

ACTION PLAN						
Domain	Priority	NPM or SPM	Objectives	Baseline Data Source for Objective	Strategies	Evidenced based/informed measures ESM
Women/Maternal Health	6. Adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support.	<b>NPM 1</b> Percent of women, ages 18 through 44, with a preventive medical visit in the past year	1. Annually increase the percent of adolescents/women who talked with a health care professional after delivery about birth spacing or birth control methods. 2. Annually increase the percent of adolescents/women who are engaged in family planning after delivery	1. BRFS 2. PRAMS 3. Quarterly program reports	1. Implement evidence based or informed home visiting services (ex. Nurse Family Partnership, Bright Futures, Partners for a Healthy Baby) 2. Implement Centering Pregnancy Programs 3. Implement innovative interconception care initiatives for women	1.5 # of women served through evidence based or informed home visiting 1.1. # of families served through Centering Pregnancy Program 1.2 % of adolescents and women engaged in family planning after delivery 1.3 % of adolescents and women who talked with a health care professional about birth spacing and birth control methods
Women/Maternal Health	9. Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.	<b>NPM 14.1</b> Percent of women who smoke during pregnancy	1. Annually decrease percentage of women who report smoking during pregnancy.	1. NVSS 2. PRAMS 3. Quarterly program reports	1. Utilize the Integrated Screening Tool (5Ps)- Institute for Health and Recovery 2. Utilize Motivational Interviewing	14.1.3 Percent of women who report smoking after confirmation of pregnancy 14.1.4 Percent of grantees who implement evidence informed tobacco free programs
Women/Maternal Health	9. Women receiving prenatal care or home visiting are screened for behavioral health and referred for assessment if warranted.		1. Annually increase number of women receiving Title V funded prenatal care or home visiting who are screened for behavioral health. 2. Annually increase the percentage of women with a home visitor who have a conversation about intimate partner violence (IPV)	Quarterly program reports	1. Utilize the Integrated Screening Tool (5Ps)- Institute for Health and Recovery 2. Utilize Motivational Interviewing	14.1.1 # of Title V funded women who are screened for behavioral health 14.1.5. # of home visitors trained in motivational interviewing 14.1.2 Percent of women who talk with a home visitor about IPV
Perinatal/Infant Health	5. Families are equipped with the education and resources they need to initiate and continue breastfeeding their infants	<b>NPM 4A</b> Percent of infants who are ever breastfed  <b>NPM 4B</b> Percent of infants breastfed exclusively through 6 months	1. Increase the proportion of PA birthing facilities that provide recommended care for breastfeeding mothers and their babies. 2. Starting with reporting year 2017, annually increase number of counties with a breastfeeding rate at or above the 2016 statewide average of 81 percent. 3. Annually identify and develop a minimum of one collaborative opportunity with programs serving MCH populations. 4. Annually implement a minimum of one media opportunity promoting breastfeeding as the infant feeding norm for the state.	1. CDC Breastfeeding Report Card/PA aggregate mPINC score; PA Breastfeeding Awareness and Support Program Vendor Reports 2. PA Birth Certificate Date, Bureau of Health Statistics and Informatics; PA Breastfeeding Awareness and Support Program 3. PA Breastfeeding Awareness and Support Program 4. PA Breastfeeding Awareness and Support Program 5. NIS	1. Facilitate the adoption and implementation of the World Health Organization's ten evidenced based 'steps' for breastfeeding within PA birthing facilities. 2. Target specified counties to implement the evidence based strategies of peer counseling; partner/family support; or media/social marketing. 3. Identify programs in the Department and with other entities that serve maternal and child health populations and develop collaborations with them to promote and support breastfeeding with and within those programs. 4. Develop specific messaging that can be utilized across media and implement messaging through identified media opportunities.	4.1 % of facilities designated as a Keystone 10 facility each fiscal year 4.2 % of counties with breastfeeding rates at or above the 2016 statewide average of 81 percent each fiscal year 4.3. # of new collaborations developed (between breastfeeding program + other program) 4.4. # of new media opportunities implemented promoting breastfeeding per fiscal year
Perinatal/Infant Health	7. Safe sleep practices are consistently implemented for all infants	<b>NPM 5A</b> Percent of infants placed to sleep on their backs <b>NPM 5B</b> Percent of infants placed to sleep on a separate approved sleep surface <b>NPM 5C</b> Percent of infants placed to sleep without soft objects or loose bedding	1. Beginning in the second year of the grant cycle, annually decrease the rate of mothers who report sleeping with their baby in the first year of life. 2. Annually decrease the percent of infants who are strangled or suffocated due to unsafe sleep environment.	1. PRAMS 2. Quarterly program reports	1. Develop a hospital based model safe sleep program 2. Implement a hospital based model safe sleep program 3. Implement a social marketing plan to increase population awareness of safe sleep practices 4. Participation in the SUID Case Registry	5.1 Number of hospitals recruited to implement the model safe sleep program 5.2 % of infants born whose parents were educated on safe sleep practices through the model program 5.3 % of hospitals with maternity units implementing the model program 5.4 # of social marketing messages disseminated (safe sleep)

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Perinatal/Infant Health	2. Appropriate health and health related services, screenings and information are available to the MCH population.	<b>SPM 3</b> Percent of newborn screening dried blood spot filter papers received at the contracted lab within 48 hours after collection.	1. By 2020, increase the annual percentage of Dried Blood Spot (DBS) samples with a transit time to the contracted lab of less than 48 hours by 5% each year to expedite diagnosis and treatment.  2. By 2020, implement a system where all newborns born in PA are screened for all conditions listed on the Recommended Uniform Screening Panel (RUSP).	Newborn Screening Data System	1.a. Review and analyze data from the Newborn Screening (NBS) system to identify submitters with collection to receipt times greater than the state average and provide these submitters with technical assistance and information on best practices to improve their collection to receipt times. 1.b. Review and analyze data from the NBS system to identify submitters with collection times greater than 48 hours and provide these submitters with technical assistance and information on best practices to improve their collection to receipt times. 1.c. Work with the contracted NBS laboratory to explore options for weekend pick-up of specimens.  2.a. Develop a strategy for identifying and implementing a revised payment system for Newborn Screening. 2.b. Develop a process for adding conditions to the mandatory screening panel after conditions are added to the RUSP.	N/A
Child Health	1. MCH populations reside in a safe and healthy living environment	<b>NPM 7.1</b> Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9	1. For each year of the grant cycle, BFH will increase the number of households that receive a home assessment or intervention.	1. SID-CHILD 2. Quarterly program reports	1.1 Provide comprehensive home assessments to identify potential home health and safety hazards. 1.2 Provide home health and safety interventions such as integrated pest management and preventive safety devices to address the leading causes of child injury and death.	7.1.1 # of comprehensive home assessments completed 7.1.2 # of health and safety hazards identified through comprehensive home assessments 7.1.3 # of health and safety interventions performed as a result of health and safety hazards identified through comprehensive home assessments
CSHCN	2. Appropriate health and health related services, screenings and information are available to the MCH populations.	<b>NPM 11</b> Percent of children with and without special health care needs who have a medical home.	1. Starting with reporting year 2015, annually increase the number of pediatric primary care providers (PCPs) engaged in efforts to adopt medical home principles and practices for their populations. 2. Starting with reporting year 2016, increase the number of youth/young adults and parents/caregivers who are trained, engaged, supported and involved at all levels of medical home program planning and implementation. 3. Annually develop a minimum of one collaboration with a child-serving system that involves them in the provision of medical home services.	1. NSCH-CSHCN 2. Quarterly program reports	1. Expand provider access to medical home concepts and tools through learning collaboratives, education and statewide technical assistance, with special attention on health care systems and medical training programs. 2. Facilitate the involvement of youth/young adults and parents/caregivers in aspects of medical homes such as program planning, practice recruitment, practice partners, and patient care navigation/coordination. 3. Identify and develop collaborations with oral and behavioral health entities to support integration of services with medical homes.	11.3 # of providers participating in a learning collaborative, education and/or statewide technical assistance  11.4. # of youth/young adults and parents/caregivers involved in aspects of medical home activities  11.5 # of new formal collaborations developed with oral and behavioral health entities that serve pediatric populations
CSHCN	2. Appropriate health and health related services, screenings and information are available to the MCH populations.		1. Annually increase the number of families of children with special health care needs (CSHCN) served by the Community to Home (C2H) program. 2. Annually increase the number of collaborations between systems of care serving CSHCN.	1. Monthly program reports 2. BFH Internal reports	1. Utilize evidence based or evidence informed strategies including the use of Community Health Workers (CHWs) model by providing service coordination, resources and information to families of CSHCN. 2. Identify and develop collaborations between systems of care serving CSHCN.	11.1 # of families who receive services through the evidence based or evidence informed strategies of the C2H. 11.2. # of new formal collaborations developed between systems of care serving CSHCN.

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CSHCN	1. MCH populations reside in a safe and healthy living environment		1. Each year, provide at least 250 families with respite care services.	Quarterly program reports	1. Respite Care Program	11.6 Number of families receiving Respite Care Program services.
CSHCN	3. MCH populations are able to obtain, process, and understand basic health information needed to make health decisions.		1. Annually increase the number of students who are receiving BrainSTEPS and/or Concussion Management Team services.	Quarterly program reports	1. BrainSTEPS program	
Adolescent Health	4. Protective factors are established for adolescents and young adults prior to and during critical life stages.	<b>NPM 9</b> Percent of adolescents, ages 12 through 17, who are bullied or who bully others	1. For the duration of the grant cycle, BFH will annually increase the number of adolescent health vendors receiving training to improve rates of intervention when bullying/harassment is witnessed and increase the number of supportive staff available to LGBTQ youth. 2. Removed. 3. Increase the number of adolescents participating in a bullying awareness and prevention program.	1. YRBSS 2. NSCHP 3. NSCHV 4. Quarterly program reports	1.1. Provide evidence-informed LGBTQ cultural competency training to BFH vendors who serve adolescents. 2.1 Removed. 3.1 Support Olweus trainers in Pennsylvania to improve the bullying prevention infrastructure.	9.1 Percent of adolescent health vendors receiving LGBTQ cultural competency training.  9.8 Number of trainers trained in the Olweus Bullying Prevention Program
Adolescent Health	4. Protective factors are established for adolescents and young adults prior to and during critical life stages.		1. For the duration of the grant cycle, BFH will annually increase the number of LGBTQ sensitive organizations which provide services to youth. 2. For the duration of the grant cycle, BFH will annually increase the number of LGBTQ youth who have access to suicide prevention interventions.	Quarterly program reports	1.1. Implement an evidence-informed approach to train youth-serving organizations to become a safe space for LGBTQ youth. 2.1 Implement an evidence-based suicide prevention training for LGBTQ youth.	9.6 Number of organizations certified as a safe space provider. 9.7 Number of LGBTQ youth receiving evidence-informed suicide prevention programming.
Adolescent Health	4. Protective factors are established for adolescents and young adults prior to and during critical life stages.	<b>SPM 5</b> Percent of youth ages 8-18 participating in evidence-based or evidence-informed programs who increased or maintained protective factors or decreased risk factors.	1. Annually increase the number of youth participating in evidence-based or evidence-informed mentoring, counseling and adult supervision programs. 2. For the duration of the grant cycle, the BFH will annually increase the number of evidence-based or evidence-informed mentoring, counseling, and adult supervision programs available to youth ages 8 - 18.	Quarterly program reports	1. 1. Implement evidence based or evidence-informed mentoring, counseling, and adult supervision programs for youth with and without special health care needs ages 8 - 18.	9.9 Number of youth participating in evidence-based or evidence-informed mentoring, counseling, or adult supervision programs. 9.5 Number of evidence-based programs implemented in high risk areas of PA
Adolescent Health	6. Adolescents and women of child-bearing age have access to and participate in preconception and interconception health care and support.	<b>NPM 10</b> Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	1. In the first year of the grant cycle, BFH will increase the number of counties with a Health Resource Center (HRC) available to youth ages 12-17 either in a school or community based setting. 2. Beginning in the second year of the grant cycle, the BFH will annually increase the number of youth ages 12-17 utilizing HRC services. 3. For the duration of the grant cycle, the BFH will increase the number of LGBTQ youth with a medical visit in the past year. 4. Starting with reporting year 2015, BFH will increase the number of youth receiving health education and counseling services during a reproductive health visit.	1. NSCH 2. Quarterly program reports	1.1. Expand the evidence-informed HRC model to nine additional counties. 2.1. Expand to a second service site in each of the nine counties identified in year one and work with the HRC sites to increase the number of youth receiving services. 3.1. Utilize LGBTQ organizations to provide drop-in services, for high-risk and LGBTQ youth. The services shall include primary medical care and support services. 4.1. Make available office visits and counseling/health education to youth as part of a reproductive health visit at a family planning provider.	10.1 Number of counties with an HRC available to youth ages 12-17. 10.2 Number of youth receiving services at an HRC. 10.3 In schools with a HRC, the percent of youth within that school utilizing the HRC services. 10.4 Number of youth receiving services at a drop-in site funded by the BFH. 10.5 Number of youth receiving health education and counseling services from a reproductive health provider.

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Cross-Cutting/Systems Building	3. MCH populations are able to obtain, process, and understand basic health information needed to make health decisions.	<b>SPM 1</b> % of Title V grantees that develop and disseminate basic health information that is accurate and clearly understandable.	1. Beginning in the first year of the grant cycle, disseminate at least one simple and clear messages about basic health information.	BFH Internal reports	1. Review and evaluate available social media platforms that can be used for messaging of basic health information. 2. Explore the feasibility of using a text messaging or smart phone app outreach program to provide basic health information. 3. Establish requirements for grantees to review disseminated health information	
Cross-Cutting/Systems Building	2. Appropriate health and health related services, screenings and information are available to the MCH population.		1. By the end of the grant cycle, all Title V vendors will have developed a plan to identify and address health disparities in the population they serve.	BFH Internal reports	1. Inclusion of health disparities language in all BFH grant agreements.	
Cross-Cutting/Systems Building	8. Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.	<b>SPM 4</b> % of Title V staff who analyze and use data to steer program decision-making.	1. By December 2021, develop resources and tools to increase the utilization of 17P by eligible women.	BFH Internal reports	1. Conduct a pilot project to identify needs surrounding 17P referral and usage.	1.6 Percent of eligible women receiving 17P treatment compared to baseline data.
Cross-Cutting/Systems Building	8. Title V staff and grantees identify, collect and use relevant data to inform decision-making and evaluate population and programmatic needs.	<b>SPM 4</b> % of Title V staff who analyze and use data to steer program decision-making.	1. By 12/31 each year, the BFH will identify one strategy to improve data collection for BFH programs. 2. By 12/31 each year, the BFH will develop at least one actionable goal for each BFH program. 3. By 12/31 each year, the BFH will disseminate data from at least two programs.	BFH Internal reports	1.1 Review program activities and goals to determine programmatic needs. 2.1 Identify and utilize at least one staff resource to conduct analysis, interpret results, and develop actionable reports. 3.1 Develop program strategies based on actionable findings 4.1 Staff will use PA PRAMS and CDR findings to inform, develop, modify and evaluate public health programs and policies in Pennsylvania. 4.2 Staff will conduct analyses of childhood lead data to inform public health programs and policies.	ALL NPMS % of BFH staff who participated in the Introduction to Data Application and Interpretation in Public Health training.