in a free education session on concussion. One club did have interest in participation. The other club stated that they did not have interest as their coaches, parents and league representatives were already informed about concussions.

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

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.

During 2017, the Safe and Healthy Homes Program (SHHP), funded with Title V money, became fully operational as the BFH's second iteration of healthy homes programming that targets five regions across the state with the highest injury rates. The SHHP incorporates the American Academy of Pediatrics guidance and interventions to reduce the risks of injuries, and it continues to provide limited housing rehabilitation and education to address safe and healthy home issues. Falls, poisoning and hot objects are the leading causes of injuries resulting in hospitalizations in Pennsylvania, especially in the MCH population. Interventions aimed at reducing these hazards to prevent injuries are supported by research that ranges from proven to promising and is offered to families who participate in the SHHP.

The four SHHP grantees completed start-up activities in the last two quarters of 2016 after encountering longer than anticipated startup delays which were closely monitored. When evaluated, the delays were determined not to be ongoing issues and resulted in no changes to the program or overall performance objectives. As described below, the SHHP exceeded two ESMS and fell short on the other ESM in 2017. Despite not achieving one ESM, the SHHP filled a void in services not provided by traditional medical providers or by housing programs.

In 2017, 875 comprehensive home assessments were targeted and SHHP grantees completed 1,069 assessments. The second quarter of 2017 marked the last quarter of the first state fiscal year for the SHHP. There was a higher than expected number of completed home assessments as several of the grantees were catching up on home assessments due to the startup delays in 2016. While not meeting the target of 7,000 health and safety hazards identified through comprehensive home assessments; the SHHP identified 6,447 hazards. The target was based on identifying eight health and safety hazards per home. In 2017, there were only six identified per home. Not meeting this target is not of great concern as it indicates that the residents were living in homes that were healthier and safer than anticipated. As a follow-up to the hazards identified during the home assessments, 4,845 health and safety interventions were performed. These interventions exceeded the 2017 ESM of 4,375 interventions. The rate of health and safety interventions in 2017 was 4.5 per home assessment which is just below the target of five per home assessment.

The SHHP grantees reported a high level of satisfaction with the services provided, including word of mouth referrals to friends and family after completing the SHHP. One of the most common areas of feedback was a reported decrease in symptoms and need for emergency medication from families who have an asthmatic child.

The BFH continued to serve as a statewide resource on healthy homes providing 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.

Child Health - Application Year

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

In 2019, the BFH will continue to enhance and strengthen the CDR program through data quality and analysis for both SUID and CDR cases. Pennsylvania continues to improve data quality for CDR and SUID through training efforts at regional and statewide meetings and targeted technical assistance. Improved data quality will enhance local CDR teams' ability to implement prevention strategies at the local level. Through federal Title V funds, the BFH will make mini-grants available to local teams to support injury prevention efforts locally. The BFH is also re-developing a State CDR Team that will be tasked with developing policies, training and recommendations at the state and local levels.

Priority: MCH populations reside in safe and healthy living environments.

BFH staff will continue to collaborate with the Violence and Injury Prevention program and to participate on the Child Safety Collaborative Innovation and Improvement Network (CS CollIN). The goal for Pennsylvania's CollIN work is to implement at least one new strategy to address falls by 2021. The newly received Pennsylvania Health Care Cost Containment Council (PHC4) data will be used to shape and evaluate the CS CollIN process measures going forward. Pennsylvania remains optimistic in promoting proper concussion protocols and offering concussion prevention and management training to sports clubs across the state. Pennsylvania hopes to partner with fire departments to install stairs guards in conjunction with smoke detectors. Reducing falls and concussions in sports will keep youth safe from brain and bodily injury. Title V will fund the staff overseeing the 2018 CS CollIN activities.

To ensure appropriate protections exist for youth athletes who participate in organized school and non-school sponsored sporting activities, the Bureau of Family Health will provide traumatic brain injury (TBI) education. TBI education will be provided through a Safety in Youth Sports Program, which will include in-person and web-based trainings. Trainings will be provided to individuals affiliated with youth sports including coaches, parents, athletes, and school personnel. In addition to the individuals involved in youth sports, the web-based training will be provided to those working in the medical community, including physicians, physician assistants, and nurses.

Lead exposure remains a concern for children with the major causes of elevated blood lead levels among U.S. children being lead-based paint and lead dust. Houses built before 1978 are likely to contain some lead paint which becomes a problem when it deteriorates or is destabilized during renovations. For the 2019 year, the LHCP will be wrapping up grant activities. The BFH will explore the option of preparing and applying for additional funding to continue the mission of reducing injury and lead poisoning in the most vulnerable children Pennsylvania. BFH will also be implementing strategies, as a result of a cooperative agreement with the Centers for Disease Control and Prevention (CDC) and the Maternal and Child Environmental Health Collaborative Improvement and Innovation Network (MCEH CollIN), to increase lead testing and improve coordination of follow-up care for children with elevated blood lead levels. Strategies will include conducting training for providers and community groups and addressing barriers that prevent the allocation or receipt of appropriate care for children with elevated blood lead levels.

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 0 through 9

As a result of the 2015 MCH Needs and Capacity Assessment, the BFH identified MCH populations residing in a safe and healthy living environment as a priority. 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. Many 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 people of low-income, 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.

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.

The BFH will continue to support the Safe and Healthy Homes Program (SHHP) for the duration of the grant period (July 1, 2016 through June 30, 2019). The SHHP is a regional program that provides services in the areas of highest need. 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 the BFH is maximizing resources. Focusing on low-cost, evidence-informed interventions that reduce injuries and provide for healthier homes such as smoke alarms, carbon monoxide alarms, and integrated pest management will allow more hazards to be addressed in each home. Using a truly preventive approach with SHHP provides more opportunities to move the dial on outcome measures. This is 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 objective by tracking the number of comprehensive home assessments completed. One of the measurable outcomes of the assessments is tracking the number of health and safety hazards that are identified. In addition to identifying the hazards, the SHHP will continue to implement and to track health and safety interventions to reduce the hazards posing an injury risk. The BFH will consider SHHP successful if identified health and safety hazards are remediated. Additionally, SHHP will collect qualitative data from participants to determine their perceptions of health and safety at home as well as test their knowledge of health and safety issues in the home environment.

Following completion of the second year (7/1/17 to 6/30/18) of the SHHP, the BFH will evaluate the program to

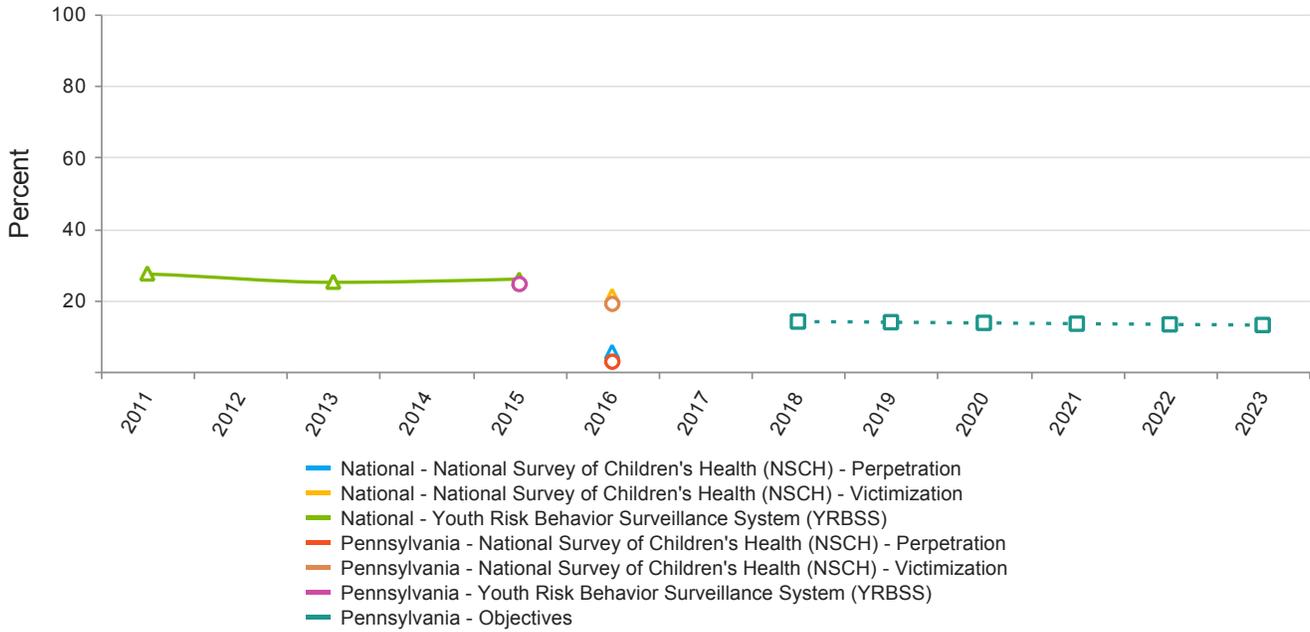
determine if changes in the scope of the program are necessary as well as review the injury data used to develop the SHHP regions. Development of the SHHP used injury data for the entire age range of children; however, the types of injuries that SHHP is best able to prevent are focused on the younger children. This may result in refocusing efforts to the areas of greatest need for the youngest children. The BFH has no doubt that interest in the SHHP will continue and will focus efforts on honing the program to best meet the needs of Pennsylvania's children and their families.

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-2016	31.6	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	10.1	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	8.2	NPM 9 NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	56.5 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	14.2 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	12.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	14.0 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	63.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	72.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	57.2 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	92.0 %	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-2016	92.7 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	15.8	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: Youth Risk Behavior Surveillance System (YRBSS)

	2016	2017
Annual Objective	14.5	14.3
Annual Indicator	24.7	24.7
Numerator	122,928	122,928
Denominator	497,526	497,526
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	2.8
Numerator	24,330
Denominator	869,039
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	18.9
Numerator	163,399
Denominator	863,295
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.1	13.9	13.7	13.5	13.3	13.1

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.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	76	83
Numerator		
Denominator		
Data Source	quarterly reports	quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	90.0	100.0	100.0	100.0	100.0	100.0

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	n/a	n/a
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	40.0	55.0	75.0	85.0	90.0

ESM 9.5 - Number of evidence-based mentoring programs implemented in high risk areas of PA.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	n/a	n/a
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7.0	9.0	11.0	13.0	15.0	17.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	20	30
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	80.0	100.0	120.0	140.0	160.0

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		150
Annual Indicator	135	368
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	175.0	200.0	230.0	270.0	410.0	410.0

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

Measure Status:	Active
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State Provided Data	
	2017
Annual Objective	15
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	30.0	30.0	45.0	45.0	60.0

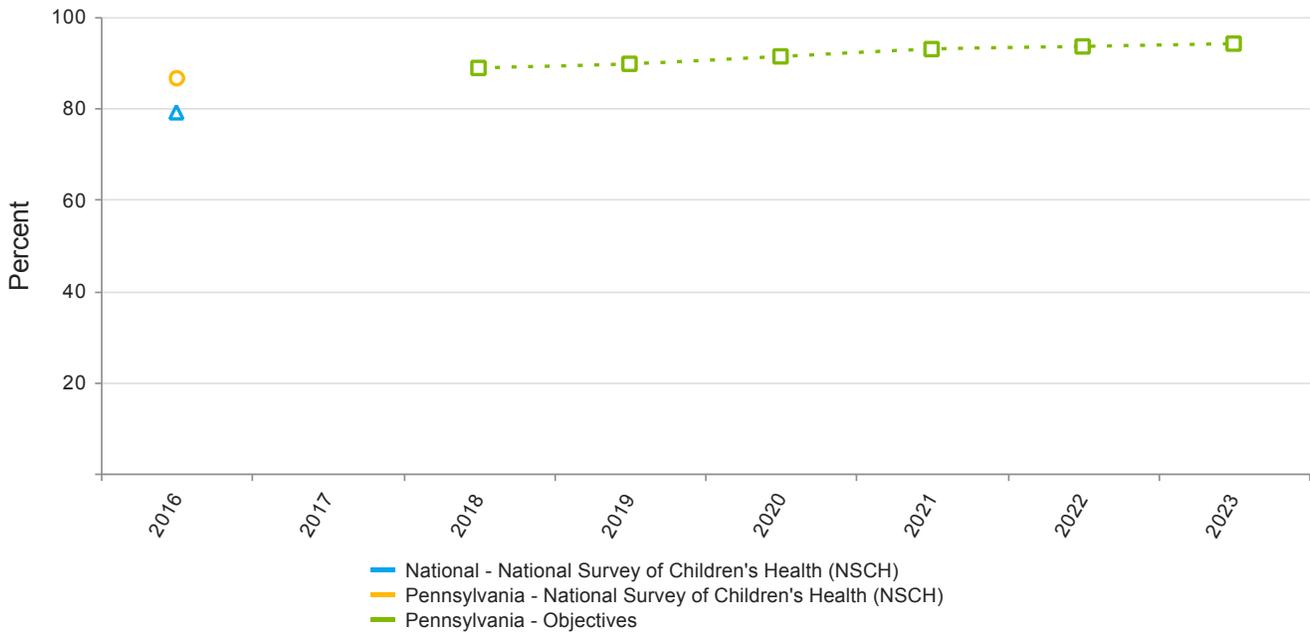
ESM 9.9 - Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.

Measure Status:	Active
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State Provided Data	
	2017
Annual Objective	250
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	425.0	475.0	525.0	575.0	625.0	1,500.0

**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	2017
Annual Objective		
Annual Indicator		86.5
Numerator		775,554
Denominator		897,142
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	88.7	89.6	91.2	92.8	93.4	94.0

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.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		10
Annual Indicator	9	8
Numerator		
Denominator		
Data Source	quarterly reports	quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	11.0	11.0	11.0	11.0	11.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		3,500
Annual Indicator	3,288	3,780
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,000.0	4,500.0	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.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	13	18
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	18.0	21.0	25.0	30.0	33.0	35.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		3,800
Annual Indicator	3,537	3,520
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,000.0	4,200.0	4,500.0	4,900.0	5,200.0	5,200.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		11,817
Annual Indicator	7,557	10,599
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15,275.0	15,375.0	15,475.0	15,575.0	16,375.0	16,575.0

State Performance Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		14
Annual Indicator	7	7.4
Numerator		
Denominator		
Data Source	List of BFH Title V programs	List of BFH Title V programs
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.0	14.0	18.0	21.0	21.0	22.0

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%.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	N/A	N/A
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	50.0	55.0	60.0	65.0	70.0

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

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

Objectives

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.

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.

Increase the number of adolescents 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.

Support Olweus trainers in Pennsylvania to improve the bullying prevention infrastructure.

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 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

NPM 10 - 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 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 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, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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

Priority Need

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

SPM

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%.

Objectives

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

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.

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

For the duration of the grant cycle, BFH will annually increase the number of LGBTQ sensitive organizations which provide services to youth.

For the duration of the grant cycle, BFH will annually increase the number of LGBTQ youth who have access to suicide prevention interventions.

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 - Annual Report

The BFH provides services to the adolescent health population domain through a combination of Title V funding and other federal funding, as described below. Within the BFH, most adolescent health programs are situated in the Division of Child and Adult Health Services. By administering all adolescent federal grants in the same division, expertise about emerging needs and best practices for the population are easily shared among Title V and other federally funded programs. Based on overall population needs and the existing capacity and accomplishments of other programs, the BFH has developed strategies for the MCH Action Plan that do not duplicate other funding sources and fill gaps that are not addressed by the existing system of care.

In 2016, the sex and race/ethnicity of Pennsylvania's adolescent population (n=1,733,940) were distributed as shown in the table below.

2016 Pennsylvania Adolescents (ages 10-19)	
Sex	
51%	Male
49%	Female
Race/Ethnicity	
71%	White
13%	Black
4%	Asian
3%	Multi-race
9%	Hispanic

According to 2015 Youth Risk Behavior Surveillance System (YRBSS) data, 36.3 percent of ninth through 12th grade students in Pennsylvania responded affirmatively that they, "ever had sexual intercourse." In 2015, 26.7 percent of ninth to 12th grade students reported that they had sexual intercourse with at least one person during the three months before taking the survey. Additionally, 11.1 percent of ninth to 12th grade students who were currently sexually active reported that they "did not use any method to prevent pregnancy" during their last sexual intercourse encounter. This combined data demonstrates the need for programming on the prevention of pregnancies and sexually transmitted infections, including HIV/AIDs in Pennsylvania.

In Pennsylvania, there is a downward trend of teen pregnancy rates and teen birth rates. Despite this trend, there remains a disparity in teen pregnancy rates in Pennsylvania, particularly by race and ethnicity, as shown in the table below.

2016 Pennsylvania Teen Pregnancy Rates, per 1,000 youth (ages 15-17)	
Race/Ethnicity	
6.0	White
25.4	Black
2.8	Asian and Pacific Islander
20.4	Multi-Race
23.7	Hispanic

The BFH addresses this disparity through several initiatives aimed at reducing teen pregnancy rates among high-risk, high-need youth, and at providing parenting supports for youth with the greatest need. The Personal Responsibility Education Program (PREP), funded by the Administration for Children and Families, educates youth on abstinence, contraception, and adulthood preparation subjects. Evidence-based curricula are implemented in settings serving at-risk, high-need youth including drug and alcohol facilities, residential treatment facilities, and community-based health or human service agencies.

The BFH also utilizes Support for Expecting and Parenting Teens, Women, Fathers and their Families funding from the Office of Adolescent Health. Funding is used for the Support. Empower. Learn. Parenting Health Initiative (SELPHI) program which helps expectant and parenting adolescents and their families navigate key social and health services in Philadelphia. Philadelphia has the highest teen birth rate of any county in Pennsylvania and ties for the third-highest teen birth rate among the 11 largest counties in the United States.

Adverse Childhood Experiences (ACEs) can have lasting effects on one's health and behaviors. ACEs are common, as shown in the 2016 Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS) survey data. For example, 35 percent of BRFSS participants reported that as a child, their parents or adults swore at, insulted or put them down one or more times in their home. Twenty-three percent of participants reported that during childhood, they lived with someone who had a drinking problem or suffered from alcoholism.

While ACEs and risk factors are associated with negative health outcomes, protective factors are those characteristics in relationships, communities, and society that lower the likelihood of negative outcomes, or even counter the effects of the risk factors. The BFH aims to increase protective factors among adolescents through evidence-based and evidence-informed mentoring programs. Healthy Youth PA, funded by the Title V Abstinence Education Grant Program, promotes abstinence from sexual activity among youth through mentoring, counseling and adult supervision programs. The program implements strategies to build protective factors for participants and promote the optimal transition of youth living in high-risk communities from middle childhood to adolescence.

Lesbian, Gay, Bisexual, Transgender and Questioning/Queer (LGBTQ) youth face unique challenges, including higher rates of bullying and harassment than their non-LGBTQ peers. In a 2015 report, a majority of Pennsylvania's LGBTQ youth regularly heard anti-LGBTQ remarks at school and had been victimized at school. Many LGBTQ youth did not have access to in-school resources and supports. Only 8 percent of students attended a school with a comprehensive anti-bullying/harassment policy that included specific protections based on sexual orientation and gender identity/expression. Due to the lack of support for these youth, 53 percent of LGBTQ students who were bullied never reported it to school staff. Among those students who did report bullying to staff, only 24 percent said reporting resulted in effective intervention by staff. In 2013, these percentages were 57 and 37 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 out-of-home placement experience bullying and harassment at even higher rates. A study found 78 percent of LGBTQ youth were removed or ran away from their out-of-home placements because of hostility based on their sexual orientation or gender identity.

According to the 2015 YRBSS, 40 percent of LGBTQ high school students in the United States seriously considered suicide (transgender teens were not included in the survey). Compared with the percentages for heterosexual peers, these numbers are exceptionally high. The survey results showed that 14 percent of straight teens had seriously considered suicide. Rates are even higher among LGBTQ youth who come from highly rejecting families: families whose behaviors rejected their child's LGBTQ identity, such as preventing a gay youth from attending family events or physically hurting a child because of their LGBTQ identity.

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

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

Objective 1: For the duration of the grant cycle, BFH will annually increase the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.

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.

Healthy Youth PA (Title V Abstinence Education Grant Program) and Personal Responsibility Education Program (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, to transgender youth, to health disparities. In 2017, 83 percent of currently active adolescent health vendors received LGBTQ cultural competency training, an increase of seven percent. An additional four vendors recently began providing services to adolescent health and will be trained in the near future. With new adolescent health programs starting October 2018, 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.

Objective 3: Increase the number of adolescents participating in a bullying awareness and prevention program.

ESM: Number of trainers trained in the Olweus Bullying Prevention Program.

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.

Based on these discussions, the BFH and Clemson University have begun negotiations for developing capacity to increase the number of trainers in community-based youth-serving organizations, rather than focusing on school-based trainers. BFH experienced contractual barriers in establishing a grant agreement with Clemson University in 2017, but anticipates an agreement to be in place and begin July 1, 2018.

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

In July of 2017, the BFH partnered with Persad Center to implement the Youth Age Opportunity Program (YAOP), funded by Title V. YAOP serves LGBTQ youth ages 17 to 24 years old who experience skill and opportunity barriers to launch successfully into adulthood. Youth are offered screenings and assessments during Persad Center's drop-in hours. Persad Center's plan was to slowly roll out new screening and assessment tools during the first quarter of implementation; however, the demand for services was so immediate, Persad Center has had to delay the development of these tools while urgent needs are addressed. New staff members, including a youth coach and outreach worker, were hired for the YAOP. In the first six months of the program, seven youth were provided services. Six of those youth received an assessment and coaching sessions. One significant barrier Persad Center is encountering is the availability of affordable housing. The youth are provided with support and resources, however, securing affordable housing is a significant hurdle for this age group.

Objective 1: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ sensitive organizations which provide services to youth.

ESM: Number of organizations certified as a safe space provider.

The BFH continues to support Persad Center and Mazzoni Center with Title V funds 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 safe space provider) in calendar year 2017, Persad Center provided 10 organizations (or 272 individuals) with training to become Safe Space certified. There were 356 youth who took advantage of the Safe Spaces provided by Persad center in 2017, 215 fewer youth than were reached last year. This decrease in numbers may not reflect the actual number of youth who were served, due to the grantee not collecting complete and accurate attendance data for events held. BFH has and will continue to provide technical assistance to Persad Center around data collection, to ensure all youth are counted.

Mazzoni Center 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 experienced staff turnover in the education department in the third quarter of the year, and the number of trainings dropped that quarter due to time spent training inexperienced staff to deliver the cultural competency and health disparities trainings. Even with the challenges of losing staff, Mazzoni Center exceeded their goals while maintaining a wide array of training sites including public schools, behavioral health non-profits and corporate sites. Overall, they trained 2,536 participants throughout the year in cultural competency and health disparities. Mazzoni trainings and trainers continue to be in high demand with organizations and they are scheduling trainings six months in advance. Mazzoni Center has begun to transition to electronic training evaluation forms which has had some logistical challenges. However, it has been a useful tool in allowing Mazzoni Center to aggregate data and look at trends. Mazzoni Center will continue to analyze the data and create more streamlined

analysis procedures.

Objective 2: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ youth who have access to suicide prevention interventions.

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

The BFH provided Title V funding to Persad Center to implement the Yellow Ribbon Suicide Prevention six times, which reached 368 youth in the calendar year 2017. This is 273 percent more than the 135 youth that were reached in 2016. 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 schools and community centers throughout Allegheny and Washington counties. 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.

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%.

Objective 1: Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs.

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

ESM: Number of evidence-based programs implemented in high risk areas of Pennsylvania.

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 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 2017. 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.

Both Objectives are realized through Healthy Youth PA, which is funded through the Title V State Abstinence Education Grant Program (AEGP). 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.

Programming saw a decrease in the amount of youth served, the total number of program hours provided to youth, and the number of parents/caregivers served in calendar year 2017 compared to calendar year 2016. There were 784 youth ages 9-14 served in calendar year 2017, compared to 1,038 in calendar year 2016. The overall goal of the program is to serve, at a minimum, 407 youth per year. It is important to clarify this goal is not a goal of the block grant, but rather an overall program goal Pennsylvania has established for the AEGP. The youth served participated in 12,269 program hours, compared to over 15,000 programming hours from calendar year 2016. And, lastly, there were 373 parents/caregivers of those youth being served who participated in activities, compared to 627 in calendar year 2016.

Agencies providing services saw a significant amount of turnover with regards to staff implementing programming in calendar year 2017. Due to an agency-wide restructuring, one agency experienced change to all program staff, including contracted staff, which led to programming being suspended for a period of time. Apart from one agency, all agencies experienced turnover which impacted numbers for youth being served.

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.

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. The BFH released a Request for Applications (RFA) in September 2017 for agencies to implement mentoring programming that aligns with this SPM. Three organizations, Big Brothers Big Sisters Independence Region, City Year Philadelphia, and Students Run Philly Style, were awarded as a result of the competitive bid process and began program implementation in January 2018. The BFH selected vendors by who they had the capacity to reach, and their ability to increase protective factors in the target population.

Priority: MCH populations reside in safe and healthy living environments.

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

Objective: As a result of Child Safety ColIN, implement at least one strategy to address interpersonal violence in PA by 2020.

Within the Child Safety Collaborative Improvement and Innovation Network (CS ColIN) Pennsylvania focuses on interpersonal violence. There are 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. Title V funded the staff who oversaw the CS CollN activities.

Participation in the CS CollN process has been a learning process. Pennsylvania has been slowly implementing the quality improvement techniques with small tests of change from the state level. However, 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. BFH has added quality improvement language into the Healthy Youth Request for Applications (RFA). The grant awardees will conduct improvement activities and ongoing evaluation of the program in partnership with the BFH.

Pennsylvania's change ideas are being used 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 (7.4%), 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.

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.

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 Title V funds to provide a variety of services to high school students through the Health Resource Center (HRC) program. The HRC program provides: sexual and reproductive health education; confidential, individual level counseling; screening for chlamydia, gonorrhea, and pregnancy testing; referrals and direct linkages to core family planning services; and distribution of safer sex materials (male and female condoms and dental dams). HRCs are located in high schools or clinics near a school, and are open during hours that are convenient to youth. AccessMatters operates HRCs in thirteen Philadelphia area schools, as well as thirteen additional sites in six counties across the Commonwealth. The thirteen additional HRCs, considered expansion sites from the original HRCs, operate in areas with high rates of teen pregnancies, STIs and school drop-outs.

Currently, there are HRCs operating in eight counties. The counties are Philadelphia, Delaware, Berks, Lackawanna, Lycoming, Dauphin, Allegheny, and Fayette Counties. The goal for ESM 10.1: the number of counties with a HRC

available to youth ages 12-17 for 2017, is ten counties. This goal was not met primarily due to projected expansion sites not coming into fruition in 2017. There were to be three additional counties covered by the expansion sites. The main challenge to implementing HRCs in the three additional counties is getting the approval from schools, or finding schools willing to implement HRCs. The three additional counties are rural counties, and planning for the expansion sites has been met with hesitation in allowing comprehensive sexual and reproductive health education in schools. Planning will continue in 2018 to establish HRCs in these additional counties. One way to potentially overcome this challenge is to shift the focus of the HRCs to more community-based agencies, which are already providing health care to youth.

In state fiscal year 2016 (July 2016-June 2017), the HRCs provided services to 3,780 youth. The goal for ESM 10.2: the number of youth receiving services at a HRC during this time period, is 3,500 youth. Even though not all expected HRC sites were operational, this goal was still exceeded.

The goal for ESM 10.3: In schools with a HRC, the percent of youth within that school utilizing the HRC services, is 15 percent. In state fiscal year 2016, the percent of youth, of all school-based HRCs, who utilized HRC services was 18 percent. Again, even though not all expected HRC sites were operational, this goal was still exceeded.

To increase visibility and youth-friendliness of the HRCs, the expansion sites were given additional funding to form Youth Advisory Boards. All expansion site counties with an active HRC, except for Berks County, have Youth Advisory Boards. The HRC in Berks County recently shifted from a school-based program to a program located in a residential facility for youth who are adjudicated delinquent. Further assessment is needed as to how best operate a Youth Advisory Board for this location. The existing Boards promote the services of the HRCs, design health awareness campaigns, inform HRC services, and ensure HRC services are teen-friendly. AccessMatters continues to provide training and technical assistance to sites for developing and maintaining Youth Advisory Boards.

While working with AccessMatters on the expansion of the HRC program to additional sites, the BFH saw an opportunity in 2016 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. After examining the process and results of the collaborative effort, BFH determined at the end of 2017 that the logistical challenges associated with integrating the teen dating violence screening and LGBTQ cultural competency services outweighed the benefits. Both the teen dating violence screening work and the LGBTQ cultural competency trainings will become stand-alone services available to all programs and not just the HRCs.

Objective 3: For the duration of the grant cycle, the BFH will annually increase the number of LGBTQ youth with a medical visit in the past year.

ESM: Number of youth receiving services at a drop-in site funded by the BFH.

Mazzoni Center provides, with Title V funds, a drop-in health center for youth to obtain a variety of health care and social services. Mazzoni Center provided 3,520 youth with medical services at their drop-in health center in calendar year 2017. This was only 17 fewer youth than last year. Mazzoni Center surpassed their goal of 500 youth served by

704 percent. Moreover, 3,281 youth received case management visits (66 more youth than calendar year 2016), and 3,180 unduplicated youth received one service.

Objective 4: Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit.

ESM: Number of youth receiving health education and counseling services from a reproductive health provider.

In state fiscal year 2017/2018, the BFH increased the Title V grant funding amounts to the family planning councils to provide more adolescent clients with reproductive health counseling services. To address inconsistent reporting procedures, data reporting forms were revised to ensure uniform data collection and reporting, and the BFH provided technical assistance as needed. In calendar year 2017, BFH provided 10,599 adolescents with services and did not meet the goal of 13,545 youth served. The increase in funding was not implemented until July 1, 2017 (halfway through the year) and BFH anticipates the family planning councils will reach more youth in calendar year 2018, as they will receive a full year of increased funding.

In addition to services provided at a traditional health visit, BFH awarded additional Title V funding to Maternal and Family Health Services, a family planning provider, to expand their promotion of the SafeTeens Answers! text line. Staffed by Planned Parenthood of the Rocky Mountains, youth can text their sexual health and healthy relationship questions to the text line and receive a complete, age-appropriate, and medically accurate response within a few hours. Referrals to the appropriate hotlines are also provided, if a texter identifies a need for prenatal care, LGBTQ support, suicide intervention, or information on rape, abuse, or neglect. From July through December 2017, 699 texts were received and 98 teens were referred to services. The most common question topics were pregnancy related, including how to know if one is pregnant.

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 the calendar year 2017, 1,256 at-risk youth completed an evidence-based program at a PREP facility. For this reporting period, the following curricula 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!, Sexual Health and Adolescent Risk Prevention (SHARP), Be Proud! Be Responsible! and Be Proud! Be Responsible! Be Protective!. Compared to the previous year, 9 percent more youth completed 75 percent of the curriculum; however, implementation sites are not meeting their agency-specific goals for number of youth reached. To address the loss of five sub-grantees and the struggles current sub-grantees have with recruitment and retention, the BFH started the Request for Applications (RFA) process in August of 2017 to select new implementation sites.

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

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

Objective 1: For the duration of the grant cycle, BFH will annually increase the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth.

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 2015 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 continue to 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. BFH has experienced procurement and contractual barriers when attempting to add this requirement to grantees’ work statements. BFH will continue to work with vendors and solicit their input to determine the most streamlined way of incorporating this requirement into grant agreements.

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.

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 with Title V funds 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. The BFH anticipates an agreement to be in place and begin July 1, 2018.

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

Objective 1: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ sensitive organizations which provide services to youth.

ESM: Number of organizations certified as a safe space provider.

The BFH will, with Title V funds, support Persad Center's engagement in coalition building activities with known ally organizations and new partners to become Safe Space certified. Persad Center is a LGBTQ-focused human service organization. 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 continue this strategy of providing places of support and acceptance for LGBTQ youth.

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.

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. Mazzoni Center, 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 will continue to partner with Mazzoni Center to implement training and improve capacity of providers.

Objective 2: For the duration of the grant cycle, BFH will annually increase the number of LGBTQ youth who have access to suicide prevention interventions.

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

The BFH intends to establish protective factors for LGBTQ youth through a partnership with Persad Center. Persad Center will implement the Question, Persuade, Refer Gatekeeper Training for Suicide Prevention (QPR) in addition to the Signs of Suicide Prevention Program (SOS) through support from the BFH and Title V funds. QPR is listed on SAMHSA's National Registry of Evidence-Based Programs and Practices. The QPR training teaches the warning signs of a suicide crisis and how to respond. The training also covers: (1) the epidemiology of suicide and current statistics, as well as myths and misconceptions about suicide and suicide prevention; (2) general warning signs of suicides; and (3) the three target gatekeeper skills (i.e. question, persuade, refer). The addition of QPR will increase the flexibility of training that Persad Center can offer to youth. The SOS program is a program with evidence of effectiveness. SOS is a universal, school-based depression awareness and suicide prevention program designed for middle school (ages 11-13) or high school (ages 13-17) students. The goals are to 1) decrease suicide and suicide attempts by increasing student knowledge and adaptive attitudes about depression, 2) encourage personal help-seeking and/or help-seeking on behalf of a friend, 3) reduce the stigma of mental illness and acknowledge the importance of seeking help or treatment, 4) engage parents and school staff as partners in prevention through "gatekeeper" education, and 5) encourage schools to develop community-based partnerships to support student mental health. The QPR and SOS programs will be implemented at the Persad Center's Gay and Lesbian Community Center in Pittsburgh, Pennsylvania and within school districts throughout Western Pennsylvania.

The BFH has chosen to measure the number of youth who are receiving 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 will utilize a 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. 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.

BFH is currently developing a program in partnership with the Pennsylvania Coalition Against Domestic Violence to address healthy relationships and intimate partner violence. Funded with Title V funds, it is expected this program will be fully operational in 2019 and more details will be provided in future reporting.

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.

Transition age LGBTQ youth have an increased need to successfully launch into adulthood. Many of these transition age youth, anxious to leave stressful family situations, lack supportive adults in their life. Persad Center will continue to implement with Title V funds the Young Adult Opportunity Program (YAOP) to address these needs. By working with a mentor, LGBTQ transition age youth can be coached and assisted in identifying needs and skills. In addition to being matched with an adult mentor, services provided will include financial literacy classes, leadership training, aptitude testing, and transportation to classes, interviews, and employment.

The BFH will measure the number of youth receiving drop-in screening and assessments. The BFH receives this data from Persad Center. This information is important to determine if this service for older, transition age youth is needed in other parts of the state.

Montgomery County Health Department will be implementing Project Adult Identity Mentoring (AIM), an evidence-based, group-level youth intervention program to serve the Montgomery County youth population. Project AIM's

curriculum is comprised of discussions and interactive activities which encourages youth ages 11-14 to imagine a positive future and discuss how current risk behaviors can be a barrier to a successful adulthood. Staff has received training and will be working with schools in the area to implement project AIM's 12-session curriculum in the Spring 2018.

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. Funded by Title V, programming will be statewide, with an emphasis on high risk areas in which youth are most likely to engage in risky behaviors and have a greater need for programming.

The BFH intends to reduce the risk of obesity and Type-2 diabetes in LGBTQ youth in the Lehigh Valley through a partnership with Bradbury-Sullivan LGBT Community Center. LGBTQ Americans are significantly affected by Type-2 diabetes. They are disproportionately diagnosed with health conditions and engage in health behaviors that put them at an increased risk for Type-2 diabetes.

In 2015 and 2016, Bradbury-Sullivan LGBT Community Center administered a comprehensive LGBTQ health needs assessment in regions across Pennsylvania. The data collected showed that the Lehigh Valley has the highest obesity disparity for the LGBTQ community in Pennsylvania. Data also revealed that 80 percent of the LGBTQ population in the Lehigh Valley does not meet the Centers for Disease Control and Prevention (CDC)-recommended exercise guideline of 150 minutes per week and a similar percentage of the community does not meet the recommended daily servings of vegetables. The needs assessment data indicates that the Lehigh Valley is a high-risk area of Pennsylvania for LGBTQ obesity.

Bradbury-Sullivan LGBT Community Center will implement an evidence-based healthy eating and active living program through support from the BFH and Title V funding through June 30, 2020. The program will provide LGBTQ youth with knowledge, strategies, and support to care for their bodies and minds through a variety of activities. Youth will be provided with interactive and low-cost healthy food demonstrations. Recreational and active-living activities will also be provided along with healthy living discussion groups. The healthy eating and active living program will be implemented at Bradbury-Sullivan LGBT Community Center in Allentown, Pennsylvania.

The BFH has chosen to measure the number of youth participating in the evidence-based healthy eating and active living program. This information will determine the reach of services at the current location.

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 issued one statewide Request for Applications (RFA) for agencies to implement mentoring programs in 2017. This RFA process was a competitive bid method to ensure the most qualified agencies are selected to provide high-quality programming that aligns with this State Performance Measure (SPM). Three organizations, Big Brothers Big Sisters Independence Region (BBBS IR), City Year Philadelphia, and Students Run Philly Style were selected as a result of the competitive bid process. Each organization awarded a grant began program implementation in January 2018, utilizing Title V funds.

Each Youth Mentoring grantee will 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.

BBBS IR will be following the evidence-based Big Brothers Big Sisters of America model to provide mentoring services to youth age 8-18. Each mentee will be matched with a mentor to receive one-on-one mentoring with the goals of improving mentee attitudes toward avoiding risk, increasing the number of mentees having a special adult in their lives, and improving educational expectations, social acceptance, scholastic competence, and grades. BBBS IR also plans on increasing staff and mentor knowledge of opiate and substance use issues to reduce mentee substance abuse.

City Year Philadelphia will provide mentoring to students ages 8-16 in high-poverty, urban schools. Using MENTOR's model, *The Elements of Effective Practice for Mentoring*, AmeriCorps members will provide academic support, attendance and behavior coaching, social-emotional skill development, positive school climate initiatives, and afterschool programming for youth. City Year Philadelphia hopes to achieve outcomes including increasing the number of youth engaged in schools, increasing the number of students graduating, and decreasing the rates of health problems and engagement in risky behaviors.

Students Run Philly Style will utilize their own evidence-based model which integrates best practices from the Big Brothers Big Sisters of America and MENTOR models. Youth ages 11-18 will be matched with a mentor to train for 10k, half and full marathon races with the goals of increasing physical activity, goal setting, resiliency, connectedness with mentors and peers, and participation in positive community activities.

The developmental assets fostered through youth mentoring serve as protective factors to help youth avoid negative risky behaviors. The positive effects of these protective factors increase as the number of assets a youth has increases. Enhancing the developmental assets of youth and adolescents promotes positive youth development outcomes and provides an opportunity for youth to transition into healthy young adults who are able to realize their individual potential around critical developmental tasks. The Youth Mentoring grants are expected to serve a total of 12,670 youth each state fiscal year.

In addition to the new Youth Mentoring Program, 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: MCH populations reside in safe and healthy living environments.

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

Objective: As a result of Child Safety CollN, implement at least one strategy to address interpersonal violence in PA by 2020.

The BFH will continue to participate in Child Safety CollN (CS CollN) in the coming year. The goal for Pennsylvania's CS CollN work is to implement at least one new strategy to address interpersonal violence by 2021. Title V will fund the staff overseeing the CollN projects in 2019. The newly received Pennsylvania Health Care Cost Containment Council (PHC4) data will be used to shape and evaluate the CollN process measures going forward. The PHC4 data

combined with advanced evidence-based strategies for interpersonal violence prevention will help Pennsylvania implement new programs and reduce interpersonal violence. Pennsylvania plans to use newly added quality improvement language in grants to improve program activities and monitor the progress of grantees. The language in the grants will allow collaboration in testing small changes in programs and evaluation. In 2019, Pennsylvania looks to use evidence-based parenting programs such as “Parents in the Know”, an innovative practice-based child sexual abuse prevention program, to help parents identify and prevent childhood trauma.

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.

Teenage pregnancy prevention services will continue to be supported through Health Resource Centers (HRCs). Services provided through HRCs include: sexual and reproductive health education; confidential individual counseling; screening for sexually transmitted infections (STIs); pregnancy testing; referrals and linkages to family planning services; and distribution of safer sex materials, such as male and female condoms and dental dams. HRCs are primarily located in school settings, but a small number are also located in clinical community-based programs in areas where schools are not an option due to varying reasons.

AccessMatters is the agency who operates the HRCs through funding from BFH and Title V. Currently, there are a total of 26 HRCs open in eight counties throughout Pennsylvania. These counties are Philadelphia, Delaware, Berks, Lackawanna, Dauphin, Lycoming, Fayette, and Allegheny Counties. It is anticipated these HRCs will remain operational in 2019. BFH will work with AccessMatters to determine the feasibility of opening additional HRCs in three counties not currently being served. These three additional counties are Lehigh, Beaver, and Venango Counties. All areas where HRCs are operating, and the three additional counties where HRCs are planned to be opened, represent areas with high rates of teenage pregnancies, high rates of STIs, and high drop-out rates from school.

Services offered through HRCs will allow youth to develop healthy coping skills when making decisions regarding their sexual and reproductive health.

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 Mazzoni Center, to provide culturally competent drop-in services for high-risk and LGBTQ youth at the Mazzoni Center's medical center. In addition to primary medical care, support services and basic necessities (food, public transportation tokens, etc.) will be provided. Services will be Title V funded.

The BFH will measure the number of youth receiving drop-in medical services. The BFH receives this data from the Mazzoni 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, through Title V, 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.

Children with Special Health Care Needs

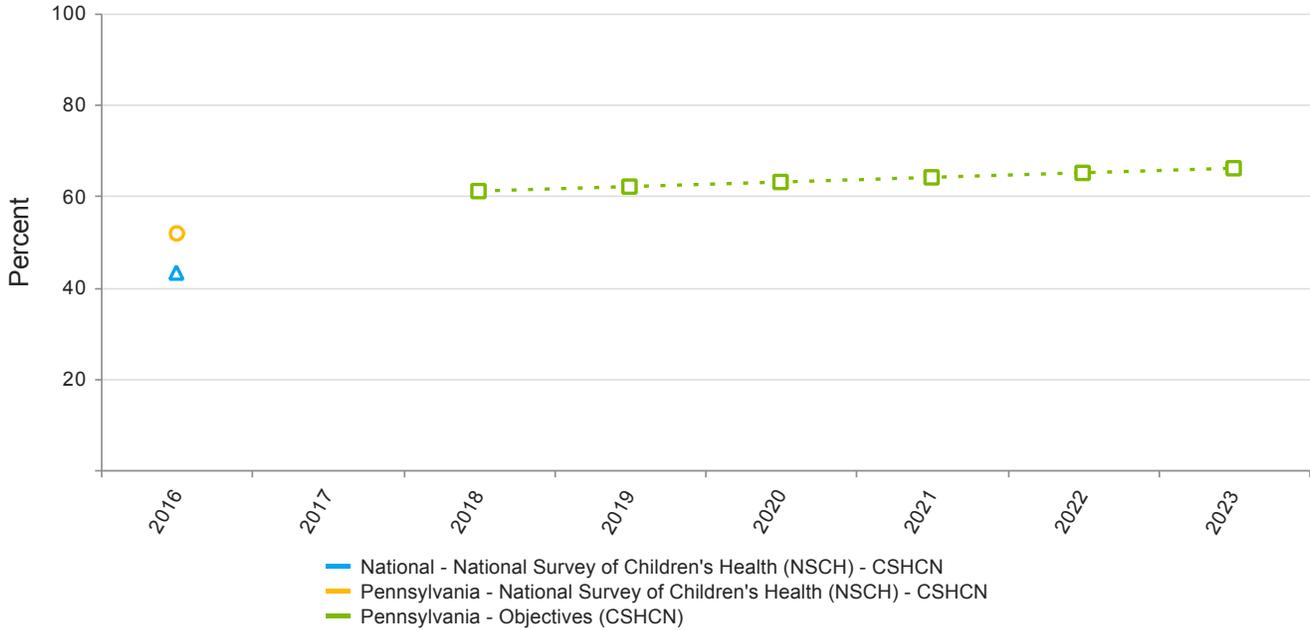
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	20.3 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	56.5 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	92.1 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	1.6 %	NPM 11

National Performance Measures

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

Baseline Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		51.8
Numerator		267,920
Denominator		517,187
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	61.0	62.0	63.0	64.0	65.0	66.0

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.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1,500
Annual Indicator	1,597	1,732
Numerator		
Denominator		
Data Source	Monthly reports	Monthly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,525.0	1,550.0	1,575.0	1,600.0	1,625.0	1,650.0

ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	BFH internal reports	BFH internal reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4.0	4.0	5.0	5.0	3.0	3.0

ESM 11.3 - Number of providers participating in a learning collaborative, education and/or statewide technical assistance.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	507	4,070
Numerator		
Denominator		
Data Source	Grantee Reports	Grantee Reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	520.0	540.0	560.0	580.0	600.0	620.0

ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		200
Annual Indicator	196	214
Numerator		
Denominator		
Data Source	Quarterly reports and internal reports	Quarterly reports and internal reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	225.0	240.0	260.0	280.0	300.0	315.0

ESM 11.5 - Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	1	5
Numerator		
Denominator		
Data Source	BFH internal reports	BFH internal reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

ESM 11.6 - Number of families receiving Respite Care Program services.

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	500.0	750.0	1,000.0	1,000.0	1,000.0

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%.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	N/A	N/A
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	50.0	55.0	60.0	65.0	70.0

State Action Plan Table

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 1

Priority Need

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

NPM

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

Objectives

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 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 one collaborations with a child-serving system 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
ESM 11.6 - Number of families receiving Respite Care Program services.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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 families of children and youth with special health care needs (CSHCN) served by the Special Kids Network (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.

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 3

Priority Need

MCH populations reside in a safe and healthy living environment.

Objectives

Each year, provide at least 250 families with respite care services.

Strategies

Respite Care Program

State Action Plan Table (Pennsylvania) - Children with Special Health Care Needs - Entry 4

Priority Need

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

Objectives

Annually increase the number of students who are receiving BrainSTEPS and/or Concussion Management Team (CMT) services.

Strategies

BrainSTEPS program

Children with Special Health Care Needs - Annual Report

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. Children with special health care needs (CSHCN) are children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and health related services beyond those usually required. The BFH provides services for CSHCN that are family centered, community based, and coordinated. Not only are CSHCN a priority within the Title V work carried out by the BFH, but more than two million dollars in state funding is allocated to serve children with the following conditions: Cooley's anemia, Cystic Fibrosis, Sickle Cell, Spina Bifida, Orthopedic and Neuromuscular Conditions, Hemophilia, Epilepsy, Tourette's Syndrome, Charcot-Marie-Tooth Disease, and services for children who are technology dependent. The BFH's mission for CSHCN is to provide statewide leadership, in partnership with key stakeholders, to create systemic changes at the local, regional and statewide level to improve health and health related outcomes for at risk individuals and families.

The Specialty Care Program (SCP) consists of 35 state-funded grants across 17 grantees (11 hospital systems, five community organizations, and one national association). The SCP targets individuals diagnosed with one of six conditions: Child Rehabilitation (serving neuromuscular and orthopedic conditions), Cooley's Anemia, Cystic Fibrosis, Hemophilia, Sickle Cell, and Spina Bifida. The SCP is focused on patient centered care through a multidisciplinary team clinic model. The goal of the SCP is to improve patient health outcomes by providing comprehensive care and reducing barriers to adherence to treatment plans. Identified barriers have been shown to be consistent across conditions, and examples include access to reliable transportation, gaps between insurance and services, coordination between care providers, and support to participate in community-based activities.

A new component to the SCP was a grantee requirement to dedicate a certain percentage of funds into a Patient Assistance Fund (PAF), addressing critical barriers or needs that affect the patient's ability to adhere to treatment or impacting the patient's quality of life. The intent is for grantees to assist families by providing immediate assistance through the PAF, long-term planning and solutions through the care plan, and care coordination to eliminate the barrier. A combination of MCHSBG funds and state matching funds are used to support Spina Bifida and Sickle Cell programs and services. State matching funds support the Cooley's Anemia, Hemophilia, and Cystic Fibrosis funds, and MCHSBG funds alone support the Child Rehabilitation program.

The BFH also provides state match funds to support outreach and education based grants for individuals diagnosed with Epilepsy, Charcot-Marie-Tooth (CMT) Disease, and Tourette Syndrome. Grants are provided to the Eastern and Western Epilepsy Foundations of Pennsylvania to support education for emergency services personnel, school staff, students, parents and caregivers along with community outreach events to increase awareness of epilepsy. The CMT Program consists of a grant provided to the CMT Association which provides an educational summer camp experience for youth diagnosed with CMT. The Tourette Syndrome Program vendor is the Pennsylvania Tourette Syndrome Alliance, Inc. (PA-TSA), which provides support and education to individuals affected by Tourette Syndrome (TS), their families and healthcare and other professionals. PA-TSA provides statewide support and community services to promote awareness and understanding of TS.

The Technology Assisted Children's Home Program (TACHP) is also provided through state funds as part of the Title V match requirement. TACHP provides for the coordination of care for technology dependent children 0-22 years of age. Technology-assisted refers to the use of a medical device (such as a feeding tube, catheter, EKG monitor, or ventilator) to compensate for the loss or diminished capacity of a vital body function. The scope of the program is to provide comprehensive non-medical services to families, as well as professional training for home health professionals and school nurses. TACHP is administered by two vendors, and is in the second year of a three-year grant in effect until June 2019.

The BFH's partnerships with hospitals, clinics, national associations, and CBOs have enabled the identification of challenges that impact patient adherence to care plans, maintaining a patient's best quality of life, and to achieving improved health outcomes. These challenges were consistent across conditions, and included access to reliable transportation, gaps between insurance and services, coordination between care providers, and supports to participate in community-based activities. By engaging with grantees, the BFH began to collect input on the challenges and implementing methods to move towards addressing barriers.

The BFH continued to partner with the PA Department of Human Services (DHS) on the PA Project LAUNCH grant, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant serves pregnant women and children birth through age eight in Allegheny County with the goal of linking existing early childhood systems and creating better outcomes. PA Project LAUNCH has collaborated with substance abuse prevention and treatment partners regarding Infant-Early Childhood Mental Health (IECMH) learning opportunities and helped to fund a conference for Home Visiting Programs on substance use and its impact on parent-child attachment. With the assistance of the grant's State and Local Young Child Wellness Councils, several community-based child development and screening activities for underserved populations were held with a focus on immigrant and refugee populations. Council members also assisted with the creation of a list of policy recommendations related to the integration of behavioral health into primary care practice and facilitated a partnership between a local mental health provider and several pediatric providers.

The Bureau of Family Health (BFH) administers the Traumatic Brain Injury (TBI) State Partnership Grant, funded by the Administration for Community Living (ACL). The primary goal of the grant is to increase TBI knowledge and awareness among parents, professionals, students and youth as well as to create a linkage to TBI services. The grant focuses on two population areas; youth in the juvenile justice system; and safety in youth sports. Youth in juvenile justice facilities are screened for TBI and referred for NeuroResource Facilitation as appropriate. Juvenile justice facility staff receive training on TBI and TBI screening. Through partnerships with stakeholders, the BFH provides outreach to ensure appropriate protections exist for youth athletes who participate in organized school sponsored as well as non-school sponsored sporting activities.

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

Objective 1: Annually increase the number of students who are receiving BrainSTEPS and/or Concussion Management Team (CMT) services.

The BrainSTEPS program operates across Pennsylvania through all 29 Intermediate Units (IU) and one school district. The IUs link with school districts to provide individualized support services for students who have had a Traumatic Brain Injury (TBI). BrainSTEPS teams prepare the student and family for return to school post TBI. The teams consist of education professionals, medical professionals, and family members who have received program training, and provide a link between medical and school personnel. There are currently 294 active BrainSTEPS Team members in place to support students. Annual student referrals to the program have shown an increase. The program has served a total of 4,245 referrals since program inception in 2007, and last year's total of 594 new referrals exceeded the goal of 500.

The BrainSTEPS program continued outreach to increase public awareness of the program's services. A Regional Team Lead Facilitator was added in the Philadelphia area to assist in program promotion, facilitation of new referrals, and aid with BrainSTEPS Team development. In addition to the Regional Team Facilitator, a pre-doctoral student was assigned to assist with Philadelphia Neighborhood Network BrainSTEPS Teams. The BrainSTEPS

Program staff provided additional outreach to the hospital and medical rehabilitation community in the Philadelphia and Pittsburgh areas. The program continued to evaluate existing education and training curriculum to ensure the materials are current.

The Concussion “Return to Learn” Management Team (CMT) Model has entered its fifth year. CMTs support both student athletes and non-athletes at the local and district level, who are returning to school while promoting recovery. Pennsylvania is the first state 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 with assistance from PA’s grantee. The BrainSTEPS program participated in an evaluation process conducted by the U.S. 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 to highlight best practices.

One goal of BrainSTEPS is to expand the number of CMTs based within school districts across Pennsylvania. There are now over 1,300 CMTs providing support for the student and family, an increase of 190 from the prior year. For concussed students who are still symptomatic after four weeks or have not returned to their academic baseline, BrainSTEPS Teams are available to schools to provide more intensive student concussion support, consultation, and training. BrainSTEPS teams are also available to consult with CMTs at any time.

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

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

Objective 1: Starting with reporting year 2015, annually increase the number of pediatric primary care providers (PCPs) engaged in efforts to adopt medical home principles and practices for their populations.

ESM: Number of providers participating in a learning collaborative, education and/or statewide technical assistance.

In 2017, approximately 899,000 children (33.7 percent of PA’s children under 18) were served by 133 PCPs that reported data to the PA Medical Home Initiative (MHI). This number includes 153,000 CSHCN. This falls short of the goal of serving 61 percent of PA children under 18, and is one of the results driving a programmatic review of MHI.

The MHI had 2,874 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home PCPs and PCPs considering a medical home approach. For 2017, the goal was to have 500 providers participate in a learning collaborative, education, and/or receive technical assistance regarding medical home concepts and tools; this was achieved, with 4,070 primary care professionals participating in encounters, however this is not an unduplicated count. The encounters included 189 educational events with PCPs, exceeding the 2017 goal of 125 educational events.

Objective 2: Starting with reporting year 2016, increase the number of youth/young adults and parents/caregivers who are trained, engaged, supported and involved at all levels of program planning and implementation.

ESM: Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.

Practice Coordinators and Parent Advisors offered onsite education, support and technical assistance to PCPs, and supported PCPs who wanted to achieve national medical home accreditation. They partnered with PEAL and other advocacy organizations to facilitate family member/caregiver engagement by showing PCPs how to recruit Parent Partners. Parent Partners served on PCP transformation teams to assist PCP professionals in medical home adoption. From 2016 to 2017, the number of Parent Partners increased from 196 to 214, meeting the goal of 200 participants.

Objective 3: Annually develop a minimum of one collaboration with a child-serving system that involves them in the provision of medical home services.

ESM: Number of new and formal collaborations developed with oral and behavioral health entities that serve pediatric populations.

The Bureau of Family Health (BFH) Medical Home Initiative (MHI) developed new collaborative relationships with five organizations: the American College of Physicians, the Health Federation of Philadelphia, PA Systems of Care, the Pediatric Palliative Care Coalition, and the Substance Abuse and Mental Health Services Administration. The collaboration with the Substance Abuse and Mental Health Services Administration met the BFH's 2017 goal of one new collaboration with mental, behavioral or oral health entities. These partnerships brought together people with similar objectives related to medical home primary care. The partnerships also helped MHI meet the following goals:

- successful health care transition for youth,
- providing two medical interpreter courses to primary care practices and other locations where primary care is provided,
- planning a conference on chronic care,
- planning a webinar on Fetal Alcohol Spectrum Disorder,
- and addressing the unique advocacy needs of the pediatric mental health population in 2017. These learning events supported PCPs in the process of adopting a medical home approach to primary care and integrating with mental, behavioral and oral health services.

The MHI held a conference which focused on integration of mental/behavioral health with physical health; 75 mental health professionals and primary care professionals participated. MHI also supported the Early Autism Spectrum Disorder Detection and Services study, worked closely with statewide partners to build oral health resources, and educated 111 primary care professionals in basic preventive oral health services such as fluoride varnish application/oral health risk evaluation.

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

Objective 1: Annually increase the number of families of children with special health care needs (CSHCN) served by SKN.

ESM: Number of families who receive services through the evidence based or evidence informed strategies of the SKN.

The Special Kids Network (SKN) utilized MCHSBG funds to support, sustain, and improve statewide services to Pennsylvania's CSHCN. The SKN served 1,732 families in 2017, meeting the goal of reaching 1,500 families

through evidence-based or evidence-informed strategies. These numbers included calls to the SKN helpline and the number of referrals that came from other sources. In 2017, SKN reached over 46,087 people through presentations, home visits and meetings with organizations and providers. The SKN also worked to increase the number of families served by partnering with state agencies, other organizations, and the Elks nurses, who provide service coordination. By working with families on advocacy and system navigation, the SKN created a more self-sufficient parent and caregiver population, allowing it to focus more resources on new families.

Objective 2: Annually increase the number of collaborations between systems of care serving CSHCN.

ESM: Number of new formal collaborations developed between systems of care serving CSHCN.

A collaboration is defined as a partnership between SKN and an organization that results in assisting families with obtaining information or providing support. The BFH met its goal of forming four new collaborations in 2017.

The first collaboration formed was with the UPMC hospital system to offer interns and residents information on effectively dealing with CSHCN. The collaboration with UPMC grew out of 2016-2017 SKN presentations to ten doctors and dentists about the needs of CSHCN. Informal meetings called “coffees” were scheduled to engage physicians in conversation regarding awareness of the special needs some children may have. Five physicians attended the “coffees” and a need was expressed for additional training.

A second collaboration was with the PA State Refugee Program, which is housed within DHS, and was brought about from an influx of refugees with disabilities entering the state. DHS staff delivered a training on Cultural Competence in August of 2017 at a face to face meeting. Information on SKN was given to DHS to share with the refugee centers. The refugee centers were encouraged by DHS to reach out to the SKN regional coordinator in their region.

A new collaboration was created as a result of the SKN “Mimi and Dona” documentary viewings. This project raised awareness of the needs of caregivers of those with disabilities and the importance of life course planning. At the end of the presentations, there was discussion on the future care of individuals with disabilities including housing support. Following this discussion, SKN became a member of the Pennsylvania Housing Choice Coalition through the Self-Determination Housing Project of Pennsylvania. SKN has helped the coalition identify barriers and potential solutions to housing services for people with disabilities.

The fourth collaboration speaks to SKN’s commitment to addressing the need for respite care for the families of CSHCN. During 2017, a collaboration with the Pennsylvania Child and Adolescent Service System Program (CAASP) began across the state. SKN regional coordinators have partnered with CAASP coordinators to identify solutions to the barriers of respite care. Through this partnership, contact with providers was made to discuss the importance of quality respite care.

In addition to these new collaborations, the SKN and BFH maintained other previously developed collaborations. The BFH continued its collaboration with the DHS System of Care Partnership to provide “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. The BFH also sustained its effort with the DHS Office of Income Maintenance to have staff from County Assistance Offices (CAO) attend SKN Gathering meetings, allowing for families to interact with CAO staff and increase family awareness of CAO staff as a resource for help with Medical Assistance.

Children with Special Health Care Needs - Application Year

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

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 more than 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, Epilepsy, Tourette's Syndrome, Charcot-Marie-Tooth Disease, and services for children who are technology dependent.

The ongoing goal of the Specialty Care Program (SCP) is to facilitate improved health outcomes by identifying and removing barriers to care. Identified barriers have been shown to be consistent across conditions, and examples include access to reliable transportation, gaps between insurance and services, coordination between care providers, and support to participate in community-based activities. The SCP model was revised and implemented late in 2017, and in 2019, the model will be assessed for effectiveness and the program will be further refined as indicated. A new component to the SCP was a grantee requirement to dedicate a certain percentage of funds into a Patient Assistance Fund (PAF), addressing critical barriers or needs that affect the patient's ability to adhere to treatment or impacting the patient's quality of life. The intent is for grantees to assist families by providing immediate assistance through the PAF, long-term planning and solutions through the care plan, and care coordination to eliminate the barrier. Grantees will be required to increase the percentage of funds allocated to the PAF in 2019. The SCP is also pairing the revised model with improved data collection and evaluation components, which will be assessed in 2019. The SCP is funded by both MCHSBG funds and state match funds.

The BFH has maintained a collaboration with the PA Department of Human Services, Office of Medical Assistance Programs, to meet bi-monthly to discuss issues within the system of care for CSHCN, share resources, reduce duplication of services, and ensure that the proper funding sources are being utilized for individuals and families. This collaboration will continue in 2019.

The BFH has revised programming for PA's metabolic treatment centers, which provide care to individuals diagnosed with metabolic conditions, both to the point of diagnosis and from post-diagnosis through age 21. This new model, being implemented in 2018, will be assessed for effectiveness and refined as indicated in 2019. The metabolic program serving individuals post-diagnosis through age 21 is funded through MCHSBG.

In 2019, the Technology Assisted Children's Home Program (TACHP) will reach the end of its three-year grant. During the grant period, the program's vendors (Children's Hospital of Pittsburgh and The Health Promotion Council of Southeastern PA) will continue to provide coordination of care and pursue other grant activities such as marketing and enrollment as they work towards grant outcomes. If maximum program capacity is reached, vendors will create and manage a waiting list for potential enrollees as others are transitioned from the program for achieving self-sufficiency. As the DOH considers grant renewals, it will evaluate factors related to vendor performance, such as the ability of grantees to demonstrate participation in the program is improving the health of enrolled children. The TACHP is funded through state match funds.

State match funds will again be utilized in 2019 to support outreach and education based grants for individuals diagnosed with Epilepsy, Charcot-Marie-Tooth (CMT) Disease, and Tourette Syndrome. The BFH works with Pennsylvania foundations and associations dedicated to these conditions. The Epilepsy Foundations will maintain their focus on outreach and education to emergency services personnel, school staff, students, family/caregivers,

and the community. The CMT Association will continue to provide education to the public and provide an educational summer camp experience for youth with CMT Disease.

As Tourette Syndrome (TS) remains widely misunderstood by the public and misdiagnosed by health care professionals, the Pennsylvania Tourette Syndrome Alliance (PA-TSA), Inc. will provide support and education to individuals affected by TS, their families, healthcare and other professionals and the community. The BFH and PA-TSA recognize it is important to continue to reach out to community organizations to identify and serve underserved populations. In 2019, PA-TSA will focus on community outreach and engagement to promote awareness and education about TS. Activities will include outreach at events in health districts, providing educational activities to organizations, and two statewide conferences.

The PA Project LAUNCH, a federally funded grant from the Office of Substance Abuse and Mental Health Services, will be in the final year of a five-year grant in 2019. Activities will include increasing the number of endorsed professionals in Infant-Early Childhood Mental Health. The BFH partners with the PA Department of Human Services on this grant and will be preparing to sustain PA Project LAUNCH activities statewide by disseminating a replication guide to all counties. The program will also provide targeted resources to support and enhance the integration of behavioral health resources into primary care settings.

The Bureau of Family Health (BFH) recently submitted two applications to the Administration for Community Living (ACL). One submission was for the TBI State Partnership Program Mentor State Funding Grant. This application proposes to develop and maintain a NeuroResource Facilitation Program in Pennsylvania along with providing TBI education for professionals, caregivers and family members. As a mentor state, the BFH would also mentor states who receive the partnership grant with enhancing or building upon the TBI infrastructure within their state. In addition, BFH will collaborate with ACL and other designated mentor state grantees to increase the impact of the TBI Program nationally. The second submission was for the TBI State Partnership Program Partner Grant. This application proposes to develop and maintain a NeuroResource Facilitation Program in Pennsylvania targeting the older adult population. The overall goal of both project proposals was to maximize the health, independence and overall well-being of individuals with TBI. Of these two submissions, ACL would fund only one grant per state. In June 2018, the BFH received notification it was awarded the TBI State Partnership Program Mentor State Funding Grant, which will be in effect from June 1, 2018 through May 31, 2021.

The BFH's Head Injury Program (HIP), funded through state funds not part of the state match funding, provides rehabilitative and therapeutic services to individuals with a TBI. To be eligible for the HIP, an individual must be a U.S. citizen, 21 years of age or older, have resided in PA at the time of injury and application, and sustained a TBI after July 2, 1985. At the current time, resources for youth with a brain injury between the ages of 18-21 are limited in Pennsylvania. Recognizing the need for rehabilitative and therapeutic services for individuals between age 18 and 21, the BFH will create a program to provide rehabilitation services to youth within this age range and funded by the MCHSBG. Services will be provided in PA by specialized brain injury providers.

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

Objective 1: Annually increase the number of students with brain injury who are receiving BrainSTEPS and or Concussion Management Team (CMT) services.

Through a grant agreement with the Department of Health and in partnership with Department of Education, the Brain Injury Association of Pennsylvania (BIAPA) has implemented a brain injury school re-entry program called

BrainSTEPS (Strategies, Teaching Educators, Parents, and Students). BrainSTEPS provides services to any student who has experienced an acquired brain injury or with a prior injury which is still impacting student performance. Once referred, the student receives services from the point of referral through school graduation. The BrainSTEPS program will continue in 2019.

BrainSTEPS will continue to provide students, families, school teams and medical providers with consultation to assist the student's transition back into the classroom setting. The program will focus on continuous quality improvement efforts. To promote consistency of the BrainSTEPS teams, BIAPA will provide training, workshops, and technical assistance to team members to ensure they are following the established program model. BrainSTEPS Team Leaders will be required to establish annual individual team goals for their coverage area. Goal development will include outreach to the medical community. The idea is to increase overall knowledge of the program and build a network within the medical community to ensure students are referred to the program at time of discharge.

The BrainSTEPS program model has developed a Concussion "Return to Learn" Management Team Model (CMT). This initiative enables schools to take ownership and implement in-house school CMT. BrainSTEPS personnel will continue to provide training and technical assistance to CMT's on concussion recognition and best practices. The additional support will ensure a designated number of new students are referred into the program along with helping additional school districts implement CMTs within their own school district.

Because of additional support, the Philadelphia and Pittsburgh areas will be better equipped to increase the number of referrals and serve additional students. There is also potential for the BrainSTEPS program model to be adopted by other states, as Colorado has already adopted the program and the BFH has received other inquiries. The BFH looks forward to collaborating with and providing assistance to other states who seek to implement "return to learn" programming. The BrainSTEPS program will continue to collect and use programmatic data to help measure the population served, pinpoint additional areas for outreach and aid in overall evaluation of program materials and training curriculum.

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.

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.

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

Objective 3: Annually develop a minimum of one collaboration with a child-serving system that involves them in the provision of medical home services.

ESM: Number of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations.

The Pennsylvania Medical Home Initiative (MHI), funded through the Title V MCHSBG, will be evaluated and restructured beginning in 2018. One purpose of this evaluation and restructuring will be to ensure that the MHI is working in tandem with a parallel program within the Department of Human Services, which administers Medicaid in PA. On January 1, 2017, DHS 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 MHI will collaborate with DHS are still being finalized.

The BFH's evaluation of MHI will also examine if the MHI is being implemented with fidelity in practices across the state and the impact the program is having on improving the health and wellbeing of those served by MHI practices, including CSHCN. Outcomes associated with clients receiving services from PCPs participating in MHI will be compared to the outcomes of clients receiving services from PCPs who are not participating in MHI. The evaluation will also determine if there are disparities in outcomes among subpopulations served by the PCPs participating in MHI. The findings of the program evaluation will be used to inform how Title V funding is used to support MHI in the future. The objectives, ESMs, and strategies related to medical home will be revised according to the results of the evaluation and the BFH's chosen direction for the MHI in 2019. It is not expected that the evaluation results and recommendations for programming will be complete until late 2019.

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 evidence based or evidence informed strategies of the SKN.

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.

The Special Kids Network (SKN) will be modifying the program utilizing an evidence-based Community Health Worker model. The current model includes three primary components which are all administered via a single grantee. The new model will move the SKN helpline operations into the BFH, which will be answered by a nurse. The systemic work currently being done through the SKN Regional Coordinators will be done through BFH staff, who can reach out to other state agencies and organizations at a higher organizational level than can a grantee. The BFH will seek direct collaborations with the state's premier organizations serving CSHCN to advance PA's system of care for CSHCN. One example is the Parent Education and Advocacy Leadership Center (PEAL), which is PA's Family to Family Health Information Center, and another is Disability Rights Pennsylvania, which is the statewide organization designated to advance and protect the rights of adults and children with disabilities.

Under the new SKN model currently being developed, Community Health Workers (CHW) will be utilized to provide

in-home care coordination and education within six rural regions of the state. CHWs will develop a care management plan to address the needs of the CSHCN and their families. The goal of the plan will be to provide CSHCN and their families with tools to allow them to become self-sufficient. CSHCN and their families will be active members of the care management plan by learning how to navigate the necessary health and human services systems. The concept of the SKN will include more intensive assistance provided to those families determined to be most in need, and thus may result in fewer families being served than through the current program.

The target population will include rural, low-income families of CSHCN with a recent diagnosis and CSHCN who have recently moved to or within PA. Families will be served using a short-term delivery process, and a needs assessment will occur during the initial home visit. The assessment results will inform the development of a care management plan customized to the family's needs. Within ten weeks of the initial visit, the CHWs will also provide an educational series with content based on the individual and family needs. During those ten weeks, CHWs will assist the family in developing a continuity of care plan which will reinforce increased independence. The revised SKN program is expected to start in January 2019.

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

Objective: Each year, provide at least 250 families with respite care services.

ESM: Number of families receiving Respite Care Program services.

Caregiver stress is an important issue noted by focus groups during the 2015 needs assessment process. Caregivers, particularly those who have 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, and often have little or no support, be it emotional, financial or physical. This lack of support 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 (RCP). The program is expected to provide at risk families in Pennsylvania with financial assistance to obtain respite services to reduce caregiver stress in Pennsylvania's Title V population. 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 BFH, the RCP will operate as a payer of last resort with a financial eligibility requirement for respite services. There will be minimal additional eligibility requirements for the program to be available to as many people as possible. After some initial delays in the implementation of the program, the anticipated start date is January 1, 2019.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percent of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	1.3
Numerator		
Denominator		
Data Source	N/A	BFH internal data collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	38.0	56.0	75.0	78.0	80.0

SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		32
Annual Indicator	29	18
Numerator		
Denominator		
Data Source	BFH internal data collection	BFH internal data collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	42.0	55.0	66.0	76.0	78.0	80.0

State Action Plan Table

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 1

Priority Need

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

SPM

SPM 1 - 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.

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.

Establish requirements for grantees to review their disseminated health information.

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 2

Priority Need

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

SPM

SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.

Objectives

By 12/31 each year, 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 by 12/31 each year.

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/Systems Building - Entry 3

Priority Need

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

SPM

SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.

Objectives

By December 2021, develop resources and tools to increase the utilization of 17P by eligible women.

Strategies

Conduct a pilot project to identify needs surrounding 17P referral and usage.

State Action Plan Table (Pennsylvania) - Cross-Cutting/Systems Building - Entry 4

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/Systems Building - Annual Report

The Bureau of Family Health (BFH) work within the cross-cutting/systems building domain is focused on the bottom of the MCH pyramid in the development of public health services and systems. The work of this domain solidifies the foundation and growth of all the programming work throughout the BFH as it is focused on building or enhancing workforce capacity especially related to data, implementing and maintaining continuous quality improvement processes, and strengthening systems and infrastructure to enhance program delivery and address key social determinants of health. The state priorities addressed in the cross-cutting/systems building domain are the following: MCH populations are able to obtain, process and understand basic health information needed to make health decisions; Title V Staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs; and appropriate health and health related services, screenings and information are available to the MCH populations. These priorities incorporate some of the ways the BFH monitors the health status of the MCH populations which include the use of Child Death Review (CDR) teams, Sudden Unexpected Infant Death (SUID) registry, and the Pregnancy Risk Assessment Monitoring System (PRAMS). While SUID and PRAMS receive federal funding from the Centers for Disease Control and Prevention (CDC) which is used to support staffing, Title V funds are used to supplement the provision of these monitoring systems and activities by supporting data collection activities and the implementation of prevention strategies based on findings from all three of these data sources. Additionally, Title V funds and State Systems Development Initiative (SSDI) funds were used to partially support the Behavioral Risk Factor Surveillance System (BRFSS). As BRFSS is the federal data source for the NPM 1: percent of women who have an annual preventive medical visit, using Title V and SSDI funds to achieve an adequate BRFSS sample maintained a vital data source for Title V outcome reporting 2017. These resources create a robust supply of data to be used by BFH staff and shared with grantees and other partners within the MCH system of care to improve the health of the MCH population in PA. A new partnership with the March of Dimes is exploring a time-limited data linkage with the state Medicaid agency to identify barriers to the usage of 17P.

Work within this domain incorporates maintaining and continued development of the BFH's public health workforce at the state level by emphasizing and enhancing the usage of these data resources to continue to drive program decision-making. Additionally, the BFH is partnering with current grantees in new ways. The BFH has begun and will continue to develop technical assistance documents and guidance for grantees not only on the development of localized health disparities plans, but also on the use of evidence-based practices targeted to those populations most at risk of poor health outcomes. The BFH prioritized addressing health disparities in 2017, these efforts will be broadened to include health literacy work at the state level in 2018. Currently, health literacy work is done at the program level, led by individual program administrators.

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

Through the Title V MCH Internship Program offered by the National MCH Workforce Development Center, the BFH was matched with Master of Public Health (MPH) interns who were tasked with developing several trainings for BFH staff, including one specific to health marketing. The training will be offered to BFH staff during summer of 2018 and will discuss health marketing's role in health promotion, awareness and education emphasizing the need for clear and basic messages. Key concepts addressed in this training will aid BFH staff in providing technical assistance to grantees integrating messaging and marketing work into their MCH programs.

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

Objective 1: Beginning in the first year of the grant cycle, disseminate at least one simple and clear

message about basic health information.

For this reporting year, one grantee (1.3 percent of grantees) newly developed and disseminated basic health information, with a focus on infant safe sleep. The infant safe sleep initiative, funded by Title V, which seeks to increase knowledge of safe sleep risk reduction methods through a hospital-based model program and supporting social marketing plan created materials to simplify the safe sleep message for all populations. Safe sleep risk reduction methods go beyond just the ABC's (Alone, Back and Crib) of safe sleep, to include the prenatal period and an infant's awake time. As part of the bundled intervention approach, brochures, palm cards, and posters with simple and consistent messaging for the hospital setting were developed. The brochures and palm cards were given to families. The posters were placed in every postpartum hospital room of the participating hospitals and used for the Southeastern Pennsylvania Transportation Authority (SEPTA) bus and subway ads. The main message is ABC for Alone, Back, and Crib to focus on the most important steps for creating a safe sleep environment for infants. While 19 safe sleep steps are outlined by the American Academy of Pediatrics, providing this information to parents of infants would be overwhelming. The safe sleep materials have focused on the most important and actionable steps and presented them in an easy to digest and memorable format.

Development of the materials began with a scan of all safe sleep materials that could be found to determine if the currently available materials were suitable for use with the hospital-based model program and social marketing component. Upon review of these materials, they were generally found to be cluttered and not consistently written to a lower literacy level. The grantee used a combination of clinical staff, home visitors, and safe sleep experts to dissect the materials for the components to keep, remove, and change. Draft materials were designed and sent back to the prior reviewers for comments and edits including testing by the intended audience of the materials. The small-scale testing ranged from formal knowledge testing to general comments about likes and dislikes with the presentation of the information.

One of the most intentional choices in the materials was the selection of pictures. The brochure makes use of several pictures to reinforce the messaging while taking care to ensure a diversity of models. One of the pictures and the focus of the posters is a mother placing an infant in a crib on its back. The picture used was carefully chosen as it is an action shot that can spread the message to those who are not able to understand the text.

To date the brochure has been translated into Spanish and French as they were the second and third most frequent languages used at the hospitals initially implementing the model program. The grantee implementing the infant safe sleep initiative is regularly reviewing the needs of hospitals to determine if brochures are needed in additional languages. During the translation of the materials, drafts were reviewed by native speakers and determined to be not quite right. While the translations were accurate, they did not achieve the simple and clear messaging the English version did. It was vital to the grantee to have these materials achieve the same quality message no matter the language. Another translator was found and able to achieve the desired simple and clear message.

The infant safe sleep initiative's social marketing component reinforces the simple and clear messages combined with consistent messaging in the community, such as through social media and transit ads. The social marketing messages are simple with a picture depicting a safe sleep environment and direct people to the safe sleep website (www.pasafesleep.org) for additional detailed information. According to the social media platform analytics, the social media messages have been well received and spread with likes, shares, and retweets more organically than anticipated as the messages were lasting for a longer duration than is typical for social media messaging. The organic spreading of messages from friend to friend will likely have a greater impact on both raising awareness and changing behavior as the message is coming from someone they know and trust.

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*.

The BFH continues to integrate the health disparities language into grant agreements as the agreements have been executed throughout the year. At the end of the state fiscal year in June 2018, the BFH will examine the submitted plans and develop further guidance on plan development and provide technical assistance for grantees as needed.

In the spring of 2017, the BFH developed and released a technical assistance document entitled “Supporting Breastfeeding with African American Communities: Evidence-Based and Research Informed Practices.” The goal of this document was to aid agencies and stakeholders in utilizing relevant research and evidence-based or research-informed strategies to address the promotion of breastfeeding within African American populations. The document was distributed via email to contacts at the county/municipal health departments and was also released to the public in August via the Department of Health’s breastfeeding support website to coincide with World Breastfeeding Week (August 1-7) and African American breastfeeding week (August 25-31). The document can be found as Attachment 2. Two of the county/municipal health departments, Erie and Bethlehem, shared the report with their local breastfeeding coalitions. The Allegheny County Health Department presented some background information on PRAMS, which provided data for the report, in conjunction with details of the report at a quarterly meeting with the Allegheny County Breastfeeding Coalition. The Philadelphia Department of Health, Division of Maternal, Child and Family Health is using the Supporting Breastfeeding report as part of the development of a breastfeeding awareness campaign to target areas and populations in Philadelphia with historically lower than average rates of breastfeeding initiation and duration.

Additionally, as part of the BFH’s work to address health disparities in the MCH population in PA, technical assistance regarding workforce development training around health equity was requested from HRSA during the 2017 on-site review of the Title V MCHSBG 2016 Report/2018 Application.

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

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

Objective 1: By December 2021, develop resources and tools to increase the utilization of 17P by eligible women.

The BFH is currently working with the March of Dimes on a pilot program to help prevent preterm births through increased awareness about the use of 17-alpha-hydroxy progesterone caproate or 17P. This pilot program is being funded through a combination of Title V funds and SSDI funds. The program is working to understand what factors influence consumers and clinicians to access or fail to access 17P. 17P is shown to be a successful intervention for extending the gestation of women at risk for preterm birth; however, not all women who could benefit from this treatment utilize it. Preterm births disproportionately affect African American infants. In 2016, the preterm birth rate for the state was 9.3 percent. Steep disparities persist with the African American rate at 13.2 percent compared to the rate for white women at 8.5 percent. The BFH is working to develop interventions to increase 17P utilization and reduce the preterm birth rate in Pennsylvania. In order to develop effective interventions, the BFH and March of Dimes will attempt to determine baseline data of current 17P utilization and barriers from both clinicians and consumers who did not recommend or use 17P but would have been viable candidates based on a history of pre-term delivery.

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

Objective 1: By 12/31 each year, identify at least one area for improvement in collecting or using data for each BFH program.

Objective 2: Staff from each BFH program will conduct analysis to develop actionable goals by 12/31 each year.

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.

Objective 4: Existing data collection programs will increase the dissemination of data to improve public health outcomes.

At the outset of 2017, the BFH data workgroup continued progress on the work plan created in 2016. Interviews with staff were continued to determine 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 developing a summary report and work plan to address the Title V MCHSBG goals while addressing the strengths and needs of BFH staff data capacity. Through the Title V MCH Internship Program offered by the National MCH Workforce Development Center, the BFH was matched with MPH interns who were tasked with reviewing, editing and revising this summary report, which contains a draft plan for BFH to work towards in 2019.

One of the primary foci identified in this summary report was the need for capacity-building training for all BFH staff on the following topics: public health concepts, data application and interpretation, and evidence-based practices in public health. The interns developed three separate trainings around these concepts. These trainings were piloted with small groups of BFH staff. Delivery of the trainings BFH-wide is planned for 2018.

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. Approximately 18 percent of staff were determined to be actively using data to direct

programmatic decision-making. This was a decrease from the 2016 baseline of 29 percent. The BFH was unable to increase this percentage, in part, due to an increase in the number of Title V staff. In order to increase the percentage of staff using data to direct programmatic decision-making, BFH will continue to educate Title V staff, using the Introduction to Data Application and Interpretation in Public Health mentioned above and one on one training for staff on this topic.

Support from senior management has been essential to the success achieved thus far; the BFH recently completed the restructure of the DBO to include data utilization and program evaluation as primary components of the work of the division. This Division is dedicated to increasing the BFH's data analytic capacities on a programmatic level. The staff identified to form the data workgroup 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.

In addition to data analysis, the BFH has focused on the integration of evidence-based and evidence-informed practices across all BFH administered programming. One part of this includes the evidence-based training listed above, another part was the development of a literature library. As BFH staff review topics and potential evidence-based/research-informed practices they are encouraged to collect this information and store it in on the BFH SharePoint page. This allows all staff to access the information and prevent future duplication of efforts.

Cross-Cutting/Systems Building - Application Year

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.

Objective 1: Beginning in the first year of the grant cycle, disseminate at least one simple and clear message about basic health information.

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.

BFH staff will be completing an introductory training on health marketing in 2018 developed as part of the work of the 2017 summer graduate interns. Some basic background in concepts and the contexts for health marketing, will position BFH staff to have broader discussions with Title V grantees around the use of clear messaging and materials when promoting health behaviors and choices. Feedback through client satisfaction surveys, now becoming a requirement in all grant agreements, will allow grantees and the BFH to understand what is working and not working as well in the provision of services including how grantees and the BFH communicate. This knowledge will allow the BFH to potentially develop technical assistance for grantees around the use of language, the appropriate reading level of materials in multiple languages to ensure basic, accurate and clear health information is being conveyed at all levels of the Title V system of care.

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.

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, including those receiving federal Title V and state MCH funding, 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. As part of the BFH's commitment to addressing health disparities and in conjunction with

the workforce development plan, a committee, comprised of internal BFH staff representing all four divisions, will be formed to take ownership and drive the work of the BFH around addressing health disparities. Two main goals have been outlined for the first year: 1) develop a training plan for internal staff on health disparities and health equity; and 2) develop an approach for internal staff to provide technical assistance to grantees developing plans to address health disparities.

The BFH plans to continue to develop technical assistance documents researching and summarizing the evidence-base for intervention strategies around specific topics and target populations at increased risk of experiencing poor health outcomes for use by grantees. Upcoming topics to be addressed will include pre-natal care and infant mortality.

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

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

Objective 1: By December 2021, develop resources and tools to increase the utilization of 17P by eligible women.

ESM (new): Percent of eligible women receiving 17P treatment compared to baseline data.

The BFH will continue its partnership with the March of Dimes, funded by a combination of Title V and State Systems Development Initiative (SSDI) funds to identify and develop interventions to increase the use of 17P among eligible women. The 17P pilot program will identify factors that lead women to pass on 17P by reviewing the choices of a group of women eligible for 17P treatment. The answers will help identify the challenges in educating eligible women and providers on the 17P treatment. This cumulative feedback will help to shape the creation of 17P awareness tools and materials. As part of the first year of work in 2018, the March of Dimes will be performing a retrospective review of medical data to establish a baseline percentage of eligible women who have received 17P. This measure will be tracked annually for the length of the project and potentially beyond to determine if there is an increase in the identification of eligible women who receive 17P.

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 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 BFH is committed to using data to steer program decision-making. The target percent for Title V staff who actively analyze and use data in program decision-making for 2019 is 55 percent. This is an increase in the number of Title V staff who regularly analyze and use data in program decision-making by approximately 25 percentage points over the base year in 2016. The BFH plans to meet with individual programs to continue discussing data collection and how program staff can better utilize data. In addition, the BFH plans to survey staff to understand exact usage of data in decision-making and identify areas where training and technical assistance is needed.

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 with funding from both the Centers for Disease Control and Prevention (CDC) and Title V. Title V funds most of the surveying work performed by a contractor, while the CDC funds are used to pay for a PA PRAMS coordinator within the BFH. The project is 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 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 to reduce preventable child fatalities. Currently, all 67 counties in Pennsylvania are covered by one of the 63 local CDR teams and review children's deaths in all 67 Pennsylvania counties. The child death review process involves the multidisciplinary team gathering and reviewing available information related to the child's life and death. This includes information derived from death certificates, traffic and law enforcement reports and hospital records. Data gathered is entered in to the National Fatality Case Reporting System. Local teams analyze their data to develop effective prevention strategies to reduce the number of 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, will be redeveloped to review data submitted by local teams and develop protocols and prevention strategies for child death review at a state level.

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. Other federal funds will be used to support administrative oversight of CDR at the state level and federal Title V funds will be used to implement prevention measures based upon CDR findings.

In addition to supporting PRAMS and CDR, PA Title V funds will continue to partially support the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a CDC supported, but not fully funded, telephone survey of U.S. adult residents used to gather information about health-related risk behaviors, chronic health conditions, and use of preventive services. As BRFSS is the federal data source for the NPM 1: percent of women who have an

annual preventive medical visit, using Title V funds to achieve an adequate BRFSS sample maintains a vital data source not only for Title V outcome reporting, but for a broad range of Department of Health programming. BRFSS allows for the addition of modules to address state data needs and the BFH plans to continue to take advantage of this opportunity as well.

Objective 1: By 12/31 each year, identify at least one area for improvement in collecting or using data for each BFH program.

To begin the process of transforming data into programmatic strategies, BFH staff will annually identify at least one area for improvement in collecting or using data for each program. While the information gathered during BFH staff interviews during 2016-2017 indicated how each program is currently collecting or using data, the BFH is going to take a closer look at what data each program is collecting, starting with an examination of what data is in annual reports submitted to the BFH by the Title V and state match grantees. This will begin the process of identifying trends, strengths and needs in the BFH's data collection efforts.

Objective 2: Staff from each BFH program will conduct analysis to develop actionable goals by 12/31 each year.

Supplementing examination of the BFH's data collection efforts will be the identification and implementation of training to assist BFH staff in identifying potential sources of data, how to link program goals to available data, and how to conduct basic analysis of data to inform the development of program performance measures. Title V funds have been set aside to support these training activities. As program goals are reviewed and data sources determined, BFH staff will be able to define process or impact measures in the form of revised ESMs or SPMs. More refined performance measures, closely linked to program goals, will enable BFH staff to not only identify areas for improvement, but more accurately describe program impact. The use of data analysis and clearly defined impact measures creates the foundation for on-going quality improvement activities and the development of actionable goals.

There continues to be a concurrent need for data analysis and program goal development within BFH programs as well as training for BFH staff with respect to these topics. It is anticipated that by the close of 2018, the BFH will have finalized a workforce development plan with identified clear, measurable goals for staff development around identifying data sources, data use and basic analysis, and the development of process and impact measures. Further, as reviews of individual program data collection activities are performed, each program will receive a tailored set of steps to move forward in conducting analysis and defining program performance measures.

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 steps 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 to prioritize and implement strategies. Since the applicable population for this objective includes Title V program staff and grantees, staff will consider whether to implement the strategy as a part of program administration at the BFH, or to integrate the strategy into grantee 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 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 grantee involvement will include the grantee in planning how best to disseminate findings and strategy outcomes.

III.F. Public Input

After submission of the 2016 Annual Report/2018 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 previous years' annual report/applications. 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 Maternal and Child Health Services Block Grant (MCHSBG) and the transformation. The BFH still maintains a resource email account on the website specific to the Title V MCHSBG to enable people to send comments or input at any time. Additionally, the 2016-2017 Title V MCHSBG interim needs assessment report, which includes the interim needs assessment survey instrument, was posted to the BFH website in April 2018.

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. When the 2016-2017 interim needs assessment report was posted to the BFH website, an announcement of the posting was shared with the CMHDs.

At the September 2017 meeting with the CMHDs, the BFH staff discussed a variety of Title V MCHSBG and MCH system of care topics. The preliminary results from the 2016-2017 Title V MCHSBG interim needs assessment as well as highlights from the 2016 Report/2018 Application submission were presented. An overview of newborn screening requirements and the Early Detection and Hearing Intervention (EDHI) were also provided. Staff from the Allegheny County Health Department presented on their case management system as multiple CMHDs have expressed interest in developing a similar system. As the BFH had recently completed and publicly released a technical assistance document for the CMHDs entitled "Supporting Breastfeeding with African American Communities: Evidence-Based and Research Informed Practices," BFH staff had an open discussion with meeting participants regarding the general helpfulness of the document, the structure, the type of content included and if there were requests for other topics to be examined. Health disparities, infant mortality, prenatal care, and early preterm births were all suggested as future topics to address in technical assistance documents. In follow-up to previous meeting's presentation, the BFH's participation in the Child Safety Collaborative Innovation and Improvement Network (CS CollIN) was again discussed and CMHD participation was requested to not only further partnership building for CS CollIN activities at the local level, but also as another tool in MCH collaborative work to implement programming more efficiently and productively beginning with small tests of change. The meeting concluded with a discussion on the status of lead poisoning prevention activities in the state.

Over the next several months, the BFH plans to form a MCH Working Group to provide structure for ongoing collaboration with community groups, service providers, system partners, families and individuals. Members will be asked to commit to a minimum one-year term. MCH Working Group meetings will be held on a quarterly basis, alternating virtual and in-person meetings. At a minimum, the BFH will offer introductory Title V MCHSBG and public health trainings to interested stakeholders and may offer additional trainings as needed. The MCH Working Group will have six subcommittees representing HRSA's Title V MCHSBG population domains, women/maternal health, perinatal/infant health, child health, children with special healthcare needs, adolescent health, and cross-

cutting/systems building. The cross-cutting/systems building subcommittee will also serve as the Pregnancy Risk Assessment Monitoring System (PRAMS) advisory committee, assisting with the selection of PRAMS supplemental survey questions and providing input into how PRAMS data should be reported and used to inform public health programming throughout the state. Anticipated activities for year one include providing input into the Five Year Needs Assessment, assisting with prioritization of programming for the Title V MCHSBG State Action Plan for Fiscal Years 2020/2021 through 2025/2025, directing client and family engagement activities, and recommending strategies for improving data collection and reporting.

After submission of the 2017 Annual Report/2019 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.

III.G. 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.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [BFH MOU 1719 Submission Draft_7.11.18.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Attachment 1.TitleV_Interim_Needs_Assessment.pdf](#)

Supporting Document #02 - [Attachment 2.TA_Breastfeeding_FINAL_Updated.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [PA Org Chart Combined_Final.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Pennsylvania

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 23,480,555	
A. Preventive and Primary Care for Children	\$ 10,986,641	(46.7%)
B. Children with Special Health Care Needs	\$ 7,923,493	(33.7%)
C. Title V Administrative Costs	\$ 2,348,055	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 21,258,189	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 48,774,500	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 48,774,500	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 20,065,575		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 72,255,055	
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)	\$ 5,231,068	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 77,486,123	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,952,047
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 265,868
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	\$ 287,910
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 157,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$ 316,429
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	\$ 300,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 89,125
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) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	\$ 795,522

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 23,527,801		\$ 23,480,555	
A. Preventive and Primary Care for Children	\$ 13,309,375	(56.6%)	\$ 12,686,325	(54%)
B. Children with Special Health Care Needs	\$ 7,865,646	(33.4%)	\$ 8,446,175	(35.9%)
C. Title V Administrative Costs	\$ 2,352,780	(10%)	\$ 2,348,055	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 23,527,801		\$ 23,480,555	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 47,153,000		\$ 46,264,233	
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)	\$ 47,153,000		\$ 46,264,233	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 20,065,575				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 70,680,801		\$ 69,744,788	
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)	\$ 5,170,360		\$ 2,592,423	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 75,851,161		\$ 72,337,211	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 161,000	\$ 361,325
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 109,293
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	\$ 113,520	\$ 79,102
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Traumatic Brain Injury	\$ 250,000	\$ 200,543
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 2,316,829	\$ 352,799
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 180,373
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,983,637	\$ 726,439
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > Lead-based Paint Hazard Control		\$ 291,447
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)		\$ 60,835
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens		\$ 230,267

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children
	Fiscal Year:	2019
	Column Name:	Application Budgeted
	Field Note:	Beginning with the FY19 budgeted period, Pennsylvania is adjusting reporting methodology to reflect the population served, rather than the outcome of the service.
2.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	FY17 expended amount is reported based on methodology that is consistent with the FY17 budgeted form. Preventive and Primary Care for Children includes expenditures related to services provided during the prenatal and infancy periods, as the intended outcome is to improve child health.

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	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 2,222,366	\$ 2,109,344
2. Infants < 1 year	\$ 1,625,087	\$ 1,377,266
3. Children 1 through 21 Years	\$ 9,377,054	\$ 9,008,800
4. CSHCN	\$ 7,857,993	\$ 8,537,090
5. All Others	\$ 50,000	\$ 100,000
Federal Total of Individuals Served	\$ 21,132,500	\$ 21,132,500

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 0	\$ 0
2. Infants < 1 year	\$ 7,554,800	\$ 5,624,064
3. Children 1 through 21 Years	\$ 36,620,000	\$ 35,424,490
4. CSHCN	\$ 2,818,179	\$ 2,903,077
5. All Others	\$ 1,781,521	\$ 2,312,602
Non-Federal Total of Individuals Served	\$ 48,774,500	\$ 46,264,233
Federal State MCH Block Grant Partnership Total	\$ 69,907,000	\$ 67,396,733

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	Field Name:	IA. Federal MCH Block Grant, 3. Children 1 through 21 years
	Fiscal Year:	2019
	Column Name:	Application Budgeted
	Field Note:	The costs reported on Form 3a for types of individuals served are categorized by the status of the individual at the time they received the service. Pennsylvania includes some services provided during the infancy period as Preventive and Primary Care for Children, as the ultimate outcome of the service is to improve health during childhood. As such, the costs reported on Form 2, Line 1A are not equivalent to Form 3a, line IA.3.
2.	Field Name:	IA. Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2019
	Column Name:	Application Budgeted
	Field Note:	Services for Children with Special Health Care Needs reported of Form 2, line 1B includes infrastructure and services for family of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.
3.	Field Name:	IA. Federal MCH Block Grant, 3. Children 1 through 21 years
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	The costs reported on Form 3a for types of individuals served are categorized by the status of the individual at the time they received the service. Pennsylvania considers some services provided during the prenatal and infancy periods as Preventive and Primary Care for Children, as the ultimate outcome of the service is to improve health during childhood. As such, the costs reported on Form 2, Line 1A are not equivalent to Form 3a, line IA.3.
4.	Field Name:	IA. Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	Services for Children with Special Health Care Needs reported of Form 2, line 1B includes infrastructure and services for family of CSHCN. Form 3a is limited to the services provided directly to CSHCN individuals.

Data Alerts:

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

Form 3b
Budget and Expenditure Details by Types of Services
State: Pennsylvania

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 4,770,195	\$ 4,306,705
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,422,129	\$ 1,263,018
B. Preventive and Primary Care Services for Children	\$ 2,385,229	\$ 2,385,969
C. Services for CSHCN	\$ 962,837	\$ 657,718
2. Enabling Services	\$ 5,350,659	\$ 5,545,025
3. Public Health Services and Systems	\$ 13,359,701	\$ 13,628,825
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		\$ 585,008
Physician/Office Services		\$ 3,721,697
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Direct Services Line 4 Expended Total		\$ 4,306,705
Federal Total	\$ 23,480,555	\$ 23,480,555

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 7,827,500	\$ 5,813,501
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 7,554,800	\$ 5,624,064
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 272,700	\$ 189,437
2. Enabling Services	\$ 0	\$ 700,000
3. Public Health Services and Systems	\$ 40,947,000	\$ 39,750,733
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 1,162,700
Physician/Office Services		\$ 973,263
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 3,677,538
Direct Services Line 4 Expended Total		\$ 5,813,501
Non-Federal Total	\$ 48,774,500	\$ 46,264,234

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: 138,661

Data Source Year: 2016

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	136,533 (98.5%)	229	109	109 (100.0%)

Program Name(s)				
Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Glycogen Storage Disease Type II (Pompe)	Maple syrup urine disease
Primary congenital hypothyroidism	S,S disease (Sickle cell anemia)	X-linked Adrenoleukodystrophy		

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	135,211 (97.5%)	15	0	0 (0%)
Methylmalonic Acidemia (methylmalonyl-CoA mutase)	135,211 (97.5%)	15	1	1 (100.0%)
Methylmalonic Acidemia (Cobalamin disorders)	135,211 (97.5%)	15	0	0 (0%)
Isovaleric Acidemia	135,211 (97.5%)	1	1	1 (100.0%)
3-Methylcrotonyl-CoA Carboxylase Deficiency	135,211 (97.5%)	6	2	2 (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
3-Hydroxy-3-Methylglutaric Aciduria	135,211 (97.5%)	6	0	0 (0%)
Holocarboxylase Synthase Deficiency	135,211 (97.5%)	6	0	0 (0%)
β -Ketothiolase Deficiency	135,211 (97.5%)	6	0	0 (0%)
Glutaric Acidemia Type I	135,211 (97.5%)	6	4	4 (100.0%)
Carnitine Uptake Defect/Carnitine Transport Defect	135,211 (97.5%)	0	0	0 (0%)
Medium-chain Acyl-CoA Dehydrogenase Deficiency	135,211 (97.5%)	10	10	10 (100.0%)
Very Long-chain Acyl-CoA Dehydrogenase Deficiency	135,211 (97.5%)	2	1	1 (100.0%)
Long-chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency	135,211 (97.5%)	0	0	0 (0%)
Trifunctional Protein Deficiency	135,211 (97.5%)	0	0	0 (0%)
Argininosuccinic Aciduria	135,210 (97.5%)	2	0	0 (0%)
Citrullinemia, Type I	135,210 (97.5%)	2	1	1 (100.0%)
Homocystinuria	135,210 (97.5%)	6	0	0 (0%)
Tyrosinemia, Type I	135,210 (97.5%)	8	0	0 (0%)
S, β -Thalassemia	136,530 (98.5%)	7	7	7 (100.0%)
S,C Disease	136,530 (98.5%)	27	27	27 (100.0%)
Biotinidase Deficiency	135,210 (97.5%)	14	12	12 (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
Critical Congenital Heart Disease	136,535 (98.5%)	296	5	5 (100.0%)
Cystic Fibrosis	135,197 (97.5%)	627	32	32 (100.0%)
Hearing loss	132,773 (95.8%)	404	315	315 (100.0%)
Severe combined immunodeficiencies	120,419 (86.8%)	17	3	3 (100.0%)
Globoid Cell Leukodystrophy (Krabbe)	2,215 (1.6%)	0	0	0 (0%)
Fabry	2,208 (1.6%)	0	0	0 (0%)
Niemann-Pick	2,208 (1.6%)	0	0	0 (0%)
Gaucher	2,208 (1.6%)	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.

The 4 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.	Field Name:	Core RUSP Conditions - Receiving At Least One Screen
	Fiscal Year:	2017
	Column Name:	Core RUSP Conditions

Field Note:

This count includes Hurler Syndrome (MPS I).

Data Alerts: None

**Form 5a
Count of Individuals Served by Title V**

State: Pennsylvania

Annual Report Year 2017

		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	5,837	51.0	0.0	10.5	9.4	29.1
2. Infants < 1 Year of Age	136,135	32.9	0.0	62.4	4.7	0.0
3. Children 1 through 21 Years of Age	729,905	0.1	0.0	0.0	0.1	99.8
3a. Children with Special Health Care Needs	171,784	0.6	0.0	0.5	0.1	98.8
4. Others	48,107	0.8	0.0	1.2	0.1	97.9
Total	919,984					

Form Notes for Form 5a:

Form Note: The Bureau does not have the capability to unduplicate numbers between the various divisions or their programs. The four divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the 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.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2017
	Field Note:	The following services are included in this count: Safe and Healthy Homes Program, Centering Pregnancy Program (CPP), Smoking Cessation, Dental-CPP only, Breastfeeding, CMHV, One Key Question, IMPLICIT, Healthy Baby line.
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2017
	Field Note:	This is the number of infants receiving at least one newborn screen. This includes infants who are being served by the metabolic treatment centers, infants served by the CF treatment centers, infants served by the HBG treatment centers, and infants enrolled in the PKU formula program. The state insurance estimates were used for this domain. The following services are also included: Safe and Healthy Homes Program, Safe Sleep Initiative, Child Rehab; Cooley's Anemia; CF, Hemophilia, Sickle Cell, Spina Bifida, Medical Home.
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	The following services are included in this count: Safe and Healthy Homes Program, LGBTQ, Reproductive Health grants, Teen Special Initiatives/HRCs, CMHH, Health Needs Assessment, Youth Care Coordinator, Nutrition Education and Counseling, CMHV, Brain Steps, Epilepsy, Medical Home, Tourette's.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2017
	Field Note:	The following services are included in this count: Safe and Healthy Homes Program, Case Management, CMHV, Medical Home Program, the PKU formula program, CF pharmacy program, Charcot Marie Tooth; CF, Cooley's Anemia, Child Rehab, Hemophilia, Spina Bifida, Special Kids Network, Sickle Cell, Home Vent, Tourette's.
5.	Field Name:	Others
	Fiscal Year:	2017
	Field Note:	The following services are included in this count: LGBTQ grants, the PKU formula program, the CF pharmacy program, the spina bifida pharmacy program, Brain Steps, Cooley's Anemia, CF, Hemophilia, Sickle Cell, Special Kids Network, Spina Bifida, Epilepsy, Healthy Baby line, Home Vent, Tourette's.

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V
State: Pennsylvania

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	96
2. Infants < 1 Year of Age	99
3. Children 1 through 21 Years of Age	56
3a. Children with Special Health Care Needs	95
4. Others	1

Form Notes for Form 5b:

The Bureau does not have the capability to unduplicate numbers between the various divisions or their programs. The four divisions within the Bureau of Family Health have broad Title V responsibilities and each serves multiple categories within the "Types of Individuals Served." The Total Served is the sum of each of the 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.

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2017
	Field Note:	The following services are included in this count: Safe and Healthy Homes Program, Centering Pregnancy Program, One Key Question, Smoking Cessation, Dental - CPP, Breastfeeding, CMHV, MI training, IMPLICIT, healthy baby line, PRAMS birth year 2017, Community Health, Keystone 10 initiative. 2017 denominator: 137,682 Source: Vital Statistics Rapid Release Report, dated May 2018
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2017
	Field Note:	This is the number of infants with at least one newborn screen. The following services are included in this domain: Safe and Healthy Homes Program, CMHV, Safe Sleep Initiative, infants served by the metabolic treatment centers, infants served by the CF treatment centers, infants served by the HBG treatment centers, infants enrolled in the PKU formula program, infants served by the Federal Hearing Grant through the Guide By Your Side (GBYS) program, Child Rehab, Cooley's Anemia, CF, Hemophilia, Sickle Cell, Spina Bifida, Medical Home. 2017 denominator: 136,863 Source: Vital Statistics Rapid Release Report, dated May 2018
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	This is the total number of children receiving a school health growth screen. This domain includes the following services: Safe and Healthy Homes Program, LGBTQ, Abstinence, PREP, Reproductive Health grants, Teen Special Initiatives/HRCs, PREP training, LGBTQ grant training, Teen Special Initiatives/HRCs training, CMHH, Health Needs Assessment, Youth Care Coordinator, Nutrition Education and Counseling, CMHV, Youth Tobacco education, Youth Bullying education, Brain Steps, Epilepsy, Juvenile Justice, Medical Home, Tourette's, School Health growth screen, Community Health. 2017 denominator: 3,205,528 Source: Census data - Population and Housing Unit Estimates page, State Population by Characteristics: 2010-2017 page, Single Year of Age and Sex Population Estimates: April 1, 2010 to July 1, 2017 – CIVILIAN
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2017

Field Note:

This is not an unduplicated count. The following services are included in this domain: Safe and Healthy Homes Program, Case Management, CMHV, School Health, infants the federal hearing grant through the GBYS program, the PKU formula program, the CF pharmacy program, Charcot Marie Tooth, CF, Cooley's Anemia, Child Rehab, Hemophilia, Spina Bifida, Special Kids Network, Sickle Cell, Medical Home, Home Vent, Tourette's, Community Health. 2017 denominator: 618,667 Source: The children ages 1-21 population estimate multiplied by 19.3%, the PA CSHCN prevalence estimate from the National Survey of Children's Health.

5. **Field Name:** **Others**

Fiscal Year: **2017**

Field Note:

The following services are included in this domain: LGBTQ grants, PREP, PREP training, LGBTQ grants training, the PKU formula program, the CF pharmacy program, the spina bifida pharmacy program, PATS TBI, Brain Steps, Cooley's Anemia, CF, Hemophilia, Sickle Cell, Special Kids Network, Spina Bifida, Epilepsy, Healthy Baby, Home Vent, Tourette's. 2017 denominator: 9,463,146 Source: Census data--the population of PA (12,805,537) less infants (136,863), less children 1-21 (3,205,528) as these are the distinct population groups.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Pennsylvania

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	138,661	92,567	17,997	15,336	78	6,178	51	3,517	2,937
Title V Served	133,445	102,088	14,421	9,802	192	4,719	41	2,182	0
Eligible for Title XIX	55,820	26,753	14,496	10,310	104	1,677	26	0	2,454
2. Total Infants in State	139,389	108,949	18,879	0	0	6,151	0	4,326	1,084
Title V Served	136,135	104,146	14,711	10,000	195	4,815	42	2,226	0
Eligible for Title XIX	76,477	34,575	17,184	13,398	69	1,885	32	0	9,334

Form Notes for Form 6:

* "Other & Unknown" for "Total Deliveries in State" includes both "unknown Hispanic origin" and "non-Hispanic other and unknown races".

*For Infant Population (Total Infants in State) - cannot delineate between non-Hispanic and Hispanic within each racial group. Hispanic origin can be of any race.

**Vital Stats numbers are for 2016.

Field Level Notes for Form 6:

1.	Field Name:	1. Title V Served
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	The counts for Title V served deliveries could not be delineated by Form 6 categories. The race and ethnicity 2017 PA population estimates from the Census were applied to the Form 5 pregnant women count to estimate the number of Title V served deliveries within these categories. Source: Census data--Resident population by sex, race, and Hispanic origin for the United States, states and counties: April 1, 2010 to July 1, 2017. Used July 1, 2017 table for PA.
2.	Field Name:	2. Total Infants in State
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	The counts for total infants in state could not be delineated by Form 6 categories. The counts for race regardless of ethnicity are included on the form. Asian and Native Hawaiian or Other Pacific Islander is combined and entered into the Asian category. For the total infants in state, the total NOT Hispanic/Latino is 124,389; the total Hispanic is 15,000. There was a count of zero for unreported ethnicity.
3.	Field Name:	2. Title V Served
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	The counts for Title V served infants could not be delineated by Form 6 categories. The race and ethnicity 2017 PA population estimates from the Census were applied to the Form 5 infants count to estimate the number to Title V infants served within these categories. Source: Census data--Resident population by sex, race, and Hispanic origin for the United States, states and counties: April 1, 2010 to July 1, 2017. Used July 1, 2017 table for PA.

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

State: Pennsylvania

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 986-2229	(800) 986-2229
2. State MCH Toll-Free "Hotline" Name	Healthy Baby	Healthy Baby
3. Name of Contact Person for State MCH "Hotline"	Bureau of Family Health	Bureau of Family Health
4. Contact Person's Telephone Number	(717) 346-3000	(717) 346-3000
5. Number of Calls Received on the State MCH "Hotline"		308

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names	Special Kids Network	Special Kids Network
2. Number of Calls on Other Toll-Free "Hotlines"		1,171
3. State Title V Program Website Address	http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Bureaus/Pages/Family-Health.aspx#.WBtzeqDD-Um	http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Bureaus/Pages/Family-Health.aspx#.WBtzeqDD-Um
4. Number of Hits to the State Title V Program Website		1,562
5. State Title V Social Media Websites	https://twitter.com/PAHealthDept ; https://www.facebook.com/pennsylvaniadepartmentofhealth	https://twitter.com/PAHealthDept ; https://www.facebook.com/pennsylvaniadepartmentofhealth
6. Number of Hits to the State Title V Program Social Media Websites		76,531

Form Notes for Form 7:

Line D6: This entry is the number of profile visits for the DOH Twitter account for Jan-Dec 2017. The Bureau does not have an individualized social media profile. No data from Facebook was available for 2017.

Form 8
State MCH and CSHCN Directors Contact Information

State: Pennsylvania

1. Title V Maternal and Child Health (MCH) Director

Name	Tara Trego
Title	Director, Child and Adult Health Services Division
Address 1	625 Forster Street
Address 2	7th Floor East Wing
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 772-2762
Extension	
Email	ttrego@pa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Erin McCarty
Title	Director, Division of Bureau Operations
Address 1	625 Forster Street
Address 2	7th Floor East Wing
City/State/Zip	Harrisburg / PA / 17120
Telephone	(717) 346-3000
Extension	
Email	erimccarty@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 2019

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
2016	77.3 %	0.1 %	104,692	135,429
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
2015	114.8	3.4	1,160	101,041
2014	120.6	3.0	1,626	134,873
2013	105.5	2.8	1,404	133,098
2012	105.5	2.8	1,418	134,364
2011	93.3	2.6	1,270	136,117
2010	85.8	2.5	1,169	136,178
2009	84.5	2.5	1,174	138,895
2008	81.8	2.4	1,136	138,884

Legends:

-  Indicator has a numerator ≤10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	18.6	1.6	131	706,159

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2017
Annual Indicator	11.5
Numerator	16
Denominator	139,356
Data Source	PA Report of Maternal Deaths, PA live births
Data Source Year	2016

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.2 %	0.1 %	11,331	138,255
2015	8.2 %	0.1 %	11,453	140,109
2014	8.3 %	0.1 %	11,713	141,638
2013	8.0 %	0.1 %	11,219	140,081
2012	8.1 %	0.1 %	11,492	141,805
2011	8.2 %	0.1 %	11,662	142,786
2010	8.4 %	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 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.3 %	0.1 %	12,962	139,175
2015	9.4 %	0.1 %	13,224	140,800
2014	9.4 %	0.1 %	13,291	142,051
2013	9.4 %	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 - 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
2016	22.7 %	0.1 %	31,574	139,175
2015	22.2 %	0.1 %	31,304	140,800
2014	22.1 %	0.1 %	31,382	142,051
2013	21.8 %	0.1 %	30,426	139,775
2012	22.3 %	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
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:
 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
2015	6.8	0.2	967	141,500
2014	6.2	0.2	881	142,663
2013	7.1	0.2	1,007	141,349
2012	7.9	0.2	1,134	143,037
2011	6.9	0.2	996	143,631
2010	7.5	0.2	1,078	143,812
2009	7.3	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
2015	6.2	0.2	867	141,047
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
2015	4.4	0.2	622	141,047
2014	4.0	0.2	571	142,268
2013	4.8	0.2	679	140,921
2012	5.0	0.2	715	142,514
2011	4.5	0.2	646	143,178
2010	5.1	0.2	734	143,321
2009	4.9	0.2	720	146,434

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.7	0.1	245	141,047
2014	1.9	0.1	267	142,268
2013	1.8	0.1	258	140,921
2012	2.0	0.1	290	142,514
2011	2.0	0.1	283	143,178
2010	2.1	0.1	302	143,321
2009	2.2	0.1	320	146,434

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	252.4	13.4	356	141,047
2014	248.1	13.2	353	142,268
2013	281.0	14.1	396	140,921
2012	287.0	14.2	409	142,514
2011	263.3	13.6	377	143,178
2010	290.3	14.3	416	143,321
2009	295.0	14.2	432	146,434

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - 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
2015	102.8	8.5	145	141,047
2014	76.6	7.3	109	142,268
2013	83.7	7.7	118	140,921
2012	88.4	7.9	126	142,514
2011	85.9	7.8	123	143,178
2010	99.1	8.3	142	143,321
2009	106.5	8.5	156	146,434

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - 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
2015	8.0 %	0.9 %	10,620	132,632
2014	6.6 %	0.9 %	8,861	134,793
2013	7.5 %	0.9 %	9,946	133,493
2012	6.1 %	0.9 %	8,175	135,030
2011	7.5 %	0.9 %	10,214	135,619
2010	7.0 %	0.9 %	9,487	135,581
2009	7.1 %	0.9 %	9,803	138,011
2008	7.1 %	0.9 %	9,894	139,733
2007	6.1 %	1.3 %	5,129	83,516

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or 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 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	13.1	0.4	1,345	102,351
2014	13.2	0.3	1,812	136,973
2013	12.3	0.3	1,652	134,181
2012	10.8	0.3	1,461	135,176
2011	9.0	0.3	1,228	136,888
2010	7.5	0.2	1,028	137,115
2009	6.1	0.2	849	140,210
2008	4.9	0.2	681	139,975

Legends:

- Indicator has a numerator ≤ 10 and is not reportable
- Indicator has a numerator < 20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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 year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	12.4 %	1.6 %	307,206	2,480,436

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	18.1	1.2	236	1,302,893
2015	15.6	1.1	204	1,309,207
2014	15.5	1.1	204	1,312,869
2013	15.5	1.1	204	1,319,788
2012	17.2	1.1	228	1,327,819
2011	16.4	1.1	218	1,329,111
2010	14.8	1.1	198	1,341,623
2009	16.7	1.1	223	1,338,778

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	31.6	1.4	499	1,577,593
2015	31.1	1.4	495	1,590,253
2014	25.6	1.3	410	1,603,732
2013	29.4	1.4	476	1,618,822
2012	32.5	1.4	534	1,644,941
2011	32.1	1.4	536	1,671,249
2010	34.0	1.4	576	1,696,217
2009	31.6	1.4	541	1,713,734

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	10.1	0.6	252	2,489,092
2013_2015	10.1	0.6	254	2,513,155
2012_2014	10.3	0.6	263	2,549,339
2011_2013	12.6	0.7	328	2,600,002
2010_2012	14.2	0.7	378	2,657,908
2009_2011	14.2	0.7	385	2,708,142
2008_2010	14.8	0.7	406	2,743,868
2007_2009	16.5	0.8	456	2,761,043

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	8.2	0.6	205	2,489,092
2013_2015	7.8	0.6	195	2,513,155
2012_2014	7.2	0.5	184	2,549,339
2011_2013	7.6	0.5	198	2,600,002
2010_2012	7.5	0.5	200	2,657,908
2009_2011	7.5	0.5	204	2,708,142
2008_2010	7.0	0.5	192	2,743,868
2007_2009	6.1	0.5	169	2,761,043

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.3 %	1.5 %	517,187	2,678,463

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	20.3 %	3.4 %	104,892	517,187

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	2.2 %	0.6 %	48,948	2,183,465

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.5 %	1.2 %	164,358	2,185,239

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	56.5 % ⚡	6.1 % ⚡	151,226 ⚡	267,559 ⚡

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	92.1 %	1.3 %	2,455,051	2,665,532

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.9 %	0.1 %	10,985	84,996
2012	13.1 %	0.1 %	12,217	93,009
2010	12.8 %	0.1 %	12,425	96,762
2008	11.6 %	0.1 %	9,904	85,595

Legends:

- Indicator has a denominator <50 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	14.0 %	0.9 %		
2009	11.7 %	0.7 %		

Legends:

- Indicator has an unweighted denominator <100 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.2 %	1.9 %	160,750	1,129,655

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	4.7 %	0.2 %	124,175	2,664,966
2015	4.0 %	0.2 %	108,644	2,686,144
2014	5.4 %	0.3 %	145,714	2,688,940
2013	5.0 %	0.2 %	134,993	2,709,009
2012	5.1 %	0.3 %	139,286	2,732,366
2011	5.4 %	0.3 %	148,564	2,758,314
2010	5.3 %	0.3 %	146,737	2,785,072
2009	5.0 %	0.3 %	138,132	2,770,999

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width 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
2016	73.7 %	3.0 %	150,812	204,682
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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	63.3 %	1.8 %	1,602,487	2,532,776
2015_2016	60.5 %	2.0 %	1,544,288	2,552,964
2014_2015	63.3 %	2.3 %	1,626,720	2,571,077
2013_2014	59.8 %	1.8 %	1,558,312	2,604,570
2012_2013	64.9 %	2.5 %	1,674,796	2,581,443
2011_2012	54.8 %	1.9 %	1,417,118	2,586,916
2010_2011	58.3 %	2.3 %	1,483,616	2,544,796
2009_2010	47.8 %	1.9 %	1,277,497	2,672,587

Legends:

- Estimate not reported because unweighted sample size for the denominator < 30 or 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
2016	72.0 %	3.3 %	273,328	379,400
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
2016	57.2 %	3.7 %	227,601	398,181
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
2016	92.0 %	1.4 %	715,105	777,581
2015	91.7 %	1.4 %	716,890	781,529
2014	93.0 %	1.4 %	732,551	787,571
2013	89.9 %	1.8 %	711,883	792,092
2012	88.4 %	1.8 %	705,991	798,314
2011	81.0 %	2.2 %	655,887	809,289
2010	74.0 %	2.5 %	613,378	829,381
2009	67.9 %	3.0 %	565,784	833,340

Legends:

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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
2016	92.7 %	1.3 %	720,506	777,581
2015	94.8 %	1.1 %	740,468	781,529
2014	95.2 %	1.0 %	749,967	787,571
2013	90.4 %	1.8 %	716,165	792,092
2012	89.4 %	1.8 %	713,612	798,314
2011	83.8 %	2.1 %	678,342	809,289
2010	79.8 %	2.3 %	661,919	829,381
2009	71.9 %	3.0 %	599,084	833,340

Legends:

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	15.8	0.2	6,385	403,321
2015	17.8	0.2	7,218	405,994
2014	19.3	0.2	7,892	409,328
2013	20.8	0.2	8,657	416,319
2012	23.7	0.2	10,049	424,484
2011	25.0	0.2	10,816	432,903
2010	27.1	0.3	11,959	440,825
2009	28.7	0.3	12,850	448,436

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	10.1 %	1.1 %	13,329	132,039
2014	10.9 %	1.1 %	14,601	133,589
2013	14.8 %	1.3 %	19,766	133,318
2012	12.4 %	1.3 %	16,782	135,521

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.6 % ⚡	0.5 % ⚡	42,363 ⚡	2,664,889 ⚡

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: Pennsylvania

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

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	2017
Annual Objective	68	68.7
Annual Indicator	66.5	66.4
Numerator	1,427,642	1,417,944
Denominator	2,148,194	2,136,103
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	69.4	70.1	71.4	72.1	73.1	73.3

Field Level Notes for Form 10a NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	74	76
Annual Indicator	73.3	81.8
Numerator	99,273	108,050
Denominator	135,367	132,020
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	78.0	80.0	82.0	84.0	86.0	88.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	17	18
Annual Indicator	20.5	23.7
Numerator	27,408	30,174
Denominator	133,488	127,300
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	23.0	26.0	27.0	30.0	33.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	79	79.8
Annual Indicator	76.7	84.0
Numerator	101,695	110,308
Denominator	132,585	131,259
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.6	82.1	83.0	83.9	84.8	85.8

Field Level Notes for Form 10a NPMs:

None

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	51
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2012-2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	53.0	54.0	54.9	55.9	56.9

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2023
	Column Name:	Annual Objective

Field Note:

Baseline data comes from PRAMS State Topic Reports on Safe Sleep 2012 – 2015. Percent change for this indicator is for 2019-2023

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	65.4
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2012-2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	67.4	68.4	69.3	70.3	71.3

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2023
	Column Name:	Annual Objective

Field Note:

Baseline data comes from PRAMS State Topic Reports on Safe Sleep 2012 – 2015. Percent change for this indicator is for 2019-2023

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

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	2017
Annual Objective	188.7	186.8
Annual Indicator	175.4	152.0
Numerator	2,553	1,654
Denominator	1,455,450	1,088,130
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	184.9	183.1	179.3	175.5	171.7	160.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2023
	Column Name:	Annual Objective

Field Note:

leave the projections for 2018-2022 as programming was based on the 2014 combined estimated for both age groups. The 2023 projection is based on children ages 0-9 only.

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

Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	2017
Annual Objective	14.5	14.3
Annual Indicator	24.7	24.7
Numerator	122,928	122,928
Denominator	497,526	497,526
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	2.8
Numerator	24,330
Denominator	869,039
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	18.9
Numerator	163,399
Denominator	863,295
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.1	13.9	13.7	13.5	13.3	13.1

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	2017
Annual Objective		
Annual Indicator		86.5
Numerator		775,554
Denominator		897,142
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	88.7	89.6	91.2	92.8	93.4	94.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		51.8
Numerator		267,920
Denominator		517,187
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	61.0	62.0	63.0	64.0	65.0	66.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2023
	Column Name:	Annual Objective

Field Note:

Numbers edited based upon the National Survey of Children's Health (combined statistic) and program evaluation projected to begin in 2018.

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	2017
Annual Objective	13.2	12.2
Annual Indicator	12.5	11.5
Numerator	17,295	15,875
Denominator	138,426	137,557
Data Source	NVSS	NVSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	9.8	8.8	7.8	6.8	6.0	10.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2023
	Column Name:	Annual Objective

Field Note:

This percentage has been increased to better reflect an attainable goal.

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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	1.3
Numerator		
Denominator		
Data Source	N/A	BFH internal data collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.0	38.0	56.0	75.0	78.0	80.0

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		14
Annual Indicator	7	7.4
Numerator		
Denominator		
Data Source	List of BFH Title V programs	List of BFH Title V programs
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.0	14.0	18.0	21.0	21.0	22.0

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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		49
Annual Indicator	48	52
Numerator		
Denominator		
Data Source	Newborn Screening Data System	Newborn Screening Data System
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	54.0	59.0	64.0	69.0	74.0	79.0

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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		32
Annual Indicator	29	18
Numerator		
Denominator		
Data Source	BFH internal data collection	BFH internal data collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	42.0	55.0	66.0	76.0	78.0	80.0

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%.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	N/A	N/A
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2023
	Column Name:	Annual Objective
	Field Note:	Programs started 1/1/18 - no numbers to report yet.

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)
State: Pennsylvania

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		300
Annual Indicator	310	330
Numerator		
Denominator		
Data Source	Quarterly reports from the Centering Pregnancy Pro	Quarterly reports from the Centering Pregnancy Pro
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	340.0	345.0	350.0	350.0	350.0	350.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** 2016

Column Name: State Provided Data

Field Note:
Number of women in LGH, AEHN and PDPH CPP

2. **Field Name:** 2023

Column Name: Annual Objective

Field Note:
number of women in LGH, AEHN and PDPH CPP. Edits were made to years 2018 - 2023 to increase the projected number of families served.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	87	85
Numerator		
Denominator		
Data Source	Quarterly reports from the County Municipal Health	Quarterly reports from the County Municipal Health
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	87.0	88.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Partial data

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	94	83
Numerator		
Denominator		
Data Source	Quarterly reports from the IMPLICIT Programs	Quarterly reports from the IMPLICIT Programs
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	83.0	84.0	85.0	87.0	88.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Partial data

ESM 1.4 - Number of individuals trained on motivational interviewing.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	50
Numerator		
Denominator		
Data Source	Grantee reports	Grantee reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

The BFH will no longer be providing MI trainings after June 2018.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		1,500
Annual Indicator	1,585	1,930
Numerator		
Denominator		
Data Source	Quarterly reports from the County/Municipal Health	Quarterly reports from the County/Municipal Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,600.0	1,700.0	1,800.0	1,900.0	1,925.0	1,950.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
number of women in prenatal and postpartum CMHD HV programs
- Field Name:** 2023

Column Name: Annual Objective

Field Note:
Edits were made to years 2018 - 2023 to increase the projected number of families served.

ESM 1.6 - Percent of eligible women receiving 17-alpha-hydroxy progesterone caproate (17P) treatment compared to baseline data.

Measure Status:	Active
------------------------	---------------

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	11.0	12.0	13.0	14.0	15.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2019
	Column Name:	Annual Objective

Field Note:

This ESM is attached to work within the Cross-Cutting/Systems Building domain within the priority: Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs. Baseline data has not been determined at this time. Projections will be included when a baseline is determined.

ESM 4.1 - Percent of facilities designated as a Keystone 10 facility each fiscal year.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	7	12
Numerator		
Denominator		
Data Source	Vendor reports and enrollment numbers	Vendor reports and enrollment numbers
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	17.0	22.0	27.0	32.0	37.0	42.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

The ESM for Objective 1 has been changed to "Percent of individual facilities becoming Keystone 10 designated each fiscal year." The 2016 annual indicator has been updated to reflect the new measure.

ESM 4.2 - Percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	37	45
Numerator		
Denominator		
Data Source	Vendor reports and PA Health Stats	Vendor reports and PA Health Stats
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	47.0	52.0	57.0	62.0	67.0	72.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
 planning activities began in mid summer 2016 so no counties implemented evidence based strategies during that year
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
 The ESM for Objective 2 has been changed to measure the percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year. 2016 data is the most recent data available and was used to set the baseline for the new ESM.

ESM 4.3 - Number of new collaborations developed (between breastfeeding program plus other program).

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	3	1
Numerator		
Denominator		
Data Source	BFH internal collection	BFH internal collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.4 - Number of media opportunities implemented promoting breastfeeding per fiscal year.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	BFH internal collection	BFH internal collection
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	2	6
Numerator		
Denominator		
Data Source	quarterly reports from the Infant Safe Sleep Initi	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	3.0	3.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2016 . Objective projections have only been made for the three year grant period.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	3
Numerator		
Denominator		
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	8.0	9.0	18.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
Grant period is 7/1/16 to 6/30/19. Model program was under development 7/1/16 to 6/30/17 and implementation begins 7/1/17. Objective projections have only been made for the three year grant period.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017. Program implementation began 7/17/17

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	0	2
Numerator		
Denominator		
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	4.0	8.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Grant period is 7/1/16 to 6/30/19. Model program was under development 7/1/16 to 6/30/17 and implementation begins 7/1/17. Objective projections have only been made for the three year grant period.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017

ESM 5.4 - Number of social marketing messages disseminated.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		160
Annual Indicator	0	42
Numerator		
Denominator		
Data Source	n/a	quarterly reports from the Infant Safe Sleep Initi
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	171.0	86.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
Grant period is 7/1/16 to 6/30/19. Implementation begins 7/1/17. Objective projections have only been made for the three year grant period.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Grant period is 7/1/16 to 6/30/19 and data is reported for the calendar year 2017. Program implementation began 7/17/17. Targets for 2018 and 2019 have been changed with details in the plan narrative due to changes upon implementation.

ESM 7.1.1 - Number of comprehensive home assessments completed.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		875
Annual Indicator	97	1,069
Numerator		
Denominator		
Data Source	Quarterly reports from Pennsylvania Safe and Health	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	900.0	920.0	920.0	920.0	920.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Grant period ends 06/30/19 with a determination of future programming not yet established.

ESM 7.1.2 - Number of health and safety hazards identified through comprehensive home assessments.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		7,000
Annual Indicator	936	6,447
Numerator		
Denominator		
Data Source	Quarterly reports from Pennsylvania Safe and Health	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7,200.0	7,360.0	7,360.0	7,360.0	7,360.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Grant period ends 06/30/19 with a determination of future programming not yet established.

ESM 7.1.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		4,375
Annual Indicator	468	4,845
Numerator		
Denominator		
Data Source	Quarterly reports from Pennsylvania Safe and Health	Quarterly reports from Pennsylvania Safe and Health
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,500.0	4,600.0	4,600.0	4,600.0	4,600.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
For the period 7/1/16 to 12/31/16. While six months of data there was a delay in startup due to training. This is not indicative of expected performance.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Grant period ends 06/30/19 with a determination of future programming not yet established.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		80
Annual Indicator	76	83
Numerator		
Denominator		
Data Source	quarterly reports	quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	90.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:
Increased numbers to reflect current status.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		25
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	n/a	n/a
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	40.0	55.0	75.0	85.0	90.0

Field Level Notes for Form 10a ESMs:

None

ESM 9.5 - Number of evidence-based mentoring programs implemented in high risk areas of PA.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	n/a	n/a
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7.0	9.0	11.0	13.0	15.0	17.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		40
Annual Indicator	20	30
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	80.0	100.0	120.0	140.0	160.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:
Updated numbers to match work statements.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		150
Annual Indicator	135	368
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	175.0	200.0	230.0	270.0	410.0	410.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
------------------------	---------------

State Provided Data	
	2017
Annual Objective	15
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	30.0	30.0	45.0	45.0	60.0

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.

Measure Status:	Active
------------------------	---------------

State Provided Data	
	2017
Annual Objective	250
Annual Indicator	0
Numerator	
Denominator	
Data Source	n/a
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	425.0	475.0	525.0	575.0	625.0	1,500.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Updated 2023 goal to better match work statements, now that grants are in place.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		10
Annual Indicator	9	8
Numerator		
Denominator		
Data Source	quarterly reports	quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	11.0	11.0	11.0	11.0	11.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:
Updated numbers to reflect current program status/goals.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		3,500
Annual Indicator	3,288	3,780
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,000.0	4,500.0	4,500.0	4,500.0	4,500.0	4,500.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

SFY 2016 number does not include the last quarter (report due end of July). Previous numbers were extremely low - updated to reflect current numbers and work statements.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		15
Annual Indicator	13	18
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	18.0	21.0	25.0	30.0	33.0	35.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:
SFY 2016 number does not include the last quarter (report due end of July).

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		3,800
Annual Indicator	3,537	3,520
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,000.0	4,200.0	4,500.0	4,900.0	5,200.0	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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		11,817
Annual Indicator	7,557	10,599
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15,275.0	15,375.0	15,475.0	15,575.0	16,375.0	16,575.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

Previous numbers were way too high, had issues with site counts. Technical assistance provided and reporting issues fixed. Numbers were updated.

ESM 11.1 - Number of families who received services through the evidence based or evidence informed strategies of the SKN.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		1,500
Annual Indicator	1,597	1,732
Numerator		
Denominator		
Data Source	Monthly reports	Monthly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,525.0	1,550.0	1,575.0	1,600.0	1,625.0	1,650.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - Number of formal collaboration developed between systems of care serving CSHCN.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	BFH internal reports	BFH internal reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4.0	4.0	5.0	5.0	3.0	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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	507	4,070
Numerator		
Denominator		
Data Source	Grantee Reports	Grantee Reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	520.0	540.0	560.0	580.0	600.0	620.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

This is a duplicated count across activities. MHI had 2,874 encounters (e.g. education, technical assistance, meetings, and electronic communications) with medical home PCPs and PCPs considering a medical home approach.

ESM 11.4 - Number of youth/young adults and parents/caregivers involved in aspects of medical home activities.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		200
Annual Indicator	196	214
Numerator		
Denominator		
Data Source	Quarterly reports and internal reports	Quarterly reports and internal reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	225.0	240.0	260.0	280.0	300.0	315.0

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.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	1	5
Numerator		
Denominator		
Data Source	BFH internal reports	BFH internal reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	3.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.6 - Number of families receiving Respite Care Program services.

Measure Status:	Active
------------------------	---------------

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	500.0	750.0	1,000.0	1,000.0	1,000.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2019
	Column Name:	Annual Objective

Field Note:

This ESM is attached to work within the CSHCN domain around the priority: MCH populations reside in a safe and healthy living environment. Program expected to begin July 1, 2018.

ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		1,000
Annual Indicator	0	1,304
Numerator		
Denominator		
Data Source	n/a	n/a
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1,400.0	1,500.0	1,550.0	1,600.0	1,650.0	1,700.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year
- Field Name:** 2023

Column Name: Annual Objective

Field Note:
Updated to reflect projections based on the progress from the first year.

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

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		75
Annual Indicator	0	89
Numerator		
Denominator		
Data Source	n/a	Grantee Reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.0	85.0	90.0	90.0	90.0	90.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year. Training on the required screening tool did not begin until 2017.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
no baseline - CMHD are to screen all women (5P) currently approximately 1500 HV's per year. Training on the required screening tool did not begin until 2017.

ESM 14.1.3 - Percent of women who report smoking after confirmation of pregnancy.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		30
Annual Indicator	20	20
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.0	26.0	25.0	24.0	23.0	22.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Partial data
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	updated 2016 number and made it final

ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	30	30
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	40.0	40.0	40.0	40.0	40.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Two of 10 CMHD have smoking cessation programs up and running in 2016
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Three of 10 CMHD have smoking cessation programs up an running as of 2017. Year 2018 - 2021 have been updated with more reasonable goals. Updated 2016 number

ESM 14.1.5 - Percent of individuals trained on motivational interviewing.

Measure Status:	Active
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		50
Annual Indicator	0	50
Numerator		
Denominator		
Data Source	Quarterly reports	Quarterly reports
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	60.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

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.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
The BFH will no longer be providing MI trainings after June 2018.

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/Systems Building

Measure Status:	Active								
Goal:	To ensure that each grantee establishes and maintains a policy and process to review information provided to patients and ensure it is clear and can be understood.								
Definition:	<table border="1"> <tr> <td>Numerator:</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>Denominator:</td> <td>The total number of Title V grantees.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of grantees who have updated or developed new materials that are accurate and can be understood by the patient population.	Denominator:	The total number of Title V grantees.	Unit Type:	Percentage	Unit Number:	100
Numerator:	The number of grantees who have updated or developed new materials that are accurate and can be understood by the patient population.								
Denominator:	The total number of Title V grantees.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	(AHS-6.1): Reduce the proportion of persons who are unable to obtain or understand the need to receive necessary medical care, dental care, or prescription medicines.								
Data Sources and Data Issues:	Grantee reporting and/or site visits. National Action Plan to Improve Health Literacy, U.S. Department of Health and Human Services, 2010; The Center for Disease Control and Preventions “Simply Put”; and the U.S. National Library of Medicine’s website “How to Write Easy-to Read Health Materials.” In order to develop materials that can be used and understood by individuals: identify the target audience; the issue that needs to be addressed; invite the intended audience to determine needs and evaluate their level of understanding; determine and design messaging based on feedback provided; and design, pretest, edit, publish, and evaluate.								
Significance:	According to Healthy People 2020, 10% of all individuals were unable to obtain care or medicines in 2007. The target set is 9%. When families do not have an understanding of the health care information provided to them, this places the patient at risk for failing to follow through on medical recommendations, adhering to recommended behaviors like safe sleep and breastfeeding. Without prevention and timely intervention, patients frequently need more care and face a difficult rehabilitative process. If materials provided to families is written and presented in a manner that it can be understood, this will result in increased knowledge and/or a change in behavior.								

SPM 2 - Percent of Title V programming with interpersonal violence reduction components.
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active								
Goal:	Increase the number of Title V programs with interpersonal violence reduction components.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of Title V programs with interpersonal violence reduction components.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of Title V programs.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of Title V programs with interpersonal violence reduction components.	Denominator:	Total number of Title V programs.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of Title V programs with interpersonal violence reduction components.								
Denominator:	Total number of Title V programs.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Not applicable.								
Data Sources and Data Issues:	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.								
Significance:	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

Measure Status:	Active								
Goal:	By tracking this measure the DOH will be able to identify submitters (hospitals, birthing facilities, and midwives) that are not meeting the standard for collection to receipt times. The DOH will provide technical assistance to these submitters to im								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of dried blood spot filter papers received at the lab within 48 hours after collection.</td> </tr> <tr> <td>Denominator:</td> <td>The total number of dried blood spot filter papers received by the lab.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of dried blood spot filter papers received at the lab within 48 hours after collection.	Denominator:	The total number of dried blood spot filter papers received by the lab.	Unit Type:	Percentage	Unit Number:	100
Numerator:	The number of dried blood spot filter papers received at the lab within 48 hours after collection.								
Denominator:	The total number of dried blood spot filter papers received by the lab.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Not applicable.								
Data Sources and Data Issues:	Newborn screening data system. No data collection issues or limitations.								
Significance:	By receiving the newborn screening dried blood spot filter papers within 48 hours of collection, the contracted laboratory will be able to report out critical results to DOH within five days of life, the industry standard. This allows DOH staff to begin the follow-up process earlier in the newborn’s life, leading to a quicker referral turnaround, diagnosis and treatment. Many newborn screening conditions are time sensitive, the sooner they are detected and acted on the better the outcome is for the long-term health of the newborn and the family.								

SPM 4 - Percent of Title V staff who analyze and use data to steer programmatic decision-making.
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active								
Goal:	To increase the percentage of Title V staff who analyze and use data to steer programmatic decision-making.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of Title V staff who analyzed and used data at least once during the reporting year.</td> </tr> <tr> <td>Denominator:</td> <td>Number of Title V staff.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of Title V staff who analyzed and used data at least once during the reporting year.	Denominator:	Number of Title V staff.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of Title V staff who analyzed and used data at least once during the reporting year.								
Denominator:	Number of Title V staff.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Not applicable.								
Data Sources and Data Issues:	Counts for the numerator will be obtained from Bureau of Family Health (BFH) internal data collection performed by the Priority 8 workgroup. This workgroup is responsible for all matters pertaining to the data priority. Counts for the denominator will be determined by BFH personnel records.								
Significance:	As the Title V block grant administrator, the BFH has purposely chosen a state priority related to data collection and analysis. Through internal assessment of all program data collection strengths and needs, the BFH aims to increase the capacity of all staff to incorporate relevant data into programmatic decision-making.								

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

Measure Status:	Active								
Goal:	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%.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</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 style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Number of youth participating in programming.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of youth participating in programming who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%.	Denominator:	Number of youth participating in programming.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of youth participating in programming who increased protective factors or decreased risk factors influencing positive youth development and health outcomes by 50%.								
Denominator:	Number of youth participating in programming.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	<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>								
Data Sources and Data Issues:	Programs will utilize pre and post assessments to measure changes in protective factors and risk factors of youth participating in programming.								
Significance:	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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active									
Goal:	Annually increase the number of families served through Centering Pregnancy Programs.									
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>The numerator is the number of families enrolled in Centering Pregnancy programs.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>500</td> </tr> </table>		Numerator:	The numerator is the number of families enrolled in Centering Pregnancy programs.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	500
Numerator:	The numerator is the number of families enrolled in Centering Pregnancy programs.									
Denominator:	Not applicable.									
Unit Type:	Count									
Unit Number:	500									
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the Centering Pregnancy Programs.									
Significance:	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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	Annually increase the percentage of adolescents and women engaged in family planning after delivery.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The numerator is the number of women engaged in family planning after delivery.</td> </tr> <tr> <td>Denominator:</td> <td>The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The numerator is the number of women engaged in family planning after delivery.	Denominator:	The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants.	Unit Type:	Percentage	Unit Number:	100
	Numerator:	The numerator is the number of women engaged in family planning after delivery.							
	Denominator:	The denominator is the number of women who are served through home visiting programs. The CMHD's have this written into their grants.							
	Unit Type:	Percentage							
Unit Number:	100								
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the County Municipal Health Departments.								
Significance:	Family planning services have important health, social, financial, environmental and economic benefits. Access to contraception helps people to avoid pregnancies they do not want, and to plan and space the pregnancies they do want. Interconception care allows women to improve their health before becoming pregnant ultimately improving the health of their children.								

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

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

Measure Status:	Active								
Goal:	Annually increase the percentage of adolescents and women who talked with a health care professional about birth spacing and birth control methods.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The numerator is the number of women served through the IMPLICIT program who talked with a health care professional about birth spacing or birth control methods.</td> </tr> <tr> <td>Denominator:</td> <td>The denominator is the number of women who are served through the IMPLICIT Programs.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	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.	Denominator:	The denominator is the number of women who are served through the IMPLICIT Programs.	Unit Type:	Percentage	Unit Number:	100
Numerator:	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.								
Denominator:	The denominator is the number of women who are served through the IMPLICIT Programs.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the IMPLICIT Programs.								
Significance:	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 - Number of individuals trained on motivational interviewing.

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

Measure Status:	Active								
Goal:	Annually increase the percentage of Title V home visitors trained on motivational interviewing in order to elicit behavior change.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>The numerator is the number of Title V home visitors trained on motivational interviewing techniques.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>n/a</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.	Denominator:	n/a	Unit Type:	Count	Unit Number:	100
Numerator:	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	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, ages 18 through 44, with a preventive medical visit in the past year**

Measure Status:	Active								
Goal:	Annually increase the number of women served by evidence-based or informed home visiting programs.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of women enrolled in home visiting programs.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> </table>	Numerator:	The number of women enrolled in home visiting programs.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	5,000
Numerator:	The number of women enrolled in home visiting programs.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	5,000								
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the County/Municipal Health Departments and Nurse Family Partnership.								
Significance:	Evidence based home visiting programs have achieved positive outcomes in reducing the incidence of low birth weight babies, fewer repeat pregnancies, improved child development and increased rates of immunizations. All of these factors together will likely improve the health of women and their children.								

ESM 1.6 - Percent of eligible women receiving 17-alpha-hydroxy progesterone caproate (17P) treatment compared to baseline data.

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

Measure Status:	Active								
Goal:	Help prevent preterm births by increasing the use of 17P by increasing identification of women eligible to receive this treatment.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of women receiving 17P</td> </tr> <tr> <td>Denominator:</td> <td>Number of women eligible to receive 17P</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of women receiving 17P	Denominator:	Number of women eligible to receive 17P	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of women receiving 17P								
Denominator:	Number of women eligible to receive 17P								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	<ul style="list-style-type: none"> • Data collection and analysis will be performed by the vendor selected by Department to carry out the activities of this program. It will be a grant deliverable as required by the work statement and reported to the Department via quarterly reports. • There is currently no baseline data available for utilization of 17P. Current utilization will be determined from a retrospective review which will then be used as the baseline to measure outcomes for the program. 								
Significance:	17P is shown to be a successful intervention for extending the gestation of women at risk for preterm birth however, not all women who could benefit from this treatment utilize it. Preterm births disproportionately affect African American infants. In 2016, the preterm birth rate for the state was 9.3 percent. Steep disparities persist with the African American rate at 13.2 percent compared to the rate for white women at 8.5 percent. The BFH is working to develop interventions to increase 17P utilization and reduce the preterm birth rate in Pennsylvania. In order to develop effective interventions, the BFH and March of Dimes will determine baseline data of current 17P utilization and then utilize that data to increase identification and utilization among eligible women.								

ESM 4.1 - Percent of facilities designated as a Keystone 10 facility each fiscal year.

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

Measure Status:	Active	
Goal:	To increase the number of facilities becoming Keystone 10 designated.	
Definition:	Numerator:	Number of facilities enrolled in initiative which are Keystone 10 designated each fiscal year.
	Denominator:	Number of facilities enrolled in initiative at the beginning of the fiscal year.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Data for the numerator will be gleaned both from the vendor reports as well as from the DOH website on which the listing of hospitals achieving steps is provided. The denominator is the total number of facilities enrolled in the initiative at the beginning of the fiscal year. The denominator will change as new facilities are added to the initiative (funding dependent).	
Significance:	The Breastfeeding Awareness and Support Program is currently funding an initiative called the Keystone 10 Initiative within Pennsylvania birthing facilities. The goal of this initiative is to facilitate the adoption and implementation of ten evidence-based steps, commonly known as the Ten Steps to Baby Friendly Hospitals. Evidence demonstrates that breastfeeding rates at facilities increase as those facilities implement the evidence based steps. Monitoring the increase in the number of facilities completing all steps and becoming Keystone 10 designated will ensure movement by these facilities towards increasing breastfeeding rates.	

ESM 4.2 - Percent of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year.

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

Measure Status:	Active								
Goal:	To increase the number of counties with breastfeeding rates at or above the 2016 statewide average of 81.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>Number of counties with a breastfeeding initiation rate at or above the state average at the end of the fiscal year.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>67 counties.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of counties with a breastfeeding initiation rate at or above the state average at the end of the fiscal year.	Denominator:	67 counties.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of counties with a breastfeeding initiation rate at or above the state average at the end of the fiscal year.								
Denominator:	67 counties.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	The numerator will indicate the number of counties with a breastfeeding rate at or above the state average of 81 percent and the denominator is a fixed number of 67 counties (2016 was used as the baseline data for this initiative as that was the most recent data available at the time the initiative was developed). Data will come from vendor reports and PA Health Stats.								
Significance:	The Breastfeeding Awareness and Support Program is currently undertaking initiatives to work with targeted counties to assist in the implementation of data based strategies. Implementation of data based strategies like intervention, providing partner/family support, and conducting media or social marketing have been shown to increase breastfeeding initiation and duration rates among women. The counties targeted for these activities are those consistently having lower breastfeeding rates than the overall Pennsylvania rate.								

**ESM 4.3 - Number of new collaborations developed (between breastfeeding program plus other program).
 NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

Measure Status:	Active								
Goal:	Annually develop a minimum of one collaborative opportunity with programs serving the MCH population.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of collaborations developed.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10</td> </tr> </table>	Numerator:	Number of collaborations developed.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10
Numerator:	Number of collaborations developed.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10								
Data Sources and Data Issues:	Numerator will be the number of collaborative opportunities developed, meaning that a focus on breastfeeding is incorporated into other programs as applicable. This information will be collected by the breastfeeding program staff.								
Significance:	The Breastfeeding Awareness and Support Program is currently pursuing collaborative opportunities within the Department of Health and with outside entities with the intent of incorporating breastfeeding awareness, support, education, materials and messaging within the work of other programs. The Program will also incorporate applicable education, materials and messaging from other programs within their breastfeeding work. Building collaborative relationships helps ensure that women and families receive consistent, public health focused messaging on particular topics and better ensures that the professionals that interact with these populations are educated and also have a point of contact for questions and additional information. It has been anecdotally reported that it is the conflicting or incomplete messages that women/families receive that impact their decisions to breastfeed and they often do not know where to turn for assistance. It is therefore important for others serving those populations to have an effective understanding of breastfeeding.								

ESM 4.4 - Number of media opportunities implemented promoting breastfeeding per fiscal year.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	Annually implement a minimum of one media opportunity promoting breastfeeding as the infant feeding norm for the state.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of media opportunities implemented.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10</td> </tr> </table>	Numerator:	Number of media opportunities implemented.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10
Numerator:	Number of media opportunities implemented.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10								
Data Sources and Data Issues:	The Numerator will capture the number of media opportunities implemented by the breastfeeding program staff.								
Significance:	The use of media to promote breastfeeding is an evidence based strategy that has been shown to increase breastfeeding rates. The Breastfeeding Awareness and Support Program is currently exploring media opportunities available to promote breastfeeding. Media encompasses the range of opportunities available from traditional print materials to advertising to a web presence and current social media platforms. This range is being utilized both to reach a diverse segment of the population and also to allow some flexibility in implementation as opportunities are often funding dependent and funding is not always available.								

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

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

Measure Status:	Active								
Goal:	Annually increase the number of hospitals that have been recruited to implement the model safe sleep program.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of hospitals that have committed to implementing the model safe sleep program within the next year.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of hospitals that have committed to implementing the model safe sleep program within the next year.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	100
Numerator:	The number of hospitals that have committed to implementing the model safe sleep program within the next year.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	The number of hospitals that have committed to implementing the model safe sleep program will foreshadow the reach of the program in the coming year.								

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

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

Measure Status:	Active								
Goal:	Annually increase the percentage of infants born whose parents were educated on safe sleep practices through the model program.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Numerator is the number of infants whose parents were educated on safe sleep practices through the model program for a year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</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;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Numerator is the number of infants whose parents were educated on safe sleep practices through the model program for a year.	Denominator:	Denominator is the number of infants who were born in Pennsylvania during the year.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Numerator is the number of infants whose parents were educated on safe sleep practices through the model program for a year.								
Denominator:	Denominator is the number of infants who were born in Pennsylvania during the year.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	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.								

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

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

Measure Status:	Active								
Goal:	Annually increase the percentage of infants born whose parents were educated on safe sleep practices through the model program.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Numerator is the number of hospitals that have implemented the model program.</td> </tr> <tr> <td>Denominator:</td> <td>Denominator is the number hospitals in Pennsylvania with a maternity unit. Unit is a percentage.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Numerator is the number of hospitals that have implemented the model program.	Denominator:	Denominator is the number hospitals in Pennsylvania with a maternity unit. Unit is a percentage.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Numerator is the number of hospitals that have implemented the model program.								
Denominator:	Denominator is the number hospitals in Pennsylvania with a maternity unit. Unit is a percentage.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Quarterly annual reports from the Infant Safe Sleep Initiative will provide the numerator. Data from the Division of Newborn Screening and Genetics will identify the number of hospitals in Pennsylvania with a maternity unit. 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.								
Significance:	This will show the reach of the hospital based model program in all hospitals eligible to implement the model program. Nearly all births in Pennsylvania occur in a hospital. Using a hospital based model program will allow for growth to provide this life saving education to the parents of 97 percent of births.								

ESM 5.4 - Number of social marketing messages disseminated.

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

Measure Status:	Active								
Goal:	Annually increase the number of social marketing messages disseminated to increase population awareness of safe sleep practices.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>The number of social marketing messages disseminated. The type of message will be counted, if multiple methods are used.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>1,000</td> </tr> </table>	Numerator:	The number of social marketing messages disseminated. The type of message will be counted, if multiple methods are used.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	1,000
Numerator:	The number of social marketing messages disseminated. The type of message will be counted, if multiple methods are used.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	1,000								
Data Sources and Data Issues:	<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>								
Significance:	<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 7.1.1 - Number of comprehensive home assessments completed.

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

Measure Status:	Active								
Goal:	Annually increase the number of comprehensive home assessments completed.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> </table>	Numerator:	The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	5,000
Numerator:	The number of homes that received a comprehensive home assessment through the Pennsylvania Safe and Healthy Homes Program.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	5,000								
Data Sources and Data Issues:	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.								
Significance:	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 7.1.2 - Number of health and safety hazards identified through comprehensive home assessments.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active								
Goal:	Annually increase the number of health and safety hazards identified.								
Definition:	<table border="1"> <tr> <td>Numerator:</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>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>20,000</td> </tr> </table>	Numerator:	The number of health and safety hazards identified through comprehensive home assessments performed through the Pennsylvania Safe and Healthy Homes Program.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	20,000
Numerator:	The number of health and safety hazards identified through comprehensive home assessments performed through the Pennsylvania Safe and Healthy Homes Program.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	20,000								
Data Sources and Data Issues:	<p>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.</p>								
Significance:	<p>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.</p>								

ESM 7.1.3 - Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments.

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

Measure Status:	Active								
Goal:	Annually increase the number of health and safety interventions performed.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments through the Pennsylvania Safe and Healthy Homes Program.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	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.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10,000
Numerator:	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.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	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.								
Significance:	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

Measure Status:	Active								
Goal:	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.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>Number of adolescent health vendors receiving LGBTQ cultural competency training.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>Number of adolescent health vendors.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of adolescent health vendors receiving LGBTQ cultural competency training.	Denominator:	Number of adolescent health vendors.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of adolescent health vendors receiving LGBTQ cultural competency training.								
Denominator:	Number of adolescent health vendors.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	<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**

Measure Status:	Active								
Goal:	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.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>Number of adolescent health vendors with a comprehensive anti-bullying/harassment policy.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>Number of adolescent health vendors.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of adolescent health vendors with a comprehensive anti-bullying/harassment policy.	Denominator:	Number of adolescent health vendors.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of adolescent health vendors with a comprehensive anti-bullying/harassment policy.								
Denominator:	Number of adolescent health vendors.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	<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 9.5 - Number of evidence-based mentoring programs implemented in high risk areas of PA.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active								
Goal:	Annually increase the number of evidence-based or evidence-informed mentoring, counseling and adult supervision programs available to youth ages 8 -18.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The measure of this strategy will be a count of evidence-based programs being implemented. We anticipate funding up to 4 separate programs throughout Pennsylvania.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>20</td> </tr> </table>	Numerator:	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.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	20
Numerator:	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.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	20								
Data Sources and Data Issues:	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.								
Significance:	<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

Measure Status:	Active								
Goal:	To annually increase the number of Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) sensitive organizations which provide services to youth.								
Definition:	<table border="1"> <tr> <td style="background-color: #2c5e8c; color: white;">Numerator:</td> <td>Number of LGBTQ sensitive organizations that provide services to youth.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2c5e8c; color: white;">Unit Number:</td> <td>500</td> </tr> </table>	Numerator:	Number of LGBTQ sensitive organizations that provide services to youth.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	500
Numerator:	Number of LGBTQ sensitive organizations that provide services to youth.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	500								
Data Sources and Data Issues:	<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>								
Significance:	<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"> o 84.6 percent of LGBTQ students reported being verbally harassed, 40.1 percent reported being physically harassed and 18.8 percent reported being physically assaulted at school in the past year because of their sexual orientation. o Nearly two-thirds (61.1 percent) of students reported that they felt unsafe in school because of their sexual orientation. o 38.4 percent of LGBTQ youth drank alcohol before age 13, compared with 21.3 percent of heterosexual youth. o LGBTQ youth report rates of suicide attempts from 20 to 40 percent and lifetime prevalence suicide attempt rates ranging from 7 to 20 percent as adults. o LGBTQ youth are also more likely to engage in behaviors that may result in unintended pregnancy: <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

Measure Status:	Active								
Goal:	To annually increase the number of LGBTQ youth who have access to suicide prevention services.								
Definition:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of LGBTQ youth who have access to suicide prevention services.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>	Numerator:	Number of LGBTQ youth who have access to suicide prevention services.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	1,000
Numerator:	Number of LGBTQ youth who have access to suicide prevention services.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	1,000								
Data Sources and Data Issues:	<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>								
Significance:	<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"> o 84.6 percent of LGBTQ students reported being verbally harassed, 40.1 percent reported being physically harassed and 18.8 percent reported being physically assaulted at school in the past year because of their sexual orientation. o Nearly two-thirds (61.1 percent) of students reported that they felt unsafe in school because of their sexual orientation. o 38.4 percent of LGBTQ youth drank alcohol before age 13, compared with 21.3 percent of heterosexual youth. o LGBTQ youth report rates of suicide attempts from 20 to 40 percent and lifetime prevalence suicide attempt rates ranging from 7 to 20 percent as adults. <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

Measure Status:	Active								
Goal:	Increase the number of community-based organizations participating in a bullying awareness and prevention program.								
Definition:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Numerator:</td> <td>Number of trainers trained in the Olweus Bullying Prevention Program</td> </tr> <tr> <td>Denominator:</td> <td>None</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of trainers trained in the Olweus Bullying Prevention Program	Denominator:	None	Unit Type:	Count	Unit Number:	100
Numerator:	Number of trainers trained in the Olweus Bullying Prevention Program								
Denominator:	None								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	Data collection and analysis will be performed by the vendor(s) selected by DOH to carry out the activities of the bullying program. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
Significance:	<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

Measure Status:	Active								
Goal:	Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.</td> </tr> <tr> <td>Denominator:</td> <td>N/A. This measure was inappropriately inactivated.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> </table>	Numerator:	A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.	Denominator:	N/A. This measure was inappropriately inactivated.	Unit Type:	Count	Unit Number:	5,000
Numerator:	A count of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs.								
Denominator:	N/A. This measure was inappropriately inactivated.								
Unit Type:	Count								
Unit Number:	5,000								
Data Sources and Data Issues:	Data will be collected from organizations implementing programming. The data will include a count of youth being served.								
Significance:	<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.**

Measure Status:	Active								
Goal:	To increase the number of counties with an HRC available to youth ages 12-17 either in a school or community based setting								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of HRCs available to youth ages 12-17</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>20</td> </tr> </table>	Numerator:	Number of HRCs available to youth ages 12-17	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	20
Numerator:	Number of HRCs available to youth ages 12-17								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	20								
Data Sources and Data Issues:	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.								
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” 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.

Measure Status:	Active								
Goal:	To increase the number annually of youth ages 12-17 utilizing HRC services.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of youth ages 12-17 receiving services at an HRC.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	Number of youth ages 12-17 receiving services at an HRC.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10,000
Numerator:	Number of youth ages 12-17 receiving services at an HRC.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	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.								
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” 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.

Measure Status:	Active								
Goal:	To increase the percentage of adolescents who utilize a HRC within their school.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of youth ages 12-17 receiving services at an HRC.</td> </tr> <tr> <td>Denominator:</td> <td>Number of youth ages 12-17 attending school with a HRC.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of youth ages 12-17 receiving services at an HRC.	Denominator:	Number of youth ages 12-17 attending school with a HRC.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of youth ages 12-17 receiving services at an HRC.								
Denominator:	Number of youth ages 12-17 attending school with a HRC.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” 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.**

Measure Status:	Active								
Goal:	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.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of youth ages 14-24 receiving services at a BFH-funded drop-in center.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	Number of youth ages 14-24 receiving services at a BFH-funded drop-in center.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10,000
Numerator:	Number of youth ages 14-24 receiving services at a BFH-funded drop-in center.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	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.								
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed. 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.

Measure Status:	Active								
Goal:	To increase the number of adolescents receiving health education and counseling services during a reproductive health visit.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of adolescents.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>50,000</td> </tr> </table>	Numerator:	Number of adolescents.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	50,000
Numerator:	Number of adolescents.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	50,000								
Data Sources and Data Issues:	Data will be collected from the four family planning providers. It will be a grant deliverable as required by the work statement and reported to DOH via quarterly reports.								
Significance:	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. Adolescents face many concerns when deciding where to seek sexual-health services. Access to care is important to youth, and when trying to seek care at a primary care physician or clinic, issues may include: “lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up.” Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) youth face unique barriers to care, including confidentiality around their sexual identity and the fear of being “outed”, as well as judgment from health care workers once their sexual orientation is disclosed. As one of the access points for youth to receive health care services, the reproductive health visit provides an opportunity for youth to receive health education and counseling, including education and counseling about STIs, HIV/AIDS, pregnancy prevention, general wellness, reducing risky behaviors, and healthy relationships.								

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, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Annually increase the number of families of children and youth with special health care needs served by SKN.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>The numerator is the number of families who received services through the evidence based or evidence informed strategies.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>5,000</td> </tr> </table>	Numerator:	The numerator is the number of families who received services through the evidence based or evidence informed strategies.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	5,000
Numerator:	The numerator is the number of families who received services through the evidence based or evidence informed strategies.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	5,000								
Data Sources and Data Issues:	Data will be collected through monthly reports from the Pennsylvania Elks Major Projects, Inc.								
Significance:	<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, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Annually increase the number of collaborations between systems of care serving CSHCN.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</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 style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The numerator is the number of collaborations developed between BFH and other organizations with a vested interest in CSHCN.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	100
Numerator:	The numerator is the number of collaborations developed between BFH and other organizations with a vested interest in CSHCN.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	Data will be collected using a spreadsheet that will be developed, when a collaboration is made.								
Significance:	<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, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Annually increase the number of pediatric providers participating in a learning collaborative, education and/or statewide technical assistance.								
Definition:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10,000
Numerator:	Number of pediatric providers participating in learning collaboratives, education and/or statewide technical assistance.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	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.								
Significance:	<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, ages 0 through 17, who have a medical home**

Measure Status:	Active								
Goal:	Annually increase involvement of youth/young adults and parents/caregivers in BFH medical home activities.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>500</td> </tr> </table>	Numerator:	Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	500
Numerator:	Number of youth/young adults and parents/caregivers involved in medical home activities at the end of the fiscal year.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	500								
Data Sources and Data Issues:	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.								
Significance:	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, ages 0 through 17, who have a medical home

Measure Status:	Active								
Goal:	Annually develop a minimum of two collaborations with oral or behavioral entities that involves them in the provision of medical home services.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of collaborations developed.</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10</td> </tr> </table>	Numerator:	Number of collaborations developed.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	10
Numerator:	Number of collaborations developed.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	10								
Data Sources and Data Issues:	The BFH's PA Medical Home Program is currently pursuing collaborative opportunities within the Department of Health and with outside entities with the intent of integrating oral and behavioral health services within medical homes. Collaborations will be deemed developed if a mutual agreement between entities is reached and provides for movement towards a definitive goal, in this case, integration of services. Numerator will be the number of collaborative opportunities developed.								
Significance:	<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 11.6 - Number of families receiving Respite Care Program services.

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

Measure Status:	Active								
Goal:	Increase the number of families receiving Respite Care Program services in order to reduce stress on caregivers who care for children with special healthcare needs.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of families receiving Respite Care Program services</td> </tr> <tr> <td>Denominator:</td> <td>Not applicable</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> </table>	Numerator:	Number of families receiving Respite Care Program services	Denominator:	Not applicable	Unit Type:	Count	Unit Number:	5,000
Numerator:	Number of families receiving Respite Care Program services								
Denominator:	Not applicable								
Unit Type:	Count								
Unit Number:	5,000								
Data Sources and Data Issues:	Data collection and analysis will be performed by the Department and the vendor selected by Department to carry out the activities of the Respite Care Program. It will be a grant deliverable as required by the work statement and reported to the Department via quarterly reports.								
Significance:	In 2015, the Behavioral Risk Factor Surveillance System (BRFSS) survey for Pennsylvania was conducted. Data from this survey concluded that almost 60% of survey respondents averaged up to eight hours a week providing care to a family member or friend with a health need or disability, while 20% of respondents averaged 40 or more hours a week providing care. Due to the need to provide this care and assistance, parents and caregivers may have more stress, less time for themselves and struggle to balance work and family responsibilities. The Respite Care Program was developed to provide non-emergent respite care services to caregivers and help to reduce the stress associated with providing this care.								

ESM 14.1.1 - Number of Title V funded women who are screened for behavioral health.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active								
Goal:	Annually increase the number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health risk factors.								
Definition:	<table border="1"> <tr> <td>Numerator:</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>Denominator:</td> <td>Not applicable.</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>5,000</td> </tr> </table>	Numerator:	The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT program who are screened for behavioral health risk factors.	Denominator:	Not applicable.	Unit Type:	Count	Unit Number:	5,000
Numerator:	The numerator is the number women in home visiting, centering pregnancy and the IMPLICIT program who are screened for behavioral health risk factors.								
Denominator:	Not applicable.								
Unit Type:	Count								
Unit Number:	5,000								
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.								
Significance:	<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 14.1.2 - Percent of women who talk with a home visitor about Intimate Partner Violence (IPV).
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active								
Goal:	Annually increase the percentage of women with a home visitor who have a conversation about IPV.								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</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;">Denominator:</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;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The numerator will consist of the number women in home visiting programs who have a conversation about IPV.	Denominator:	The denominator will consist of the number of women in home visiting programs.	Unit Type:	Percentage	Unit Number:	100
Numerator:	The numerator will consist of the number women in home visiting programs who have a conversation about IPV.								
Denominator:	The denominator will consist of the number of women in home visiting programs.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the home visiting programs.								
Significance:	<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 14.1.3 - Percent of women who report smoking after confirmation of pregnancy.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active								
Goal:	Annually decrease the percentage of women who report smoking during pregnancy.								
Definition:	<table border="1"> <tr> <td>Numerator:</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>Denominator:</td> <td>The denominator is the number of pregnant women in home visiting and centering pregnancy programs.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The numerator is the number women in home visiting and centering pregnancy programs who report smoking after confirmation of pregnancy.	Denominator:	The denominator is the number of pregnant women in home visiting and centering pregnancy programs.	Unit Type:	Percentage	Unit Number:	100
Numerator:	The numerator is the number women in home visiting and centering pregnancy programs who report smoking after confirmation of pregnancy.								
Denominator:	The denominator is the number of pregnant women in home visiting and centering pregnancy programs.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Data will be collected through Quarterly reports from the home visiting, centering pregnancy and IMPLICIT programs.								
Significance:	Decreasing the number of women who report smoking after pregnancy confirmation will decrease the number of preterm births, low birth rate, respiratory problems and SIDS and increase the health of babies before and after birth. The DCAHS chose to focus on smoking after confirmation of pregnancy due to the fact that nearly 50% of pregnancies are unintended and it is a better indication of behavioral changes and overall health throughout the pregnancy.								

ESM 14.1.4 - Percent of Grantees who implement evidence informed tobacco free programs.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active	
Goal:	Annually decrease the percentage of women who report smoking before, during and after pregnancy.	
Definition:	Numerator:	The numerator is the number of vendors implementing evidence based or evidence informed tobacco free programs.
	Denominator:	The denominator will consist of the number of vendors.
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Data will be collected through vendor reporting.	
Significance:	Increasing the number of evidence based or evidence informed tobacco free programs will help to decrease the number of women who report smoking before, during and after pregnancy. Women who smoking before pregnancy have more difficulty becoming pregnant. Women who smoke during pregnancy are more likely to deliver preterm babies, low birth weight babies and babies who are more likely to die from Sudden Infant Death Syndrome (SIDS). Women who smoke after pregnancy have babies with weaker lungs increasing risk factors for other health problems.	

ESM 14.1.5 - Percent of individuals trained on motivational interviewing.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active								
Goal:	Annually increase the percentage of Title V home visitors trained on motivational interviewing in order to elicit behavior change.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The numerator is the number of Title V home visitors trained on motivational interviewing techniques.</td> </tr> <tr> <td>Denominator:</td> <td>The denominator is the number of Title V home visitors.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.	Denominator:	The denominator is the number of Title V home visitors.	Unit Type:	Percentage	Unit Number:	100
Numerator:	The numerator is the number of Title V home visitors trained on motivational interviewing techniques.								
Denominator:	The denominator is the number of Title V home visitors.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	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.								
Significance:	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](#)