

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
<p>Help reduce the risk and impacts of chronic disease in the MCH population.</p>	<p>1. Increase the use of the Postpartum Plan by Title V partners, by hosting 2 trainings on the tool and its utility by December 2027.</p> <p>2. Meet with OHCA staff and MCOs to determine how to document and define the extended postpartum benefit uptake among OK mothers by January 2027.</p>	<p>1a. Develop trainings for Pregnancy Resource Navigators, Community Health workers, Maternity Clinic staff and community partners.</p> <p>1b. Develop tracking system for reach of Plan to monitor use and printing needs.</p> <p>2a. Schedule a series of meetings to discuss claims data utilization on the extended postpartum benefits to understand better what families are able to access.</p> <p>2b. Promote the extended benefits at meetings, conferences, health fairs, etc.</p>	<p>ESM PPV.1 - Create the postpartum plan training for the County Health maternity providers</p>	<p>NPM - Postpartum Visit</p>	<p>Linked NOMs: Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety</p>
Perinatal/Infant Health					
<p>Expand access to resources and educational opportunities for parents and families.</p>	<p>1. Maintain the number of hospitals participating in the Safe Sleep Sack Program at 28 for FFY 2026.</p> <p>2. Maintain 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, at 8 for FFY 2026.</p>	<p>1. Provide safe sleep training and technical assistance to birthing hospitals.</p> <p>2a. Continue partnership with OHCA to fund and distribute the cribs and materials.</p> <p>2b. Work with the Department of Communications on creating the PSAs and marketing materials for safe sleep education.</p>	<p>ESM SS.1 - Percent of infants put to sleep on their back among Cribs Program participants.</p>	<p>NPM - Safe Sleep</p>	<p>Linked NOMs: Infant Mortality Postneonatal Mortality SUID Mortality</p>
<p>Reduce differences in health outcomes for</p>	<p>1. Revise the Preparing for a Lifetime Infant Mortality Reduction initiative to educate the community and policymakers on topics</p>	<p>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.</p>	<p>No ESMs were created by the State. ESMs are optional for this measure.</p>	<p>SPM 1: Ratio of differences in the infant mortality rate</p>	<p>Linked NOMs: Infant Mortality</p>

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the MCH population.	<p>impacting infant health by December 2026.</p> <p>2. Screen 100% of newborns in Oklahoma and maintain timely follow-up to definitive diagnosis and clinical management for infants with positive screens.</p>	<p>1b. Determine if there are emerging issues that need to be addressed by the initiative, including health disparities.</p> <p>1c. Engage workgroups and stakeholders on needed changes and community education.</p> <p>2a. Provide funding and staff support for the Oklahoma Birth Defects Registry and Lead Poisoning Prevention Program.</p> <p>2b. Assist with the distribution of folic acid to women in Family Planning Clinics.</p>			
Expand access to resources and educational opportunities for parents and families.	<p>1. Establish a comprehensive breastfeeding telehealth service by 2026, providing prenatal and postpartum education and clinical care to participants of the county health department.</p> <p>2. Increase the number of Baby-Friendly designated hospitals by at least five additional hospitals by 2030, thereby enhancing breastfeeding support and improving maternal-infant health outcomes statewide.</p> <p>3. Maintain the number of delivering hospitals participating in the Period of PURPLE Crying Abusive Head Trauma curriculum at 38 in 2026.</p>	<p>1a. Integrate telehealth services delivered by International Board Certified Lactation Consultants (IBCLCs) into existing programs to provide seamless support for families.</p> <p>1b. Establish clear pathways for referring clients to telehealth to ensure timely and appropriate care.</p> <p>1c. Leverage existing networks and foster new collaboration.</p> <p>2a. Maintain current contracts and enhance community partnerships.</p> <p>2b. Continue to enhance reimbursement structures to alleviate financial barriers for hospitals seeking Baby-Friendly designation.</p> <p>3. Provide training via webinars and ongoing support as needed to participating hospitals, including promotion of the PURPLE app and data collection to assist in education efforts for abusive head trauma prevention, soothing, breastfeeding and safe sleep.</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Ratio of differences in the infant mortality rate	<u>Linked NOMs:</u> Infant Mortality
Child Health					
Help reduce the risk and impacts of chronic disease in the	Increase to 90% the number of students who are screened for food insufficiency by Title V contracted school nurses by December 2028.	<p>Identify a tool for school nurses to use to screen students for food insecurities during health office visits.</p> <p>Work with the schools and community partners for resources for referrals for students who screen positive for food insufficiency.</p>	ESM FS.1 - Create a tool to determine the percent of students who presented to the school nurse who	NPM - Food Sufficiency	<u>Linked NOMs:</u> School Readiness Children's Health Status Behavioral/Conduct Disorders Flourishing - Young Child

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MCH population.		Staff will work to create and disseminate education and resources as requested.	were screened and referred for food insufficiency		Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All Adverse Childhood Experiences
Reduce differences in health outcomes for the MCH population.	Create two funded partnerships with rural Family Resource Centers to address local food insufficiency in areas of high need by September 2026.	Identify partners to work on a new or expanded food sufficiency project for children 0-12. Begin collecting data on efforts to determine additional funding or capacity needs. Enhance the effectiveness of nutrition education and outreach by collaborating with the Family Resource Centers to provide continuity of resources and outreach by developing relevant nutrition education, recipes, and educational platforms.	ESM FS.1 - Create a tool to determine the percent of students who presented to the school nurse who were screened and referred for food insufficiency	NPM - Food Sufficiency	Linked NOMs: School Readiness Children's Health Status Behavioral/Conduct Disorders Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All Adverse Childhood Experiences
Improve quality health care access for the MCH population.	Strengthen Child Health Clinics in County Health Department Clinics for mobile and traditional settings by 2030.	Work with county staff to foster clinic practices and materials, including ways to increase client base and successfully promote clinics in underserved areas. 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. Continue to assess food insecurities during APRN Child Health visits and make appropriate referrals, ensuring timely support for families in need.	ESM MH.1 - Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to the topic of medical home. ESM MH.2 - 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.	NPM - Medical Home	Linked NOMs: Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Improve quality health care access for the MCH	1. Strengthen school-based health capacity through targeted education and support annually through 2030.	1a. Maintain and update all training materials, guidelines, manuals, policies, and procedures, to align with the current best practices and statutory requirements.	ESM MH.1 - Percent of family caregivers and professionals who report an increase in	NPM - Medical Home	Linked NOMs: Children's Health Status CSHCN Systems of Care Flourishing - Young Child

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population.	2. Fund the expansion of access to school-based telehealth for rural and underserved school districts via the Southwestern Oklahoma State University's School-Based Health Centers (SBHCs), from 6 to 25 districts by 2030.	<p>1b. Provide at least 12 presentations annually for school nurses, school staff on diabetes management in school, vision screening provider training, vision screening trainer of providers, medication administration, food insecurities, and school-based health clinic best practices.</p> <p>1c. Provide ongoing technical assistance to school personnel and community partners, developing additional training modules in response to emerging needs or policy changes.</p> <p>2a. Contract with Southwestern Oklahoma State University to establish a Registered Nurse position to assist in educating school nurses and other school staff on the telehealth equipment and needs for the practitioner.</p> <p>2b. Assist in training and data collection efforts to assure monitoring of student health outcomes, reducing barriers to care, and enhancing academic performance through integrated, community-focused healthcare delivery.</p>	knowledge after receiving training related to the topic of medical home. ESM MH.2 - 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.		Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Expand access to resources and educational opportunities for parents and families.	Create and provide a resource list for food security support of Oklahoma families to adolescent health specialists and community partners to be shared as needed by 2027.	<p>Have the Adolescent Health Coordinator work with the FSPS Nutritionist to create a food support resource list for areas where adolescent health specialists and contracted community partners serve.</p> <p>Share the resource list and train adolescent health specialists and community partners on food insufficiency and how it relates to adolescent health and well-being.</p> <p>Offer training opportunities and develop educational materials on Energy Drink Consumption among Teens.</p>	ESM FS.1 - Create a tool to determine the percent of students who presented to the school nurse who were screened and referred for food insufficiency	NPM - Food Sufficiency	Linked NOMs: School Readiness Children's Health Status Behavioral/Conduct Disorders Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All Adverse Childhood Experiences
Help reduce the risk and impacts of chronic disease in the MCH population.	<p>1. Serve at least 68,000 students statewide through Healthy Schools OK, It's All About Kids (THD), and Health at School (OCCHD) by 2026.</p> <p>2. By 2030, 80% of children ages 6-11 will participate in physical activity for at least 60 minutes a day within the Title V-funded school health programs.</p>	<p>1. 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 physical activity, social emotional learning, skills-based health education, nutrition education, and bullying prevention.</p> <p>2a. Students will take a pretest and post-test over their knowledge of physical activity and attend weekly lessons from MCH contractors on physical activity.</p> <p>2b. Funding assistance will continue for Action-Based Learning programs to incorporate physical activity in everyday learning.</p>	ESM PA-Child.1 - Percent of students who agreed with the statement "I will get at least 60 minutes physical activity everyday" on the post assessment survey.	NPM - Physical Activity - Child	Linked NOMs: Children's Health Status Child Obesity

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		2c. 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.			
Adolescent Health					
Strengthen supports and needed training for child care and youth-serving providers.	<p>1. Collaborate with the Oklahoma Health Care Authority to provide transition information and at least 1 training to their provider network by 2026.</p> <p>2. Develop, in partnership with Sooner SUCCESS, the Oklahoma Family Network (OFN), and other agencies, an Adolescent Guide for Transitioning to an Adult Health Care Model, along with a related presentation for schools, community partners, and local medical providers, to support the transition of all youth to adult health care by 2026.</p>	<p>1. Establish connections with Medicaid Managed Care Organizations.</p> <p>2. Meet with the identified partner and determine existing resources, cross-sections, and what materials need to be created to develop the Guide.</p>	<p>ESM TAHC.1 - Percent of families participating in the Sooner SUCCESS program who report having a plan for their child's transition to adult healthcare.</p> <p>ESM TAHC.2 - Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to transition to adult healthcare.</p>	NPM - Transition To Adult Health Care	Linked NOMs: CSHCN Systems of Care
Expand access to resources and educational opportunities for parents and families.	Provide at least two trainings on being a trusted adult for youth-serving providers by 2026.	<p>Provide training and technical assistance to adolescent health specialists and community partners.</p> <p>Strengthen the Title V MCH Youth Consultant project at county levels through adolescent health specialists and recruit at least two youth annually to provide input regarding adolescent health issues.</p> <p>Begin work on the 2027 Adolescent Health Summit, including the youth perspective, and invite youth-serving providers.</p> <p>Provide trainings through county Adolescent Health Specialists on communicating relationship values to youth.</p>	ESM ADM.1 - Percent of students participating in the PREP & OHY program who reported they were more likely to talk to a trusted person/adult.	NPM - Adult Mentor	Linked NOMs: Adolescent Depression/Anxiety Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Improve the mental and	Through adolescent health specialists and community	Continue to provide funding and contract monitoring for Adolescent Health Specialists, Tulsa Health Department, and Oklahoma City County Health	ESM ADM.1 - Percent of students	NPM - Adult Mentor	Linked NOMs: Adolescent Depression/Anxiety

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behavioral health of the MCH population.	partners provide prevention education to 5,000 Oklahoma youth per year between by 2026.	Department for the provision of social emotional learning, parent-child communication, healthy relationships and bullying prevention. Continue to provide technical assistance for contractors and partners as needed.	participating in the PREP & OHY program who reported they were more likely to talk to a trusted person/adult.		Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

Children with Special Health Care Needs

<p>Improve quality health care access for the MCH population.</p>	<p>1. Streamline coverage, application, and referral processes to increase the total of children served through Sooner SUCCESS’s Professional Services, Adaptive Equipment, and Supplemental Nutrition programs by at least 10% each year through September 2030.</p> <p>2. Increase the number of infant transition patients who have a medical home by 20% by September 2030.</p> <p>3. Offer a minimum of eight bilingual trainings annually, covering key topics such as Health Care Transition (HCT), Care Notebook training, Applied Behavioral Therapy (ABA) techniques for caregivers, as well as information on local services and programs.</p> <p>4. Establish at least two partnerships with healthcare providers at Children’s Hospital to provide TEFRA and Sooner Care resources for patients hospitalized</p>	<p>1a. Complete presentations and provide handouts at trainings and community events to increase awareness of available programs.</p> <p>1b. Evaluate current supplemental nutrition ordering limits through cost analysis and review of existing data.</p> <p>1c. Adjust current ordering limits and procedures to expand services to at least 10 new recipients each year, including recipients from counties not previously served.</p> <p>2a. Establish baseline of current patients and current patients with a medical home through data collection efforts including questionnaires, electronic health records, follow up appointments, etc.</p> <p>2b. Assess all patients and assist to assure they have set up services with a medical home in their demographic area.</p> <p>2c. Develop a plan to provide a medical home “hotline” for patients to be able to contact & communicate any questions and concerns with a neonatal specialist.</p> <p>3a. Identify and reach eligible children from underserved populations.</p> <p>3b. Provide one-on-one individual support and care coordination to at least 36 new CYSHCN and their families from the underserved populations.</p> <p>3c. Provide translation and interpretation services to ensure families can access programs and services that support their health and enhance the quality of care.</p>	<p>ESM MH.1 - Percent of family caregivers and professionals who report an increase in knowledge after receiving training related to the topic of medical home. ESM MH.2 - 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.</p>	<p>NPM - Medical Home</p>	<p><u>Linked NOMs:</u> Children’s Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All</p>
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	<p>in the Complex Medical Needs Unit by September 2026.</p> <p>5. Create a database of families participating in JumpStart that allows tracking of phone call attempts at the 1-month mark after JumpStart visits as well as any additional points of contact made to support service navigation or other family assistance by September 2026.</p> <p>6. Complete at least 15 trainings annually to enhance the quality, accessibility, and coordination of medical home services and provide resources for CUSHCN through September 2030.</p>	<p>4a. Strengthen collaboration with TEFRA eligibility teams, specifically to be able to refer families to access a comprehensive psychological evaluation.</p> <p>4b. Refer families utilizing the secured online referral link to the Family Partner.</p> <p>4c. Schedule psychological evaluations at the appropriate site based families' location and availability.</p> <p>5. Provide direct referral support and assistance to all patients/families accessing JumpStart services on the date of service.</p> <p>6a. Conduct trainings to promote partnerships between families and providers via OFN.</p> <p>6b. Provide resources on medical/diagnosis information, family supports, organizing medical information, community resources, family and professional partnerships, sharing your story in addition to other training provided by OFN or partners.</p> <p>6c. Provide training and resources via OFN on care coordination, patient flow and communication, value-based care and preventative care, including resources on telemedicine.</p>			
Expand access to resources and educational opportunities for parents and families.	<p>1. Increase the number of families and providers who are aware of the need for transition services by establishing at least two new partnerships with healthcare providers in rural counties and conducting at least four transition clinics annually until September 2030.</p> <p>2. Complete at least five healthcare transition trainings by 2030 to enhance knowledge, improve service delivery, and health outcomes for adolescents and</p>	<p>1a. Provide healthcare transition resources to transition-age children in rural areas.</p> <p>1b. Create a survey to provide to youth who have received healthcare transition resources to assess the effectiveness of the resources provided.</p> <p>1c. Conduct quarterly combined adult/pediatric transition clinic trainings for patients with sickle cell disease.</p> <p>1d. Continue the transition program for adolescent patients with sickle cell disease with a dedicated transition coordinator.</p> <p>1e. Utilize questionnaires to assess transition readiness and tailor education accordingly.</p>	<p>ESM TAHC.1 - Percent of families participating in the Sooner SUCCESS program who report having a plan for their child's transition to adult healthcare.</p> <p>ESM TAHC.2 - Percent of family caregivers and professionals who report an increase in knowledge after receiving training</p>	NPM - Transition To Adult Health Care	Linked NOMs: CUSHCN Systems of Care

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	<p>young adults with special healthcare needs.</p> <p>3. Title V CSHCN, MCH, and contracted partners will meet to create a plan to address transition to adult healthcare by conducting at least two combined partner meetings by September 2026.</p>	<p>2a. Seek new medical providers to update appropriate county resource guides for families in rural counties.</p> <p>2b. Strategize and develop a plan with all partners to improve outcomes and measure the impact of current trainings and resources.</p> <p>3a. Schedule and conduct combined partner healthcare transition planning meetings in February and July 2026.</p> <p>3b. Complete written plan to include at least two new HCT initiatives by September 2026.</p>	related to transition to adult healthcare.		

Cross-Cutting/Systems Building

Promote safe school and home environments for children and youth.	Support Poison Center in delivering educational outreach to children and youth on medication safety, substance exposure, and marijuana ingestion to at least 24,000 students annually.	<p>1. Continue the contract with the Poison Center so that they will partner with school districts and communities to provide education on the prevention of toxic exposures, including household items, medication, and substances, to improve public awareness.</p> <p>2. Attend health fairs, school wellness events, and community safety events.</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: The percent of families who are able to access services for their child with behavioral health needs	
Expand access to resources and educational opportunities for parents and families.	Provide 2 trainings on mental and behavioral health to adolescent health specialists and community partners by December 2026.	<p>1. Collaborate with youth and parents to identify the most needed training for professional partners.</p> <p>2. Contract with trainers who specialize in the identified training.</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: The percent of families who are able to access services for their child with behavioral health needs	
Improve the mental and behavioral health of the MCH population.	<p>1. Expand access to services across settings (schools, primary care, community) through training and services among CYSHCN partners from the established baseline by at least 5% each year from September 2026 until September 2030.</p> <p>2. Provide Navigating Autism Training to at least 400 new childcare professionals by</p>	<p>1a. Establish baseline of current access through data collection efforts including surveys, interviews, and advisory groups.</p> <p>1b. Educate at least 25 families of CYSHCN with behavioral and mental health needs by providing leadership and partnership skills to ensure a family voice at all levels of their decision-making process.</p> <p>1c. Connect families of CSHCN with behavioral and or mental health needs to resource information, emotional support, respite, and training to ensure access to needed services and supports.</p> <p>1d. Screen for depression and have the psychologist meet with each</p>	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: The percent of families who are able to access services for their child with behavioral health needs	

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	<p>September 2026, with participants increasing in knowledge across critical areas by at least 30% on average.</p> <p>3. Establish at least two new community partnerships throughout the state, specifically in rural counties to host Mobile Autism Clinic (MAC) Unit events by September 2026.</p>	<p>patient/family with sickle cell disease at least annually, with additional supports and referrals provided as needed.</p> <p>1e. Build community partnerships, like hosting community awareness events to help promote Camp Claphans, and connect CARES/Social Work departments with families receiving respite care to identify additional support within their community.</p> <p>2a. Schedule 4 full-day training sessions (2 in-person, 1 virtual, and 1 bilingual version in-person).</p> <p>2b. Assess participants in the critical areas of understanding autism, behavior management, and communication strategies through a survey to measure their perceived knowledge pre- and post-training.</p> <p>2c. Provide a certificate of completion for 6.0 hours of continuing education and offer available resources.</p> <p>2d. Collaborate with OKDHS Child Care Services to develop a mechanism for assessing the approximate number of children attending each participating childcare facility to better track the total number of children being impacted by the training.</p> <p>3a. Seek new community partnerships in rural areas, along with the MAC Unit team providers throughout the state.</p> <p>3b. Share the purpose and plan for the MAC Units with community partners.</p>			