Oklahoma State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Improve the health of reproductive age individuals	1a. As part of postpartum/interconception care, partner with home visitation programs (Healthy Start, Children First) to promote the importance of postpartum visits, well woman visits, and early prenatal care for future pregnancies. 1b. Continue disseminating the postpartum postcards encouraging new mothers to attend their postpartum visit and follow-up on any health issues. 2a. Participate in the Medicaid and CHIP Postpartum Affinity Group's quality improvement project with the Oklahoma Health Care Authority. 2b. Educate reproductive age males and females on being healthy before and between pregnancies through community baby showers, health fairs, March of Dimes walks, and public service announcements. 2c. Educate health care providers on the importance of preconception health education and screening through Oklahoma Perinatal Quality Improvement Collaborative activities, Maternal Mortality Review, and local prenatal care services in county health departments.	1. Increase the number of women returning for the postpartum visit from 88.0% in 2016-2019, 2021 to 96.0% in 2025. 2. Improve birth intention by increasing the usage of the most effective methods of contraception among women on Medicaid and at risk for unintended pregnancy from 16.7% in 2022 to 20.0% in 2025.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: The number of service sites and community partners utilizing the new preconception assessment tool developed by the Oklahoma State Department of Health and CoIIN team* ESM 1.2: Percentage of mothers with Medicaid paid deliveries who had coverage 60 days – 12 months postpartum.	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births

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					NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Increase quality health care access for the MCH population	Promote the importance of reproductive life planning through utilization of the preconception health client engagement tool and My Life. My Plan for adolescents. Disseminate the client engagement tool for reproductive health planning through the Maternal Health Task Force. Promote LARCs to prevent unintended pregnancies and closely spaced pregnancies in county health departments and Medicaid recipients. See activities to reduce teen pregnancy in the Adolescent Health Plan.	Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births from 27.5% in 2021 to 25.0% by 2025.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: The number of service sites and community partners utilizing the new preconception assessment tool developed by the Oklahoma State Department of Health and CoIIN team* ESM 1.2: Percentage of mothers with Medicaid paid deliveries who had coverage 60 days – 12 months postpartum.	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate

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					per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Improve the health of reproductive age individuals	Continue to facilitate the Maternal Mortality Review Board. As part of the Alliance for Innovation on Maternal Health (AIM) project, provide technical assistance for hospitals in developing policies for care of patients with postpartum hemorrhage, hypertension, and opioid use disorder to decrease morbidity and mortality. Provide simulation exercises to ensure all staff are familiar with policy and procedures for emergencies.	Reduce maternal mortality rate from 28.8 maternal deaths per 100,000 live births in 2016-2018 to 23.6 by 2025.	SPM 1: Maternal mortality rate per 100,000 live births		
Improve the mental and behavioral health of the MCH population	Provide education, training and information on the available and appropriate screening tools. Support the county health department social workers as they work on postpartum depression and other mood disorders in their counties.	Increase the percent of county health department sites appropriately utilizing the PHQ-9 tool for screening and the new codes for positive and negative screening from 61 sites in February 2020 to 90 sites by 2025.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: The number of service sites and community partners utilizing the new preconception assessment tool developed by the Oklahoma State*	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight

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				Department of Health and CoIIN team ESM 1.2: Percentage of mothers with Medicaid paid deliveries who had coverage 60 days – 12 months postpartum.	deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

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Increase health equity for the MCH population	Work with internal partners and outside community partners to identify individuals and families willing to share their experiences and stories about PMADs. Coordinate with Department of Communication within the State Health Department to create the PSAs and promote them utilizing appropriate media strategies and outlets.	Create culturally competent public service announcements (PSAs) and messages on maternal mental health that are representative of African-American, Native, and Latinx women and men impacted by Perinatal Mood and Anxiety Disorders (PMADs) by 2025.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	***Inactive -*** *ESM 1.1: The number of service sites and community partners utilizing the new preconception assessment tool developed by the Oklahoma State Department of Health and CoIIN team* ESM 1.2: Percentage of mothers with Medicaid paid deliveries who had coverage 60 days – 12 months postpartum.	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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					NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth
Perinatal/Infant Health					
Reduce infant mortality	1. Provide safe sleep training and technical assistance to birthing hospitals. 2. Provide training and technical assistance to home visiting programs, child care centers, and other community and health organizations that address the needs of newborns and infants. 3a. Assign a person from the Infant Safe Sleep Work Group to assist with social media projects. 3b. Develop partnerships to assist in finding families and individuals willing to share their experiences and stories about infant safe sleep and breastfeeding. 3c. Work with the Department of Communications on creating the PSAs and marketing them appropriately to social and traditional media sources.	1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 27 in 2019 to 35 in 2025. 2. Increase the number of trainings and community outreach activities by Infant Safe Sleep Work Group members for providers and professional organizations on infant safe sleep from 10 in 2020 to 20 in 2025. 3. Join with internal partners and outside community partners to create culturally competent public service announcements (PSAs) and messages that focus on integrating infant safe sleep and breastfeeding messages for each population with disproportionately high infant mortality rates by 2025.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	***Inactive -*** *ESM 5.1: The percentage of infants delivered at birthing hospitals participating in the sleep sack program* ESM 5.2: Percent of infants put to sleep on their back among Cribs Program participants.	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Increase health equity for the MCH population	1a. Provide safe sleep training and technical assistance to birthing hospitals with high numbers of African American and American Indian births. 1b. Target specific populations through outreach efforts, including, community baby showers, health fairs, family conference partners (OFN,	1. Increase the percent of American Indian and African American births in hospitals participating in the Safe Sleep Sack Program, from 73.3% in 2018 to 80.0% in 2025.	NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of	***Inactive -*** *ESM 5.1: The percentage of infants delivered at birthing hospitals participating in the sleep sack program*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births

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	DHS), and local schools to increase education on safe sleep practices and guidelines. 1c. Provide opportunities to train community leaders and educate non-traditional partners, including faith based organizations and non-profit organizations that help women and infants. 2a. Work with Cribs Project partners to identify and educate families of infants on culturally and racially specific safe sleep practices. 2b. Continue to evaluate the effectiveness of the crib project, by conducting a caregiver survey between one month and three months post distribution.	2. Increase the number of hospitals and other facilities serving American Indian and African American families participating in the Cribs Project, distributing pack-n-plays and safe sleep tools and education for families, from 5 in 2020 to 8 by 2025.	infants placed to sleep without soft objects or loose bedding	ESM 5.2: Percent of infants put to sleep on their back among Cribs Program participants.	NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Reduce infant mortality	1a. Coordinate with the WIC Breastfeeding Task Force to develop materials and participate in planning a variety of statewide breastfeeding trainings for WIC, county health department and independent agency staff, and statewide health care providers as they are scheduled. 1b. Provide support for the Oklahoma Breastfeeding Hotline, the Oklahoma Hospital Breastfeeding Education Project, and the Becoming Baby-Friendly in Oklahoma (BBFOK) Project to increase the number of women receiving IBCLC care. 1c. Provide support for the Oklahoma Mothers' Milk Bank (OMMB) efforts to provide safe, pasteurized milk donated by healthy, screened breastfeeding mothers to ensure that vulnerable babies can receive human milk to promote growth and development and help fight infections. 2. Work with partners to identify and share best practice resources and tools, develop comprehensive online trainings and create or make available materials appropriate for providers and families, to include best breastfeeding and safe sleep practices. 3a. Coordinate with partners to increase Oklahoma Breastfeeding Friendly Worksites, by reaching out to schools and child care centers via the Oklahoma Child Care Resource and Referral Association, Department of Education, and COBA. 3b. Coordinate with the OSDH Center for Chronic Disease and Health	1. Increase the percent of mothers who breastfeed their infants at hospital discharge from 80.4% in 2018 to 85.0% by 2025. 2. Increase the percent of mothers who exclusively breastfeed their infants through 6 months of age from 29.6% in 2016 to 35.0% by 2025. 3. Increase the number of Oklahoma Breastfeeding Friendly Worksites, including schools and child care centers, from 380 sites in 2022 to 400 sites in 2025.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	***Inactive -*** *ESM 4.1: The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs.* ESM 4.2: The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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	Promotion and Department of Education to develop the Breastfeeding section of the Employee Wellness Practice Brief promoting BFF Worksites and offer professional development in breastfeeding education for teachers and administrators. 3c. Coordinate with COBA to promote the activities in the strategic plan, including workplace law review and greater awareness of COBA's mission.				
Increase health equity for the MCH population	1a. Work with WIC to promote hiring ethnically diverse peer counselors. 1b. Coordinate with the BBFOK Project to include at least one session focused on Reducing Racial and Ethnic Inequities in Breastfeeding in the yearly BBFOK Summit for hospital leadership teams. 1c. Support COBA's efforts to promote breastfeeding among African American mothers and families through building partnerships with ethnically diverse organizations, such as Black Nurses Associations. 1d. Target outreach to communities with low breastfeeding rates through community baby showers, health fairs, family partners, and local schools to increase education on breastfeeding guidelines and practices. 1e. Increase the number of mothers with WIC who are exposed to at least seven of the Ten Steps to Successful Breastfeeding.	1. Increase the percent of American Indian and Black mothers who exclusively breastfeed their infant to 8 weeks or more from 46.4% and 45.9% in 2016-2018 to 50.5% and 51.1% by 2025.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	***Inactive -*** *ESM 4.1: The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs.* ESM 4.2: The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
Improve access to social workers and support systems throughout the state	Share guidelines for supporting breastfeeding families in emergency situations with food pantries, professionals, and families.	Develop information and guidelines for food pantries, shelters, regarding supporting breastfeeding in emergency situations.	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	***Inactive -*** *ESM 4.1: The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs.* ESM 4.2: The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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Increase quality health care access for the MCH population	Continue to provide funding and technical assistance to Screening and Special Services for screening and follow-up services statewide. Collaborate with Screening and Special Services to offer multi-vitamins to family planning clients to increase folic acid consumption before and between pregnancies.	Screen 100% of newborns in Oklahoma and maintain timely follow-up to definitive diagnosis and clinical management for infants with positive screens.	SPM 2: Infant mortality rate per 1,000 live births		
Increase quality health care access for the MCH population	1a. Work with OPQIC to determine barriers to women accessing early prenatal care (physician preference, lack of access either geographically or lack of provider, insurance coverage, etc.). 1b. Add new partnerships through the State Maternal Health Innovation Grant to expand access to early and adequate prenatal care. 2. Promote the toolkit for providers regarding opioid use and treatment during pregnancy and postpartum.	1. Increase the number of women who receive prenatal care in the first trimester of pregnancy from 70.4% in 2018 to 77.9% by 2025. 2. Reduce prevalence of substance-exposed newborns from 6.2 per 1,000 in 2016 to 5.0 in 2025.	SPM 2: Infant mortality rate per 1,000 live births		
Reduce infant mortality	1a. Contact delivering hospitals to increase participation in the PURPLE curriculum. 1b. Provide training via webinars and ongoing support as needed to participating hospitals, including promotion of the new PURPLE app and data collection to assist in education efforts for abusive head trauma prevention, soothing, breastfeeding and safe sleep. 1c. Assist a minimum of two community educators who work with grandparent groups to pilot the Grandparent Toolkit for Infant Care and Safety. 2a. Continue to utilize the MCH staff member who is a certified CPS technician to assist Injury Prevention Services and Safe Kids Oklahoma with car seat checkup events and education throughout the year. In addition, county health department certified CPS staff will support families with car seats and installation and education. 2b. Provide support and technical assistance to families and caregivers with car seat questions and concerns.	1. Increase the number of delivering hospitals participating in the Period of PURPLE Crying Abusive Head Trauma curriculum from 40 in 2020 to 42 by 2023. 2. Reduce the rate of fatal motor vehicle injuries in children ages 0 to 5 from 3.2 per 100,000 in 2018 to 2.9 by 2024.	SPM 2: Infant mortality rate per 1,000 live births		
Increase health equity for the MCH	1a. Review data on key contributors to infant mortality to determine what changes, if any, are necessary to work groups and programs to further address the high infant mortality rate in the state.	1. Revise the Preparing for a Lifetime annual report and one-pager on the initiative to educate	SPM 2: Infant mortality rate per 1,000 live births		

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population	1b. Engage workgroups and stakeholders on contributions to the annual report and community education. 2a. Determine if there are emerging issues that need to be addressed by the initiative, including health equity and disparities. 2b. Collaborate with the marketing team to develop messages on emerging issues and disperse them among social media, television, streaming applications, and radio. 3a. Complete train-the-trainer program facilitator and participant guides and have reviewed by work group leaders and professional researchers for efficacy. 3b. Train at least 10 professionals to deliver the training to their organizations. 3c. Develop a tracking system to record the number of professionals and community liaisons trained on health disparities, implicit bias, and birth equity. 4a. Implement a media campaign to educate families and providers on the benefits of aspirin therapy to help prevent pre-eclampsia, which potentially impacts prematurity and maternal morbidity and mortality rates. [New] 4b. Create a toolkit for aspirin therapy awareness, with information for both families and providers. [New] 4c. Create an evaluation plan for the aspirin therapy campaign with the Oklahoma Health Care Authority, to better understand the impact on low-income women in the state. [New]	the community and policymakers on topics impacting infant health by December 2024. 2. Develop and implement two new marketing campaigns focused on diversity and equity in addressing infant health, including mortality and morbidity, by December 2024. 3. Develop and implement a train-the-trainer program to educate 50 professionals and community liaisons on health disparities, implicit bias, and birth equity impacting infant health by December 2024. 4. Implement a statewide aspirin therapy campaign, based on emerging evidence, for pregnant women and obstetric health care providers by December 2024. [New]			
Child Health					
Improve quality health education for children and	1. Continue to provide funding and contract monitoring for the the Oklahoma Center for Poison and Drug Information to provide presentations, educational materials on poisoning prevention and the hotline for possible poisoning incidents, as well as staffing for call response.	1. Via the Oklahoma Center for Poison and Drug Information provide poisoning and toxin prevention education presentations	NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes	***Inactive -*** *ESM 8.1.1: Number of schools participating in an activity (training,*	NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

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youth	2. Continue to participate in advisory boards, committees and partnerships such as the Oklahoma DHS Child Care Advisory Committee, the Oklahoma State Obesity Planning Team, Safe Kids Oklahoma, Sunbeam, the Oklahoma Partnership for School Readiness (OPSR), and the Oklahoma Tribal Child Care Association to promote best practices in early childhood care and education. 3. Print and distribute the revised version of the Good Health Handbook to all licensed child care programs, elementary schools, and county health departments. Offer training on utilizing the Good Health Handbook. 4a. Continue to provide funding and contract monitoring for the Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD) for the provision of social emotional learning, skills-based health education, nutrition education, and bullying prevention. 4b. Establish partnerships with tribal organizations and with county health departments to collaborate on professional development activities and service provision for evidence-based health education activities in their jurisdictions. 5a. Assist the Oklahoma State Department of Education and partners, as requested, as they begin planning for the new health education mandate for Oklahoma public schools to begin in 2023-2024. 5b. Identify community partners that can assist in providing evidence-based health education and training for staff in their local schools. 6a. Continue to fund the rural school health nurses to provide evidence-based health education and services in their school districts and the PHOG unit's Child Health APRN positions. 6b. Create and distribute school nurse resources, promote the use of the School-based Health Center Toolkit, and provide technical assistance to school nurses and other school staff. [Revised] 6c. Plan and host an Annual School Nurse Summit. Assist in Planning the	at least 4 times per month, presenting to 24,000 students and community members across the state annually. [Revised] 2. Provide staff support, expertise, and consultation by participating in and attending 75% of the meetings of the DHS Child Care Advisory Committee, the State Obesity Planning Team, Safe Kids Oklahoma, Sunbeam Health Advisory Committee, Head Start Collaboration Advisory Committee, and the Oklahoma Tribal Child Care Association. [Revised] 3. Distribute and promote the revised version of the Good Health Handbook by 2024, including training on utilization. [Revised] 4. Serve at least 58,000 students statewide Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD) by 2024. 5. Identify areas in need of evidence-based health education and develop three lessons for OSDH Health Educators in the state by 2025. [Revised] 6. Increase the number of Public Health On the Go mobile units partnering with MCH-funded school nurses to develop school-based child health clinics from 2 to	per day	*professional development, policy development, technical assistance) to improve physical activity among children ages 6-17.* ESM 8.1.2: Percent of teachers who reported the lessons related to physical activity had a positive (high or medium), long-term impact on their students.	NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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	PATH forward Annual Conference in partnership with OSDE. Work with the OSDE School Nurse Coordinator to provide monthly trainings to school nurses. [Revised] 7. Facilitate in-person and virtual trainings in partnership with school nurses and OSDE.	6 by 2025. [New] 7. Provide at least 12 presentations annually for school nurses and staff on diabetes management in school, vision screening, medication administration, and school-based health clinics. [Revised]			
Increase health equity for the MCH population	1. Provide training on trauma-informed care and ACES to contractors or find acceptable online alternatives. 2a. Work with county staff to foster clinic practices and materials, including ways to increase client base and successfully promote clinics in underserved areas. 2b. Host a minimum of quarterly Pediatric Review sessions, hands-on training for clinical staff, or Question and Answer sessions, to share best practices and provide opportunities for networking and instruction from the MCH Medical Director. [Revised]	1. Identify areas in need and develop Adverse Childhood Experience (ACES) and Protective And Compensatory Experiences (PACES) training for school staff, OSDH contractors, and OSDH health educators in the schools providing a minimum of 2 presentations by 2025. [New] 2. Strengthen Child Health Clinics in pilot County Health Department Clinics for mobile and traditional settings by 2025. [Revised]	NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	***Inactive -*** *ESM 8.1.1: Number of schools participating in an activity (training, professional development, policy development, technical assistance) to improve physical activity among children ages 6-17.* ESM 8.1.2: Percent of teachers who reported the lessons related to physical activity had a positive (high or medium), long-term impact on their students.	NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
Adolescent Health					
Improve the mental and behavioral health of the MCH population	1a. Provide training and TA to county health departments and other youth-serving organizations in evidence-based methods following appropriate best practices. 1b. Refer MCH-funded staff to suicide prevention and positive youth development trainings, as appropriate, annually.	1. Increase the number of annual trainings provided by MCH-funded staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with or care for adolescents from 1 in 2020 to 10 by 2026.	NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	***Inactive -*** *ESM 9.1: The number of trainings provided to school and community staff on bullying prevention*	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000

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	2a. Identify and work with existing youth groups in the Oklahoma Healthy YOUth coverage areas on adolescent health activities to build a Public Health Youth Council infrastructure. 2b. Strengthen the MCH Youth Consultant project in partnership with the Oklahoma Family Network, and recruit at least two youth annually to provide input regarding adolescent health issues to MCH, CSHCN, and other programs within and outside of OSDH. 2c. Provide TA and materials to Adolescent Health Specialists (AHS) on suicide prevention, bullying, positive youth development, and other adolescent health topics. 2d. In partnership with youth, design a toolkit for 2024 National Adolescent Health Month. 3a. Strengthen partnerships and work with the Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma State Department of Education to provide training to parents and community members to understand the pervasiveness and the damaging effects of bullying, learn the signs of bullying and how to help schools and communities implement effective strategies to prevent the continuation of bullying in the community. 3b. Develop a manual and train county health department health educators in social emotional learning to assist in training school staff and communities on this issue. 3c. Recruit the two school districts for the Olweus bullying prevention program and begin implementation.	2. Conduct youth-informed public health activities with youth across the state regarding adolescent health issues, including teen pregnancy prevention, suicide prevention and bullying by 2024. 3. Work with county health departments, Oklahoma State Department of Education, and local school districts to provide Olweus training and technical assistance with at least two school districts by May 2025.		ESM 9.2: Percent of SEL tools indicating a decrease in challenging behaviors among students who were given SEL presentations. ESM 9.3: Percent of teachers who reported that lessons related to topics on bullying prevention had a positive (high or medium) impact on their students.	
Improve quality health education for children and youth	1a. Maintain the number of adolescents participating in state-funded evidence-based teen pregnancy prevention programs by supporting the Adolescent Health Specialists in the counties. 1b. Maintain the current number of adolescents participating in the Personal Responsibility Education Program (PREP). 1c. Establish or leverage existing networks of administrators, principals,	1. Increase by 5% annually the number of adolescents participating in state or federally funded evidence-based teen pregnancy prevention programs (Baseline: 4,856 adolescents for the 2019-2020 school year).	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	***Inactive -*** *ESM 10.1: The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum*	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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	teachers, school nurses, health educators, adolescent health specialists, community leaders, and parents who are advocates for evidence-based education. 1d. Coordinate and/or provide training on evidence-based curricula for new PREP and state-funded teen pregnancy prevention staff and interested partners annually or as needed. 2. Work with local healthcare providers and agencies to review and adapt (as needed) any existing materials related to expectant and parenting youth. [Revised] 3a. Collaborate with state and community partners on teen pregnancy prevention and sexual violence prevention activities. 3b. Monitor fidelity logs for documentation of consent education provided before, during, or after implementation of evidence-based teen pregnancy prevention curricula, as required by law. 4a. Identify areas of highest need based on most current data available. 4b. Partner with county health department regional directors in the areas of highest need to begin targeted prevention efforts. 4c. Establish partnerships with tribal organizations and collaborate on professional development activities and service provision to adolescents in their jurisdictions. 5a. Evaluate the planning and implementation process for the 2023 Adolescent Health Summit based on participant and planning group feedback. [New] 5b. Convene a committee to assist in planning and implementation of the 2025 Summit. [New]	2. Work with local agencies and healthcare professionals to deliver training on how to provide youth-friendly, high-quality services to expectant and parenting teens by 2026. 3. Consent education will be provided at least once to all participants in the evidence-based teen pregnancy prevention curricula classes, and to at least 14 schools as a stand-alone presentation by December 2024. 4. Expand coverage of state or federally funded, age-appropriate, evidence-based teen pregnancy prevention projects in rural counties with teen birth rates higher than the national average from 46 in 2022 to 74 by 2024. 5. Plan and host the 3rd biennial Adolescent Health Summit to provide education and resources for youth-serving professionals and parents/caregivers of youth by 2025. [Revised]		ESM 10.2: Percent of students participating in the PREP and Healthy Youth programs who reported they were more likely to better understand what makes a relationship healthy.	NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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					NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Increase quality health care access for the MCH population	1a. Add information to the MCH webpage and provide social media content on the importance of transition to adulthood, and how to prepare as a parent and a healthcare provider. 1b. Establish a relationship with OCHA to provide relevant transition information for provider newsletter, social media pages, and create meaningful transition training for providers. 2a. Work in partnership with Sooner SUCCESS, Oklahoma Family Network (OFN), and other agencies to determine the needs for transition education for all youth and families, irrespective of health condition, and build on the existing toolkit to create a Guidelines document for all youth. [Revised] 2b.Incorporate transition information into presentations, activities of Adolescent Health Specialists and Adolescent Health staff.	1. Collaborate with the Oklahoma Health Care Authority to provide transition information and at least 1 training to their provider network by 2025. [Revised] 2. Develop, in partnership with Sooner SUCCESS, Oklahoma Family Network (OFN), and other agencies, an Adolescent Guide for Transitioning to an Adult Health Care Model and a related presentation for schools, community partners, and local medical providers on adolescent transition to adult health care for all youth by 2025. [Revised]	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	***Inactive -*** *ESM 12.1: The number of providers who address transition to adult health care in their practice* ESM 12.2: Percent of families participating in the Sooner SUCCESS program who report having a plan for their child's transition to adult healthcare. ESM 12.3: Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to transition to adult healthcare.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Increase health equity for the MCH population	Evaluate existing trainings based on evidence-base, ability to be online or in-person, content, and affordability and select those most appropriate for staff working with youth. Create trainings, if needed, for staff in the counties to use with their educators, nursing staff, and school-based personnel to strive for more	Increase the number of annual health equity, trauma-informed practices, and inclusivity trainings provided by MCH-funded staff from 1 in 2021 to 3 by 2025.	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	***Inactive -*** *ESM 10.1: The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development*	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15

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	equitable and inclusive programming and services. Provide trainings to MCH staff, contractors, and project staff working with youth via PREP/TPP semi-annual meetings, MCH general staff meetings, etc.			*curriculum* ESM 10.2: Percent of students participating in the PREP and Healthy Youth programs who reported they were more likely to better understand what makes a relationship healthy.	through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have

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					received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
Children with Special Health Care Needs					
Improve access to family-centered programs via family support navigators	1a. Promote research-based health care transition resources on the Sooner SUCCESS website and social media platforms. [New] 1b. Continue to address ongoing feedback from families and providers by creating a HCT Provider Directory, flyers and other resources specific to Oklahoma. [New] 2. Continue quarterly HCT committee of Title V partners, providers, and families of CYSHCN to improve ongoing efforts related to health care transition. 3. Provide families of CYSHCN with information and support to access and navigate ongoing, culturally effective, community-based, coordinated, comprehensive care which includes health care transition. 4a. Identify primary care physicians, specialty providers, interns and students at health care institutions throughout Oklahoma to help them establish health care transition goals both for the institution and their patient population. 4b. Continue to assist primary care and specialty providers at a major state health care institution in establishing health care transition goals both for the institution and their specific patient population, in accordance with the six core elements of health care transition. [New] 4c. Disseminate information to families and providers in both urban and	1. Maintain the Healthcare Transition Toolkit by continuing to update specific resources for families and providers by 2025. 2. Increase the number of families who are aware of the need for transition services from 37% in 2019-2020 to 40% in 2025. 3. Increase number of families of CYSHCN who report receiving transition services from 21.8% in 2017-2018 to 24.4% in 2025. 4. Continue to expand the ongoing initiative between Sooner SUCCESS and selected clinics at OUHSC, as well as other urban and rural clinics across the state, to establish a formal health care transition policy by 2025. 5. Complete a minimum of two provider trainings on Healthcare Transition by 2023.	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	***Inactive -*** *ESM 12.1: The number of providers who address transition to adult health care in their practice* ESM 12.2: Percent of families participating in the Sooner SUCCESS program who report having a plan for their child's transition to adult healthcare. ESM 12.3: Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to transition to adult healthcare.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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	rural clinics across the state on health care transition. 5a. Determine requirements needed to provide CMEs in order to encourage provider trainings. 5b. Develop provider training that meets CME requirements.				
Increase health equity for the MCH population	Identify individuals, families and agencies to help develop a plan to address health disparities for CYSHCN. Identify resources within the state that have data regarding health disparities for CYSHCN, including the Oklahoma Health Care Authority.	Develop a plan to increase healthcare transition awareness among the CYSHCN population, to include addressing health disparities for CYSHCN, by 2025.	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	***Inactive -*** *ESM 12.1: The number of providers who address transition to adult health care in their practice* ESM 12.2: Percent of families participating in the Sooner SUCCESS program who report having a plan for their child's transition to adult healthcare. ESM 12.3: Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to transition to adult healthcare.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
Increase quality health care access for the MCH population	1a. Provide trainings to families of CYSHCN, served through CSHCN contract providers, including health care notebook training, parent-professional partnership training, advocacy/leadership training, one-on-one supports and services. 1b. Work with contractors to create a pre-discharge hospital questionnaire for new parents to determine their baseline knowledge regarding medical home.	1. Increase the percent of children with special health care needs, ages 0 through 17, who have a medical home from 39.7% in 2018 to 42.5% in 2025. 2. Continue to improve care integration and cross-provider	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	***Inactive -*** *ESM 11.1: Number of CYSHCN who received care coordination services from Title V CSHCN contract providers in the past year.*	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a

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	1c. Develop family-centered educational materials for parents regarding a medical home for use across programs. 2a. Distribute current outreach material to pediatricians. [New] 2b. Establish a survey for pediatricians around the state, including rural providers and family providers, to determine knowledge deficits regarding the care of their patients who have discharged from hospital NICUs. [New] 2c. Revise outreach materials for pediatricians who are caring for discharged patients from hospital NICUs to incorporate feedback from the survey. [New] 3a. Define the type of patient that would be a candidate for a NICU follow-up telemedicine visit. [New] 3b. Develop parent information regarding telemedicine usage. [New] 3c. Create a system where discharging neonatologists can utilize the established Zoom platform to provide a handoff for complex patients to the child's pediatrician. [New]	communication for healthcare providers using evidence-based tools by 2025. 3. Educate health care providers on the use and benefits of telemedicine and how to implement strategies to increase usage, including billing, by 2025. [New]		ESM 11.2: Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to the topic of medical home. ESM 11.3: Percent of families receiving information or services by the Oklahoma Family Network who report they will use information acquired to help their child/family receive appropriate care.	mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Improve the mental and behavioral health of the MCH population	Collaborate with all Title V CSHCN partners to connect families with behavioral and mental health services. Educate at least 25 families of CYSHCN with behavioral and mental health needs by providing leadership and partnerships skills to ensure a family voice at all levels of their decision making process. Support families through a Title V CSHCN partner, OITP, to provide neurodevelopmental and psycho-social assessments and referrals connecting families with behavioral and infant mental health services. Provide support, through a Title V CSHCN partnership with the JD McCarty Center, for families to utilize respite services while accessing opportunities for behavioral and mental health assistance.	Increase the number of children who receive behavioral and mental health services from 6.7% among children with Autism/ASD and ADD/ADHD disorders in 2017 to 7.8% by 2025.	SPM 3: The percent of families who are able to access services for their child with behavioral health needs		

Cross-Cutting/Systems Building

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Improve access to social workers and support systems throughout the state	1a. Partner with local county health departments to create and implement an initiative using evidence-based curriculum to increase fathers' knowledge on the importance of engagement with their children, the importance of their unique role, and how to work effectively with their co-parent. 1b. Utilize reporting from counties in the project to inform the design and implementation of the expansion of the fatherhood project. 2a. Finish assembling the topical area presentations and resource lists, based on identified needs from the grandparent survey. [New] 2b. Work with Communications to promote and finalize the presentations and handouts. [New] 2c. Connect with and solicit feedback from the grandparent population on the completed Grandparent Toolkit. [New]	1. Implement a fatherhood initiative project in at least three new counties by 2024. 2. Complete and promote the Grandparent Toolkit for use in community settings, to assist grandparents supporting their grandchildren with information and resources on a variety of topics by December 2025. [New]			