



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

**State Narrative for  
Pennsylvania**

**Application for 2009  
Annual Report for 2007**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.  
***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

The appropriate Assurances and Certifications (non-construction program, debarment and suspension, drug free workplace, lobbying, program fraud, and tobacco smoke) are signed and on file in the Director's Office of the Bureau of Family Health. They can be obtained by calling (717) 787-7192.

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

***/2009/The Bureau of Family Health's solicitation of meaningful public input relative to the MCH Block Grant 2007 annual report/2009 application was comprehensive.***

***Public notification was provided in the PA Bulletin and the draft MCH Block Grant application was made available on the Department's website from June-August 15, 2008. A total of 121 E-mails were sent to MCH Stakeholders personally inviting them to provide input on the 2009 draft application. Sixteen MCH stakeholders provided feedback and input on the Block Grant application via e-mail and letters.***

***Routine mechanisms are in place to obtain input and feedback on MCH programs. DOH utilizes advisory groups and task forces that regularly advise specific MCH programs. The following activities were linked specifically to the application process to solicit comments. Such activities included:***

- CSHCN Stakeholder Workgroup and the PEAL Center***
- Newborn Technical Advisory Group***
- Newborn Advisory Committee***
- Web Posting***
- Public Notices***
- Mass E-mail Outreach to Specific Stakeholders***

***An MCH Block Grant Public Meeting was held at Temple University Health System on Friday, July 18, 2008. Pennsylvania Department of Health, Director of Bureau of Family Health Ms. Melita J. Jordan hosted the public comment meeting which provided the opportunity to seek public comment on the Draft Title V Block Grant Program 2007 Report***

**and 2009 Application.**

***Please see below the various MCH Stakeholder Meetings that were held at various locations throughout the Commonwealth during the May to July 2008 period.***

- ***Allegheny Co Health Dept - Pittsburgh, PA (5/6/08)***
- ***Allegheny Co Health Dept - Pittsburgh, PA (7/8/08)***
- ***Montgomery Co Health Dept - Norristown, PA (7/15/08)***
- ***Allegheny (Pam Long) Health Dept - Pittsburgh, PA (7/16/08)***
- ***Erie Co Health Dept - Erie PA (7/17/08)***
- ***Wilkes-Barre Health Dept - Wilkes Barre, PA (7/17/08)//2009//***

## **II. Needs Assessment**

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

*/2009/In February 2007, a meeting was held to decide a topic for the Interim MCH Needs Assessment. Out of eight public health concerns discussed, breastfeeding was selected because breastfeeding initiation rate among Pennsylvania's WIC population is 20% lower than total population and WIC breastfeeding duration rate average is 11 weeks, with little change over the past 5 years. The overall goal of the Interim MCH Needs Assessment is to identify and gain insight to direct and indirect causes affecting breastfeeding initiation and duration by analyzing the past 12 months of WIC client data from the WIC databank. A comprehensive analysis of WIC client data will focus primarily on WIC client's relationship relevant to breastfeeding has not been undertaken in Pennsylvania. Results will be utilized to develop/support program strategy to improve breastfeeding duration among WIC participants.*

#### ***Analysis goals:***

- 1. Describe patterns in breastfeeding intention, initiation, continuation, and exclusivity among WIC participants***
- 2. Describe patterns in the relationship between breastfeeding intention and initiation based on specified demographic, socioeconomic, and birth-related factors***
- 3. Identify independent demographic, socioeconomic, and birth-related correlates of breastfeeding intention, initiation, continuation, and exclusivity among WIC participants***
- 4. Identify primary reasons for the discontinuation of breastfeeding among WIC participants prior to 6-months postpartum based on the timing of discontinuation***

***Project Timeline: the project is scheduled for completion by October 2008. For more details related to Pennsylvania's MCH priorities; please read section "IV. Priorities, Performance and Program Activities" concerning the bureau's revised state performance measures and priorities.//2009//***

### III. State Overview

#### A. Overview

*/2009/The Bureau of Family Health promotes and protects the health of pregnant women, infants, children, and children with special health care needs and their families through education and health promotion, food benefits and access to quality health care. Everyday we strive to meet the healthcare and nutritional needs of Pennsylvania families.*

*In Pennsylvania, Title V dollars support comprehensive adolescent health services, education and family support through home visiting programs, direct health services for children with special health care needs, information and referral services, primary and preventative care for children, teen pregnancy prevention programs, newborn hearing and metabolic screening and follow up, lead poisoning prevention, needs assessments, outreach to children and their families, and postpartum depression services.*

*In order to accomplish our mission, the Bureau coordinates with many agencies, both public and private, profit and non-profit. We partner with all the children's hospitals in the state for a variety of initiatives and service delivery. We partner with eleven county and municipal health departments around the state including Allegheny, Erie, Chester, Montgomery, Bucks, Allentown, Bethlehem, Wilkes-Barre, Philadelphia, Chester city (Delaware County) and York city. In addition, whenever possible, the Bureau joins with the six Healthy Start projects in Pennsylvania to apply for other federal grants. The Bureau has active and engaged relationships with other state agencies such as the Department of Insurance, the Department of Education, the Department of Aging, Department of Labor and Industry and the Department of Public Welfare.//2009//*

#### Geography

Pennsylvania is located in the Mid-Atlantic region of the United States. Its neighboring states are New York, New Jersey, Delaware, Maryland, West Virginia, and Ohio. Pennsylvania has an average east-to-west distance of 285 miles and an average north-to-south distance of 156 miles. The state ranks 33rd in total area among the fifty states with 44,817 square miles of land area and 735 square miles of water area, largely consisting of Lake Erie. Pennsylvania is comprised of 67 counties, 56 cities, and 962 boroughs (Pennsylvania State Data Center, 2004). Forty-eight of Pennsylvania's 67 counties are classified as rural, according to the Center for Rural Pennsylvania (Pennsylvania Abstract, A Statistical Fact Book, 2004). Pennsylvania has a sizable farm population with almost one-third of the population residing in rural areas of the Commonwealth. Between 1990 and 2000, Pennsylvania's rural areas had a four percent population increase while urban areas had a three percent population increase. In fact, rural counties in eastern Pennsylvania grew three times faster than rural counties in central and western regions of the State ([www.ruralpa.org](http://www.ruralpa.org), accessed 6/14/05).

#### Government

At the heart of Pennsylvania's government is the General Assembly. These are the men and women elected by the people of the Commonwealth to serve as our state Senators and Representatives. Pennsylvania's General Assembly is the legislative branch of government. Commonly called the state Legislature, it consists of two bodies--the Senate and the House of Representatives. Article II of the Constitution establishes the General Assembly's existence, authority, and limitations.

The executive branch of Pennsylvania government, consisting of elected and appointed officials, is headed by the Governor, who holds the state's highest office. Citizens look to the Governor as a leader who not only sets the agenda for state government, but also ensures that current problems are dealt with effectively and plans for the future are in place (PA Archives, 2004). The Governor's Office promulgates major program and priority changes.

## Population

As the sixth most populated State in the country; Pennsylvania has a population of 12.3 million people and a population density of 274 persons per square mile (U.S. Department of Commerce, Bureau of the Census, Census of Population & Housing, 2000). It is projected that Pennsylvania will be home to 12.4 million people in 2010. The population of Pennsylvania is diverse in geography, age, race, culture, and linguistic make up. The gender distribution is 51.6 percent female and 48.4 percent male.

According to the U.S. Bureau of the Census, the overall population increased by 3.4 percent from 1990 to 2000, comparatively, the population of women of reproductive age decreased by 4.7% to 2,561,139 in 2000, but the number of individuals 65 and older for the same period increased by 4.7%. The number of individuals 65 and older for 2004 represents 15.3 percent of the total population and is the fastest growing sector of the population (Pennsylvania State Data Center, 2004). /2007/ Although, Pennsylvania has one of the highest rates of health care coverage, the current budget includes \$14.6 million in total funds for "Cover All Kids". This new state program will provide affordable health insurance coverage for all uninsured children in Pennsylvania. The Cover All Kids initiative will enroll nearly 15,000 uninsured children in 2006-07. (Governor's Executive Budget, Budget in Brief 2/06)//2007//

/2008/ On November 2, 2006, Governor Rendell signed into law Act 136 of 2006, expanding the income eligibility rules for the Children's Health Insurance Program (CHIP). Cover All Kids second year of funding provides \$12.2 million in state funds and \$20.5 million in federal funds to cover an estimated 21,000 children to be enrolled by 2007-08. (Governor's Executive Budget, Budget in Brief 2/07)

During the budget address on February 6, 2007, Governor Edward G. Rendell announced a Prescription for Pennsylvania. The Governor's plan would offer adults affordable health insurance coverage for physical and behavioral health as well as prescriptions. A portion of the plan provides \$719,000 for the Council on Health Literacy. The Health Literacy initiative will promote better communication that will help people who have difficulty understanding health information learn how to take better care of themselves.//2008//

***/2009/The commonwealth is making progress in implementing the Prescription for Pennsylvania. Recently, the Pennsylvania House of Representatives passed a proposal called Pennsylvania Access to Basic Care, or PA ABC. This plan would provide more than 270,000 uninsured working Pennsylvanians access to basic health care and making it more affordable for small businesses to provide health insurance for their employees.***

***The number of children in Pennsylvania's Children's Health Insurance Program has risen by one-third from 125,983 in January 2003 to 166,969 in January 2008. Enrollment is expected to grow to new highs of 185,764 in 2008-09 and 215,823 by 2011-12. The commonwealth's 2007-08 budget includes \$2.9 million to increase access to primary health care in underserved areas, including new community health centers and mobile health clinics.***

***In July 2007, Governor Rendell signed several bills into law that expand the ability of the following***

- ***medical professionals to serve Pennsylvanians:***
- ***physicians' assistants***
- ***certified registered nurse practitioners***
- ***clinical nurse specialists***
- ***nurse midwives***
- ***dental hygienists***

***(2008-09 Proposed Governor's Executive Budget)//2009//***

Of the state's 12.3 million residents, approximately 26 percent are under the age of 19, 34

percent are 20 to 44, 25 percent are 45 to 64, and 15 percent are 65 and above. The median age of Pennsylvania residents is 38 years of age. In 2003, there were 2,966,157 children and teens ages 2 to 19 living in the state. Of that group, 51 percent were male and 49 percent were female. Twenty-five percent of these children were in the two to six year-old age group. Nearly half (45 percent) were in the 7 to 14-year-old age group. Fifteen to 19-year-olds comprised 30 percent of this group (Pennsylvania State Data Center, 2003).

### Race and Ethnicity

Pennsylvania's largest minority groups are African-Americans, Hispanics, and Asian-Pacific Islanders. African American's comprise 10.3 percent of the state's population, while the Hispanic group, which can span more than one racial category, accounts for 3.4 percent of the Commonwealth's residents. Asian-Pacific Islanders, American Indians, and Others comprise 2.0 percent, 0.2 percent, and .09 percent, respectively. Philadelphia County contains the largest African American population in the state, 43.2 percent. The State's Hispanic population is concentrated in the counties of Lehigh and Berks, comprising 10.2 percent and 9.7 percent of the county populations, respectively. It is important to note that while the minority population is broken down into three major groups--African-Americans, Hispanics, and Asian-Pacific Islanders--there are major subgroups within these groups, which differ significantly in language and culture (SHIP Special Report on The Health Status of Minorities in Pennsylvania, 2002).

Since the mid-1970s, more than 100,000 refugees have made Pennsylvania their home (Pennsylvania Refugee Resettlement Program). Arriving from over 30 nations, these refugees represent a vast number of ethnic minorities, with a majority becoming naturalized citizens of the United States. Thirty seven percent of Pennsylvania's refugees reside in Philadelphia County, with significant representation also seen in the Allegheny, Bucks, Cumberland, Dauphin, Delaware, Erie, Lancaster and Lehigh Counties. Some of the services we provide to these multicultural immigrants include: 1) Special Supplemental Nutritional Program for Women, Infants and Children; 2) newborn screening and follow-up for metabolic conditions; and 3) genetic counseling.

### Income

According to The Economic Outlook for FY 2005-06 in the Governor's Budget Address, "Growth in real personal income within Pennsylvania lagged behind the national rate during a period when the economy was expanding in the late 1990's. During this same period the Commonwealth's growth in real personal income outperformed the national average in 2001 and 2002 and nearly matched the growth nationally in 2003." According to the U.S. Census Bureau, the annual per capita income in Pennsylvania in 2004 was \$20,880--female per capita income was \$26,687 compared with male per capita income of \$37,051.

The 2005 Federal poverty guidelines designate a family of four with a gross yearly income of \$19,350 as living in poverty. The Census Bureau estimates that 8 percent of Pennsylvania families have incomes that place them below the poverty level. Children living in families headed by a female are more likely to live in poverty compared to children living in a household with two married parents.

/2007/ The most recent Index of state Economic Momentum, published by State Policy Reports, indicates that the Commonwealth vaulted twelve spots to 30th in total economic momentum in the 2005 Index, as measured by the combination of population growth, personal income growth, and employment growth. The Commonwealth ranked 26th in personal income growth in the 2005 Index, an improvement over the 35th ranking in the category in the same study from 2004 and a 38th ranking in 2003.

Personal income growth in Pennsylvania has remained strong and positive. In fact, the Commonwealth actually outperformed the United States in terms of annual percent growth in real personal income in 2005. This performance indicates both a strengthening state economy as well

as a tightening state labor market.//2007//

/2008/ By November 2006, total non-farm jobs reached a record high of 5.7 million.

Commonwealth job growth has lagged the U.S. by around one-half of a percent per month.

(Governor's Executive Budget, Budget in Brief 2/07.//2008//

***/2009/The Governor is calling for immediate passage of a onetime rebate of up to \$400 per household that would go to more than 475,000 of the commonwealth's lower-income working families.//2009//***

## Employment

According to the Governor's Budget Address, improvements in the Commonwealth's economic performance will be largely dependent upon job growth, which has been rebounding since 2004. Historically, the commonwealth's economy has relied heavily on its manufacturing sector. However, changes in the global marketplace have significantly impacted Pennsylvania economy. Since 1989, Pennsylvania has continued to lose manufacturing jobs more quickly than the rest of the country--170,000 manufacturing jobs have been lost since 2000 (PA Department of Labor and Industry). The implications of the industry's decline include job loss and wage stagnation, which have burdened workers, their families, and the communities in which they live.

"Pennsylvania employment grew by 2.7 percent in 2004, while employment nationally rose by only 1.3 percent. The unemployment rate averaged 5.4 percent in 2004--the lowest average annual level since 2001." The statewide unemployment rate was 5.1 percent as of January 2005 with significant variation by county. Unemployment rates range from a high of 12.2 in Forest County to a low of 3.0 in Cumberland County. With the exception of Philadelphia County, the counties with the lowest unemployment rates are concentrated in the Southeast region of the State (Bureau of Labor Statistics, U.S. Department of Labor, 2005).

From 1979 to 2003, the median inflation-adjusted wage among men with some college (but no degree) dropped from \$15.50 an hour to \$13.85 an hour. Among those with only a high school education, wages dropped from \$15.73 an hour to \$13.50 an hour. Among those who did not finish high school, median wages dropped from \$14.56 an hour to \$9.95 an hour. Low-wage employees (those earning more than 10 percent but less than 90 percent of all employees) saw their wages stay virtually unchanged over this period (\$7.04 in 1979 and \$7.07 in 2003), while the costs of many other essentials, such as housing and medical care, increased significantly (PA Hunger Action Center website, accessed 1/05). /2007/ Significant strides have been accomplished in reducing unemployment. The state's unemployment rate averaged 5 percent in 2005, down from 5.5 percent in 2004 and 5.7 percent in 2003. Pennsylvania's unemployment rate was lower than the national rate in six of the last 12 months. (Governor's Executive Budget, Budget in Brief 2/06)//2007//

/2008/ In 2005 and 2006, Pennsylvania experienced continued job creation and somewhat slower growth in the overall labor force, as compared to the national average. This led to a decline in Pennsylvania's unemployment rate, to a low of 4.5 percent in November 2006. (Governor's Executive Budget, Budget in Brief 2/07).//2008//

***/2009/Pennsylvania's 2007 projected job growth of 0.8 percent, while less than the projected national average of 1.0 percent, was still better than the surrounding states of New Jersey, Delaware and Ohio. (Governor's Executive Budget, Budget in Brief 2/08).//2009//***

## Housing

U.S. Census 2000 identified 5,249,750 housing units in Pennsylvania, a 6.5 percent increase from 1990. Of the total Pennsylvania housing units, 4,777,003 (91 percent) were occupied. Of those occupied, 3,406,337 (71 percent) were owner occupied and 1,370,666 (29 percent) were renter occupied (U.S. Census Bureau, 2000). Philadelphia and Allegheny Counties, the two largest urban areas, together accounted for 1,127,688 (24 percent) of those occupied units.

The median housing value in 2000 was \$97,000, an increase of 8.0 percent since 1990. However, the national average in 2000 was \$119,600 (23.3 percent more). In 2000, approximately 66 percent of Pennsylvania's housing units were built before 1970; approximately 80 percent were built before 1980 (U.S. Census Bureau, 2000). Pennsylvania has the second highest rate of old housing in the U.S. (2nd only to New York State) (U.S. Census Bureau, 2000). It is important to note the correlation between old housing stock and lead-based paint. As a result, lead-based paint was banned in 1978. The most common source of children's exposure to lead is contaminated dust from older homes that contain lead-based paint. Although all children living in older homes (where lead-based paint is most prevalent) are at risk, low income and minority children are much more likely to be exposed to lead hazards. Therefore, eliminating lead-based paint hazards in older low-income housing is essential if childhood lead poisoning is to be eradicated (Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards, 2000). Given the relatively high percentage of older houses in Pennsylvania, many families run the risk of living in units with lead hazards.

***//2009/ Housing construction slowed in Pennsylvania in 2007, down from a high of 45,000 new units in 2005. (Governor's Executive Budget, Budget in Brief 2/08. Based on the number of housing units built before 1950 as reported in the U.S. Census Bureau's 2000 Census, Pennsylvania had the second highest number of old housing behind New York State (U.S. Census Bureau, 2000). //2009//***

The Bureau of Family Health's top 13 priorities in the 2006 application closely reflected the results of the statewide needs analysis conducted in 2005 and include:

1. Addressing health disparities in the rates of low birth weight and premature birth;
2. Improving statewide access to prenatal care and labor and delivery services;
3. Promoting smoking cessation in pregnancy;
4. Improving oral health of children and adolescents;
5. Increasing access to childhood lead screening;
6. Promoting the health and wellness of school age children;
7. Reducing childhood obesity;
8. Strengthening health and physical education activities within the schools;
9. Decreasing the rate of teen suicide;
10. Decreasing alcohol related driving morbidity and mortality among teens;
11. Increasing coordination of programs serving CSHCN;
12. Increasing awareness of the Medicaid EPSDT Program; and,
13. Increasing the availability of MCH program data. /2007/ Reducing childhood obesity, decreasing the rate of teen suicide, and decreasing alcohol related driving morbidity and mortality among teens are no longer priorities within the Bureau of Family Health because the Bureau of Health Promotion and Risk Reduction and the Bureau of Drug and Alcohol Programs have responsibility for these programs.//2007//

/2008/ The Bureau of Family Health has changed the language of the Medicaid EPSDT priority, converting "utilization" to "awareness". Reducing childhood obesity although is no longer a priority

but it remains a State Performance Measure and the responsibility of the Department's Division of School Health.//2008//

***/2009/ The primary funding source for the Bureau's programs is Title V in conjunction with Title V state appropriated funds. However, Pennsylvania is fortunate to have multiple other funding sources to support services for women, children and families such as Centers for Disease Control and Prevention (Childhood Lead Poisoning Prevention and Pregnancy Risk Assessment Monitoring System (PRAMS)), Environmental Protection Agency (Lead Information Line and Contractor training), Housing and Urban Development (Lead Hazard Control), and the Pennsylvania Department of Public Welfare's Medicaid program. The Bureau also has other HRSA grants to support service delivery and infrastructure such as the Universal Newborn Hearing Screening and Intervention grant, Traumatic Brain Injury and State Systems Development Initiative.***

***In our efforts to assure accountability and quality, the Bureau is seeking to fund evidence-based programs rather than programs that do not meet scientific rigor. As the Department moves forward with distributing funds, we will be more stringent in our evaluation and monitoring of programs. This evaluation will include an outcomes-based review of the merits of the program, its sustainability, its effectiveness and viability. The Department has initiated an oversight review team that meets bi-monthly to assess the fiscal and administrative performance of the grantees.***

***Pennsylvania is at a crossroad. In Fiscal Year 2007 following the reassignment of the Bureau of Family Health to the Deputy Secretary for Administration, a comprehensive review of all Bureau of Family Health MCH operating and capital activities was undertaken. Over the past several years, Pennsylvania's Maternal and Child Health Services Block Grant funding has either remained level funded or has been reduced while the costs of administering and maintaining programs have grown. These costs include: commonwealth employee and vendor salary and benefit increases, and escalating pharmaceutical and technology costs. These costs, combined with other management and administrative issues resulted in an over-obligation of funds. As a result, the Bureau was required to make funding reductions.***

***As the Department made difficult decisions regarding the funding reductions, our main goal was to ensure that our decisions had the least negative impact on the people we serve everyday. In order to mitigate the impact on program services, the Department initiated a number of administrative cost saving efforts such as suspending proposed media campaigns, freezing the existing complement, delaying the hiring of key positions and reducing administrative expenses for current and future fiscal years.***

***The Department conducted an exhaustive review of our programs and spending patterns. There were a number of factors that were taken into account regarding the amount a vendor's budget would be reduced. In general, a 7% budget reduction was instituted for most program areas. However, in some instances, budgets were reduced based on prior year's spending. This may have resulted in a greater than 7% decrease if funds were unspent. In other instances, it was clear that funding sources such as Medical Assistance could be leveraged. And, in other cases, programs were not able to demonstrate measurable or discernable outcomes. The Bureau also reviewed funded initiatives to determine whether we have the resources and capacity to bring the work "in house." Finally, the Bureau developed a Strategic Plan and established new priorities and state performance measures (discussed in next section) to help focus our spending.***

#### ***MCH Priorities***

***As an outgrowth of the strategic planning sessions, key Bureau staff identified areas of most significance that we believe we can and should address through funding, leadership***

*and policies. On December 12, 2007 the Bureau of Family Health began the process of establishing bureau-wide Strategic Planning Sessions. The sessions were initiated by the Deputy Secretary of Administration. Each of the Bureau's Divisions undertook efforts to produce a comprehensive Strategic Plan. This strategic planning process resulted in an identification of new priorities. Previously, a number of priorities that were selected were outside of the Bureau's scope of specific responsibility and we wanted our new priorities to be areas that we can directly impact.*

*The Bureau's Strategic Planning group met for half day planning sessions and by May 28, 2008, the Bureau's new strategic plan was completed. A decision was made to combine MCH priority areas into 14 priority statements that reflect inter-related MCH topics. What follows are the Bureau of Family Health's new top 14 priorities.*

#### ***MCH Priorities- 2009***

- 1. Increase the number of high risk, vulnerable youth who have access to comprehensive health care***
- 2. Reduce pregnancy among females ages 15-17***
- 3. Reduce risk factors (individual, family, peer, school, community) and increase protective factors for youth.***
- 4. Increase lead testing among children under age 6.***
- 5. Increase coordination of systems, services and programs serving CSHCN***
- 6. Reduce health risks for, and mortality of infants and children***
- 7. Increase percent of pregnant women, including those at high risk, who receive early and adequate prenatal care***
- 8. Expand the number of medical homes serving all children statewide***
- 9. Reduce health disparities through the provision of culturally, cognitively and linguistically appropriate services***
- 10. Increase statewide breastfeeding initiation and duration***
- 11. Increase access to health and human services through implementation of statewide 2-1-1 system***
- 12. Promote the healthy development of children through Newborn Screening, and improving early identification of heritable disorders and genetic susceptibilities***
- 13. Increase family participation in decision making, programming and statewide policy***
- 14. Develop a comprehensive, cohesive statewide MCH policy***

***1. Increase the number of high risk, vulnerable youth who have access to comprehensive health care.***

***During the transition from childhood to adulthood, adolescents establish patterns of behavior and make lifestyle choices that affect both their current and future health. As adolescents begin to make this transition and take responsibility for their own health, preventive health care services become very important. Adolescents and young adults may be adversely affected by unmet health care needs such as: mental illness, alcohol and other drug use, inadequate medical history information, asthma, sexual abuse, traumatic brain injury, sleep disturbances, ingestion of lead, fetal alcohol spectrum disorder, periodontal disease, delay in immunizations, and pregnancies in older teens.***

***The Bureau of Family Health has started to address access to comprehensive health care for adolescents through the issuance of a Request for Application (RFA) in January 2007. As a result of that RFA six new Grant Agreements were awarded for the provision of comprehensive adolescent health care services which will increase the number of youth receiving services.***

## ***2. Reduce pregnancy among females ages 15-17.***

***Teen pregnancy rates in Pennsylvania have declined however; there are significant racial and ethnic disparities in the teen pregnancy rates. From 2000-2004 the overall teen pregnancy rate for PA residents ages 15-17 decreased from 28.1 to 23.0 per 1000. However, there are significant racial/ethnic disparities. In 2004 the teen pregnancy rate (15-17 year olds) for white teens was 12.9, for black teens 71.5 and for Hispanic teens 67.2 per 1000.***

***The Bureau of Family Health currently funds teen pregnancy prevention initiatives and is moving towards funding science-based teen pregnancy prevention approaches and programs. The Bureau of Family Health is partnering with the Pennsylvania Coalition to Prevent Teen Pregnancy to provide the Department's teen pregnancy prevention grantees with training on how to select, implement, and evaluate science-based teen pregnancy prevention programs.***

## ***3. Reduce risk factors and increase protective factors for children***

***There are a number of prenatal and perinatal factors that predict either positive or negative outcomes for children, including teen pregnancy, maternal smoking/alcohol consumption/drug use during pregnancy, domestic violence, pregnancy and delivery complications, birth spacing, maternal attachment, maternal depression, family and other caregiver management.***

***Parents are a critical factor in the development of children. A whole host of studies have produced empirical findings that indicate parental behavior can either increase or decrease a child's risk for delinquency and other problem behaviors. Research demonstrates that supportive parent-child relationships, positive discipline methods, close monitoring and supervision, parental advocacy for their children, and parental pursuit of needed information and support, consistently buffer youth against problem behaviors. Many of these issues can be addressed through home visiting programs and evidence based parent training programs.***

***Data exists that suggest Pennsylvania can better support families in strengthening protective factors and reducing risk factors. For example, according to the Pennsylvania Department of Public Welfare's 2006 Annual Child Abuse Report, the highest incidence of abuse or neglect causing death occurred in children under age five (90% of total deaths). Further, parents were the most frequent perpetrators of child abuse deaths (mothers accounted for 36% of all perpetrators in child deaths due to abuse while fathers accounted for 30%).***

#### **4. Increase lead testing among children under age 6**

**Considerable progress has been made in reducing blood lead levels in Pennsylvania's children. However, lead poisoning, which is a preventable environmental health problem in which children are the most susceptible to the adverse health, neurological and behavioral reactions from exposure to lead-containing products. An elevated blood lead can cause mental retardation, learning disabilities, and behavioral problems in children. In some cases, high blood levels can cause seizures, coma and even death.**

#### **5. Increase coordination of systems, services and programs serving CSHCN**

**The 2005 Maternal and Child Health Needs and Capacity Assessment Report (MCH-NCA Report) identified that services in Pennsylvania are isolated, with different eligibility requirements resulting in either service overlap or gaps in services due to geographic service delivery areas, insurance coverage or the child's age. Due to the fragmented nature of responsibilities and funding stream requirements, the quality of care for a special needs child or youth can depend solely on where that child lives, the advocacy skills of the parents and available professional resources and supports.**

**The 2005/2006 NS-CSHCN identified ethnic disparities, such as:**

- 1. Overall 15% of families in PA reported that community-based service systems are not organized so families can use them easily as compared to 21% for other, non-Hispanics, and to 17% for multi-racial, non-Hispanics.**
- 2. Overall 54% of YSHCN in PA reported they did not receive the services necessary to make transitions to all aspects of adult life. This outcome was NOT achieved by 78% of Hispanics, 65% of Blacks, non-Hispanic, 71% with incomes under 0%-99% FPL, 73% for CSHCN with functional limitations, and 61% for CSHCN with above routine need for service.**

**To help provide additional resources to increase coordination of systems, services and programs serving CSHCN, , the Bureau of Family Health has applied for and was awarded the State Implementation Grant for Integrated Communities for CYSHCN as of June 1, 2008.**

#### **6. Reduce health risks for, and mortality of, infants and children.**

**The deaths of children account for less than five percent of all deaths in the United States. The national infant mortality rate has declined by 10 percent since 1995 however; the rate has not declined much since 2000. In Pennsylvania, the rate of infant deaths in 2005 was 7.2, in 2004 it was 7.1, in 2003 it was 7.3, in 2002 it was 7.6, in 2001 it was 7.2 and in 2000 it was 7.0 per 1,000 live births. Sudden Infant Death Syndrome (SIDS) is the leading cause of death for infants during the post neonatal period.**

**The Bureau of Family Health is committed to reducing health risks and mortality in infants and children. The SIDS prevention and awareness program seeks to educate parents and caregivers on risk reduction measures that can reduce the risk of SIDS, suffocation and strangulation in unsafe sleep environments. In April, 2008 over 200 attendees came together in Pittsburgh for the First Annual Cribs for Kids Conference, to discuss and learn from the experts the importance of a safe sleep environment for infants and the need for accurate and consistent classification and coding of sudden unexplained infant deaths. There has been an increase in infant deaths due to the lack of safe sleep education and safety approved cribs. The Bureau provides SIDS brochures to hospitals and parent education programs across the Commonwealth to promote safe sleep environments. Safe Sleep mini grants were also provided to community groups to spread the safe sleep message and provide portable cribs for infants in previous years.**

**7. Increase percent of pregnant women, including those at high risk, who receive early and adequate prenatal care.**

**Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care. Early and adequate prenatal care helps identify conditions in pregnant women that could have the potential to cause negative birth results. Behaviors such as smoking during pregnancy, drug and alcohol abuse, and inadequate nutrition during pregnancy are risk factors that can be detected and treated by appropriate obstetrical facilities across the state.**

**Pennsylvania supports many programs to improve access to prenatal and infant care, including Healthy Start, Medicaid, Children's Health Insurance Program (CHIP), as well as ten county and municipal Health Districts strategically located across the state that provide home visitation programs for potentially high risk pregnant women. Home visitation programs offer an effective mechanism to ensure ongoing prenatal education, social support, and linkage with public and private community services. Benefits from this program have resulted in increased birth weights among infants, fewer emergency department visits, and a decrease in maternal smoking and incidences of child abuse and neglect. Pennsylvania also supports public health campaigns to promote healthy habits among parents who are planning, expecting, or caring for a child by providing education and training services to promote healthier growth and development.**

**Increasing access to early and adequate prenatal care has a direct linkage to the Healthy People 2010 goal of reducing infant mortality. As Pennsylvania works toward Healthy People 2010, efforts will continue to promote health and disease prevention on a statewide level.**

**8. Expand the number of medical homes serving all children statewide**

**When children receive care through a medical home, their health outcomes improve. Through this model of coordinated care, a number of positive outcomes can be achieved such as a decrease in missed school days, decrease in emergency room and doctor visits and parents miss fewer work days. While Pennsylvania's Medical Home Program is growing, the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) indicated that 46% of the children in Pennsylvania had a medical home. However there was significant variation among subpopulations: this outcome was achieved by 23% of Hispanics, 32% of Blacks, non-Hispanic, 33% multi-racial, non-Hispanics, 25% with incomes under Federal Poverty Level (0%-99% FPL), and 42% of CSHCN ages 0-5 years old, 36% of CSHCN with functional limitations and 31% who need above routine use of services.**

**The program has trained 62 practices, 39 of which continue ongoing quality improvement activity. These practices represent 29 counties, urban, rural, suburban areas and multiple ethnic and racial groups within all six regions of Pennsylvania.**

**9. Reduce health disparities through the provision of culturally, cognitively and linguistically appropriate services.**

**Like many states, Pennsylvania continues to strive to reduce health disparities across diverse populations. However, disparities persist in several areas. Significant differences exist between blacks and whites in key areas related to perinatal outcomes including the likelihood of having received prenatal care and the incidence of low and very low birth weight babies. Additionally, there are noteworthy differences in infant, neonatal and post-neonatal death rates among whites, Blacks and Hispanics. Finally, Pennsylvania**

*continues to see significant differences in the teen birth rate of white teenagers versus black and Hispanic teenagers.*

*The Department continues to develop creative solutions aimed at serving minority and underserved populations in a culturally appropriate manner in the communities where they live. To this end, the Department has recently developed an Office of Health Equity which advises the Secretary on matters concerning health inequity and recommends actions which are data driven, evidence based and culturally aware. Additionally, the Bureau of Family Health is working closely with Grantees to evaluate the language in their grant agreements related to the elimination of health disparities. A staff member completing her Master's degree in Social Work will complete her field placement work by evaluating the county and municipal health departments' efficacy in addressing health disparities.*

#### **10. Increase state wide breastfeeding initiation and duration**

*Significant racial differences exist in Pennsylvania's breastfeeding initiation rates. African-Americans are Pennsylvania's largest minority group, comprising 15% of the state's births. In 2006, this group has the lowest initiation rate of 51%. Hispanics, comprising 8% of births has an initiation rate of 63%.*

*Despite scientific evidence and public health benefits, in 2006, only 65% of Pennsylvania's women choose to initiate breastfeeding (Pennsylvania Bureau of Health Statistics and Research, Birth Certificate). Individual county breastfeeding initiation rates ranged between 42 and 81 percent. Although rates have increased each year between 2003 (61%) and 2006, rates need further improvement to meet national breastfeeding initiation rate of 2003 (73%), 2004 (74%), and 2005 (77%).*

*In 2005, 37% of Pennsylvania's breastfed children were still breastfeeding at 6 months placing Pennsylvania 22nd in the nation. Only 14% were exclusively breastfed for 6 months. Some reasons for Pennsylvania's breastfeeding mothers stopping breastfeeding within four months are: return to work/school (30% CI:19-43), pain or problem with milk supply (36% CI:24-50) and mother's medical condition (6% CI:3-12) (Pennsylvania Bureau of Health Statistics and Research 2007 Behavioral Risk Factor Surveillance System).*

#### **11: Provide access to health and human services through implementation of a statewide 2-1-1**

*The Bureau of Family Health has long been a proponent 2-1-1, and of building infrastructure systems to make access to care and support services less burdensome for families. To that end, the Health and Human Services Call Center (HHSCC) was established in 2004. This pilot consolidation of helplines mirrored the effect of 2-1-1 services currently in place to some degree in 47 states. Over the first three years of Call Center operations, the intended expansion of resource availability became a reality. A call to one helpline makes the resources of seven other helplines available.*

*The Commonwealth team is dedicated to finding the best solution for achieving 2-1-1 services in Pennsylvania. The motivations and benefits include: cost savings for Commonwealth agencies through cost sharing and efficiencies of consolidation; eliminate duplication of toll-free telephone services; optimal use of Commonwealth personnel; collaboration with community providers of information and referral; and most importantly improved citizen access to services provided by the Commonwealth as well as the best array of services provided by community-based organizations. These have both been confusing, at best, to identify and efficiently access, resulting in lack of service delivery and citizen dissatisfaction.*

#### **12. Promote the healthy development of children through Newborn Screening and**

*improving early identification of heritable disorders and genetic susceptibilities.*

*Pennsylvania's Newborn Screening and Follow-up Program (NSFP) screens for 6 state-mandated genetic conditions. Early identification and treatment prevents serious health problems, mental retardation, and death.*

*On July 4, 2008, Governor Edward G. Rendell signed into law HB 883 that became Act 36. The new law provides that the Department, beginning in July 2009, add an additional 22 conditions for the follow up of rare genetic and metabolic diseases. Adding these 22 conditions for follow-up to the Department's existing six will bring the total for follow-up to 28.*

*The Department already carries out the provisions of Pennsylvania's Infant Hearing Education, Assessment, Reporting and Referral Act (IHEARR--Act 89 of 2001). Pennsylvania's newborn hearing screening rate for in-hospital births of 98% for 2006 was above the national average of 96%. Two-hundred-ninety infants born in 2006 were diagnosed with hearing loss as a result of early screening and follow-up.*

**13: Increase family participation in decision making, programming and statewide policy.**

*Family members have personal experience with accessing health care services to meet the everyday needs of their children. They have the ability to observe firsthand which programs and policies are useful and which can be burdensome. The input from families who have actual experience with these services is of utmost importance in order to provide community members with the best services in the most efficient manner possible. In addition, the results of our Title V Needs and Capacity Assessment of 2005, identified a need for more family involvement and participation.*

*The Bureau has been working with Family Voices and other states that have hired parents as staff. As a result, the Bureau is developing a job description so that a parent can be hired as part of our staff complement. This individual will be an advocate for those families with disabilities and will be responsible for the helping to develop future programming and/or policies.*

**14. Develop a comprehensive, cohesive statewide MCH policy**

*Given that one of the primary purposes of the Pennsylvania Maternal and Child Health Services Block grant is the improvement of the health of all mothers and children, there is a need to identify a mechanism for collaboration among state and local departments that share responsibility for children, mothers and families.*

*At the present time, there is limited coordination for sharing data, consensus on outcome measures, or shared vision. Each agency works to achieve that which is defined by its individual mission. Therefore, the Bureau of Family Health, as the Title V administering agency, will work with other state departments under the Governor's jurisdiction, as well as with the local health departments, and community agencies to develop a policy which will guide our efforts.//2009//*

## **B. Agency Capacity**

Promoting Health of Mothers and Children including CSHCN

***/2009/The Bureau of Family Health (BFH), through its Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO), Newborn Screening and Genetics (NSG), and Special Supplemental Nutrition Program for Women Infants and Children (WIC) exercises its capacity to promote and protect the health of all mothers and children, including children with special health care needs (CSHCN), through a variety of services.//2009//***

Health and Human Services Call Center (HHSCC)

Disseminating information statewide is an integral part of public education and linkage to health and human services in the Commonwealth. We provide resource and referral information about pregnancy, special health care needs, pediatric care, oral health, lead poisoning, head injury, newborn hearing screening, and newborn metabolic screening to callers via seven toll-free helplines answered by the HHSCC. The HHSCC consolidates lines (including all of the Title V funded lines) in the same physical location and serves 15 distinct program areas. The HHSCC was initiated in response to a historical annual volume of more than 198,000 calls from individuals requesting health and human services.

*/2007/ Prior to consolidation, because each Information and Referral (I&R) Specialist had access to referral resources for only one helpline, the call volume of 198,000 represented 198,000 helpline needs served. Since the HHSCC Certified I&R Specialists are cross trained, they can address caller needs using multiple helplines. Each assisted helpline need is referred to as an "event". In March 2006, the rate of calls and events together trended at 239,244 per year, which represents a 20 percent increase in helpline needs met, as compared to the pre-HHSCC annual volume of 198,000.//2007//*

*/2008/ In calendar year 2006, actual (not trended) calls and events increased by 12%.//2008//  
/2009/ In calendar year 2007, calls and events totaled 210,408, representing a 2% drop from the previous calendar year. An Auto Attendant system was introduced to filter out callers requesting application status for the Adult Basic and CHIP programs, which could have contributed to the drop in actual calls for 2007. Auto Attendant is an Interactive Voice Response (IVR) system that processes inbound phone calls, plays recorded messages and fulfills the caller's request without a transfer or routing calls to an in-house specialist.//2009//*

County and Municipal Health Departments

The Bureau of Family Health works very closely with 10 county/municipal health departments to ensure that CSHCN have access to services in these ten counties or municipalities, and that services for CSHCN are included in all community programs. These local health departments provide a variety of services through their professional staff and promote an array of Bureau programs. They identify priority needs for their cities/counties through an annual needs assessment. Local health departments are located in Allentown, Bethlehem, Wilkes-Barre, and York; county health departments consist of Allegheny, Bucks, Chester, Erie, Montgomery, and Philadelphia.

***/2009/ Pennsylvania ranks 19th in a report card on children's health care released by the Commonwealth Fund. The report card is based on factors such as access, cost and quality of health care available to children in each state. Pennsylvania's overall rank of 19th was based on its ranking in five categories. It ranked 17 in access, 10th in quality, 42nd in costs, 8th in equity and 37 in potential for a child to lead a healthy life. (Harrisburg Patriot-News, 5/27/08)***

***In 2006, the Bureau of Family Health continued to fund prenatal care through the Montgomery and Philadelphia County health programs. A total of 400 uninsurable pregnant women received services during this period, a decrease in 50% over the previous year. Language continues to be a major challenge in delivering services where more than***

***21 languages have been identified as being the primary languages of the patients accessing care at different health centers in Philadelphia. Health centers have installed language lines to address this need and prenatal providers are utilizing the health center interpreters where they are available to continue providing prenatal care to uninsurable pregnant women.//2009//***

#### PA Developmental Disabilities Council (PDDC)

Bureau of Family Health staff represent the Secretary of Health on the PDDC. The Council's mission is to encourage and support the creation of an environment in which all citizens of Pennsylvania can thrive without regard to disability. This council is mandated by the Administration on Disabilities, and is administered by the Department of Public Welfare. Five state agency Secretaries are represented on the Council: Aging, Education, Health, Public Welfare and Labor & Industry. The Council is composed of Agency staff, advocates and persons with disabilities. The Council engages in advocacy, systems change and capacity building for people with disabilities and their families in order to: Support people with disabilities in taking control of their own lives; Ensure access to goods, services and supports; Build inclusive communities; Pursue a cross-disability agenda; Change negative societal attitudes towards people with disabilities. The Council issues grants to community and advocacy organizations on a cyclical basis to support the mission stated above.

/2008//The Council's Executive Director is named by the Governor to the Cabinet on People with Disabilities.//2008//

#### Community Based Initiatives Targeting MCH Concerns

The BFH supports many community-based initiatives including three mini-grant programs that award up to \$3,000 per fiscal year to community-based organizations. The concept of providing mini-grants was an initiative that started with one small program in the fall of 2001. It turned out to be so successful that the concept was expanded to include two additional programs. The Building Inclusive Communities Mini-Grant Program supports costs related to innovative and interactive educational events about inclusion of CSHCN in their communities. The Barrier Elimination Project helps to remove environmental barriers to community inclusion. A third mini-grant program advances the initiation and long-term duration of breastfeeding. Annually, \$300,000 is available to support these mini-grant programs. The attached Table 4 (Building Inclusive Communities Mini-Grant Program Projects) displays several of the projects that have been initiated.

#### Multidisciplinary Clinics

The Bureau of Family Health coordinates multidisciplinary team clinics across the state to serve children and adults with special health care needs. The clinics provide professional expertise to a community-based provider network managing complex medical problems. Agreements are maintained with local medical and ancillary care providers to assure availability and accessibility to care other than in a tertiary center. The Commonwealth provides funds to support services for spina bifida, adult cystic fibrosis, Cooley's anemia, hemophilia and home services for children who are ventilator dependent. Outreach and communication between the multidisciplinary team staff and other health care providers, family members and school staff assures continuity of care and encourages comprehensive care management. One-stop multidisciplinary team clinic visits afford patients a full gamut of necessary services to manage complex medical conditions. Services include specialized physician and surgical care, nutrition, case management, laboratory, radiology, pharmacology, speech therapy, physical therapy, occupational therapy, orthotic care, dental care and health education.

#### EPIC-IC Medical Home Training Program

The EPIC-IC Medical Home Training Program addresses six core outcomes for measuring success for CSHCN. These outcomes specifically state that all CSHCN in Pennsylvania will receive ongoing comprehensive care within a medical home. The Program incorporates a unique Care Coordination component that links practice-based care coordinators. This linkage provides integrated care coordination services to children and youth with special health care needs and their families served by participating physician practices. Integrated care coordination includes the development and implementation of comprehensive care plans, completion of home assessments when necessary, obtaining physician signature and medical records, and accompanying families to sub-specialist visits and Individualized Education Plan meetings. Currently 27 physician practice sites involving 102 physicians, 19 nurse practitioners, 122 nurses and 36 family advisors are actively participating in the Program in 18 Pennsylvania Counties. These physician practice sites include urban, suburban, and rural locations throughout Pennsylvania, which provide ongoing comprehensive care in a medical home to 4,000 CSHCN and their families.

/2007/ In response to the Bureau priority to "Increase the availability of MCH program data," records of each patient encounter are now being collected. Medical Home Project staff are analyzing whether client outcome indicators such as: labs, x-rays, missed school days, specialty visits, emergency department visits and unplanned hospitalizations have been prevented as a result of having a medical home. A completed analysis of one year's worth of data is expected to be completed by December 2006.//2007//

/2008/ By the end of 2006, the EPIC-IC program trained a total of 34 pediatric practice staff an increase of seven practices since the inception of the program. The number of CYSHCN in the program increased from 4,000 to 8,000 clients.//2008//

***/2009/ As of February 2007, the data suggested that over 690 emergency department visits, 203 unplanned hospitalizations, 258 parent/guardian work days missed, 397 school days missed have been prevented as a result of implementation of core medical home principles at EPIC IC practices. In response to the President's Freedom Initiative, the Bureau of Family Health submitted a "State Implementation Grant for Integrated Services for Children and Youth with Special Health Care Needs" application for the project period of June 1, 2008 through May 31, 2011.//2009//***

#### Sickle Cell Disease (SCD) Program

The Bureau of Family Health administers a SCD Program, which has established agreements with six community-based organizations across the state. In 2002, 82 Pennsylvania infants were born with sickle cell anemia. The number of children with sickle cell anemia remains relatively stable; 83 infants were diagnosed with SCD in 2004. The six community based organizations, in collaboration with local medical providers, ensure that individuals with SCD have access to quality psychosocial support services within their communities designed to help maintain the highest possible quality of life. As advocates, these organizations assist clients in locating needed medical, social, transportation, vocational and other social services including health insurance.

/2007/ In 2005, there were 92 infants diagnosed with SCD. This represents an 11% increase in the number of newborns diagnosed since 2004. The Bureau's SCD Program received a \$200,000 increase in state funding for 06-07 to provide additional access and health care resources for diagnosed individuals and their families.//2007//

/2008/ In 2006, 104 infants were diagnosed with SCD, representing a 12% increase from 2005 statistics. The number of diagnosed infants has increased steadily since 2002 with more significant increases occurring from 2003 forward. Pennsylvania's African Americans and Asians/Middle Easterners populations have increased slightly over these years, while the Caucasian population has declined slightly. Both African Americans and Asians/Middle Easterners have a higher incidence of Hemoglobinopathies.//2008//

***/2009/ In 2007, 90 infants were identified through newborn screening that were diagnosed with SCD which represents a decrease of 12% from 2006. Three state-wide provider meetings were held to improve coordination and collaboration among internal and external stakeholders.//2009//***

## Collaboration with Other Pennsylvania State and Community-Based Agencies

The BFH actively collaborates with other State Agencies and private organizations, supports communities, and coordinates with the health components of community based systems. Collaboration with local agencies is accomplished at all levels by centralized Bureau program staff and regionally by MCH and SHCN consultant field staff and community health nurses located in State Health Centers in 57 counties. They also work with school health nurses to ensure access to services, to respond to community needs and to provide public health education and outreach.

The Bureau of Family Health developed the Pennsylvania Perinatal Partnership (PPP). The PPP includes representatives from the BFH, Pennsylvania's Healthy Start Program and local Title V funded health departments. The mission of the PPP is to improve perinatal health outcomes in Pennsylvania through collaboration, intervention, joint strategies and advocacy. Since its inception, the PPP has developed initiatives to raise awareness of perinatal depression and managed care needs for CSHCN.

The Lead Poisoning Prevention and Control Program (LPPCP) collaborates with other state agencies through various initiatives. Most recently, the LPPCP, through its Childhood Lead Poisoning Prevention Program, created a Lead Elimination Workgroup. The Workgroup, comprised of approximately 30-40 individuals representing healthcare organizations, physicians, property owner associations, tenant associations, attorneys, and City and State government. Over the course of a few months, the Workgroup developed a plan that eliminates childhood lead poisoning by 2010 by focusing on surveillance, housing, outreach, and case management. The Plan was submitted to the Centers for Disease Control and Prevention in 2004; a comprehensive strategic plan with specific tasks and objectives for implementation is proposed for 2005.

Other initiatives include a collaborative data match project with the Department of Public Welfare designed to share lead data and assist each agency with lead surveillance. In addition, the Bureau's Lead Hazard Control Program (LHCP) developed a Partnership Group, which includes participants from the Departments of Community and Economic Development, Environmental Protection, Labor and Industry, and Public Welfare whose focus is to bring stakeholders together to maximize Pennsylvania's resources.

Staff responsible for the Newborn Disease Prevention and Identification (NDPI) screening program regularly collaborate with the March of Dimes (MOD) and Hospital Association of Pennsylvania (HAP) to support hospitals in providing follow-up services to newborns. Together, the NDPI and the MOD conducted a Stakeholders Meeting in December of 2004 attended by representatives from the HAP, physicians, geneticists, hospital newborn screening laboratories and other community health professionals for the purpose of evaluating the expansion of newborn screening in Pennsylvania.

***//2009/ The Newborn Screening and Follow-up Program staff collaborate with the March of Dimes (MOD), the Hospital Association of Pennsylvania (HAP), metabolic treatment centers, technical advisory board members and other health care stakeholders to support expanded newborn screening in Pennsylvania and to improve the quality of follow-up services and therapeutic interventions provided to newborns, children and pregnant women with metabolic disorders.//2009//***

## Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The BFH operates many programs aimed at promoting preventative and primary care services for pregnant women, mothers and infants. The Genetics Program collaborates with four Family Health Councils and six hospitals throughout Pennsylvania to provide pre-conceptional health screenings and/or genetic counseling services designed to provide individuals and families information about the occurrence, or risk of recurrence, of a genetic condition or birth anomaly. In the most recent reporting year, 3,054 eligible at risk clients were screened.

/2008/ Three bills were introduced by the Pennsylvania Legislature in 2007 to amend the Newborn Child Testing Act of 1965. House Bill 950 proposes to add the screening of retinoblastoma to the 6 existing mandated screening tests; House Bill 883 and Senate Bill 847 each propose to expand the number of screening conditions subject to reporting and follow-up from 6 to 28. No bill become law during the 2007 Legislative session. However, House Bill 883 was passed by the House on July 3, 2007 and was referred to the Senate Public Health and Welfare Committee on July 8, 2007.//2008//

***/2009/ The Pennsylvania Breastfeeding Awareness and Support Program was created in Fall 2004 because increases in breastfeeding initiation, duration and exclusivity rates result in decreases in child morbidity and mortality. In July 2007, Pennsylvania passed its first breastfeeding legislation: Act 28 -- Pennsylvania's Freedom to Breastfeed Act, permitting a mother to nurse her child in public.***

***The Bureau's "Love'em with a Check-Up" outreach initiative encourages women to receive early prenatal care, thus serving a preventive function. Related mass media messages feature a woman early in her pregnancy and showcase the Healthy Baby Helpline phone number 1-800-986-BABY as a point of contact for additional information and a place to receive help "as soon as a women thinks she may be pregnant."***

***/2009/ In 2007, a monthly average of 2,500 users accessed the "Love'em with a Check-Up" webpage, an outreach initiative that encourages women to receive early prenatal care. In 2007, 1,057 women contacted the Healthy Baby helpline because of the "Stork" commercial, a related media message featuring a woman early in her pregnancy and showcasing the Healthy Baby Helpline phone number 1-800-986-BABY as a point of contact for additional information and a place to receive help as soon as a woman thinks she may be pregnant.//2009//***

The Healthy Baby Helpline provides pregnant women with access to prenatal care providers as well as health care coverage options. Callers are screened for eligibility for the Medicaid program and given a presumptive eligibility provider name and contact information in order to receive care as soon as possible. Women are also offered information on the WIC Program as well as other Department programs for pregnant women. Brochures on immunization and newborn screening are distributed to callers along with the Guide to a Healthy Pregnancy booklet that features information on pregnancy, labor and delivery, nutrition for mom and baby, breastfeeding, newborn screening and a variety of other topics of interest to pregnant women. Medicaid applications can be mailed as requested or Specialists can complete the application via the web during the call. Follow-up calls are placed to women, upon their agreement, to determine satisfaction with the services provided by the helpline and to provide additional referrals if necessary. /2007/ Women in the Commonwealth did well in several areas of the 2004 Women's Health and Mortality Chartbook. Pennsylvania is among the top states for the number of women with health insurance coverage, with low death rates from chronic lower respiratory disease, low death rates from influenza and pneumonia, and for the number of women who receive a mammogram. On the other hand, Pennsylvania in comparison to other states, ranked as having some of the highest rates of death among females due to breast and colorectal cancer. Pennsylvania also ranks among the highest for the number of women who smoke, which significantly increases the risk of dying from cancer and other diseases. Pennsylvania women in comparison to other states ranked 45th (28.5%) for breast cancer deaths and 43rd (24.4%) for smoking. (Brett KM, Hayes SG. Women's Health and Mortality Chartbook. Washington, DC: DHHS Office on Women's Health. 2004)//2007//

/2008/ The first step in applying for prenatal care under the Medical Assistance program is medically verifying the pregnancy. One of the most frequent referrals provided on the Healthy Baby Helpline is for free or low cost pregnancy testing. In 2006, 866 callers contacted the Health Baby line for referrals to a clinic or provider offering free or low/cost pregnancy testing. The helpline assisted 1,466 pregnant women with referrals to prenatal coverage and providers that accept Medical Assistance.//2008//

***/2009/ In 2007, 852 callers contacted the Healthy Baby helpline for free or low cost***

***pregnancy testing and 1,155 callers were provided referrals to prenatal providers that accept Medical Assistance (MA).//2009//***

The Bureau of Family Health funds Montgomery and Philadelphia county health departments to provide prenatal care to 520 undocumented residents annually. The program model follows the guidelines identified in the Healthy Beginnings Plus prenatal care program implemented by the Department of Public Welfare, Office of Medical Assistance Programs. A significant number of providers are not equipped to deliver services to this population due to cultural and language barriers. The Prenatal Service Program provides \$800 per person at three participating hospitals and a regional health center to deliver prenatal care to these undocumented Hispanic pregnant women. In 2004, allocated funds in the amount of \$136,000 ensured prenatal services for 170 women in Norristown, Montgomery County. Without this funding source, the clinics either provide care without any compensation or women receive little or no prenatal care at all.

/2007/ In 2005, the Bureau of Family Health continued to fund prenatal care through the Montgomery and Philadelphia County programs. A total of 558 women received services during this period. Additional funding is planned for 2006.//2007//

/2008/ In 2006, the Bureau of Family Health continued to fund prenatal care through the Montgomery and Philadelphia County programs. A total of 800 uninsurable pregnant women received services during this period, an increase of 43% over the pervious year. Additional funds have been added to this initiative for 2007.//2008//

The Bureau seeks to reduce the incidence of Sudden Infant Death Syndrome (SIDS) and to minimize the devastating impact of sudden infant deaths on affected families through the SIDS Program. Maternal and Child Health (MCH) Consultants located within each of the six Department of Health District Offices provide SIDS services at the local level. These services include information and counseling to families who experience a sudden infant death as well as provide education and consultation to health care professionals to encourage timely, helpful, and coordinated responses to families following a death. The MCH Consultants in each District also educate the public about SIDS through educational presentations and the distribution of brochures and other materials from the national "Back to Sleep" campaign. Since the start of the campaign, the SIDS rate for African Americans has declined dramatically, as it has for the total population

/2007/ The number of SIDS deaths in Pennsylvania has declined from 109 in 1999 to 74 in 2003 and increased to 81 in 2004 (Source: PA Department of Health Bureau of Health Statistics and Research). This is a 9% increase in the incidence of SIDS from 2003 to 2004. The Bureau will be working with the newly created Office of Health Equity to develop strategies for addressing the health disparities. The PA AAP Early Childhood Education Linkage System (ECLS) provides technical assistance and training on SIDS prevention to child care sites where the rate of SIDS deaths are higher than expected.//2007//

/2008/ In 2004, 81 infant deaths were due to SIDS and in 2005, there were 59 infant deaths due to SIDS (Source: PA Department of Health Bureau of Health Statistics and Research). This represents a 27% decline in infant deaths due to SIDS. The Bureau of Family Health will be distributing newly created DOH SIDS brochures to hospitals and continue working with Office of Health Equity to develop strategies for addressing the health disparities.//2008//

***/2009/ In 2006, 54 infant deaths were due to SIDS. (Source: PA Department of Health Bureau of Health Statistics and Research). The Bureau will continue to distribute brochures on SIDS as an education and prevention tool to maternity and birthing hospitals statewide. Safe Kids affiliates will receive safe sleep mini-grants and partner with the Maternity Care Coalition and SIDS of PA to provide safe sleep education and portable cribs to eligible families. The Bureau will continue to participate in the Co-sleeping Workgroup with DPW Office of Children Youth and Families to develop policy on co-sleeping.//2009//***

WIC provides targeted nutrition and breastfeeding education, food, and referral services in all of Pennsylvania's 67 counties for pregnant, breastfeeding and non-breastfeeding postpartum women. Infants are certified for a one-year period, and can continue to receive program benefits

until they turn five years old. Pennsylvania contracts with 24 county and private non-profit agencies to deliver WIC services at the local level at over 356 sites. WIC received over \$140 million in funding to administer the Program to provide food benefits in fiscal year 2005. In addition, WIC received an estimated \$61 million in rebate funds for infant formula, infant cereal, and infant juice. More than one third of total WIC caseloads are paid for by rebate funds. The Program provides benefits to over 245,000 women, infants, and children each month.

/2008/ There are currently 330 WIC clinic sites throughout the Commonwealth. Funding has remained relatively unchanged with WIC receiving over \$141 million in fiscal year 2006, with an additional \$62 million in rebates from infant formulas, juices and cereals. The average monthly caseload was 242,000.//2008//

**/2009/ There were 326 WIC clinic sites throughout the Commonwealth in 2007. Funding for federal fiscal year 2007 was approximately \$154 million, with an additional \$66 million in rebates from infant formulas, juices and cereals. The average monthly caseload was 244,156.//2009//**

The Newborn Screening Program provides grant funds to four hospitals to provide confirmatory testing and follow-up services to newborns, and has two contracts with newborn screening laboratories to test all Pennsylvania newborns for six state-mandated metabolic or endocrine disorders. The Program also provides metabolic formula to PKU clients under the age of 21 and pregnant women to prevent adverse effects of the disease. /2007/ Services are now provided until a client reaches age 22.//2007//

**/2009/The current grants with the four metabolic treatment centers (centers) expire on July 1, 2008. To prepare for new grants, the NSFP staff met with all of the centers in 2007 to discuss and obtain feedback regarding new grant deliverables and funding. Upon receiving the feedback from the centers, the NSFP is developing grants that build capacity to: 1) improve the health infrastructure and systems of care; 2) reduce health barriers and disparities; and 3) build evaluation tools and promote health and follow-up services to assure quality of care.//2009//**

The STD Program provides funding through the Infertility Prevention Project from the Centers for Disease Control and Prevention (CDC) for chlamydia screening, treating, and counseling uninsured young women in Family Planning clinics. This population is at increased risk of chlamydia due to risky behaviors and inconsistent use of condoms. Young women are physically more prone to having a chlamydia infection than older women due to the number of columnar epithelial cells on the cervical surface. In Pennsylvania's Family Planning clinics in 2004 there was a 5.6 percent positivity rate of chlamydia in people 17 and younger (9.5 percent for males and 5.5 percent for females). There were approximately 18,000 young people 17 and under screened for chlamydia in Family Planning clinics in Pennsylvania in 2004.

/2007/ In 2005, there was a 4.9% positivity rate of chlamydia in people 17 and younger (8.2% for males and 4.8% for females). There were approximately 16,000 young people 17 and under screened for chlamydia in Family Planning clinics in Pennsylvania in 2005.//2007//

/2008/ In 2006, there was a 6.3% positivity rate of chlamydia in people 17 and younger (8.8% for males and 4.8% for females). The 6.3% positivity rate represents a 1.4% increase from 2005. There were approximately, 17,000 young people 17 and under screened for chlamydia in Family Planning Clinics in Pennsylvania in 2006.//2008//

**/2009/In 2007, there was a 4.0% positivity rate of chlamydia in people 17 and younger (10.5% for males and 3.7% for females). The 4.0% positivity rate represents a 2.3% decrease from 2006. There were approximately, 26,000 young people 17 and under screened for chlamydia in Family Planning Clinics in Pennsylvania in 2007. This is an increase of 9,000 or a 53% increase in people 17 and under being screened than the previous year.//2009//**

Preventive and Primary Care Services for Children

The Bureau of Family Health recommends preventive care for children through the Pennsylvania Child Death Review (CDR) Program. The mission of the Program is to promote the safety and well being of children and to reduce preventable child fatalities. This is accomplished through timely, systematic, multi-disciplinary and multi-agency reviews of child deaths. Information from these reviews is used to develop inter-disciplinary training, community-based prevention education and data-driven recommendations for legislation and public policy. The State CDR Team was formally convened in November 1994. As of August 2004, 58 local teams representing 60 counties were operational. The local teams review all child deaths under the age of 20 years. /2007/

The Epilepsy Foundation of Western Pennsylvania partnered with Penn State University targeting African American and Hispanic outreach efforts and the University of Pittsburgh targeting African American outreach efforts. Focus groups, literature reviews and a pre-tool assessment of knowledge about Epilepsy were conducted. As a result, more direct partnerships were developed to provide Epilepsy education to those communities. A direct link with the Erie Hispanic Association resulted in two training sessions on Seizure Disorder, conducted in English and in Spanish, for the staff of the Hispanic American Council, including case managers and daycare staff and the second training for the Council's clients and families.//2007  
***/2009/ In the Spring of 2007, an in-depth and bi-lingual epilepsy training program was conducted for case-managers from the International Institute of Erie and the Hispanic-American Council of Erie. New print materials in Spanish have been developed. Together these efforts have resulted in additional Hispanic clients seeking assistance from the Foundation.//2009//***

The Healthy Kids Helpline provides families with access to primary care providers as well as health care coverage options. Callers are screened for eligibility for the Medicaid Program and Children's Health Insurance Program (CHIP). Based upon initial eligibility screening, the helpline mails Medicaid or CHIP applications to families. Additionally, Specialists offer to complete the application via the web during the call. Referrals to primary care providers are also given to callers.

The four Family Health Councils previously described provides comprehensive family planning services directed toward sexually active patients 17 years of age and younger. These services include routine gynecological care, pregnancy testing, contraception, Pap smear screening, sexually transmitted disease identification and treatment as well as education, counseling, and general health screening. These Councils served 17,939 young people in state fiscal year 2004. /2007/ The four Family Health Councils served 18,228 young people in calendar year 2005. This is a 1.61% increase in the numbers served from 2004 to 2005.//2007//  
***/2009/ The four Family Health Councils served 19,174 young people in calendar year 2007. This is a 5.19% increase in the numbers served from 2005 to 2007. //2009//***

Preventive care is provided to children through the medical providers participating in the Sickle Cell Disease Program. These providers offer comprehensive health care services that include complete physical exams, medical history, assessments, preventative medical therapies such as penicillin and folic acid, referrals to medical specialists and age appropriate health care including immunizations and patient education.

#### Rehabilitative Services for Blind and Disabled Individuals

The Department of Labor and Industry, provides blind and visual services for children throughout the Commonwealth via professional staff in District Offices located in Altoona, Erie, Philadelphia, Harrisburg, Pittsburgh, and Wilkes-Barre City. Services include: counseling; advocacy for educational services; transition services; guidance and counseling for children and their families; community orientation and mobility instruction; children's summer programs; rehabilitation teaching; adaptive equipment; and, low vision services. Financial and visual eligibility is

established before goods and services are purchased for the child.

#### Family-Centered, Community Based, Coordinated Care to CSHCN

The Bureau supports statewide outreach and education activities for two important special needs conditions: Epilepsy and Tourette syndrome. Two grantees provide comprehensive support and education services for individuals diagnosed with a seizure disorder and their affected loved ones. The Pennsylvania Tourette Syndrome Association provides similar services to family members with children diagnosed with Tourette syndrome. All three organizations play an important role in assisting families by attending meetings between families and schools in the development of their child's Individualized Education Plan (IEP) and assisting families in navigating the service delivery system.

The Special Kids Network supports a network of six Regional Offices that provide Community Systems Development (CSD) activities and technical assistance to local community-based organizations and families for the creation or enhancement of services for children with special health care needs. The staff performs on-going needs assessment within communities to prioritize their work. Once a need is identified, the CSD Director brings the appropriate players to the table, places the appropriate resources and tools in the hands of a community coalition to create change, and facilitates the process with the community being the recipient and eventual owner of the program. Once underway, leadership of a CSD initiative is handed off to a recognized community coalition member.

/2007/ A single contractor has been selected to manage the work encompassed by the previous 7 providers. This centralized model will provide expansion of the work accomplished. The new contract is targeted to begin September 1, 2006.//2007//

/2008/ The Special Kids Network expanded community-based services in December 2006 through a new three-year contract for a System of Care. The contract supports six regional Coordinators working within their local communities to provide community systems development, outreach, and focused resource mapping services to ten communities. In addition, a new service coordination component supports ten Elks Nurses who provide direct service coordination for children and youth with special health care needs and their families.//2008//

***/2009/Based on one of the 4 components of the System of Care (SOC) contract, service coordination, the contractor has subcontracted with a statewide agency, the Elks Home Service Program. These nurses are required to maintain a roster of at least 60 clients at all times. For calendar year 07-08, the Elks Nurses exceeded that contractual mandate by 47%. Another function of the contract has been the development of a communication tool for use by parents and providers, a web portal to be used as a clearinghouse for community/resources information. It is currently in the testing phase prior to going live for public access. Two new outreach materials, a rack card and a flyer have been developed to describe and promote SOC activities. Both have developed in part with the assistance of staff from the contractor and Media, Outreach and Promotion from the Bureau.//2009//***

#### Culturally Competent Maternal Child Health Care.

The provision of appropriate information and educational messages and materials are important components in culturally competent systems of care. The Bureau has special staff located in the Media Outreach and Promotion Section who review all print materials, advertising and outreach efforts to assure message effectiveness and cultural sensitivity.

Health and Human Services Call Center (HHSCC) staff regularly attends Hispanic community events where information is communicated to attendees concerning the availability of HHSCC services. Materials about the helplines, health care coverage applications, and general health information are printed in English and Spanish and are distributed at these events. Calls received at the HHSCC can be taken live in English, Spanish, and Russian. The AT&T Language Line

provides translation services for over 100 additional languages.

/2007/ Sensitive to the need for cultural and linguistic competencies in providing access to services, the HHSCC contractor has added staff fluent in Spanish, French Creole and German.

/2008/ During calendar year 2006, the call center helped 2,025 Spanish speaking callers and 41 Russian speaking callers.

***/2009/ The SKN/SOC has developed a plan and strategy to assure all services and outreach materials are provided in a culturally competent manner. Strategies include: identify and implement policies and practices that promote cultural competency; assure that all materials are developed at an appropriate literacy level; identify funding sources or in-kind services to support the development of materials in other languages; assure that the Regional Action Forum are promoted to the public through local media; educate all staff about the need to provide culturally competent services; assure that web portal information is accessible in multiple formats; and assure that all projects are developed in relation to the cultural diversity of the population being served. //2009//***

### **C. Organizational Structure**

Edward G. Rendell was inaugurated as the Commonwealth of Pennsylvania's 45th Governor on January 21, 2003. The Governor serves as Chief Executive of the nation's 6th most populous state, and oversees a \$24 billion budget. The Governor's Cabinet is comprised of senior staff, Agency Heads and Deputy Secretaries. Each Secretary is responsible for the oversight of his or her agency. An equally important responsibility of all Cabinet members is advising the Governor on subjects related to their respective agencies.

***/2009/ In 2007 Edward G. Rendell was elected to another four year term. Please see attached file for Department of Health Organization Chart//2009//***

Governor Rendell appointed Calvin B. Johnson, M.D., M.P.H., as Secretary of the Pennsylvania Department of Health April 2003. In this role, Dr. Johnson serves as the primary public health advocate and spokesman for Pennsylvania. He is the senior adviser to Governor Rendell on health matters, identifying priorities and outlining objectives to achieving these goals. Dr. Johnson sets overall policy and direction, defines the Department's mission, and establishes strategic goals and outlines specific objectives. He prepares annual budgets for submission to the Governor, identifying priorities and accountability in fiscal matters. He also proposes initiatives to further the Pennsylvania Department of Health (DOH) objectives and represents DOH and the Administration before other State Agencies, the legislature, professional organizations, the health industry, community and stakeholder groups, consumers, and the general public.

***/2009/ Calvin B. Johnson was re-appointed to another four year term in 2007. On September 9, 2008, Dr. Johnson announced his resignation //2009//***

The DOH's goal is to achieve optimal health outcomes for all Pennsylvanians. The Department's total budget for 2004-2005 was \$865,644,000, and the proposed 2005-2006 budget is \$816,894,000 (Pennsylvania Department of Health, 2005).

/2007/ The Department's total budget for 2005-2006 was \$851,799,000 and the proposed 2006-2007 budget is \$824,373,000. The proposed budget represents a 3.2 percent decrease in funding to existing services. (Pennsylvania Department of Health, 2006)//2007//

The mission of the Pennsylvania DOH is to 1) promote healthy lifestyles, 2) prevent injury and disease, 3) ensure the safe delivery of quality health care services for all Pennsylvanians and 4) eliminate health disparities. This mission is reflected in the Department's core functions identified as assessing health needs, developing resources, ensuring access to health care, promoting health and disease prevention, ensuring quality, and providing leadership in the area of health planning and policy development. The core functions of the DOH are carried out by the Offices of 1) Health Planning and Assessment, 2) Quality Assurance, 3) Health Promotion and Disease

Prevention, and 4) Administration. Bureaus housed within these Offices that play a significant role in program administration and service delivery to the maternal and child population are highlighted under its corresponding Office.

***/2009/******During his tenure, Dr. Johnson led the Department of Health in successfully addressing significant, public health issues, which include:***

- Managing the largest single-source Hepatitis A outbreak in U.S. history in 2003, which garnered the department national recognition.***
- Responding to Governor Rendell's call to improve the quality of life for all Pennsylvanians by creating the Office of Health Equity, which takes a coordinated approach to eliminating health disparities through continued collaboration with community-based organizations, other state agencies and the public.***
- Implementing several pieces of Governor Rendell's health care reform initiative, including decreasing the rate of health care-associated infections that have been shown to significantly increase both hospital in-patient stays and related costs.***
- Promoting and championing the need to protect Pennsylvanians from the deadly health effects of secondhand smoke culminating in the enactment of the Clean Indoor Air Act, which prohibits smoking in most public places.***
- Creating an innovative and comprehensive intervention and surveillance initiative, entitled Pennsylvania Injury Reporting and Intervention System, to address gun violence.***
- Using \$505 million in Tobacco Master Settlement Agreement funds to focus on biomedical and clinical investigations and health services research.//2009//***

Many of Pennsylvania's public health personnel are concentrated in the 10 municipal and county health departments. In Pennsylvania, 1,209 public health workers are employed by the State, another 2,214 are employed by county and municipal health departments, and an additional 1,042 are employed by private agencies. In relation to its population, Pennsylvania has the lowest number of public health personnel of any State, with only 38 professionals per 100,000 residents, which is significantly lower than the national average of 138 professionals. The most significant shortages are public health nurses, who account for about 15 percent of the public health work force.

The Department of Health oversees health services administered to residents of Pennsylvania's 67 counties through a system of 6 community health districts, 57 State health centers, and 10 county and municipal health departments through its Bureau of Community Health Systems, represented in the MCH needs analysis. The six community health districts have the following geographic designations: Northwest, Northcentral, Northeast, Southwest, Southcentral, and Southeast.

The DOH Office of Health Promotion and Disease Prevention is responsible for developing and implementing a wide variety of educational, preventative, and treatment programs across all ages in the areas of communicable diseases; family health, including infant nutrition programs; cancer; HIV/AIDS; and tobacco, drug, and alcohol abuse. The Bureau of Family Health (BFH), which is responsible for administration of Title V programs, is one of five Bureaus housed within this Office.

***/2009/******The Bureau was temporarily transitioned to the DOH Office of Administration and was transitioned back to the Office of Health Promotion and Disease Prevention on July 1, 2008.//2009//***

The BFH is the State Title V Agency and oversees the MCH Title V Block Grant as well as other initiatives focused on maternal, child and family health. The mission of the BFH is to improve the health of pregnant women, infants, children, and children/youth with special health care needs. To support this mission, the BFH developed the following policy and program guidelines:

1. Services are planned in response to a community needs assessment, including opportunity for public input and client participation, and are provided in the least restrictive environments;
2. Services are community based, family centered, culturally sensitive, and responsive; and,
3. Service quality is maintained and improved by setting measurable goals, objectives, and action steps consistent with best practices, the definition of realistic time frames, the assignment of staff responsibility, and timely modification.

The BFH is comprised of the following five Divisions:

1. The Division of WIC administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which is designed to improve the nutrition of pregnant and breastfeeding women, infants, and children under age 5 who are identified as at nutritional risk. Participants receive vouchers for healthy foods as well as nutrition education, breastfeeding support, and referrals to other needed services. The WIC Program has over 350 clinics statewide that are strategically located to provide the greatest reach to its eligible population in all of Pennsylvania's 67 counties. Each of the 24 local agencies is mandated to designate one staff person to serve as its Breastfeeding Coordinator, who coordinates the breastfeeding promotion and support activities for all staff within the agency. The State Agency provides extensive technical training on breastfeeding counseling and education to all WIC employees annually. /2007/ The WIC Program has 346 clinics statewide.//2007// //2008/ The number of PA WIC clinics decreased from 346 during the previous year to 330 clinics statewide during 2006.//2008// **/2009/ The number of PA WIC clinics decreased from 330 clinics statewide in 2006 to 326 during 2007.//2009//**

In addition, the state WIC agency has a Breastfeeding Coordinator that reviews all annual local agency Breastfeeding Plans, is responsible for policy development and guidance, provides training and technical assistance to local agencies, and monitors and evaluate breastfeeding initiatives across the state. The state WIC Breastfeeding Coordinator partners with the Bureau of Family Health's Lactation Consultant to insure that each program works collaboratively, minimizing duplication of effort, and maximizes program resources. The Breastfeeding initiation rate among African American women was 29% compared to 41% of all racial/ethnic groups enrolled in WIC in 2004. **/2009/ Breastfeeding initiation rates increased in 2006 to 42.6% of the WIC population. The initiation rate also rose among the black population to 32.5% according to data from the CDC Pediatric Nutrition Surveillance System.//2009//**

2. The Division of Child and Adult Health Services is responsible for Title V program planning and development. Specifically, the Division is responsible for ensuring the availability and adequacy of services for pregnant women and teens, including prenatal care, and for direct medical services for children with special health care needs. The Division is responsible for the development of new program services as needed and identified through needs assessment and based on direction from the Governor's Office. Data analysis is critical in the program planning and development phase and also in reviewing performance of programs.

3. The Division of Community Systems Development and Outreach oversees the operation of all Department of Health helplines that are currently part of the Health and Human Services Call Center. Division staffs work closely with the other Commonwealth Agencies that are part of this multi-agency contract for information and referral services and serve as project management experts for the programs that the helplines support. The Division operates a Media Outreach and Promotion Section (MOP), which develops many different types of marketing strategies to

promote and raise the awareness of services that the Bureau offers. MOP has developed radio and television advertisements and print materials, including a coupon that was displayed in retail stores featuring a helpline number. This Section also administers two programs whose charge is to educate and support those that have been diagnosed with Tourette syndrome and Epilepsy. The newest program, currently under development, is the Breastfeeding Initiative that in coordination with our Division of Women, Infants, and Children, will seek to educate and support new mothers in their attempt to breastfeed their children.

/2007/ Since July 2005, The Division has begun to manage the Department's Environmental Protection Agency Lead Grant Program. In previous years, this grant was managed by the Division of Child and Adult Health Services. This grant includes funds for the Lead Information Line (LIL). Geographic areas and neighborhoods identified as having a number of homes that were built prior to 1978 were focal areas for distribution. Many of these areas are in low-income neighborhoods with high minority populations and an increased potential for greater health disparities. In addition, attendance and presentations at health fairs (42 events), conferences and trainings occurred.//2008//

**/2009/ In calendar year 2007, outreach was continued to the target groups through print materials (72,116 pieces) attendance and presentations at health fairs, conferences and trainings (17 events).**

**The Community Systems Development and Outreach Section trained 69 persons at the Lead Abatement Training Center in Danville, Pennsylvania during calendar year 2007. The training contract starting date was August 2007, and the above number reflects persons trained between August 1, 2007 and December 31, 2007.//2009//**

/2008/ In December 2006, the SKN expanded its scope of service to a System of Care (SoC) concept. A new contract was established with the Central Susquehanna Intermediate Unit's Center for Schools and Communities (CSC) for the management of SoC services. These community-based services include Community Systems Development (CSD), Resource Mapping (RM), Service Coordination (SC), and Outreach. SoC services provide an environment of mutual support and interaction with the Department's Division of Community Systems Development and Outreach, and the Department's District Offices. System of Care work is done in cooperation with the Department and its related contractors and partners, including, but not limited to, the following: the multi-agency Health and Human Services Call Center (HHSCC); the Medical Home Initiative; the Department's various programs serving similar populations, and future programs such as the anticipated 211 statewide service.

In 2006, the Bureau was awarded a grant to manage a new Abstinence Education Program with funds from the federal Administration on Children, Youth and Families. The Division of Community Systems Development and Outreach was asked to manage this new program. Efforts to disburse the funds through the Department's Request for Application process are underway.//2008//

**/2009/ The Division of Community Systems Development and Outreach completed a Request for Application Process by May 2007 and was about to start the grant award process when it became clear that the Title V Abstinence Education Program would not be re-authorized by the US Congress by June 30, 2007. Because Pennsylvania would not have these FFY 2006 funds obligated as of that date, Pennsylvania's Title V Abstinence Education Program was terminated. Pennsylvania did not apply for FFY2007 Title V Abstinence Education funds.//2009//**

4. Division of Newborn Screening & Genetics is responsible for protecting the lives of the approximate 144,000 newborns born each year in Pennsylvania through its newborn screening and follow-up program and newborn hearing-screening program. The Division is also responsible for a genetics services program, birth defects outreach pilot project, and numerous contracts with hospitals and community providers. Division staffs provide technical assistance to birthing hospitals, physicians, midwives and county/municipal health departments.

***/2009/ The Division now screens for an increased newborn population of more than 148,510. The Maternal Child Health - Epidemiology Program recognized the hearing screening program and invited the Department to present at its annual meeting in December, 2007. With a reorganization, this Division is now additionally responsible for direct medical services for children with special health care needs, including sickle cell disease, formerly managed by the Division of Child and Adult Health Services.//2009//***

5. The Division of Bureau Operations is a non-programmatic Division charged with managing all aspects of Bureau operations and administrative functions. This includes budgeting, contracting, procurement, information technology, equipment, human resources and the Bureau's implementation efforts related to HIPPA A requirements and the privacy of patient information. This Division also administers the MCH Title V Block Grant on behalf of the Bureau. This includes coordination the annual MCH Needs Assessment and composition and submission of the Annual Block Grant Report/Application.

***An attachment is included in this section.***

#### **D. Other MCH Capacity**

Bureau of Family Health -Director: Melita Jordan, C.N.M., M.S.N., APRN C, Ms. Jordan has served in her current capacity as Director of the Bureau of Family Health since September 2004. Ms. Jordan has more than two decades of experience in the field of maternal child health. Previously she served as Director of Women's Services and Director of Nurse-Midwifery Services at Mercy Hospital of Philadelphia. From 1988 to 1990, she served as Chair of the Mayor's Commission for Women's Health Task Force for the City of Philadelphia. Ms. Jordan graduated from Seton Hall University with a B.S. in Nursing and received her Master of Nursing Science from the University of Medicine and Dentistry of New Jersey. ***/2009/ Ms. Jordan serves as an Adjunct Faculty member at Drexel University School of Public Health Doctorial and Executive MPH Program.***

***/2009/ Angelina K. Riley, Central P, E, as Executive Policy Specialist was reassigned within DOH's Policy Office.***

***Bureau of Family Health -Director of the Division of Bureau Operations: Wayne Fleming***

***Wayne Fleming was Acting Division Director of the Division of Bureau Operations from August 24, 2007 to July 4, 2008. Prior to becoming acting Director of the Division of Bureau Operations, Wayne, for the past two years been employed by the Pennsylvania Department of Health, Bureau of Family Health as the Title V MCH Block Grant Coordinator. Mr. Fleming earned his undergraduate degree from Lincoln University and later received a Masters of Public Administration, healthcare administration concentration, from the Pennsylvania State University. While attending Penn State he was selected as a graduate assistant and participated in a Robert Wood Johnson Health Policy Fellowship sponsored study. Mr. Fleming began his career with the Commonwealth in 2003, as a Policy Analyst and later as an Information Technologist with the Pennsylvania Insurance Department's, Children's Health Insurance Program (CHIP). He has held health services positions working for a major local health insurer as well as for a pharmacy benefit management company.//2009//***

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

Terry Hertzler, Central, DA as Data Manager Jenny Smeltz, Central, P, DA as Fiscal Manager  
Henrietta Smith, Central, P, DA as Contracts Manager  
***/2007/ Wayne Fleming, Central, P, DA as Quality Assurance Manager & MCH Block Grant Coordinator Donna Green, Central, P, DA as Budget Analyst Henrietta Smith is no longer with the Bureau//2007//***

/2008/ Division of Program Support and Coordination is now know as Division of Bureau Operations.//2008//

**/2009/ Jenny Smeltz has left the Bureau of Family Health. Terry Hertzler has retired from the Commonwealth.//2009//**

Bureau of Family Health -Director of the Division of Child and Adult Health Services: Carolyn Cass

Ms. Cass has worked in the field of public health for the past eight years. Prior to that, she worked in the field of behavioral health for over 15 years, primarily providing drug and alcohol treatment services for adolescents and individuals in the state hospital system. Ms. Cass has served as adjunct faculty at West Chester University since 1994, having served on the faculty at Temple University as well. Ms. Cass graduated with a B.S. in Criminal Justice and Corrections and a M.A. in Sociology from Ball State University, Muncie. In her current position, she is responsible for oversight and direction of most of the Title V programs.

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

Tony Norwood, Central, P, E, DA Administers the Childhood Lead Poisoning Surveillance Program

Milo Woodward, Central, P, E, DA as Supervisor of the Family Support Section Ken Huling, Central, P, E, DA Administers Prenatal Systems Programs Barbara Caboot, Central, P, E, DA Administers Child Services Programs Phyllis Welborn, Central, P, E, DA Administers Adolescent Health Programs Edward Spahr, Central, P, E, DA Administers CSHCN and Family Support Programs

/2007/ Joseph McLaughlin, Central, P, E, DA now Supervisor of the Childhood Lead Poisoning Section

Kelly Holland, Central, P, E, DA Administrator of the Adolescent Health Program

Wendy Shuey, Central, P, E, DA Assistant Administrator for Childhood Lead Poisoning Surveillance Program

Tracie Gray, Central, P, E, DA Administrator for Childhood Lead Poisoning Prevention Program

Kimberly Early, Central, P, E, DA, Administrator for Child Health Services

Milo Woodward transferred to the Division of Women, Infants & Children

Phyllis Welborn transferred to the Division of Community Systems Development and Outreach

Barbara Caboot has left the Bureau of Family Health

Edward Spahr has left the Bureau of Family Health//2007//

/2008/ Amy Flaherty, Central, P, E, DA Supervisor for the Family Support Section

Candace Johndrow, Central, P, E, DA Supervisor for the Special Conditions Section

Sally Grumbine, Central, P, E, DA Administrator for Prenatal Systems Program

Ken Huling, Central, P, E, DA now Administrator for PRAMS Grant

Danielle Tedesco, Central, P, E, DA Administrator for Traumatic Brain Injury Program

Joseph Foner, Central, P, E, DA Administrator for Childhood Lead Poisoning Prevention Program

Faith Blough, Central, P, E, DA Administrator for Lead Hazard Control Program

Cindy Dundas, Central, P, E, DA Administrator for Lead Hazard Control Program

Tara Landis, Central, P, E, DA Assistant Administrator for Lead Hazard Control Program

Tracie Gray has left the Bureau of Family Health//2008//

**/2009/ Wendy Queen, Central P, E, DA Administrator for Traumatic Brain Injury Program Candace Johndrow resigned from State government in 2007.**

**Danielle Tedesco was reassigned in 2008 to another Bureau.//2009//**

Bureau of Family Health -Director of the Division of Community Systems Development and Outreach: Michelle Connors

Ms. Connors has been employed by the Department of Health since 1989. Ms. Connors graduated with a B.S. from Penn State University. She has functioned as an advocate for the elderly population, another group that has very "special needs". In her role as surveyor and supervisor in the Division of Nursing Care Facilities, she was responsible for the evaluation of the care provided in Pennsylvania's nursing homes. This role became the groundwork for the new position that she acquired in March 2002 with the Bureau of Family Health.

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

Jane Mitchell, Central, P, E, DA Supervisor of the I&R Section responsible for the HHSCC James Marchaman, Central, P, E, DA Quality Assurance and Monitoring for the HHSCC Mary King-Maxey, Central, P, E, DA Coordinator of Operations for the HHSCC Adeline Barwick, Central, P, E, DA Coordinator of the Community Systems Development Program  
Wanda Godar, Central, P, E, DA Supervisor of the Media & Outreach Section  
C. Sanderson, Central, P, E, DA Program Administrator for the Tourettes Syndrome Program /2007/ Candace Sanderson has left the Bureau of Family Health. Peggy Forte, Central, P, E, DA, Quality Assurance and Monitoring for the HHSCC

James Umana, Central, P, E, DA, Administrator for the Environmental Protection Agency Lead Grant Lissette Cortes, Central, P, E, DA, Administrator for the Tourette Syndrome Program Cindy Findley, Central, P, E, DA, Administrator for the Epilepsy Support Services Program Martha Kautz, Central, P, E, DA, Nursing Services Consultant for the Breastfeeding Program Phyllis Welborn, Central, P, E, DA, Administrator of the Parent to Parent, Medical Home, and Family Consultant Programs, transferred from the Division of Child and Adult Health Services. James Marchaman retired and left the Bureau.//2007//

***/2009/Mary King-Maxey has been promoted to a Program Manager in the Division of Newborn Screening and Genetics, Cindy Findley has left the Bureau for a promotion to a Manager position with the Division of Immunization, Scott Steffen has joined the Division as Program Administrator of the EPA Program, and Karen Reed has joined the Division as an Assistant Administrator with the System of Care Program.***

***Bureau of Family Health - Director of the Division of Newborn Screening and Genetics:  
David Marchetto***

***Mr. Marchetto has served the healthcare community for over 20 years, working as an epidemiologist and healthcare administrator in both the private and government sectors. He began employment with the Pennsylvania Department of Health in the Department of Epidemiology in 2002 and served as a District Epidemiology Manager before joining the Bureau of Family Health. Mr. Marchetto received his Masters Degree in Epidemiology from the Harvard School of Public Health and his Certificate in Public Health from the University of Toronto.//2009//***

***/2009/ The Bureau implemented a reorganization plan creating a new section in the Division of Newborn Screening and Genetics. This new section, Genetics Services, is comprised of the Special Conditions and Sickle Cell Programs, formerly managed by the Division of Child and Adult Health Services, and the Genetics Program.//2009//***

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

***/2009/Robert Staver, Central, P, E, DA as Program Manager, Hearing Screening and Genetics Section left the agency  
Steven Horner, Central, P, E, DA, as Program Manager, Newborn Screening and Follow-up Section left the agency//2009//***

Arthur Florio, Central, P, E, DA Administrator, Hearing Screening Program  
Kelly Holland, Central, P, E, DA Administrator, Genetics Program  
/2008/ Deb Tyler, Central, P, E, DA Administrator, Newborn Screening and Followup//2008//  
**/2009/Mary King-Maxey, P, E, DA as Program Manager, Hearing Screening Section  
Suzanne Bellotti, Central, P, E, DA, as Acting Program Manager, Newborn Screening and  
Follow-up Section, Deb Tyler left the Bureau. Patty Sheaffer, Central, P, E, DA as Program  
Manager of the Genetics Services Section. Susan Duff, Central P, E, DA Administers  
Comprehensive Specialty Care Programs. Ellen Bierbower, Central, P, E, DA Administers  
the Sickle Cell Disease Program.//2009//**

Bureau of Family Health -Director of the Division of WIC: Frank Maisano Mr. Maisano has been with the WIC Program since 1981, first as the Director of WIC Fiscal Administration. /2008/  
Bureau of Family Health -Director of the Division of WIC: Gregory Landis Mr. Landis has been with the WIC Program since July 1988 first as Chief of the Grants and Retail Store Management Section. In May 2007 he assumed the role of Division Director.//2008

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

Shirley H. Sword, Central, P, E, DA as Chief, Planning and Review Section

Chief Counsel's Office -Bureau of Family Health Designated Attorney: Rachel Hammond Ms. Hammond is the attorney assigned to the Bureau of Family Health (excepting WIC operations) from the Governor's Office of General Counsel. /2007/ Bureau of Epidemiology -Bureau of Family Health Designated Epidemiologist: Ronald Tringali, Ph.D., R.N.

Bureau of Epidemiology the Bureau of Family Health designated Epidemiologist is now Ronald Tringali, Ph.D., R.N. Dr. Tringali served as Section Chief for the Health Assessment Section of the Division of Environmental Epidemiology and as Cancer Epidemiologist for the statewide Breast and Cervical Cancer Program. He was Director of Research for the Hospital & Healthsystem Association of Pennsylvania. Dr. Tringali was also the Research Clinical Nurse Specialist for the Center for Nursing Research at the Penn State Milton S. Hershey Medical Center. Dr. Tringali has held an adjunct appointment in the School of Nursing at the University of Pittsburgh.//2007//

Bureau of Community Health Systems -Director: Michael Huff Mr. Huff as the Director of the Bureau of Community Health Systems administers the statewide implementation and evaluation of public health programs through a network of six health district offices and 57 health centers. Mr. Huff's previous positions with the Department include Director of the Breast and Cervical Cancer Early Detection Project, Director of the Division of Communicable Disease, Director of the Division of Chronic Disease Prevention, and Acting Director of the Office of Public Health Preparedness. /2008/ Michael Huff is currently the Deputy Secretary of Health Planning and Assessment. Ms. Alice Gray, became the Director, Bureau of Community Health systems, effective June 8, 2007.//2008//

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

Jon Dale, Central, P, E, DA as Director of the Division of School Health Mr. Dale has been Director of the Department of Health's Division of School Health since 1994. His office has overall responsibility for the administration of the statewide mandated school health program. His prior experience includes: 14 years with the Department of Health's Office of Drug and Alcohol Programs; 3 years with a private agency involved with employee assistance programs and professional training; 3 years experience in higher education as director of counseling services and instructor in human services courses. Mr. Dale obtained his B.A. from Mansfield State University and his M.S. from Shippensburg State University.

Bureau Health Promotion and Risk Reduction (BHPRR)-Director: Leslie Best Ms. Best currently serves as Director of the BHPRR overseeing statewide planning and implementation of health promotion and disease prevention programs. The BHPRR addresses heart disease and stroke, cancer, arthritis, diabetes, tobacco prevention and cessation, oral health, physical activity, and health education services. Previously, Ms. Best served in the Bureau of Health Planning, directing statewide programs to improve access to primary health care for underserved populations. Prior experience in the Department of Public Welfare includes responsibility for the statewide direction of the licensure of personal care homes.

Employees in this Division that have Title V responsibilities: Name, Location, Responsibility for Planning (P), Evaluation (E), or Data Analysis (DA)

Teri Taschner, Central, P, E, DA Assistant Administrator of the Safe Kids Program /2007/  
Stephen Gensemer, Central, P, E, DA Assistant Administrator of the Safe Kids Program Linda Sansom, Central, P, E, DA Administrator of Clean Air for Healthy Children Program//2007//  
Six parents of children with special needs are on staff within the Bureau of Family Health. Four are involved in program administration, evaluation and data analysis. Two provide administrative support to the Bureau.

## **E. State Agency Coordination**

The Departments of Health and Public Welfare contract with four regional Family Health Councils to support family planning services at approximately 246 local clinics throughout Pennsylvania. Utilizing funding from four different sources, these State agencies pay for services through one integrated reimbursement system utilizing a common fee schedule. Funding sources include the Department of Health's Title V funding for teens 17 years of age and under, the Department of Public Welfare's Title XIX and Title XX funding, and State funding for breast cancer screening and women's medical services. The United States Department of Health and Human Services Title X funding is provided directly to the Councils.

Bureau of Family Health staff, along with staff from the Department of Public Welfare's Office of Medical Assistance Programs and the Insurance Department's Children's Health Insurance Program (CHIP), participate in bi-monthly Reaching Out Partnership meetings to identify and coordinate common interests relating to services for individuals receiving Title V, Title XIX, and Title XXI services. This interagency work group coordinates activities to achieve shared outcomes for these populations. These activities include refining the definition and eligibility criteria of populations served, sharing data, linking provided services, and sharing of respective agency needs assessment and satisfaction survey data. This partnership has expanded beyond the three original Agencies to include all partner Agencies under the Health and Human Services Call Center.

Division of Community Systems Development and Outreach (CSDO) staff represents the Secretary of Health on the Pennsylvania Developmental Disabilities Council. Under its federal mandate, the Council's mission is to encourage and support the creation of an environment in which all citizens of Pennsylvania with developmental disabilities can thrive. As a Council member, the State Title V Agency participates in reviewing and responding to grant proposals submitted by community-based agencies interested in developing service systems for members of their local communities who are developmentally disabled. Representatives from the Departments of Public Welfare, Health, Labor and Industry, Aging and Education participate on the Council, whose members are by law composed of at least 50 percent individuals with developmental disabilities or their family members.

The Interagency Committee to Coordinate Services Provided to Individuals with Disabilities, The IDEA Memorandum of Understanding, was established by the Governor's Executive Order in 1998. This MOU is the underpinning of a collaborative work effort among the Departments of

Labor and Industry Office of Vocational Rehabilitation, Public Welfare, Education, and Health to improve coordination of services to children across the Commonwealth. The PA Community on Transition, State Leadership Team carries out the intent of the MOU and works together in supporting the post-school outcomes for youth and young adults with disabilities transitioning into adult life. The mission of the Leadership Team is to build and support sustainable community partnerships that create opportunities for youth and young adults with disabilities to transition smoothly from secondary education to the post-secondary outcomes of competitive employment.

CSDO staff also represents the Secretary of Health on the Home and Community Based Services Stakeholder Planning Team. Under the "Olmstead" Supreme Court decision, this team was formed to advise the Secretary of Public Welfare on barriers to services and supports in the most integrated setting for individuals with disabilities of all ages. The team makes recommendations to eliminate those barriers and provide support to people to live independently, where they choose, engage in productive employment, and to participate fully in community life.

/2007/ The Stakeholder Planning Team continues to see recommendations from their strategic plan enacted into practice. In the 2005-2006 State Budget, the Department of Public Welfare (DPW) closed the Harrisburg State Hospital for individuals with mental health issues and the Altoona Center for individuals with Mental Retardation. Funding earmarked to support residents in the facilities was reallocated to those individual communities for the purpose of building community support. In addition, the Secretary of Public Welfare traveled across the state to hold town hall meetings for the public to provide feedback and input on the budget changes as well as ideas for saving Medicaid services monies. Each of these initiatives were recommendations of the Team.//2007//

/2008/ The activities and recommendations of the Stakeholder Planning Team continue to influence the DPW. A Governor's Executive Order created a Cabinet on People with Disabilities and an Advisory Committee on People with Disabilities on January 24, 2007. DPW recently established the Bureau of Autism Services within the newly created Office of Developmental Programs. This Office is also an outgrowth of recommendations provided by this team. The Bureau of Autism Services is working on establishing statewide diagnostic standards and tools for use by medical professionals. Another focus is creating a model of service delivery for the child and adult service systems which will benefit individuals with Autism. The Department of Health's Special Kids Network has agreed to share information on autism programs with the public through routine updating of provider resources, the training of information and referral specialists on Autism affairs, and sharing the latest updates with the Department's Children with Special Health Care Needs Consultants who are in the community, interacting with the public.//2008//

***/2009/ The Bureau of Family Health, through its SKN/SOC, will work with members of the Stakeholder Planning Team to support the efforts of the newly formed Public Education Unit for Long Term Living (LTL). This new unit supported by the Rendell Administration will launch a statewide education and outreach effort to provide information on the importance of LTL planning and the LTL options available to all Pennsylvanians, including people with disabilities.//2009//***

The Bureau administers renal, cystic fibrosis, spina bifida, phenylketonuria (PKU), and maple syrup urine disease (MSUD) pharmaceutical reimbursements through the Pennsylvania Department of Aging's Pharmaceutical Assistance Contracts for the Elderly (PACE) Program. The PACE Program is a large pharmaceutical assistance program for low-income Pennsylvania residents over age 55. The agreement with the Department of Aging allows the Bureau to take advantage of PACE's online pharmaceutical claims adjudication system, expands the number of accessible pharmacies, and consolidates pharmaceutical claims processing through a single administrative agency. The Department of Aging validates all requests for pharmaceuticals to assure quality and cost effectiveness.

The Bureau of Family Health is an active participant on the Tobacco Cessation among Women of Reproductive Age Action Learning Lab (ALL) Pennsylvania State Team. The team is headed by the Bureau of Chronic Disease and Injury Prevention's Division of Tobacco Control. This ALL is

sponsored by the American College of Obstetrics and Gynecology. The goal of the ALL is to reduce smoking among all women of reproductive age, especially those who may be pregnant. The team is pulling a variety of stakeholders together to commence in the development of a statewide plan for smoking cessation among this population.

*//2007/ During 2005, the team established a goal of increasing the number of women who use Pennsylvania's cessation services with a particular focus on pregnant women. Included in the action steps were developing a plan to provide tobacco cessation awareness, education and messaging to patients and providers in key MCH locations that serve pregnant women and women of child-bearing age and evaluating the program impact through the number of women participating in smoking cessation and the cessation rates at 3, 6, and 12 months. Members of the team included representatives from Title V, PA's Division of Tobacco Prevention and Control, PA ACOG, PA Planned Parenthood, PA American Academy of Pediatrics, and the Department of Public Welfare.*

The Bureau of Family Health assessed tobacco cessation programming in the maternal and child health programs at the 10 local health departments. The assessment indicated that all programs had been trained in the Clean Air for Healthy Children curriculum, but there were varying levels of implementation. An in-service was provided by staff from the Tobacco Control Program to increase client utilization of available tobacco cessation services.*//2007//*

*//2008/ Stop Tobacco in Pregnancy (STOP) is an evidence-based cessation program developed at Magee Women's Hospital of UPMC. The STOP program has been in place for four years; the quit rate (during pregnancy) is 34%. Of the 34% (252) who quit smoking, 89% remained smoke free (224) through delivery.*//2008//**

***//2009/ On June 10, 2008, Senate Bill 246 was approved which effectively bans smoking in all public places including hospitals, schools and sports facilities. The bill eliminates smoking in all restaurants but contains a list of exemptions allowing smoking in certain workplaces and entertainment venues, including casinos.***

***According to the Surgeon General's Report on Women and Smoking from 2001, the risk for perinatal mortality--both stillbirth and neonatal deaths--and the risk for sudden infant death syndrome (SIDS) have increased among the offspring of women who smoke during pregnancy. Infants born to women who smoke during pregnancy have a lower average birth weight and are more likely to be small for gestational age than are infants born to women who do not smoke. Women who quit smoking before or during pregnancy reduce the risk for adverse reproductive outcomes, including conception delay, infertility, pre-term delivery and low birth weight.***

***The Department has continued the partnership with the Department of Public Welfare (DPW) to educate low-income women about the dangers of smoking while pregnant and to encourage pregnant women who are receiving Medicaid benefits to quit smoking. The Departments are collaborating in training exercises that include an overview of the PA Free Quitline services to the DPW Medical Directors and their quality assurance managers. Representatives from the Quitline vendor provided in-depth information including on-going clinical research, counseling services, data reporting, and evaluation.***

***In collaboration with the PA Department of Health and the PA Department of Welfare, the PA Area Health Education Center (AHEC) provided a CME accredited tobacco cessation program for healthcare providers titled "Tobacco Cessation Training for Medicaid Providers, Redefining Success". This program was presented May 15, 2007 in Monroeville, PA. There were 160 participants, including over 70 physicians and dentists. Nurse practitioners, physician assistants, pharmacists, nurses, dental assistants, psychologists, social workers, and allied health professionals were also in attendance.*//2009//****

The Bureau of Family Health routinely partners with the Department of Public Welfare around its administration of several programs utilized by MCH populations. Programs include Medical

Assistance (Pennsylvania Medicaid Program, EPSDT, and HealthChoices, the State's Medicaid managed care program); mental health and substance abuse services (services available to children and adults in conjunction with the Health Department's Bureau of Drug and Alcohol Programs); mental retardation and early intervention services; children, youth and families services including child welfare, adoption, and abuse investigation; and, other services (food stamps, TANF, and energy assistance).

/2007/ Eighty percent of Medicaid managed care enrollees whose age is less than one year received at least one initial periodic screen in 2005.//2007//

/2008/ The Department partnered with the University of Pittsburgh School of Dental Medicine and the American Cancer Society to provide a continuing education session to medical and dental staff at community health centers in the central and eastern parts of the state. The program focused on oral cancer prevention, risk factors and detection, with the goal of increasing routine screening by primary health care providers and decreasing mortality from cancers of the head and neck. An evaluation was conducted to assess the effectiveness of the continuing education program relative to impacting oral cancer screening behaviors among primary care providers. The proportion of primary care providers reporting screening high-risk patients increased significantly. A pre-test conducted indicated that only 13% of providers reported screening patients deemed high-risk, while at post-test 23% of providers reported screening patients deemed high-risk. In addition, referrals to the Free Pennsylvania Quitline increased as well. At pre-test, 31 % of providers referred to the Quitline, while at post-test, 45 % of providers referred to the Quitline. There were 105 participants in the 26 sessions.//2008//

***/2009/The Department completed a grant from the National Association of Chronic Disease Directors through its State-Based Examples of Network Innovation, Opportunity, and Replication (SENIOR) Grant Program to implement an initiative entitled "Oral Health in the Older Adult: Strategies for Intervention". In cooperation with the University of Pittsburgh School of Dental Medicine, the Pennsylvania Department of Aging, the University of Pittsburgh Center for Healthy Aging, and the Allegheny County Community College, the Department utilized the grant funds for the following initiatives: the assessment of the oral health behaviors, knowledge, and utilization among a group of older adults; data analysis to determine oral health needs, information gaps and utilization; and the design of interventions to address the needs and provide education and referral for the older adults in the survey group. Thirty-five adults (65+) in the Center for Healthy Aging "10 Keys to Healthy Aging" Community Ambassador Course participated in the oral health project. Conclusions: Oral health is an important part of the Course.***

***Adults can be oral "health ambassadors" to improve oral health knowledge and access to care in underserved populations. The knowledge and the resources gained by the participants of this project were of significant benefit. //2009//***

/2008/ The percent of Medicaid enrollees whose age is less than one year receiving at least one initial or periodic screening rate has remained steady at 83% in 2004, 80% in 2005 and 82% (69,109) in 2006.//2008

The Bureau of Family Health funds two full-time positions within the Division of School Health who act as liaisons to the Department of Education in its oversight of Pennsylvania's 501 school districts and 29 intermediate units. Six School Health Consultants, located in each of the Department's District Offices oversee over 2000 school nurses. These consultants coordinate all Health District program initiatives related to school health and collaborate with the Bureau in addressing school district health program issues.

/2007/ The Department of Education oversees 117 charter schools, 11 comprehensive vocational-technical schools, and 29 intermediate units.//2007//

/2008/ The Department of Health also received a grant for the 2006-2007 fiscal year from the National Association of Chronic Disease Directors through its State-Based Examples of Network Innovation, Opportunity, and Replication grant program to implement a program entitled "Oral Health in the Older Adult: Strategies for Intervention". In cooperation with the University of Pittsburgh School of Dental Medicine, the Pennsylvania Department of Aging, the University of

Pittsburgh Center for Healthy Aging, and the Allegheny County Community College, the Department is using the grant funds for the following initiatives: the assessment of the oral health behaviors, knowledge, and utilization among a group of older adults; data analysis to determine oral health needs, information gaps and utilization; and the design of interventions to address the needs and provide education and referral for the older adults in the survey group.//2008//

The goal of Pennsylvania's Build Initiative is to construct a coordinated early care and learning system for children from birth to age five, drawing on collaboration from numerous agencies. These efforts are being led by an Early Learning Team assembled by the Governor's Office and including representatives from the Bureau of Family Health, and the Departments of Education, and Public Welfare. The Director of this effort is housed within the Pennsylvania Department of Education.

Beginning in State Fiscal Year (SFY) 1997/98, the Bureau of Drug and Alcohol Programs (BDAP) dispersed its Substance Abuse Prevention and Treatment Block Grant allocation for pregnant women and women with children to the state's 49 Single County Authorities. BDP has partnered with the Center for Substance Abuse Treatment (CSAT) of the Federal Substance Abuse and Mental Health Services Administration on a cooperative 5-year project (Screening, Brief Intervention, Referral and Treatment) to encourage health care providers to screen and provide advice or counseling to patients who misuse alcohol or other drugs. In addition, BDAP is working in cooperation with the Office of Mental Health and Substance Abuse Services (OMHSAS) to develop a system of care for individuals with co-occurring substance use and psychiatric disorders. BDAP implemented a pilot program for women offenders and their children in FY 04. The Women and Children's Halfway House program coordinates a multi-system approach to provide a community-based continuum of treatment, aftercare, and intensive case management services to women who are currently under state supervision and who have custody of their dependent children.

/2007/ Bureau Staff has partnered with the Department of Education and become a member of the PA Family Involvement Network. The Network is a product of the Bureau of Community and Student Services and is facilitated by the Center for Schools and Communities. It is an interagency effort to eliminate Pennsylvania's children's academic achievement gap. The mission of the group is to engage families, schools, and communities to improve the academic achievement of all students, especially those of color. The group has been asked to develop a policy to share with all of the 501 school districts. It is well known that some districts have good parental involvement but others have troublesome communication issues. The challenges identified to achieve strong family involvement are: need for communication, empowerment for parents, continued education of parents, and collaboration amongst all parties.

Bureau Staff has partnered with the Department of Education to join another previously established consortium. This effort is coordinated by the Goodling Institute of Pennsylvania State University. The Consortium began in 2000 when the Department of Education received a grant from the United States Department of Education entitled, "Statewide Educational Quality for Family Literacy". The grant was to be used to foster quality in many aspects of child literacy: professional development, program improvement, accountability, and the creation of a consortium. Our current Governor, Edward G. Rendell, became very interested in the consortium's efforts and asked that the group continue its efforts in expanding and coordinating family literacy activities. The main goal of the workgroup is to maximize services available to families through collaboration thus the reason for the invitation made to sister agencies such as the Department of Health. We attend on behalf of the Department to ensure that the needs of all children are met especially those with special needs.//2007//

/2008/ In partnership with the Pennsylvania Perinatal Partnership (PPP), the Southwest Maternal and Child Health Consultant has worked on subcommittees to provide training for providers in the state regarding post partum depression and Fetal Alcohol Spectrum Disorder. The PPP held programs in three areas of the state to address the issue of post partum depression. The programs were well attended with the Southwest region having 82 providers participating in postpartum depression training.

Additionally, a second program was provided related to Dialectical Behavior Therapy which presented providers with a method of dealing with patients that pose difficulty when providing treatment. The program had 35 providers in attendance and plans are to replicate the program in the central and southeast parts of the state.

The subcommittee on Fetal Alcohol Spectrum Disorder (FASD) also presented programs to address this issue in the three areas of the state to providers. This program in the Southwest was attended by 46 providers, and provided an awareness of the issues and behavior of the children affected by alcohol. It reinforced the need for services for children and families affected by alcohol. FASD information was provided to 180 providers, including teachers, foster parents, university students, school social workers and psychologists. The programs helped to both identify this issue involving children with FASD and stressed the importance of prevention.

***/2009/ In May 2007, the subcommittee on Fetal Alcohol Spectrum Disorders (FASD) held a FASD Leaders Forum to present best practice recommendations as a result of FASD roundtables attended by over 120 local and regional stakeholders. The recommendations promoted both prevention and treatment approaches. These treatment approaches will be incorporated with a statewide plan currently being developed by a task force convened by the Department of Health's Bureau of Drug and Alcohol Programs.//2009//***

The Bureau of Family Health works closely with the Penn State Milton S. Hershey Medical Center in its administration of the Shaken Baby Syndrome (SBS) Prevention and Awareness Program. In 2007, the Bureau provided funding to the SBS program to continue operation. As of May 2006, every Obstetric and Neonatal Intensive Care Unit in Pennsylvania is actively participating in the SBS Program. Hospitals are reaching 85 to 90% of the families of infants born in their hospitals with information about SBS.

***/2009/ The Bureau of Family Health will continue to work closely with the Penn State Milton S. Hershey Medical Center in its administration of the SBS Prevention and Awareness Program. The Bureau will provided funding to the SBS program to continue its operation at Obstetric and Neonatal Intensive Care Units in Pennsylvania at maternity and birthing hospitals.//2009//***

The Bureau of Family Health is working closely with the Bureau of Drug and Alcohol Programs (BDAP) to raise awareness of Fetal Alcohol Spectrum Disorders (FASD). BDAP, as the lead agency for the Department of Health, coordinates a state Task Force on FASD that has been meeting since mid-2006. The Bureau of Family Health sponsored two roundtable events in 2006 to increase awareness of FASD. Additionally, the Bureau is working with Pennsylvania State University to develop a prevention message for college-aged women and provide a plan for distributing the message.

The Bureau of Family Health continues to work with the Pennsylvania Perinatal Partnership (PPP) on the issue of Perinatal Depression.

***/2009/ In 2007, the PPP held a Pennsylvania Leadership Summit on Depression with nearly 200 participants throughout the state to create an action plan to guide future activities for the Perinatal Depression Project. An audio conference for mental health workers was held where 267 individuals participated in the event, 79 of which were awarded continuing education credits in Social Work. The PPP in collaboration with the Maternal Care Coalition have continued to conduct cross systems trainings on this issue. Additionally, the PPP has expanded its training reach to include the training of professionals in Federally Qualified Health Centers (FQHC). This audio conference training will provide information to FQHCs on symptoms, screening and treatment of perinatal depression. Activities for 2008 include follow up cross systems trainings and the completion of a research study for fathers and family members.***

***The Adolescent Health Program is in the process of expanding from a family planning/teen pregnancy prevention program to a comprehensive adolescent health program. The***

***Division of Child and Adult Health Services issued a Request for Applications (RFA) in January 2007 for comprehensive adolescent health services. Forty-seven applications were received. As a result of the RFA, six health centers or clinics were awarded funding to enhance their existing adolescent health program. The Adolescent Health Program awarded six organizations with funding for comprehensive adolescent health care services. The grant agreements for these services began on September 1, 2007 and continue until June 30, 2009.//2009//***

During calendar year 2007, the Division of Child and Adult Health Services finalized plans to establish a state-wide School Re-entry Program for Children and Adolescents living with a TBI. Specialized Mini-teams from schools and Intermediate Units throughout the Commonwealth will be trained over the next two years. These Mini-teams will provide education and guidance to schools and families as students with TBI transition into educational settings. The program is scheduled to begin July 1, 2007.

***/2009/ In August 2007, the Division of Child and Adult Health Services fully executed its grant with the Brain Injury Association of Pennsylvania for state-wide implementation of a Child and Adolescent Brain Injury School Re-entry Program. The Program Coordinator began program duties in September 2007.***

***Based on a best practice model, the Brain STEPS (Strategies Teaching Educators, Parents, and Students) program focused its activities on forming and training School Re-entry Consulting Teams across the state. Initial two-day training sessions were conducted in February 2008 for fourteen Brain STEPS School Re-entry Consulting Teams with a total of 103 individual team members trained. Consulting teams are currently located in the Canton and Allentown School Districts and in the following Pennsylvania Intermediate Units: Allegheny, Midwestern, Northwest Tri-County, Appalachia, Central, Lincoln, BLaST, Luzerne, Northeastern, Colonial, Carbon-Lehigh, and Bucks County. A one-day follow-up training for current Brain STEPS team members is scheduled for May 2008. The Brain STEPS program is actively recruiting to establish the next series of consulting teams in areas not yet served.***

***Consulting teams are comprised of professionals from varying disciplines who provide education, guidance, and resources to schools and families in order to facilitate the transition of students with brain injury into educational settings. Brain STEPS ensures that those who provide educational support to children and adolescents with brain injury have a good understanding of the effects and resulting challenges of the injury and the available supports and interventions that will help students achieve optimal educational success.//2009//***

***/2009/ The CDR Program will continue to develop prevention project and recommendations for local communities according to need and will assist local CDR teams in developing a community based education projects.//2009//***

## **F. Health Systems Capacity Indicators**

### **Introduction**

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	60.7	49.3	43.4	47.1	

Numerator	4436	3600	3170	3442	
Denominator	730943	730462	731167	731116	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

**Notes - 2007**

data not available.

**Notes - 2006**

HSCI #01: ICD-9CM Codes for primary diagnosis.

Numerator source: PA Health Care Cost Containment Council. Denominator source: PA State Data Center.

**Notes - 2005**

HSCI #01: ICD-9CM Codes for primary diagnosis.

Numerator source: PA Health Care Cost Containment Council. Denominator source: PA State Data Center.

**Narrative:**

Pennsylvania asthma surveillance system data indicates that asthma affects approximately 1 in 10 Pennsylvanians and disproportionately affects racial and ethnic minorities and low income residents. In Pennsylvania the rate per 10,000 of children less than five years of age hospitalized for asthma has steadily declined from a high in 2003 of 60.7 per 10,000 to a low of 43.4 in 2005. The most current rate indicates a slight increase to 47.1 for calendar year 2006.

In 2007, lifetime prevalence for Pennsylvania children, under age 18 was approximately 15% (95% CI: 13-17). The current prevalence for Pennsylvania children is approximately 11% (95% CI, 9-13). The source for this data is the Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS.)

In 2005 approximately 18.8 inpatient admissions, for every 10,000 Pennsylvania residents, had a primary discharge diagnosis of asthma. Children younger than 5 in Pennsylvania had the highest asthma hospitalization rate, 43.3 per 10,000, followed by the 65+ group rate of 30.5 per 10,000. Over 23,756 inpatient hospitalizations were due to asthma. The Source for this data is the Pennsylvania Health Care Cost Containment Council.

The Pennsylvania Asthma Action Plan 2006, a comprehensive plan to reduce the burden of asthma in Pennsylvania, was developed by stakeholders for use by all concerned with improving asthma control in the Commonwealth. Implementation of the Plan includes interventions that will train targeted health care providers and school personnel consistent with National Asthma Education and Prevention Program guidelines and community based asthma education and asthma management programs.

The 2006 Pennsylvania Asthma Burden Report illustrates the prevalence, morbidity and mortality related to asthma in the Commonwealth through analysis of available data. Analysis of the most current data available will be used to update this report and to target and evaluate intervention efforts in Pennsylvania.

The Pennsylvania Asthma Control Program has implemented the Pennsylvania Asthma Partnership (PAP), a multi-disciplinary state-wide partnership with the Department of Health. The

PAP mission is to partner collaboratively in the dedication of expertise and resources in the development and implementation of a sustainable statewide asthma action plan that expands and improves the quality of asthma care and management, education and awareness, prevention and surveillance and seeks to eliminate the disproportionate burden that asthma places on racial and ethnic minorities and low income Pennsylvania residents.

\*HSCI #01: ICD-9CM Codes for primary diagnosis. Numerator source: PA Health Care Cost Containment Council. Denominator source: PA State Data Center.

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	83.0	80.4	81.7	75.4	
Numerator	44994	53246	56096	56739	
Denominator	54193	66211	68651	75220	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2007**

data not available.

**Notes - 2006**

Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2006 – 09/30/2007. The denominator is the SFY monthly average of Medicaid enrollees who are less than one year old.

**Notes - 2005**

HSCI #02: Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2005 – 09/30/2006. Recipient age for the report was determined as of December 2006.

**Narrative:**

The percent of Medicaid enrollees whose age is less than one year receiving at least one initial or periodic screening has remained consistent at 83% in 2003, 80% in 2004, and 82% in 2005. FY 2006 witnessed a decrease to 75.4% which could be attributable to significant increases in the number of enrollees. The parents of children under age 2 are reminded of EPSDT screening through letters which are generated through the automated enrollment system "PROMISE". Additionally, a Medicaid vendor "New Client Welcome Calls" are made to all fee-for-service and managed care organization's new clients. Pennsylvania's Medicaid managed care program ACCESS Plus has recently adopted a periodic screening quality improvement initiative which targets ages 3, 4, 5 and 6.

As an ongoing activity an ACCESS Plus subcontractor notifies providers which in turn contacts

families offering assistance in scheduling appointments, providing reminders for upcoming screening appointments, as well as helping to arrange transportation if needed. Additionally, if an appointment is missed they will contact the family to offer help with rescheduling the missed appointment.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	56.7	42.6	53.0	62.8	66.5
Numerator	1334	578	683	787	968
Denominator	2351	1357	1289	1253	1455
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

Numerator and denominator were provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/06 to 09/30/07.  
Source: PA Department of Insurance

**Notes - 2006**

HSCI #03: Numerator and Denominator were provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/05 to 09/30/06.  
Source: PA Department of Insurance

**Notes - 2005**

HSCI #03: Numerator and Denominator were provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/05 to 09/30/06.  
Source: PA Department of Insurance

**Narrative:**

The percentage of CHIP children receiving periodic screening has fluctuated between 2003 and 2006, with a low of 42.6% in 2004 and a high of 66.5% in 2007. The rates for EPSDT screens and follow-up have improved significantly. During the period October 1, 2005 to September 30, 2006 almost 63 percent (n=787) of CHIP children under 1 year of age had at least 1 reported well-child check-up/EPSDT.

This past year, CHIP focused on increasing its marketing tools and outreach efforts to motivate parents to "apply now" and enroll their children in the program. Final approval for The CHIP program expansion was granted in February, 2007. The CHIP program was officially launched by Governor Rendell on May 1, 2007. As a result of the increase in outreach and marketing efforts, another 12,382 children were enrolled in the program for 2007.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	64.6	65.6	66.6	66.0	
Numerator	73376	74663	75623	75410	
Denominator	113585	113779	113626	114297	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

**Notes - 2007**

data not available

**Notes - 2006**

HSCI #04: Calculated with missing data (adequacy measure could not be computed) removed from denominator.

Source: PA Department of Health, Bureau of Health Statistics and Research

2004 data have been revised as of April 26, 2007.

**Notes - 2005**

HSCI #04: Calculated with missing data (adequacy measure could not be computed) removed from denominator.

Source: PA Department of Health, Bureau of Health Statistics and Research

2004 data have been revised as of April 26, 2007.

**Narrative:**

The percent of women (15 through 44) with a live birth and who's observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index has remained steady over the past four years. The numerator and denominator for the past four years also remained relatively unchanged. The 2005 indicator is 66.6 percent which is a slight increase from 65.6 percent in 2004 and 64.6 percent in 2003. In contrast, the 2006 indicator of 66.0 percent has remained relatively consistent with the 2005 indicator.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	78.6	86.6	92.0	88.9	
Numerator	775943	833010	874776	882745	
Denominator	986819	962085	950670	993176	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

**Notes - 2007**

data not available

**Notes - 2006**

HSCI #07A: Numerator is provided by the PA Department of Public Welfare, from their Enterprise Data Warehouse based on claims having a date of service during the period 10/01/06 to 09/30/07, regardless of the claim adjudication date or payment date. Numerator is the number of children age 0 to 20 who received a service approved by MA either through the Fee-for-Service or Managed Care Delivery System. DPW cannot provide a number for children potentially eligible for MA who did not apply. The denominator is the number of children who have been determined to be eligible for MA who are age 0 to 20 during the reporting period.

**Notes - 2005**

HSCI #07A: Numerator is provided by the PA Department of Public Welfare, from their Enterprise Data Warehouse based on claims having a date of service during the period 10/01/05 to 09/30/06, regardless of the claim adjudication date or payment date. Numerator is the number of children age 0 to 20 who received a service approved by MA either through the Fee-for-Service or Managed Care Delivery System. DPW Cannot provide a number for children potentially eligible for MA who did not apply. Denominator is the number of children who have been determined to be eligible for MA who are age 0 to 20 during the reporting period.

**Narrative:**

The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program peaked at 94.3% in 2001, then dropped to 78.6% by 2003. In 2004, the percentage increased to 86.6% and continued to increase to 92.0%.in 2005. The State has made a strong commitment to reducing the number of uninsured children in Pennsylvania and ensuring access to healthcare services. Activities have included:

Pennsylvania Act 136 of 2006 "Cover All Kids" expanded the income eligibility rules for the Children's Health Insurance Program (CHIP). Act 136 also allows the collection of co-pays for income levels greater than 200% of the Federal Poverty Limit. "Cover All Kids," expands CHIP to all children and families with incomes over 300% of the federal poverty level. The Act potentially assists children with special health care needs that are ineligible for Medicaid.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	37.9	37.9	38.6	38.3	41.4
Numerator	66539	69373	76564	79334	86749
Denominator	175730	183039	198133	206929	209765
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

HSCI #07B: Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2006 – 09/30/2007.

**Notes - 2006**

HSCI #07B: Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2005 – 09/30/2006.

**Notes - 2005**

HSCI #07B: Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2004 – 09/30/2005. Recipient age for the report was determined as of September 30, 2005.

**Narrative:**

The percent of EPSDT eligible children aged 6 through 9 receiving a dental service rose slightly during the 2002 to 2007 period. The EPSDT percentage was at a low of 36.4% in 2002 and rose to a high of 41.4% in 2007. While Pennsylvania’s EPSDT Program provides dental examinations for all enrolled children providing necessary treatment and services to correct/ameliorate defects found, targeted promotion of the EPSDT Program in Pennsylvania is needed to ensure all eligible children are indeed enrolled in the program and benefiting from Program services. In Pennsylvania MA covers all medically necessary dental services for enrolled children. This includes teeth cleaning, x-rays, cavity fillings, crowns and other services.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Indicator	0.2	0.0	0.0	0.1	0.0
Numerator	87	3	9	58	7
Denominator	44095	58360	57809	56556	59545
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2007**

HSCI #8: Since State SSI beneficiaries are eligible for Medical Assistance, the percent of beneficiaries receiving benefits from the State’s CSHCN program is expected to be very low relative to the number of SSI beneficiaries in the State. The majority of identified SSI beneficiaries from the State’s CSHCN program were children receiving comprehensive specialty care by multi-disciplinary teams.

Numerator is State Fiscal year data from CORE (SFY 07-08).

Denominator is number of children receiving SSI payments in PA as of December 2007, the Social Security Administration's December 2007 report.

**Notes - 2006**

HSCI #8: Since State SSI beneficiaries are eligible for Medical Assistance, the percent of beneficiaries receiving benefits from the State's CSHCN program is expected to be very low relative to the number of SSI beneficiaries in the State. The majority of identified SSI beneficiaries from the State's CSHCN program were children receiving comprehensive specialty care by multi-disciplinary teams.

Numerator is State Fiscal year data from CORE (SFY 06-07).

Denominator is number of children receiving SSI payments in PA as of December 2006, the Social Security Administration's December 2006 report.

**Notes - 2005**

HSCI #8: Since State SSI beneficiaries are eligible for Medical Assistance, the percent of beneficiaries receiving benefits from the State's CSHCN program is expected to be very low relative to the number of SSI beneficiaries in the State. The majority of identified SSI beneficiaries from the State's CSHCN program were children receiving comprehensive specialty care by multi-disciplinary teams.

Numerator is State Fiscal year data from CORE (SFY 05-06).

Denominator is number of children receiving SSI payments in PA as of December 2005, the Social Security Administration's December 2005 report.

**Narrative:**

The percent of the State CSHCN participants is low every year since Pennsylvania SSI beneficiaries are eligible for Medical Assistance. The majority of identified SSI beneficiaries from the State's CSHCN program were children receiving comprehensive specialty care by multidisciplinary teams.

**Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	10.8	7.3	8.5

**Notes - 2009**

See form notes.

**Narrative:**

The Pennsylvania Department of Health's data source for this indicator is the payment source noted on the birth certificate. In 2006, 10.8% of all Pennsylvania Medicaid births were low birth weight compared to 7.3% of Non-Medicaid births. This represents a slight increase from the 2005 figure of 10%. LBW is of public health importance because of the strong relationship between birth weight and infant mortality and morbidity. Reducing the prevalence of LBW deliveries in Pennsylvania has been difficult. The Department continues to stress the importance of prenatal care in reducing low birth weight babies via home visiting programs administered at the local level

by county/municipal health departments. The proportion of LBW babies has remained fairly constant over the last five years, as has the disparity between the Medicaid and Non-Medicaid populations in this regard.

**Health Systems Capacity Indicator 05B:** *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	payment source from birth certificate	0	0	7.5

**Notes - 2009**

HSCI #05: The Title V program does not have the capability to break the data into Medicaid and non-Medicaid for section b) infant deaths per 1,000 live births.

**Narrative:**

The Title V program does not have the capability to break the Infant deaths per 1,000 live births data into Medicaid, non-Medicaid, and all populations in the State -- Infant deaths per 1,000 live births.

However, studies have shown significant disparity in access to prenatal care between these two populations. The Department of Public Welfare implemented a pilot project last year aimed at enhancing early prenatal care for pregnant women. It is expected that, over time, this pilot program will engender early enrollment into prenatal care and reduce poor birth outcomes and their associated program costs.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	70.1	84.7	80.1

**Notes - 2009**

See form notes.

**Narrative:**

The 2006 figures remain consistent with 2005; 70.1% of Medicaid covered pregnant women giving birth received prenatal care in their first trimester compared to 84.7% of Non-Medicaid covered women.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	63.6	67.4	66

**Notes - 2009**

See form notes.

**Narrative:**

In 2006 the percent of Medicaid covered pregnant women giving birth who received adequate prenatal care was 63.6% versus 67.4% of Non-Medicaid pregnant women. This represents a slight increase over the 2005 figures. The Pennsylvania Department of Health's data source for this indicator is the payment source noted on the birth certificate. In 2005, 62.1% of Medicaid covered pregnant women giving birth received adequate prenatal care compared to 65.7% of Non-Medicaid covered.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 <i>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2006	185
INDICATOR #06 <i>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2006	200

**Notes - 2009**

The percent of poverty level for eligibility in PA's Free CHIP program for infants under 1 is 185%-200% of the Federal Poverty Level (FPL).

The percent of poverty level for eligibility in PA's Subsidized 1 CHIP program is 201% - 250% FPL regardless of age.

The percent of poverty level for eligibility in PA's Subsidized 2 CHIP program is 251% - 275% FPL regardless of age.

The percent of poverty level for eligibility in PA's Subsidized 3 CHIP program is 276% - 300% FPL regardless of age.

Note: Children in CHIP Subsidized 1 program pay 25% of the premium, 35% of the premium in Subsidized 2, and 40% of the premium in Subsidized 3.

**Narrative:**

The Medicaid income limits used to determine eligibility for pregnant women and infants up to age one is 185% Federal Poverty Income Guidelines (FPIG), children age one to age six is 133% of FPIG.

On November 2, 2006, Governor Rendell signed into law Act 136 of 2006, making Cover All Kids a reality by expanding the income eligibility rules for the Children's Health Insurance Program (CHIP) and allowing the State to collect a monthly premium as permitted by the Federal Government. The Pennsylvania Insurance Department conducted a major marketing effort for the "Cover All Kids" initiative in 2007. The program expands the Children Health Insurance Program (CHIP), providing medical coverage for families with an income over 300% of the federal poverty level. The "Cover All Kids" initiative could potentially provide medical insurance for families with children with special health care needs that are ineligible for the Medicaid Program. The initiative enables qualified families to purchase coverage at the Commonwealth's rate of \$150.00 a month per child, potentially assisting children with special health care needs that are ineligible for Medicaid. In 2007, the dissemination of CHIP applications increased from 25,555 in 2006 to 32,361, or by 27%, as an outcome of this initiative.

A current policy dictates that children eligible for Medical Assistance can not be also enrolled in CHIP. Same response for 6A, B & C: The Department of Public Welfare's percent of poverty by age has not changed from the past reporting periods.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to )	2006	133 100
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to )	2006	200 200

**Notes - 2009**

The percent of poverty level for eligibility in PA's Free CHIP program for children 1-5 is 133% - 200% FPL.

The percent of poverty level for eligibility in PA's Free CHIP program for children 6-18 is 100% - 200% FPL.

The percent of poverty level for eligibility in PA's Subsidized 1 CHIP program is 201% - 250% FPL regardless of age.

The percent of poverty level for eligibility in PA's Subsidized 2 CHIP program is 251% - 275% FPL regardless of age.

The percent of poverty level for eligibility in PA's Subsidized 3 CHIP program is 276% - 300% FPL regardless of age.

Note: Children in CHIP Subsidized 1 program pay 25% of the premium, 35% of the premium in Subsidized 2, and 40% of the premium in Subsidized 3.

**Narrative:**

"Cover All Kids" initiative in 2006 expanded the Children Health Insurance Program (CHIP), The initiative enable qualified families to purchase coverage at the Commonwealth's rate of \$150.00 a month per child, potentially assisting children with special health care needs that are ineligible for Medicaid. In 2007, the dissemination of CHIP applications increased from 25,555 in 2006 to 32,361, or by 27%, as an outcome of this initiative.

HSCI #06: MA information is from PA Department of Public Welfare. CHIP information is from PA Department of Insurance.

The Department of Public Welfare's Medicaid and Pennsylvania Insurance Department Eligibility

- a) Age is infants under 1.
- b) Medicaid Infants: 185%
- Medicaid pregnant women: 185%
- Medicaid - Children age 1-5 = 133%
- Children age 6-18 (includes 18 year olds born after 9/30/83) = 100%
- Children age 18 born on or before 9/30/83 = 37.6%
- a) SCHIP -- Age is infants under 1 = 185% to 200% Federal Poverty Level
- b) SCHIP - Children age 1-5 = 133% to 200% Federal Poverty Level
- Children age 6-18 = 100% to 200% Federal Poverty Level

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2006	185
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women	2006	200

**Notes - 2009**

The percent of poverty level for eligibility in PA's Free CHIP program for children 6-18 is 100% - 200% FPL.

The percent of poverty level for eligibility in PA's Subsidized 1 CHIP program is 201% - 250% FPL regardless of age.

The percent of poverty level for eligibility in PA's Subsidized 2 CHIP program is 251% - 275% FPL regardless of age.

The percent of poverty level for eligibility in PA's Subsidized 3 CHIP program is 276% - 300% FPL regardless of age.

Note: Children in CHIP Subsidized 1 program pay 25% of the premium, 35% of the premium in Subsidized 2, and 40% of the premium in Subsidized 3.

**Narrative:**

The Department of Public Welfare (DPW), Office of Medical Assistance Programs, recognizing the importance of seamless, consistent prenatal care is instituting the Pilot for Pregnant Women. Since 2004, under this pilot program, eligible women have begun Medicaid coverage as soon as they are determined to be pregnant and then rapidly transitioned into managed care. This pilot program combines flexible eligibility guidelines with a simplified application and eligibility determination process to enable eligible pregnant women to obtain comprehensive primary care during pregnancy and the postpartum period. This pilot program will prevent gaps in service for pregnant women and provide earlier enrollment in prenatal programs to ensure quality care for pregnant women.

The Department of Public Welfare's Medicaid and Pennsylvania Insurance Department Eligibility

- a) Age is infants under 1.
- b) Medicaid Infants: 185%
- Medicaid pregnant women: 185%
- Medicaid - Children age 1-5 = 133%
- Children age 6-18 (includes 18 year olds born after 9/30/83) = 100%
- Children age 18 born on or before 9/30/83 = 37.6%
- a) SCHIP -- Age is infants under 1 = 185% to 200% Federal Poverty Level

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	1	No

Annual linkage of birth certificates and newborn screening files	2	No
<b>REGISTRIES AND SURVEYS</b> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

**Notes - 2009**

**Narrative:**

During 2007, in response to the increasing challenge to provide data support for program development, goal measurement and analysis, a small subgroup of the CSHCN Stakeholder Group focused on the goal of increasing the Bureau of Family Health's access to continuous, real-time data sources to provide meaningful information to parents, caregivers, policy-makers and other stakeholders in support of funding, programmatic and policy decisions. The Group developed a data matrix to identify data sources pertinent to the Bureau and made progress toward creating a system that will convey data related information to those who need it. The Bureau of Family Health received a HRSA grant award for a State Systems Development Initiative (SSDI) program for the first time in November of 2006. The project period for the SSDI program is for a five year period beginning starting in November of 2006 and ending October 31, 2011. The five year funding award amount is approximately \$500,000. The Pennsylvania Department of Health has a variety of health information systems that are segmented and were developed to serve individual public health programs.

The goals of this initiative are to collaborate with other public and private health partners to develop and sustain data linkages to improve access to maternal and child health information. Furthermore, to assure that linkages and access to health information are operational and data obtained from these linkages are utilized to improve access to health care services. The final goal is to improve program planning, quality of care for the purpose of meeting the needs of the maternal and child health population.

The Pennsylvania Child Death Review Program uses child death data to drive programs. Information derived from local child death reviews is used to develop inter-disciplinary training, community-based prevention education and data-driven recommendations for legislation and public policy. The data that is collected follows a national protocol which is part of the National CDR Resource database.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior	1	No

Survey (YRBS)		
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**Notes - 2009**

**Narrative:**

Sustained tobacco prevention efforts in Pennsylvania are proving successful. The Youth Tobacco Survey was developed by the Centers for Disease Control and Prevention to provide states with the data necessary to support the design, implementation, and evaluation of a comprehensive tobacco-control program. The Division of Tobacco Prevention and Control in the Bureau of Health Promotion and Risk Reduction conducted the Pennsylvania Youth Tobacco Survey (YTS) in the fall and winter of the 2006-2007 school year.

Prevalence:

- Eighteen percent of high school students (CI: 15-20 percent) in the school year 2006-2007 smoked cigarettes, which is significantly less than the 2002-2003 school year of 23 percent (CI:21-25).
- There was no difference in the rate of smoking between males and females in either high school or middle school.
- In high school, Whites were significantly more likely to smoke cigarettes than Black students (19 percent, CI:16-23, vs. 10 percent, CI:6-15).
- Among middle school students, two percent (CI:1-3) and among high school students, six percent (CI:4-8), currently used smokeless tobacco.
- In the current school year, 2006-2007, four percent of middle school students (CI: 3-6 percent) smoked cigarettes, significantly fewer than in school year 2002-2003, when it was eight percent (CI:7-9).

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

The Pennsylvania Department of Health, Bureau of Family Health contracted with Health Systems Research, Inc. to conduct a five-year statewide assessment of maternal, child, and family health. The purpose of this assessment of maternal, child, and family health is to gather and present up-to-date information about the health and well being of the women, infants, children, children with special health care needs (CSHCN), and families residing in the Commonwealth. The information will be used to guide policies and services to promote the health and well being of children and families and to facilitate the appropriate and effective allocation of resources. The assessment is designed to be useful to all those in Pennsylvania concerned with the health and well being of the State's mothers, infants, children, youth, and CSHCN. The assessment was conducted under the auspices of the Federal Title V Maternal Child Health (MCH) Program in accordance with its mandate to the States to conduct an in depth maternal child needs and capacity assessment every five years.

*/2009/The Bureau's strategic plan was utilized to create 14 MCH priority statements. From the 14 MCH priorities, 7 of the priorities have been translated into Pennsylvania's State Performance Measures. These measures will enable the state to monitor progress related to MCH priorities.*

*The New State Performance Measures include the following:*

- 1. State Performance Measure 5: Percent of callers who have expressed satisfaction with the services provided by the Special Kids Network Helpline.*
- 2. State Performance Measure 6: Rate of infant deaths as a result of Sudden Infant Death Syndrome (SIDS) and accidental suffocation and strangulation in bed per 1,000 live births.*
- 3. State Performance Measure 9: The rate of pregnancy (per 1,000) among females ages 15-17*
- 4. State Performance Measure 10: Percent of children ages 6 years and younger tested for elevated blood lead levels*
- 5. State Performance Measure 11: The percent of tested children ages 6 years and younger with confirmed elevated blood lead levels*
- 6. State Performance Measure 12: The percentage of statewide breastfeeding initiation*
- 7. State Performance Measure 13: The percentage of infants with failed hearing screenings that are lost to follow-up//2009//*

### **B. State Priorities**

*/2009/ Previously, a number of priorities selected were outside of the Bureau's scope of specific responsibility and there was a desire for our new priorities to be areas that we can directly affect. The Bureau developed a strategic plan, new priorities, and state performance measures to help focus MCH spending. The Bureau's new strategic plan was completed and a decision was made to combine MCH priority areas into 14 priority statements that reflect inter-related MCH topics. What follows are the Bureau of Family Health's new top 14 priorities. The Bureau's new priorities and state performance measures are discussed below.*

**The Bureau of Family Health's 2009 priorities are as follows:**

1. **Increase the number of high risk, vulnerable youth who have access to comprehensive health care**
2. **Reduce pregnancy among females ages 15-17**
3. **Reduce risk factors (individual, family, peer, school, community) and increase protective factors for youth.**
4. **Increase lead testing among children under age 6**
5. **Increase coordination of systems, services and programs serving CSHCN**
6. **Reduce health risks for, and mortality of infants and children**
7. **Increase percent of pregnant women, including those at high risk, who receive early and adequate prenatal care**
8. **Expand the number of medical homes serving all children statewide**
9. **Reduce health disparities through the provision of culturally, cognitively and linguistically appropriate services**
10. **Increase statewide breastfeeding initiation and duration**
11. **Increase access to health and human services through implementation of statewide 2-1-1 system**
12. **Promote the healthy development of children through Newborn Screening, and improving early identification of heritable disorders and genetic susceptibilities**
13. **Increase family participation in decision making, programming and statewide policy.**
14. **Develop a comprehensive, cohesive statewide MCH policy//2009//**

**An attachment is included in this section.**

### **C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	195	226	212	197	200
Denominator	195	226	212	197	200
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2007**

Data is currently provisional

**Notes - 2006**

Numerator data

Data source: Division of Newborn Screening and Genetics

**Notes - 2005**

**a. Last Year's Accomplishments**

The performance objective for this performance measure of 100 percent has been met for every year from 2003 to 2007.

Over the past years, the Program has remained in compliance with Program guidelines and thereby has consistently met its Performance Objective. Expanded screening provided for by House Bill 883/Act 36 increases the number of conditions that the Department will be required to follow-up on to 28 medical conditions. This additional amount of activity will require access to additional data sets for follow-up. The introduction of a new software system will enable the Program to obtain data on follow-up for the additional 22 conditions that House Bill 883/Act 36 provides for.

Six inborn errors of metabolism were mandated for screening by Pennsylvania as listed on Form 6. NSFP provided screening on 149,367 filter papers from newborns. Two-hundred newborns were diagnosed with one of the 6 state-mandated conditions: 92 sickle cell disease and hemoglobinopathies, 62 congenital hypothyroidism, 20 phenylketonuria (PKU), 17 galactosemia, 6 maple syrup urine disease and 3 congenital adrenal hyperplasia.

NSFP met with the 4 metabolic treatment centers to establish performance based grants that will provide comprehensive follow-up services and build capacity for assessment, confirmatory testing and diagnosis, patient and family education, care coordination and case management and preventive therapeutic interventions.

NSFP had several other accomplishments including a full revision of its guideline policies and additional activities with its Technical Advisory Committee (TAC) to revise its approach to follow-up for galactosemia. In March of 2007, NSFP requested a consultancy from the Health Resources and Services Administration (HRSA) to evaluate its program. Dr. Bradford Therrell from the National Newborn Screening and Genetics Resource Center convened a site team that made a recommendation to acquire a new information system. As a result of this review, NSFP consulted with an outside vendor (Veridyne) to determine the requirements for a system to enhance its data processing.

NSFP expanded its statewide metabolic pharmacy program that enables clients with PKU to obtain metabolic formula at a pharmacy in their locale. Reports indicate a continuing level of satisfaction with this retail pharmacy approach.

To better educate families on the benefits of newborn screening, MCH Nurse Consultants

distributed to obstetricians and birthing hospitals more than 10,000 copies of the NSFP brochure, Pennsylvania Screening Services for Newborn Babies.

NSFP has kept current on pending legislation for House Bill 883 that was quickly approved by the House in 2007 and advanced to the Senate Appropriations Committee. This legislation will increase the number of screening conditions subject to reporting and follow-up from 6 to 28.

The Department of Health's Genetic Services Program has grants with the 4 metabolic treatment centers to provide genetic counseling services to persons who are identified with abnormal screening results. During calendar year 2006, 934 patients received genetic counseling services at the four metabolic treatment centers.

In 2007, the program requested a consultant to complete a software review of commercial off-the-shelf (COTS) products in order to assist the program to determine whether a COTS product(s) would meet the program's requirements for an information system.

The consultant completed the COTS software review and provided information to the program. The program is evaluating its options under Pennsylvania's Procurement Code to procure a COTS product that would meet the program requirements and substantially upgrade the capabilities of the program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Specimen Collection	X			
2. Laboratory Testing	X		X	
3. Diagnostic Evaluation	X			
4. Treatment	X			
5. Follow-up		X	X	
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In anticipation of the passage of House Bill 883 for expanded newborn screening, NSFP is working with the Department of Public Welfare to examine strategies to expand newborn screening from 6 to 28 conditions (recommended by the March of Dimes and the American College of Medical Genetics). NSFP is preparing for a shift of activities that would transfer much of the follow-up services to its stakeholders in the laboratories and metabolic disease treatment centers. Best practices from the states are currently being sought for the means of conducting optimal follow-up.

NSFP continues to collaborate with its Technical Advisory Committee to administer 3 new workgroups in 2007 for expanded newborn screening, cystic fibrosis, and filter paper design.

NSFP continues to expand and improve the newborn screening information available to parents, providers and stakeholders through the Department's website. NSFP has just developed a provider manual for newborn screening that is available on its website and serves as a resource guide for healthcare providers.

**c. Plan for the Coming Year**

The NSFP anticipates that legislation for House Bill 883 expanding the number of screening conditions subject to reporting and follow-up from 6 to 28 will become law by the end of the 2008-2009 legislative session. NSFP is revising the manner in which it conducts follow-up and will identify new partners and the means of financing the new follow-up model. Partners will include other state providers, laboratories, metabolic disease treatment centers, and other healthcare providers. The Governor's Office will participate with NSFP and the Department of Public Welfare to coordinate strategies to reimburse for the approximate 35% of newborns screened who are covered by Medical Assistance. NSFP will explore alternative sources for follow-up providers. NSFP will provide education to its stakeholders regarding the changes in the screening and follow-up requirements. On January 1, 2009, the NSFP will issue new participating laboratory agreements with qualified laboratories to provide newborn screening services.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	65	67	69	71	73
Annual Indicator	64.8	64.8	64.8	64.8	60.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	73	73.2	73.2	73.5	73.5

**Notes - 2007**

Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

No denominator or numerator data was available

**Notes - 2005**

The data was pre-populated and presently no data is available for this performance measure.

**a. Last Year's Accomplishments**

The 2007 performance objective for this performance measure was 73 percent. Data from the 2007 survey showed that 60.6 percent of CSHN families partner in decision making and are satisfied with services in PA. The annual performance objective was not met in 2007. The percent of satisfaction has remained steady from 2003 to 2006 with a decrease of almost 4 percent in 2007. PA provides an array of services all designed to promote family participation in decisions at all levels: the Medical Home program, the referral information provided to parents by the Special Kids Network, and the support provided to parents by our condition-specific programs such as Sickle Cell, Tourettes, Epilepsy and others. The reason for the small decrease in 2007 is not clear, other than parent expectations may have changed since the level remained steady in prior surveys.

The Special Kids Network (SKN), an information and referral service that connects families with children that have special health care needs is in its 12th year of operation. The SKN database houses over 15,000 resources for helpline callers. Respite care services, special education advocacy groups, mental health/mental retardation services, support groups, parent networking and financial assistance were some of the foremost resources provided by SKN. In 2006, over 1,500 PA children affected by Tourette Syndrome and their families were assisted by the PA Tourette Syndrome Association (PA-TSA) with services such as phone consultations, support groups and advocacy. Family representation is evident at all levels of service provision by the contractor, from Association's board meetings, conferences and Legislative Breakfasts to presence at all meetings related to their children. The first Parent and Kids conference was held in March 2007 with 79 individuals in attendance. In 2006, advocates accompanied parents to 173 meetings as members of the Individual Education Plan teams to advocate, educate and recommend accommodations and supports within the school setting. The impact of the advocacy fostered inclusion for CSHN which was revealed in statewide parental evaluations. The results of the evaluation indicated that over 90 percent of the parents strongly agreed that advocates gave emotional support, accurate information and answered questions in a timely manner.

Last year DOH's SKN/SOC Service Coordination contracted with the Elks Nurses which made referrals to 80 families with CSHN. The Elks nurses have increased access to Medical homes for CSHN. The most common services included: emotional support, assessments, health services, advocacy, and information and referral. SKN/SOC Service Coordination conducted a statewide survey "Opinionaire" which was completed by every parent participating in Service Coordination at intake and every six months thereafter. The instrument asks basic questions about parents' experiences with the health care system regarding their CYSHCN. Overall, the data show that current clientele have positive experience: most have a Primary Care Physician (94%), access to different types of medical insurance (between 80 and 90%), satisfaction with medical services (91% were either very or somewhat satisfied), and had doctors who appreciated their values and customs (83% reported always or frequently). These respondents also reported that health care providers "always" or "frequently" coordinate care (65%), and the respondents were either very satisfied or somewhat satisfied (83%) with coordination of their CYSHCN's healthcare. However, among CYSHCN over 14 years of age, none had a transition plan in place.

Within the System of Care contract, the project officer felt it beneficial to begin to gather the representatives from the medical home, and the call center together so they could share information on a quarterly basis. They not only were hearing the same issues but they started to brainstorm about additional ways that they would be able to share data so that they could serve families better.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. PA Recreation & Leisure Line for Individuals with Disabilities		X		X
2. Special Kids Network/system of Care		X		X
3. Sudden Infant Death Syndrome Program			X	X
4. Medical Home Integrated care Coordination Initiative				X
5. Special Healthcare Needs Consultants				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Special Kids Network (SKN) continues to distribute satisfaction surveys to willing helpline callers and used to monitor customer service standards. Some needs indicated in the survey as unmet are: health/dental insurance, grants for services for children, advocacy and support groups, and group home placements for adolescents. Some improvements suggested for SKN were: on-line guide to services, in-person services rather than phone, check agency details, and increase agency listings.

The Department of Health's SKN website is periodically updated with current information to keep the public informed. The System of Care (SOC) web pages were revised to reflect new community-based services available to Pennsylvania citizens. Elks Nurses will continue to serve a minimum of 60 clients and administer the "Opinionaire."

In 2007-2008, Pennsylvania Tourette Syndrome Association (PA-TSA) advocates continue to log an average of 1800 miles per month to attend school team meetings and make presentations for educators, peers and professionals on behalf of individuals with Tourette Syndrome. Packets of information continue to be provided to newly diagnosed individuals, family members, educators, physicians and other professionals. The PATSA will be designing and instituting training for the Department of Corrections in late 2008. The training will educate all officers on the scope of Tourette Syndrome to ensure proper treatment of inmates with Tourette Syndrome.

**c. Plan for the Coming Year**

Elks Nurses will continue to serve children with disabilities and the Special Kids Network will continue to assess parents' views on full participation in their childrens' care, through its Question of the Month program and enhanced customer service by monitoring their key performance indicators. A consumer panel will be enlisted during the calendar year 2008 to provide feedback to I&R Specialists and the HHSCC about services for their children. During the upcoming year the process for issuing a request for proposals will be initiated, and care will be used to assure the Special Kids Network remains responsive to parents' needs regardless of the scope of the resulting contract. Additional work will be done with the Department's newly established relationship with the Peal Center, the recipient of the Family to Family Information Grant. Not only has the group began to network statewide but they are helping us establish contacts with groups such as Family Voices. The need for family involvement becomes most evident when it involves coordination of care. Our medical home program and its parent partner concept has emulated this principle and taken on the road and this will continue to grow and become even better as we implement the State Implementation Grant which became effective 6/1/08. The medical home concept is a perfect way to encourage family involvement in their child's care.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	52	54	52	53	54
Annual Indicator	51.2	51.2	51.2	51.2	45.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	54	54.1	54.1	54.2	54.2

**Notes - 2007**

Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

No denominator or numerator data was available

**Notes - 2005**

The data was pre-populated and presently no data is available for this performance measure.

**a. Last Year's Accomplishments**

The 2007 performance objective for this performance measure was 54 percent and the survey data showed that 45.8 percent was achieved. The target for this performance measure was not met. The percent of children in this category has remained constant from 2003 to 2006 and saw a drop of almost 6 percent in 2007. The state has supported a nationally recognized medical home project since 2001. The reason for the 7% drop is unclear since there are 62 trained medical home practices as of 2007. The state applied for and received a federal State Implementation Grant in 2008. Therefore for the next three years, additional resources will be available to assure that more children received coordinated care by promoting the medical home concept thru learning collaboratives, the PA Rural Health Centers and PA Federally Qualified Health Centers.

As of February 2007, 34 participating practices participated in the EPIC IC Medical Home Training Program and collected encounter data for 8,012 children. The data suggested that: 2400 (30%) had asthma, 1047 (13%) had a developmental delay, 529 (6%) had cerebral palsy, 887 (11%) were diagnosed with autism spectrum disorder 313(3%) met the definition for obesity and 21 (0.2%) suffered from fetal alcohol spectrum disorders. Records of each patient encounter have been collected by the enrolled medical home practices since 2005. Project staff is analyzing the 37,409 forms collected as of February 2007 to determine the effect on client quality of life and cost-effectiveness. Preliminary analysis shows that participating practices have favorably impacted quality of life of both CYSHCN and parents by preventing almost 400 missed school days and over 250 missed parental work days. In addition, 203 hospitalizations and 690 emergency room visit were reported to have been prevented as a result the coordinated care

received through the medical home practice.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Integrated Care Coordination Initiative				X
2. Comprehensive Specialty Care Programs				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

As of January 2008, 62 practices have been trained, 39 of which continue ongoing quality improvement activity with the EPIC IC program. Encounter data was collected for 9,657 children. The data suggested that: 2659 (31%) had asthma, 1102 (13%) had a developmental delay, 419 (5%) had cerebral palsy, 921(11%) were diagnosed with autism spectrum disorders; 460 (5%) met the definition for obesity and 47 (0.5%) suffered from fetal alcohol spectrum disorder. The expectation is that the increased awareness of specific diagnoses within a practice will facilitate linkages to appropriate resources and improved quality of care for CYSHCN.

The Elks Nurses work with the System of Care and the Medical Home Programs to coordinate the care of children with special health care needs. Not only do they assist the needs of the children and the families but they also refer the names of potential "new" practices to the Medical Home team so that staff can follow-up and see if the Pediatric practice is interested in learning more about the concept. The medical home concept is a "win-win" for everyone, not just for the child but for the physician as well. The Elks have referred 31 practices to the EPIC IC Medical Home Initiative.

**c. Plan for the Coming Year**

The Bureau has submitted a proposal for the State Implementation Grant for "Integrated Community Systems for Children and Youth with Special Health Care Needs". If the proposal is funded as of June 1, 2008, the Bureau of Family Health will focus its efforts on implementing the three MCHB Core Outcomes. The three MCHB Core Outcomes to be implemented, recognizing that the remaining three Outcomes will indirectly get addressed as well: MCHB Core Outcome 2- CYSHCN receive coordinated ongoing comprehensive care within a medical home; MCHB Core Outcome 5 - Community--based service systems will be organized so families can use them easily, and MCB Outcome 6 -Youth with special health care needs will receive the services necessary to make transition to all aspects of adult life, including health care, work, and independence

The Elks Nurses will continue to lay the foundation for expansion of the Medical Home Initiative by promoting the initiate to providers in non-Medical Home service areas and encouraging providers to participate.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	62	64	66	68	70
Annual Indicator	61.4	61.4	61.4	61.4	66.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	70	70	70	70	70

**Notes - 2007**

Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

No denominator or numerator data was available

**Notes - 2005**

The data was pre-populated and presently no data is available for this performance measure.

**a. Last Year's Accomplishments**

The performance objective for this 2007 performance measure was 70 percent. The survey data for this performance measure shows that 66.2 percent of families with children with special health care needs between the ages of 0 and 18 have adequate insurance to pay for the services they need. Therefore the target for this measure was not met. The percent of children in this category had remain constant at 61.4 percent from 2003 to 2007 and then experienced almost a 5 percent increase in the number of children who had adequate private and/or public health insurance in 2007.

SKN helpline Specialists are trained to ask callers if they or their children have health care coverage. In 2007, 169 callers were referred to their local County Assistance Office, 385 referrals were made to Department of Health's Special Needs Unit, 5 referrals were made to the on-line COMPASS application system and 9 callers received Medicaid Application assistance. Children whose parents are divorcing may be considered to have special needs and can be stripped of healthcare coverage during the divorce proceeding. Pennsylvania law provides protection for them, requiring parents to maintain coverage before, during and after the divorce. To assist parents whose children's coverage is endangered by divorce, the Bureau of Family Health piloted an outreach program in partnership with the Philadelphia Family Court system. Funding was

provided to prepare outreach videos promoting COMPASS application for CHIP and Medicaid, and hiring two individuals to work in the Family Court building. These employees assisted families in determining need and applying for insurance. As a result of this effort, 659 children were served, of whom 127 were CSHCN, and additionally, 189 adults were served, including 8 pregnant women.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Specialty Care Program	X			
2. Specialty Kids Network/System of Care		X		X
3. Love EM With a Checkup Program		X		X
4. Medical Home Integrated Care Coordination Initiative				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Pennsylvania Insurance Department conducted a major marketing effort for the "Cover All Kids" initiative in 2007. The program expands the Children Health Insurance Program (CHIP), providing medical coverage for families with an income over 300% of the federal poverty level. The "Cover All Kids" initiative could potentially provide medical insurance for families with children with special health care needs that are ineligible for the Medicaid Program. In 2007, the dissemination of CHIP applications increased from 25,555 in 2006 to 32,361, or by 27%, as an outcome of this initiative. This outreach by the Department of Insurance was just one initiative. Although we co-fund the helpline that receives the calls from the Healthy Kids Line, our Bureau has not conducted any specific media to encourage insurance application over the past year., According to the National Survey of Children with Special Health Care Needs Chartbook 2005-2006, the percent of children with children with special health are needs age 0-18 whose families have adequate private and/or public insurance in PA is 66.2 vs 62.0 nationally.

**c. Plan for the Coming Year**

The Special Kids Network (SKN) provides information and referral services that are outside the scope of insurance coverage but necessary to attain a better quality of life. Outcomes from the focus group study will assist the SKN program to improve and increase current resources for helpline callers. Parents are primarily searching for Early Intervention services for children just diagnosed with a special needs condition and transitional programs for children leaving high school. Coordinating and communicating with other parents was noted as a key avenue for parents to stay informed and learn about resources. Awareness and educational programs targeted at health care professionals and educators was a repeated theme as a result of the study.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	74	76	78	80	82
Annual Indicator	73.4	73.4	73.4	73.4	89.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	89.5	89.5	89.5	89.5	89.5

**Notes - 2007**

Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

No denominator or numerator data was available

**Notes - 2005**

The data was pre-populated and presently no data is available for this performance measure.

**a. Last Year's Accomplishments**

The 2007 performance objective for this performance measure was 82 percent. The national survey reported that in PA 89.5 percent of families with children with special health care needs felt that community-based systems of services were well organized and that they could access them easily. The target for this performance measure was exceeded. This percent represents a significant increase of 16.1 percent from the previous year.

The Special Kids Network provided a dual approach to develop better and more coordinated service systems through its Information and Referral Helpline and its System of Care activities. This dual approach addresses the need for immediate services and the aspiration to build capacity within the community to address longer term solutions.

The SKN/SOC provided Community System Development opportunities to assist local community partners and stakeholders in identifying, creating or enhancing community-based services that are comprehensive, coordinated, community-based, family-focused, and culturally appropriate. The SOC Coordinators identified partners within the ten identified communities to assist in the development, collection and verification of data for the community profiles presented on the web portal. These identified partners will continue to update this information on the web portal in the following years.

In early 2007, the Epilepsy Foundations' Project School Alert evaluation tools were refined by the University of Pittsburgh Office of Child Development based on the 06-07 school year experience. The Foundations piloted the new instruments between March and June 2007. The report of the results of the pilot testing as well as a review of usable data collected prior to the pilot testing

showed that the educational programming performed by both Foundations to the over 10,000 children, teens, teachers and school nurses reached had positive statistically significant outcomes related to knowledge change among the school staff and teens who make up their educational program audiences. A total of 15 Building Inclusive Communities and 17 Barrier Elimination mini-grants were awarded during 2006-2007. Presentation topics included transition, inclusive puppet shows, and disability is natural. Items purchased for the barrier elimination grants included lifts, audiobooks, and adaptive playground equipment targeted to the visual, hearing and physical and developmental challenges the children need to overcome to enable them to be included into everyday environments.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Integrated Care Coordination Initiative				X
2. Special Kids Network/Systems of Care				X
3. Maternal and Child Health Services via Local Health Department	X	X	X	X
4. NBS		X		
5. Special Health care Programs in the Philadelphia Health		X		X
6. Cooperative Efforts and Technical Assistance		X		X
7. PA Recreation & Leisure Line For Individuals with Disabilities		X		X
8.				
9.				
10.				

**b. Current Activities**

When reviewing the National Survey of Children with Special Health Care Needs Chartbook 2005-2006, Pa is serving 89.5 of the families in a manner that they feel which is organized. This figure is slightly better than the National figure of 89.1 percent. We plan to update the Special Kids Network (SKN) referral resource database regularly with changes to existing entries and new services. The call center updated 4,545 health care agencies, service providers and organizations, and added 25 new resources in calendar year 2007. While 140 caller needs were identified as unmet by appropriate referral resources during a call, 87% or 122 of those needs were met through follow-up activities including call-backs and research for appropriate referrals.

The SKN/SOC web portal is in the testing phase and will be available to the public no later than June 2008. SOC community partners will continue to update current data and resources on the web portal. Four Building Inclusive Communities mini-grants which support costs related to community presentations that build inclusiveness were funded for 2007-2008 fiscal year. Efforts to reach out to various ethnic groups are continuing by both Epilepsy Foundations in order to assure that parents of all cultures are made aware of the Foundation support services. Both Foundation have sent paid and volunteer staff to the national Epilepsy Foundation's conference on reaching out to minority populations.

**c. Plan for the Coming Year**

Proposed changes to the Health and Human Services Call Center (HHSCC) database will update existing reports and create additional queries to evaluate caller needs met and unmet. The changes encompass data driven tables that will extract key demographic data such as age, race and gender for utilization of Department of Health programs.

The SKN/SOC will add another ten community profiles and their identified resources to the current list of profiles available. SKN/SOC community partners will continue to update current

data and resources on the web portal.

For 2009, the two Epilepsy Foundations will continue to monitor their School Alert Project both thru the pre/post tests but also with other measures targeted to more intermediate outcomes. Both Foundations have staff placed in regions throughout the state and use them to identify families in need of advocacy and information services. Both Foundations have found that what both the general population as well as the medical community know and believe varies significantly from region to region and are adapting their education message to meet local educational needs.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	30	32	34	36	38
Annual Indicator	5.8	5.8	5.8	5.8	46
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	48	50	50	52	52

**Notes - 2007**

Source: Child and Adolescent Health Measurement Initiative. 2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.

No denominator or numerator data was available

**Notes - 2006**

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

No denominator or numerator data was available

**Notes - 2005**

The data was pre-populated and presently no data is available for this performance measure.

**a. Last Year's Accomplishments**

The 2007 performance objective for this performance was 38 percent. With a score of 46 percent the target for this performance measure was exceeded. This represents a significant increase of over 40 percent from the previous reporting years.

The Individuals with Disabilities Education Act (IDEA) mandates that schools provide a summary of academic achievement and functional performance with recommendations to assist the student

in meeting postsecondary goals. As part of a school's accountability, IDEA requires a State Performance Plan to implement the requirements and purposes of IDEA as they relate to transition. These measures include Indicators 13 and 14. Indicator 13 assesses the percent of youth aged 16 and above with an IEP that includes coordinated, measurable annual IEP goals and transition services that will reasonably enable the student to meet identified post-secondary goals. Indicator 14 assesses the percent of youth who had IEPs, are no longer in secondary school, and who have been competitively employed, enrolled in some type of post-secondary school or both within one year of leaving school. These IDEA mandates put renewed emphasis on transition and greatly expand the number of students receiving services.

The 2007 Pennsylvania Community on Transition Forum: "Achieving Outcomes Through a Shared Agenda" was held from July 18 through 20, 2007. The primary purpose of this forum was to expand the capacity of schools and community partners to promote the successful transition of youth and young adults with disabilities to the post-school outcomes of: Employment; Post-Secondary Education and Training; and Healthy Lifestyles, Community Participation and Independent Living. The Forum had more than 700 attendees, 40 of whom were students with disabilities (6%). Transition is a huge issue in the lives of youth with special needs and one that is avoided by parents and providers alike. Forums to discuss the issue have arisen across the state and country but all too few as many of our teens are outgrowing their pediatricians and all too few general practitioners are ready to tackle their "childhood specialties" and issues such as transportation and other activity of living issues. The medical home and the system of care program have taken this issue to heart and adopted the transition issue as a part of their mission.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Integrated Care Coordination Initiative				X
2. Special Kids Network/System of Care		X		X
3. Family Health Nursing Consultant Program		X		X
4. Ineragency MOU Team on Transition		X		X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The State Leadership Team on Transition will sponsor a four-part series of trainings from January through April 2008 for school nurses, educators, family members, and agency staff to address the issue of health and how it relates to the transition process and post-secondary school outcomes. Sessions will focus on:

- educating professionals, school nurses, transition coordinators, local education administrators, family members, and agency staff about the key role they play in helping youth with special health needs and disabilities transition from the school setting to post-secondary education, employment, and independent living;
- creating health plans for youth with complex medical needs and health conditions (Spina Bifida, down Syndrome, ventilator-dependent, and orthopedic);
- addressing the needs of transitioning students with asthma or diabetes and how to include their

health goals;

- sharing of practical tips and best practices for the inclusion of healthcare issues in the transition process.

**c. Plan for the Coming Year**

SKN/SOC will continue to take a leadership role in implementing the MOU Shared Agenda on Transition and development of next year's transition conference. Potential activities include: sharing of staff resources; sharing of cost and utilization data to facilitate the reduction in duplication of efforts and improve interagency communication for service planning and delivery; strengthening the Pennsylvania Community on Transition's current membership through outreach to additional partners and enhancing local, state, and national connections; expanding our unified cross-stakeholder capacity building efforts; supporting statewide, comprehensive systems change by adopting research/evidence-based practices; identifying gaps and opportunities in services and supports from a cross-systems perspective; and jointly pursuing public and private resources to proactively coordinate agency funding requests. All school age children who have a 504 Waiver or IEP should receive transition planning services from the age of 14 forward. The Pennsylvania Department of Education (PDE) is responsible for monitoring this activity and reporting of post-school outcomes. The PDE, guided by Indicator 14 of IDEA, has begun to collect survey data on all graduates/completers as they exit school and for one year after exit.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	90	90	87	87	87
Annual Indicator	86.2	85.7	83.2	84.6	
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	85	85	86	86	86.5

**Notes - 2007**

Data not available. Currently the data information is embargoed until published in the MMWR. Usually these data are available in September of the following year

**Notes - 2006**

The Annual Performance indicator for 2003, 2004, 2005 and 2006 was obtained from the 2003, 2004, 2005 and 2006 National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available.

Data should be in this form:

2003: 86.2+/-4.1  
2004: 85.7+/-4.0  
2005: 83.2+/-5.2  
2006: 84.6+/-4.4

Data for 2006 will not be available until later in the year 2007.

#### **Notes - 2005**

The Annual Performance Indicator for 2002, 2003, 2004 and 2005 was obtained from the 2002, 2003, 2004 and 2005 National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Data are for children 19-35 months of age. Numerators and denominators are not available.

Data should be in this form:

2002 82.4+/-4.5  
2003: 86.2+/-4.1  
2004: 85.7+/-4.0  
2005: 83.2+/-5.2

Data for 2005 will not be available until later in the year 2006.

#### **a. Last Year's Accomplishments**

The 2006 performance objective for this performance measure was 87 percent.

According to the National Immunization Survey for 2006, 84.6% of children 19-35 months old received 4 doses of a DTP vaccine, 3 doses of polio vaccine, 1 dose of measles/mumps/rubella vaccine, 3 doses of haemophilus influenzae type B vaccine and 3 doses of hepatitis B vaccine. The percent of 19 to 35 month olds who have received a full schedule of age appropriate immunizations has shown slight variability over the past four years, 2003 (86.2%), 2004 (85.7%), 2005 (83.2) and 2006 (84.6%).

A major focus of the Bureau of Communicable Disease, Division of Immunization is to eliminate or control vaccine-preventable diseases. Vaccines are provided to public and private health care providers for infants, children, adolescents and adults to protect against diseases such as measles, diphtheria, tetanus, pertussis (whooping cough), polio, mumps, rubella (german measles), hepatitis A, hepatitis B, influenza, haemophilus influenzae type b, pneumonia, varicella (chickenpox), meningococcal, human papilloma virus and rotavirus.

The 2007 Annual Assessment of Progress toward goals to prevent perinatal hepatitis b virus transmission reported a 60.7% compliance rate for appropriate follow-up of infants born in 2006 to hepatitis B positive females. In 2007, approximately 77,195 doses of these vaccines were made available to 86 provider sites.

The Department of Health provides vaccines at no cost to schools interested in participating in the School Based Immunization Catch-up Program. As of March 2008, there are 7 schools participating in the SICU. The SICU currently offers the following vaccines: hepatitis b, varicella, tetanus/diphtheria/pertussis and meningococcal. By school year 2008/2009, plans are to incorporate all newly recommended vaccines into 100% existing school immunization catch-up programs (SICU).

Annually, each public and private school in Pennsylvania is required to report the immunization status of their students; the number of students on provisional enrollment pending completion of immunization requirements; and the number of students who are have a medical or religious exemption from immunizations. For the 2007-2008 school year schools were asked to report antigen specific information for kindergarten and seventh grades only for both public and private schools: for the majority of antigens the percentage of up to date averaged 96% of the students

were completely in compliance with all immunization requirements; 1.5% were provisionally enrolled; 0.44% were medically exempt; and 0.95% claimed religious exemption.

Annually, Childcare Group Settings are required to report immunization histories for children in their facilities. This requirement coincides with Pennsylvania's Department of Public Welfare's licensure requirement that children in licensed childcare facilities are appropriately immunized. This requirement affects approximately 111,179 infants and children, two months through five year of age, who attend 4,359 Childcare Group Settings throughout the Commonwealth.

The development, implementation and expansion of Pennsylvania's Statewide Immunization Information System (SIIS) serves as a vehicle for monitoring, tracking and accounting for more than 2 million doses of vaccines on an annual basis among nearly 1700 provider sites. Other areas of focus involve a special emphasis on hepatitis B prevention for newborns, pregnant females and high-risk individuals; influenza immunization outreach and pandemic planning; provider education; vaccine preventable disease surveillance; and emergency response preparation.

Coalitions have actively promoted, strengthened and expanded with the establishment of the statewide Pennsylvania Immunization Coalition (PAIC) and the network of county specific and regional coalitions. In addition to PAIC, Pennsylvania currently has 16 local coalitions that service 46 counties.

The PAIC partnered with CVS Pharmacies to develop a statewide immunization campaign to increase immunization awareness among residents in PA All 346 CVS pharmacies in PA participated by printing 4 immunization messages on their prescription bag labels at various times during targeted to different age groups during specified time frames throughout the year. A Timely Immunization Campaign for Pennsylvania was developed in collaboration with the PAIC, PCAAP andof JAMA which examines the timeliness of receipt of vaccines for a sample of U.S. children. Wyeth.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Immunization Program	X		X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

During March 2008, National Infant Immunization Week (NIIW) tool-kits were developed and distributed to all Department District Offices and County Municipal Health Departments. At least one outreach activity for minority, disparate, or underserved children was developed in each area.

Quality Assurance Regional vaccine education programs will be conducted by the Pennsylvania Chapter of the American Academy of Pediatrics(PA AAP) contract on behalf of the Vaccines for Children (VFC) Program. These regional programs are a result of the increased volume of storage and handling problems encountered by VFC Providers and Cold Chain Failures. The

comprehensive topics include a review of vaccine preventable diseases and vaccines, the immunization schedules for children and adolescents, proper vaccine storage and handling, actions to take when temperatures in vaccine storage units fall out of range, proper vaccine administration, and statewide immunization information system (SIIS).

**c. Plan for the Coming Year**

During calendar year 2009 plans are to continue expanding the development and implementation of VFC provider recruitment plans thereby increasing provider enrollment. Other plans include development of a vaccine safety fact sheet which will be distributed to at least 3 state wide agencies providing services for children (i.e., schools, child care facilities, WIC clinics). Strategies will be developed to promote all recommended immunizations with new partners to reach children in identified Pockets of Need (PON) areas with a predicted immunization coverage rate of less than 80%.

A 2009 objective is to ensure that one program area is evaluated for effectiveness and the program chose education and outreach, specifically the Immunization Education Trainings.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	16	15	14	13	12
Annual Indicator	16.6	15.7	15.4	16.0	
Numerator	4376	4198	4162	4313	
Denominator	264088	267596	269471	270122	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	15.3	15.1	14.9	14.9	14.7

**Notes - 2007**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year

**Notes - 2006**

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

**Notes - 2005**

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

**a. Last Year's Accomplishments**

The 2006 performance objective was 13 births per 1,000 teens in the age group. The data showed that the rate in this age group for this time period was 16 births per 1,000 live births, so therefore, the target was not met. Nationally, birth rates for black, white, and Hispanic teens increased in 2006, however, the rate of teenage births in Pennsylvania has remained fairly consistent since 2003.

The Division of Child and Adult Health Services continued to support teen pregnancy prevention initiatives through a grant agreement with Adagio Health Inc. The initiatives included condom distribution, health promotion campaigns, peer education training, and a teen advisory committee. A new three year grant agreement began on July 1, 2007.

On September 1, 2007 the Division of Child and Adult Health Services began six new grant agreements for comprehensive adolescent health care services. The grants focus on providing services to high risk adolescents between the ages of 13 up to their 22nd birthday.

The Division of Child and Adult Health Services along with the Allentown Bureau of Health and the PA Coalition to Prevent Teen Pregnancy created a team and was selected to participate in a Teen Pregnancy Prevention Roundtable and Training sponsored by AMCHP and CityMatCH. The roundtable and training took place in September 2007. As a result of the training the team created an action plan to implement a teen pregnancy prevention initiative in the City of Allentown.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent Health Program	X		X	
2. Family Planning Service System	X			X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Division of Child and Adult Health Services is continuing to support teen pregnancy prevention initiatives through a grant agreement with Adagio Health Inc. The initiatives include condom distribution, peer education, a health resource center program, Wise Guys(r), and Streetwise to Sexwise(r). The Division of Child and Adult Health Services will be working with the grantee to move towards science-based teen pregnancy prevention programs.

The Division of Child and Adult Health Services is working with the Allentown Bureau of Health and the PA Coalition to Prevent Teen Pregnancy to select a science-based teen pregnancy prevention program for the City of Allentown. The Division of Child and Adult Health Services has committed funding to the City of Allentown for a teen pregnancy prevention grant agreement that will begin in October 2008.

During the course of the past year, staff completed a thorough review and analysis of the various

teen pregnancy initiatives being funded by the MCHSBG. As a result, a decision was made that in the future, the Department will only fund science based/evidence based teen pregnancy prevention programs or promising practices.

In addition, the Division of Child and Adult Health Services hosted a communications workshop titled "Building Public Will for Youth." The Konopka Institute at the University of Minnesota was able to provide this training at no cost to the Department's adolescent health and family planning grantees.

**c. Plan for the Coming Year**

In 2009 the Division of Child and Adult Health Services will continue to move its grantees towards science-based teen pregnancy prevention programs. This will include continuing to fund the Adagio Health Inc. teen pregnancy prevention initiatives grant agreement, the six comprehensive adolescent health grant agreements, and the Allentown Bureau of Health grant agreement for a science-based teen pregnancy prevention program.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	30	34	38	38	38
Annual Indicator	0.0	23.2	25.3	29.5	
Numerator	0	10491	11510	13895	
Denominator	1	45177	45576	47061	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	30	31	31.5	32	32.4

**Notes - 2007**

Data not available. Usually these data are available 6 months from the close of the calendar year.

**Notes - 2006**

Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/07 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the SFY monthly average of Medicaid enrollees who are 8 years old. Numerator and denominator source: PA Department of Public Welfare.

**Notes - 2005**

Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/06 who have a protective sealant on at least one permanent molar tooth, based on paid dental claims. The denominator is the number of Medicaid enrollees who are 8 years old as of 09/30/06.

Numerator and denominator source: PA Department of Public Welfare

**a. Last Year's Accomplishments**

In 2007 the Department of Health funded the development and/or expansion of four dental sealant programs throughout the Commonwealth in order to expand the availability and accessibility to this important preventive oral health measure. Healthy People 2010, Objective 21-8, has a goal to increase the proportion of 8 and 14 year olds with at least one dental sealant to 50 percent. The Department's Oral Health Needs Assessment (OHNA) found that only about 25 percent of 8 and 14 year old children in Pennsylvania have at least one dental sealant. A school-based dental sealant program for students between the ages of 6 to 8 and 12 to 14 will be implemented at schools with 50% or more students enrolled in the Free and Reduced Cost School Meal Program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School-based dental sealant program	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In 2008 funding for the school-based dental sealant programs will be for the January 1, 2008 through September 30, 2008 period. Programs are being funded at the Erie County Department of Health, Allegheny County Health Department, Chester County Health Department, and the York City Bureau of Health. Approximately 2,200 students are expected to participate. In addition, the Department will utilize the Sealant Efficiency Assessment for Locals and States (SEALS) data collection program.

**c. Plan for the Coming Year**

Pending available funds, the Department will continue the school-based dental sealant programs in 2009. It is estimated that over 2400 students will receive sealants in the coming year.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	3.1	3.1	2.5	2.4	2.3
Annual Indicator	2.7	2.5	2.3	2.9	
Numerator	63	59	54	66	
Denominator	2356033	2339033	2326570	2313503	
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	2.3	2.3	2.3	2.3	2.3

**Notes - 2007**

Data Not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2006**

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

**Notes - 2005**

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

**a. Last Year's Accomplishments**

The performance objective for 2006 was 2.4 deaths per 100,000 children and 2.9 were achieved. The target was met. The data shows that the trend has remained relatively consistent over the last four years.

The rate of deaths to children ages 0-14 caused by motor vehicle crashes declined from 2.7 in 2003 to 2.3 per 100,000 in 2005, before increasing again to 2.9 per 100,000 in 2006. During 2007, Safe Kids Pennsylvania Coalition provided technical assistance and training to 48 local coalitions and chapters through site visits, telephone technical assistance, distribution of injury prevention materials, and three statewide meetings.

During 2007, three editions of the Safe Kids Pennsylvania Coalition newsletter were sent to 3,600 injury prevention partners across the state. During 2007, three statewide meetings were held in November, March and June. Approximately 60 persons were in attendance at each of the meetings. In addition, Safe Kids Pennsylvania hosted training for all Safe Kids coordinators and members of the advisory council.

The Safe Kids Pennsylvania Coalition attended a multitude of public events that were held throughout the year. Some of these events included: Pennsylvania State Farm Show; the American Trauma Society, Pennsylvania Division, Conference; Redner's Baby Expo; Allison Hill Multicultural Festival; Child Passenger Safety Press Conference; Lancaster County Safe Kids Day; Dauphin County Safe Routes to School; Lower Allen Safety Day; Lights On for Life; and Allegheny County Safety Diorama.

Safe Kids Pennsylvania hosted the second Safe Kids Pennsylvania Coordinators Retreat on April 16-18, 2007. Approximately 30 coordinators and co-coordinators attended workshops focused on advocacy and public policy issues.

In 2007, 13 bicycle safety mini-grants were awarded to community organizations and police departments across the state. Two meetings were held for the bicycle safety grantees. Topic areas at these meetings included: grant requirements, bicycle derby basics, educational models, and media relations. The Safe Kids Pennsylvania Coalition conducted site visits to four of the grantee sites. Bicycle Safety grantees distributed 3,340 bicycle helmets during 2007.

The goal of the bicycle safety grants is to increase bicycle safety while reducing bicycle related injuries. The primary target audience for the grant is children and youth ages 5 to 15 years of age. By conducting pre and post observations for those youth who did not use a bicycle helmet prior to receiving one from the grant program, grantees learned through helmet observations that there was a 20% increase in helmet use among those youth that received a helmet from the grant program.

The 48 Safe Kids Pennsylvania Coalitions and Chapters conducted 398 child safety seat events during 2007. At these events, 5,455 child safety seats were checked for proper fit and installation. Of the 5,455 child safety seats that were checked, 1,847 of those were child safety seats that were distributed by the chapters and coalitions to families in need.

Safe Kids Pennsylvania Chapters and Coalitions distributed 5,181 bicycle helmets during 2007. Therefore, the overall number of bicycle helmets distributed during this time frame is 8,521.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Safe Kids Program			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The CDR Program has worked with the Pennsylvania Department of Transportation (PennDOT) to secure approval to obtain data on traffic fatalities from the Crash database. Data will be retrieved from the Crash Reporting System and which will assist Local Teams in their review of deaths that occurred due to motor vehicle accidents by receiving traffic reports.

There are currently 49 Safe Kids Pennsylvania Coalitions and Chapters that are in operation. There are currently 11 bicycle safety mini-grants that were awarded to community organizations and police departments. There are currently 23 Safe Kids mini-grants awarded to chapters and coalitions.

Safe Kids Pennsylvania plans to continue its efforts to reduce child deaths and injuries from motor vehicle crashes and improve child passenger safety by continuing to sponsor child safety seat check-up events. Safe Kids Pennsylvania and its chapters/coalitions will also host technician training courses to assure that trained personnel are available to check seats. A press conference will be scheduled for the week of September 21-27, 2008, for Child Passenger Safety Week. Local coalitions and chapters will hold events across the Commonwealth during that week.

To date in 2007, Safe Kids Pennsylvania has attended the Pennsylvania State Farm Show and the American Trauma Society, Pennsylvania Division, Conference. The selection process for the Safe Kids PA mini-grants will take place during summer 2008.

**c. Plan for the Coming Year**

Safe Kids Pennsylvania will continue to seek new lead agencies for chapter formation in counties without a Safe Kids presence. Safe Kids PA will continue to partner with Child Death Review to develop prevention projects in the local communities according to need.

During 2009, the Safe Kids Pennsylvania will hold three statewide meetings and four Advisory Council meetings. Safe Kids affiliates will receive mini grants, through federal funds in FY 08-09 to provide education to parents and caregivers on proper use of car seat, booster seat and seat belt restraints for children statewide.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	35	35	35	38.5	40
Annual Indicator	30.9	32.7	37.5		
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	40	41	42	43	44

**Notes - 2007**

2006 birth data should become available in 2009/2010. Data delay as CDC is developing new system of data collection by year of birth. These data are collected over a 3-yr period and final data are available 4 yrs from date of birth

**Notes - 2006**

2006 birth data should become available in 2009/2010. Data delay as CDC is developing new system of data collection by year of birth.

The Annual Indicator for 2003, 2004, and 2005 was obtained from the 2003, 2004, and 2005 National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Numerators and denominators are not available.

Data should be in this form:

- 2003: 30.9+/-4.2
- 2004: 32.7+/-4.9
- 2005: 37.5 +/-5.2

new data not available until August 2008.

**Notes - 2005**

The Annual Performance Indicator for 2003, 2004, and 2005 was obtained from the 2003, 2004, and 2005 National Immunization Survey conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. Numerators and denominators are not available.

**a. Last Year's Accomplishments**

The performance objective for 2005 for this performance measure was 35 percent of mothers would be breastfeeding at six months. The 2005 National Immunization Survey indicates that 37.5 percent of Pennsylvania mothers were breastfeeding their infants at 6 months of age, exceeding the target. The data demonstrates that the percent of women breastfeeding their infants at six months of age has increased by 6.6 percent from 2003 to 2005, the last year that data was available. This data trend is reflected in the data Pennsylvania collects from its birth certificates as well. This increase reflects several trends: the increase in knowledge among young parents regarding the benefits of breastfeeding, the slow but steady elimination of barriers in the hospitals, at the doctor's offices, at work and socially at the mall, restaurants, etc. Also, more WIC mothers are breastfeeding longer than before reflecting the above reasons and new WIC policies making it more difficult for breastfeeding mothers to get formula which before that policy change was resulting in short duration. Since 2004, when a full-time lactation consultant was hired, the health department has worked hard to influence stakeholders to reduce barriers to breastfeeding duration.

In 2007, 27 breastfeeding mini-grant applications valued at \$75,498 were awarded. An additional three special initiative mini-grants targeting environmental support for breastfeeding were funded with \$9,000 provided by the Bureau of Chronic Disease, Division of Nutrition and Activity. The Program continues to manage, support and monitor the third and last year of the MCH/WIC Breastfeeding Collaborative Project. A WIC program focus in the City of York is targeted towards Latino mothers. The WIC programs conducted in Luzerne and Lycoming counties are targeted toward low-income rural mothers with low initiation and duration breastfeeding rates. Both programs target the ethnic groups within their geographic area.

Ten pilot sites provided feedback on four breastfeeding promotion posters with impact messages that address known barriers as part of a public awareness campaign. This feedback provided the basis for changes in the design and content of the posters.

Based on the results of a WIC 2006 participant survey which showed that infant fussiness was a major reason for premature weaning and formula supplementation, the Pennsylvania Breastfeeding Awareness and Support Program and Pennsylvania-WIC co-sponsored a conference in June 2007 for WIC and Bureau-supported MCH field nurses teaching practical techniques for dealing with infant and toddler fussiness.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Program	X	X		
2. Breastfeeding Mini-Grant Program		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

For the state fiscal year 07-08, 14 breastfeeding mini-grant applications valued at \$42,000 were awarded. Two additional special initiative mini-grants totaling \$6,000 were awarded with funds provided by a continuing collaboration with the Bureau of Chronic Disease, Division of Nutrition and Activity. As of August 2007, due to budget cuts, no new mini-grants awards were accepted.

Distribution of breastfeeding promotion public awareness posters throughout the state began in 2007. To date, a total of 5,000 posters have been distributed, reaching every Pennsylvania county.

The Breastfeeding Awareness and Support Program in collaboration with PA-WIC will certify 250 WIC staff over the next two years in The Happiest Baby techniques based on pediatrician Dr. Harvey Karp's methods for calming fussy infants to improve breastfeeding duration rates, decrease formula issuance and decrease Shaken Baby Syndrome incidence. Fayette County Nurse-Family Partnership is in partnership with University of Pittsburgh to determine the effectiveness of the methods for low-income families.

To address breastfeeding promotion barriers related to lack of physicians office practice support and lack of community understanding of the benefits of breastfeeding, two Requests for Applications (RFA) were announced in June 2007. In October 2007, just before the three finalists were announced, funding was withdrawn, and the 10 applicants informed of the activities' termination.

**c. Plan for the Coming Year**

In 2008-09, the Breastfeeding Program's projected initiatives based on evaluation and feedback from current activities include:

1. Developing a CD of breastfeeding posters to share with out of state requests. To date, 22 requests from two countries and nine states have requested Pennsylvania's breastfeeding promotion posters with plans to print state specific posters for public awareness campaigns.
2. Continuing certification of WIC staff in The Happiest Baby techniques, tracking number of education contacts and determining impact on breastfeeding rates.
3. Conducting pilot site evaluation for the breastfeeding promotion DVD and then distributing the DVD in Latino and African-American population-dense counties.
4. Adding to breastfeeding pages on Department of Health's website.
5. Collaborating with the Pennsylvania State Breastfeeding Coalition in a state-wide effort to increase community and business awareness in ways of supporting working mothers.
6. Seeking partnering opportunities to address breastfeeding barriers and eliminate disparities related to physician office practices and poor breastfeeding promotion and support for mothers of low birth weight and premature infants.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
---------------------------------------	------	------	------	------	------

Annual Performance Objective	85	85	98	98	98
Annual Indicator	97.9	98.4	98.0	98.0	
Numerator	139503	138750	138495	141791	
Denominator	142566	141013	141341	144749	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	98	98	98	98	98

**Notes - 2007**

Data not available and usually these data are not available until 24 months from the close of the calendar year.

Denominator only - Usually these data are available 6 months from the close of the calendar year.

**Notes - 2006**

Numerator

data source: Division of Newborn Screening and Genetics

Birth figures (denominator) are final births in hospitals supplied by the PA Department of Health, Bureau of Health Statistics and Research.

**Notes - 2005**

Birth figures (denominator) are final births in hospitals supplied by the PA Department of Health, Bureau of Health Statistics and Research.

Our statutory objective, according to Act 89 of 2001 is that 85% of newborns are screened.

**a. Last Year's Accomplishments**

The 2006 performance objective met its designated target of 98 percent. The data shows that the target for this performance indicator has met or exceeded the performance indicator each year since 2003. Exceeding this percentage would be very challenging because of the optimal functioning of the Program. For example, some parents will always refuse screening and some newborns will have serious health problems that preempt hearing screening.

Two issues will help to continue this high success rate: 1) acquiring a new software program for hearing screening, and 2) improving data collection on each newborn through electronic methods. The Program is currently involved in a pilot test with 4 hospitals in Central Pennsylvania that are submitting results via the electronic birth certificate. The eventual expansion of this enhanced electronic birth certificate process after evaluation will serve the Program well. The Program would like to obtain screening results directly from the hospital equipment via a new web based hospital tracking system. The Program is also looking to gather information from early intervention that will enable greater detail for follow-up (currently, federal privacy regulations apply).

In Calendar Year 2007, 142,899 infants received newborn hearing screening before hospital discharge. One-hundred-thirty-thousand-six-hundred-two passed their initial screening and 8,133 needed a re-screening. One-thousand-three-hundred-thirty-eight infants did not pass their re-

screening.

As of the writing of this report, 337 infants received and passed a diagnostic evaluation, 176 were diagnosed with a hearing loss, 70 were linked to early intervention services and 66 were documented as receiving on-going medical treatment.

Ten birthing hospitals were provided grants to purchase hearing screening and audiological diagnostic equipment and educational information. Approximately \$250,000 was distributed across the state.

A partnership with Part C Early Intervention technical assistance developed into a training contract to provide Early Intervention providers with information on the needs of infants with hearing loss, their developmental capabilities and outcomes after participation in the program. Family Support and development of a web directory for pediatric audiologists was also included.

In 2007, the program requested a consultant to complete a software review of commercial off-the-shelf (COTS) products in order to assist the program to determine whether a COTS product(s) would meet the program's requirements for an information system. The consultant completed the COTS software review and provided information to the program. The program is evaluating its options under Pennsylvania's Procurement Code to procure a COTS product that would meet the program requirements and substantially upgrade the capabilities of the program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening			X	
2. Diagnostic Evaluation	X			
3. Follow-up	X			
4. Intervention	X			
5. Training and Evaluation				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The PA Chapter of the American Academy of Pediatrics will work with the Early Intervention Technical Assistance to survey licensed audiologists to determine if they have the proper equipment to provide complete hearing diagnosis and pediatric amplification services. The PA Chapter of the American Academy of Pediatrics will also work to build a web accessible resource list of audiological services across Pennsylvania.

The PA Chapter of the American Academy of Pediatrics sponsored a teleconference as one of its branded "Let's Talk" series of lunch hour teleconferences. The target audience for this educational teleconference is physicians, nurses and office staff and the goal is to educate primary care physicians and other on the importance of diagnosis of a child with suspected hearing loss by 3 months and referral to Early Intervention by 6 months of age.

**c. Plan for the Coming Year**

A small number of hospitals will be receiving grants for hearing screening equipment. The out-of-hospital newborn hearing screening program will purchase supplies and have funds reserved for maintenance of the 20 machines currently in rotation.

A publication will be developed, as a parent guide and will contain information on communication options, Early Intervention Services, and family support.

The program is going to provide some mini-grants for parent support groups and parent training for parent peer supporters to pilot test some different methods of family support.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	6.5	6.2	9.2	9.2	9.1
Annual Indicator	8.4	10.2	8.3	7.3	
Numerator	239000	291000	235000	203000	
Denominator	2852000	2844000	2830000	2778000	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	7.3	7	6.7	6.7	6.7

**Notes - 2007**

Data not available. Usually these data are available 9 months from the close of the calendar year

**Notes - 2006**

Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us. The U.S. Census Bureau data for 2007 will not be available until September of 2008, so there will be a gap in our reporting on these figures. The data for year 2004 were revised based on improvements to the algorithm that assigned coverage to dependents, and there was an adjustment to the weights.

**Notes - 2005**

Percent and denominator are from Table HI-5, Health Insurance Coverage Status and Type of Coverage by State, Children Under 18, prepared by the U.S. Census Bureau. The numerator was calculated using the data from Table HI-5. PA has chosen to use the U.S. Census Bureau data because we believe it is the most consistent, reliable, and objective data available to us. The U.S. Census Bureau data for 2006 will not be available until September of 2007, so there will be a gap in our reporting on these figures. The data for year 2004 were based on improvements to the algorithm that assigned coverage to dependents, and there was an adjustment to the weights.

There are at least two other ways that Pennsylvania could choose to derive the numerator for this performance measure. The numerator 258,000 was calculated a few years ago by the PA Insurance Commission (which administers CHIP). 258,000 is the number officially in use by the PA Insurance Commission and by many advocacy groups across the state. Families USA has also released a study (available at [www.familiesusa.org](http://www.familiesusa.org)) which indicates that 636,000 children under 18 were uninsured for at least one month during the years 2001 and 2002.

**a. Last Year's Accomplishments**

The 2006 performance objective for this performance measure was set at 9.2 percent. The data showed that 7.3 percent of children in Pennsylvania did not have health insurance, therefore, exceeding the target. The data demonstrates that there has been a steady decrease since 2004 in the percent of children without health insurance.

The Family Court Pilot continued past its intended completion date as some of the funds had not been spent by the court since the contract had began October 2006. Working with the Department of Public Welfare, we wrote a Notification of Subgrant to utilize the remaining \$41,000. Within the period of 10/06-12/07, the court staff served over 670 clients. In coordination with the Insurance Department and the CHIP contractors serving Philadelphia, CHIP brochures and applications were available throughout the courthouse. 2,580 Brochures were distributed and approximately 1,900 applications were provided. The CHIP brochure directed families to call the 1-800-986-KIDS help line to obtain more information and apply for coverage over the phone. During the project, the number of callers that referenced domestic relations as their source of the phone number increased by an average of 50%. The application assistance service available in the courthouse was marketed in a unique way. Staff did presentations in the waiting areas of each courtroom, signs were displayed in most public areas of the courthouse, phone calls were made to families in the domestic relations system that had no record of health care coverage for their children.

The Department of Health co-funds with two other agencies, Insurance and Public Welfare, the Healthy Kids Help Line. That Helpline has been established to enroll children in insurance. The line is part of the Commonwealth's Health and Human Services Call Center. The Center answered over 150,000 call last year and 65% of those calls were to the Healthy Kids Helpline.

This past year, CHIP focused on increasing its marketing tools and outreach efforts to motivate parents to "apply now" and enroll their children in the program. Final approval for The CHIP program expansion was granted in February, 2007. The CHIP program was officially launched by Governor Rendell on May 1, 2007. CHIP continued its successful internet search engine advertising, utilizing Google, Yahoo and other popular search engines, which netted millions of hits on its Web site. CHIP employed new efforts to focus more on the teen uninsured population through radio spots, billboards and front page newspaper stickers featuring teens. To assist with strategic messaging and planning, and to better target areas where CHIP could provide more marketing and outreach, listening sessions were held with community advocacy partners and CHIP contractors. The CHIP office added movie screen CHIP ads in theaters. CHIP sponsored a Farm Show booth in 2007, where information and giveaways were distributed and application assistance was provided to families. The theme was "tell a friend or family member to apply today". More than 500,000 citizens attended the 10 day Farm Show event. As a result of the increase in outreach and marketing efforts, another 12,382 children were enrolled in the program for 2007.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Specialty Care Program	X			

2. Special Kids Network/Community Systems Development				X
3. Love EM With a Checkup Program				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

As of April 8, 2008, 67,400 children were able to take advantage of the CHIP program, exceeding the 2007-2008 goal by 26 percent.

CHIP started a new "Uninsured Study" in September. Results of the interviews are pending and will be released in the fall of 2008.

**c. Plan for the Coming Year**

CHIP's goal for 2009 is to insure an additional 17,000 children. In an effort to reach that goal, staffs from the Bureau of Family Health and the Department of Public Welfare are collaborating with the Insurance Department in its application to the Robert Wood Johnson (RWJ) Foundation's Maximizing Enrollment for Kids grant program. The proposal and accompanying letters of support were submitted August 6, 2008 and site visits by the Foundation are expected in October and November of 2008. Pennsylvania could receive \$1 million over a four year period to assess its enrollment and retention systems, and participate in technical assistance and peer-to-peer learning activities. The grant activities are conducted in close collaboration with the RWJ Foundation. Pennsylvania's record of outstanding enrollment and retention practices in the past supports this worthy application.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective		13.5	13.9	13.8	13.7
Annual Indicator		25.8	25.0	24.7	
Numerator		26828	25787	25570	
Denominator		103968	103151	103524	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	13.6	13.5	13.4	13.4	13.4

**Notes - 2007**

Data not available

**Notes - 2005**

2005 Data Not Available.

2005 Objective: 13.9

2004 Data

Objective: 14.0

Percentage: 14.0

Numerator: 103,968

Reported from 2004 Pediatric Nutrition Surveillance from CDC Table 2C.

**a. Last Year's Accomplishments**

The 2006 performance objective was set for no more than 13.8 percent of WIC children ages 2 to 5 to be at or above the 85th percentile for BMI. The 2006 report from the Pediatric Nutritional Surveillance at the Centers for Disease Control (CDC) indicated that 24.7 percent of children ages 2 to 5 years receiving WIC services had a Body Mass Index (BMI) at or above the 85th percentile. The measure was not met. The data illustrated that BMI's at or above the 85th percentile has remained unchanged since 2004.

Calendar year 2006 data from the CDC Pediatric Nutrition Surveillance System (PedNSS) shows that the percent of 2 to 5 year old children in PA WIC with a BMI at or above the 85th percentile is 24.7%, as compared to the national rate of 30.8%. This represents a drop from 25.1% the previous year, while the national rate essentially stayed the same (30.9%). Pennsylvania has continually observed decreases in the rate of children at risk or overweight for the past four years, when the rate reached a peak of 26.8% in calendar year 2003. Clearly, we are not close to meeting the 13.8% when looking at the combined group of at or above the 85th percentile. However, in reviewing the group of 2-5 year old WIC children between the 85th and 95th percentile in calendar year 2007, the percentage is currently at 13.3%, compared against 2006 data which was 13.6%.

It should be noted that the 2007 PedNSS Summary Report from CDC (reflecting data from 2006), shows Pennsylvania with the second lowest percentage of overweight WIC children between 2-5 years (=95th percentile) in the country (11.1%), with only Colorado having a smaller percentage of children in this category (9.6%). In the 2006 Summary Report (reflecting data from 2005), Pennsylvania had the seventh lowest percentage of overweight children, at 11.8%. The national average remained the same for both years at 14.8%. This is encouraging news for the WIC children in our state.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Specialty Care Programs	X			
2. Special Kids Network/Community System Development				X
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

**b. Current Activities**

While the Pennsylvania WIC Program has not conducted any new activities that can be directly related to the continual downward trend for weight issues in our children, the State Agency has identified efforts that potentially could be impacting this trend. Since 2000, local WIC agencies have been addressing Obesity Prevention as an education topic with all families having children two years of age and up. The introduction of our Obesity Prevention modules was instrumental in incorporating key behavior-based messages in our daily encounters with participants.

As use of the modules progressed, local agencies also made continued efforts to incorporate goal-setting with the participants to encourage and facilitate behavior changes in feeding practices. While some local agencies accomplished this to a higher degree than others, it is a strategy that is continuing to be developed through a research project funded by the United States Department of Agriculture (USDA). We are currently in the final year in the development and formal evaluation of a module to teach staff on a "Guided Goal Setting" educational methodology for use in counseling WIC participants.

Additionally, with the implementation of the QuickWIC data collection system in 2002, model food packages were set to correspond to recommendations from the American Academy of Pediatrics on juice and milk consumption.

**c. Plan for the Coming Year**

The WIC Program faces its greatest challenge in the coming year as it plans to implement the new Food Package rule issued by USDA in late November 2007. State agencies will have until October 1, 2009 to implement significant changes in the foods offered to our participants. There will be changes in quantities of some foods currently being provided and the addition of new foods that will align the WIC Food Package with the Dietary Guidelines for Americans. Fruits and vegetables, whole grain foods, infant foods, and soy beverages and tofu will be offered by the WIC Program for the first time since the program came into existence in 1974. This major change will require the full cooperation of the local WIC agencies, the participants, the retail store community, and medical providers. It is hoped that the wider variety of foods will help to contribute to continual decreases in weight in our population.

WIC continues to move towards the implementation of another USDA initiative that will assist in our efforts to improve the health of our participants. The Value Enhanced Nutrition Assessment (VENA) initiative is another piece of USDA's efforts to revitalize quality nutrition services. Local agencies will require training to improve the competencies necessary for conducting assessments in WIC, which will make it easier for staff to identify behavior based changes for participants that can be addressed through the Guided Goal Setting process. It is anticipated that the results of the ongoing research project will justify training of all local agency staff on Guided Goal Setting. Another USDA Special Project Grant was awarded to the Pennsylvania WIC Program to develop e-Learning modules to assist with the training of WIC staff on VENA. Improving staff competencies will increase the quality of nutrition services provided to our participants. These services include nutrition education, referrals, tailoring of the food benefits, and breastfeeding promotion and support.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				14.2	14
Annual Indicator				13.7	
Numerator				19559	
Denominator				142397	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	14	14	13.9	13.8	13.7

**Notes - 2007**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2006**

Unknowns excluded in calculations.

Source: PA Department of Health, Bureau of Health Statistics

Unable to enter 2004 and 2005 data as follows:

Data for 2004

Annual Performance Indicator 14.1  
 Numerator 19,423  
 Denominator 138,077

Data for 2005

Annual Performance Indicator 14.0  
 Numerator 19,516  
 Denominator 138,988

**Notes - 2005**

Unknowns excluded in calculations.

Source: Pa Department of Health, Bureau of Health Statistics and Research.

2005 data not available. Unable to enter 2004 data as follows:

Annual Performance Indicator: 14.4  
 Numerator: 19,423  
 Denominator: 135,077

**a. Last Year's Accomplishments**

The 2006 performance objective for this performance measure was set for no more than 14.2 percent of pregnant women to smoke at the end of pregnancy and 13.7 percent was achieved exceeding the target. This is the only year we have data for regarding this performance measure.

The Department has continued the partnership with the Department of Public Welfare (DPW) to educate low-income women about the dangers of smoking while pregnant and to encourage pregnant women who are receiving Medicaid benefits to quit smoking. The Departments are collaborating in training exercises that include an overview of the PA Free Quitline services to the

DPW Medical Directors and their quality assurance managers. Representatives from the Quitline vendor provided in-depth information including on-going clinical research, counseling services, data reporting, and evaluation.

The Department's 48 primary contractors continued to target pregnant women who smoke. For example, in Erie County the contractor established the Booker T. Washington Center Baby and Me program in 2006. Participants have increased since last year (45 to 55) and the number of moms who quit smoking and stayed non-smoking have increased. Being that the Booker T. Washington Center is a WIC site, the majority of our participants have been channeled to us from them. The majority of participants are white, non-married women, pregnant for the first time. They normally live with a parent or the baby's father and in both of the living situations the girls are most often living with smokers. The program provides tools and support to remain smokefree, even during the stressful times of infancy and an environment of smoking family members and friends. Cessation services are offered to family members living in the same household as the client to improve the child's chances of a healthier environment.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Service System	X			
2. County Municipal Health Department Education Programs			X	X
3. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V)				X
4. Smoking Cessation Program	X			
5. Family Health Nurse Consultant Program	X	X	X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Department of Health (Department) is the lead agency for the Commonwealth's Tobacco Use Prevention and Cessation program, and has successfully administered the program over the past four years. The Department recognizes that addressing the issue of tobacco use requires a comprehensive health promotion approach that will sustain and strengthen capacity in communities, involve multiple public agencies, promote policies that improve health, and build supportive environments.

The Department has consistently followed the Centers for Disease Control and Prevention (CDC) Best Practices for Comprehensive Tobacco Control Program. Over the past funding cycles the Department has demonstrated both accomplishments and barriers to implementing a comprehensive tobacco control program through county-based contracting. In an effort to reduce duplication of services and to fund the most cost effective service delivery system, the Department transitioned from 48 county-based primary contractors to 8 regional primary contractors.

Regional primary contractors continue to target pregnant women who smoke and have established program delivery systems throughout their service areas. The partnership with the Department of Public Welfare to address pregnant women who smoke is continuing. On-line CME cessation training for established Medicaid providers is now available to increase the cessation services.

**c. Plan for the Coming Year**

On-going evaluation of regional initiatives that target pregnant women who smoke will continue and successful programs will be replicated where appropriate. A media campaign targeting pregnant women, women with children and other adults residing in the home will be implemented as a pilot initiative in the southwest region.

DPW initiative will also continue and will include monitoring cessation services by Medicaid providers, outcome data, and quitline statistics.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	6.4	6.2	8.2	8.1	6
Annual Indicator	8.0	7.3	6.2	5.4	
Numerator	72	67	57	50	
Denominator	904628	918572	924662	928078	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	5.2	5.1	5.1	5	5

**Notes - 2007**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2006**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research.  
Denominator source: PA State Data Center.

**Notes - 2005**

Numerator source: PA Department of Health, Bureau of Health Statistics and Research.  
Denominator source: PA State Data Center.

**a. Last Year's Accomplishments**

The 2006 performance objective for this performance measure was 8.1 suicide deaths per 100,000 teens age 15-19. The target was exceeded with a rate of 5.4 suicide deaths per 100,000 teens age 15-19. The data demonstrates that there has been a steady decrease in the rate of suicide deaths in this age group since 2003. the rate between 2003 and 2006 has dropped by 2.6 per 100,000.

Since the 1980's, Pennsylvania has made strong efforts toward the prevention of youth suicide through programs such as the Commonwealth Student Assistance Program (SAP), Services for Teens at Risk (STAR-Center), the Yellow Ribbon Program and a variety of other approaches in local areas.

The PA Youth Suicide Prevention Group along with the PA Adult and Older Adult Suicide Prevention Group and the Suicide Prevention Conference Advisory Committee coordinated the first statewide Suicide Prevention Conference on September 12, 2007, entitled, "Suicide Across the Age Span; Saving Lives Together" with over 340 attendees. The Departments of Health and Public Welfare collaborated to provide current information on risk factors for suicide and depression. The conference identified special populations at risk for suicide and examined the effects of suicide on co-workers and family members and how to respond to their diverse needs.

The Child Death Review (CDR) Program provided mini grants to Wayne County for Suicide Prevention and Choking Game education and to Chester County for Suicide Training for the Yellow Ribbon Program. The CDR Program is also involved with the Pennsylvania Suicide Prevention Initiative.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Safe Kids Program			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The PA Youth Suicide Prevention Group continues to develop and fine-tune its five-year plan for PA regarding the prevention of youth suicide. The PA Department of Public Welfare, with support from the Departments of Health and Education, applied for grant funds authorized under the Garrett Lee Smith Memorial Act in 2007. The grant funds will allow states to build upon existing suicide prevention efforts, to implement early identification systems, and to increase access to outpatient behavioral health services.

The Suicide Prevention Conference Advisory Committee continues to meet regularly in planning the 2nd Annual Suicide Prevention Conference to be held on September 9-10, 2008.

The CDR Program is working with the Pennsylvania Suicide Prevention Initiative regarding Suicide Prevention and Awareness Programs and their expansion into elementary schools and working with other identified populations, such as faith-based groups, athletic leagues, and music and theater groups. The CDR Program is also on the Suicide Prevention Monitoring and Joint Advisory Committee.

**c. Plan for the Coming Year**

The PA Department of Public Welfare, with support from the Departments of Health and Education, will continue to seek funding in 2009 to build upon existing suicide prevention efforts, to develop early intervention strategies, and to further public and private sector collaboration. The PA Youth Suicide Prevention Group continues to develop and fine-tune its five-year plan for PA regarding the prevention of youth suicide. The PA Department of Public Welfare, with support

from the Departments of Health and Education, applied for grant funds authorized under the Garrett Lee Smith Memorial Act in 2007. The grant funds will allow states to build upon existing suicide prevention efforts, to implement early identification systems, and to increase access to outpatient behavioral health services.

Suicide Prevention Awareness Week activities will continue in September 2009.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	69.5	70	80.1	81.9	82.5
Annual Indicator	77.7	76.1	76.0	81.1	
Numerator	1797	1736	1727	1942	
Denominator	2312	2282	2272	2394	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	82.5	82.7	82.7	82.9	82.9

**Notes - 2007**

data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2006**

Source: PA Department of Health, Bureau of Health Statistics and Research.

2004 data have been revised as of April 26, 2007

**Notes - 2005**

Source: PA Department of Health, Bureau of Health Statistics and Research.

2004 data have been revised as of April 26, 2007

**a. Last Year's Accomplishments**

The 2006 performance objective for this performance measure was 81.9 percent and 81.1 percent was achieved, barely missing the target. The data over the past four years suggests a steady increase in the percent of very low birth weight infants who are being delivered at facilities for high-risk deliveries and neonates.

According to the Surgeon General's Report on Women and Smoking from 2001, the risk for perinatal mortality--both stillbirth and neonatal deaths, and the risk for sudden infant death syndrome (SIDS) have increased among the offspring of women who smoke during pregnancy. Infants born to women who smoke during pregnancy have a lower average birth weight and are more likely to be small for gestational age than are infants born to women who do not smoke.

Women who quit smoking before or during pregnancy reduce the risk for adverse reproductive outcomes, including conception delay, infertility, pre-term delivery and low birth weight. The MCH Consultants worked in the six Health Districts worked with pregnant women who were not receiving prenatal care. This engagement included assistance in obtaining care, follow-up to ensure care was received and support during the postpartum period.

In collaboration with the PA Department of Health and the PA Department of Welfare, the PA Area Health Education Center (AHEC) provided a CME accredited tobacco cessation program for healthcare providers titled "Tobacco Cessation Training for Medicaid Providers, Redefining Success". This program was presented May 15, 2007 in Monroeville, PA. There were 160 participants, including over 70 physicians and dentists. Nurse practitioners, physician assistants, pharmacists, nurses, dental assistants, psychologists, social workers, and allied health professionals were also in attendance.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V)				X
2. County Municipal Health Department Education Program			X	X
3. Family Health Nurse Consultant Program	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Department has continued the partnership with the Department of Public Welfare (DPW) to educate low-income women about the dangers of smoking while pregnant and to encourage pregnant women who are receiving Medicaid benefits to quit smoking. The Departments are collaborating in training exercises that include an overview of the PA Free Quitline services to the DPW Medical Directors and their quality assurance managers. Representatives from the Quitline vendor provided in-depth information including on-going clinical research, counseling services, data reporting, and evaluation.

The Consultants continue to work in the six Health Districts with pregnant women who are not receiving prenatal care. This includes assistance in obtaining care, follow-up to ensure care was received and support during the postpartum period.

**c. Plan for the Coming Year**

The MCH Consultants will continue to work in the six Health Districts with pregnant women who are not receiving prenatal care. The Department will continue to partnership with the Department of Public Welfare (DPW) to educate low-income women about the dangers of smoking while pregnant.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective	85.5	86	83	83.5	84
Annual Indicator	81.9	81.3	81.1	80.1	
Numerator	97053	97316	97194	96697	
Denominator	118524	119668	119787	120770	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	81	81.2	81.3	81.3	81.4

**Notes - 2007**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar.

**Notes - 2006**

Unknowns excluded in calculations.  
Source: PA Department of Health, Bureau of Health Statistics and Research.

**Notes - 2005**

Unknowns excluded in calculations.  
Source: PA Department of Health, Bureau of Health Statistics and Research.

**a. Last Year's Accomplishments**

The 2006 performance objective for this performance indicator was 83.5 percent satisfaction. The data shows that the percent of women receiving prenatal care beginning in the first trimester was 81.1 for 2006. Indicating that the objective was not met. The percent of women in this category has remained relatively constant from 2003 to 2006.

The Bureau of Family Health renewed grant agreements with six of the local/county municipal health departments to continue to facilitate early entrance into prenatal care through home visiting and outreach initiatives targeting low income and at risk women. Home visiting programs have been successful in assessing the physical and emotional well being of the mother, monitoring compliance with medical appointments, and providing information on a variety of educational topics such as breastfeeding, nutrition, smoking cessation, and the impact of alcohol and substance abuse on the developing fetus.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V)				X
2. County Municipal Health Department Education Program			X	X

3. Family Health Nurse Consultant Program	X	X	X	X
4. Healthy Babies/Healthy Kids Help line				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Bureau of Family Health is currently in the process of renewing grant agreements with four of the local/county municipal health departments. Renewal of these activities will permit the continuation of home visiting services for low income and at risk women. Additional health department activities include community outreach initiatives to educate community agencies about health department services as well as programs geared to assist families and children with special health care needs.

**c. Plan for the Coming Year**

The Bureau of Family Health is currently exploring ways to develop and enhance efforts to increase access to prenatal care and ultimately improve birth outcomes through programs offered by the ten local/county municipal health departments. Barriers to prenatal care include transportation, lack of child care, and losing wages as a result of missing work. Through programming by the local/county municipal health departments, the goal is to provide services designed to reduce these barriers such as providing evening and weekend hours; providing child care on site during appointments; and, providing incentives to assist in public or private transportation.

**D. State Performance Measures**

**State Performance Measure 5:** *Percent of callers who have expressed satisfaction with the services provided by the Special Kids Network Helpline.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				100	92
Annual Indicator			94.3	90.3	91.9
Numerator			482	167	406
Denominator			511	185	442
Is the Data Provisional or Final?				Final	Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	92	92	92	92	93

**Notes - 2006**

1,695 surveys were sent to callers by the Health and Human Services Call Center (HHSCC) from September thru December 2006, and mailing continues in 2007. Professional surveys were not mailed in calendar year 2006, but will be sent during calendar year 2007.

Historically, MCH Block Grant satisfaction rate was based on a positive response to question #9 of the survey. The following data reflects the outcome of responses to this question:

"Would you recommend the Special Kids Network to someone you know?"

Objective 100% Satisfied Callers.

Percentage of Respondents Satisfied:

Numerator: respondents who stated they were satisfied

Denominator: total survey respondents

Percentage of satisfied callers for Calendar year 2006: (90.3%)

**a. Last Year's Accomplishments**

The 2007 performance objective for this performance measure was 92 percent satisfaction. The data shows that a satisfaction rate of 91.9 percent was achieved for 2007. The data shows that in 2005 the satisfaction rate was 94.3 percent and then dropped to 90.3 percent for 2006 before rising slight to the current level in 2007. The Health and Human Services Call Center (HHSCC) resource database that consists of over 12,000 records was transferred from the previous contractor. HHSCC database clean up activities may explain the increase in satisfaction rate for calendar year 2007.

In calendar year 2007, the Health and Human Services Call Center (HHSCC) mailed 2,164 Customer Satisfaction surveys to callers. 281 Family Customer Satisfaction and 161 Professional Satisfaction Survey responses were returned to the Department of Health. Overall customer satisfaction rate based on survey responses was maintained at 90%. The following questions from the surveys were utilized to assess customer satisfaction:

Family Customer Satisfaction Survey: Question #8, "Would you call the Special Kids Network again?" Response: 250 callers indicated they would call again; 16 stated they would not; 15 provided "no response." Professional Customer Satisfaction Survey: Question #6, "Would you call the Special Kids Network again?" Response: 156 callers stated they would call SKN; 5 responded "no."

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Special Kids Network/System of Care		X		X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The HHSCC continues to distribute the SKN Family and Professional Surveys to agency callers. A trending document is near completion to analyze and assess survey responses for 2004, 2005 and 2006. An analysis of the surveys will help identify unmet needs, exclusions and assess performance trends. SKN may work with an outside contractor to assist in analyzing the

responses.

In April 2007, SKN resumed the "Question of the Month" (Q of M), which has been inactive since 2003. Utilizing the same set of questions approved for the 2003 survey, the Call Center is posing a discreet set of questions every other month to every SKN caller that consents. The survey will conclude in February 2008. Q of M questions for 2007 will be compared with 2003 responses to identify progress toward attainment of objectives described in 2010 Express, as observed through the SKN caller population. The questions focus on 6 performance outcomes: 1) Satisfaction of services for families with children with special health care needs; 2) Coordination of ongoing, comprehensive care within a medical home; 3) Adequate private and/or public insurance for children with special health care needs; 4) Early intervention; 5) Community based systems; and 6) Transition needs to all aspects of adult life.

SKN is currently consulting with the Department of Health, Bureau of Statistics and Research to assist in identifying data that will help evaluate the contractor's performance.

**c. Plan for the Coming Year**

Special Kids Network will continue to survey parents and professional helpline callers for satisfaction rates, and will continue to issue its Question of the Month oral survey over the phone. Bureau of Family Health staff plan to create a decision framework as a result of their work with staff from the Bureau of Health Statistics, in keeping with the Department's Data Driven Management (DDM) initiative.

**State Performance Measure 6:** *Rate of infant deaths as a result of Sudden Infant Death Syndrome (SIDS) and accidental suffocation and strangulation in bed per 1,000 live births.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective				0.5	0.5
Annual Indicator		0.7	0.5	0.4	
Numerator		100	73	59	
Denominator		144194	145033	148706	
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	0.5	0.5	0.5	0.5	0.5

**Notes - 2007**

Data not available. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2006**

Source: PA Department of Health, Bureau of Health Statistics and Research.

**Notes - 2005**

Source: PA Department of Health, Bureau of Health Statistics and Research.

**a. Last Year's Accomplishments**

The 2006 target for this performance measure was 0.5 per 1,000 live births. Data for 2006 indicates that a rate of 0.4 per 100,000 live births was achieved, exceeding the target. The data demonstrates a steady decrease from .07 to 0.5 infant deaths per 1,000 births related to SIDS and accidental suffocation.

The Bureau of Family Health continued to provide SIDS prevention and education brochures to

Pennsylvania hospitals and birthing centers as well as community parenting education programs.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Death Review Team				X
2. Cribs for Kids Program			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In April, 2008 over 200 attendees came together in Pittsburgh for the First Annual Cribs for Kids Conference, to discuss and learn from the experts the importance of a safe sleep environment for infants and the need for accurate and consistent classification and coding of sudden unexplained infant deaths. At this conference a 12 minute video created by pediatrician, Dr. Eileen Tyralla, entitled "Safe Sleep for Your Baby- Right from the Start" was screened during the welcome reception. The video is targeted for use by hospitals, health departments and Doctor's office waiting rooms to be shown to parents and caregivers.

In February, 2008 the Pennsylvania Child Death Review Team sent a letter, signed by the medical director for Child Death Review, the President of the American Academy of Pediatrics, the Chair of the PA Section of American College of Obstetricians and Gynecologist, Medical Director for the Cribs for Kids Program, and the President of the Pennsylvania Academy of Family Physicians, to pediatricians, family physicians, and Obstetricians/Gynecologists remind them to educate patients on safe sleep environments. The Child Death Review Team found that despite the 2006 recommendations from the American Academy of Pediatrics that all infants should sleep in their own crib, they continued to see infants dying in unsafe sleep environments through local child death reviews.

**c. Plan for the Coming Year**

The Bureau of Family Health will be providing funding to Bureau of Health Promotion and Risk Reduction's FFY 08-09 grant agreement with Pennsylvania Safe Kids. Part of the funding the Bureau will provide will impact the rate of infant deaths due to SIDS and accidental suffocation and strangulation through safe sleep environment mini grants. A requirement of mini grant awardees will be to collaborate with either Cribs for Kids or the Maternity Care Coalition in their efforts to educate and prevent infant deaths due to unsafe sleeping environments. The Bureau of Family Health continues to look for cost effective avenues to increase public awareness as demonstrated by our collaboration with the Children's Safety Network's technical support. Additionally, the Department has collaborated with the Department of Public Welfare (DPW) as DPW develops a safe sleep training message to be delivered by DPW's Office of Children, Youth and Families' caseworkers.

**State Performance Measure 9:** *The rate of pregnancy (per 1,000) among females ages 15-17*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective					
Annual Indicator			22.3		
Numerator			6016		
Denominator			269471		
Is the Data Provisional or Final?					
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	22.3	22.3	22.2	22.1	22

**Notes - 2007**

Data currently not available.

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

Usually these data are available 12 to 18 months from the close of the calendar year

**Notes - 2006**

Data currently not available.

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

**Notes - 2005**

Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

**a. Last Year's Accomplishments**

Data has not been available for this performance measure for the past two years, so no trend analysis is possible at this time.

This is a new state performance measure, the most recent data available for this measure is from 2005. As this is a new measure there is no data to do a trend analysis and there was not a performance objective for 2005 so the program cannot address whether the performance objective has been met. The Division of Child and Adult Health Services plans to move towards only funding science-based teen pregnancy prevention programs in an effort to have a greater impact on the teen pregnancy rate throughout the Commonwealth.

The Division of Child and Adult Health Services continued to support teen pregnancy prevention initiatives through a grant agreement with Adagio Health Inc. The initiatives included condom distribution, health promotion campaigns, peer education training, and a teen advisory committee. The Division of Child and Adult Health Services along with the Allentown Bureau of Health and the PA Coalition to Prevent Teen Pregnancy created a team and was selected to participate in a Teen Pregnancy Prevention Roundtable and Training sponsored by AMCHP and CityMatCH. The roundtable and training took place in September 2007.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Adolescent Health Program	X			

2. Family Planning Service System	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Division of Child and Adult Health Services is continuing to support teen pregnancy prevention initiatives through a grant agreement with Adagio Health Inc. The Division of Child and Adult Health Services is working with the Allentown Bureau of Health and the PA Coalition to Prevent Teen Pregnancy to select a science-based teen pregnancy prevention program for the City of Allentown, which will be implemented by October 2008.

**c. Plan for the Coming Year**

The Division of Child and Adult Health Services will move towards only funding science-based teen pregnancy prevention programs, including the Grant Agreements with Adagio Health Inc. and the Allentown Health Bureau.

**State Performance Measure 10:** *Percent of children ages 6 years and younger tested for elevated blood lead levels*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective					
Annual Indicator				10.7	
Numerator				109894	
Denominator				1031796	
Is the Data Provisional or Final?				Final	Provisional
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	13	13.2	13.5	14	15

**Notes - 2007**

Numerator data source: PA NEDSS

Denominator Source: PA State Data Center.

Usually these data are available 11 to 12 months from the close of the calendar year.

**Notes - 2006**

Numerator data source: PA NEDSS

Denominator Source: PA State Data Center.

**Notes - 2005**

Data currently not available

Numerator data source: PA NEDSS

Denominator Source: PA State Data Center.

**a. Last Year's Accomplishments**

Data for this performance measure for 2006 indicates that 10.7 percent of children ages 6 years of age and younger were tested for elevated blood lead levels. No data for previous years are available to conduct further analysis.

A comparison of annual indicators to performance objectives can not be made since the baseline data (2006) is all that is available at this time. And, trend analysis can not be conducted at this time for the same reason; however, preliminary data supports a positive trend in terms of overall children tested for lead. The Pennsylvania Childhood Lead Poisoning Prevention Program (CLPPP) intends to improve performance through various steps including the Penn State Cooperative Extension Service childhood lead testing initiative, more rigorous monitoring and oversight of laboratory reporting, targeted testing based on analysis and mapping of high risk indicators, as well as more targeted education and outreach initiatives. The PA CLPPP and its sub-grantees utilize the Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) to track, process, analyze and manage all cases of childhood lead poisoning in Pennsylvania. This web-based application accommodates real time reporting and comprehensive information collection. With automated processes designed to streamline interventions the system continues to improve with each Release. Utilizing the system's Analysis and Reporting (A&R) module, surveillance staff is able to conduct analysis and develop extensive reports designed to target statewide high risk areas. Future plans include the inclusion of GIS mapping capabilities.

Lead reporting laboratories continue to be brought on board with the new, streamlined Pennsylvania Electronic Laboratory Reporting (PA-ELR) system thereby improving the accuracy and timeliness of reporting to PA-NEDSS. Several PA-NEDSS training sessions were also conducted for statewide system users as a way to keep skills and knowledge current.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Childhood Lead Poisoning Prevention Program			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The requirements for the data match project with the DPW have been formally documented. A letter of Agreement summarizing the details of patient sharing between both Departments is with the DPW. The Statewide Case Management Guidelines for children with confirmed elevated lead levels will soon reside on a shared web location accessible by all PA-NEDSS users. Therefore, the guidelines will be more readily available and accessible for users to reference as they manage caseloads within the application. Ten PA CLPPP sub-grantees continue to provide comprehensive childhood lead poisoning prevention services in targeted high-risk areas

throughout the Commonwealth. The Department is currently working with the Pennsylvania State University Cooperative Extension to conduct outreach, provide education, and distribute lead dust testing kits to rural areas. The CLPPP and the LHCP are collaborating on this effort utilizing funds from the CDC and HUD.

**c. Plan for the Coming Year**

During the coming year, continued training and outreach can be expected to ensure investigators are utilizing and maximizing PA-NEDSS functionality. The developmental evolution of PA-NEDSS can be expected to continue and further improve its usability as the sole surveillance system within the Commonwealth.

**State Performance Measure 11:** *The percent of tested children ages 6 years and younger with confirmed elevated blood lead levels.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective					
Annual Indicator					2.3
Numerator					3026
Denominator					130954
Is the Data Provisional or Final?					Final
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	2.3	2.3	2.2	2.2	2.1

**Notes - 2007**

Source: PA NEDSS

**Notes - 2006**

Source: PA NEDSS

**Notes - 2005**

Source: PA NEDSS

**a. Last Year's Accomplishments**

Data for this performance measure for 2007 indicates that 2.3 percent of children ages 6 years of age and younger who were tested for elevated blood lead levels had confirmed elevated blood lead levels. No data for previous years is available for further analysis.

A comparison of annual indicators to performance objectives can not be made since the baseline data (2007) is all that is available at this time. And, trend analysis can not be conducted at this time for the same reason; however, preliminary data supports a positive trend in terms of overall decrease in the percent of children tested with a confirmed blood lead level.

Lead reporting laboratories continue to be brought on board with the new, streamlined Pennsylvania Electronic Laboratory Reporting (PA-ELR) system thereby improving the accuracy and timeliness of reporting to PA-NEDSS. Several PA-NEDSS training sessions were also conducted for statewide system users as a way to keep skills and knowledge current.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Childhood Lead Poisoning Prevention Program			X	
2. Lead Elimination Workgroup				X
3. Lead Screening Expansion into WIC Clinics			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The requirements for the data match project with the DPW have been formally documented. A letter of Agreement summarizing the details of patient sharing between both Departments is with the DPW. The Statewide Case Management Guidelines for children with confirmed elevated lead levels will soon reside on a shared web location accessible by all PA-NEDSS users. Therefore, the guidelines will be more readily available and accessible for users to reference as they manage caseloads within the application. Ten PA CLPPP sub-grantees continue to provide comprehensive childhood lead poisoning prevention services in targeted high-risk areas throughout the Commonwealth. The Department is currently working with the Pennsylvania State University Cooperative Extension to conduct outreach, provide education, and distribute lead dust testing kits to rural areas. The CLPPP and the LHCP are collaborating on this effort utilizing funds from the CDC and HUD.

**c. Plan for the Coming Year**

During the coming year, continued training and outreach can be expected to ensure investigators are utilizing and maximizing PA-NEDSS functionality. The developmental evolution of PA-NEDSS can be expected to continue and further improve its usability as the sole surveillance system within the Commonwealth.

**State Performance Measure 12: *The percentage of statewide breastfeeding initiation***

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator			63.7	64.6	
Numerator			86720	90282	
Denominator			136168	139794	
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	67	68	69	70	71

**Notes - 2007**

No data are available for 2007 at this time. Usually these data are available 12 to 18 months from the close of the calendar year.

**Notes - 2006**

Source: PA Department of Health, Bureau of Health Statistics and Research.

**Notes - 2005**

Source: PA Department of Health, Bureau of Health Statistics and Research.

**a. Last Year's Accomplishments**

The 2006 data for this performance measure shows that 64.6 percent of women in PA who gave birth to a live baby initiated breastfeeding. This was a slight increase of 0.9 percent over the previous year.

This slight increase reflects several trends: the increase in knowledge among young parents regarding the benefits of breastfeeding and the promotion of breastfeeding among WIC enrollees. Since 2004, when a full-time lactation consultant was hired, the health department has worked hard to influence stakeholders to increase barriers initiation and duration.

In 2007, 27 breastfeeding mini-grant applications for a total of \$75,498 have been received. Three special initiative mini-grants totaling \$9,000 will be awarded with funds provided by a new collaboration with the Bureau of Chronic Disease, Division of Nutrition and Activity.

The Program will continue to manage, support and monitor the third and last year of the MCH/WIC Breastfeeding Collaborative Project. A WIC program focus in the City of York is targeted towards Latino mothers. The WIC programs conducted in Luzerne and Lycoming counties are targeted toward low-income rural mothers with low initiation and duration breastfeeding rates. Both programs target the ethnic groups within their geographic area.

The Breastfeeding Awareness and Support Program in collaboration with PA-WIC (Happy Baby project) provided 250 certifications kits to WIC staff to become Happy Baby Certified Educators. This certification enables staff to assist WIC mothers to calm fussy babies, the most common reason for breastfeeding failure during the early weeks.

All new WIC staff received training on the common reasons for breastfeeding discontinuance (fussy baby, return to work, maternal fatigue, inadequate milk supply) to equip them to address these issues with participants.

The 4-step breastfeeding promotion training was modified extensively to provide staff with more practical examples on how to apply the procedure in real life clinic situations. Ten pilot sites have provided feedback on four breastfeeding promotion posters with impact messages that address known barriers as part of a public awareness campaign. This feedback will serve as framework for change and design of future posters.

A WIC participant survey conducted in 2006 showed that infant fussiness is a major reason for premature weaning and formula supplementation. Therefore, the Pennsylvania Breastfeeding Awareness and Support Program and Pennsylvania-WIC will co-sponsor a conference in June 2007 for professionals covering techniques for dealing with infant and toddler fussiness.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Program	X	X		
2. Breastfeeding		X		X
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

**b. Current Activities**

In 2008, 14 breastfeeding mini-grant applications for a total of \$42,000 have been received. Two special initiative mini-grants totaling \$6,000 will be awarded with funds provided by a continuing collaboration with the Bureau of Chronic Disease, Division of Nutrition and Activity.

Distribution of breastfeeding promotion public awareness posters throughout the state began in 2007. To date, a total of 5,000 posters are distributed, reaching every Pennsylvania County.

The Breastfeeding Awareness and Support Program in collaboration with PA-WIC will certify 250 WIC staff over the next 2 years in The Happiest Baby techniques based on pediatrician Dr. Harvey Karp's methods for calming infants to improve breastfeeding duration rates, decrease formula issuance and decrease Shaken Baby Syndrome incidence. To date, 150 staff have been certified. Fayette County Nurse-Family Partnership is in partnership with University of Pittsburgh to determine the effectiveness of the methods for low-income families.

Development of infant growth assessment curriculum: Inadequate infant weight gain is another frequently stated reason for breastfeeding discontinuance. Based on new research, breastfed infants do not follow same weight gain pattern as formula fed infants. This can lead to inaccurate assessment as growth pattern of formula fed infants is used as the standard norm and results in unnecessary formula supplementation and/or breastfeeding discontinuance.

**c. Plan for the Coming Year**

In 2008-09, the Breastfeeding Program's projected initiatives based on evaluation and feedback from current activities include:

1. Developing a CD of breastfeeding poster images to share with out of Pennsylvania requests. To date, 22 requests from two countries and nine states have requested Pennsylvania's breastfeeding promotion posters with plans to print state specific posters for public awareness campaigns.
2. Continuing certification of WIC staff in The Happiest Baby techniques and expand group/individual instructions. Tracking number of education contacts and determining impact.
3. Conducting pilot site evaluation for the breastfeeding promotion DVD and then distributing the DVD in Latino and African-American population dense counties.
4. Adding to breastfeeding pages on Department of Health's website.
5. collaborating with the Pennsylvania State Breastfeeding Coalition in a state-wide effort to increase community and business awareness in ways of supporting working mothers.
6. Developing and presenting a WIC staff update in assessing infant growth patterns.
7. Developing and fostering partnerships with organizations with related initiatives, such as obesity prevention, safe sleep, and worksite wellness.
8. In-service WIC staff on new trends in infant growth assessment.
9. Continue WIC staff training on breastfeeding promotion and duration protocols

**State Performance Measure 13:** *The percentage of infants with failed hearing screenings that are lost to follow-up*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Annual Performance Objective					
Annual Indicator			19.3	20.7	
Numerator			271	290	
Denominator			1402	1400	
Is the Data Provisional or Final?				Final	
	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Annual Performance Objective	19.5	19	18.5	18	17

**Notes - 2007**

2007 data not available because of a 1 year turn-around time in final data

**Notes - 2006**

Source: Division of Newborn Screening and Genetics

**Notes - 2005**

Source: Division of Newborn Screening and Genetics

**a. Last Year's Accomplishments**

The 2006 data on this performance measure indicates that 20.7 percent of infants who failed hearing screenings were lost to follow-up. This was a slight increase (1.4 percent) over the data from 2005.

The Program with only 20.7 percent loss to follow up had half that reported by the CDC of 45%. The loss to follow-up percentage was steady from 2005 through 2006.

Performance enhancements are expected to occur with the introduction of a new data system. Newborn screening software will enable more timely and accurate information acquisition. Acquiring information from the electronic birth certificate, newborn screening software, hospital screening programs, and from early intervention would also enhance data collection in this area.

The Program will be entering into a pilot program with the National Center for Hearing Assessment and Management to provide for OAE (otoacoustic emission) hearing screening testing in 8 early head start programs. Another way that we hope to increase our out-of-hospital screening rates is to work more closely with the many midwives in Pennsylvania.

The newborn hearing screening program has been an active participant in the National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative Project which was sponsored by the Health Resources and Services Administration. The initiative in Pennsylvania brought together a partnership of hospitals, primary care providers, audiologists, early intervention providers, parents and the Department of Health to reduce delays and loss to follow-up for infants identified with hearing loss. This team has worked with various primary care practices covering a mix of rural, suburban, and urban areas to identify key causes of the loss to follow-up problem and to develop remedies in policies, operating procedures, and follow-up protocols.

Letters sent to parents throughout the state by DOH whose newborns did not pass hearing screening were modified to allow for easier reading and to improve health literacy. In addition to simplifying the language of the letters, a paragraph offering parents guidance on the next steps in the hearing screening process was added along with a DOH contact number for parents to call with questions or updates on their child's status. These modifications were initially sampled on 25 letters and yielded a 70% response rate, a dramatic improvement on the minimal response

rate from the original version. Based on these findings, DOH has implemented the statewide use of the modified letters in both English and Spanish. A separate similar letter, which will be addressed to the primary care physician, is currently being designed for testing.

The DOH Hearing Screening form which is used by 120 birthing hospitals to make referrals for follow-up was modified to include alternate contact information in an attempt to decrease the number of infants lost to documentation. This revised form was tested in two hospitals in June and July, 2007. Results for this effort were extremely successful.

The PA NICHQ team designed an audiological brochure for primary care physicians in Northeastern Pennsylvania. The brochure was disseminated to primary care physicians in the area to aid them in making proper referrals to facilities that provided hearing and screening services for infants. Results for this effort are being gathered and analyzed.

The PA NICHQ team designed an audiological brochure for parents in Northeastern Pennsylvania. The brochure was disseminated to parents whose babies did not pass initial hearing screens to aid them in learning about different testing techniques available for their babies and provided information about facilities in their area available to conduct those tests. Results for this effort are being gathered and analyzed.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Diagnostic Evaluation	X			
2. Screening	X		X	
3. Follow-up	X			
4. Intervention	X			
5. Education & Training				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

This year we are redesigning the Hearing Screening form which is used by 120 birthing hospitals to make referrals for follow-up. Following the pilot testing and its success we are working with the hearing screening advisory committee to design the form with the additional information to improve lost to follow-up and show consistencies between our program guidelines and hospital communications.

We are also pilot testing with the Bureau of Vital Statistics, adding the hearing screening information to the electronic birth certificate. Our follow-up nurses will be able to access the family's information from the Vital Statistics abstract to confirm the address and possibly improve lost to follow-up cases.

Lastly, we are in the beginning phases of purchasing a new data system that will import the information from the vital statistics as well as the hearing screening equipment in hospitals.

**c. Plan for the Coming Year**

We plan to purchase the new data system and print the newly designed hearing screening form. The new program guidelines will be distributed and a hospital teleconference will be held in the fall. The teleconference will improve our relationship with the birthing hospitals in the state. By improving our relationship and communications we hope to acquire more accurate consistent data from hospitals to improve our chances of contacting families and improving our lost to follow-up rates.

## **E. Health Status Indicators**

### ***/2009/ Health Status Indicator 1A -- The percent of live births weighing less than 2,500 grams***

*While the percentage of live births resulting in a low birth weight (LBW) infant in Pennsylvania in 2006 (8.5) was not significantly different from that observed in 2005 (8.3), the 2006 percentage does continue the relatively steady incremental increase in the percentage of LBW live births observed in Pennsylvania over recent years.*

*Based on an examination of stratified data available through the year 2006, this trend appears to primarily be driven by a slight increase in the percentage of LBW live births among white women (6.9% in 2001 vs. 7.4% in 2006). While an increase was also observed among black women (13.6% in 2004 vs. 14.0% in 2006) in more recent years, this increase was not statistically significant. Unlike other racial/ethnic groups, a statistically non-significant decline in the percentage of LBW live births was observed among Hispanic women (9.2% in 2004 vs. 8.7% in 2006) over the specified timeframe. Despite such trends, previously documented racial/ethnic disparities continue to be evident. In 2006, the percentage of LBW live births among black women (14.0%) and among Hispanic women (8.7%) was significantly ( $p < .05$ ) higher than that observed among white women (7.4%).*

*Similar variation is also evident when examining the percentage of LBW live births by other maternal characteristics. When stratified by age, the lowest percentage of LBW live births in 2006 was observed among women 30 to 34 years of age (7.5%), with the highest percents observed among women under 15 years of age (17.6%) and women over 45 years of age (14.5%).*

*When compared to the state percentage (8.5) in 2006, three counties had significantly higher percentages of LBW live births: Allegheny (9.0), Cambria (10.2), and Philadelphia (11.5).*

### ***Health Status Indicator 3B -- The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among children aged 14 years and younger***

*The death rate from unintentional injuries associated with motor vehicle accidents in Pennsylvania among those 14 years of age and younger in 2006 was approximately 2.9 deaths per 100,000 children within the specified age range, marking a slight increase from 2005 (2.3 deaths per 100,000 children 14 years of age and younger). Based on 2005 data, stratification by age within this childhood group fails to document any statistically significant variation in observed death rates; however, the death rate from unintentional injuries associated with motor vehicle accidents is relatively higher among adolescents 10 to 14 years of age (3.3 deaths per 100,000 population) in comparison to children 5 to 9 years of age (1.4 deaths per 100,000 population) and those 4 years of age and younger (2.2 deaths per 100,000 population). A statistically inadequate number of deaths resulting from*

*motor vehicle accidents within this age group prevents the calculation of stable race-specific rates.*

**Health Status Indicator 3C -- The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years**

*The death rate from unintentional injuries associated with motor vehicle accidents in 2006 among adolescents 15 to 24 years of age was 20.1 deaths per 100,000 adolescents within the specified age range, a rate lower than that observed in 2005 (24.2 deaths per 100,000 adolescents 15 to 24 years of age). Based on 2005 data, the death rate from unintentional injuries associated with motor vehicle accidents among adolescents 15 to 19 years of age was 19.9 deaths per 100,000 adolescents within the specified age range. During the same year, the death rate from unintentional injuries associated with motor vehicle accidents among adolescents 20 to 24 years of age was 28.8 deaths per 100,000 adolescents within the specified age range. Although substantial fluctuation has been observed in the death rate from unintentional injuries associated with motor vehicle accidents among adolescents 20 to 24 years of age over recent years, the 2005 rate marked a statistically significant ( $p < .05$ ) increase from that occurring in 2004 (21.5 deaths per 100,000 population). Based on data from 2005, white adolescents 15 to 24 years of age (26.1 deaths per 100,000 population) exhibit a statistically significant ( $p < .05$ ) higher death rate from unintentional injuries associated with motor vehicle accidents compared with black (16.3 deaths per 100,000 population) and Hispanic (12.5 deaths per 100,000 population) adolescents in the same age range. A comparable yearly rate for Asian/Pacific Islander adolescents is not available given the low number of associated deaths within this racial/ethnic population.*

**Health Status Indicator 5A: The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia**

*Approximately 12,033 cases of Chlamydia were reported in Pennsylvania in 2006 among females 15 to 19 years of age, corresponding to a rate of 26.1 cases per 1,000 females. In contrast to the declines observed the previous two years, this rate marks a statistically significant ( $p < .05$ ) increase from the rate observed in 2005 (25.2 cases per 1,000 females) within this age group. Interestingly, the rate of Chlamydia slightly declined among white females 15 to 19 years of age between 2005 (6.5 cases per 1000 females) and 2006 (6.2 cases per 1000 females), slightly increased within the black population (82.5 vs. 82.7 cases per 1000 females), and significantly ( $p < .05$ ) increased within the Hispanic population (22.7 vs. 30.4 cases per 1000 females). While the rate of Chlamydia in 2006 among black females 15 to 19 years of age remains significantly ( $p < .05$ ) lower than that observed in 2003 (88.5 cases per 1000 females), the recent increase in the rate of Chlamydia among Hispanic females 15 to 19 years of age reverses the declines observed in 2004 and 2005, resulting in a current rate within the Hispanic adolescent population slightly higher than that observed in 2003 (27.9 cases per 1000 females).*

**Health Status Indicator 5B: The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia**

*Approximately 15,513 cases of Chlamydia were reported in Pennsylvania in 2006 among females 20 to 44 years of age, corresponding to a rate of 7.6 cases per 1000 females. This rate marks a statistically significant ( $p < .05$ ) increase from the rate observed in 2005 (7.1 cases per 1000 females). The rate of Chlamydia among black (18.7 cases per 1000 females) females 20 to 44 years of age in 2006 was substantially higher than that observed among Hispanic (8.3 cases per 1000 females) and white (2.2 cases per 1000) females within the same age group.*

**Health Status Indicators 6A & 6B -- Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity**

**Based on estimates from the Pennsylvania State Data Center, approximately 4,114,037 infants and adolescents 0 to 24 years of age resided in Pennsylvania in 2006, representing 33.1% of the state population. Infants less than 1 year of age (3.5%) comprised the smallest percentage of this population, followed by children 1 to 4 years of age (14.3%) and children 5 to 9 years of age (18.6%). Adolescents 10 to 14 years of age accounted for 19.8 percent of the population under 25 years of age, while those 15 to 19 years of age and those 20 to 24 years of age accounted for 22.6% and 21.2% respectively.**

**The age distributions within the Hispanic and Asian/Pacific Islander populations deviated slightly from that seen within the state as a whole. Approximately 22.6% of the Hispanic population under 25 years of age was accounted for by infants and children 4 years of age and younger, while a smaller percentage was accounted for by those 20 to 24 years of age (18.6%). Among Asian/Pacific Islanders, the age distribution was weighted towards each end of the age spectrum with 20.3% of the Asian/Pacific Islander population under 25 years of age accounted for by infants and children 4 years of age and younger and 23.5% accounted for by those 20-24 years of age.**

**Health Status Indicators 7A & 7B -- Live births to women (of all ages) enumerated by maternal age, race and ethnicity**

**In 2006, there were 148,526 resident live births reported for Pennsylvania (excluding women of unknown age giving birth), resulting in a crude birth rate of 11.9 births per 1,000 population. The majority of live births in 2006 occurred among white women (73.8%), followed by black women (14.5%), Asian/Pacific Islander women (3.9%), and American Indian/Native Alaskan women (0.1%). Hispanic women accounted for approximately 8.9% of resident live births. Approximately 9.3 percent of live births in 2006 were to adolescents less than 20 years of age. During the same year, 74.8% of resident live births occurred among women 20 to 34 years of age, and 15.9% among women 35 years of age and older.**

**Recent estimates document small increases in age-specific birth rates within most age categories between 2005 and 2006. In particular, statistically significant ( $p < .05$ ) increases were observed among adolescents 18 to 19 years of age (46.5 vs. 48.7 births per 1,000 females), women 25 to 29 years of age (113.1 vs. 115.6 births per 1,000 females), and women 35 to 39 years of age (44.4 vs. 46.5 births per 1,000 females). While these increases represent a continuation of previous trends observed among older aged women, such increases among adolescents are in contrast to previous years in which age-specific birth rates remained relatively stable or declined.**

**Health Status Indicators 9A & 9B -- Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity**

**Estimates concerning the percentage of the childhood population 19 years of age and younger enrolled in programs specifically designed to address economic needs fluctuated slightly between the 2005 and 2006 fiscal years, with the most recent available data documenting a slight decline (6.0% vs. 5.5%) in Temporary Assistance for Needy Families (TANF) program enrollment and a slight increase (16.1% vs. 16.3%) in Food Stamp program enrollment.**

**Slight increases in both the absolute number and estimated percentage of the childhood population 19 years of age and younger enrolled in programs targeted toward addressing gaps in health insurance coverage were observed between the 2005 and 2006 fiscal years. Medicaid enrollment within this population increased from 29.8% ( $n=969,606$ ) to 30.9% ( $n=1,000,480$ ) over the specified timeframe, while SCHIP enrollment increased from 4.7% ( $n=152,905$ ) to 5.6% ( $n=182,317$ ).**

**Health Status Indicator 10 -- Geographic living area for all resident children aged 0 through 19 years**

***In 2006, 88.6% of the childhood population less than 20 years of age resided in an urban area of the state, with the remaining 11.4% living in rural areas. These percentage estimates signify little change in the geographic distribution of the specified childhood population from the previous year.***

**Health Status Indicator 11 -- Percent of the State population at various levels of the federal poverty level**

***Based on data from the American Community Survey, an estimated 12.1 percent of the Pennsylvania household population had an annual income below the federal poverty level in 2006. Approximately 16.7 percent of the household population had an annual income greater than or equal to 100% the federal poverty level but less than 200%. It is estimated that 71.2 percent of the state household population in 2006 had an income greater than or equal to 200% the federal poverty level. A slight increase in the percentage of people with a household income below the federal poverty level was observed between 2002 (10.5%) and 2006 (12.1%) according to estimates from the American Community Survey.***

**Health Status Indicator 12 -- Percent of the State population aged 0 through 19 years at various levels of the federal poverty level**

***Based on recent estimates available from the Current Population Survey Annual Social and Economic Supplement, a 3-year average poverty rate of 16.7% was observed from 2004 to 2006 among the childhood population 19 years of age and younger in Pennsylvania.//2009//***

## **F. Other Program Activities**

Hearing Screening Program staffs are also working with the Pennsylvania Chapter of the American Academy of Pediatrics (PA-AAP) on ongoing programs and materials that will promote hearing screening education and outreach to hospitals, physicians and audiologists. As part of the EPIC-EHDI Outreach to Physicians project being undertaken with PA-AAP, 200 videos of the model grand round presentation about newborn hearing screening were produced. One hundred and fifty were distributed to birthing hospitals and community health nurses in regional DOH offices and county and municipal health departments. The one-hour presentation includes essential medical information from a physician and audiologist, a short parent advocate presentation, and information about state EHDI program tracking and follow-up services. A special evaluation tool was distributed along with the video to measure its effectiveness in conveying these essential messages and to gauge prospects for positive changes in program performance. /2007/ The integrated newborn screening system went live in September 2005 and functionality will be assessed throughout 2006.//2007//

/2008/ The Bureau of Family Health is working closely with the PA Chapter American Academy of Pediatrics to reduce losses to follow-up. The Bureau is also working with Early Intervention Technical Assistance (EITA) to provide training for Part C Service Coordinators and others. (NOTE: EITA is an early intervention training consortium with statewide presence funded by the Departments of Education and Public Welfare. It is the single training entity for both Departments to assure consistent Early Intervention training across the Commonwealth. EITA supports early intervention programs through staff professional development and family informational services.)//2008//

***/2009/ The integrated newborn screening system for metabolic and hearing screening is still problematic and malfunctioning. In 2007, an assessment of the current system was conducted that identified major system issues and provided a recommendation that a new***

**software solution be selected to replace the current system (previously described in Performance Measure 1).//2009//**

The Bureau of Family Health funds prenatal services to pregnant women in eight county/municipal health departments. The services focus on health and parenting education on such topics as smoking cessation, healthy nutrition during pregnancy, infant child and safety, child development and the warning signs of premature labor/delivery. Some county/municipal programs monitor women to ensure they keep their prenatal care appointments. These services are provided directly by the local health department or through BFH Title V sub-grants, which utilize registered nurses to provide the service. Assistance in obtaining social services is also provided. The county/municipal health departments also provide various educational training events to the public and service providers to raise awareness of prenatal issues.

The Bureau of Family Health funds twelve consultants, who serve as the "implementation arm" for many Bureau programs. The six Special Healthcare Needs Consultants (SHCNC) and the six Maternal and Child Health Consultants (MCHC) are nurses who serve clients at the local level in each of the six community health districts. They ensure that pregnant women, mothers and children have access to services at the local level, in all counties in their district. These nurses provide case management: care coordination, education, consultation, technical assistance and promotion and outreach. The consultants routinely consult with staff in the Department of Health State Health Centers regarding the scope, content and effectiveness of MCH services. /2007/ The Bureau of Family Health is also working closely with the Penn State Milton S. Hershey Hospital in its Shaken Baby Syndrome (SBS) Education statewide research study to ensure that all parents receive SBS information.

**/2009/ The Consultants in collaboration with the Breastfeeding Awareness and Support Program, are being certified in Dr. Harvey Karp's The Happiest Baby techniques. Once certified, they find local venues to teach these techniques to promote breastfeeding duration and exclusivity, prevent child abuse and Shaken Baby Syndrome. //2009//**

The Bureau of Family Health is working closely with the Bureau of Drug and Alcohol Programs (BDAP) on raising awareness of Fetal Alcohol Spectrum Disorders (FASD). BDAP, as the lead agency for the Department of Health is coordinating a state Task Force on FASD with its first meeting scheduled mid-2006. The Bureau of Family Health has multiple activities planned for 2006. The Bureau will hold two forums to identify issues of concern to health services providers and parents; air a statewide broadcast of 30-minute radio interview discussing FASD; and work with Pennsylvania State University to develop an effective prevention message for college-aged women as well as provide a recommendation as to the most effective way to distribute the message.

The Bureau of Family Health is working with the Pennsylvania Perinatal Partnership (PPP) on the issue of Perinatal Depression.

/2008/ Reports found on the Bureau of Health Statistics and Research website that contain maternal and child health data:

Pennsylvania Vital Statistics-2005 Report  
County Health Profiles-2006 Edition  
Health Status Indicators for Pennsylvania Counties and Health Districts-2006 Report  
Maternal and Child Health Status Indicators for Pennsylvania and Major Municipalities  
2005 Report  
Family Health Statistics for Pennsylvania and Counties-2007 Report

Reports from other organizations that use our maternal and child health data:

Pennsylvania Partnership for Children --The State of the Child in Pennsylvania-2004 Report  
Quality Resource Systems, Inc. --Health Status of Women in Region III-2004 Report  
Pennsylvania State Data Center --Pennsylvania County Data Books-2007 Edition  
Pennsylvania State Data Center --Pennsylvania Statistical Abstract-2006 Edition  
Battelle Reports

Evaluation of the Special Kids Network Hispanic Preconception Health Initiative//2008//  
*/2009/ During FY 06-07 there were 430 total patients treated through the Donated Dental Services Program with a value of treatment provided at \$898,279. The State Public Health Dentist has also presented an oral health educational module at all six of the Department District Health Offices. Training was targeted to Nursing Staff and community clinic staff to enhance their ability to recognize oral health problems among the clientele they serve and to provide guidance regarding oral hygiene and oral care. The initial target populations are pregnant women and children up to age two. Future training modules have been developed for the remainder of the life cycle and will be presented to the District Office staff./2009//*

## **G. Technical Assistance**

The Bureau of Family Health has two technical assistance requests at this time:

1. Children and youth with special health care needs are of paramount concern. Data from the MCH Needs Analysis suggest a gap in Title V care coordination and case management services for this population. The Bureau of Family Health seeks technical assistance around developing statewide survey data to develop high quality care systems for children and youth with special health care needs.

This assistance is requested from HRSA or any State with identified best practices in this area.

2. The Commonwealth of Pennsylvania, unlike its neighboring states, does not participate in the Pregnancy Risk Assessment Monitoring System (PRAMS). Information from a population-based survey tool would be valuable in planning and evaluating prenatal care, tobacco cessation during pregnancy, and breastfeeding statewide. The Bureau of Family Health seeks technical assistance around development of such a tool.

*/2007/ In April 2006, the PA Department of Health received a CDC grant award for the Pregnancy Risk Assessment Monitoring System (PRAMS) to collect state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The Bureaus of Family Health and Health Statistics and Research have partnered in the development of a grant application to implement PRAMS in Pennsylvania.*

This assistance is requested from HRSA or any State with identified best practices in this area.

1. The lack of available and useful data from some programs conducting MCH activities makes it difficult to monitor and assess the effectiveness of activities. A need to promote collaboration among similar programs and develop data reporting tools.

Reason: It was identified during the most recent Needs and Capacity Assessment.

What Organization: TA assistance is requested by HRSA or any State with best practices in like initiatives and in the collection of focused data.

2. Assistance in the review of EPSDT screening data from children enrolled in the Commonwealth's managed care programs and Community/Migrant Health Center data is needed for the purpose of identifying sub-groups with low participation rates.

Reason: It was identified during the most recent Needs and Capacity Assessment.

What Organization: TA assistance is requested by HRSA or any State with best practices in like initiatives and has attained success in EPSDT targeted promotion.

3. Racial/ethnic disparities in perinatal outcomes exist for some groups namely Blacks and Hispanic women who experience poor birth outcomes. Assistance is needed to gather additional data to describe the most needed areas in the State.

Reason: It was identified during the most recent Needs and Capacity Assessment.

What Organization: TA assistance is requested by HRSA or any State with best practices in like initiatives and has attained success in reversing poor birth outcomes for this targeted population.//2007//

/2008/ On February 20, 2007, the Bureau of Family Health was informed that we were selected to receive funding for the Association of Maternal and Child Health Programs State Data & Assessment Technical Assistance (DATA) Mini-Grant Program. The grant application awarded a mini-grant up to \$5000.

Products and outcomes from DATA will include: 1) tools and training materials that increase knowledge and skills in MCH data and assessment; 2) diffusion of best practices in the collection, analysis and use of MCH data; and 3) increased state capacity to translate MCH data into action. A select group of 15 bureau and MCH staff attended the data analysis training on June 22nd and 29th 2007.//2008//

***/2009/ The Bureau received notification that it was awarded continuing funding the Association of Maternal and Child Health Programs State Data & Assessment Technical Assistance (DATA) Mini-Grant Program. The grant application awarded a mini-grant up to \$5000. The data training will occur on June 20th and 27th 2008.//2009//***

## **V. Budget Narrative**

### **A. Expenditures**

*/2009/ Form 3 (State Maternal and Child Health Funding Profile), Form 4 (Budget Details by Types of Individuals Served and Sources of Other Federal Funds), and Form 5 (State Title V Program Budget and Expenditures) have been completed in accordance with the guidance./2009//*

### **B. Budget**

#### **/2009/ 3.3.1 Completion of Budget Forms**

*Form 2 (Maternal and Child Health Budget Details for FY 2009), Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served and Sources of Other Federal Funds), and Form 5 (State Title V Program Budget and Expenditures by Types of Service) have been completed.*

#### **3.3.2 Other Requirements**

*Pennsylvania's proposed budget for Federal Fiscal Year 2009 is in full compliance with the federally mandated "30%-30%" requirements. Of Pennsylvania's proposed federal grant award for 2009, \$13,335,000 is designated for the support of preventive and primary services for children, and \$8,945,000 is designated for the support of services for children with special health care needs. Following is a summary of the utilization of available funds.*

##### **Administrative Costs**

*Section 505 of the Maternal and Child Health (MCH) Services Block Grant legislation limits the amount of the State's allocation that can be used for administration to not more than 10 percent. In FFY 2009, Pennsylvania plans to expend \$2,044,168 or 8.4 percent for administration. The following is the definition of Administrative Costs used by the Pennsylvania Department of Health in administering the Maternal and Child Health Services Block Grant.*

##### **1. Personnel Costs**

*Personnel costs, including salaries and associated fringe benefits, are considered administrative if those costs are not incurred in the direct or indirect provision of prevention, education, intervention, or treatment services.*

*All personnel costs not included in this definition would be considered program and would not fall under the block grant administrative costs restriction.*

##### **2. Operational Costs**

*Operational costs are considered administrative if they are not required for the delivery of direct or indirect program services. Operational costs are considered program if they are utilized to support program-designated activities. The designations are by minor object of expenditure.*

##### **Maintenance of Effort Match**

*Section 505 of the Maternal and Child Health (MCH) Services Block Grant legislation requires that a State receiving funds shall maintain the level of funds being provided*

**solely by such State for maternal and child health programs at a level at least equal to the level that the State provided for such programs in fiscal year 1989.**

**Pennsylvania bases maintenance of effort on a federal fiscal year, only including those state appropriations which are solely used for MCH; i.e., 100 percent MCH-related. In Federal Fiscal Year 1989, Pennsylvania's maintenance of effort was \$20,065,574.58, as detailed below in Table 2. For Federal Fiscal Year 2008, Pennsylvania's match will exceed the 1989 maintenance of effort level. The proposed expenditure of state Maintenance of Effort for 2009 is detailed below in Table 3.**

**Table 2  
Maintenance of Effort (Match)  
Federal Fiscal Year 1989**

**State Funded Appropriations Amount**  
108 School Health Services \$17,265,914.86  
112 Maternal and Child Health \$1,661,120.00  
120 Sickle Cell Summer Camps \$35,000.00  
137 Tourette Syndrome \$100,000.00  
164 Home Ventilators \$1,003,539.72  
TOTAL \$20,065,574.58

**Table 3  
Planned Maintenance of Effort (Match)  
Federal Fiscal Year 2009**

**State Funded Appropriations Amount**  
108 School Health Services \$38,842,000  
112 Maternal and Child Health \$2,473,000  
TOTAL \$41,315,000

**Note: Consistently, since 1989, the Bureau has used a constant set of appropriations to indicate our maintenance of effort match. Based on advice received from Region III when preparing the 2001 application, the Bureau increased the maintenance of effort to include all state appropriations administered by the Bureau. Afterward, it was noted by changing these variables, we would not have a constant comparison from year-to-year and were advised to return to the method indicated in this application.//2009//**

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.