Maternal and Child Health Services Title V Block Grant

State Narrative for PENNSYLVANIA

Application for 2007 Annual Report for 2005

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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.
An attachment is included in this section.

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
The Bureau of Family Health's solicitation of meaningful public input around the needs assessment and MCH Block Grant 2004 annual report/2006 application was comprehensive. Stakeholder meetings were held in six different locations throughout the Commonwealth during June 2005. The meetings were broadly advertised to ensure the attendance of families, community-based organizations, professional associations, consumer organizations, and key informants. During these meetings, the purpose and process of the needs and capacity assessment process and regional findings were shared. Facilitated group discussion occurred to ascertain attendee perspectives on MCH needs and capacity issues. An overview of the Title V MCH Block Grant application process was also provided. Attendees were encouraged to review and comment on a DRAFT of the annual report/application posted to the Department of Health's web site May - June 2005. Comments received were incorporated into the final document as appropriate. A combined response to all comments received was posted on the DOH web site August 2005.

The finalized assessment and annual report/application was distributed to a vast audience of stakeholders Fall 2005. It is the hope of the Bureau that both will be used by groups and organizations across the Commonwealth interested in improving the health and wellness of Pennsylvania's pregnant women, children and families.
/2007/ A draft 2005 annual report/2007 Application was posted to the Department's web site June-July 2006. Comments received were incorporated into the final document as appropriate.//2007//

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview
A. Overview
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, 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//

Age Distribution

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.

Migrant and Seasonal Farm Workers

Each year, Pennsylvania's agricultural industry significantly draws on approximately 45,000-50,000 migrant and seasonal farm workers, 91 percent of whom are Mexican-born. Ironically, these workers whose efforts contribute to high-quality and affordable foods for the U.S. population often suffer from food insecurity, malnutrition, poor health status, and poverty.

Chester and Adams Counties contain the highest numbers of migrant and seasonal farm workers. The counties' agricultural industries vary affecting the stability of workers in each location. Adams County relies on migrant farm workers directly from Mexico on H2A work visas that obligate them to work exclusively for the grower hiring them or return to Mexico. Chester County employs a large number of seasonal farm workers in the year-round mushroom industry, fostering a more settled population and leading to higher annual wages. In Chester County, many families come independently and remain year round while the men travel back and forth on H2A visas. Because of the nature of the mushroom industry, these workers are often not considered "true" migrant farm workers who move from location to location following crops, and subsequently do not receive benefits and services (The Center for Rural Pennsylvania website, accessed 1/05).

Income

According to The Economic Outlook for FY 2005-06 in the Governor's Budget Address, "Growth

in real personal income within Pennsylvania lagged the national rate during the period when the economy was expanding in the late 1990's while the Commonwealth's growth in real personal income outperformed 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//

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. From 1969 to 1989, 524,000 manufacturing jobs were lost, more than twice the number of jobs lost in the United States during the same period. 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//

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.

Education

The Commonwealth has 501 school districts that educate 83.4 percent of its children (16.6 percent are enrolled in private and nonpublic schools). There are 3,253 public schools, which include 102 charter schools, 15 area vocational technical schools (AVTS), and 66 occupational AVTS. Act 22 established charter schools in 1997. AVTS are operated by a school district, group of districts, or intermediate unit to provide career and technical education services to students. Numerous other alternative programs, such as 21st Century Community Learning Centers, Dropout Prevention, Homeless Education, Migrant Education, Service Learning, and Teen Parents, offer students educational opportunities as well. Children in Pennsylvania are also educated through a system of private and nonpublic schools, which account for 2,446 schools in the Commonwealth.

In Harrisburg, the State's capital, reorganization, reforms, and improvements are making a real difference in the lives of many students and families in the Harrisburg School District. A comprehensive educational system from age three, with Early Childhood, to adult post-graduate level programs, is being created in Harrisburg. The Balanced Literacy Program is aimed at district-wide upgrades in the literacy skills of all students. A comparison of 2000 and 2004 district PSSA reading score shows a 76 percent increase in Grade 5, 91 percent increase in Grade 8 and 264 percent in Grade 11 (Harrisburg Community Newsletter, Spring 2005).

In the past decade, overall school enrollment in Pennsylvania has remained essentially unchanged, but when examined by age, a distinct trend emerges. Enrollment has increased by 11.3 percent among students in secondary schools, but has decreased by 6.2 percent among elementary students. Long-term estimates project that by 2013 enrollment in public and private schools will experience a decline, which is contrary to the national trend in school enrollment (PA Department of Education).

Educational attainment is related to a number of important factors that influence health and wellness. The level of educational attainment can impact earning power, employment stability, and health-seeking behavior. U.S. Census Bureau 2000 statistics indicate that 82 percent of the Commonwealth's citizens have obtained at least a high school diploma or its equivalent. Nevertheless, over five percent of the population fails to remain in school beyond the eighth grade. Residents living in the counties surrounding Philadelphia and Pittsburgh have the highest levels of educational attainment in the State. Twenty to 42.5 percent of these residents are college educated. In Carbon County in 2002, one in ten children was born to mothers with less than a high school education (per 100 births) (State of the Child and Family in Carbon County, 2004).

The Pennsylvania Department of Education (PDE) has responsibility for ensuring that all adults have basic literacy skills. The Bureau of Family Health (BFH) represents the Department of Health as a member of PDE's Adult Basic and Literacy Education and Interagency Coordinating Council (ABLE ICC). In 2002, this agency focused on developing plans for Health Literacy. In 2005, the ABLE ICC is looking at literacy needs more comprehensively. BFH staff is providing the public health perspective related to the concept that a "healthy community is a literate community", wherein "community" is envisioned as the client with its own strengths and support needs. Public health has been attempting to tease out the criteria of what defines a healthy community and has made considerable strides. However, having literate community residents is a measure of "health," which has been under the radar screen in health planning. The Bureau continues to facilitate discussions with the literacy and health planning advocates.

Every day in every Pennsylvania school district, the Education Accountability Block Grant is helping educators boost achievement for the Commonwealth's students. Now in its second year, the Accountability Block Grant provides $200 million for school districts to invest in academic programs that are proven to help students learn.

As a result of this year's Accountability Block Grant:

- More than 3,000 children are enrolled in prekindergarten;
- More than 53,000 children are enrolled in full-day kindergarten;
- Nearly 21,000 students in kindergarten through third grade are in smaller classes;
- More than 46,000 struggling students are receiving tutoring; and
- Hundreds of thousands of students are benefiting from the additional teacher training.

The Bureau of Family Health's top 13 priorities closely reflect 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 the utilization 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//

1. Addressing health disparities in the rates of low birth weight and premature birth

The Needs Analysis suggests that like other states, Pennsylvania is experiencing significant racial/ethnic disparities in perinatal outcomes. Although overall pregnancy outcome indicators are generally in line with national rates, for some population groups, namely black and Hispanic women, rates of low birth weight and premature birth are of concern. The assessment data indicates that for the most part, women at risk of poor outcomes reside in particular areas of the State.

Research has established a high correlation between the incidence of low birth weight babies, infant mortality and specific socio-economic and demographic factors. These factors include, among others, race, poverty, and the availability and utilization of maternity care services.

Infant mortality rates have declined in Pennsylvania over the last two decades for white and black infants. However, per 2003 data, the black infant death rate was over two and a half times as high as that for whites. The percentage of babies born with low birth weight decreased slightly from 8.2 percent in 2002 to 8.1 percent in 2003. WIC data as reported during FY '05 increased to 6.87% (4,758 infants) with a birth weight less than or equal to 5Lb 8 oz of all live births certified using the Risk Criteria DC (LBW).
/2007/ On April 19, 2006 the Secretary of Health announced the creation of the Office of Health Equity within the Department of Health. This Office will address service access issues related to health disparities across state government agencies.//2007//

2. Improving statewide access to prenatal care and labor and delivery services

According to the Needs Analysis the status and evenness of perinatal systems throughout the Commonwealth are unclear given the reduction in the number of obstetrical beds and uncertainty about the availability of and access to obstetrical care across the State.

Infant mortality and morbidity statistics are sensitive indicators of the utilization of obstetrical services in a population where socio-economic factors play a role in health care. Access to transportation across the state may inhibit mobility and access to maternity services. In addition, the cost of transit fare, where available, may place limitations on a pregnant woman's access in urban and rural areas in the state. Pennsylvania has ten county and municipal Health Districts strategically located across the state; however, Pennsylvania experienced a decline in the number of birthing facilities for maternity services from 148 in 1997 to 126 in 2005. Currently, data gathering by various stakeholders including State and local government officials and professional organizations is underway to determine the impact on obstetrical services in the Commonwealth.

3. Promoting smoking cessation in pregnancy

Smoking during pregnancy is clearly linked to fetal and infant deaths. Infants born to mothers who smoke while pregnant have three times the risk of Sudden Infant Death Syndrome. In addition, smoking can result in low birth-weight and premature birth. According to a report from the Surgeon General, in 20 percent of low birth-weight births, eliminating smoking during pregnancy could have prevented 8 percent of preterm deliveries, and 5 percent of all prenatal infant deaths.

In fact, among the 50 largest cities in the United States, Pittsburgh has the highest rate of pregnant women who smoke in the nation. According to a survey conducted by the Annie E. Casey Foundation, 23.3 percent of women who gave birth in Pittsburgh reported they smoked during pregnancy in 2000. Pittsburgh has held this ranking for ten out of the last eleven years according to the survey (KIDS COUNT Special Report Annie E. Casey Foundation, 1998). Although rates are particularly high in Pittsburgh, high rates of smoking during pregnancy in Pennsylvania are not confined to this region. According to the Casey Report, Philadelphia ranked 30th out of 50 cities with 14 percent of mothers smoking during pregnancy. Rates are also

troubling in many rural counties: in York County, the figure is close to 22 percent, in Clinton County, 30 percent, in Venango County, 33.4 percent, and in Greene County, 33.6 percent (The State of the Child in Pennsylvania: 2002).

The Bureau of Family Health collaborated with the Department of Public Welfare's Office of Medical Assistance Programs to develop interventions targeting pregnant women and providers through a multifaceted action plan consisting of, but not limited to, interventions that will increase awareness of the dangers of smoking while pregnant and raising the awareness of the ill effects of smoking around children of all ages, especially newborns.
/2007/ In June 2006, Pennsylvania House Bill 1489, proposed to establishing the Clean Indoor Air Act; was defeated. The legislation proposed a statewide ban on smoking in public places. It will be reintroduced in fall 2006.//2007//

4. Improving oral health of children and adolescents

In a recent report, the U.S. Surgeon General, Vice Admiral Richard H. Carmona, M.D., charged that access to care among low-income citizens and oral health literacy are major concerns related to the oral health status of American citizens. The importance of oral health to the overall health of children and adolescents is well recognized by the Commonwealth, and the Department of Health has been active along with other stakeholders in the promotion of oral health. However, given the importance of this issue and rates of utilization of dental care, the data suggests that more should be done.

According to Oral Health America: A Report of the Surgeon General, published in 2000, oral diseases in the United States are a "silent epidemic" that has a disproportionate effect on minorities, children, the elderly, and the disabled. Each year, fewer than 20 percent of children covered by Medicaid receive preventive dental screenings, although these screenings are mandated through the Early and Periodic Screening, Diagnosis and Treatment programs.

National data indicated that in 1999-2000, untreated dental caries in ages two through five years of age was 23.2 percent; in ages six through 17 years, it was 22.6 percent and in persons 18 to 64 years of age for the same period it was 25.7 percent.

As of September 2002, there were 67 Dental Health Professional Shortage Areas (DHPSA) impacting 1,521,000 citizens. Forty-nine of the 67 dental shortage areas were designated as special populations because there were sufficient dentists to serve the population but there were very few dentists willing to see low-income patients, especially patients on Medicaid. Nearly one in seven Pennsylvania residents is Medicaid eligible. Pennsylvania clearly demonstrates that there is an income and access disparity to oral health services in the state. Eighty percent of the dental disease is now found in 20 percent of the children, usually children from low income families.
/2007/ As of April 30, 2006, there were 64 DHPSA impacting 1,522,000 citizens. Forty of the 64 dental shortage areas were designated as special populations because there were sufficient dentists to serve the population but there were very few dentists willing to see low-income patients, especially patients on Medicaid. Nearly one in seven Pennsylvania residents is Medicaid eligible. Pennsylvania clearly demonstrates that there is an income and access disparity to oral health services in the state. Eighty percent of the dental disease is now found in 20 percent of the children, usually children from low income families.
The Bureau of Health Planning continues to place a high emphasis on dental access issues and potential solutions. Thirty-seven of 76 Community Challenge Grants (grants to communities in designated underserved areas where services are lacking to start or expand primary care medical or dental clinics) that were awarded since 1994 have had a focus on dental initiatives, totaling $4,001,001.//2007//
Using national statistics, it is projected that 48% of Pennsylvania's children age six to eight had dental caries. 51% of African-American children in this age group had dental caries and 68

percent of Hispanic children in this age category had dental caries.

Oral health issues are not only a problem for children. Poor oral health in pregnant women contributes to poorer birth outcomes. Although more research is needed to confirm how periodontal disease affects pregnancy outcomes, evidence suggests that pregnant women who have periodontal disease may be seven times more likely to have a baby that is premature and low birth weight (Journal of Periodontology, March 2005).

To begin to address the problems and gaps in Pennsylvania's oral health system, a full time State Public Health Dentist has joined the Department of Health Staff. An Oral Health Stakeholders Planning Group has been established and consists of dentists, dental hygienists, and representatives from the three dental schools, the Pennsylvania Dental Association, and other vested stakeholders. The State participates in the CDC Water Fluoridation Reporting System. The Department also administers the Loan Repayment Program, which provides repayment to physicians, dentists and mid level professionals who agree to practice in a federally designated shortage area. Pennsylvania receives funding from the National Foundation of Dentistry for the handicapped population in eastern and western Pennsylvania.

The Bureau of Health Planning launched a special initiative to increase the recruitment and retention of dental professionals to underserved areas in response to community concerns about access to dental services for the low-income population. Each year, the Bureau has the ability to place up to 30 primary health care practitioners (including dentists) in underserved areas in Pennsylvania through the Loan Repayment Program, which repays up to $64,000 in student loans in exchange for a 4-year commitment to practice full time in designated health professional shortage area. All loan repayment participants must agree to not discriminate based on ability to pay and must accept Medicare, Medicaid, and have a sliding fee scale. Those recipients located in a low-income health professional shortage area must demonstrate that at least 30% of their patients are low-income. Since the beginning of the program, 39 dentists have participated. ***/2007/ The Bureau of Health Planning also administers the Loan Repayment Program, which provides loan repayment to physicians, dentists, and midlevel professionals who agree to practice in a federally designated Health Professional Shortage Area. There have been 42 loan repayment commitments from dentists since the beginning of the program in 1993 for $266,683 million in support. Currently, 11 dentists are participating in the Program. The Bureau also has one full-time position dedicated to addressing dental access issues.//2007//***

5. Increasing access to childhood lead screening

While lead poisoning is a preventable environmental health problem, children are the most susceptible to adverse health, neurological and behavioral reactions from exposure to lead because their nervous systems and brains are still developing. Lead poisoning can cause mental retardation, learning disabilities, and behavioral problems in children. High blood lead levels can cause seizures, coma, and even death.

Risk factors contributing to lead poisoning in children include the child's age, socio-economic status and age and condition of the child's primary residence. Pennsylvania, like other states, is not immune to these factors.

According to the Centers for Disease Control and Prevention (CDC), Pennsylvania ranks fifth in the United States for the estimated number of children with elevated blood lead levels. In addition, based on the CDC's estimate of the number of children with elevated blood lead levels in cities, Pennsylvania was identified to have four cities in the top 129. In cities such as Philadelphia, Pittsburgh, and Erie, large numbers of children who are below the poverty level live in older, deteriorating housing. In several smaller cities such as Allentown, Bethlehem, and York there are concentrations of high-risk housing placing children who reside in these homes at increased risk for lead exposure.

The amount of lead in paint is much greater in older homes. Pennsylvania ranks second in the nation in terms of the number of units of pre-1950 housing (2,113,422 units) after the state of New York. While lead was banned from house paint in 1978, it remains in millions of homes across the country. Based on the 2000 Census, it is estimated that 4,029,533 (77 percent) of all housing units in Pennsylvania were built before 1978. The housing stock in Pennsylvania consists of 80 percent residential units built prior to the year 1980, 55 percent built prior to the year 1960, 40 percent built prior to the year 1950, and 30 percent built prior to 1940.
/2007/ During calendar year 2005, the Lead Hazard Control Program made 100 homes lead-safe for low-income families with children under age six.//2007//

By utilizing PA-NEDSS, a sophisticated, web-based, disease reporting application, various surveillance initiatives can be implemented to monitor, track and analyze childhood blood lead levels across Pennsylvania. Additionally, the Pennsylvania CLPPP, in conjunction with the Philadelphia Department of Public Health, developed a comprehensive Lead Elimination Plan designed to eradicate childhood lead poisoning by 2010. This Lead Elimination Plan recommends universal screening of all children at ages one and two and for all children age three through six without a confirmed prior lead blood test.
/2007/ According to PA-NEDSS, the number of children ages 1 and 2 years of age tested for lead has increased from 33,994 in 2004 to 44,640 in 2005. The change represents a 31.32% increase. Pennsylvania has crafted the Childhood Lead Prevention Act to ensure access to medical care and financial compensation for expenses incurred due to injuries received as a result of lead paint hazards.//2007//

6. Promoting the health and wellness of school age children

The Department of Health through the Division of School Health in the Bureau of Community Health Systems monitors and evaluates school districts' compliance with State laws, regulations, and policies; provides consultation and technical assistance to districts to support and improve health programs and services; develops policy, procedures, guidelines and adopts records and report forms to support and facilitate the efficient operation, administration and evaluation of the school health program as well as fosters state and local cooperation and coordination of programs and services. Health coverage can meet children's behavior, health, and assessment needs. Title V dollars support a full time School Health Consultant in each of the Department's six District Offices across the state to provide information, consultation, technical assistance, training, and coordination of programs and services to schools, parents, and the community at large regarding school health programs and services.

Article XIV of the Pennsylvania Public School Code provides that all children attending public, private, and parochial schools receive school health services. These services include medical and dental examinations and five different health screenings (growth, vision, hearing, scoliosis, and tuberculosis) at specified intervals; nursing services, including the treatment of acute and chronic conditions, first aid, and emergency care; medication administration; health counseling and health promotion; maintenance of student health records; and assessment for school immunizations. Article XXV of the Code provides for Health Department reimbursement to districts for a portion of the costs associated with the provision of these school health services.

7. Reducing childhood obesity

Obesity is a leading cause of preventable death in the United States and is second only to tobacco use. Childhood obesity is a national epidemic. In children ages six to eighteen years, the prevalence of being overweight (defined as BMI greater than 95 percentile) is 15.4 percent and is increasing rapidly, especially in children of color. Furthermore, an additional 15 percent are at risk for becoming overweight (defined as BMI greater or equal to 85th percentile but less than 95th percentile). The numbers in Pennsylvania are even more alarming with 27% of low-income children between two and five years of age in Pennsylvania being overweight or at risk of

becoming overweight (CDC PedNSS, 2002). According to the Pennsylvania Assessment of Overweight Children and Youth report in 2002, 18.2 percent of eighth graders are overweight and an additional 17 percent are at risk of becoming overweight.
/2007/ In the last few years, scores of data gathered throughout Pennsylvania and the U.S. have begun to unveil the invisible and critical consequences over being overweight. The rate of overweight Pennsylvania children is 18%, which currently exceeds the national average. The numbers in Pennsylvania are even more alarming with 25.8% of low-income children between 2 and 5 years of age being overweight or at risk of becoming overweight (CDC PedNSS, 2004).

The Child Nutrition and WIC Reauthorization Act was signed as Public Law 108-265 on June 30, 2004. The law contains several provisions that impact School Nutrition Programs. Section 204, Local Wellness Policy, requires all Local Education Agencies (LEA's) that participate in the National School Lunch or School Breakfast Program to develop and implement a Local Wellness Policy by July 1, 2006.//2007//

The causes of the childhood obesity epidemic are numerous, but it is clear that the dramatic change in lifestyles--resulting in increased energy intake and decreased energy expenditure--over the last two decades is largely responsible. Bigger portion sizes, intake of high-fat fast foods, and energy dense drinks such as soft drinks have contributed greatly to the increased caloric intake and reduction in physical activity. Increase in sedentary activities such as television, video and computer use has contributed to the decrease in energy expenditure.

Comparing these facts with Pennsylvania data demonstrates:

*51 cents of the Pennsylvania nutrition dollar is spent on food consumed outside the home
*Pennsylvania adolescents consume 13 percent of their total calories on soft drinks;
*Greater than 50 percent of 12-17 year olds watch three-five hours of television per day; and,
*62.9 percent of elementary school students and 15 percent of secondary school students receive less than 45 minutes of physical education per week.

8. Strengthening health and physical education activities within the schools

The Department of Health is partnering with the Pennsylvania Department of Education to exemplify the high level of interest in meeting the requirements of our children's daily physical activity needs as an ongoing part of a healthy lifestyle.

According to a review of the literature, children, like adults, benefit from regular exercise and healthy eating habits. The growing body of evidence indicates that the antecedents of many adult health problems begin in childhood. While the Department of Education provides guidelines and academic standards in Health, Safety, and Physical Education, the No Child Left Behind Act does not currently classify physical education as a core content. Therefore, physical education is not offered consistently across the Commonwealth. A 2001 survey of PA schools reported: 63% of elementary schools promote 45 minutes or less of physical education per week; 57% of secondary schools promote 90 minutes or less of physical education per week. National guidelines are 225 minutes per week (PSAHPERD survey: The Status of Physical Education in PA Survey, 2002).

9. Decreasing the rate of teen suicide

Since the mid 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 throughout the state.

In 2001, professionals within Pennsylvania opted to develop a "formal" youth suicide prevention

plan. The Interagency Committee of SAP took the lead in convening a workgroup of about 50 stakeholders from across the state to formalize a plan using the " National Strategy for Suicide Prevention: Goals and Objectives for Action" as a template to include what already exists in Pennsylvania and to address gaps in those strategies. The Pennsylvania Strategy for Youth Suicide Prevention creates a framework for youth suicide prevention for Pennsylvania by encouraging and empowering groups and individuals to work together. The intent is to provide the general public with a greater understanding of the extent of the problem, about ways teen suicide can be prevented, and the roles individuals and group can play in prevention efforts. The stronger and broader the support and collaboration gained through these strategies, the greater the chance for the success of this public health initiative to continue to reduce youth suicide and youth suicidal behavior.

National death rates for youth 15-19 year olds due to suicide have decreased from 10.5 per 100,000 in 1995 to 7.9 per 100,000 in 2001 according to data collected by the CDC. During the same period, Pennsylvania's suicide rate reflected the national trend dropping from 11.3 per 100,000 (92 per 815,508 teens ages 15-19) in 1996 to 7.95 per 100,000 (67 per 842,741 ages 15-19) in 2001 (Annie E. Casey Foundation, Kids Count Data book, www.aecf.org/kidscount/databook).
/2007/ 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, will be applying for grant funds as authorized under the Garrett Lee Smith Memorial Act. The grant funds will allow states to build upon existing suicide prevention efforts, to develop early intervention strategies, and to further public/private sector collaboration.

See attached TVIS file within the "Overview" section to view suicide rates from 1990 to 2004 for Pennsylvania Residents aged 15-19.//2007//

10. Decreasing alcohol related driving morbidity and mortality among teens

Motor vehicle crashes are a leading cause of death among youth, especially teenagers. According to the National Highway Traffic Safety Administration, while the number of highway deaths overall rose 0.4 percent in 2003, fatalities in crashes involving drivers ages 16 through 20 rose 1.3 percent. Teenage drivers are involved in fatal crashes at twice the rate of drivers overall and have a fatality rate four times that of drivers ages 25-29.

Approximately three in every ten persons in the United States will be involved in an alcohol-related motor vehicle crash in their lifetime. Fatal injuries caused by motor vehicle crashes in which a driver, occupant or non-occupant was under the influence of alcohol remains a serious problem. At all levels of blood alcohol concentration, the risk of involvement in a motor vehicle crash is greater for teens than for older drivers (Insurance Institue for Highway Safety, Fatality Facts: Teenagers 2002).

In order to reduce mortality and morbidity from alcohol related teen driving deaths, the Bureau of Family Health will work across state agencies to coordinate activities with the Safe Kids Coalition, the PA Department of Transportation, the PA Liquor Control Board, and the Bureau of Drug and Alcohol Programs in FY 05-06 to launch a statewide multimedia campaign.

11. Increasing coordination of programs serving CSHCN

The BFH has developed an extraordinary array of program components designed to serve the Commonwealth's CSHCN and their families. These programs include the hospital-based family consultants, the Special Kids Network Help line and Community System Development, the Parent to Parent Network, and the District CSHCN consultants. However the assessment data suggests that the coordination between these components is at best, uneven, resulting in fragmented service delivery. This fragmentation is also a barrier to the effective use of available resources.

The BFH is also committed to developing creative and evidence based programs targeting the needs of older CSHCN including preadolescents, adolescents and young adults. In response to these findings, the Division of Community Systems Development and Outreach will develop a statewide correction action plan for FY 05-06.
/2007/ As a first step to improving care coordination for CSHCN, the Bureau of Family Health (BFH), created a CSHCN Stakeholder Group, comprised of both internal and external stakeholders, including parents. By December 2006, this Group will complete recommendations and action plans for the top five identified service needs.//2007//

12. Increasing the utilization of the Medicaid EPSDT Program

The Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a valuable mechanism to reach, screen and refer children for services important to assuring their health and well-being. The number of children covered by CHIP has increased to 133,472 in August 2003. Average CHIP enrollment for calendar year 2004 was 134,885. While the Commonwealth has done an outstanding job assuring the availability of health insurance for children, many Pennsylvania children remain uninsured. The rates for EPSDT screens and follow-up, while steadily increasing, could be improved substantially. The Department of Health and the Department of Insurance have partnered to improve children's health and access to health services by increasing the number of children with health coverage.

13. Increasing the availability of MCH program data

Using data as a framework to identify problems and detect trends in the overall population as well as in the state's subpopulations, policies and programs can be developed or enhanced to address issues impacting health in the Commonwealth. In some cases, the lack of available and useful data from programs focused on MCH health conditions and disease impact for this target population makes it difficult at the program level to monitor and assess the effectiveness of services. Title V funding supports the Bureau of Family Health's MCH epidemiologist to assist the Bureau with projects addressing health conditions affecting mothers and children in the state. The Bureau of Epidemiology directs multifaceted public health surveillance and assessment programs that allow the Bureau of Family Health to better define Pennsylvania's disease burden. For example, aggregate data is collected to describe linkage to services and follow-up related to pre-natal care, geo-spatial characteristics of infant mortality, morbidity, and low birth rate in Pennsylvania.

Prenatal data describe trends and geo-spatial characteristics of low birth rate in Pennsylvania. Evaluation of available data allows the identification of factors that contribute to the continuing racial disparities in maternal mortality, low birth weight, pre-term births, pre-natal care, and access to health care. Data is also used to establish trends in injury to pregnant women and birth outcomes. Data gathering facilitates the evaluation and description of the population of Children with Special Health Care Needs.

At the population level, the Pennsylvania Department of Health maintains many data sources that are vital to the Bureau of Family Health, such as Vital Statistics, mortality records and birth records, cancer incidence records, Pennsylvania Cancer Incidence Registry and patient hospital discharge records, Pennsylvania Health Care Cost Containment Council, the Pennsylvania FORE Families birth defect data monitoring systems, and the Bureau of Laboratory--Pennsylvania National Electronic Disease Surveillance System (NEDSS). Department contractors also provide data on rape, domestic violence, and youth violence.
/2007/ In April 2006, the 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.//2007//

Health Indicators

A challenge for Pennsylvania is that not all Pennsylvanians have equal access to healthcare. Even today, racial, ethnic and non-English speaking minorities are more likely to experience great differences in their health as compared to the white population. Therefore, minority populations carry an unequal burden of disease and poor health. For example, data for 2003 shows the infant death rate for blacks (16.1) was more than two and a half times higher than that for whites (6.3) and the infant death rate for Hispanics (7.7) was slightly higher than whites.

Other challenges include mothers who use tobacco during pregnancy and those who delay prenatal care which makes them more likely to have low birth weight babies. Research shows maternal smoking during pregnancy is associated with miscarriages, low birth weight, and infant mortality. In Pennsylvania, approximately 33 percent of women ages 18 to 44 reported smoking every day. The percent of black women who reported smoking during pregnancy increased from 14.5 (2002) to 16.8% in 2003.
An attachment is included in this section.

B. Agency Capacity

Promoting Health of Mothers and Children including CSHCN

The Bureau of Family Health (BFH), through its Divisions of Child and Adult Health Services (CAHS), Community Systems Development and Outreach (CSDO), Newborn Disease Prevention and Identification (NDPI), 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. These services, as well as selected activities conducted by the divisions collaboratively, are described in the following paragraphs.

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 help lines 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 help line, the call volume of 198,000 represented 198,000 help line needs served. Since the HHSCC Certified I&R Specialists are cross trained, they can address caller needs for multiple help lines. Each assisted help line need is referred to as an "event". Since the center's inception, the numbers of answered calls and events have been documented. For the month of March 2006, the rate of calls and events together trended at 239,244 per year, which represents a 20 percent increase in help line needs met, if compared to the pre-HHSCC annual volume of 198,000.//2007//

The PA Recreation and Leisure Line (R&L)

The R&L officially began to take calls January 1, 2001. This Line was created to assist individuals of all ages with special needs in locating accessible, inclusive recreational activities across the Commonwealth. A database of over 2,000 resources includes athletic programs, parks, recreation areas, camps, cultural enrichment activities, hobby instruction, professional sporting events, intrastate travel opportunities, and more. Available information includes wheelchair accessibility and hearing, vision, speech, and behavioral accommodations.

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.

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. Four State Agencies are represented on the Council: Aging, Education, Health, and Public Welfare. The Council is composed of Agency staff, advocates and persons with disabilities. Among the accomplishments of the Council are the ongoing Policy Information Exchange, which informs decision-makers and program participants alike about the various legislative initiatives that will impact the lives of persons with disabilities; a voter awareness initiative which will continue to educate voters with disabilities about their rights to accessible voting venues; and position papers on a variety of issues that reflect the rights and considerations of individuals with disabilities.

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.

State Early Childhood Comprehensive Systems (SECCS) Grant

The Bureau of Family Health ensures a statewide system of services for all children, including CSHCN, through the SECCS Grant, which is an initiative funded by the Maternal and Child Health Bureau of the Health Resources and Services Administration. The purpose of the SECCS Grant is to support State Maternal and Child Health Agencies and their partner organizations in collaborative efforts to strengthen the State's early childhood system of services for young children and their families. The ultimate goal of the SECCS Grant is the development of a statewide strategic plan that will support the implementation of a comprehensive early childhood system that promotes the health and well-being of children in Pennsylvania, thus enabling them to enter school healthy and ready to learn. The five priority areas that are addressed in the plan include: 1) access to health insurance and medical homes, 2) early care and education, 3) mental health and socio-emotional development, 4) parent education, and 5) parent support.

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//

Sickle Cell Disease (SCD) Program

The Bureau of Family Health also 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 with the Disease since 2004. The Bureau's SCD Program received a $200,000 increase in state funding for state fiscal year 06-07 to provide additional access and health care resources for diagnosed individuals and their families and the community-based organizations that serve them.//2007//

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 is accomplished at all levels by centralized Bureau program staff and regionally by MCH and SHCN consultant field staff. The Consultants collaborate with innumerable local and state agencies in addition to 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 State Early Childhood Comprehensive Systems (SECCS) Grant represents tremendous collaboration among state and local agencies. The SECCS Grant Steering Committee and workgroups consist of key individuals from both State Government as well as local organizations that promote the well being of young children and their families.

The Bureau of Family Health (BFH) was instrumental in the development of 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 issues around managed care for CSHCN. After a meeting with key stakeholders in the state, the PPP has identified key issues and is developing recommendations for a plan of action. In addition, the PPP held two round table discussions on managed care and CSHCN. These meetings brought together key leaders from both government offices and state contracted managed care providers to identify issues that families face in coordinating and receiving care 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 diverse individuals from both public and private organizations, represents an extremely broad range of interests from healthcare organizations, physicians, property owner associations, tenant associations, attorneys, and City and State government entities. Over the course of a few months, the Workgroup met regularly and developed a plan that eliminates childhood lead poisoning by 2010. The result, a Statewide Lead Elimination Plan focusing on surveillance, housing, outreach, and case management. The Plan was submitted to the Centers for Disease Control and Prevention in 2004 and a comprehensive strategic plan with specific tasks and objectives for implementation is proposed for 2005.

Other initiatives demonstrating the Department's commitment to eliminating childhood lead poisoning 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.

Staffs 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.

Pennsylvania Statutes Impacting on Title V Programs

There are several Pennsylvania statutes affecting administration of programs administered by the

BFH. The attached Table 5 (Pennsylvania Statutes Impacting on Title V Programs) lists those statutes relevant to Title V program authority and describes the impact of each on the BFH Title V funded programs.

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 NDPI 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.

Similarly, the Bureau's "Love'em with a Check-Up" outreach initiative encourages women to receive early prenatal care, thus serving a preventative function. Related mass media messages feature a woman early in her pregnancy and showcase the Healthy Baby Help line 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."

The Healthy Baby Help line 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 help line and to provide additional referrals if necessary.

/2007/ Women in the Commonwealth favored 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//

The Bureau of Family Health also utilizes Title V dollars to fund two county health departments (Montgomery and Philadelphia Counties) for the provision of 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. Norristown, Montgomery County, had an infant mortality rate of 9.7 for the 5-year period of 1998-2002, compared to the State rate of 7.2 for the same 5-year period. In that period there were 25 total infant deaths in Norristown, 8 white and 17 black. Births to Hispanic women in Norristown more than doubled from 1998 (13.9 percent) to 2002 (30.6 percent). 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 for these undocumented Hispanic pregnant women. This program is hugely successful and vital to the

Norristown Community. In 2004, allocated funds in the amount of $136,000 ensured prenatal services for 170 women. It is estimated that an additional 210 women were eligible for this program, but could not be served due to inadequate funding. This reimbursement is essential to treating these women who are undocumented or have limited means of payment. 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//

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 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. Despite the dramatic decline in SIDS over the last decade, SIDS still claims the lives of roughly 2,500 infants each year. Since 1994, SIDS rates for both the white and the African American populations have declined by about 50 percent, but a significant disparity still remains (Source: The National Institute of Child Health and Human Development of the National Institutes of Health). The number of SIDS deaths in Pennsylvania has declined from 109 in 1999 to 74 in 2003 (Source: PA Department of Health Bureau of Health Statistics and Research).
/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 (ECELS) provides technical assistance and training on SIDS prevention to child care sites where the rate of SIDS deaths are higher then expected.//2007//

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.

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//

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//

The Bureau of Communicable Diseases, Division of HIV supports Young Adult Roundtables designed to provide youth ages 13 to 24 representation in Pennsylvania's HIV prevention community planning process. Each of the current six roundtables is comprised of 15 - 20 "high-risk" young adults from diverse communities across the state. Each Roundtable meets five times during the year to discuss current issues and to provide important HIV prevention needs assessment information to the Pennsylvania HIV Prevention Community Planning Committee.

Preventive and Primary Care Services for Children

The Bureau of Family Health provides preventative 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 derived 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, and 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. The teams review deaths and identify and investigate risk factors that lead to the death so that future deaths can be prevented. Teams recommend policies and educational programs that can prevent future child deaths.
/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//

The Healthy Kids Help line 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 help line 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 provide 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 21,075 young people in Calendar Year 2005. This is a 15% increase in the numbers served from 2004 to 2005.//2007//

Additionally, preventative 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 providing age appropriate health care including immunizations and patient education.

Rehabilitative Services for Blind and Disabled Individuals

Our sister Agency, 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. Each Office has two CSD staff working directly with local community partners, one Research and Referral Specialist identifying and mapping resources within the region, and one Administrative Assistant. The CSD staff uses a uniform approach to meet a variety of service 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. Costs stimulated and incurred by the community coalitions are underwritten by donations and grant opportunities that are pursued by the coalition.
/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//

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 help lines, 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. These personnel were critical during the relocation of families to Pennsylvania from the New Orleans area following Hurricane Katrina in September of 2005.//2007//

Bureau of Family Health staff participate on statewide cultural oriented planning groups. For example, a member of the WIC staff serves on the Governor's Advisory Commission on Asian-American Affairs' Health, Education and Public Welfare Committee. This group is designing practical strategies to meet the needs and concerns of Asian Americans residing in Pennsylvania.

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.

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.

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.

Under the leadership and direction of Secretary Johnson, the Department of Health developed a strategic plan in accord with Healthy People 2010 and the Department's mission. The Department's goals include:
1. Achieve Pennsylvania Healthy People 2010 objective, specifically focusing on eliminating disparities in health and health care;
2. Elevate both public awareness and the positive public perception of the Department of Health by improving communication with and delivering exceptional customer service to all Department of Health constituents;

3. Recruit, develop, and maintain a well-trained and high skilled workforce to meet current and future public health demands;
4. Establish and maintain the Department of Health as a national leader in public health; and,
5. Ensure staff, program, and contractor accountability through data driven decision-making, monitoring and evaluation of all Department of Health program and function.

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.

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//

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.

Delineation of breastfeeding rates among WIC participants with low birth weight (less than 2500 gm) is calculated as those infants currently enrolled in WIC. Of the 4,722 LBW infants currently enrolled, 42 % (1,966) initiated breastfeeding. The number of WIC infants of very low birth weight (VLBW) (less than 1500 gm) who are currently enrolled is 2,857. Initiation rates among these VLBW infants are 45% (1,308).

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 help lines 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 help lines 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 help line 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). An outreach campaign was initiated increasing the volume of calls to the Call Center. Billboards were created and displayed in January 2006. The call to action message was for the public to call the LIL if they were concerned that their children may be affected by lead poisoning. According to data collected by the Call Center, the percentage of callers who cited the billboard, when asked How You Heard was 30% in January, 41% in February, and 42% in March, 2006. These billboards (both English and Spanish) were placed in strategic locations across the state: Bethlehem, Harrisburg, Johnstown, Lancaster, Philadelphia, Scranton, and York based on the number of homes that were built prior to 1978.

In November 2005, the Division also took over the administration of the Medical Home Program, the Parent to Parent Program, and the Family Consultant Program. These programs were previously managed by the Division of Child and Adult Health Services (CAHS).//2007//

4. The Division of Newborn Disease Prevention and Identification 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 registry 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.

5. The Division of Program Support and Coordination 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 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.

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.

Bureau of Family Health - Director of the Division of Program Support and Coordination: Candace Johndrow
Ms. Johndrow graduated with a B.S. in Psychology from The Pennsylvania State University in 1995. She has worked in the Bureau of Family Health (BFH) for the past three years. In her current position, she acts as chief administrative officer and director of all BFH operations. Prior to assuming her present position, she administered multiple statewide programs benefiting young people with special needs. Prior to her tenure with the Bureau, she worked for a large community-based federal grantee of family planning and related reproductive health care services, with administrative oversight of three regional STD/HIV programs. She had previously worked for several years as a residential supervisor at a treatment and program facility for children and young adults with severe physical and developmental disabilities.

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//

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)

Jane Wolfe, Central P, E, DA Administers Comprehensive Specialty Care Programs
Dawn Johnson, Central, P, E, DA Administers the Sickle Cell Disease Program
Joseph McLaughlin, Central, P, E, DA Administers the Childhood Lead Poisoning Prevention Program
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//

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 as 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//

Bureau of Family Health - Director of the Division of Newborn Disease Prevention and Identification: Karen Espenshade
Ms. Espenshade has served the healthcare community for over 35 years, working in both the private and government sector. She has served the Pennsylvania Department of Health since 2001. Ms. Espenshade is a registered nurse and has a B.S. in Business Management. She attained the rank of Captain in the United States Air Force while serving six years on active duty. Her experience extends to all areas of clinical nursing, practice management and consulting services. Her 16 years of hospital clinical experience includes obstetrics/gynecology, pediatrics, operating room and emergency services. Ms. Espenshade served as CEO for a cardiovascular surgery practice for 13 years and was President and CEO of Compliance Link, a medical practice consulting firm prior to entering state government.

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

Robert Staver, Central, P, E, DA as Program Manager, Hearing Screening and Genetics Section
Steven Horner, Central, P, E, DA, as Program Manager, Newborn Screening and Follow-up Section
Arthur Florio, Central, P, E, DA Administrator, Hearing Screening Program
Kelly Holland, Central, P, E, DA Administrator, Genetics Program
/2007/ Suzanne Bellotti, Central, P, E, DA Administrator, Newborn Screening and Follow-up
Kelly Holland transferred to the Division of Child and Adult Health Services//2007//

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. In 1985, he assumed the role of Division Director. Mr. Maisano received his B.S. and M.S. degrees in Business Education from Shippensburg University. He has been recognized nationally by his peers for his leadership of the PA WIC Program over the years, most notably for his work on the funding formula, minimum data set, cost-containment initiatives, and implementation of the first web-based WIC data system.

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: Crystal Fox
Ms. Fox is the attorney assigned to the Bureau of Family Health (excepting WIC operations) from the Governor's Office of General Counsel. Ms. Fox has a number of years of Commonwealth administrative service experience, including a year spent in the Bureau of Family Health as the MCH Block Grant Coordinator, during which time she organized the preparation of the 2002 Annual Report/2004 Application. Ms. Fox's responsibilities include offering legal advice and assistance with grants and contracts, legislation and legislative issues, program operation and design, and any other legal issues that arise in the Bureau.

/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.

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 BCDIP 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 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 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//

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//

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//

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//

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//

F. Health Systems Capacity Indicators

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	56.9	50.4	60.7	49.3	
Numerator	4171	3699	4436	3600	
Denominator	733496	734593	730943	730462	
Is the Data Provisional or Final?				Final	

Notes - 2005
Not Available.

Notes - 2004

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

Notes - 2003
HSCI #01: ICD-9CM Codes for primary diagnosis.
Numerator source: PA Health Care Cost Containment Council. Denominator source: PA State Data Center.

Narrative:
Health System 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.

Asthma prevalence, morbidity, and mortality in Pennsylvania have followed the national trends for the past several years. Many Pennsylvania residents are directly affected by asthma, and many more feel the impact of this disease in their communities, families, schools, and workplaces. Pennsylvania's Behavioral Risk Factor Surveillance System (BRFSS) provides information on asthma prevalence. In 2004, the BRFSS data estimated that 860,000 Pennsylvania adult residents aged 18 years and older reported currently having asthma. Pennsylvania rates for current asthma prevalence are similar to those of the United States as a whole. Pennsylvania BRFSS data for adults aged 18 years and older indicate that African-Americans, females, young adults, persons with low income, and persons with limited education are disproportionately burdened by asthma.

The Vital Statistics reporting system provides information on asthma mortality for Pennsylvania and for the whole country. During the 5 year period from 1998-2002, an average of 180 Pennsylvania residents died from asthma annually. Pennsylvania age-adjusted rates for asthma mortality are similar to those of the United States as a whole. The Pennsylvania rates meet the Healthy People 2010 goals for persons aged 65+, but exceed them for all other age groups where data are available. Pennsylvania vital statistics data for the last few years indicate that African-Americans are disproportionately burdened by asthma in terms of mortality, with age-adjusted mortality rates about 3 times those of Caucasians. Several Pennsylvania counties, most notably Philadelphia county, appear to be particularly burdened by asthma.

Reports are also available that illustrate aggregate county totals (sorted by PA Department of Health District) for selected types of health conditions as reported for school students. The statistics that appear were obtained from the Department's Division of School Health database. All information in the database is submitted annually to the Department via Pennsylvania's public school districts, comprehensive vocational-technical schools, and charter schools. The schools report only aggregate statistics for each condition. Data are not available by age, grade, sex, or race. Based on recent data (1997-2003) from the Bureau of Community Health Systems and Bureau of Epidemiology, reported asthma prevalence rates for students (grades K-12) in Pennsylvania have increased every year.

The average reported prevalence rate over the 6 years (1997-2003) is 7.9 percent. In the 1997-1998 school year there were 137,792 students (grades K-12) in Pennsylvania reported to have asthma from an average daily enrollment of 2,080,634 total students, computing to a prevalence rate of 6.6 percent for that year. In the 2002-2003 school year there were 189,691 students (grades K-12) in Pennsylvania reported to have asthma from an average daily enrollment of 2,080,634 total students, computing to a prevalence rate of 9.2 percent for that year

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	80.0	86.4	83.0	80.4	
Numerator	39055	43571	44994	53246	
Denominator	48806	50434	54193	66211	
Is the Data Provisional or Final?				Final	

Notes - 2005
Not Available.

Notes - 2004
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 10/01/2004 – 09/30/2005. Recipient age for the report was determined as of September 30, 2005.

Notes - 2003
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 10/01/2003 – 09/30/2004. Recipient age for the report was determined as of September 30, 2004.

Narrative:
Health System 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.

Eighty-three percent of Medicaid managed care enrollees whose age is less than one year received at least one initial periodic screen in 2004. In 2005, 80% received an initial screen. This represents only a minor decrease in screening. Despite the importance of these services, there is concern that families are not sufficiently informed of benefits and that enrolled children are not receiving them. Increased targeted promotion of the EPSDT Program is needed in Pennsylvania. Therefore, we have requested HRSA/MCHB's assistance in the review of EPSDT screening data from children enrolled in the Commonwealth's managed care programs for the purpose of identifying sub-groups with low participation rates.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) 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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	43.0	48.7	56.7	42.6	53.0
Numerator	313	1001	1334	578	683
Denominator	728	2055	2351	1357	1289
Is the Data Provisional or Final?				Final	Final

Notes - 2005
HSCI #03: Numerator and Denominator were provided by CHIP contractors using HEDIS-like parameters and reported for federal fiscal year 10/01/04 to 09/30/05.
Source: PA Department of Insurance

Notes - 2004
HSCI #03: PA's CHIP program, which is administered by the PA Insurance Commission, collects this data individually from the commercial CHIP insurers, who do not all report to CHIP in the same way. The Commission is migrating to a new computer system, which promises to make this reporting much easier in subsequent years.

The data collected from the commercial insurers was based on CPT codes 99381 (preventive visit, new, infant), 99391 (preventive visit, established, infant) and, 99432 (newborn care, not in hospital).

Notes - 2003
HSCI #03: PA's CHIP program, which is administered by the PA Insurance Commission, collects this data individually from the commercial CHIP insurers, who do not all report to CHIP in the same way. The Commission is migrating to a new computer system, which promises to make this reporting much easier in subsequent years.

The data collected from the commercial insurers was based on CPT codes 99381 (preventive visit, new, infant), 99391 (preventive visit, established, infant) and, 99432 (newborn care, not in hospital).

Narrative:
Health System Capacity Indicator #03:
The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The number of Pennsylvania children covered by CHIP has increased from 133,472 in 2003 to 140,179 in 2005. While the Commonwealth has done an outstanding job assuring the availability of health insurance for children, not all CHIP covered children are receiving a periodic screen in their first year. The percent receiving such screening has fluctuated between 2001 and 2005, with a low of 43.0% in 2001 and a high of 56.7% in 2003. The current rate for 2005 is 53.0% The rates for EPSDT screens and follow-up could be improved substantially. The Departments of Health, Insurance, and Public Welfare have partnered to improve children's health and access to health services by increasing the number of children with health coverage via numerous strategies. However, without targeted promotion of the EPSDT Program and related benefits, participation will not increase in Pennsylvania.

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	70.8	69.4	64.6	65.6	
Numerator	92389	88710	73376	74668	
Denominator	130561	127870	113585	113779	
Is the Data Provisional or Final?				Final	

Notes - 2005
Not Available.

Notes - 2004

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.

Notes - 2003
HSCI #04: Calculated with the missing data (adequacy measure could not be computed) removed from the denominator. Source: PA Department of Health, Bureau of Health Statistics and Research.

Narrative:
Health System 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.

The percent of women (15 through 44) with a live birth whose observed to expected prenatal care visits are greater than or equal to 80% on the Kotelchuck Index has been approximately 65% for the past two years. The newly awarded Pregnancy Risk Assessment Monitoring System (PRAMS) grant from the Centers for Disease Control and Prevention will greatly assist the Bureau in gathering individual data in attitudes about and barriers to prenatal care among this population, and inform perinatal health programs and policies. Never before has the PRAMS survey been completed in Pennsylvania.

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	94.3	79.1	78.6	86.6	
Numerator	825373	748622	775943	833010	
Denominator	875251	946031	986819	962085	
Is the Data Provisional or Final?				Final	

Notes - 2005
Not Available.

Notes - 2004
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 10/01/04 to 09/30/05, 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.

Notes - 2003
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 10/01/02 to 09/30/03, 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.

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

The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program peaked at 94.3% in 2001 and then dropped to 78.6% by 2003. In 2004, the percentage increased to 86.6%. It is too soon to tell whether this increase represents the beginning of an upward trend.

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	21.3	36.4	37.9	37.9	38.6
Numerator	182337	63689	66539	69373	76564
Denominator	856900	174994	175730	183039	198133
Is the Data Provisional or Final?				Final	Final

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.

Notes - 2004
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, 2004.

Notes - 2003
HSCI #07: Data is provided to the Title V program by PA Department of Public Welfare, from their CMS416 Report for the service date period 10/01/2002 – 09/30/2003. Recipient age for the report was determined as of September 30, 2003.

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

The percent of EPSDT eligible children aged 6 through 9 receiving a dental service during the year has steadily increased from 21.3% in 2001 to 38.6% in 2005 but there is still much improvement needed in this area. While Pennsylvania's EPSDT Program provides dental examinations for all enrolled children and also provides necessary treatment and services to correct/ameliorate defects found, regardless of whether the follow-up services are otherwise covered under the state Medicaid plan, 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.

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0.1	0.2	0.2	0.0	
Numerator	55	85	87	3	
Denominator	44360	41300	44095	58360	
Is the Data Provisional or Final?				Provisional	

Notes - 2005
Data not available.

Notes - 2004
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 04-05).
Denominator is number of children receiving SSI payments in PA as of December 2005, from Table 5 of the Social Security Administration's December 2005 report.

Notes - 2003
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 03-04).
Denominator is number of children receiving SSI payments in PA as of December 2002, from Table 5 of the Social Security Administration's December 2002 report.

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

Data reported reflect a substantial decrease in the number of children and youth under age 16 receiving rehabilitation services while on SSI. Pennsylvania is currently assessing the factors that together are most likely responsible for this decrease. These factors include youth "aging out", children and youth no longer needing rehabilitation services, and children and youth no longer receiving SSI. It is important to note that SSI status if self-reported. Therefore SSI status data is not always accurate.

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

INDICATOR #05	YEAR	DATA SOURCE	POPULATION		
Comparison of health			**MEDICAID**	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of low birth weight (< 2,500 grams)	2004	payment source from birth certificate	10.1	7.6	8.8

Narrative:
Health System Capacity Indicator #05A:
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Percent of low birth weight (<2,500 grams).

The Pennsylvania Department of Health's data source for this indicator is the payment source noted on the birth certificate. Of all Pennsylvania low birth weight (LBW) births in 2004, 10.1% were Medicaid covered versus 7.6% as Non-Medicaid. 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 proportion of LBW infants has remained fairly constant over the last three 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 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2004	other	0	0	7.1

Notes - 2007
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:
Health System Capacity Indicator #05B:
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Infant deaths per 1,000 live births.

In 2004, the infant death rate per 1,000 live births was 7.1%. The Title V Program does not have the ability to break this data down into Medicaid versus Non-Medicaid.

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

INDICATOR #05 ***Comparison of health system capacity***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	payment source from birth certificate	69.4	85.1	81.3

Narrative:
Health System Capacity Indicator #05C:
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Percent of pregnant women entering care in the first trimester.

The Pennsylvania Department of Health's data source for this indicator is the payment source noted on the birth certificate. In 2004, of all women receiving prenatal care within their first trimester of pregnancy, 69.4% were Medicaid covered versus 85.1% as Non-Medicaid. There is a significant disparity in access to prenatal care between these two populations. The Pennsylvania Department of Public Welfare (DPW), Office of Medical Assistance Programs, recognizing the importance of seamless, consistent prenatal care instituted a pilot program for pregnant women. DPW had found that many women needing these services are those most likely to lose eligibility through non-compliance with administrative processes. During a single six-month study period, DPW identified 700 women who lost eligibility for managed care and care management services. Retroactive reinstatement of the fee-for-service benefit cannot replace the lost opportunity to support these high-risk women in obtaining the services needed to deliver healthy infants at term. To address this problem, DPW developed the Pilot for Pregnant Women. Under this pilot program, eligible women begin 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. Additionally, the option for the woman to apply for other family members at this time is available. The goal of the intervention is to eliminate gaps in eligibility and maintain continuous managed care enrollment throughout the pregnancy. This continuous enrollment will enable care management to continue uninterrupted and is expected over time to substantially reduce poor birth outcomes and their associated program costs.

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 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**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])	2004	payment source from birth certificate	61.1	65	65.6

Narrative:
Health System Capacity Indicator #05D:
The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]).

The Pennsylvania Department of Health's data source for this indicator is the payment source noted on the birth certificate. In 2004, 61.1% of Medicaid covered pregnant women received adequate prenatal care compared to 65% of Non-Medicaid covered women. *See HSCI #5C

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 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2004	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2004	185

Notes - 2007
Please see form note.

Notes - 2007
Please see form note.

Narrative:
Health Systems Capacity Indicator #06A & 06B:
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

Same response for 6A, B & C: The percent of poverty by age has not changed from the last reporting period. The Pennsylvania Department of Public Welfare supplies this data and does not change the age breakdown and percentage every year.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2004	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2004	 133 100

Notes - 2007
Please see form note.

Notes - 2007
Please see form note.

Narrative:
Same response for 6A, B & C: The percent of poverty by age has not changed from the last reporting period. The Pennsylvania Department of Public Welfare supplies this data and does not change the age breakdown and percentage every year.

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

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2004	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2004	

Notes - 2007
Please see form note.

Notes - 2007
Please see form note.

Narrative:
Same response for 6A, B & C: The percent of poverty by age has not changed from the last reporting period. The Pennsylvania Department of Public Welfare supplies this data and does not change the age breakdown and percentage every year.

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

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS 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 - 2007

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

Pennsylvania's Title V Program seeks to improve around this Health Systems Capacity Indicator. Therefore, in 2005, "Increasing the Availability of Program Data" was established as a priority need as a means to enhance Pennsylvania's MCH-related data capacity.

Pennsylvania has since received a Pregnancy Risk Assessment Monitoring System (PRAMS) grant from the Centers for Disease Control and Prevention. PRAMS is an ongoing, state-specific, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy. The purpose of the program is to assist state public health agencies in generating state-specific data for informing perinatal health programs and policies that are targeted by programmatic activities.

Pennsylvania has also recently applied for a State Systems Development Initiative (SSDI) grant from the Health Resources and Services Administration to support increased collaboration among various state agencies to establish and improve data linkages between birth records, newborn metabolic and hearing screening records, WIC data, Medical Assistance files, death records, PRAMS data, and Pennsylvania's birth defects surveillance system.

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

DATA SOURCES	Does your state participate in the YRBS	Does your MCH program have direct access to the state YRBS database for

	survey? (Select 1 - 3)	analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	1	No

Notes - 2007

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

While Pennsylvania does not currently participate statewide in the Youth Behavior Risk Surveillance Survey, the Title V Agency sponsored a statewide youth survey through the Gallup Organization to collect data on adolescent behavior. In total, Gallup completed a total of 410 interviews with 297 teenagers ages 13 to 17, and 113 young adults ages 18 to 21, representing 330 households. A response rate of 57% was achieved.

With regard to lifetime cigarette smoking, when asked if they ever tried smoking, one out of four Pennsylvania teens/young adults replied that they have (25%). A gender gap exists -- 23% of males have tried smoking versus 28% of females. Far greater distinctions are recorded by age group, with 17% of teens, 13 to 17, reporting smoking compared to 45% of young adults, 18 to 21.

With regard to age of first whole cigarette, three out of 10 (29%) teen/young adult respondents who said they ever tried smoking, report smoking their first whole cigarette before they were 13 years of age, including 6% who say they did so when they were 8 or younger. Males are less likely than females to report smoking a whole cigarette before turning 13, by a margin of 26% to 32%. Seventy-one percent of young smokers report smoking their first whole cigarette at 13 years of age or older, including 25% who did not do so until 17 years or older.

With regard to current cigarette use, among teens/young adults who ever tried smoking, 44% reporting smoking cigarettes on one or more days of the 30 days preceding the survey. On this measure, males are significantly more likely to report smoking cigarettes during this time period than are females, 52% to 37%, respectively. Among the population who has tried smoking, the majority, 56%, say they smoked no cigarettes during the past 30 days. In contrast, 27% say they smoked cigarettes on all 30 days. Thirty-nine percent of teens, ages 13 to 17, smoked cigarettes at least one day in the past 30 days; significantly more young adults did so, 49%.

With regard to chewing tobacco, snuff, or dip, just 2% of the Pennsylvania teen/young adult population used chewing tobacco, snuff, or dip on one or more days during the past 30 days. There are no differences by age or gender.

With regard to cigars, five percent of adolescent survey respondents say they smoked cigars, cigarillos, or little cigars on one or more days during the past 30 days, including 7% of males and 2% of females. Young adults age 18 to 21 are twice as likely to smoke cigars as teenagers (9% versus 4%).

IV. Priorities, Performance and Program Activities
A. Background and Overview
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.

In addition to the 18 National Performance Measures, the Bureau of Family Health senior management staffs, in collaboration with advisory council members and family members, have identified the following priorities, which are consistent with recommendations contained in the Needs Assessment. These priorities have been translated into Pennsylvania's State Performance Measures. These measures will enable the state to monitor progress related to MCH priorities.

The State Performance Measures include the following:

1. To reduce proportion of all live births with low birth weight;
2. To reduce the rate of motor vehicle crashes caused by teen drinking drivers ages (17-19);
3. To increase the percent of pregnant women who receive early and adequate prenatal care;
4. To increase the percentage of WIC enrolled mothers who breastfeed their infants for at least the first six months of life;
5. To increase the percentage of callers to the SKN who received at least one referral to resources;
6. To reduce the infant death rate due to SIDS and accidental suffocation and strangulation in bed;
7. To increase the percentage of children ages (1-2 yrs) screened for lead poisoning; and,
8. To reduce childhood obesity.

B. State Priorities
B. State Priorities

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

Addressing disparities in the rates of low birth weight and premature birth (relates to NPM #15 and SPM #01):

The United States continues to have a high incidence of infant mortality, ranking 28th internationally. It is a well-known fact that babies are more often at risk of dying in their first year of life if born premature. Furthermore, the risk for non-white babies is disproportionately higher than for white babies.

The Needs Analysis suggests that like other states, Pennsylvania is experiencing significant racial/ethnic disparities in perinatal outcomes. Although overall pregnancy outcome indicators are

generally in line with national rates, for some population groups, namely black and Hispanic women, rates of low birth weight and premature birth are of concern. The assessment data indicates that for the most part, women at risk of poor outcomes reside in particular areas of the State.

Low birth weight babies are more likely to die than full term babies. As a result of interruption of fetal maturation or growth potential at a given gestational age, these babies are at increased risk for poor outcomes. Research has established a high correlation between the incidence of low birth weight babies, infant mortality and specific socio-economic and demographic factors. These factors include, among others, race, poverty, and the availability and utilization of maternity care services.

Infant mortality rates have declined in Pennsylvania over the last two decades for white and black infants. However, per 2003 data, the black infant death rate was over two and a half times as high as that for whites. The percentage of babies born with low birth weight decreased slightly from 8.2 percent in 2002 to 8.1 percent in 2003.
/2007/ In 2004, the gap between white and black infant deaths was reduced; however the black infant rate remains almost two and a half times greater than the rate for whites (whites, 6.3; blacks, 15.0 per 1,000 live births). The percentage of babies born with low birth weight increased by 9% from 8.1% in 2003 to 8.8% in 2004.//2007//

Decreasing Alcohol Related Driving Morbidity and Mortality among Teens (relates to SPM #02):

Motor vehicle crashes are a leading cause of death among youth, especially teenagers. According to the National Highway Traffic Safety Administration, while the number of highway deaths overall rose 0.4 percent in 2003, fatalities in crashes involving drivers ages 16 through 20 rose 1.3 percent. Teenage drivers are involved in fatal crashes at twice the rate of drivers overall, and have a fatality rate four times that of drivers ages 25-29.

Approximately three in every ten persons in the United States will be involved in an alcohol-related motor vehicle crash in their lifetime. Fatal injuries caused by motor vehicle crashes in which a driver, occupant or non-occupant was under the influence of alcohol remains a serious problem in Pennsylvania.

In order to reduce mortality and morbidity from alcohol related teen driving deaths, the Bureau of Family Health will work across state agencies to coordinate activities with the Safe Kids Coalition, the PA Department of Transportation, the PA Liquor Control Board, and the Bureau of Drug and Alcohol Programs in FY 05-06 to launch a statewide multimedia campaign.

Maintaining Statewide Access to Prenatal Care and Labor and Delivery Services (relates to NPM #18 and SPM #03):

According to the MCH Needs Analysis the status and distribution of perinatal systems throughout the Commonwealth are unclear given the reduction in the number of obstetrical beds and uncertainty about the availability of and access to obstetrical care across the State.

Infant mortality and morbidity statistics are sensitive indicators of the utilization of obstetrical services in a population where socio-economic factors play a role in health care. Access to transportation across the state may inhibit mobility and access to maternity services. In addition, the cost of transit fare, where available, may place limitations on a pregnant woman's access in urban and rural areas in the state. Pennsylvania has ten county and municipal Health Districts strategically located across the state; however, Pennsylvania experienced a decline in the number of birthing facilities for maternity services from 148 in 1997 to 126 in 2005. Currently, data gathering by various stakeholders including State and local government officials and professional organizations is underway to determine the impact on obstetrical services in the Commonwealth.

Enrolling WIC participants who breastfeed their infants (relates to NPM #11 and SPM #04):

The public health benefits of breastfeeding have been extensively documented. Experts agree that breastfeeding is the optimal way to feed infants. Breastfeeding significantly promotes infant and maternal immediate and long-term health, decreases the frequency of doctor visits, hospitalizations, and medication utilization and thereby lowers medical costs. As a result, the decision to breastfeed is of significant importance to the newborn child, the mother, and the public health and healthcare system.

CDC's National Immunization Survey, which collects data on breastfeeding practices, indicates that in 2003 nationally 71 percent of women initiated breastfeeding at the birth of their baby. In Pennsylvania in 2003, 64 percent of women initiated breastfeeding. This same survey found that in 2003, nationally 36 percent of women were still doing some breastfeeding (only 14 percent were doing it exclusively); while in Pennsylvania 31 percent were breastfeeding at 6 months (13 percent doing so exclusively).

Increasing Coordination of Programs Serving CSHCN (relates to NPM #04, #05, #06, #13 and SPM #5):

The BFH has developed an extraordinary array of program components designed to serve the Commonwealth's CSHCN and their families. These programs include the hospital-based family consultants, the SKN Help line and Community System Development Program, the Parent to Parent Network, and the District CSHCN consultants. However the assessment data suggests that the coordination between these components is at best, uneven, resulting in fragmented service delivery. This fragmentation is also a barrier to the effective use of available resources. The BFH is also committed to developing creative and evidence based programs targeting the needs of older CSHCN including preadolescents, adolescents and young adults. In response to these findings, the Division of Community Systems Development and Outreach will develop a statewide correction action plan for FY 05-06.

In response to the Title V Needs Assessment, the Special Kids Network is implementing a series of activities to improve caller satisfaction and constituent services for CSHCNs in the Commonwealth of PA. The primary goal is to provide quality consumer services in a cost-efficient manner. This goal is accomplished by establishing outcomes that can be met within a designated timeframe through multi-disciplinary collaboration
/2007/ A survey of callers to the Special Kids Network collected a baseline satisfaction rating for a six-month period. Over 3,710 surveys were mailed to callers during this period, with a return rate of 601. Those surveyed were families and professionals who had previously called the Special Kids Network. The outcome results of the surveys resulted in a satisfaction rate of 91.3%. The survey will be continued when funding is in place and responses collected and disseminated on (minimally) a quarterly basis. In addition to the SKN survey, an overall satisfaction survey will be implemented in September of 2006 to measure caller satisfaction for all of the other lines in the Health and Human Services Call Center.//2007//

Promoting Smoking Cessation in Pregnancy (relates to SPM #06):
Smoking during pregnancy is clearly linked to fetal and infant deaths. Infants born to mothers who smoked while pregnant have three times the risk of Sudden Infant Death Syndrome. In addition, smoking can result in low birth-weight and premature birth. According to a report from the Surgeon General, in 20 percent of low birth-weight births, eliminating smoking during pregnancy could have prevented 8 percent of preterm deliveries, and 5 percent of all prenatal infant deaths.

Among the 50 largest cities in the United States, Pittsburgh has the highest rate of pregnant women who smoke in the nation. According to a survey conducted by the Annie E. Casey Foundation, 23.3 percent of women who gave birth in Pittsburgh reported they smoked during pregnancy in 2000. Pittsburgh has held this ranking for ten out of the last eleven years according

to the survey (KIDS COUNT Special Report Annie E. Casey Foundation, 1998). Although rates are particularly high in Pittsburgh, high rates of smoking during pregnancy in Pennsylvania are not confined to this region. According to the Casey Report, Philadelphia ranked 30th out of 50 cities with 14 percent of mothers smoking during pregnancy. Rates are also troubling in many rural counties: in York County, the figure is close to 22 percent, in Clinton County, 30 percent, in Venango County, 33.4 percent, and in Greene County, 33.6 percent (The State of the Child in Pennsylvania: 2002).

The Bureau of Family Health collaborated with the Department of Public Welfare Office of Medical Assistance Programs to develop interventions targeting pregnant women and providers through a multifaceted action plan consisting of, but not limited to, interventions that will increase awareness of the dangers of smoking while pregnant and raising the awareness of the ill effects of smoking around children of all ages, especially newborns.

Increasing Access to Childhood Lead Screening (relates to SPM #07):
Lead poisoning is a preventable environmental health problem, which affects many people across the Commonwealth in a variety of ways. However, children are the most susceptible to adverse health, neurological and behavioral reactions from exposure to lead because their nervous systems and brains are still developing. Lead poisoning can cause mental retardation, learning disabilities, and behavioral problems in children. High blood lead levels can cause seizures, coma, and even death.

Risk factors contributing to lead poisoning in children include the child's age, socio-economic status and age and condition of the child's primary residence. Pennsylvania, like other states, is not immune to these factors.

According to the Centers for Disease Control and Prevention (CDC), Pennsylvania ranks fifth in the United States for the estimated number of children with elevated blood lead levels. In addition, based on the CDC's estimate of the number of children with elevated blood lead levels in cities, Pennsylvania was identified to have four cities in the top 129. In cities such as Philadelphia, Pittsburgh, and Erie, large numbers of children who are below the poverty level live in older, deteriorating housing. In several smaller cities such as Allentown, Bethlehem, and York there are concentrations of high-risk housing placing children who reside in these homes at increased risk for lead exposure.

The amount of lead in paint is much greater in older homes. Pennsylvania ranks second in the nation in terms of the number of units of pre-1950 housing (2,113,422 units) after the state of New York. While lead was banned from house paint in 1978, it remains in millions of homes across the country. Based on the 2000 Census, it is estimated that 4,029,533 (77 percent) of all housing units in Pennsylvania were built before 1978. The housing stock in Pennsylvania consists of 80 percent residential units built prior to the year 1980, 55 percent built prior to the year 1960, 40 percent built prior to the year 1950, and 30 percent built prior to 1940.

By utilizing PA-NEDSS, a sophisticated, web-based, disease reporting application, various surveillance initiatives can be implemented to monitor, track and analyze childhood blood lead levels across Pennsylvania. Additionally, the Pennsylvania Childhood Lead Poisoning Prevention Program, in conjunction with the Philadelphia Department of Public Health, developed a comprehensive Lead Elimination Plan designed to eradicate childhood lead poisoning by 2010. This Lead Elimination Plan recommends universal screening of all children at ages one and two and for all children age three through six without a confirmed prior lead blood test.
/2007/ Prevention is a crucial element in the eradication of lead poisoning as a public health problem. Dissemination of information at conferences, expos, presentations, etc., such as the Home Builder's Show, provides the EPA program with an opportunity to talk about lead-based paint and hand out fulfillment materials. At the February 25 -- March 5, 2006 Home Builder's Show over 420 lead fulfillment materials were made available to the participants, and in 2005 the Health & Human Services Call Center (HHSCC) mailed 21,874

fulfillment materials to 864 callers. Federal regulations have been designed to help prevent lead poisoning and under TSCA 402, certification is required for lead-based paint professionals. Through the EPA State Lead Grant Program, the Environmental Training Center at Danville, PA, conducts accredited training courses for governmental and non-profit employees that enable individuals to become licensed in lead abatement, enforcement, and more lead-certified disciplines (ten in all). In 2005, the number of targeted and actual inspections was 74, meeting the standard set by the Department of Labor and Industry, a step that helps to prevent, reduce and eliminate child lead poisoning. Resulting from the recommendations of the Lead Elimination Workgroup, the Department is drafting lead legislation that calls for mandatory universal blood lead testing of all children ages one and two and for all children ages three to six without a confirmed blood lead test. This draft lead legislation is expected to be introduced to the Commonwealth's Legislature in the fall of 2006.//2007//

Reducing Childhood Obesity (relates to SPM #08)

Obesity is a leading cause of preventable death in the United States and is second only to tobacco use. Childhood obesity is a national epidemic. In children ages six to eighteen years, the prevalence of being overweight (defined as BMI greater than 95 percentile) is 15.4 percent and is increasing rapidly, especially in children of color. Furthermore, an additional 15 percent are at risk for becoming overweight (defined as BMI greater or equal to 85th percentile but less than 95th percentile). The numbers in Pennsylvania are even more alarming with 27% of low-income children between two and five years of age in Pennsylvania being overweight or at risk of becoming overweight (CDC PedNSS, 2002). According to the Pennsylvania Assessment of Overweight Children and Youth report in 2002, 18.2 percent of eighth graders are overweight and an additional 17 percent are at risk of becoming overweight.
/2007/ The percentage of children between two and five years of age in Pennsylvania who are overweight or at risk of becoming overweight in 2004 was 25.8% (CDC PedNSS, 2004).//2007//

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	100	100	100	100	100
Annual Indicator			100.0	100.0	100.0
Numerator			195	226	212
Denominator	143972	142972	195	226	212
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2004
The numerator is patients needing treatment that received treatment (D- form 6). The denominator is the number of confirmed cases (C-form 6).

Notes - 2003
2003 data are estimates based on 2002 and 2004 data. 2003 data are not available.

a. Last Year's Accomplishments
During Calendar Year (CY) 2005, The Pennsylvania Newborn Screening and Follow-Up Program (NSFP) screened all newborns born in Pennsylvania, except those opting out for religious reasons, for six inborn errors of chemistry as listed on Form 6.

Approximately 99 percent of Pennsylvania newborns receive screening for over 30 additional conditions through the supplemental screening program, offered to parents by birthing facilities. Act 47 of 2004 passed in December and amends the Newborn Child Testing Act, Act 86 of 1992, allowing health care facilities to choose alternative certified laboratories to perform the newborn screening tests. Pennsylvania health care submitters are sending the newborn screening specimens to two laboratories. During calendar year (CY) 2005, the NSFP provided screening on 143,380 filter papers from newborns. A total of 212 newborns were diagnosed with one of the six state-mandated conditions. The following conditions were diagnosed: 65 congenital hypothyroidism, 9 congenital adrenal hyperplasia, 93 sickle cell disease and hemoglobinopathies, 27 phenylketonuria, 1 maple syrup urine disease and 17 galactosemia.

The NSFP's Nursing Services Consultants provided follow-up services on abnormal test results from two laboratories for the six state-mandated conditions and referred newborns with positive test results to one of four treatment centers. Through state appropriated funding, the NSFP supported four metabolic treatment centers that provide: (1) consultation services; (2) confirmatory testing; (3) patient and family education; and (4) care coordination and case management. The Genetics Program also funded six hospitals to provide genetic counseling services to families of newborns diagnosed with inborn errors of chemistry or to families at risk.

The PA FORE Families project continued building a statewide birth defects database from birth certificate data and hospital discharge data records and continued sending rack cards and linkage letters to parents residing in the four county pilot areas. During the one-year pilot, the BFH also sent 18,873 rack cards and provided follow-up for responses received from the mailings. Seventy-six responses were received from the 611 linkage letters mailed to parents of children identified with congenital anomalies. From these responses, and subsequent contact with parents and families, 45 children not previously receiving services were referred.

The NSFP started implementation of a statewide PKU/MSUD Pharmacy Program on July 1, 2005. The pharmacy program allows clients with PKU to obtain PKU formula at a pharmacy in their locale. Over 1,400 pharmacies in Pennsylvania participate in the program. The pharmacy program has improved client access to formula and it is estimated that the pharmacy program will save over $500,000 during the first year of operation.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
The Bureau prepared an evaluation report of the PA FORE Families project, with recommendations to continue and improve the program. The Department will continue to build a birth defects surveillance database and will use new and improved methods to provide earlier linkage to health care services and early intervention programs for newborns and children with birth defects. Efforts will also be made to provide statewide education and outreach about available services and programs to assist children with birth defects. The Secretary of Health approved the continuation of the pilot project in the four county area of southeastern Pennsylvania for another twelve months.

The NSFP is collaborating with the Newborn Screening Technical Advisory Committee and The March of Dimes, who is leading a campaign nationally, as well as within Pennsylvania, to screen and report additional newborn genetic conditions. Two bills were introduced by the Pennsylvania Legislature to amend the Newborn Child Testing Act. House Bill 755 and Senate Bill 819 propose to increase the number of genetic conditions that newborns are screened from six to 29 conditions. The BFH is collecting and analyzing data regarding the costs that would be incurred if the Department would mandate additional screening of newborns from the current six state-mandated conditions to the 29 uniform conditions panel and 25 reportable conditions recommended by the American College of Medical Genetics.

In CY 2006, outreach and education for providers will be a focus. MCH Nurse Consultants plan to educate obstetricians throughout Pennsylvania about the benefits of educating pregnant women before delivery about newborn screening. Consultants plan to visit practices and distribute the newborn screening brochure, Pennsylvania Screening Services for Newborn Babies. This initiative is in response to a national initiative to build awareness about newborn screening during prenatal visits. The trend towards more direct consumer involvement in health care decisions and prevention indicates the need for enhanced educational programs for the public. There are also plans to distribute a provider manual to primary care physicians, which will serve as a resource guide for newborn screening procedures and guidelines.
The new integrated metabolic and hearing follow-up system was implemented and The PNSP is collaborating with the Hospital Association of Pennsylvania and ten Pennsylvania hospitals to develop a hospital user group, which assists the Program in designing a system for hospitals to report data and access newborn screening results.

c. Plan for the Coming Year
The Pennsylvania Newborn Screening Program (PNSP) plans to integrate the Newborn Screening and Follow-Up, Newborn Hearing Screening, Genetics, and Sickle Cell Programs housed in the Bureau of Family Health in regards to providing prompt screening, interventions, counseling, and access to quality health care services for eligible clients.

The PNSP is improving the availability of data through development of an integrated web-based data system involving the Newborn Screening and Follow-up and Newborn Hearing Screening Programs.

The PNSP is modifying its Healthy People 2010 objective that specifically focuses on eliminating disparities in health and health care. PNSP began developing a baseline for the number of children screened in Pennsylvania by having Pennsylvania hospitals and nurse midwives report to the Department the number of live births, the number of newborns screened, and the number of newborns not screened due to religious reasons and expiring prior to screening. This data will be analyzed in the coming year.

The Pennsylvania Newborn Screening Program (PNSP) plans to collaborate with children's hospitals in Pennsylvania to serve as treatment and diagnostic centers for conditions added as a result of expanded newborn screening. PNSP will also collaborate with the TAC to develop follow-up guidelines for the additional 22 conditions that will be added to follow-up when the law passes.

The PNSP is working with the Department of Public Welfare (DPW) to reimburse for newborn metabolic screening for those clients covered through Medical Assistance. Currently the Department of Health (DOH) pays for mandated newborn screening for all newborns, regardless of insurance status. With the implementation of the new policy, DPW will reimburse DOH for Medicaid clients, approximately 40% of all newborns born in Pennsylvania. Future plans are to initiate discussions with commercial insurers regarding payment for newborn screening.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			65	67	69
Annual Indicator		64.8	64.8	64.8	64.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	71	73	73	73	73

Notes - 2005
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2004
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2003
The data was pre-populated and presently no data is available for this performance measure.

a. Last Year's Accomplishments
In 2005, the Epilepsy Foundations served a total of 1,452 new clients, of which 350 were children with epilepsy and seizure disorder and 918 were adults with epilepsy and seizure disorder and the remaining 184 were various family members. Realizing that although the prevalence of epilepsy is the same in ethnic populations as it is in the dominant white population, the condition is less understood or accepted among African Americans and Hispanics, the Foundations undertook a marketing study. Contracting with the University of Pittsburgh to conduct focus groups, this effort has resulted in collaborations with faith-based health outreach programs. This is in keeping with the work of the Health Department's new Office of Health Equity.

Parents of children with TS attended and participated at the PTSA board meetings, workshops, conferences, in-services, and Legislative Breakfasts. In 2005, the PA-TSA served a total of 3,317 individuals of which 1,649 were children with TS and 1,668 were adults with T S. The Association conducted 27 in-service sessions and 69 Individual Education Plans/advocacy meetings and school consultations.

The Parent-to-Parent Program (P2P) provided resource information and support to approximately 1,072 CSHCN and their families. Five hundred and thirty six peer mentors who are parents of

CSHCN were matched with parents contacting the P2P for information or support.

The Bureau's Family Consultant Program uses parents of CSHCN employed as Family Consultants in four of Pennsylvania's tertiary Children's Hospitals serving CSHCN. The Family Consultants provided consultation, resource information and support to families with special needs children while hospitalized. In 2005, 2,661 families received services.

SKN information and referral staff continue to rely on the input from the Community Systems Development and other partner programs to expand the number of resources within the HHSCC database.

The SKN collaborated with community-based agencies and families of CSHCNs on projects aimed at developing playgrounds and camps that were inclusive of CSHCNs. The SKN Regional Office Community System Development staff work with local community groups and agencies to develop/enhance programs for CSHCN within their local communities. During calendar year 2005, the Regional Offices supported 32 major projects, 243 other projects, 64 projects in support of the six (6) statewide initiatives (transition, respite care, home modification, inclusion, oral health, and transportation), and 22 outreach projects. 1,840,122 children were served in local community-based projects that included both CSHCN with typical abilities

A Medical Home Index for Families has also been developed by the Center for Medical Home Improvement measuring family participation in decision-making regarding the care of their CSHCN. Families completing the Index report increased levels of satisfaction with the delivery of care to their CSHCN from physician practice.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Parent to Parent of PA		X		
2. PA Family Consultant Program		X		
3. PA Recreation & Leisure Line for Individuals with Disabilities				X
4. Special Kids Network/Community Systems Development				X
5. Sudden Infant Death Syndrome Program				X
6. Medical Home Integrated care Coordination Initiative		X		
7. Special Healthcare Needs Consultants	X			X
8.				
9.				
10.				

b. Current Activities

The Family Consultant Program continues to encourage the development of Family Advisory committees at each of the Children Hospitals in the state. Each hospital has developed Parent Advisory Committees using voluntary parent participation. These committees vary in composition, meet usually quarterly with representatives of hospital care committees, providing their perspective on the delivery of family-centered care.

The Family Advisory Committees developed at each hospital are actively involved at all levels of hospital matters, including assisting the planning for new hospital facilities at two of the hospitals. A series of meetings between Bureau staff and each Family Consultant will result in the completion of a Logic Model Plan for their programs in order to identify a plan for measuring program outcomes.

The SKN has 13,206 agencies in the database. Updates are completed on a rolling basis

throughout the year, assuring that callers are provided with current and accurate referral information. The Help In PA web portal will soon be available to agencies to update their information electronically via the internet.

The SKN I&R staff continues to recognize the need to maintain communications within local communities and relies on regional and district staff for new agency information as well as community events that may be helpful to the families that call. Monthly outreach calendars are shared between the regional offices and the call center outreach coordinator to keep staff apprised of activities and possible networking opportunities. The I&R function and the CSD function of the network are jointly presented at any event involving the SKN

c. Plan for the Coming Year

The Parent-to-Parent Program is developing new procedures for parent matching, mentoring and follow-up on completed matches with a survey tool to determine satisfaction with their services. Their new contract, requires that more emphasis be placed on minority outreach.

After a careful review of the lack of documentation of significant achievement and impact of the P2P program, and the need to reallocate resources to remediate the state's fragmented care for CSHCN, the Bureau will fund P2P through June 2007.

The SKN caller satisfaction survey is another way we obtain feedback from our callers. The survey will be utilized as a tool in continuously measuring the satisfaction level of the help line's service and utilize the survey responses to improve services to our families.

In 2005, an evaluation plan was developed by the University of Pittsburgh to determine the effectiveness of the outreach services provided through the Epilepsy Support Services Program. Data was collected through the use of 12 different survey instruments developed by the University of Pittsburgh during the 05-06 school year. Several of the survey instruments were not usable for a variety of reasons and will be revised for the 06-07 school year. In addition, in 2007 manuals detailing procedures for statistical analysis will be prepared to assure standardization between the two Epilepsy Foundations.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			52	54	52
Annual Indicator		51.2	51.2	51.2	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	53	54	54	54	54

Notes - 2005

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

Notes - 2004
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2003
The data was pre-populated and presently no data is available for this performance measure.

a. Last Year's Accomplishments
The Medical Home Training Program, which is collaboratively sponsored and operated by the BFH and the Pennsylvania Chapter of the American Academy of Pediatrics, provided training to 16 physician practices using the American Academy of Pediatric medical home curriculum, modified for Pennsylvania's physician practices. The training program was provided to 102 physicians, 19 nurse practitioners, 122 nurses and 36 family advisors in urban, rural, and suburban physician practices. The physician practices participating in the EPIC-IC medical home training program provided medical homes for 4,000 (approximately one percent of the CSHCN identified in Pennsylvania in 2001 by the National Survey of Children with Special Needs) children and youth with special health care needs in 18 counties throughout the state. According to the SLAITS Survey (2001), 13.8 percent (approximately 52,400) of CSHCN were uninsured. 327,700 CSHCN, or 86.4 percent of the population, do have medical homes, based upon the data provided from the SLAITS Survey (2001). In 2004, the physician practices participating in the EPIC-IC medical home training program provided medical homes for 3,000 (approximately one percent of the CSHCN identified in Pennsylvania in 2001 by the National Survey of Children with Special Needs) children and youth with special health care needs in 18 counties throughout the state.

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. Early Childhood Education Linkage System (ECELS)	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The EPIC IC program in 2006 has 26 participating physician practices. To better identify the population within each practice, the EPIC IC program initially asked each of their funded practices to identify their special needs population. Upon receiving their lists, the EPIC IC program then asked their non-funded practices to do the same. The EPIC IC program observed that the registries received were not inclusive of all populations of special needs children. To address this, the EPIC IC program is beginning a "diagnosis of the month" feature to highlight a specific diagnosis in order that practices consider whether patients within their practice fit into the featured diagnosis and then add that patient to the Medical Home registry. Practices seem to have the most difficulty in capturing children with asthma, ADD/ADHD, pervasive developmental delay and obesity. Therefore, these conditions are the initial area of focus. In the early summer of 2006, the EPIC IC team will target practices and Federally Qualified Health Centers in central Pennsylvania, Erie and Scranton areas, to increase the number of practices enrolled in the Medical Home project.

The BFH is developing and supporting an integrated care coordination service model. These services integrate practice-based services from seven physician practices that have demonstrated high levels of competency with community-based care provided by the Pennsylvania Elks Home Services Program.

As of January 2006, 17 practices are receiving funding for care coordination activities. The EPIC IC Program contracted with the Elks Home Service Program to provide community support to these practices. Efforts to track time spent on care coordination continue. A database was completed to record patient information and diagnosis. The data base now supports over 5,000 children with an identified need.

c. Plan for the Coming Year
The Medical Home Training Program goal is to increase the number of participating physician practices to 34, with 16 of the practices providing integrated care coordination services by 2007. The number of children and youth receiving comprehensive care through a medical home is projected to increase by 50 percent (6,000) as a result in this increase in training. The EPIC IC program expects to reach its contracted goal of a database with 6,000 identified children. The Program will also be increasing the number of participating practices.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			62	64	66
Annual Indicator		61.4	61.4	61.4	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	68	70	70	70	70

Notes - 2005
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2004
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2003
The data was pre-populated and presently no data is available for this performance measure.

a. Last Year's Accomplishments
The new Health and Human Services Call Center (HHSCC) started taking calls on August 1, 2004 for all programs but the Traumatic Brain Injury Line. Each help lines' database was converted into one consolidated database called Customer Tracking and Agency Referral Application or "CTARA". Families calling the Special Kids Network can now be screened and mailed an application for Medicaid or Children's Health Insurance Program (CHIP) as a result of this consolidation.

Families contacting the SKN continue to have immediate access to applications to Medicaid and CHIP through a new event in the CTARA application. During calendar year 2005, approximately

37 individuals who called the Special Kids Network were assisted with applying for healthcare coverage. Five of those families were given a referral to Commonwealth Of Pennsylvania Application for Social Services (COMPASS) website to apply for health care coverage.

The BFH, in collaboration with a Robert Wood Johnson (RWJ) grant, surveyed 8,000 dentists regarding services provided, insurances accepted and capacity and preparation needed to treat CSHCN. The RWJ grant ends on June 30, 2006. The help lines will continue to survey those dentists that have agreed to continued participation in order to maintain a significant number within the system. There are over 300 dental providers in the call center's database as a result of the RWJ grant effort.

The Reaching Out Partnership, a unique blend of outreach focused staff from the Departments of Health, Public Welfare, and Insurance met six times during the calendar year with a group of community partners. The group's focus was not only to share information about the status of enrollment in the public insurance programs, but also to share new and innovative ways to spread the word that these services were available to the public.

Now that the Partnership is sharing information electronically many community organizations and partner programs have inquired about Special Kids Network and Recreation and Leisure outreach print materials. Several hundred rack cards have been requested and mailed to Community Based Organizations and County Assistance Offices.

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/Community Systems Development				X
3. Love EM With a Checkup Program				X
4. Medical Home Integrated Care Coordination Initiative				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The HHSCC refers CSHCN to the following five categories of services:

1. Education and training;
2. Therapies such as Hippotherapy, water therapy, psychological services, special camps;
3. Recreation (accessibility of park services, health clubs, theatres, pools);
4. Advocacy (Legal, education, benefits managers, early childhood interventions); and,
5. Special equipment (adaptive, DME, lifts, automobile modifications, communication devices).

The Special Kids Network facilitates applications for Medicaid. Through the cross training and unique data system available at the HHSCC, families can receive application for Medicaid through the mail or an information and referral specialist can assist families in the application process while on the telephone.

The BFH will continue to randomly tape calls made to the HHSCC, monitoring appropriate tone, valid data entry into databases, and adherence to protocols. These HHSCC quality assurance measures have improved services and referrals made to families calling the Special Kids

Network. The BFH is seeking accreditation of the HHSCC by the Alliance of Information and Referral Systems (AIRS).

BFH staff now has the ability to listen to live and recorded calls from their offices. Staff utilizes the existing monitoring score sheet to rate each call. Feedback is provided to the management staff at the HHSCC. Corrective action and training is conducted immediately, if possible, and communicated to the BFH staff.

One SKN television promotion consisting of traditional and non-traditional advertisements was accomplished in 2004. Statewide advertisements were run or TV stations. They included vignettes promoting SKN, local station's magazine programs and public interest stories, focusing on CSHCN. Consumer feedback of these advertisements has been favorable, suggesting that the messages are on target. Due to funding limitations, no media activities were conducted during the fall of 2005 or the spring of 2006. The BFH has developed and distributed a SKN awareness flyer in several languages including Albanian, Cambodian, and traditional Chinese.

c. Plan for the Coming Year

The BFH, through SKN media campaigns, plans to increase the number of needs that are served per call to the HHSCC. It was interesting to note that the two semi-annual television media flights did not produce the surge in calls to the help line as expected. A change in strategy will be discussed to gain insight as to the best way to reach the targeted audience of women who typically call the line to seek information and services for their children. Aside from television, print materials are used as a way to market the help line service. A new rack card is being developed to share with the call center staff and those that work in the Community Systems Development section of the Special Kids Network. The rack card briefly describes the services provided by the network and encourages the reader to call the help line for more information.

The Bureau is planning SKN media for SFY 06/07 which include: phone directory and internet advertisements and an informational postcard mailing to medical providers. All media and outreach messaging will be consistent with the "I can do anything...if you believe I can" message previously developed for the Program.

Funds were added to the HHSCC contract to increase visibility at health fairs and other public awareness events. In addition, a collaborative display is being developed for Call Center use for outside marketing events.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			74	76	78
Annual Indicator		73.4	73.4	73.4	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	82	82	82	82

Notes - 2005

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

Notes - 2004
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2003
The data was pre-populated and presently no data is available for this performance measure.

a. Last Year's Accomplishments
In 2005, the Family Consultants operating in four tertiary Children's Hospitals, provided information, resources and support to families of CSHCN during periods of hospitalization. Consultants referred all families to the SKN for medically related services needed after their child's discharge. In addition, the consultants provided in-service education to hospital staff to enhance the delivery of family centered care.
The Family Consultant Program continued to provide consultation and family support services by serving a total of 2,661 families in 2005. Community-based multi-disciplinary clinics provided CSHCN children with access to multiple services in one location. Clinic professionals participated in local health partnerships designed to coordinate care with community based service systems and primary care physicians. In addition, 187 participating provider agreements were established to provide direct medical care in an outpatient setting, which allows for greater access to special health care services. Note: this is for PSC to review.

The HHSCC is installing an automated satisfaction survey mechanism in its database, whereby a caller who provides an address and is willing to be surveyed will be automatically mailed a survey which is returned to the Department when completed, using unique identifying numbers for privacy. While the survey has not been in place during the first year of operation, it will be retrospectively mailed to all SKN callers and a random sampling of the other seven help lines in the HHSCC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Integrated Care Coordination Initiative		X		X
2. Special Kids Network/Community Systems Development				X
3. Maternal and Child Health Services via Local Health Department	X	X	X	X
4. Family Health Nursing Consultant Program		X		
5. PA Family Consultant Program		X		
6. Parent to Parent of PA		X		X
7. Special Health care Programs in the Philadelphia Health Department		X		X
8. Building Inclusive Communities Mini-Grant In		X		X
9. Cooperative Efforts and Techincal Assistance		X		X
10. PA Recreation & Leisure Line For Individuals with Disabilities				X

b. Current Activities

The HHSCC has installed an automated satisfaction survey mechanism and client satisfaction has proven to be positive.
Partner programs' relationships with the Call Center continue to grow and improve. Networking with those programs occurs through extensive trainings and communication protocols. Through trainings the Information and Referral specialists increase their awareness of programs and conditions, thereby improving their ability to better serve callers. Additionally, the programs work

together to cover outreach events representing the Special Kids Network.

In addition to this caller feedback, Bureau staffs have embarked on a remediation plan for SKN that includes stakeholder meetings. Staff will secure the services of the Commonwealth's consulting group, Bureau of Management Consulting, to facilitate planning and implementation of quarterly stakeholders meetings. Stakeholders include Community based organizations, families of CSHCN, and collaborative partners from other Commonwealth programs. It is hoped that the implementation will occur by Spring 2006. The HHSCC will continue training and communication efforts with partner programs including the new CSHCN System of Care provider, which will be selected in Spring/Summer 2006, replacing and expanding the SKN Community Systems Development program.

There has been a steady increase in the number of practices (comprised of primary care providers and their office staff) that participate in the EPIC-IC training on how to create a medical home for CSHCNs. Typically, approximately 70 to 80 participants attend these training events. In 2006, approximately 95 to 100 practices participated in EPIC-IC conferences.

The BFH, working in collaboration with 11 agencies and seven CSHCN families, has developed a Transition Health Care Checklist, which identifies steps that older CSHCNs and their families can use for transitioning from pediatric to adult health care services. This checklist is being presented to programs involved in transition of children and youth with special health care needs and will be posted on multiple Commonwealth websites. They found it difficult to obtain medications and treatments. This new Checklist identifies resources and steps to assist youth/young adults and families in making a successful transition to adult living.

Partner programs' relationships with the Call Center continue to grow and improve. Networking with those programs occurs through extensive trainings and communication protocols. Through trainings the Information and Referral Specialists increase their awareness of program and conditions, thereby improving their ability to better serve callers. Additionally, the programs work together to cover outreach events representing the Special Kids Network.

c. Plan for the Coming Year

The Family Consultant Program will enhance family-centered care for families of CSHCNs, when these children are hospitalized in the tertiary Children's hospitals. The Family Consultant program has continued family-centered care efforts with families for whom they receive physician generated requests. In 2007 the Family Consultants will be field testing parents and medical staff satisfaction surveys as a means to measure the impact of their interventions.

The Medical Home Program will continue its effort to increase the number of physician practices that receive information and referral instructions for community-based services, including Title V, CHIP and MA from 26 to 34. Staff will continue to encourage collaboration between the tertiary centers and community based medical resources through medical team meetings, correspondence and telemedicine resources. The Medical Home Program will continue to promote these collaborative efforts to reach new staff.

BFH staff associated with the HHSCC will collate follow-up survey information to measure satisfaction in the following areas: information specialist demeanor, understanding of need, quality of information provided, amount of information provided, quality of service provided by referral resource, willingness to call again, benefits of calling HHSCC/SKN, and willingness to recommend HHSCC/SKN to an acquaintance. In addition, there are open-ended questions to permit comments on referral agencies, inability to access referral agency services, the HHSCC/SKN itself, and promotion of HHSCC/SKN.

Not CSDO below

As a result of the TBI Needs and Resources Assessment and recommendations of the TBI advisory board, CAHS is developing a comprehensive TBI school re-entry program to help children with neurological disabilities, their families, and school personnel negotiate hospital to school transition issues, and facilitate an effective school re-entry plan that meets the needs of each child. Title V dollars are being used to support this new initiative.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			30	32	34
Annual Indicator		5.8	5.8	5.8	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	36	38	38	38	38

Notes - 2005
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2004
The data was pre-populated and presently no data is available for this performance measure.

Notes - 2003
The data was pre-populated and presently no data is available for this performance measure.

a. Last Year's Accomplishments
The Individuals with Disabilities Education Act (IDEA) Memorandum of Understanding (MOU) with the Departments of Public Welfare, Labor and Industry and Health defines the entitlements of students with disabilities, identifies programs and services students might be eligible to receive, establishes a process for interagency collaboration, defines fiscal and programmatic responsibilities for each agency, and establishes a dispute resolution process.

The IDEA MOU continued to add partners and stakeholders through a series of six regional meetings that introduced the concept of Community of Practice Groups. These groups provide structure to focus work on outcomes and issues that include: employment outcomes, community participation, healthy lifestyles, transportation, juvenile justice and child welfare, mental health, and youth engagement. 500 educators, parents, and agency representatives attended these sessions.

The Community Systems Development (CSD) Directors contributed to Local Transition Coordinating Councils (LTCC). Pennsylvania's 2004 IDEA-MOU annual conference provided specific sessions on health care transitioning and for the first time sponsored a simultaneous Youth Forum for approximately 50 youths/young adults ages 16-21 on transitioning to work or school.

The BFH continued the Educating Practices in Community Integrated Care (EPIC-IC) Medical Home Training Program in 2004. The program includes a component to train physicians and families of CYSHCN to assure they receive services necessary to make appropriate transitions to all aspects of adult life, including adult health care, work and independence. The collaborative

effort with the Pennsylvania Chapter of the American Academy of Pediatrics provided medical home training to 16 physician practices that included 102 physicians, 19 nurse practitioners, 122 nurses and 36 family advisors in urban, rural, and suburban physician practices during 2004. The physician practices participating in the EPIC-IC Medical Home Training Program are providing a medical home to 4,000 CYSHCN in 18 counties throughout the state. In addition, seven of 16 participating practices demonstrating advanced competency following completion of the EPIC-IC training are receiving funding support from the Bureau to provide combined integrated practice-based and community-based care coordination services to assist the transition of CYSHCN.

The Children's Hospital of Philadelphia (CHOP) developed and implemented a one-year pilot program. The pilot provided needed insight into how youth and young adults are coping with the rigors of current transition processes and struggling to gain independence, self-advocacy, and employment skills. This project ended on February 28, 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Medical Home Integrated Care Coordination Initiative		X		X
2. Special Kids Network/Community Systems Development		X		X
3. Family Health Nursing Consultant Program		X		X
4. Individuals with Disabilities Education Act (IDEA) Governmental Interagency Memirandum of Understanding		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The BFH is collaborating with The Children's Hospital of Philadelphia to develop and implement a one-year pilot that will help support a multidisciplinary and multi-agency team of professionals to provide "transition to independence services" for youth and young adults with special health care needs. This project will identify a best-practice model that can be adopted by the BFH. The project identified employment as the overriding need expressed by the youth. Parents identified a need for more parent-to-parent support in dealing with the apprehension and anxiety of "letting go" and having the confidence to allow their children to embrace independence. Elements of the pilot will be continued through the REACH (Rapport, Empowerment, Achievement through Connections and Health) project and CHOP's affiliation with the Medical Home Initiative.

The IDEA-MOU Team will produce the 2005 conference, Strengthening Transition: Achieving Results. As part of that effort, the team will develop outcomes that measure transition activities and accomplishments. This annual conference of parents, educators, youth and young adults with special health care needs, employers and others interested in CSHCN, has grown steadily since first introduced in 2002 and attendance is expected to reach 1,000 for the conference to be held July 20-22, 2005. Executives from all agencies represented on the Community on Transition Team will form a panel to act as keynote to the conference. There will also be a young adult panel to share their transition experiences. Each participating department provides scholarship money to accommodate the attendance costs for 10 youth with special health care needs.

The 2006 Pennsylvania Community on Transition will hold this year's conference, Expanding Capacity: Realizing Outcomes, on July 18-22, 2006. The primary purpose of this conference is

to expand the capacity of community partners to promote the successful transition of youth/young adults with disabilities to post-school outcomes of employment, post-secondary education and training, community participation, and healthy lifestyles. Participants will learn about successful practices to assist youth/young adults with disabilities in achieving successful post-school outcomes. In addition, participants will have the opportunity to listen, share information, and network. The conference will include approximately 78 sessions most of which will include a focus on youth and youth participation. Presentations will be developed to address a diverse audience of youth and young adults, families/caregivers, educators, agency staff, advocates and community partners.

c. Plan for the Coming Year

The Bureau will continue to support the EPIC-IC Medical Home Training Program and increase the number of physician practices participating in the Program to 34 by 2007. The Bureau expects to see an increase in the number of Pennsylvania CYSHCN receiving comprehensive care through a medical home by 50% (6,000). Many of these children will require and receive appropriate transitions to adult health care, work, and independence with assistance from the physician practices completing the Bureau's Medical Home Training Program.

On February 10, 2006, the process to create a Memorandum of Understanding (MOU) for a Shared Agenda for Youth and Young Adults with Disabilities was finalized. The process began on July 11, 2005 when Deputy Secretaries, Directors and lead transition staff of the Departments of Education, Labor and Industry, Health and Public Welfare met to discuss their leadership role in developing a unified front to position our state for expanding potential resources to meet the many program, service and support gaps for youth with disabilities in their transition to adult life. The resulting MOU for a Shared Agenda was a reaffirming of the underling principles established in the earlier MOU on Transition, and a renewed agreement among the participating Department's Deputy Secretaries to support this effort through staff and other resources.

This agreement is the first step in committing, across program offices, to develop a statewide strategy that supports cross-system policy development and fidelity to evidence-based, quality-driven practices. It constitutes a call to action, a source of accountability, a declaration of common purpose, and a pledge to collaborate and share resources.

The PA Community on Transition State Leadership Team held a series of six Practice Groups workshops, Realizing Outcomes Regional Meetings, from April 18 to 26, 2006 across the Commonwealth. The primary purpose of these workshops is to expand the capacity of community partners to promote the successful transition of youth/young adults with disabilities to post-school outcomes. The audience will gain knowledge and obtain valuable resources on effective preparation of youth with disabilities to successfully transition into post-secondary education and training. Participants will learn specific strategies for career development and also strategies to prepare youth for successful competitive employment. This session will address ways to utilize interagency personnel and resources to ensure that health care issues are considered and addressed in transition planning. In addition, participants will have the opportunity to learn how to use the PA Community on Transition Web Site to further the work of the outcome and issue practice groups.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	90	90	90	90	87
Annual Indicator	78.8	82.4	86.2	85.7	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	87	87	88	89	89

Notes - 2005
Not available at this time due to current data collection periods.

Notes - 2004
The Annual Performance Indicator for 2000, 2001, 2002, 2003 and 2004 was obtained from the 2000, 2001, 2002, 2003, and 2004 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:
2000: 77.8+/-4.6
2001: 78.8+/-4.2
2002: 82.4+/-4.5
2003: 86.2+/-4.1
2004: 85.7+/-4.0
Data for 2005 will not be available until later in the year 2006.

Notes - 2003
The Annual Performance indicator for 2000, 2001, 2002 and 2003 was obtained from the 2000, 2001, 2002 and 2003 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. Numerator and denominator not available.
Data should be in this form:
2000: 77.8+/-4.6
2001: 78.8+/-4.2
2002: 82.4+/-4.5
2003: 86.2+/-4.1
Data for 2004 will not be available until later in the year 2005.

a. Last Year's Accomplishments
According to the National Immunization Survey for 2004, 81.8% of children 19-35 month olds 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, 3 doses of hepatitis B vaccine and 1 dose of varicella vaccine. Other DOH accomplishments include:

• Implemented the regulatory requirement that all Childcare Group Settings report immunization histories for children in their facilities to the Department of Health. Approximately 89% of children 19-47 months of age were immunized against diphtheria, tetanus, pertussis, measles, mumps, rubella, haemophilus influenza type B and hepatitis B.

• Provided hepatitis A and B vaccines available to 78 Sexually Transmitted Disease Clinics, 9 Drug and Alcohol Treatment Centers, 79 HIV Screening and Testing sites and other sites that provide health care to high risk individuals.

• Provided the hepatitis B vaccine to 85 out of the 123 birthing hospitals for administration to infants prior to their discharge. This initiative also included an immunization educational

program for new parents while still in the hospital.

• Mailed Hallmark greeting cards to approximately 145,268 birth parents across the Commonwealth. This card included and immunization message from Governor and Mrs. Rendell.

• Achieved the immunization coverage rate of 87.1% for four doses of diphtheria/tetanus/pertussis; three doses of polio; one dose of measles/mumps/rubella; three doses of haemophilus influenza type b; and three doses of hepatitis B vaccines according to the Centers for Disease Control and Preventions (CDC) National Immunization Schedule for 2004.

• Collaborated with the Pennsylvania Immunization Coalition (PAIC) to establish a partnership with CVS Pharmacies in order to promote immunizations and increase public awareness for all age groups about the recommended vaccines. Immunization information was printed on customer prescription bags which highlighted four age groups at specific times of the year when immunizations are recommended for that age. Approximately 2,599,688 messages were distributed.

Facilitated three immunization conferences which included: the statewide Pennsylvania Immunization Conference (PIC), Southwest Immunization Coalition Conference (SWICC), and the Erie County Immunization Conference (ECIC). Topics included current immunization recommendations, national vaccine policies, vaccine preventable diseases, Pennsylvania Statewide Immunization Information System (SIIS), and other immunization issues.

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
The following are current year DOH accomplishments:

• Expanding the implementation of the SIIS to additional private provider practices and outreaching to Health Maintenance Organizations.

• Implementing enhanced vaccine safety initiatives to include the CDC's Assessment Feedback Incentives eXchange (AFIX) model to provide immunization education and information to pediatric providers.

• Planning the Annual Pennsylvania Immunization Conference for public and private immunization providers from across the Commonwealth. This conference features national immunization advocates and educators to provide the most current immunization information

c. Plan for the Coming Year
Many of the current DOH activities and initiatives will be continued during the coming year as well as the following:

- Work with county and regional coalitions to enhance their work in local communities with the promotion of immunizations.

- Increase staff numbers to concentrate on perinatal hepatitis B follow-up by ensuring the infants born to hepatitis B positive females receive appropriate hepatitis B vaccine and prophylaxis.

- Increase staff numbers to enhance vaccine quality assurance activities to ensure that all vaccines administered are safe and viable.

- Develop new immunization outreach materials targeted to minority and diverse populations.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	18	17	16	15	14
Annual Indicator	17.3	16.4	16.6	15.7	
Numerator	4390	4279	4376	4198	
Denominator	253109	260384	264088	267596	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	13	12	11	11	11

Notes - 2005
Not available due to current data collection periods.

Notes - 2004
Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

Notes - 2003
Numerator source: PA Department of Health, Bureau of Health Statistics and Research.
Denominator source: PA State Data Center.

a. Last Year's Accomplishments
In 2005, the Department's Adolescent Health Task Force convened several meetings and identified its priority issues and associated goals. The priorities and goals it identified will serve as a framework for the development of a comprehensive adolescent health program.

Bureau contractor Maternal and Family Health Services, Inc., continued their Teen Outreach Initiative with three main components:
1) An interactive educational website aimed at teens which allow teen access to information and links to community services and resources on wellness, self-esteem, and other character building themes. The website content incorporates positive and fact-oriented messages on teen sexuality

and responsible behavior. 2) A toll-free phone number and call center 1-866-SAFETEENS.
3) Distribution of the Teen Wallet Card marketing and reference tool in both English and Spanish. In Calendar Year 2005 Maternal and Family Health Services, Inc. distributed 34,635 English language wallet cards and 5,925 Spanish language cards. Additionally, each of the other three family planning councils was provided with 10,000 English and 5,000 Spanish wallet cards.

Title V funds continued to support the education of families and guardians on sexuality, developmental stages, and communications skills.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adolescent Health Program		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 in the process of evaluating its adolescent health program, using the recommendations, priority issues and goals received from the Adolescent Health Task Force. These goals include: Adolescents adopt behaviors that support healthy sexuality, Services are client-driven and designed with input from adolescents, and confidential health services for adolescents are available to encourage adolescents to seek health care and provide complete and candid information to health care providers. The program is moving toward a healthy youth development and comprehensive adolescent health approach for new programs. The Division is also planning and collaborating with the University of Pennsylvania School of Medicine and Health System and the Children's Hospital of Philadelphia to write a grant which would provide for an adolescent health van which would provide comprehensive health care services to adolescents at a selected high school in Philadelphia which does not currently have a health resource center.

The Division is continuing teen pregnancy prevention initiatives which include the development and distribution of educational materials/resources, and training about adolescent health topics (i.e., pregnancy prevention, STDs, general health issues). Title V dollars are used to support the Communicating Healthy Advice to Teens program which includes a focus on an abstinence first message. Additionally, teen pregnancy prevention initiatives continue such as the teen website, teen and parent focused publications including magazines and brochures, peer education training and distribution of wallet cards to youth. In the first quarter of Calendar Year 2006, the Safe Teens website received 64,432 hits. Data is currently incomplete regarding the number of calls to the Safe Teens hotline. Preliminary data indicates that the website is utilized significantly more then the hotline. The Department of Health is distributing the Teen Wallet Cards that were developed by Maternal and Family Health Services, Inc. to high school students in Philadelphia, during presentations that address several adolescent health issues, including teen pregnancy prevention.

c. Plan for the Coming Year
BFH will collaborate with the Department of Education, Public Welfare, and community groups to support programs to identify and implement best practices to further reduce teen pregnancy. The Division of Child and Adult Health will implement the adolescent health van at a high school in Philadelphia, as well as, establishing two pilot projects for comprehensive adolescent health care services that focus on high risk adolescents.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	26	28	30	34	38
Annual Indicator	NaN	NaN	0.0	23.2	
Numerator	0	0	0	10491	
Denominator	0	0	1	45177	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	38	38	38	38	38

Notes - 2005
Not Available.

Notes - 2004
Numerator is number of Medicaid enrollees who are 8 years old as of 09/30/05 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 09/30/05.

Numerator and denominator source: PA Department of Public Welfare

Notes - 2003
Pennsylvania is developing the capacity to report this data by augmenting student health status information reported to the Department on annual health reports from school districts (this data is managed by the Department of Health, Bureau of Community Health Systems, School Health Division). This information will include aggregate data regarding oral health screening outcomes, including the presence of sealants in grades K/1, 3 (8-year olds), and 7. This data augmentation is expected to be pilot tested in school year 2003-2004, and to become a requirement in school year 2004-2005. Until implementation of this revised data, Pennsylvania will not have the ability to report on this measure. Prior reporting was based upon a one-time survey completed in 2000.

a. Last Year's Accomplishments
The survey conducted in 2004 yielded over 300 new dental providers who were added to the Healthy Baby Help Line's database. Since the consolidation into the HHSCC, callers to all of the HHSCC help lines will also have access to those identified dental providers

In 2005, the Bureau of Family Health provided Title V funding to an additional three local health departments (Erie County, Montgomery County, and Wilkes-Barre City) to provide preventive dental care for uninsured children. The care includes application of sealants as well as dental cleanings. In all, in 2005 there were six local health departments providing some type of dental service to approximately 630 children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Bureau of Health Promotion & Risk Reduction				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A portion of the money was used to fund a special needs dental practice facility. The project has been implemented and administered by the Department of Public Welfare and a facility has been selected. The emphasis was to provide a dental safety net for Medicaid special needs population. The goal is to serve low-income special needs children through this project as well as to increase the percentage of third graders that receive protective sealants on a least one molar tooth. The Department's project includes the following:

o A training component, designed to increase the numbers of expanded function dental assistants (EFDAs) in the State to broaden the provider network and expand access for the low-income Medical Assistance (MA) and Children's Health Insurance Program (CHIP) populations. Pennsylvania is one of only a few States that allow these mid-level dental providers to offer services.
o A clinical component to expand the dental safety net for MA special needs patients. Collaboration with the Department of Public Welfare and its contracted Medicaid Managed Care Organizations (MCOs) to replicate a clinic that provides comprehensive treatment of special needs MA patients in Philadelphia.
o A dental recruitment and referral component for the Healthy Babies/Healthy Kids hotline identified dentists willing and able to see low-income women, children, and families, and individuals with special needs.

The second statewide survey of licensed dentist will be administered in spring 2006. The HHSCC and Oral Health Program staffs hope to increase the number of returned surveys by offering several options for completing the survey (i.e., mail, phone, and internet).

In 2006, local health departments continue to provide preventative dental services to children within their jurisdiction. The Montgomery County and Allentown City Health Departments have renewed their Title V grants for this year. The health departments will continue their focus on preventive care by coordinating the application of sealants to patients at a free or reduced-cost.

c. Plan for the Coming Year
In 2007, local health departments will continue to provide preventative dental services to children within their jurisdiction. Two health departments, Chester and Bethlehem, will renew their Title V grants in 2007 and will continue to provide dental services by coordinating free or reduced-cost dental treatment. The HHSCC will continue to update and add dental providers to the HHSCC database through research and outreach, especially in geographic areas where callers have

identified dental care as an unmet need.

The Department partnered with the Department of Public Welfare (DPW) and Action Health to increase dental service to persons with special needs. Action Health located in Northumberland County developed a special needs dental practice site. Action Health is located in a DHPSA and has a trained pediatric dentist on the staff. Action Health accepts MA and Gateway Health Plan members, the area's managed care plan. In addition, Action Health is a State Health Improvement Plan partner with the Department, is funded by a community health partnership and governed by a joint partnership of five area hospitals. Action Health has begun to implement the initiative. This initiative will provide increased capacity within the community for individuals to receive services that were unavailable prior to the project.

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	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	3.2	3.2	3.1	3.1	2.5
Annual Indicator	2.6	2.8	2.7	2.5	
Numerator	63	67	63	59	
Denominator	2387431	2371006	2356033	2339033	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	2.4	2.3	2.3	2.3	2.3

Notes - 2005
Not available.

Notes - 2004
Numerator Source: PA Department of Health, Bureau of Health Statistics and Research.

Denominator Source: PA State Data Center.

Notes - 2003
Numerator source: PA Department of Health, Bureau of Health Statistics and Research.
Denominator source: PA State Data Center.

a. Last Year's Accomplishments
In 2005, 269 child safety seat check-up events were held; 4,026 seats were checked and 917 seats were distributed to families. In addition, The Pennsylvania Child Death Review Team reviewed and reported on 238 transportation fatalities. Of these 61 were under the age of 15. Of the 61, 56% were males; 31 reported pedestrian and bicycle related fatalities; and 6.5% involved all terrain vehicles.

There are 44 PA SAFE KIDS Chapters and Coalitions in operation. These Chapters and Coalitions conduct year round child safety seat events across the state and also provide community-based activities to promote child passenger safety and prevent unintentional injuries to children ages 14 and under. Venango County established a Safe Kids chapter in December, 2005.

The Pennsylvania SAFE KIDS Coalition partnered with Penn Dot to present the Buckle-Up campaign, a statewide effort to enhance child passenger safety through media outreach, community outreach, education and training, public policy efforts, and research. The goal of the

Buckle Up campaign is to reduce the number of child deaths and injuries from motor vehicle crashes and improve child passenger safety. The program is designed to ensure that caregivers receive both accurate, easy-to-understand information on child passenger safety and hands-on technical assistance in selecting and installing the correct restraint for their child. The program has three strategies: raising public awareness through a substantive media campaign; reaching out through the health and education community; and providing detailed education to the community by General Motors dealers who have been trained and certified to educate their communities. The Buckle Up program offers opportunities for families to participate in child safety seat checks and safety seat inspection stations within their communities.

In FY 04-05, 31 bicycle safety mini-grants were awarded to community organizations and police departments across the State. The goal of the 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 22% increase in helmet use among those youth that received a helmet from the grant program.

The 44 PA SAFE KIDS Coalitions and Chapters conducted 269 child safety seat events during FY 04-05. At these events, 4,026 child safety seats were checked for proper fit and installation. Of the 4,026 child safety seats that were checked, 917 of those were child safety seats that were distributed by the chapters and coalitions to families in need.

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

Currently there are 44 PA SAFE KIDS Coalitions and Chapters that are conducting year round child safety seat events across the State. There are currently 17 bicycle safety mini-grants that were awarded to community organizations and police departments.

The PA SAFE KIDS Coalition 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.

The Child Death Review Transportation Taskforce continues to encourage coroners and medical examiners to complete toxicology reports for all deceased adolescent drivers and passengers during death investigations and autopsies. Additionally, the taskforce expects to identify and support safety belt use among youths and teens, support legislation to strengthen youth driving policies, encourage local teams to identify and support education programs with goals and

missions devoted to teen driving, and encourage use of the PA AAP Traffic Injury Prevention Program and PennDOT Comprehensive Highway Safety coordinators. The Taskforce will also continue to partner with the Pennsylvania SAFE KIDS Coalition and the Traffic Injury Prevention Project.

CDRT and Safe Kids will jointly sponsor an injury prevention conference in September, 2006 to provide training for community groups.

A new chapter is being formed in Clarion County and Tioga County has established a Safe Kids chapter to provide injury prevention information and interventions to their communities.

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 will continue to partner with Child Death Review to develop prevention projects in the local communities according to need.

During 06-07, the PA SAFE KIDS Coalition will hold three statewide meetings and the PA SAFE KIDS Advisory Council will hold four meetings throughout the year. The selection process for the mini-grants will take place during Summer 2006. The bi-annual Injury Prevention Conference will be held September 26-28 in conjunction with the annual Child Death Review Statewide Meeting.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	12.9	13	13.1	13.2	13.3

Notes - 2005
2005 Data not available at this time.

2055 Objective: 12.8

2004 Data

Objective: 12.7
Percentage: 12.6
Numerator: 23,381

Reported from 2004 Pediatric Nutrition Surveillance from CDC Table 13C.

a. Last Year's Accomplishments
Breastfeeding data information was added to the PA birth certificates in 2003. This data shows that Breastfeeding initiation rate in 2003 in Pennsylvania was 61%. Individual county initiation rate

ranged from 38.9% to 77.9%. Breastfeeding initiation in WIC increased to 41.6% in July 2005 and remained at that rate through December 2005. An International Board Certified Lactation Consultant was hired as Program Coordinator in June 2005 for the newly established Pennsylvania Breastfeeding Awareness and Support Program.

In 2005, five specially trained lactation specialists handled approximately 152 calls to the Healthy Baby Helpline dealing with Breastfeeding promotion and technical assistance. Flyers with information ranging from basic breastfeeding techniques, to milk storage to pumping and returning to work are mailed regularly.

Twenty-five breastfeeding mini-grant applications were received in 2004-05, with 17 funded for a total of $46,157. Grantees included community organizations, hospitals, health care provider offices, schools, clinics, and non-profit agencies that work in the community with diverse low-income families and pregnant teens. Examples of funded activities were purchase of educational materials and equipment, establish breastfeeding peer support groups, conferences for healthcare professionals and a billboard campaign. Total number of individuals served through these mini-grants was 25,296.

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

In 2005-06, a Breastfeeding Awareness and Support Plan for Pennsylvania was written. This document identifies barriers to breastfeeding initiation and duration and outlines suggested action steps to eliminate or decrease barriers. This document provides the framework for future strategy planning for the Program. Other 2005-2006 Program activities included: development of a help line service for breastfeeding mothers with questions, phone line cards distributed throughout the state, breastfeeding promotion brochure and Program awareness lectures throughout the state.

In 2005-06, 21 breastfeeding mini-grant applications have been received with 20 grants funded for a total of $56,442. A new Maternal Child Health/WIC Breastfeeding Collaborative Project goal is to decrease the issuance of formula to breastfeeding mothers. The first quarter of the new project goal witnessed a total of 1,687 individuals who were served. One of the Bureau's current breastfeeding mini-grant recipients is the Central Susquehanna Intermediate Unit, serving Columbia, Montour, Union, Snyder and Northumberland Counties. Several of these counties do not have an OB service hospital and have little to no access to lactation help, support or services. They are using their $3,000 grant to provide staff and supplies for education, peer support, breast pumps and one-on-one lactation support for 120 pregnant teens with the goal of increasing breastfeeding duration rates. This effort was chronicled in a local newspaper.

The WIC Program and the Breastfeeding Support Program Administrator will continue to train the Lactation specialists on the Healthy Baby Help Line. A new Breastfeeding Support business card with the Healthy Baby Help line phone number has been created and added to all Love'em booklet packages which are offered to all pregnant women and families with a child under one year of age that call any of the HHSCC help lines.

c. Plan for the Coming Year
An abbreviated version of the four step process is being made available to WIC local agency staff as an option in 2006. Regular refresher trainings of Lactation Specialists continued through the distribution of the Breastfeeding Support program's business card, information will spread and calls will increase in the coming year.

In 2006-07 The Breastfeeding Awareness and Support Program plans to finalize and implement the State Plan. Projected 2006-07 objectives include:
1. Continue to manage, support and monitor the second year of the MCH/WIC Breastfeeding Collaborative Project
2. Continue the Breastfeeding mini-grants
3. Plan and implement a statewide Mother-Friendly Employer Project to educate and facilitate employers in supporting breastfeeding employees.
4. Plan and implement a health care provider education effort to include the physician and their office staff by conducting training through regional conferences and development of an office resource notebook.
5. Create breastfeeding education and promotion pages within the Department of Health website.
6. Print and distribute breastfeeding promotion posters with impact messages that address known barriers as part of a public awareness campaign.
7. Seek opportunities to communicate Department of Health breastfeeding initiatives with local coalitions, faith-based organizations, advocacy groups and schools.

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	2001	2002	2003	2004	2005
Annual Performance Objective	30	85	85	85	98
Annual Indicator	50.2	86.6	97.9	98.4	98.2
Numerator	72325	63143	139503	138750	138495
Denominator	143972	72878	142566	141013	141075
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	98	98	98	98	98

Notes - 2005
Birth figures (denominator) are preliminary 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.

The annual indicator has exceeded the annual performance objective, however the data being used to calculate the annual indicator are preliminary data and when final data becomes available

the annual indicator will change. We feel that the annual performance objective is closer to reality than the annual indicator at this time.

Notes - 2004
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.

The annual indicator has exceeded the annual performance objective, however the data being used to calculate the annual indicator are preliminary data and when final data becomes available the annual indicator will change. We feel that the annual performance objective is closer to reality than the annual indicator at this time.

Notes - 2003
Birth figures (denominator) are preliminary data 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 by July 1, 2003.

a. Last Year's Accomplishments
In Calendar Year 2005, 138,495 of the state's 141,075 hospital births (98.2 percent) received newborn hearing screening. Ninety-three percent of those screened passed their initial screening and 7 percent needed follow-up rescreening. Approximately 90 percent of infants in need of rescreening received it, with 17 percent not passing. Only 414 refusals of initial screening were reported statewide (less than 0.3 percent of births).

A total of 2,181 infants born in 2005 were referred to the state newborn hearing screening program for follow-up. Of the cases followed to conclusion as of this writing, 1,837 received rescreening, 575 received and passed a diagnostic audiological evaluation, and 239 were diagnosed with hearing loss. Of those diagnosed, 114 were linked to early intervention services. Eighty-two at-risk infants were receiving ongoing treatment and monitoring.

Progress continued with the Early Hearing Detection and Intervention (EHDI) program to provide physician outreach and education efforts. Eleven grand round presentations were given during 2005, reaching 240 persons (approximately 70% of them physicians).

Progress continued toward design and development of a centralized, web-based, reporting and follow-up tracking data system to fulfill the needs of both the metabolic and newborn hearing screening programs. In October 2005, the system was placed into production. Each day, information from two laboratories that perform metabolic testing is exported into the new system. DOH follow-up staff access the system and add hearing screening information based on reports received from birthing facilities for each newborn who does not pass a hearing rescreen or who does not receive a rescreen. From that point, the system is used by DOH staff for case follow-up activities. The system generates reminders for follow-up staff, produces letters based on a case status and has a variety of reports.

Approximately 3,400 infants in PA are born in out-of-hospital (OOH) settings each year. On average, 32% of these births occur in Freestanding Birthing Centers (FBCs) and some 68% occur in other locations including physician's offices and residences, but not including freestanding birthing centers (FBCs). Since 2004, local screening networks have been established in selected areas with high concentrations of OOH births. Certified nurse and lay midwives in these areas have been trained to screen newborns with portable Automated Brain Response (ABR) units provided by the Department of Health. Reporting of screening results began May 2004. Initial data indicated that 451 OOH births were screened between May and December 2004, equating

to approximately 20% of the OOH births statewide during those months. In calendar year 2005, 947 OOH births were screened equating to approximately 28% of the OOH births statewide during the calendar year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Hearing Screening and Intervention Program			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The EPIC-EHDI physician outreach and education initiative is moving forward at full pace. Three grand round presentations were conducted in birthing facilities between January and March of 2006 reaching 53 hearing screening staff (approximately 70% of them physicians).

In an effort to increase hearing screenings for the approximately 3,400 infants who are born in out-of-hospital (OOH) settings each year, DOH has purchased five additional portable ABR hearing screening units. Plans are to reinforce the existing screening networks that have been already established in rural areas with high concentrations of OOH births, and to establish additional networks. Additional midwives will be trained to use these units. OOH Program goals for 2006 are: (1) Screen 50% to 60% of OOH Births; (2) Provide educational updates to Midwives or Birthing Centers in an effort to improve program performance; (3) Make optimal and economic use of portable hearing screening units; (4) Improve communications with midwives, free-standing birthing centers, the Infant Hearing Screening Advisory Committee and other interested parties; and, (5) Provide additional staff resources for the OOB Hearing Screening Program.

Six (6) one-day regional training workshops for professional staff of County Mental Health/Mental Retardation (MH/MR) Offices and/or local Early Intervention agencies who provide early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA) to infants diagnosed with hearing loss/hearing impairment as a result of early screening were launched in May 2006. The general purpose of the regional training workshops is to provide training to those professionals primarily involved in providing early intervention services to infants diagnosed with hearing loss about the unique needs of such infants and the various communication options and assistive technology typically used to prevent developmental delay and enhance social, emotional and cognitive outcomes. The regional training workshops are also intended to strengthen the early intervention linkage process with respect to programs for deaf and hard of hearing infants and their families.

c. Plan for the Coming Year

DOH plans to launch two new programs by January 2007. The first program will provide professional development training to Part C, EI providers in order to increase their understanding

of the unique needs of infants diagnosed with hearing loss, increase their awareness of various communication options in relation to individual needs and preferences, and develop their capability to monitor infant progress. Finally, it seeks to evaluate Part C, EI outcomes for infants linked to services through the UNHSI program. This effort would be carried out in collaboration with the Department of Public Welfare's Office of Child Development, under contract through its leading provider of Part C, EI training and monitoring services, Early Intervention Technical Assistance of the PA Technical and Training Assistance Network (EITA/PaTTAN).

The second new program will foster coordination of effort between primary care providers (PCP's) and audiologists to improve services for deaf and hard-of-hearing infants and their families. This effort would be carried out by the PA Chapter of the American Academy of Pediatrics (PA AAP) under a new contract, with a modified version of the successful, Educating Physicians In their Communities--Early Hearing Detection and Intervention (EPIC-EHDI) program. PA AAP will also provide technical assistance to birthing facilities regarding early referral of infants to DOH and its importance in the chain of events leading to prompt diagnosis, treatment and intervention.

PA AAP will continue to work with the University of Pittsburgh School of Medicine to enhance an existing online web-based training program (ONLI-EHDI). Existing case studies will be modified to include information concerning how primary care physicians can help families find a qualified audiologist, how they can link families with EI services, and how to advise families regarding their communication option preferences.

Plans are being made to enhance the centralized, web-based, reporting and follow-up tracking data system. Methods to allow birthing facilities to export hearing screening results are being explored. Also, information is being gathered to allow for improvements in electronic communication between DOH and birthing facilities //2007//.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	7.2	6.8	6.5	6.2	9.2
Annual Indicator	8.0	10.2	8.4	10.7	
Numerator	219760	290000	239000	304000	
Denominator	2747000	2843000	2852000	2850000	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.2	9.1	9	9	9

Notes - 2005
Not Available.

Notes - 2004
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 2005 will not be available until September of 2006, so there will be a gap in our reporting on these figures.

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 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) which indicates that 636,000 children under 18 were uninsured for at least one month during the years 2001 and 2002.

Notes - 2003
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 2004 will not be available until September of 2005, so there will be a gap in our reporting on these figures.

There are at least two other ways that Pennsylvania could choose to derive the numerator for this performance measure. The numerator 133,000 has been derived by a Health Insurance Survey conducted in 2004 by the PA Insurance Commission (which administers CHIP). Families USA has also released a study (available at 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
Unique to Pennsylvania's CHIP and Medicaid program is collaboration. There is a common application form for both programs as well as automatic forwarding of applications for families over/under income. The Commonwealth of Pennsylvania's Application for Social Services (COMPASS) web application has made it possible to assist callers with the application process while on the phone. In 2005, 4,308 COMPASS applications were completed by the specialists.

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
The Call Center has successfully piloted benefit renewal calls for the Insurance Department. Staff at the HHSCC performs outbound calls to contact members whose expiration dates are imminent to determine need to re-enroll.

The Insurance Department was charged by the Governor to add 10,000 new children to the CHIP program this year. Along with advertising, renewal efforts began. Specialists at the HHSCC contact families that are due to renew their enrollment to assist in the renewal process. Renewals for CHIP and Medicaid are now available through COMPASS. Families can enter some identifying information and the system will locate their existing information, the individual updates the information and mails the corresponding documentation to the appropriate office.

c. Plan for the Coming Year
The Philadelphia Family Court is partnering with the BFH and the Insurance Department to increase access to health care coverage and services for children in the family court system. The BFH will fund two positions within the Court to assist families in applying for health care coverage using COMPASS. The Insurance Department and the Department of Public Welfare will provide extensive training on the public health care coverage programs available and the COMPASS web application and provide print materials for the staff to utilize in this outreach effort.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					0.0
Numerator					0
Denominator					1
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	13.8	13.7	13.6	13.5	13.4

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
Calendar Year 2004 data is the most recent data available. According to the CDC Pediatric Nutrition Surveillance System (PedNSS) report for calendar year 2004, the percent of 2 to 5 year old children in WIC with a BMI at or above the 85th percentile is 25.8%. This compares to the national percentage of 30.4%. Please see attached file.

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
The WIC Program in the state of Pennsylvania (PA) continues to advance and expand the use of the Obesity Prevention Modules among all the local agencies. These modules were written in 2000 and 2001, and were first introduced to the local agencies in June 2000. There are 8 modules including an introductory module that contains survey questions that provide the springboard for discussions with caregivers on child feeding practices. The modules were put on the USDA's WIC Works Resource System in the fall of 2002, and help to move staff towards fostering behavior change in their clients. The modules consist of background material for the trainer, staff reference sheets, the outline for discussion points during the counseling session, and handouts that can be distributed to clients that provide concrete suggestions for behavior change.

c. Plan for the Coming Year
WIC local agencies will continue to use the Obesity Prevention Modules to guide nutrition education provided to WIC clients. PA WIC continues to help local agency staff assist clients to establish goals for healthier eating. In FY 2005 USDA awarded the PA WIC Program a three-year special project grant to formally develop and evaluate a training module to teach local agency staff how to use Guided Goal Setting as a nutrition education methodology. Development of a curriculum and formal evaluation will occur in FYs 2007 and 2008. The idea is to present concrete suggestions for small behavior changes, document the suggestions a client is willing to try, and follow-up at the next immediate WIC appointment on the success of implementing the change. The intent is to provide continuity of care, create an expectation that WIC is interested in helping a client change behaviors, and build a client's confidence that change is possible, and can be good for them.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	14.2	14	13.8	13.5	13.2

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
Pennsylvania's Medicaid funded tobacco cessation services represent the national standard in services.

Pennsylvania Medicaid (MA) services authorize drug therapy or counseling services. Although it is recommended that drug therapy should be used concurrently with a tobacco cessation counseling program, the MA program will cover either the drug products or the counseling services for those MA recipients who do not want both or will cover both in combination for those who do and are eligible for pharmacy services

The Pennsylvania Tobacco Cessation Program offers counseling, training, and funding to local primary contractors. The program has a free Quitline that is available 24 hours a day, 7 days a week. The Program offered 11 traditional face-to-face workshops to 420 community-based physicians. In addition 600 community-based physicians completed self-directed learning programs. The program also had three face-to-face workshops for 138 professionals in oral health. There were 1,000 dental practitioners who completed the self-directed learning program. Other training included 302 sites that received the Clean Air for Healthy Children Program.
The state's tobacco cessation program also had programs focusing on African-Americans and Hispanics. The program for African Americans (Love Thy Neighbor) utilized church-wide community engagements and equipped churches with the resources they needed. Adult "street teams" distributed bilingual quit guides and solicited personal information from Hispanic smokers who were interested in quitting. The results of the state's tobacco cessation program are impressive, and include:
- In 2003 24.4% (7,539) of resident mothers aged 18-49 who smoked during the three months prior to their pregnancy quit smoking during the first trimester of their pregnancy. (PA Department of Health, Bureau of Health Statistics and Research).
- Smoking by high school students dropped from 27.6% to 23.1% (Youth tobacco survey, 2002)
- The illegal sale of cigarettes to minors decreased from 27.9% in 2001 to 7% in 2004
- Smoking among Pennsylvania adults dropped from 25% (±2) to 23% (±2) (Pennsylvania Risk Factor Surveillance Survey 2004)

Pennsylvania was one of ten states that participated in an Action Learning Lab (ALL) being conducted as part of a collaborative effort among the Association of Maternal and Child Health Programs, the American College of Obstetricians and Gynecologists (ACOG), the Planned Parenthood Federation of America, and the Women's Tobacco Prevention Network. 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 test interactive kiosks to deliver tobacco cessation awareness, education and messaging in key MCH locations to serve pregnant women and women of child-bearing age and assessing the extent of smoking cessation activities at key MCH service points.

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
3. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V)				X
4. Smoking Cessation Program				X
5. Family Health Nurse Consultant Program				X
6. Nurse Family Partnership (Title V provides technical assistance)				X
7.				
8.				
9.				
10.				

b. Current Activities
The Action Learning Lab has continued to assess smoking cessation services at maternal and child health organizations that focus on serving pregnant and postpartum women. In Fall 2006, the team will implement interactive kiosks. The kiosks will provide information about the dangers of smoking and will possibly provide a direct link to the Pennsylvania free Quitline where the individual can be provided with cessation services including up to eight one-on-one counseling sessions.

DPW will study the feasibility of surveying Healthy Beginnings Plus providers to assess their current activities in providing tobacco cessation services.

As part of the Bureau's Pregnancy Risk Assessment Monitoring System (PRAMS) project, the Bureau will consider adding state-specific questions around smoking. (See NPM #18 for more information about PRAMS)

The Department of Health (DOH) has already begun linking birth certificate data to other public health programs' information systems within DOH. DOH will explore linking with Medical Assistance (MA) information systems housed in DPW. PA's tobacco cessation program continues programs identified in the previous section.

c. Plan for the Coming Year
In 2007, The ALL team will deploy and test the interactive kiosks and determine their effectiveness in increasing utilization of smoking cessation services. The team will also continue to meet and expand its in-state stakeholder group.

The Bureau will work with the Division of Tobacco Prevention and Control to determine if there is an increase in utilization of services associated with increased outreach efforts conducted through the Healthy Baby line.

The Bureau of Family Health will begin collecting data as part of the PRAMS. (See NPM #18 for more information about PRAMS).

The tobacco Quitline will examine its ability to share counseling information with Medicaid and will continue programs described in the "Last Year's Accomplishment" section.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	6.8	6.6	6.4	6.2	8.2
Annual Indicator	7.5	8.1	8.0	7.3	
Numerator	66	72	72	67	
Denominator	876840	894289	904628	918572	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	8.1	8.1	8	8	8

Notes - 2005
Not Available.

Notes - 2004
Numerator source: PA Department of Health, Bureau of Health Statistics and Research.
Denominator source: PA State Data Center.

Notes - 2003
Numerator source: PA Department of Health, Bureau of Health Statistics and Research.
Denominator source: PA State Data Center.

a. Last Year's Accomplishments
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.

In Pennsylvania, the 2004 teen suicide rate between the ages 15 through 19 was 7.3 per 100,000. During 2004 the PA Child Death Review Team reviewed 67 suicides among this teen age group. Of these: 27% were adolescent ages 14 -- 19; 77% were males; 48% used firearms. The PA Youth Suicide Initiative and PA CDRT, Suicide Prevention Subcommittee became a joint group that supports the 11 goals and objectives of the state's work plan.

The PA Youth Suicide Prevention Group, along with the PA Adult Suicide Prevention Group, coordinated Suicide Prevention Awareness Day on September 6, 2005. Various county task forces, organizations from across the state, and state officials met at the Capitol Building with Secretary of Health Dr. Calvin Johnson, Secretary of Aging Nora Dowd Eisenhower, and Deputy Secretary Joan Erney from the Department of Public Welfare's Office of Mental Health and Substance Abuse Services. The event also featured a reading of Senate Resolution 153, which proclaimed Suicide Awareness Week in PA as September 4-10, 2005. Attendees were encouraged to bring a pair of shoes in memory of any family or fiends who completed suicides and all of the shoes were displayed on the Capitol steps. The goal of the event was to raise awareness and promote suicide prevention for both youth and older adults.

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
21 PA Counties reported having some type of community taskforce that addresses suicide prevention and suicide-related issues. Local Child Death Review teams continue to collaborate with these local and state programs. A review of the Youth Suicide Prevention database reports that 573 organizations, schools, communities, agencies and individuals received training in via the Yellow Ribbon, TeenScreen and Survivors of Suicide (SOS) programs.

SAP, a collaborative program started in 1985 between the state Departments of Education (PDE), Health (DOH), and Public Welfare (DPW), exists in all 501 school districts. Every secondary school building is required to have a student assistance program.

The DPW Office of Mental Health and Substance Abuse Services (OMHSAS) funds county Mental Health/Mental Retardation (MH/MR) Programs and DOH Bureau of Drug and Alcohol Programs (BDAP) funds Single County Authorities (SCA) to provide SAP liaison services to all secondary buildings. Commonwealth Approved Trainers (CATS) provide training for all school core teams and ten Regional SAP Coordinators provide technical assistance to the state's nine regions. The core teams in each secondary building, comprised of teachers, principals, school counselors, school nurses, psychologists, social workers, and community liaisons from the mental health and drug and alcohol agencies, assist in identifying students at risk for suicide or other behavioral health problems. Preparatory work continues on the development of the suicide prevention grant application. An Interagency team composed of staff from the Departments of Public Welfare and Health, working with Dr. Guy Diamond, University of Pennsylvania, is in the process of responding to a federal grant announcement, regarding suicide prevention. Staff is targeting three to five counties with the highest rates of youth suicides, large pediatrics practices and existing resources with the intention to:

- Establish a gate keeper training program for physicians in primary care and family practice offices in the targeted areas of the grant;
- Implement a standardized and computerized screening tool for suicide and other related risk factors in selected primary care and family practice locations;
- Develop a triage process that will reduce the burden to physicians by managing appropriate referrals to MH/SA treatment; and,
- Create an infrastructure that will build collaboration between primary care and family physicians, school SAP teams, and mental health/substance abuse providers and the community, with the collective aim of reducing the suicide rates of youth.

During 2005-2006, as a result of a Bureau award, the Children's Hospital of Philadelphia prepared and aired two suicide prevention TV public service announcements as part of the hospital's Teen Health Connections program. This program develops health related spots written, produced and acted by teens from the greater Philadelphia area.

c. Plan for the Coming Year

The PA Department of Public Welfare, with support from the Departments of Health and Education, will be applying for grant funds as authorized under the Garrett Lee Smith Memorial Act. The grant funds will allow states to build upon existing suicide prevention efforts, to develop early intervention strategies, and to further public/private sector collaboration. Up to 12 awards will be given, with each award not exceeding $400,000 per year. The grant period will not exceed three years.

Suicide Awareness Week will repeat in September of 2006.

The PA CDRT will continue to expand its curriculum for a "Collaborative Approach to Child Death Scene Investigations" expanding the section on youth suicide and risk behavior to enhance death scene investigations to determine cause and manner of death.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	68	69	69.5	70	80.1
Annual Indicator	70.5	73.0	77.7	63.5	
Numerator	1545	1690	1797	2044	
Denominator	2190	2315	2312	3218	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	81.9	82.5	83.7	83.7	83.7

Notes - 2005
Not Available.

Notes - 2004
Source: PA Department of Health, Bureau of Health Statistics and Research.

Notes - 2003
Source: PA Department of Health, Bureau of Health Statistics and Research.

a. Last Year's Accomplishments
In 2005, a four-prong approach was implemented to impact the percentage of very low birth weight infants being delivered at facilities designed to manage the care of high-risk infants and neonates.

1. The Pennsylvania Perinatal Partnership (comprised of the BFH, local County/Municipal Health Departments receiving Title V funding, MCH Consultants and the Nurse Family Partnership) worked collaboratively to promote that high risk mothers, high risk infants and neonates deliver and receive care in the appropriate risk--level facility. Each program area addressed this performance measure within the service system available.

2. The MCH Consultants worked in the six Health Districts to find and engage pregnant women who were not receiving prenatal care. This engagement included assistance in obtaining care, follow-up to ensure care was being received, and support during the postpartum period.

3. The Nurse Family Partnership is a very intensive program that initiates services early in the prenatal period and continues for mother and baby services through the second year of life of the baby.

4. The provision of prenatal care for undocumented citizens by the Philadelphia Department of Public Health and the Montgomery County Health Department address the needs of high-risk mothers and their unborn babies. Each effort, though different from the other, provides support to assure that mothers and babies arrive at the appropriate facility and receive the necessary care to assure good health for the mother and the infant. The combined efforts of these programs, serve to impact the number and percentage of high-risk infants and mothers who were delivered in the appropriate facilities for their individual levels of risks.

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
4. Nurse Family Partnership (Title V provides technical assistance)				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2006, the four (4) programs have continued to provide services to high-risk mothers and babies as indicated above. In late 2006, a stakeholders meeting will be held to address Pennsylvania's national rankings relative to infant mortality and low birth weight. The purpose is to create a common backdrop for developing strategies and interventions to impact low birth weight and infant mortality across the Commonwealth.

In the current year, the BFH, the Pennsylvania Perinatal Partnership, the Nurse Family Partnership and the MCH Consultants are working collaboratively to determine the impact that mandated manage care systems have had on MCH populations.

c. Plan for the Coming Year
In 2007, the BFH will convene a major stakeholders meeting to develop the strategies, programming needed for implementation and future direction for impacting very low birth weight, low birth weight and infant mortality. Some of the strategies will have to include actions and strategies for assuring that high-risk mothers, neonates, and infants are receiving care in the facility appropriate for the level of risk.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	84.5	85	85.5	86	83
Annual Indicator	80.9	84.6	81.9	81.3	
Numerator	116005	112799	97053	97316	
Denominator	143404	133335	118524	119668	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	83.5	84	84.5	84.5	84.5

Notes - 2005
Not Available.

Notes - 2004
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research.

Notes - 2003
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research.

a. Last Year's Accomplishments
The Bureau of Family Health has collaborated with local health departments and other state agencies to promote access to care, such as the Health Baby Help line. Women who call the Help line are greeted with support and encouragement to get medical care. Referrals to Medicaid, Obstetricians, free pregnancy testing and the Women, Infants, and Children (WIC) program are frequent. Callers are assisted with application for health care coverage offered to so they can receive prenatal care as quickly as possible.

The message for the Love'em with a Check-up Program is that getting a check-up is important if you think you might be pregnant. New commercials were created focusing on women in the initial stages of pregnancy to encourage women who THINK they are pregnant to call the Healthy Baby Help line as soon as possible. At the end of 2005, television commercials began running statewide for two weeks at a time with two weeks off in between. The commercials are planned through the summer of 2006.

The Bureau of Family Health collaborated with local health departments and other state agencies to promote access to care. The staffs at local health departments assisted women in applying for health care coverage so they received prenatal care as quickly as possible. Staff also assisted women in obtaining low-cost or charity prenatal care and maintained contact with local providers to ensure they were aware of the prenatal services in their jurisdiction. The local health departments used a variety of means to advertise their services. They distributed flyers, spoke at various community meetings, or even maintained service information on internet websites. In 2005, the Bureau of Family Health renewed three-year grants with Allegheny County, Erie County and Philadelphia to provide prenatal services within their jurisdictions.

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
3. Family Health Nurse Consultant Program				X
4. Nurse Family Partnership (Title V provides technical assistance)				X
5. Healthy Babies/Healthy Kids Help line				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Bureau of Family Health's media plan for Love'em with a Check-up campaign is to target an audience of women 18-24 and African/Hispanic populations. Employing the theory of "recency media planning", reaching as much of the audience as possible on a consistent basis, the "stork " commercial will continue to run focusing on this audience through targeted media outlets and geographical areas across the state.

As a receiver of federal funding for Health and Human Services, the Pennsylvania Department of

Health is required by law, Title VI, to ensure that no person is denied access to services and benefits as the result of the inability or limited ability to communicate in the English language. It is the responsibility of each Bureau to ensure through its contracts, grants, or other means, that contractors, subcontractors and grantees ensure meaningful access to benefits and services for individuals with Limited English Proficiency (LEP).

Currently staff at local health departments and their sub grantees, Healthy Start sites, and Nurse Family Partnerships conduct outreach to get women into prenatal care in their first trimester. All are participating in collaborative planning to improve access to prenatal care services in their communities. Many programs provide health education materials in several languages to reach out to those whose first language is not English. Interpreters and linguistic services are provided in most prenatal clinics where undocumented pregnant women receive services. In 2006, the Bureau of Family Health will renew three-year grants with Montgomery County and the Allentown City Health Bureau.

The Bureau of Family health will be monitoring a Department of Public Welfare pilot program to provide prenatal care to undocumented women in selected areas of the state. The major concerns are the extent of service to be provided (only prenatal care or all medical needs) and will women be too afraid of applying for service. The Bureau of Family Health is collaborating with the Department of Public Welfare to improve access and quality of services to the MCH population in Pennsylvania.

c. Plan for the Coming Year

The new rack card began distribution in the fall of 2005 with the message "Not all pregnancies are planned". New initiatives for the coming year include possible web advertising through different search engines as well as another television flight. The reprint of the English and the Spanish versions of the "Guide to a Healthy Pregnancy" will be enhanced to reflect updated information about breastfeeding and also include information on pre-natal smoking and the Pennsylvania Quit Line contact telephone line.

In 2007, the Bureau of Family Health will continue to monitor current grant agreements with the local health departments and, if requested, renew grants with Bethlehem City Bureau of Health, Bucks County, Chester County, and York City Bureau of Health. It will continue to work with the local health departments to
monitor their communities' needs and services.

The Department will continue with its State Adolescent Health Task Force to provide specific direction for teen pregnancy prevention and begin to detail the health needs of Pennsylvania's adolescent population.

The Bureau of Family Health will hold a stakeholder meeting in FY 07 to implement a community action plan toward a comprehensive statewide MCH care system.

The Bureau of Family Health will finalize its PRAMS state protocol and begin collecting data. The first report will not be available until mid 2008.

D. State Performance Measures

State Performance Measure 1: *The percent of live births weighing less than 2,500 grams.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				8.8	
Numerator				12574	
Denominator				143475	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7.9	7.8	7.8	7.8	7.8

Notes - 2005
Not Available.

Notes - 2004
Unknowns excluded in calculations.
Source: PA Department of Health, Bureau of Health Statistics and Research.

Notes - 2003

a. Last Year's Accomplishments
During calendar year (CY) 2005, the NSFP provided screening on 143,380 filter papers from newborns. A total of 212 newborns were diagnosed with one of the six state-mandated conditions. The following conditions were diagnosed: 65 congenital hypothyroidism, 9 congenital adrenal hyperplasia, 93 sickle cell disease and hemoglobinopathies, 27 phenylketonuria, 1 maple syrup urine disease and 17 galactosemia.

The Bureau prepared an evaluation report of the PA FORE Families project, with recommendations to continue and improve the program. The Department will continue to build a birth defects surveillance database and will use new and improved methods to provide earlier linkage to health care services and early intervention programs for newborns and children with birth defects. Efforts will also be made to provide statewide education and outreach about available services and programs to assist children with birth defects. The Secretary of Health approved the continuation of the pilot project in the four county area of southeastern Pennsylvania for another twelve months.

The NSFP is collaborating with the Newborn Screening Technical Advisory Committee and The March of Dimes, who is leading a campaign nationally, as well as within Pennsylvania, to screen and report additional newborn genetic conditions. Two bills were introduced by the Pennsylvania Legislature to amend the Newborn Child Testing Act. House Bill 755 and Senate Bill 819 propose to increase the number of genetic conditions that newborns are screened from six to 29 conditions. The BFH is collecting and analyzing data regarding the costs that would be incurred if the Department would mandate additional screening of newborns from the current six state-mandated conditions to the 29 uniform conditions panel and 25 reportable conditions recommended by the American College of Medical Genetics.

The NSFP started implementation of a statewide PKU/MSUD Pharmacy Program on July 1, 2005. The pharmacy program allows clients with PKU to obtain PKU formula at a pharmacy in their locale. Over 1,400 pharmacies in Pennsylvania participate in the program. The pharmacy program has improved client access to formula and it is estimated that the pharmacy program will save over $500,000 during the first year of operation.
The new integrated metabolic and hearing follow-up system was implemented in October 2005. The PNSP is collaborating with the Hospital Association of Pennsylvania and ten Pennsylvania hospitals to develop a hospital user group, which assists the Program in designing a system for hospitals to report data and access newborn screening results.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nurse Family Partnerships (Title V provides technical assistance)				X
2. County Municipal Health Department Education Programs				X
3. Norristown Initiative		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Bureau of Family Health is working in collaboration with multiple partners to improve quality of service to pregnant women. Our focus is on meeting the cultural and linguistic needs of women in Pennsylvania and building infrastructure to ensure that women throughout the state have access to care.

The Bureau of Family Health was awarded a PRAMS grant and began the process to hire additional personnel and process to contract with a data collection agency. In addition, it will begin consideration of state-specific questions and prioritizing stratification samplings. Other tasks include forming an Oversight Committee and developing the state protocol for CDC approval. Eventually the Bureau could identify low birth weight as one of its stratification samplings.

c. Plan for the Coming Year
The Bureau of Family Health will hold a stakeholder meeting in FY 07 to implement a community action plan toward a comprehensive statewide MCH care system.

The Bureau of Family Health will finalize its PRAMS state protocol and begin collecting data. The first report will not be available until mid 2008.

State Performance Measure 2: *The rate of motor vehicle crashes caused by teen drinking drivers ages (17-19).*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				157.0	
Numerator				870	
Denominator				554305	
Is the Data Provisional or Final?				Final	

	2006	2007	2008	2009	2010
Annual Performance Objective	157.5	150.5	150.5	150.5	150.5

Notes - 2005
2005 Data Not Available.

Notes - 2004
Numerator source: PA Department of Transportation
Denominator source: PA State Data Center

a. Last Year's Accomplishments
PA CDR Teams reviewed 135 fatalities involving teens ages 17-19 that occurred in 2004. In an effort to provide improved data on teen fatalities PA CDR will continue to train local teams and communities on the National CDR Resource, Case Reporting System. From past reviews, local teams only have toxicology reports on drivers. The PA CDRT transportation subcommittee continues to support the recommendations that all transportation fatalities have death scene investigations that include toxicology for drivers and passengers. Of the 135 fatalities, 134 were referred to Coroners and 54 received autopsies.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Death Review Team			X	X
2. Injury Prevention Program			X	
3. Adolescent Health Program			X	
4. Safe Kids Program		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Local Child Death Review (CDR) Teams requested that the transportation subcommittee review data and research that focuses on teen driver fatality combined with the use of alcohol and drugs. Local CDR Teams were encouraged to attend Town Meetings supported by PA Against Underage Drinking during the spring of 2006. The summary report is pending.

The PA CDR Team continues to identify local programs that work with their communities in addressing the many transportation issue identified. County Coroners, Emergency Service, and Law Enforcement are providing very graphic presentations that focus on teen driving and DUI. Additionally, several communities are in the process of developing outreach and educational programs to assist parents as they complete the 50-hours driving education to the newly permitted teen driver.

During a state CDR meeting DOH, Injury Prevention Program provided a brief narrative to the CDR that proposed the development of a work group focused on teen driving in Pennsylvania.

c. Plan for the Coming Year
Continue to improve local CDR team ability to collect and access data for their reviews. Identify new opportunities to obtain information on drug and alcohol use for these fatalities. Assist

communities in identifying gaps in service. Support the development of a statewide work group to identify and discuss issues related to Teen Driver Fatalities and Injuries.

Support the CDR recommendations that all transportation fatalities death scene investigations include toxicology for drivers and passengers.

State Performance Measure 3: *Percent of live births to mothers who receive early and adequate prenatal care.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				65.6	
Numerator				74872	
Denominator				114181	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	65.5	66	66	66	66

Notes - 2005
Not Available.

Notes - 2004
Calculated with missing data (adequacy measure could not be computed) removed from the denominator.
Source: PA Department of Health, Bureau of Health Statistics and Research.

Notes - 2003

a. Last Year's Accomplishments
Currently staff at local health departments and their sub grantees, Healthy Start sites, and Nurse Family Partnerships conduct outreach to get women into prenatal care in their first trimester. All are participating in collaborative planning to improve access to prenatal care services in their communities. Many programs provide health education materials in several languages to reach out to those whose first language is not English. Interpreters and linguistic services are provided in most prenatal clinics where undocumented pregnant women receive services. In 2006, the Bureau of Family Health will renew three-year grants with Montgomery County and the Allentown City Health Bureau.

The Bureau of Family health will be monitoring a Department of Public Welfare pilot program to provide prenatal care to undocumented women in selected areas of the state. The major concerns are the extent of service to be provided (only prenatal care or all medical needs) and will women be too afraid of applying for service.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. County Municipal Health Department Education Programs			X	X
2. Nurse Family Partnerships (Title V provides technical				X

assistance)				
3. Folic Acid Education Program			X	
4. Adolescent Health program			X	
5. Pennsylvania Perinatal Partnership Collaborative (Healthy Start and Title V)				X
6. Love Em With a Checkup Program				X
7.				
8.				
9.				
10.				

b. Current Activities

Ensuring the health message about folic acid is communicated, the Bureau of Family Health assisted in the creation of stand alone displays with healthy messaging about folic acid. A high-impact display was created for each of the six District Offices to ensure statewide use at health fairs, local community events and conferences.

The Bureau of Family Health is realigning how title V funds are awarded to the county/municipal health departments. Currently, agencies establish their own priorities. Under the new funding, county/municipal health departments will be asked to address state priorities and national/state performance measures. The focus will be on addressing early and adequate prenatal care among minority populations. In addition, the Bureau is partnering with the Medicaid managed care organizations to identify best practice interventions.

In conjunction with the Department's CSTE MCH Epidemiology Fellow, the Bureau of Family Health is exploring a grant opportunity that will examine critical issues related to disparities in obtaining early and adequate prenatal care.

c. Plan for the Coming Year

In 2007, the Bureau of Family Health will continue to monitor current grant agreements with the local health departments and, if requested, renew grants with Bethlehem City Bureau of Health, Bucks County, Chester County, and York City Bureau of Health. It will continue to work with the local health departments to
monitor their communities' needs and services.

The Department will continue with its State Adolescent Health Task Force to provide specific direction for teen pregnancy prevention and begin to detail the health needs of Pennsylvania's adolescent population.

State Performance Measure 4: *Percent of WIC enrolled breastfeeding mothers who breastfed their infants for at least the first six months of life.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				12.6	
Numerator				23381	
Denominator				184998	
Is the Data Provisional or Final?				Provisional	

	2006	2007	2008	2009	2010
Annual Performance Objective	14.8	14.8	14.8	14.8	14.8

Notes - 2005
Data not available.

Notes - 2004
Data Source: 2004 Pediatric Nutrition Surveillance Report -CDC Table 13C
Denominator estimated

a. Last Year's Accomplishments
This was a new state performance measure for 2006. The most recent available data from CDC is for calendar year 2004. The percent of infants breastfed at least 6 months of age for the 2004 reporting period was 12.6%.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities
Pennsylvania WIC provides breastfeeding support to its mothers in a variety of ways. Breastfeeding promotion and support activities in WIC were required by law starting in 1989. Among the activities that help to support breastfeeding among our population has been the distribution of breast pumps to WIC mothers, the development of a county-specific resource guide that lists local lactation consultants, support groups, and hotlines/helplines, peer counseling programs in select WIC sites, a social marketing campaign to build breastfeeding-friendly communities which includes the establishment of local breastfeeding coalitions and other networking opportunities with local healthcare providers.

c. Plan for the Coming Year
The FFY 2007 statewide breastfeeding goal for Pennsylvania WIC is to decrease the percentage of women who discontinue breastfeeding within the first three months of birth. It is hoped that reducing the number of women who quit breastfeeding within the first 12 weeks after birth will have a positive impact on increasing duration rates. The State Agency Breastfeeding Coordinator will provide local agency WIC staff with a curriculum on how staff can effectively handle early requests for formula as well as a series of bulletin boards which address reasons for early discontinuance of breastfeeding. These efforts will be added to the current activities described above.

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)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
Data not available. It is expected to be available for 2006.

Notes - 2004
Data not available.

Notes - 2003
Data not available.

a. Last Year's Accomplishments
The nine question caller survey baseline indicated 91.3% were satisfied with the service received by the Call center. The baseline was developed by collecting test data from surveys sent October 2004 through March 2005. Over 3,710 surveys were mailed to callers during this period, with a return rate of 601 (16%). Those surveyed were families and professionals who had previously called the Special Kids Network. Families responding "yes" to "Would you recommend the Special Kids Network to someone you know?" and professionals responding "yes" to "Would you call the Special Kids Network again?" were included in the baseline satisfaction percentage. The HHSCC is working on a mechanism to prevent multiple surveys going to repeat callers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Special Kids Network/Community Systems Development				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Funding is in place with the renegotiation of the Health and Human Services Call Center (HHSCC) to continue with the caller surveys. The Bureau anticipates satisfaction rates to increase based on the continued training efforts at the HHSCC. Program staff will continue to receive the surveys and tally the results.

c. Plan for the Coming Year

The survey will continue as well as follow-up on issues resulting from survey responses. Professional presentation requests will be forwarded to the Health and Human Services Call Center to make contact and mail fulfillment information. Training will also continue on a regular basis to keep specialists up-to-date on current issues and happenings in the disability community.

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)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				0.7	
Numerator				100	
Denominator				144194	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0.5	0.5	0.5	0.5	0.5

Notes - 2005
Not Available.

Notes - 2004
Source: PA Department of Health, Bureau of Health Statistics and Research.

a. Last Year's Accomplishments
Since the inception of PA Child Death Review (CDR) Team there has been an initiative to improve the quality of death scene investigations, interviews, reporting and autopsies for infant deaths determined to be SUIDS or SIDS. Pennsylvania does not have a standardize death scene investigation protocol for these deaths. Through a collaboration supported by PA CDR, and with representation from the PA Coroner, Law Enforcement, Medical and Public Health, Child Protection and Emergency Response a three-day educational curriculum for those who respond to scenes of infant death was developed. 120 attendees attended two training sessions during 2004 and 2005.

Additionally, DOH organized a community group to assist in the development of a statewide manual. "Protocols: Responding to an Infant Death" this product is pending approval before release.

In November 1998, SIDS of Pennsylvania established the Cribs for Kids Program in an effort to reduce infant mortality by providing families in the low-income areas of Pittsburgh with cribs for their infants. Cribs for Kids is a safe-sleep education program for low-income mothers to help reduce the risk of injury and death of infants due to unsafe sleep environments. Safe, portable cribs are given to families who are unable to purchase one. In addition, Cribs for Kids provides education and training on proper sleep position and sleep environment to all families that receive a crib, as well as to health and human service providers and to other local organizations. Through the donation of thousands of cribs, Cribs for Kids has been making an impact on the rates of babies dying of SIDS and accidental suffocation/strangulation. This effort has been underway in the Pittsburgh area since 1998. In 2005, the Bureau of Family Health purchased and made available 257 cribs to the Cribs for Kids Program and to the Maternity Care Coalition in Philadelphia. The Infant Safe Sleep Promotion Program will improve the health and safety of infants and reduce infant mortality rates across the state. The incidence of infant death due to factors such as Sudden Infant Death Syndrome (SIDS) and accidental suffocation/strangulation of infants in adult beds is expected to decrease as a result of this program.

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	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2006, the Maternity Care Coalition in Philadelphia established a Cribs for Kids Program to serve families in the Philadelphia area. Both SIDS of PA and MCC received grants in 2006 from the Bureau of Family Health to continue promotion of safe sleep through the purchase of cribs and mattresses. Title V dollars were used to support the wide spread distribution of portable cribs. The grants include a data collection and analysis requirement; preliminary data are not available at this time.

PA CDRT continues to support the improvement of death scene investigations and interviews. Many counties have hired staff to complete infant death scene investigations, interviews and reporting. Coroners and Medical Examiners continue to improve death scene investigations that will assist in determining deaths of SUIDS/SIDS or those that involved accidental strangulation or suffocation. Additionally, the workgroup created a CD/DVD titled "Death Scene Preservation" to assist those responding to infant deaths. This CD/DVD has been released to communities, services and those who participated in past education.

In 2005/2006 PA CDRT proposed recommendations:

- Continue to the improvement of death scene investigations and autopsies through education to those who respond to infant death scene
- Encourage those who complete the investigations and interviews to use the CDC recommended protocols and forms.
- Foster a message that provides information on infant death risk reduction and safe sleep practices.
- Support the AAP statement and recommendation that addresses bed sharing and co-sleeping with infants
- Advocate for a statewide statement that would support the AAP statement related to safe sleep and risk reduction related to infant death.
- Continue the effort of cross-matching between CDR and DOH to assure all unexpected infant deaths are reported to DOH.
- Continue to support and improve education to the prenatal population on best practices for risk reduction for infant death.

c. Plan for the Coming Year

PA CDRT plans to identify resources to support annual training using material developed for infant death scene investigation and death scene preservation. To see more risk reduction and

safe sleep education provided to the medical community through grand rounds or educational opportunities.
Provide standardized education to those involved in prenatal care and those who are involved in pediatric care.

Continue to develop local Crib for Kids teams.

State Performance Measure 7: *Percent of children ages (1-2 yrs) screened for lead poisoning.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				11.6	15.3
Numerator				34042	44706
Denominator				293378	293000
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	26.4	29.4	32.4	35.4	35.4

Notes - 2005
Numerator source:PA National Electronic Disease Surveillance System (PA-NEDSS) Lead Annual Report
Denominator source: This is estimated for 2005 and will be updated when final figures are available.

Notes - 2004
Numerator source:PA National Electronic Disease Surveillance System (PA-NEDSS) Lead Annual Report
Denominator source: PA State Data Center

a. Last Year's Accomplishments
A Lead Elimination Workgroup comprised of community and agency leaders collaborated to formulate a strategic Lead Elimination Plan aimed at eliminating lead poisoning in Pennsylvania's children by 2010. The Lead Elimination Workgroup is a joint effort with the Philadelphia Department of Public Health. The Lead Elimination Workgroup consists of four subcommittees: Surveillance, Primary Prevention -- Housing, Primary Prevention -- Outreach, and Case Management.

With a Surveillance Program Administrator and, subsequently, an Assistant Administrator in place during 2005, this has lead to closer monitoring and communication between lead licensed laboratories, common medical providers of lead testing, statewide CLPPP grantees and the Bureau of Information Technology, ultimately improving and increasing the number of childhood lead reports (34,042 tests in 2004 compared to 44,706 tests in 2005).

Comprehensive childhood lead poisoning prevention services are provided in targeted high-risk areas of the Commonwealth through 10 Department of Health (DOH)-funded Childhood Lead Poisoning Prevention Program (CLPPP) projects.

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 Information Line (not Title V funded)				X
3. Lead Elimination Workgroup				X
4. Lead Screening Expansion into WIC Clinics			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2005 and 2006, Joanne Corte Grossi, Deputy Secretary for Health Promotion and Disease Prevention, Pennsylvania Department of Health, provided lead testimony before the House Health and Human Services and Urban Affairs Committees on three different occasions. The first legislative hearing on childhood lead poisoning prevention was held March 2005 in Philadelphia, a second hearing was held December 2005 in Harrisburg, and the third hearing took place February 2006 in Pittsburgh. The Committee Chairs, George Kinney and John Taylor have committed to introducing legislation that requires universal screening for all one and two year old children and children three to six years without a documented blood lead level test.

The DCAHS is currently working on drafting legislation that will contribute to the National goal of eliminating childhood lead poisoning by the year 2010. By increasing screening and lead safe housing, the goal is to eliminate childhood lead poisoning as a public health issue in Pennsylvania.

The PA CLPPP continues to work closely with the Department of Public Welfare (DPW) and the CLPPP sub-grantees regarding the delivery of childhood lead poisoning prevention services.

The DPW currently reimburses the Department of Health for environmental investigations the CLPPP sub-grantees provide to Medicaid and Medicaid Health Maintenance Organization (HMO) enrolled lead-poisoned children. A data-sharing project has been initiated with the DPW to ensure all children enrolled in Medicaid are being tested for lead poisoning.

Comprehensive childhood lead poisoning prevention services will continue to be provided in targeted high-risk areas of the Commonwealth through 10 PA projects. In addition, the PA CLPPP will develop a screening plan to increase the number of blood lead testing conducted at Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinic sites and Head Start.

c. Plan for the Coming Year

Our goal is to increase the number of WIC sites that provide blood lead testing and therefore increase the number of children screened. In 2006/2007 the goal is to increase the number of WIC sites providing lead testing from 40 to 59 and increase the number of counties providing lead testing at WIC centers from 16 to 36.

There are currently 127 Primary WIC sites throughout the Commonwealth of Pennsylvania. Of the 127 WIC sites, 40 conduct blood lead testing. Of the 67 counties in Pennsylvania, 16 (24%) are providing lead testing at WIC sites, 51 (76%) counties do not provide lead testing.

State Performance Measure 8: *The percent of school aged children who are overweight (obese).*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	0	0	0	0	0

Notes - 2005
Aggregate BMI data is currently not available but will be provided in a phased in process beginning 2005-2006 with Kindergarten to 4th grade. Kindergarten to 12th grade will not be available until Spring 2009.

BMI Screening Phase-In Plan: Data Available:

05-06 School Year......K-4th Spring 2007
06-07 School Year......K-8th Spring 2008
07-08 School Year......K-12th Spring 2009

Notes - 2004
Aggregate BMI data is currently not available but will be provided in a phased in process beginning 2005-2006 with Kindergarten to 4th grade. Kindergarten to 12th grade will not be available until Spring 2009.

BMI Screening Phase-In Plan: Data Available:

05-06 School Year......K-4th Spring 2007
06-07 School Year......K-8th Spring 2008
07-08 School Year......K-12th Spring 2009

Notes - 2003
Aggregate BMI data is currently not available but will be provided in a phased in process beginning 2005-2006 with Kindergarten to 4th grade. Kindergarten to 12th grade will not be available until Spring 2009.

BMI Screening Phase-In Plan: Data Available:

05-06 School Year......K-4th Spring 2007
06-07 School Year......K-8th Spring 2008
07-08 School Year......K-12th Spring 2009

a. Last Year's Accomplishments
In fiscal year 2004-05, the Department released the Pennsylvania Assessment of Overweight Children and Youth Report. The assessment, conducted in 2001-02, reviewed over 25,000 student health records of eighth graders. Findings indicated that 18 % were overweight (obese) and another 17 % were at risk of being overweight (overweight). Additionally, a pilot test of the Department's draft growth screening procedures in ten schools also yielded similar results of 21 % and 17%, respectively. The Division of School Health released revised School Growth

Screening Procedures in the fall of 2004 that required the calculation of student Body Mass Index (BMI) and BMI-for-Age Percentile. Schools were instructed to begin implementation for grades K-4 in school year 2005-06.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. School Growth Screening Procedures			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In school year 2005-06, schools implemented the now mandatory revised Growth Screening Procedures in grades K-4. Schools will provide aggregate data to the Department in their annual year end report that includes the number of students with BMI-for-Age Percentiles in the categories of at risk for underweight, at risk for overweight (overweight), and overweight (obese). Of note is that 79 school entities in grades K-6 and 49 in grades 7-12 voluntarily conducted growth screens on 233,724 students, using the revised procedures, during school year 2004-05. Results of those screened were 2% in the-at-risk for underweight, 13% in the at risk for overweight (overweight), and 19% in the overweight (obese) categories. The Division of School Health collaborated with Pennsylvania Advocates for Nutrition and Activity (PANA), its primary partner regarding childhood obesity, to develop a Growth Screening Communication Kit for Schools and Communities, a valuable resource

c. Plan for the Coming Year
Future Accomplishments: The Division of School Health will require schools to expand the implementation of the revised Growth Screening Program to grades K-8 in school year 2006-07 and grades K-12 in 2007-08. Schools will continue to provide aggregate growth screening data to the Department in their annual year end report. The Division will continue to collaborate with PANA in developing resources to assist families, providers, and schools in addressing the issue of childhood obesity. This will include the continued development and expansion of the Youth Obesity Prevention and Weight Management Inventory, a web-based statewide directory of pediatric weight management and weight gain prevention programs, by county.

E. Health Status Indicators
Health Status Indicator #1A: The percent of live births weighing less than 2,500 grams

Since 2000, the percentage of low birth weigh babies has actually increased among all births to residents and among both whites and blacks. In 2004, 8.8 percent of resident live births were classified as low birth weight (under 2,500 grams), compared to 8.1 in 2003. Prematurity and low birth weight remains a major public health problem and a significant contributor of health disparities. The addition of the Pregnancy Risk Monitoring System (PRAMS) will assist as an additional surveillance tool to effectively monitor maternal behavior, before, during and after

pregnancy to support the development of a coordinated state health policy for improving the maternal and child health system to produce better pregnancy outcomes.

Health Status Indicator #3A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Keeping children and youth safe remains a challenge for the state. Unfortunately victims of unintentional injuries among children aged 14 years vary across the state. Philadelphia saw an increase of 15 percent in gun related injuries in this age group. The top three causes of child death are preventable. The lack of health care access and childhood poverty, which exposes more children to risks, are major factors to childhood deaths, while poor parenting skills, substance and alcohol abuse, and child abuse and negligence and access to guns are contributing factors.

Health Status Indicator #03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

See Health Status Indicator 3A

Health Status Indicator #03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth age 15 through 24 years.

The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth age 15 through 24 years decreased from a rate of 25 in 2003 to 20.6 in 2004. Pennsylvania Adolescent Health Survey (2006) reports 1 out 10 or 9% of teens report riding in a car or other motor vehicle driven by someone who had been drinking alcohol. Utilization of data and identifying outcomes is key steps in improving programs.

Health Status Indicator #5A: The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

The Pennsylvania Adolescent Health Survey (2006) results indicated nearly half (47%) of Pennsylvania teens/young adults who are sexually active report having been tested for a sexually transmitted infection during their lifetime. This percentage includes 34% of males and 60% of females. Not surprisingly, a higher number of older teens/young adults have been tested (54%) than their younger counterparts, teens 13 to 17, 38%.

Chlamydia rates for women aged 15 through 19 years has remained relatively constant from 2003-2005. However, the Chlamydia rate among teens ages 15- 19 in 2004 decreased by .5% from 2003. Pennsylvania currently has a Chlamydia prevalence rate of 4.2%. This rate has hovered between 4.1% and 4.5% for females, exclusive of Philadelphia for the past three years since Pennsylvania move to amplified testing.

Health Status Indicator # 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

Case data from 2003 -- 2005 indicate the number of reported cases of Chlamydia in women aged 20 through 44 years remained unchanged.

Health Status Indicator # 06A: Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race.

In 2004, there were 4,098,694 infants and children aged 0 through 24 years of age living in the state. One in 11 Pennsylvanians 16-21 is physically inactive while 60% of idle youth in Pennsylvania are white at the same time only 1 in 3 African and Hispanic youth make-up this

group.

Health Status Indicator # 07A & #07B-Live births to women (of all ages) enumerated by maternal age and race and ethnicity.

Pennsylvania's babies were born to an increasingly diverse group of women in 2004, with births to white women accounting for 75.6% of all births; births to black women accounting for 13.8%; births to Asian/Pacific Islander women accounting for 3.4%; and births to Hispanic women accounting for 8.0% of all births. Please note that Hispanics can be of any race.

Health Status Indicator # 09A & #09B Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity

One Pennsylvania child in 12 lacks basic health insurance. Currently, a family of four living up to 200% of poverty level earning $37,700 struggles to make ends meet therefore, minimizing the amount of resources a family can allocate to meet basic needs.

Health Status Indicator #10 -Geographic living area for all resident children aged 0 through 19 years old.

There are 3,257,605 Pennsylvania children aged 0-19 living in either urban or rural areas of Pennsylvania. The Title V Agency considers the geographic living area of all target MCH populations when planning services and new initiatives.

Health Status Indicator #11 -Percent of the State population at various levels of the federal poverty level.

In census year 2000, of Pennsylvania's 12,281,054 residents 4.9% were living below 50% of poverty, 10.6% were living below 100% of poverty, and 26.5% were living below 200% of poverty.

Health Status Indicator #12 -Percent of the State population aged 0 through 19 at various levels of the federal poverty level.

Speaking to children and youth specifically, in census year 2000 2,922,221 Pennsylvania residents were children and youth aged 0 to 19 years old with 6.8% living below 50% of poverty, 14.4% living below 100% of poverty, and 33.8% living below 200% of poverty.

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//

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. Examples of specific activities conducted by Consultants include: collection of PKU monitor specimens, follow-up of children not passing their hearing screening, participate in breastfeeding initiatives and coalitions, teen pregnancy prevention, Child Death Review, conduct home and client assessments for lead exposure, and provide education on health topics to childcare centers.
/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. In 2005, the Bureau provided funding to the Hershey program for it to obtain reproduction rights for an educational video and to distribute the video to birthing hospitals in PA. In 2006, the Department hosted a joint meeting with Hershey staff and Department of Health staff to review Hershey's findings to date and to discuss the Department's hospital survey results.

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. During 2006, the PPP and its partners have offered training concerning perinatal depression and effective screening to Nurse Family Partnership Programs, the PPP membership, and other MCH service providers. The PPP is also hosting separate audio conference training for obstetricians, pediatricians and WIC providers and Family Planning staff. These three audio conferences feature nationally recognized experts in the field of perinatal depression. Finally, in late 2006, the PPP will host a statewide perinatal depression summit to bring together MCH service providers to identify and discuss future needs for the state.

The Department partnered with University of Pittsburgh's School of Dental Medicine to provide a continuing education session to medical and dental staff at community health centers in the southwestern part 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 in impacting oral cancer screening behaviors among primary care providers. The proportion of primary care providers reporting screening all adult patients increased significantly. There were 120 participants in the 20 sessions

During State Fiscal Year 2005-2006, the Department in partnership with the University of Pittsburgh's School of Dental Medicine and the American Cancer Society expanded the program to the central and eastern parts of the state.//2007//

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//

V. Budget Narrative
A. Expenditures
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.

B. Budget
3.3.1 Completion of Budget Forms

Form 2 (Maternal and Child Health Budget Details for FY 2007), 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 2007 is in full compliance with the federally mandated "30%-30%" requirements. Of Pennsylvania's proposed federal grant award for 2007, $8,899,379 is designated for the support of preventive and primary services for children, and $8,332,550 is designated for the support of services for children with special health care needs. Following is a summary of the utilization of available funds in relation to the levels of the pyramid.

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 2007, Pennsylvania plans to expend $1,930,000 or 7.83 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 2007, Pennsylvania's match will exceed the 1989 maintenance of effort level. The proposed expenditure of state Maintenance of Effort for 2007 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's 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 2007

State Funded Appropriations Amount
108 School Health Services $38,842,000.00
112 Maternal and Child Health $ 2,084,000.00
TOTAL $40,926,000.00

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.

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.