Pennsylvania Title V Program Overview

The Bureau of Family Health (BFH) as the Pennsylvania (Pa.) Title V administrator serves an estimated 2.6 million individuals of the maternal and child health (MCH) population annually, using over $76 million of Title V, state match, and other federal funding to support programming, state-level program management, and public health systems. In partnership with over 45 grantee and partner groups, the BFH applies a life course approach across the Title V population domains. An intentional effort to apply a health equity mindset to improve the health and well-being of the most underserved and expand the scope of work of Title V in Pa. to include an examination of a range of social determinants of health (SDOH) –most importantly those systems and policies reinforcing discrimination and increasing the allostatic load of populations marginalized by institutional systems of oppression and power – is foundational.

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

The BFH continues to implement components of a family engagement workplan, which involves increasing awareness, guidance, and assistance on developing and implementing strategies that meaningfully engage the populations being served in the design, conduct, and evaluation of MCH programs, policies, and systems.

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

As part of its systems-building work, the BFH has implemented processes to maintain a continuous cycle of feedback through interim needs assessment surveys, focus groups, and client satisfaction initiatives. Through this work, the BFH aims to ensure all MCH voices, including those most underserved, are heard. These processes were further actualized through the Five-Year Needs and Capacity Assessment completed in 2019 and the most recent Interim Needs Assessment Update in 2023.

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

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

The BFH recognizes the importance of evaluating performance and adapting to meet the ever-changing needs of the MCH populations in Pa. The strategies, objectives achieved, and lessons learned from the 2015-2020 action plan inform the work of this cycle. Given that the scope of direct services is limited by program capacity and funding, the BFH sees an opportunity to enhance existing strategies and develop system-level strategies to address maternal health. Ongoing work to ensure that women, birthing individuals, and mothers in Pa. have the support and services they need before, during, and after pregnancy includes home visiting, group prenatal care through Centering Pregnancy, and implementation of innovative preconception and

interconception care models. In addition to increasing access and use of services that are protective and may decrease the likelihood of maternal morbidity and mortality, the BFH supports Title V strategies including implementing community-based maternal care models such as a doula program and a fourth trimester pilot program aimed at improving care in the postpartum period. The BFH will use Maternal Mortality Review Committee (MMRC) recommendations to inform Title V programming and collaborate with other state and local agencies to ensure that funds are being leveraged to deliver non-duplicative services. These efforts aim to drive improvement in the Well-Woman Visit National Performance Measure around increasing women's access to and use of preventive medical services.

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

Among children, in addition to enhancing the existing capacity of CDR teams, the BFH aims to address behavioral, mental, and developmental health needs among children and to develop systems-level strategies addressing trauma. Updated programming around maintaining a home free of hazards will continue to drive improvement in the child injury and mortality rates. Title V will also continue to support CDR and efforts aimed to reduce head injury and concussion among youth. Over the course of the funding cycle, the BFH will seek to use CDR recommendations to inform future programming and develop system-level strategies to complement and enhance existing programming on child injury prevention and trauma. These efforts aim to drive improvement in the Injury Hospitalization NPM around reducing the rate of hospitalization for non-fatal injury among children.

For the CSHCN domain, the BFH will continue to administer direct and enabling programming aimed at providing children with well-coordinated, family-centered care. Gap-filling home visiting services for CSHCN will continue as will strategies supporting students with return to school settings following an acquired brain injury. Other Title V-supported strategies related to the provision of screening and specialty care to children with conditions such as sickle cell anemia and autism spectrum disorder will also continue. Other strategies, such as efforts associated with improving access to a medical home, have been adapted over the course of the funding cycle and new

strategies related to improving access to transition services have been developed. Moving forward, CSHCN programming may also be informed by CDR recommendations, especially those related to reducing and addressing experiences with trauma. Additional strategies designed to strengthen the public health services and systems which support a well-functioning system of care are being identified over the course of the funding cycle. These efforts aim to drive improvement in the NPM around increasing the percent of CSHCN who have accessible, family-centered, continuous, comprehensive, and coordinated care, ideally in a medical home.

Among adolescents, the BFH sees an opportunity to enhance existing gap-filling direct and enabling services and to develop a system-level strategy addressing mental and behavioral health. Existing strategies which help youth establish protective factors associated with positive mental, behavioral, and developmental health outcomes will continue, including bullying prevention and mentoring programming. Title V funds continue to support services for LGBTQ youth, as well as reproductive health services and programming aimed to promote healthy relationships for youth in Pa. A youth advisory committee will also provide a mechanism to gather youth input on relevant issues and better ensure strategies developed are reflective and respectful of the communities being served. These strategies serve to advance the mental, behavioral, and developmental health priority, the priority aiming to address child mortality, a SPM which aims to assess the percentage of youth in Pa. who have a mentor, and the NPM around increasing youth access to and use of preventive medical care.

For the cross-cutting domain, the BFH continues to prioritize efforts to build staff capacity to analyze and use data from sources such as the Pregnancy Risk Assessment Monitoring System (PRAMS) and the National Survey of Children's Health (NSCH) and efforts are made to ensure that data from the CDR and the MMRC are reviewed and utilized to inform program design, planning, and implementation. These efforts connect to priority 6 and aim to drive improvement in tracking the extent to which policies and programs are modified as a result of data use and review of available evidence. Additionally, a strategy connecting to priority 7 aims to continue to build knowledge and understanding of health equity in the BFH. This strategy, and others developed over the course of the funding cycle, aims to drive improvement in the new SPM which will track the marked disparities between Black and white persons for key MCH indicators – mortality rates among infants, children, and mothers.

The BFH intends to achieve its objectives, maintain infrastructure, and support public health services and systems through partnerships. BFH works with local Title V agencies and selects partners throughout the state to provide public health, enabling, or direct services to the MCH population. BFH uses population and public health data to identify areas or populations for interventions, and then selects qualified grantees. For all grant agreements, BFH staff develop objectives, work statements, and budgets, and provide oversight and monitoring of grantee progress toward the stated goals. The BFH also coordinates efforts and collaborates with other Bureaus within the Department of Health (DOH) as well as with agencies at the local, state, and federal level. Given that many other organizations share the mission of advancing the health of MCH

populations in Pa., remaining abreast of the work of these other entities remains essential. Convening of regular cross-agency meetings has been incorporated into the action plan and these intra- and interagency relationships, and the corresponding work, have been and will continue to be formalized through the creation of memoranda of understanding.

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

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

Priority Needs	Strategies	Objectives	Type of Service	National and State Performance Measures (NPMs and SPMs)	Evidence-Based Strategy Measures (ESMs	National Outcome Measures (NOMs)
Women/Maternal Health	**Women/Maternal**	**Women/Maternal**	**Women/Maternal**	**Women/Maternal**	**Women/Maternal**	**Women/Maternal**
1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Increase the percent of women or birthing individuals who successfully complete evidence-based or informed home visiting programs	Increase the percent of women or birthing individuals who successfully complete evidence-based or informed home visiting programs by 2% each year	Enabling	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.1: Percent of women or birthing individuals who successfully complete evidence-based or informed home visiting programs	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Increase the percent of adolescents, women, and birthing individuals enrolled in Centering Pregnancy programs who talk with a health care professional about birth spacing or birth control methods	Annually increase the percent of adolescents, women, and birthing individuals who talked with a health care professional about birth spacing or birth control methods by 1%	Enabling	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.2: Percent of adolescents, women, and birthing individuals women enrolled in Centering Pregnancy programs who talked with a health care professional about birth spacing and birth control methods	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Implement care models that include preconception and interconception care	Increase the percent of women and birthing individuals enrolled in IMPLICIT ICC program screened for risk factors during well-child visits by 1.5% each year	Public Health Services/Systems	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.3: Percent of women and birthing individuals served through the IMPLICIT ICC program that are screened for the 4 risk factors during a minimum of one well-child visit	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Implement community-based, culturally relevant maternal care models	Increase the number of community-based doulas providing services in priority neighborhoods	Public Health Services/Systems	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.4: Number of community-based doulas trained in communities served by the program	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Implement care models that include maternal behavioral health screenings and referral to services	Increase the percent of women and birthing individuals enrolled in Title V home visiting, Centering Pregnancy, and IMPLICIT programs that are referred for services by 1% annually, following a positive screening	Enabling	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.6: Percent of women and birthing individuals enrolled in home visiting, Centering Pregnancy and IMPLICIT that are referred for behavioral health services, following a positive screening	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Implement care models that encourage women and birthing individuals to receive care in the early postpartum period	Increase the percent of women and birthing individuals that receive early postpartum care through a 4th trimester pilot program, compared to the year 1 baseline data, by at least 3% annually, starting with reporting year 2022	Public Health Services/Systems	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.7: Percent of women and birthing individuals who attend a postpartum visit within 28 days of delivery through the 4th trimester pilot program	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Use Maternal Mortality Review Committee (MMRC) recommendations to inform programming	Implement a minimum of 1 MMRC recommendation annually	Public Health Services/Systems	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.8: Number of MMRC recommendations implemented	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity	Initiate regular meetings and collaboration between DOH, DHS, and MIECHV	Convene quarterly meetings between agencies that provide services related to maternal health	Public Health Services/Systems	Well-Woman Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	WWV.9: Number of meetings held between DOH, DHS and MIECHV annually (maternal health)	Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

1. Reduce or improve maternal morbidity and mortality, especially where there is inequity				Postpartum Visit: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components		Early Prenatal Care, Severe Maternal Morbidity, Maternal Mortality, Low Birth Weight, Preterm Birth, Early Term Birth, Perinatal Mortality, Infant Mortality, Neonatal Mortality, Postneonatal Mortality, Preterm-Related Mortality, SUID Mortality, Drinking during Pregnancy, Neonatal Abstinence Syndrome, Teen Births, Postpartum Depression

Perinatal/Infant Health	Perinatal/Infant Health	Perinatal/Infant Health	Perinatal/Infant Health	Perinatal/Infant Health	Perinatal/Infant Health	Perinatal/Infant Health
2. Reduce rates of infant mortality (all causes), especially where there is inequity	Facilitate the adoption and implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within Pa. birthing facilities	Annually increase the percent of PA birthing facilities designated as a Keystone 10 facility each fiscal year	Public Health Services/Systems	Breastfeeding: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	BF.1: Percent of Keystone 10 facilities that progressed by one or more steps each fiscal year	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality
2. Reduce rates of infant mortality (all causes), especially where there is inequity	Collaborate with the Safe Sleep Program to promote and support breastfeeding within each program	Annually identify and develop collaborative opportunities between the Safe Sleep Program and the Breastfeeding Program	Public Health Services/Systems	Breastfeeding: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	BF.2: Convene a meeting between the Safe Sleep Program and the Breastfeeding Program four times per year	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality
2. Reduce rates of infant mortality (all causes), especially where there is inequity	Collaborate with community-based organizations to increase breastfeeding initiation and duration rates statewide	Annually provide breastfeeding education, and community outreach to improve breastfeeding initiation and duration rates	Public Health Services/Systems	Breastfeeding: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	BF.3: Convene five regional breastfeeding collaborative meetings twice per year each year BF.4: Award 15 mini-grants to community partners to provide breastfeeding support each year	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality

2. Reduce rates of infant mortality (all causes), especially where there is inequity	Use Child Death Review data to inform infant programming	Annually increase the number of recommendations from CDR teams related to preventing infant death that are reviewed for feasibility and implemented each year	Public Health Services/Systems	Safe Sleep: 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	SS.1: Number of CDR recommendations implemented (infant health)	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality
2. Reduce rates of infant mortality (all causes), especially where there is inequity	Implement a hospital-based model safe sleep program	Increase the number of birthing hospitals implementing the hospital-based model safe sleep program by 3% annually	Enabling	Safe Sleep: 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	SS.2: Number of hospitals recruited to implement the model safe sleep program	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality
2. Reduce rates of infant mortality (all causes), especially where there is inequity	Implement a hospital-based model safe sleep program	Increase the number of birthing hospitals implementing the hospital-based model safe sleep program by 3% annually	Enabling	Safe Sleep: 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	SS.3: Percentage of infants born whose parents were educated on safe sleep practices through the model program	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality

2. Reduce rates of infant mortality (all causes), especially where there is inequity	Implement a hospital-based model safe sleep program	Increase the number of birthing hospitals implementing the hospital-based model safe sleep program by 3% annually	Enabling	Safe Sleep: 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	SS.4: Percentage of hospitals with maternity units implementing the model program	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality
2. Reduce rates of infant mortality (all causes), especially where there is inequity	Use data, as determined by the 6-step PPOR process, to implement prevention initiatives or interventions in the selected communities	Increase the number of targeted prevention initiatives or interventions implemented utilizing PPOR data	Public Health Services/Systems	Safe Sleep: 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	SS.5 Number of targeted prevention initiatives or interventions implemented utilizing PPOR data	Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality SUID Mortality
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Review and analyze data from iCMS to identify submitters with requested repeat filter papers obtained; provide non-compliant submitters with technical assistance and information on best practices to improve their follow-up process	Increase the number of requested repeat filter papers obtained each year to expedite diagnosis and treatment	Public Health Services/Systems	SPM 1: Percent of newborns with on time report out for out of range screens	Percent of newborns with a requested repeat filter paper obtained	

4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Utilize the match with the Vital Records Registry to identify newborns with a dried blood spot (DBS) screening	Annually increase the percent of newborns receiving a DBS screening	Public Health Services/Systems	SPM 1: Percent of newborns with on time report out for out of range screens	Percent of newborns born in Pennsylvania receiving a DBS screening	
Child Health	**Child Health**	**Child Health**	**Child Health**	**Child Health**		**Child Health**
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Work with the Child Death Review (CDR) program to determine possible opportunities to collaborate	Perform a data comparison and match newborns who were reported as SUID to the CDR teams with newborns in the Pennsylvania Internet Case Management System (iCMS) to determine if any infant reported to have expired had abnormal DBS, CCHD, or NAS results or missed initial timely screening that may have contributed to demise	Public Health Services/Systems	SPM 1: Percent of newborns with on time report out for out of range screens	Meet with Child Death Review program for collaboration between programs four times per year	
6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Increase access to and use of Child Death Review data sources to enhance program planning, design and implementation	Annually increase the number of reviews by local CDR teams of prematurity deaths that include identification of the underlying causes of death	Public Health Services/Systems	SPM 2: Increase the number of programs or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	Increase percent of prematurity cases reviewed by local CDR teams that include identification of the underlying causes of death by 5% each year ESM: Number of annual trainings to local CDR teams on guidelines of identifying the underlying causes of prematurity deaths	

3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs				Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home		
5. Reduce rates of child mortality and injury, especially where there is inequity	Use Child Death Review data to inform child safety programming	Annually increase the number of recommendations from CDR teams related to preventing child death that are reviewed for feasibility and implemented each year	Public Health Services/Systems	Injury Hospitalization-Child : Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	ESM IH-Child.1: Number of recommendations from CDR teams that are implemented (child health)	Child Mortality
5. Reduce rates of child mortality and injury, especially where there is inequity	Reduce head injury amongst participants in school and non-school related sports	Annually increase the number of ConcussionWise trainings provided by the Safety and Youth Sports Program to athletic personnel by 2 per year	Public Health Services/Systems	Injury Hospitalization-Child : Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	ESM IH-Child.2: Number of ConcussionWise trainings to athletic personnel	Child Mortality

5. Reduce rates of child mortality and injury, especially where there is inequity	Provide comprehensive in-home child safety education visits	Annually increase the number of comprehensive in-home child safety education visits completed	Enabling	Injury Hospitalization-Child : Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	ESM IH-Child.3: Number of comprehensive in-home child safety education visits completed	Child Mortality
5. Reduce rates of child mortality and injury, especially where there is inequity	Provide home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits	Annually increase the number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits	Enabling	Injury Hospitalization-Child : Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	ESM IH-Child.4: Number of home safety interventions performed as a result of needs identified during comprehensive in-home child safety education visits	Child Mortality
5. Reduce rates of child mortality and injury, especially where there is inequity	Provide technical assistance and capacity building to support Child Death Review teams that provide the underlying causes of death data of reviewed child deaths.	Annually increase the number of child injury and child death review professionals who attend child injury prevention summits hosted by the Safe Kids Pennsylvania State Office and the Bureau of Family Health	Public Health Services/Systems	Injury Hospitalization-Child : Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	ESM IH-Child.5: Number of child injury prevention professionals and child death review professionals who attended child injury prevention summits hosted by the Safe Kids Pennsylvania State Office and the Bureau of Family Health	Child Mortality
5. Reduce rates of child mortality and injury, especially where there is inequity	Increase access to evidence-based and evidence-informed child injury prevention strategies.	Annually increase the percentage of Pennsylvania counties within the Safe Kids affiliate network	Public Health Services/Systems	Injury Hospitalization-Child : Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	ESM IH-Child.6: Percent of Pennsylvania counties within the Safe Kids affiliate network	Child Mortality
Children with Special Health Care Needs (CSHCN)	**Children with Special Health Care Needs (CSHCN)**	**Children with Special Health Care Needs (CSHCN)**	**Children with Special Health Care Needs (CSHCN)**	**Children with Special Health Care Needs (CSHCN)**	**Children with Special Health Care Needs (CSHCN)**	**Children with Special Health Care Needs (CSHCN)**

3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special health care needs	Prevention recommendations from CDR teams, including recommendations related to addressing trauma will be regularly reviewed and implemented	Annually increase the number of recommendations from CDR teams related to preventing CSHCN death that are reviewed for feasibility and implemented each year	Public Health Services/Systems	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM MH.1: Number of recommendations from CDR teams that are implemented (CSHCN)	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Families are partners in decision making, and are satisfied with the services received	Annually increase the number of person-centered plans developed with the BrainSTEPS teams by 5% each year	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.2: Number of person-centered plans developed by BrainSTEPS teams	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Families are partners in decision making, and are satisfied with the services received	Annually a minimum of 80% of families will report that they were partners in decision making through the Community to Home program	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.15: Percent of families reporting through surveys that they were partners in decision making	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	CSHCN receive coordinated, ongoing, comprehensive care within the medical system	Annually increase the number of collaborative agreements with medical providers through the Sickle Cell Community-Based program by 8 per year	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.4: Number of medical provider collaborative agreements established by the Sickle Cell Community-Based program	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care

4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	CSHCN receive coordinated, ongoing, comprehensive care within the medical system	Annually increase the percentage of CSHCN receiving quality care through project-funded FQHC health systems	Public Health Services/Systems	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.14: Percentage of CSHCN receiving quality care in participating FQHC health systems	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	CSHCN receive coordinated, ongoing, comprehensive care within the medical system	Increase the percent of children enrolled in the Room2Breathe program who have well-controlled asthma	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.5: Fifty percent of children with asthma measured as "not well-controlled" at baseline will have "well-controlled" asthma after completing four visits (i.e., one month) in the Room2Breathe program.	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Initiate regular meetings and collaboration between DOH and DHS	Convene quarterly meetings between agencies that provide services related to CSHCN	Public Health Services/Systems	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.6: Number of meetings held annually between DOH and DHS (CSHCN)	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	CSHCN are screened early and continuously for special health care needs	Annually increase the number of children screened for autism spectrum disorder through the Autism Diagnostic Clinic by 5 each year	Direct	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.7: Number of children screened for autism spectrum disorder through the Autism Diagnostic Clinic	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care

4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Community based services are organized so families can use them easily	Conduct outreach and BrainSTEPS program promotion to increase referrals by 15 per year	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.8: Number of referrals to BrainSTEPS program	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Community based services are organized so families can use them easily	Annually increase the number of partnerships engaging community-based providers established by the Sickle Cell Community-Based program by 8 per year	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.10: Number of community-based provider partnerships established by the Sickle Cell Community-Based program	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Youth with SHCN receive services to make appropriate transitions	Annually increase the number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program by 4 per year	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.11: Number of youth with special health care needs receiving evidence-based or -informed leadership development training through the Leadership Development and Training Program	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Youth with SHCN receive services to make appropriate transitions	Of youth age 14 and older being served in Community to Home, 50% will have appropriate transition plans within 6 months of receiving services	Enabling	Medical Home: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	MH.12: Number of youth age 14 and older enrolled in Community to Home program who received a transition plan to transition to adult healthcare	CSHCN Systems of Care, Mental Health Treatment, Children's Health Status, Forgone Health Care

4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Review and analyze neonatal abstinence syndrome (NAS) cases reported in iCMS to identify birth hospitals that are not making Early Intervention Referrals and provide technical assistance to improve referral rates	Annually increase the percentage of reported NAS cases receiving a referral to Early Intervention	Public Health Services/Systems	SPM 3: Percent of hospitals making referrals to EI	Percent of NAS cases within iCMS referred to Early Intervention	
4. Improve the percent of children and youth with special health care needs who receive care in a well-functioning system	Collaborate with the Office of Children, Youth and Families to help support the enrollment into Plan of Safe Care	Annually identify and develop collaborative opportunities to share data and trends in NAS reporting and follow-up	Public Health Services/Systems	SPM 4: Percent of eligible infants with a Plan of Safe Care	Frequency data will be shared to enable OCYF and DNSG identify all infants who should have a Plan of Safe Care	

Adolescent Health	Adolescent Health	Adolescent Health	Adolescent Health	Adolescent Health	Adolescent Health	Adolescent Health
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs	Improve the mental and behavioral health of youth while increasing access of care for youth through Health Resource Centers (HRCs)	Annually increase the number of youth ages 12-17 utilizing HRC services by 2% each year	Enabling	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.1: In schools with an HRC, the percent of youth within that school utilizing the HRC service s	Mental Health treatment, Children's Health Status, Teen Births
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs	Improve the mental and behavioral health of youth while increasing access of care for youth through Health Resource Centers (HRCs)	Annually increase the number of youth ages 12-17 utilizing HRC services by 2% each year	Enabling	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.2: Number of referrals provided to school and community-based resources	Mental Health treatment, Children's Health Status, Teen Births
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs	Improve the mental and behavioral health of youth while increasing access of care for youth through Health Resource Centers (HRCs)	Annually increase the number of youth ages 12-17 utilizing HRC services by 2% each year	Enabling	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.3: Percent of visits that include counseling	Mental Health treatment, Children's Health Status, Teen Births
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs	Improve interpersonal relationships among youth through staff training and implementation of the Olweus Bullying Prevention Program (OBPP) for Community Youth Organizations	Annually increase the number of community-based organization staff trained in a bullying awareness prevention program by 5% each year	Public Health Services/Systems	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.4: Number of community-based organization staff trained in the OBPP AWV.5: Number of youth participating in the OBPP at a community-based organization	Adolescent Mortality, Adolescent Suicide
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and	Increase the dissemination of information to youth through social media and other technology-based platforms	Annually increase the number of users who access SafeTeens.org by 2% each year	Enabling	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.6: The number of users who accessed the SafeTeens.org site	Teen Births

without special healthcare needs						
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs	Increase the dissemination of information to youth through social media and other technology-based platforms	Annually increase the number of text messages received on the SafeTeens Answers! text line by 2% each year	Enabling	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.7: The number of teens referred to in-person counseling or health services through the SafeTeens Answers! text line	Teen Births
3. Improve mental health, behavioral health and developmental outcomes for children and youth with and without special healthcare needs	Increase protective factors for LGBTQ-identified youth through evidence-based or evidence informed behavioral health programs	Increase the percentage of LGBTQ-identified youth participating in an evidence-based or evidence-informed program who report increased positive coping strategies, specifically, support-seeking, problem-solving, distraction, and escape strategies by 2% over the course of the program	Enabling	SPM 5: Percent of children ages 6-17 who have one or more adult mentors	Percentage of LGBTQ-identified youth participating in an evidence-based or evidence-informed behavioral health program who report an increase in positive coping strategies, specifically, support-seeking, problem solving, distraction, and escape strategies over the course of the program period	Adolescent Mortality, Adolescent Suicide, Mental health treatment, Children's Health Status
5. Reduce rates of child mortality and injury, especially where there is inequity	Individuals working in the field of drug and alcohol or brain injury will have a greater understanding of the correlation between substance use and brain injury	Increase the number of brain injury and Opioid trainings provided to substance use and brain injury rehabilitation programs by 1 per year	Public Health Services/Systems	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.8: Number of substance use and brain injury professionals receiving brain injury and Opioid training	Adolescent Mortality, Adolescent Suicide, Mental health treatment, Children's Health Status

5. Reduce rates of child mortality and injury, especially where there is inequity	Implement Child Death Review (CDR) recommendations as they become available	Annually increase the number of recommendations from CDR teams related to preventing adolescent deaths that are reviewed for feasibility and implemented each year	Public Health Services/Systems	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.9: Number of CDR recommendations implemented	Adolescent mortality, Adolescent motor vehicle death, Adolescent suicide
5. Reduce rates of child mortality and injury, especially where there is inequity	Young adult and adolescent males will increase their understanding of healthy relationships through evidence-based or -informed programs	Annually increase young adult and adolescent males receiving trainings through the Coaching Boys into Men Curriculum by 4 per year	Enabling	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.10: Number of young adult and adolescent males receiving trainings through Coaching Boys into Men Curriculum	Adolescent mortality, Adolescent motor vehicle death, Adolescent suicide
7. Support and effect change at the organizational level and system level by supporting and promoting policies, programs and actions that advance health equity, address the social, environmental, and economic determinants of health, and deconstruct institutionalized systems of oppression	Increase the number of youth who are receiving sexual health services and education, including effective contraception methods	Increase the percentage of clients who are provided a most effective or moderately effective contraceptive method by 3% each year	Direct	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.11: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a most effective or moderately effective contraceptive method	Teen births

7. Support and effect change at the organizational level and system level by supporting and promoting policies, programs and actions that advance health equity, address the social, environmental, and economic determinants of health, and deconstruct institutionalized systems of oppression	Increase the number of youth who are receiving sexual health services and education, including effective contraception methods	Increase the number of youth who are receiving sexual health services and education, including effective contraception methods	Increase the number of youth who are receiving sexual health services and education, including effective contraception methods	Adolescent Well-Visit: Percent of adolescents, ages 12 through 17, with a preventative medical visit in the past year	AWV.12: The percentage of adolescents aged 21 years of age or younger at risk of unintended pregnancy who are provided a LARC method	Teen births

Cross-Cutting	Cross-Cutting	Cross-Cutting	Cross-Cutting	Cross-Cutting	Cross-Cutting	Cross-Cutting
6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Assess BFH programs to determine existing data and determine methods for sharing data with internal and external partners	Review BFH programs to evaluate existing data sources and provide supplemental data sources where available to at least 10% of programs per year	Public Health Services/Systems	SPM 2: Increase the number of program or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	ESM: Number of technical assistance requests for data made to DBO each year using the established guidelines	
6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Increase staff access and use of National Survey for Children's Health data sources to enhance program planning, design and implementation	Disseminate annual NSCH data to program staff after it is released on childhealthdata.org each year to support and develop MCH programming	Public Health Services/Systems	SPM 2: Increase the number of program or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	ESM: Percent of staff trained annually on availability of NSCH data and how to access that data	
6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	To use PRAMS to conduct epidemiological surveillance of the maternal and child health population in Pa.	Annually produce and disseminate at least two PRAMS data analysis products	Public Health Services/Systems	SPM 2: Increase the number of program or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	ESM: Percentage of PRAMS data requests resulting in a new or modified program or policy in each calendar year	
6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	To use PRAMS to conduct epidemiological surveillance of the maternal and child health population in Pa.	Annually produce and disseminate at least two PRAMS data analysis products	Public Health Services/Systems	SPM 2: Increase the number of program or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	ESM: Number of programs or policies created or modified as a result of the dissemination of PRAMS data analysis products in each calendar year	

6. Strengthen Title V staff's capacity for data-driven and evidence-based decision making and program development	Increase the number and quality of local CDR team reviews to enhance program planning, design and implementation	Annually increase the number of reviews by local CDR teams that include identification of the underlying causes of death	Public Health Services/Systems	SPM 2: Increase the number of program or policies created or modified as a result of staff's use of evidence-based, data driven decision making each calendar year	ESM: Increase the Percent of CDR cases reviewed by 5% each year	
7. Support and effect change at the organizational and system level by supporting and promoting policies, programs and actions that advance health equity, address the social, environmental, and economic determinants of health, and deconstruct institutionalized systems of oppression	Increase staff understanding of Health Equity principles	Annually provide at least one training, education or policy guidance technical assistance on principles of Health Equity for all BFH staff	Public Health Services/Systems	SPM 6(A): Rate of the mortality disparity between black and white infants SPM 7(B): Rate of the mortality disparity between black and white children, ages 1-4 SPM 8(C): Rate of the maternal mortality disparity between black and white persons	ESM: Percentage of staff trained annually on the principles of Health Equity and the effectiveness of Health Equity plans	