# Maternal and Child Health Services Title V Block Grant

# Oklahoma

# FY 2022 Application/ FY 2020 Annual Report

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## I. General Requirements

## I.A. Letter of Transmittal

Lance Frye, MD
Commissioner of Health
State of Oklahoma

OKLAHOMA
State Department
of Health

Joyce Marshall, MPH
Director
Maternal and Child Health Service

HRSA Grants Application Center
Attn: MCH Block Grant
901 Russell Avenue, Suite 450
Gaithersburg, Maryland 20879

To Whom It May Concern:

Please find attached the Title V Maternal and Child Health Services Block Grant Annual Report for October 1, 2019 through September 30, 2020, and the Annual Plan for October 1, 2021 through September 30, 2022.

For further information regarding this application, please contact Joyce Marshall, Director, Maternal and Child Health Service at 405-426-8113 or JoyceM@health.ok.gov

Sincerely,

Lance Frye Digitally signed by Lance Frye
Date: 2021.06.25 13:55:58 -05'00'

Lance Frye, MD
Commissioner of Health
Oklahoma State Department of Health

## I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

## I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

## II. Logic Model

*Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.*

## III. Components of the Application/Annual Report

## III.A. Executive Summary

### III.A.1. Program Overview

The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is the only federal program devoted to improving the health of all women, children, and families. Title V provides funding to state maternal and child health (MCH) programs, which serve an estimated 56 million women and children in the U.S. Since 1935, federal and state funds have supported state activities that improve the health of pregnant women, mothers and infants, children, and children with special health needs. These groups are often referred to as the "MCH population."

Title V funds are used to address the state's maternal and child health priorities. In 2020, Oklahoma benefited approximately 1.3 million women, infants, and children with Title V programs. In Oklahoma, Title V is administered by the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (DHS), in close partnership with the Oklahoma Family Network (OFN). This assures families have a voice in the services they receive.

**Population Needs and Title V Priorities:**

In December 2018, MCH analysts began data collection of MCH health indicators relevant to the populations of women, infants, and children, including those with special health care needs. Health-related data were reviewed from a variety of sources, including birth and death certificates, population-based surveillance systems, school-based surveys, and focus groups. A public input survey was released in March to identify emergent needs. Tribal listening sessions were conducted with nine of the largest tribal nations in the state and their health care providers. MCH conducted two non-tribal listening sessions - one with a family-youth center in Tulsa, Oklahoma, focused on serving an African American community, the second was held in conjunction with the Joining Forces Conference convened by the Oklahoma Family Network. The Joining Forces sessions included families and caregivers of children and youth with special health care needs (CYSHCN).

MCH, CSHCN, and OFN synthesized and discussed the information received from the public input survey, listening sessions, and the data analysis to establish the following Title V priorities for 2021-2025, See Table 1.

| Table 1. Oklahoma Title V Priorities |
|---|
| Reduce Infant Mortality |
| Improve the health of reproductive age individuals |
| Improve access to social workers and support systems throughout the state |
| Improve quality health education for children and youth |
| Improve access to family-centered programs via family support navigators |
| Increase quality health care access for the MCH population |
| Increase health equity for the MCH population |
| Improve the mental and behavioral health of the MCH population |

**Oklahoma's Progress on National and State Performance Measures:**

In Oklahoma, the Title V program utilizes a lifecourse framework for needs assessment, program planning and performance reporting at the state and local levels. Trainings, data, and activities are structured to emphasize the importance and effectiveness of reducing risk factors and increasing protective factors early in life to reduce poor health and social outcomes later in adolescence and adulthood. The most prominent examples of this are the *Preparing for a Lifetime, Its Everyone's Responsibility* infant mortality reduction initiative led by MCH and the

lifecourse work accomplished with families through OFN.

Both MCH and CSHCN Title V, in partnership with OFN, support and assure comprehensive, coordinated and family-centered services via a system of trainings, partnerships, contracts, and direct services. The provision of services for MCH populations are accomplished through county health departments, professional service agreements, vendor and state agency contracts, requests for proposals, and invitations to bid. Although administratively separate, the Oklahoma City-County Health Department and the Tulsa Health Department are essential MCH partners, providing services and administering projects via direct contracts. MCH continues to be integrally involved with the work of the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC), which aims to improve the care of women and infants throughout the state and the Oklahoma Health Improvement Plan (OHIP) Child Health Group, which brings together multi-disciplinary professionals focused on improving health for children and youth in the state. CSHCN Title V has contracts in place with the Comprehensive Pediatric Sickle Cell Clinic, Family Support 360°, the Oklahoma Infant Transition Program, Family Partners, Sooner SUCCESS, and the JD McCarty Center to provide high quality, family-centered services to Oklahoma's CYSHCN.

Programs administered in some part with Title V funds include: *Preparing for a Lifetime, It's Everyone's Responsibility;* the Collaborative Improvement and Innovation Network (CoIIN) on Preconception/Interconception Health; Oklahoma Perinatal Quality Improvement Collaborative, Maternal Mortality Review Committee; Period of PURPLE Crying program; Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey(TOTS) and Youth Risk Behavior Surveillance System (YRBS) surveillance programs; Teen Pregnancy Prevention and Positive Youth Development Projects throughout the state; State Systems Development Initiative; Fetal Infant Mortality Review (FIMR) projects; Infant Safe Sleep Cribs and Sleep Sacks Projects; Oklahoma Maternal Health Task Force*; Becoming Baby Friendly Oklahoma;* Every Mother Counts Initiative and other-related programs and initiatives.

**Maternal/Women:**

*Accomplishments:*

- Continued work on a CoIIN team focused on preconception health with various partners: two family planning clinics and four Healthy Start organizations. The team distributed and began using the woman-centered patient engagement tool for a well woman visit to improve the preconception health status of women of reproductive age, particularly low-income women and women of color.
- Continued Maternal Mortality Review (MMR), completed the first annual report for MMR, and promoted postpartum hemorrhage and hypertension bundles published by the Patient Safety Council for birthing hospitals in Oklahoma.
- Established the Oklahoma Maternal Health Task Force (OMHTF), which continued to meet virtually during the pandemic, and completed initial strategic map and profile.

*Plans:*

- Continue to work with the Oklahoma Health Care Authority (OHCA) to provide family planning services to low-income females and males of reproductive age not eligible for Medicaid-covered services, and facilitate enrollment in Medicaid for those eligible.
- Continue work with the MMR Committee and OMHTF to reduce disparities in maternal death.
- Coordinate maternal health activities with county health departments and the State Maternal Health Innovation Program grant to improve prenatal and postpartum care in areas of need.

**Perinatal:**

*Accomplishments:*

- Reduced the Infant Mortality Rate to 7.0.
- Provided funding and support for the Oklahoma Mothers' Milk Bank (OMMB) and the Oklahoma Breastfeeding Hotline (OBH). Promoted breastfeeding duration and the establishment of Baby-Friendly Hospitals through funding and support of the Oklahoma Hospital Breastfeeding Education (HBEP) and Becoming Baby-Friendly in Oklahoma (BBFOK) Projects.
- Distributed 264 cribs to families in need via the crib project for safe sleep and continued the sleep sack hospital program in 28 birthing facilities.
- Screened 100% of all newborns in Oklahoma through Newborn Screening Program and 100% of affected newborns received short-term follow-up and were referred to long-term follow-up care coordination.

*Plans:*

- Continue the media campaign for *Preparing for a Lifetime* to reduce infant and maternal deaths.
- Continue to partner with and support newborn screening activities in the state.
- Promote breastfeeding initiation and duration through various initiatives.
- Recruit additional delivery hospitals to participate in the Infant Safe Sleep Hospital Sleep Sack and Cribs Projects.
- Continue work with the Oklahoma Perinatal Quality Improvement Collaborative and partners to address opioid use/abuse in pregnant women and increasing rates of newborns diagnosed and treated for neonatal abstinence syndrome.

**Child:**

*Accomplishments:*

- Continued support for Child Passenger Safety (CPS) activities, including staff time for the installation of car seats to families in need and providing staff to train new CPS technicians.
- Provided funding for the Oklahoma Poison Control Hotline for training and technical assistance to families, students, health care providers and child care programs.
- Supported county health department and Central Office staff in COVID-19 response efforts, including contact tracing, childcare for essential workers, COVID-19 Hotline, and vaccine and testing pods.

*Plans:*

- Provide leadership on the Infant Injury Prevention Work Group, as part of the statewide infant mortality initiative, *Preparing for a Lifetime, It's Everyone's Responsibility*.
- Maintain a collaborative relationship with Injury Prevention Service (IPS) and Safe Kids Oklahoma, through MCH staff assistance with car seat safety events, CPS training, and seat installations.
- Continue work with MCH-funded school nurses to assure evidence-based practices and communicable disease guidelines are being followed.
- Continue funding Poison Control Center education and outreach activities.
- Support the provision of well child health visits in county health department clinics in areas of high need.
- Assist state schools and the Oklahoma Department of Education in planning implementation for the new Health Education requirement for public schools.

**Adolescent:**

*Accomplishments:*

- Maintained three state-funded adolescent pregnancy prevention projects in local county health departments, and administered the Personal Responsibility Education Program (PREP) grant for Oklahoma City and Tulsa County Health Departments. Although most programming was halted due to COVID-19 some virtual

implementation and trainings were able to occur.

- Began a Community of Practice for Sexual Health/Teen Pregnancy Prevention Education Providers to exchange information, best practices for virtual implementation and support during COVID-19 and beyond.
- Participated in a work group to design and disseminate bullying prevention social media materials, including bullying due to COVID-19 and mask-wearing.
- Provided family planning clinical services to adolescents in county health departments and contract clinics.

*Plans:*

- Collaborate with local county health departments to establish and support local Public Health Youth Councils which identify issues within their communities affecting adolescents and work with public health professionals to implement solutions.
- Conduct trainings with others who work with youth using evidence-based methods such as Question Persuade Refer (QPR), Positive Youth Development (PYD), and Life Course Perspective.
- Ensure MCH-funded school health education and promotion programs will continue to provide age and grade appropriate health and wellness information, integrating education and health via the Whole School, Whole Community, Whole Child (WSCC) model.
- Continue to provide family planning services to adolescents in county health departments and contract clinics.

**CYSHCN:**

*Accomplishments:*

- Funded Sooner SUCCESS activities, including a provider survey to assess transition processes and policies for primary care and specialty clinics.
- Funded parent-to-parent support, sibling support, training, and opportunities for family leadership via OFN.
- Continued funding the Oklahoma Infant Transition Program (OITP), Jump Start/Autism Clinic Family Partner, the OU Pediatric Sickle Cell Clinic, and the Oklahoma Family Support 360º Center.
- Provided supplemental formula, adaptive equipment, and medical care to CYSHCN with financial need that was not otherwise covered by Title XIX Medicaid funds.
- Provided funding to J.D. McCarty and the Supplemental Security Income-Disabled Children's Program (SSI-DCP) for respite vouchers to families with CYSHCN.

*Plans:*

- Continue to provide formula, adaptive equipment, and medical care to CYSHCN with financial need.
- Continue contracts with Sooner SUCCESS, OFN, Jump Start, J.D. McCarty, OITP, Family Support 360°, and the Sickle Cell Clinic to further work in the state for the families of children and youth with special health care needs.
- Disseminate the transition toolkit for primary care providers.
- Work with partners to identify ways to connect families with services to meet behavioral health needs.

**Comments and Suggestions:**

MCH, CSHCN, and OFN welcome comments and suggestions for needs and issues not discussed in this Block Grant Application and Annual Report. Oklahoma Title V is committed to an ongoing review of health needs and capacity issues across the state. It is recognized that collaboration and partnership are necessary to truly impact the health of the state's MCH population.

For more information about this document, the process, to provide comments, or to partner with Title V please contact: **Joyce Marshall**, MCH Title V Director, OSDH at 405-271-4480 or joycem@health.ok.gov or **Carla**

**McCarrell-Williams**, CSHCN Title V Director, DHS at 580-471-1990 or Carla.McCarrell-Williams@okdhs.org.

### III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Title V funding in Oklahoma enables the state MCH program to engage in infant mortality and maternal mortality projects and initiatives to work towards reducing rates in the state. As one of the only states in the nation with no mandatory health education in schools, Title V monies are utilized to bolster health education programs in the two largest school districts in the state. Funding also supports school and community-based teen pregnancy prevention projects in rural areas identified as high need. MCH utilizes Title V federal funding to maintain data analytic capacity, to assure that monitoring and health surveillance activities for all key projects are able to continue uninterrupted.

Title V allows the CSHCN program to provide specialty services to children with special needs and their families. Included services are neonatal services, specialty services for children with sickle cell anemia, durable medical supplies, and respite care. Additionally, the monies enable family partner programs to assist families in finding community-based resources, participate in Title V partnership and decision-making, and attend family-professional partnership trainings, like the Association of Maternal and Child Health Programs (AMCHP) Conference. This helps assure families have a voice in MCH and CSHCN services.

Since March 2020, many Title V-funded staff have been providing assistance for the current COVID-19 virus pandemic. This includes county health department and Central Office staff working on multiple aspects of pandemic response, from the frontlines of contact tracing, testing, and vaccine clinic to staffing the COVID-19 hotline, providing additional epidemiological support, collecting data on pregnant mothers and their infants, writing and researching guidelines and best practices for schools and programs, and social media efforts.

The CSHCN partner programs took a lead role beginning in March in responding to COVID-19- related needs. The community partners assisted families in procuring necessary personal protective equipment (PPE) as well as accommodating families technologically in order to help them access benefits, medical visits, and trainings. Families were provided important COVID-related information in Spanish, if that was their primary language.

**III.A.3. MCH Success Story**

The primary success of 2020 for Oklahoma was the ability of Oklahoma Title V to pivot to meet the needs of families, staff, and individuals in the midst of the COVID-19 pandemic. Technology, creativity, staff expertise, and compassion were exercised in new ways beginning in March 2020. Telework and video meetings went from being the exception to the norm and day-to-day work varied based on state, agency and customer need.

In MCH, almost every staff person assisted in some way with pandemic mitigation efforts, from hotline calls, to epidemiology support, to testing and (finally!) vaccine pod assistance. In addition, staff found new ways to stay connected to programs and contractors, envisioned new groups to support existing activities (like virtual trainings and Communities of Practice), and found ways to safely provide existing and necessary services such as Preparing for a Lifetime initiative, family planning, AIM maternal safety bundles and car seat installations.

OKDHS made rapid and unexpected adjustments to multiple business processes as thousands of employees, including CSHCN staff, were abruptly reassigned to their homes to telework. OKDHS swiftly pivoted to a Service First model which prioritized the agency's customers over brick and mortar structures, as many initially temporarily closed county offices and buildings around the state were ultimately closed permanently. Families were strongly encouraged to use online tools for applications and reviews. The OKDHS Call Center was scaled up to accommodate higher needs of those families needing assistance. Telephone communication for questions, conversations and interviews were prioritized over face-to-face interactions, whenever possible. An Appointment Only system was established for customers to schedule an in-person visit, if necessary. Minimal staff were utilized in the county offices once they were reopened. All meetings and trainings with staff and/or customers and community partners were converted to Zoom or Microsoft Teams, and social media was enhanced.

OFN enhanced its Zoom account and added three additional accounts to provide greater capacity and flexibility for staff. Staff meetings were held weekly instead of monthly in order to support staff more intensely. The expanded Zoom access allowed OFN to open up opportunities to Title V and other partners to run virtual meetings and conferences, by removing technology barriers (including the planning of the 2021 Adolescent Health Summit). These opportunities built new partnerships for OFN. The Zoom accounts were also utilized to host well-received gathering events for caregivers and children throughout the pandemic and to record and edit trainings. OFN posted trainings to a YouTube Channel. Podcasts were also created and recorded via Zoom. The audio was posted to a new podcast channel, and has over 1,800 listeners. All support groups were shifted to virtual and stipends to assist with the cost of additional data were made available through a Family Voices Technology Grant. OFN staff mailed out personal notes, encouragement packages, training packages and conference boxes for families and professionals as well. Private Facebook Groups were also utilized. The 14th Annual Joining Forces Family Professional Partnership Conference was held March 26, 2021 via Zoom in order to continue developing partnerships by bringing families and professionals together to learn from and alongside each other.

## III.B. Overview of the State

### 1. The state's demographics, geography, economy and urbanization

**Demographics**

In 2019, Oklahoma, the 28th most populous state, accounted for 1.2% of the United States population. The state's population of approximately 3.9 million individuals had grown by 5.5% since the decennial 2010 Census. A rural state, Oklahoma has three large cities. Oklahoma City, the state's centrally located capital, is the largest of these and home to 16% (649,000 residents) of the state's population. About 100 miles to the northeast is Tulsa, a city accounting for 10% (401,000 residents) of the state's population. Nearly 90 miles southwest of the capital, sits Lawton, a city consisting of 93,000 residents, or 2.4% of Oklahoma's population.

Nearly a quarter (24.1%, 952,000) of the Oklahoma population is less than 18 years of age. Individuals aged 65 years and older make up 16.1% of the population, and roughly 60% of the population is between 18 and 64 years of age. The male-female ratio is about 1:1, with slightly more females (1.99 million) than males (1.96 million). Females of childbearing age (15-44 years) number 775,000, about 20% of the total population. The number of females aged 15-19 years account for 128,700, about 17% of childbearing age females. The number of women aged 30-34 has increased by 10% between 2010 and 2019, rising from 118,800 to 130,300.

Where residents choose to live varies by race and ethnicity. Largest in number the white population tends to be geographically diffuse, while African Americans generally reside in the Oklahoma City and Tulsa metropolitan areas. The American Indian population has a larger presence in the northeast quadrant of the state, a legacy of the U.S. government's removal programs of the 19th century. In 2019, 77% of Oklahoma's population was classified as white, while American Indians represented 11% and African Americans, 9% of the state's population. Approximately 3% of the population is categorized as Asian or Pacific Islander. The Hispanic population has grown from 8% (302,000) of the total population in 2010 to 11% (438,000) in 2019, a growth of 45% over the time period. Oklahoma is home to the largest number of federally recognized American Indian tribal governments (38), and according to the American Indian Cultural Center and Museum, more languages are spoken in Oklahoma than in all of Europe.

Data from the U.S. Bureau of Economic Analysis indicate that Oklahoma's per capita personal income was $49,249 in 2020, ranking 41st among all states, and representing about 82% of the national average of $59,729. U.S. Census Bureau data show that 15.2% (583,000 people) of Oklahoma residents were living in poverty in 2019, a decrease from 15.6% the previous year. Females (16.4%) were more likely to be living in poverty than were males (13.9%). Among children less than 18 years of age, 19.9% lived in poverty in 2019. Poverty status was more likely in minority populations when compared to the white population, with Native Hawaiian or Other Pacific Islanders (45.8%) having the highest percentage of residents in poverty, followed by African Americans (28.2%) and American Indians (19.3%).

Oklahoma's birth rate was 12.4 births per 1,000 total population in 2019, ranking 43rd among other states, and about 9% higher than the comparable U.S. birth rate (11.4). Since 2010, the birth rate has decreased by 12.1%, with the state averaging about 52,000 births per year. Similarly, the fertility rate has decreased from 71.9 births per 1,000 females aged 15-44 years to 63.3 over the same time period. Oklahoma has experienced a strong decrease in the rate of births to teens but still ranks poorly when compared nationally. In 2019, Oklahoma's teen birth rate for ages 15-19 was 27.4 births per 1,000 population, ranking 4th for the highest (worst) teen birth rate.

**Geography**

Positioned in the South-Central region of the United States, Oklahoma has a diverse geography, with a quarter of its

land mass covered by forests. The state is home to four mountain regions – the Arbuckle Mountains, in south-central Oklahoma; the Ouachita Mountains, in the southeast; the Ozark Plateau, in the northeast; and the Wichita Mountains, in the southwest part of the state. Oklahoma is one of only four states with more than 10 distinct ecological regions. To the west, the state has semi-arid plains, while in the state's center, transitional prairies and woodlands give way to the elevated terrain of the Ozark and Ouachita Mountains, which stretch out to Oklahoma's eastern border. Oklahoma is landlocked in the center of the 48 contiguous states, bordered by Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas.

**Economy**

Oklahoma is a major producer of natural gas, oil, and agricultural products. The state's economic base relies on aviation, energy, telecommunications, and biotechnology. The two largest metropolitan centers, Oklahoma City and Tulsa, serve as the primary economic anchors for the state. The top employers by workforce size for Oklahoma include the Department of Defense (68,000 employees, military and civilian) and Walmart Associates, Inc. (32,000). In the health sector, INTEGRIS Health has 8,800 employees, followed by the University of Oklahoma Health Sciences Center (6,700), Mercy Health (6,200), Saint Francis Hospital (6,100), OU Medical Center (4,300) and St. John Medical Center (3,900).

Oklahoma's real gross domestic product (GDP), the output of all goods and services produced by the economy in current dollars, totaled $185.8 billion in 2020, according to data from the U.S. Bureau of Economic Analysis, down by 2.3% from 2015 ($190.2 billion). The private sector comprises 82% of Oklahoma's real GDP, with government making up the remainder (18%). As a percentage of GDP, the industry share in the economy was led by the FIRE sector (i.e., finance, insurance, real estate; 15%), manufacturing (13%), trade (12%), natural resources and mining (8%) and transportation and utilities (8%). Education and health care services also comprised 8% of the state's GDP.

Gaming (lotteries and casinos) continue to be a major contributor to the state's economy. The state of Oklahoma collected over $123 million in tribal gaming exclusivity fees in fiscal year 2020, a 16.6% decrease from the fiscal year 2019. Those fees were based on $2.0 billion in tribal gaming revenue. Exclusivity fees were distributed to the Education Reform Revolving Fund ($108.5 million), the General Revenue Fund ($14.8 million), and the Department of Mental Health and Substance Abuse Services ($250,000). This distribution of fees is determined by Oklahoma statute.

Data from the U.S. Bureau of Labor Statistics for calendar year 2020 showed that annual average unemployment rate for Oklahoma was 6.1%, ranking the state 13$^{th}$ nationally and approximately 25% lower than the US unemployment rate at that time. Of the state's 77 counties, 40 counties had an unemployment rate less than the state average, 35 counties had a rate in excess of the state average, and 2 counties had the same unemployment rate for 2020. County unemployment rates ranged from 2.0% (Cimarron County, located in the state's panhandle) to 6.3% (Latimer County, southeast region of state). Oklahoma's employment-population ratio, the number of working age persons who are employed divided by the total population of working age persons, was 56.8 in 2020, equal to the national rate.

**Urbanization**

Approximately 61% of the Oklahoma population resides in the metropolitan statistical areas (MSAs) of Oklahoma City (1,408,950; 36%) and Tulsa (998,626; 25%), while a much smaller proportion of the state's citizens lives in the Lawton MSA (126,415; 3%). The remainder of the Oklahoma population resides in rural cities and towns. The Oklahoma City MSA is made up of seven counties (Canadian, Cleveland, Grady, Lincoln, Logan, McClain, and Oklahoma) surrounding the principal city, Oklahoma City. Population growth in the Oklahoma City MSA has been

strong, increasing by 12% between 2010 and 2020. Likewise, the Tulsa MSA is comprised of the seven counties (Creek, Okmulgee, Osage, Pawnee, Rogers, Tulsa, and Wagoner) encircling the principal city, Tulsa. Population growth in the Tulsa MSA reached 6% between 2010 and 2020. Meanwhile, the Lawton MSA, made up of Comanche and Cotton counties, has lost population, down 4% between 2010 and 2020.

**2. The state's unique strengths and challenges that impact the health status of its MCH population (e.g., availability and access to health care services)**

Oklahoma's MCH Service has developed close partnerships, both internal and external to OSDH, including other state agencies and community organizations. Since 2009, with the inception of the *Preparing for a Lifetime, It's Everyone's Responsibility*, the statewide infant mortality reduction initiative, MCH has collaborated with OSDH service areas to staff the initiative, perform analyses, formulate and implement strategies, and develop MCH-related programming. Internal partners include the Chronic Disease Service; Injury Prevention Service; Family Support and Prevention Services; Screening and Special Services; Nursing Service; WIC Service; SoonerStart/Early Intervention; Center for Health Statistics; Immunization Service; and the county health departments (CHD). These service areas and CHDs have participated in other state and national efforts as well, including the Maternal Health Innovation Program, CoIIN to Reduce Infant Mortality, the Oklahoma Perinatal Quality Improvement Collaborative, the Oklahoma Health Improvement Plan Child Health Group, the Period of Purple Crying Program, the MCH Safe Sleep Project, the Oklahoma Maternal Health Task Force, as well as other activities not mentioned here.

Joining the internal partners mentioned above were entities external to OSDH, who contribute in large and meaningful ways. Sister agencies like the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, the Oklahoma Department of Human Services (OKDHS), the Oklahoma Commission on Children and Youth, and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) are frequent and routine collaborators on the many efforts to improve and promote health in the maternal, infant, and child populations. Other colleagues in MCH-related work include those from the Oklahoma Hospital Association, the Office of Perinatal Quality Improvement (OPQI), Tulsa Health Department, the Oklahoma City-County Health Department, the Oklahoma Family Network, and the Southern Plains Tribal Health Board (SPTHB). These relationships continued to be drawn on, as well as new ones created, to inform the 2021-2025 Title V MCH Five-Year Needs Assessment. The many partnerships and collaborations developed and maintained by Oklahoma Title V programs were essential for achieving MCH goals, particularly during the pandemic.

Oklahoma has experienced a number of successes related to health outcomes and behaviors. Every Week Counts, a partnership among MCH, OPQI, and state birthing facilities active between 2011 and 2014, brought about a 96% reduction in the number of early elective deliveries. In January 2017, the March of Dimes recognized MCH's achievement of lowering the preterm birth rate by 8% since 2010 by awarding the state with the Virginia Apgar Prematurity Campaign Leadership Award. However, for the last four reporting years (2016 through 2019) for which Oklahoma birth data are final, the state has observed an increase in preterm birth rate, rising from a low of 10.3% in 2015 to 11.5% in 2019. Despite still having the 4th highest birth rate among teens aged 15-19, Oklahoma has experienced significant declines in the last two decades. In 2019, the teen birth rate for this population group was 27.4 births per 1,000 female population, a slight increase of 0.7% over the recorded rate of 27.2 in 2018. While Oklahoma's 2019 teen birth rate was still much higher than the comparable national rate (16.7), it was a remarkable improvement since the year 2000, when the state rate was recorded at 59.1 (decrease of greater than 50%). Another improvement includes the uptake in the use of long acting reversible contraceptives (LARCs), the result of program emphasis on providing LARCs, when indicated, for women not seeking to become pregnant. With the efforts of the *Preparing for a Lifetime* initiative, along with other state activities, Oklahoma's infant mortality rate has decreased from 8.6 per 1,000 live births in 2007 to 7.0 in 2019, a relative decrease of 18.6% over the study period. Still, IMR varies sharply among race/ethnic groups in Oklahoma with African American infants dying at more than

twice the rate of white infants. Moreover, the trend among other minority groups (American Indian, Asian/Pacific Islander, and Hispanic) shows rising rates of infant mortality.

Oklahoma identified its first case of COVID-19 on March 6, 2020 and the first confirmed COVID-19 death on March 18. From the onset of the pandemic until early May 2021, more than 450,000 cases, over 26,000 hospitalizations, and more than 8,300 provisional COVID-19 deaths have been recorded in the state. Oklahoma's governor, Kevin Stitt, with Executive Order 2020-7 issued on March 15, 2020, declared a state of emergency in the State of Oklahoma, effective for all 77 state counties, and activating the State Emergency Operations Plan. The executive order was effective for 30 days but amended repeatedly over the course of 2020, then superseded by ensuing executive orders. On May 3, 2021, Governor Stitt with Executive Order 2021-11 withdrew from the state of emergency, which had been issued with Executive Order 2021-7 to continue emergency status for the coronavirus pandemic. Since the initiation of the vaccine rollout in the state, approximately 1.3 million individuals have been fully vaccinated with more than 2.8 million doses administered. The Oklahoma Pandemic Center for Innovation and Excellence was founded in October 2020 by the Stitt administration as an initiative to protect Oklahoma residents from future pandemics.

According to Oklahoma Works, there have been 9,700 Oklahoma business locations which have temporarily or permanently discontinued operations between March 2020 and January 2021. Industries hit hardest included retail (1,165); professional, scientific, and technical services (1,070); and health care and social support services (1,017). In May 2021, the Oklahoma Employment Security Commission reported that it paid out greater than $5 billion in unemployment benefits since the beginning of the coronavirus pandemic in March 2020. The state's unemployment rate in March 2020 was 3.2%, rising sharply with the onset of the pandemic to reach 13.0% in April 2020. Since that time, the unemployment rate has steadily declined to 4.2% in March 2021.

### 3. The defined roles, responsibilities and targeted interests of the state health agency and how they influence the delivery of Title V services

With governor, Kevin Stitt, assuming office in January 2019, state health and human services were re-organized under the Cabinet Secretary of Health and Mental Health and the Cabinet Secretary of Human Services. Respectively, these positions are held by Kevin Corbett and Justin Brown. Health and Human Services agencies in Oklahoma include the OSDH, Oklahoma Department of Human Services (DHS), ODMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, OHCA, Oklahoma Commission on Children and Youth (OCCY), Office of Disability Concerns, and the J.D. McCarty Center.

The Oklahoma State Department of Health, created under Oklahoma Statute Title 63 § 1-105, is responsible for protecting and improving the public's health status through strategies that focus on preventing disease. There is one major health service branch making up OSDH – Community Health Services (CHS). CHS is configured into four Assistant Deputy Commissioner areas: Community Health, Family Health, Personal Health, and Protective Health. Family Health is home to the MCH Service, along with Screening and Special Services, Family Support and Prevention Service, Dental Health Service, WIC Service, and SoonerStart. Community Health Service is comprised of Oklahoma's county health departments, Community Evaluation and Records Support, Nursing Service, and Emergency Preparedness and Response Service. Services comprising Personal Health include Community Development, Sexual Health and Harm Reduction Service, Chronic Disease Service, Injury Prevention Service, and Immunization Service. Lastly, Protective Health is made up of Consumer Health Service, Long Term Care Service, Medical Facilities, and Health Resource Development Service.

Oklahoma administers the MCH Title V Block Grant through two state agencies, the OSDH and the OKDHS. OSDH,

as the state health agency, is authorized to receive and disburse the MCH Title V Block Grant funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108. These sections created the OSDH, and originally charged the Commissioner of Health to serve under the Board of Health, and outlined the Commissioner of Health's duties as "general supervision of the health of citizens of the state." In 2018, new legislation was enacted making the Board of Health an advisory body to the Commissioner of Health, who is now appointed by the state's governor. Title 10 of the Oklahoma Statutes, Section 175.1 et. seq., grants the authority to administer the CSHCN Program to the OKDHS.

The MCH Title V Program is located in the OSDH within Family Health Services (FHS). Joyce Marshall, Director of the MCH Service, is directly responsible to the Assistant Deputy Commissioner of the FHS, Tina Johnson, who is directly responsible to the Deputy Commissioner of Community Health Services, Keith Reed. Mr. Reed reports directly to the Commissioner of Health, Lance Frye, MD, who was confirmed by a Senate vote on April 14, 2021. Gitanjali Pai, MD, is the Chief Medical Officer for the OSDH.

Programs administered in some part with Title V funds include: *Preparing for a Lifetime, It's Everyone's Responsibility* infant mortality reduction initiative; Maternal Mortality Review; Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), and the Youth Risk Behavior Survey (YRBS) surveillance programs; adolescent pregnancy projects throughout the state; State Systems Development Initiative (SSDI); Fetal and Infant Mortality Review; School Health; Oklahoma Birth Defects Registry; Becoming Baby Friendly Oklahoma; and, other-related programs and initiatives.

The Title V CSHCN Program is located in the OKDHS within the Health Related and Medical Services (HR&MS) unit. HR&MS is organizationally placed under the Adult and Family Services Division. Carla McCarrell-Williams, the CSHCN Director, is directly responsible to the Deputy Director of Programs Linda Cavitt, AFS Assistant Director for Program Operations Shawn Franks, and AFS Director Patrick Klein. Title V CSHCN provides funding for respite through periodic vouchers to caregivers and through short-term inpatient stays at the J.D. McCarty Center, adaptive equipment, and supplemental formula not covered by Title XIX. Likewise, funding and supports are provided to several groups at the University of Oklahoma Health Sciences Center and OU Children's Medical Center to enhance services for CSHCN families. These groups include Oklahoma Family Network (family-to-family support), Family Support 360 Center (family health system navigation), Jump Start/Autism Clinic Family Partner (developmental and behavioral screening services), Sooner SUCCESS (comprehensive system of health and educational services), the Sickle Cell Clinic (healthcare transition services) and the Oklahoma Infant Transition Program (family support for newborns in the NICU). Title V CSHCN also collaborates with Child Welfare Services at DHS to provide funding for psychological evaluation assessments not covered by Medicaid.

**4. Components of the state's systems of care for meeting the needs of underserved and vulnerable populations, including CSHCN. This discussion may include, but is not limited to, the following descriptors:**

**1. Population served;**

Overall, in FFY 2020, 2,076 Oklahoma children with special health care needs received direct services from a Title V partner. Per the National Survey of Children's Health, there were an estimated 219,136 children in Oklahoma with a special health care need in 2018-2019.

Note: The number of children served is a conservative estimate intended to reduce the risk of duplication. Additionally, Title V representatives continue to encourage collaboration across partners and to reach out to families in under-served populations by speaking at family support group meetings and attending local health conferences that address children with special health care needs.

**2. Health services infrastructure (e.g., number of children's hospitals, pediatric specialists, accountable care organizational structure, etc.);**

The state has three Children's Hospitals – the Children's Hospital at Saint Francis in Tulsa, Oklahoma, the Children's Hospital at OU Medical Center in Oklahoma City, and the INTEGRIS Children's Hospital at Baptist Medical Center, also in Oklahoma City. The Children's Hospital at Saint Francis provides comprehensive medical care through inpatient and outpatient services and a network of more than 100 pediatricians and 65 pediatric subspecialists covering eastern Oklahoma. The Children's Hospital at OU Medical Center has 314 inpatient beds and is the only freestanding pediatric hospital in Oklahoma solely dedicated to the treatment of children. During the height of COVID, the hospital transitioned PICU beds to adult beds to accommodate needs. Its NICU contains 93 beds (level V NICU) providing the highest level of neonatal care in the state. INTEGRIS Children's includes a 40-bed level III NICU, a 26-bed pediatrics unit, and a 10-bed pediatric intensive care unit.

According to the Oklahoma Board of Medical Licensure and Supervision, there were 663 active pediatricians in the state in May 2021.

OHCA administers two health programs for the state. The first is SoonerCare, Oklahoma's Medicaid program. SoonerCare works to improve the health of qualified Oklahomans by ensuring that medically necessary benefits and services are available. Qualifying Oklahomans include certain low-income children, seniors, the disabled, those being treated for breast or cervical cancer and those seeking family planning services. The second program OHCA operates is Insure Oklahoma, which assists qualifying adults and small business employees in obtaining health care coverage. Under certain circumstances, Insure Oklahoma extends coverage to dependents within the household, which may include children with special health care needs.

**5. Integration of services, such as physical, social and behavioral services;**

Oklahoma has 77 counties with 68 county health departments where families of children and youth with special health care needs can access reproductive health care, vaccines, and, in some cases, mental health services. This allows families affordable access to care, some services at no charge while others have sliding scale fees.

Additionally, 66 counties in Oklahoma have Systems of Care Wrap Around for youth experiencing serious emotional disturbance. Wrap Around provides a Family Support Provider offering mentoring and systems navigation as well as a Care Coordinator supporting access to necessary medical, mental health, school and social services. Oklahoma also has 18 Community Mental Health Centers where free and sliding scale mental health services can be accessed as well as 93 Federally Qualified Health Center sites which provide medical care and in many cases, dental, vision and mental health care.

Children and youth with special health care needs may also receive services while they are in school. There are 250 nurses across the state in schools providing a limited scope of services. Many school districts contract with mental health providers to provide services during and after the school day. All of these services add to the services available in the child's community.

**1. Financing of services (e.g., managed care arrangements and Medicaid eligibility).**

Medicaid (SoonerCare) is managed by the Oklahoma Health Care Authority, Oklahoma's Medicaid agency. CHIP funding is blended with other Medicaid dollars to ensure better access for more children. Some examples include funding long-acting reversible contraceptives for adolescents and providing cribs to Medicaid-eligible families. At the close of FFY2020, Oklahoma had 829 children 18 years and under accessing SoonerCare via TEFRA. Additionally,

16,680 children received SoonerCare based on their Aged/Blind/Disability (ABD) status. Both groups, TEFRA and ABD, have high medical needs and/or significant disabilities and are better able to access needed medical/mental health services because of their access to SoonerCare. The Oklahoma Health Care Authority also manages Insure Oklahoma, which is a premium assistance program for families of low income status. In addition, several community, state and national programs provide access to grants and other funds to assist youth in receiving needed durable medical equipment, respite, co-pay assistance, etc. These vital funds fill gaps where families cannot afford to meet their child's needs.

On June 20, 2020, Oklahoma voters passed State Question 802 by a slim majority vote to expand Medicaid eligibility to adults aged 19-64 with income less than or equal to 138% of the federal poverty level. Governor Stitt, opposing direct Medicaid expansion, proposed SoonerCare 2.0 as an alternative; benefit restrictions were applied under this model. However, concerns over higher number of individuals with eligibility due to rising unemployment during the coronavirus pandemic compelled Stitt to veto the bill written to fund SoonerCare 2.0. Simultaneously, the state withdrew its plan to expand coverage by July 2020. Currently, SoonerCare is experiencing changes, moving to a managed care model due to take effect in 2021. Eligible enrollees began signing up for the program on June 1. Although the original plan by the Governor was to implement managed care administered by private companies for those eligible for SoonerCare expansion, in June 2021, the Oklahoma Supreme Court invalidated the plan because justices said it did not receive required legislative approval.

**6. Specific state statutes and other regulations that have relevance to the MCH Block Grant authority and impact the state's MCH and CSHCN programs.**

MCH serves as a resource and provides education to state legislators and their staff prior to and during the legislative session each year to assist in the setting of state policy and procedure. Analyses of bills are accomplished each year during session to identify issues that may present obstacles to improving the health of Oklahoma's maternal and child health population. These written analyses are shared with legislators and their legislative staff by the Commissioner of Health and the OSDH Legislative Liaison. MCH also participates in state boards, task forces, work groups, and committees during and between sessions per request of members of the state Legislature or as appointed by the governor. MCH is able to provide to the legislative process the latest in national health care policy and practice; information on national, regional, and state health care issues and practices; and the most recent available national, regional, and state data for the maternal and child health population.

The following is a list of some of the legislative bills that were monitored by OSDH and MCH during the 2nd regular and special legislative sessions of the 57th legislature (2020), as well as the 1st regular session of the 58th legislature (2021). SB indicates a Senate bill, HB, a House bill.

*Community and Family Health Services*
SB 1823 created Shepherd's law, which provides for oversight and licensing of midwifery for the Oklahoma State Department of Health. It also required midwives to disclose certain information to prospective clients at the beginning of a professional relationship. Governor Stitt signed into law on May 18, 2020 and the law became effective on November 1, 2020. MCH staff were integral to the agency rules writing process for this piece of legislation.

HB 1598 permitted the Oklahoma State Department of Education to approve individuals to conduct vision screenings for students. After passing legislative voting, Governor Stitt vetoed the bill, claiming the "Department of Education is not the appropriate state entity to approve healthcare providers…" to carry out the vision screening. Those responsibilities will remain with the OSDH.

SB 89 requires health education to be taught in public schools beginning in the 2023-2024 school year. Health education shall include, but is not limited to, physical health, mental health, social and emotional health and intellectual health. This bill was signed by the Governor on April 28, 2021.

*Data/Policy*
SB 1423 adjusted the age required to purchase tobacco products from 18 years of age or older to 21 years of age or older, and updated any relevant labeling and selling requirements. Governor Stitt signed into law on May 19, 2020 and the law became effective immediately.

SB 1905 increased the requirements for counties to have city-county boards of health from 225,000 residents to 500,000 residents yet permitted the creation of such boards for counties containing populations of this size should they so desire.

*Operations*
SB 285 required employers to provide reasonable paid break time to an employee who needed to breastfeed or express breast milk for her child to maintain milk supply and comfort in a designated lactation room. Governor Stitt signed into law on May 19, 2020 and the law became effective on November 1, 2020.

SB 1349 replaces the State Board of Health with the State Commissioner of Health with regards to receiving recommendations from Health Advisory Councils. SB 1349 updates statutory language within the Oklahoma Public Health Advisory Council Modernization Act to reflect recent legislative changes. The State Board of Health is changed to the State Commissioner of Health as the oversight authority. Governor Stitt signed into law on May 20, 2020 and the law became effective on November 1, 2020.

SB 1877 requires appropriate authority of covered public buildings to ensure the availability of a lactation room and provide certain break time. SB 1877 requires a building owned or leased by the state, and where state employees work, to contain a lactation room for state employee use. Governor Stitt signed into law on May 19, 2020 and the law became effective on November 1, 2020.

SB 1058 sets budget limits for the Oklahoma State Department of Health. This bill directs funding authorized under SB 1922 to cover an increase in sickle cell outreach ($50,000), operations for the Oklahoma Athletic Commission ($100,000), the implementation of Choosing Childbirth Act ($2 million), operations of the Dental Loan Repayment Program ($463,670), and to increase access to primary care in medically underserved areas and populations through health centers. Further, the bill allows for appropriations to be budgeted for FY 2021 or FY 2022. Governor Stitt signed into law on May 20, 2020 and the law became effective on July 1, 2020.

*Indirect Impact Bills*
SB 131 creates the Oklahomans Caring for Oklahomans Act to direct the Oklahoma Health Care Authority, the state's Medicaid authority, to develop a state-run managed care program meeting certain standards for Medicaid beneficiaries. SB 131 became law on May 27, 2021, without Governor Stitt's signature and became effective as of July 1. Due to the Oklahoma Supreme Court decision, managed care for beneficiaries will not be implemented at this time.

**III.C. Needs Assessment**
**FY 2022 Application/FY 2020 Annual Report Update**

Ongoing needs assessment activities.
MCH Assessment continued with routine analyses of data related to the health and health care of women, infants, and children in the state of Oklahoma. While these efforts are not regularly acknowledged as ongoing needs assessment initiatives, study findings are integrated into the understanding of the populations represented and served, and assist as a baseline for initiating the Five-Year Needs Assessment process. These efforts are constructed around established MCH priorities, grant requirements, project analysis plans, and emerging issues important to MCH target populations.

Collection, management, analysis, and reporting of state-level data are built around MCH surveillance activities for the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), and the Youth Risk Behavior Survey (YRBS). These are surveillance projects which are mainstays for Oklahoma MCH. The state's PRAMS project has been active for more than 30 years, consistently producing high-value data for use in monitoring population health indicators for women and infants. PRAMS continues to collect data but has been facing real and deep challenges to its viability. Response rates have decreased sharply in recent years with Oklahoma not achieving the stated response threshold for receipt of weighted analysis data for use in generalizing to the population at large. The latest PRAMS year for which data collection was completed is 2019; unfortunately, the response rate was insufficient for weighted data. Year 2020 is likely to yield similar findings. MCH Assessment published two reports using PRAMS data in 2020 – *Oklahoma Maternal and Child Health Data Review* and *Breastfeeding Facts at a Glance*.

TOTS is Oklahoma's own follow-back survey to PRAMS respondents, active since 1994. TOTS collects data from PRAMS mothers at the time their children are two-years-old. Alone it is doing fairly well, given the climate of support and participation for observational studies. Yet, this project struggles due to the challenges underway with the PRAMS surveillance system. TOTS response rates are not simply a function of its own response performance. Rather, TOTS response is product of PRAMS response and that achieved during TOTS survey administration. As a result, TOTS response flags, yielding response rates inadequate for data weighting, and compromising our ability to report single year estimates. This has delayed publication of TOTS materials as we wait for data availability to develop multi-year estimates and data products.

With the impact of the coronavirus pandemic in Oklahoma, MCH Assessment elected to delay the administration of the YRBS 2021 from spring to fall, meaning the 2021 questionnaire will not be conducted until October-December months of the 2021-2022 academic year. The 2021 survey includes the 16 questions on adverse childhood experiences. Staff have met regularly to prepare for this surveillance activity. YRBS publications using the latest cycle data available (2019) were published during 2020, focusing on mental health, unsafe driving, alcohol use, sleep health, nutrition, dating violence, and adolescent suicide. Cycle 2021 data should become available mid-year 2022.

Other assessment and data capacity carried out under the auspices of the State System Development Initiative (SSDI) can be found in section (iii) MCH Data Capacity (b) State Systems Development Initiative (SSDI). The OHCA/MCH Medicaid Data Sharing Workgroup developed a linked dataset for births and Medicaid administrative records for calendar year 2018. Combined with previously linked data (2015-2017), the workgroup was able to analyze infant mortality, Native American Medicaid enrollees' demographic profile, and smoking among mothers receiving Medicaid benefits.

Further, MCH Assessment has participated in the CDC's COVID-19 Pregnancy Module, which seeks to collect

pregnancy and neonate data from women who tested positive for COVID-19 during their pregnancy. Initially, this effort was devoted to contacting by phone pregnant women to complete case report forms with the data then keyed into DCIPHER, the CDC's Data Collation and Integration for Public Health Event Response platform. Overtime, the volume of cases and the desire for more detailed information led MCH Assessment, in cooperation with CDC, to develop a sample of cases based on priority issues (infant loss, fetal loss, maternal death, ICU admission, neonatal COVID infection) for which medical records will be abstracted with collected data then submitted to CDC for analysis and research publication.

Changes in health status and needs of the state's MCH population

Oklahoma MCH has made no changes to the list of program priorities, remaining focused on the 10 priority needs established with FY2021 grant application. The state continues to implement and maintain programs that address priorities across the lifespan.

Oklahoma has observed improvements in select indicators. The rate of infant mortality decreased slightly (1.4%) from 7.1 infant deaths per 1,000 live births in 2018 to 7.0 in 2019. Since the onset of the *Preparing for a Lifetime, It's Everyone's Responsibility* in 2009, the statewide infant mortality reduction initiative, Oklahoma has seen a decrease of 11.0% in the infant mortality rate. Teen birth rates have continued to decline across all age groups between 2015 and 2019 – ages 15-17 down 30.8% to 11.0 births per 1,000 population, ages 18-19 down 18.8% to 52.1, and ages 15-19 down 21.3% to 27.4.

Preterm birth (PTB), on the other hand, is trending in the wrong direction. In 2014 and 2015, the percentage of births born prior to 37 completed weeks of gestation was 10.3% in each of those years. However, the incidence of PTB has climbed each year from 2015, reaching 11.5% in 2019. Relatedly, low birth weight (LBW) had reached 7.9% of all births in 2015, a year in which Oklahoma outperformed the nation (8.1%), only to rise to 8.3% in 2018, before falling slightly to 8.2% in 2019. Maternal mortality has increased as well, rising from 20.1 maternal deaths per 100,000 live births in 2014-2016 to 23.5 in 2017-2019.

Changes in the state's Title V program capacity

Oklahoma's Title V programs have experienced staffing changes and reassignments which impacted the ability to carry out its mission and goals. In Perinatal and Reproductive Health, a long serving Advanced Practice Registered Nurse, essential to the work done in the division, retired. The position has been refilled and has assumed the responsibilities. The Child and Adolescent Health Division had a School Health Consultant resign in January 2020. This position is instrumental to the success of the YRBS. It took some months to refill the position which did occur in August 2020. MCH Assessment lost a staff analyst (MCH Medicaid Analyst) in October 2020. Recruitment for the position is ongoing but the vacancy remains. PRAMS and TOTS surveillance experienced staff turnover in 2020, losing two telephone interviewers to resignation and the PRAMS Data Manager, Wanda Thomas, retired in April 2020. While replacement was prolonged, the interviewer positions have been filled with staff undergoing the appropriate training to support these projects. The PRAMS Data Manager position was combined with the TOTS Data Manager position, a position held by Rebekah Rodriguez, a long serving staff member of the MCH Assessment Division. In addition to the above staffing changes, the CSHCN Director took a position in another division at DHS in late May 2021. The CSHCN Director position remains vacant with the position currently posted for replacement.

The greatest challenge to Title V program capacity has been the impact of the coronavirus pandemic. While there are many duties or responsibilities that can be completed remotely via telework, there are those that cannot, which require in-person collaboration and cooperation. Having staff working remotely for extended months has slowed or delayed projects and trainings. Some work could only be placed on hold until such time that "normal" operations were resumed. Some staff were reassigned temporarily to assist with COVID mitigation efforts, for at least a few days

each week. Contributing to additional capacity issues, the entire OSDH moved buildings from October through December, requiring staff to allot time and energy to packing, scanning, sorting and moving offices, many of which had been occupied for decades.

Title V partnerships and collaborations

Oklahoma Title V programs have many internal and external relationships that enable or facilitate the successful achievement of goals and objectives. These partnerships and collaborations have been challenged by the coronavirus pandemic given the inability to freely meet in-person. While virtual meetings offer a substitute, they are limited and inhibit or prevent some activities. MCH and CSHCN personnel and their many partners thrive on the interaction gained by working closely together on collaborative projects. Work carried on, but full potential was likely hampered by distancing constraints and staff reassignments to assist with pandemic efforts. With the pandemic abating and the relaxation of guidelines, there will be opportunities to resume meetings with existing partners and to build new connections meaningful to building the data capacity necessary for comprehensive needs assessments of the MCH populations.

Operationalizing the Five-Year Needs Assessment process and findings

Oklahoma's process for preparing the Five-Year Needs Assessment follows a standard stepped process that builds on preceding stages. Initially, MCH leadership and staff hold a series of brainstorming and planning meetings. The early stages focus on clarifying partners and key informants, outlining data collection procedures and constructing collection tools, assigning responsibilities, and formulating a tentative schedule of events. Routine meetings are scheduled to be spaced out over an 18- to 24-month period. As the submission deadline approaches, the frequency of meetings is escalated to assure that milestones are met and to troubleshoot challenges. All members of MCH staff are directly or indirectly involved in the process, with level of participation determined by the roles and responsibilities of staff. Broad oversight of the needs assessment process is provided by MCH leadership (MCH Director and Division Administrative Program Managers), as well as the Director of the CSHCN Program and the Executive Director of the Oklahoma Family Network. Day-to-day coordination of needs assessment activities is carried out by the SSDI Analyst.

Changes in organizational structure and leadership

In May 2020, Lance Frye, MD, was appointed by Governor Kevin Stitt as the Interim Commissioner of Health at the Oklahoma State Department of Health. Dr. Frye was appointed after the previous appointee, Gary Cox, was denied confirmation by the Oklahoma Senate. In April 2021, the Senate confirmed Frye as Commissioner of Health. The health agency has experienced several organization changes in the last year. The greater part of health-related services is organized under a single Deputy Commissioner, Keith Reed, MPH, with services aligned under four Assistant Deputy Commissioners for Community Health, Family Health, Personal Health, and Protective Health. Community Health is comprised of Nursing Services, Community Evaluation and Records Support, Emergency Preparedness and Response Service, and the county health departments. Family Health contains MCH, Screening and Special Services, Family Support and Prevention Service, Dental Health, WIC, and SoonerStart. Personal Health is made up of Community Development, Sexual Health and Harm Reduction, Chronic Disease, Injury Prevention, and the Immunization Service. Lastly, Protective Health includes Consumer Health, Long Term Care, Medical Facilities, and Health Resource Development Service.

One of the more important changes in structure has been the relocation of the Public Health Lab from the OSDH in Oklahoma City to Oklahoma State University in Stillwater, Oklahoma, just over an hour north of Oklahoma City. This move was incorporated into the founding of the Oklahoma Pandemic Center for Innovation and Excellence, an institutional named by the Governor's Office in response to the coronavirus pandemic. These units fall under the Deputy Commissioner of Health Innovation at OSDH.

## Five-Year Needs Assessment Summary
## (as submitted with the FY 2021 Application/FY 2019 Annual Report)

**III.C.2.a. Process Description**

MCH and CSHCN worked collaboratively to plan and conduct the Title V Five-Year Needs Assessment for grant years 2021-2025. In July 2018, the Title V MCH Director, Title V CSHCN Director, the MCH Assessment Division Administrative Program Manager, the State Systems Development Initiative (SSDI) Project Analyst, and the Child and Adolescent Health Division Administrative Program Manager, began meeting to develop a plan and timeline for Oklahoma's Title V Five-Year Needs Assessment. The SSDI Project Analyst was designated as the coordinator for leading the state-wide needs assessment. Staff from the MCH Service, CSHCN at the Oklahoma Department of Human Services (OKDHS), and the Oklahoma Family Network (OFN) met to discuss the collaborative effort in October 2018. The focus of the meeting was to provide all members, existing and new, a foundational understanding about the process for the needs assessment. The SSDI Project Analyst developed a strategic plan and Gantt chart outlining the schedule for the two-year process to direct staff in the evaluation and selection of Title V priorities and performance measures.

In December 2018, MCH analysts began data collection of MCH health indicators relevant to the populations of women, infants, and children, including those with special health care needs. Data were compiled from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), birth and death certificate data, client services data, and the National Survey of Children's Health. A narrative template was designed to guide analysts in preparing summaries of data analysis. The narrative template provided a uniform, standardized guide for the preparation of stand-alone topic-specific reports. Thereby, extending the topic reports beyond the Five-Year Needs Assessment, allowing use as briefs on MCH-related health issues. However, the primary purpose of the narratives was to inform staff and leadership in the identification and selection of health priorities. The SSDI Project Analyst used the data compiled for the health indicators to build MCH dashboards, which would be maintained to give MCH and its partners' timely access to data.

In March 2019, MCH Assessment released a public input survey via Qualtrics, the online survey software platform. The public input survey was completed by 681 respondents. Survey cards designed with QR codes were distributed at state meetings and conferences, listening sessions, and various routine meetings. Using a smartphone with a QR reader, respondents were routed to the Qualtrics website for completion of the survey. All responses were voluntary and anonymously recorded in the Qualtrics system. Results from the survey were used to identify topics that needed more in-depth assessment and to inform discussions in each Title V domain priority-selecting session.

Nine listening sessions were conducted between February 2019 and January 2020. Seven were tribal listening sessions that were held at different venues, including the Go Red for Women Conference which focused on native women (American Heart Association, representative from several Oklahoma tribes), a community baby shower (Cheyenne and Arapaho Tribes), and five separate tribal health care facilities (Choctaw Nation, Cherokee Nation, Chickasaw Nation, Muscogee (Creek) Nation, and the Northeastern Tribal Health System). The purposes of the tribal listening sessions were two-fold: 1) inform Title V programs about the needs and concerns of Oklahoma's tribal communities, and 2) incorporate the American Indian perspective in the development of MCH priorities for the 2021-2025 Title V MCH Block Grant. The tribal listening sessions provided an improved understanding of the challenges experienced by Oklahoma's American Indian population when accessing health care, the importance of culturally-informed care, and how programs and services could be improved. MCH conducted two non-tribal listening sessions – one with a family-youth center in Tulsa, Oklahoma, focused on serving the local African American community; the second was held in conjunction with the Joining Forces conference convened by the Oklahoma Family Network. The Joining Forces sessions included families and caregivers of children and youth with special health care needs.

In May 2020, MCH launched a Key Informant Survey via Qualtrics. This survey was constructed to collect data from MCH partners to determine if their programs and/or organizations focus on the selected Title V priorities for the upcoming grant cycle 2021-2025. Key informants included MCH partners who lead programs, departments, or agencies which provide health-related services to MCH target populations. Collected information was used to characterize the capacity of Oklahoma's MCH-oriented health services and programs to meet the needs of MCH populations, as well as to identify areas

of mutual interest and possible collaboration on future projects.

All compiled data from surveillance and registry systems, the public input survey, and the key informant survey enabled MCH staff to select performance and strategy measures and to formulate a Five-Year Action Plan. The plan continues to be assessed with key strategies targeting stated priority needs. Modifications and refinements to the plan are likely as local developments and emerging issues impact MCH programs, requiring changes or adaptations. MCH, CSHCN, and OFN are committed in partnership to use quality data for monitoring and evaluation efforts to achieve Title V program goals.

### III.C.2.b. Findings

### III.C.2.b.i. MCH Population Health Status

**MCH Population Needs**

The findings are organized by population domains and by the National and State Performance Measures Oklahoma selected for 2021-2025. Developed by MCH Analysts, the following narrative provides health care professionals with information on a topic's contributing factors, incidence and prevalence, related social determinants of health, burden in Oklahoma, and what is being done in Oklahoma to address these issues.

**WOMEN/MATERNAL HEALTH**

***Well Woman Care.*** The significance of the well-woman or preconception visit is that it provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunization, and it is a means of optimizing preventive health care across a woman's lifetime. In 2018, 69.7% of Oklahoma women, ages 18 through 44, reported having a preventive medical visit during the previous year, slightly below the U.S. rate of 73.6% (Behavioral Risk Factor Surveillance System). Lack of insurance coverage is a significant factor as to whether women have a well woman visit in the previous year. Oklahoma women with health insurance reported a visit rate of 76.8%, compared to Oklahoma women who lacked health insurance coverage with a visit rate of 44.4%. Also, improvements in racial disparities, based on the preventive medical visit in the past year, show that 87.3% of non-Hispanic (NH) Black women to have had a preventive medical visit in the past year, highest rate for any race or ethnicity in 2018.

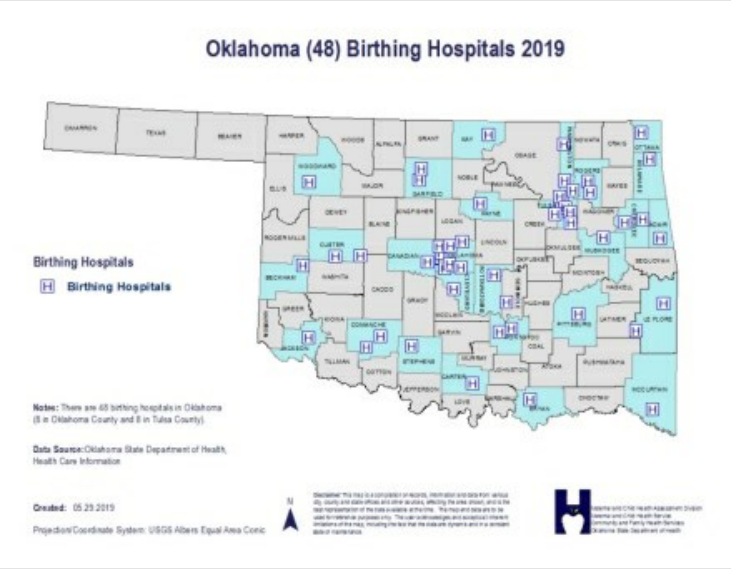
Current strategies in maternal health in Oklahoma include the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative, the Preconception Collaborative Improvement and Innovation Network (CoIIN), COVID-19 in Pregnancy, and others. MCH partners with the Oklahoma Hospital Association (OHA) and the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) to develop methods that will standardize designation levels related to the levels of care at birthing facilities.

***Maternal Mortality.*** MCH at the Oklahoma State Department of Health (OSDH) works in tandem with other agencies and organizations to improve Oklahoma's maternal mortality and severe morbidity outcomes. Oklahoma identified the necessity for reducing risks for maternal mortality as one of the key measures identified for improvement in the 2020 Oklahoma Health Improvement Plan (OHIP). The target is to reduce the maternal mortality rate (MMR) from 29.1 per 100,000 live births (2018) to 26.2 per 100,000 live births by 2020. For the period 2004-2018, the majority of maternal deaths in Oklahoma were to mothers aged between 20 and 34 years (54.3%) whereas those mothers of an advanced age (42.6%), were 35 years and older.

The MMR reveals racial/ethnic disparities with African American/Blacks being three times more likely and Native Americans to be 1.5 times more likely to experience maternal death compared to whites. The Hispanic 2016-2018 MMR of 4.4 was the lowest among the populations (Table 1).

| Table 1. Oklahoma 3-year race specific maternal mortality ratio (per 100,000 live births) | | | | |
|---|---|---|---|---|
| | White | Black | Am. Indian | Hispanic |
| United States PMSS[1] (2011-2013) | 12.7 | 43.5 | * | * |
| Oklahoma (2011-2013) | 19.4 | 25.6 | 10.8 | 8.5 |
| Oklahoma (2014-2016) | 11.8 | 67.2 | 21.7 | 9.0 |
| Oklahoma (2016-2018) | 20.4 | 48.8 | 16.7 | 4.4 |
| *Numbers were suppressed due to small cell size (<5) | | | | |
| Source: 1 Pregnancy Mortality Surveillance System (PMSS) | | | | |

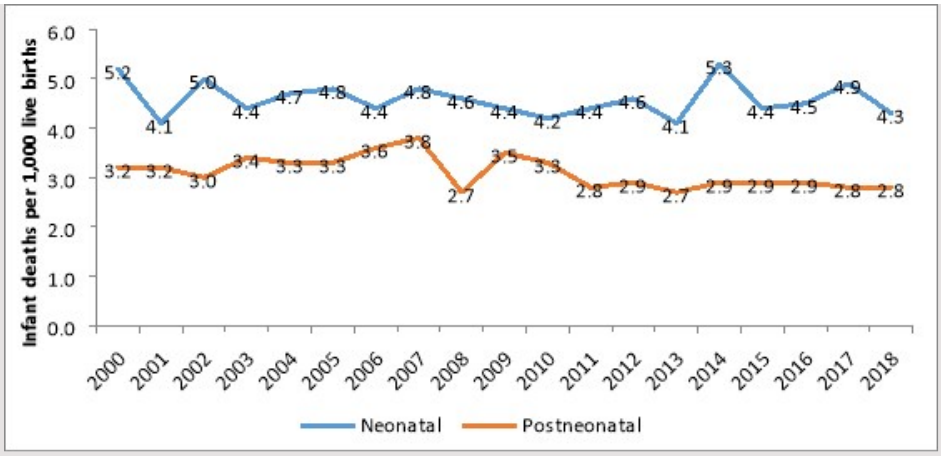
Oklahoma participates in the Alliance for Innovation on Maternal Health (AIM) Program to tackle the rising maternal mortality and morbidity rates. And, Oklahoma is one of nine states awarded the five-year State Maternal Health Innovation Program Grant in 2019. Currently, Oklahoma only has 48 birthing hospitals as seen on the map below.




**PERINATAL/INFANT HEALTH**

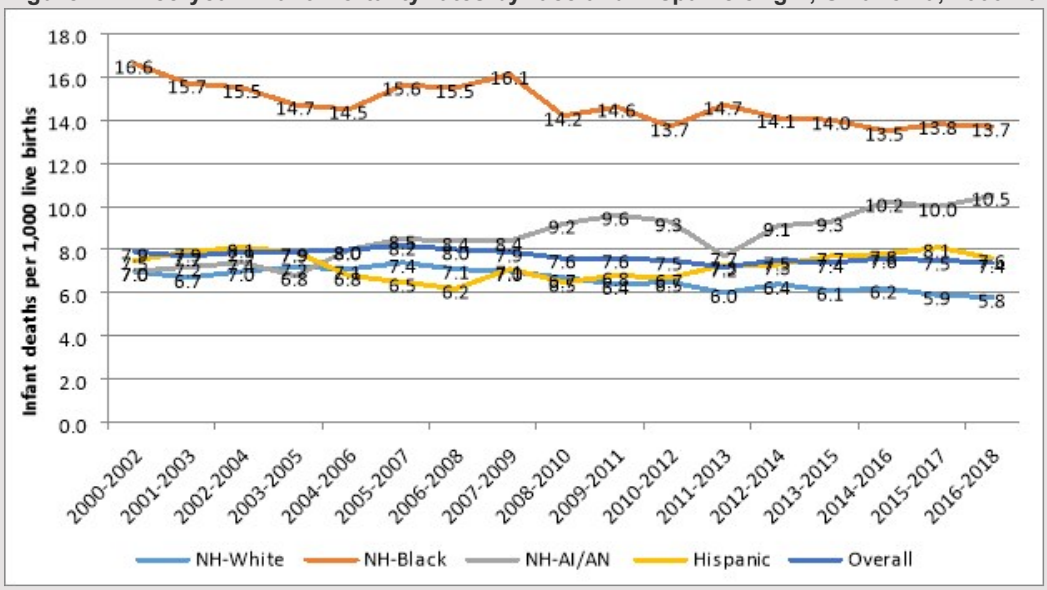
***Infant mortality.*** Oklahoma experienced a 15% decline from 8.4 per 1000 live births in 2000 to 7.1 in 2018. Oklahoma ranked 46$^{th}$ in the nation in 2018. Approximately two-thirds of the infant deaths occur in the neonatal period (before 28 days), with the remaining third occurring in the post-neonatal period (28 days to 1 year), Figure 1. For the three-year period 2016-2018, NH-Blacks had the highest Infant Mortality Rate (IMR) at 13.7 per 1,000 live births, followed by NH-American Indian with 10.5 per 1,000 live births. The lowest IMR occurred among NH-Whites with 5.5 per 1,000 live births.

**Figure 1. Neonatal and postneonatal mortality rates, Oklahoma, 2000–2018**




Despite progress, IMR disparities continue to exist. NH-Black and NH-American Indian infants are twice as likely to die as NH-White infants. Whereas, the ratio of IMRs for NH-Black to NH-White has remained constant since 2000, the NH American Indian to NH-White ratio has increased, especially since 2012, Figure 2.

**Figure 2. Three-year infant mortality rates by race and Hispanic origin, Oklahoma, 2000-2018**




The risk of infant mortality has been shown to rise as pre-pregnancy body mass index (BMI) increases. Approximately 61% of infant deaths occurred to mothers' whose pre-pregnancy was in the overweight or obese range, compared to 36% of infant deaths to a mother with pre-pregnancy weight within the normal range. Over 60% of the infant deaths were to mothers who were either overweight or obese prior to pregnancy.

For the three-year period 2016-2018, the top three leading causes of infant deaths were congenital anomalies, disorders related to short gestation and low birth weight (LBW), and sudden infant death syndrome (SIDS). The leading causes of neonatal mortality were preterm, congenital anomalies, and maternal complications of pregnancy. SIDS, unintentional injuries, and congenital anomalies were the leading causes for post-neonatal mortality. In 2016-2018, 64% of infant deaths were preterm, that is, born before 37 weeks of gestation, and 53% were born very low or low birth weight.

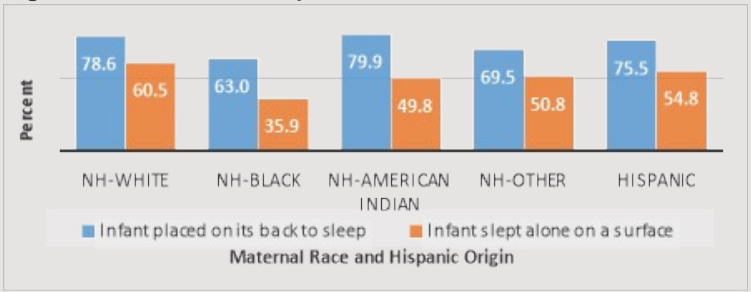
Oklahoma supports several programs to reduce infant mortality including statewide initiatives such as *Preparing for a Lifetime*, the Fetal Infant Mortality Review (FIMR) projects, the Infant Mortality Alliance, and the Maternal Mortality Review Committee. The state also participates in the national Preconception Collaborative Improvement and Innovation Network

(CoIIN) project to improve the health of women prior to pregnancy.

***Safe Sleep***. Although infant sleep-related deaths are preventable, Oklahoma sleep-related infant deaths account for nearly one in five infant deaths. Some improvements have been seen, as the percentage of infants placed on their backs to sleep has steadily improved from 55.7% in 2000 to 76.1% in 2017, and Oklahoma has met the Healthy People 2020 goal of 75.9%.

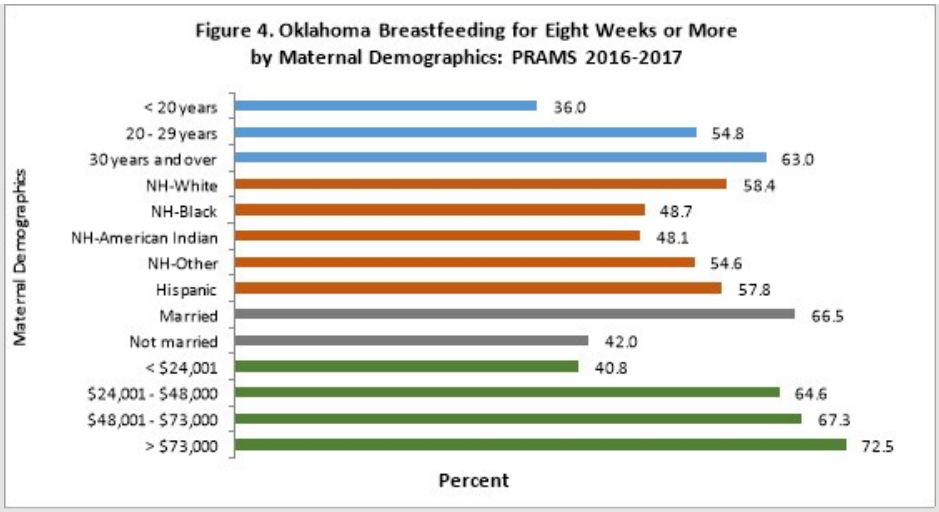
For the two-year period 2016-2017, approximately 56% of Oklahoma infants shared sleep surface with someone else. Figure 4 shows rates of supine sleeping was highest among NH American Indians (79.9%), while NH Whites had the highest rate (60.5%) for putting the infants to sleep alone. NH Black infants had the lowest percentage for supine sleeping (63.0%) as well as the lowest percentage for sleeping alone (35.9%) on a surface (Figure 3).

**Figure 3. Infant Safe Sleep Practices – Oklahoma PRAMS 2016-2017**




Initiatives such as *Preparing for a Lifetime* have raised awareness among parents and caregivers about sleep factors that prevent infant deaths. The *Preparing for a Lifetime* Safe Sleep Work Group utilizes the American Academy of Pediatrics guidelines when educating Oklahoma families and caregivers, provides sleep sacks at participating hospitals, and maintains a crib project for families in need.

***Breastfeeding.*** Mothers and babies who breastfeed experience improved health outcomes and lower risks for certain diseases. For the period 2016-2017, Oklahoma met the HP 2020 breastfeeding initiation goal of 81.9% with 84.7% of infants ever breastfed (PRAMS data) and just over 56% of Oklahoma infants were breastfed eight weeks or more. Although Oklahoma experienced an upward trend since 2004 in the overall percentage of infants ever breastfed and breastfeeding duration of 8 weeks or more, significant disparities by maternal age, race, Hispanic origin, marital status, and annual household income still exist. The 2016-2017 duration rates of breastfeeding eight weeks or more for Non-Hispanic (NH) American Indian women (48.1%) and NH-African American women (48.7%) were much lower than rates for NH-Hispanic White (58.4%) and Hispanic (57.8%) women, Figure 4. Breastfeeding duration rates among adolescent mothers (36.0%), having an annual income less than $24,000, and not being married (42.0%) were the lowest rates among all demographic age groups.




Disparities, although improving, continue to exist. Maternal practices in hospitals and birth centers can influence breastfeeding behaviors during a period critical to successful establishment of lactation. Oklahoma hospitals have enacted several practices as part of the Baby-Friendly Hospital Initiative in order to address potential barriers. There are 10 certified Baby Friendly Hospitals in Oklahoma.

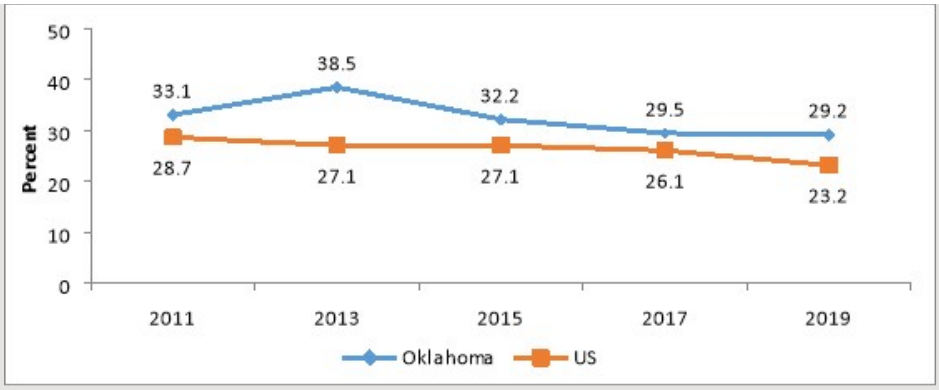
## CHILD AND ADOLESCENT HEALTH

### Physical Activity/Obesity Prevention

Data from the National Survey of Children's Health 2017-2018 show that 31.4% of children ages 6-11 years in Oklahoma were reported by their parents to have been physically active for at least 60 minutes on each of the past seven days. This is not statistically different than the 27.7% observed for the US. Among adolescents ages 12-17 in Oklahoma, 18.5% were reported by their parents have gotten at least 60 minutes of physical activity during the past seven days compared to 17.5% for the US. This difference was not statistically significant.

Data from the Youth Risk Behavior Survey show that the percentage of high school students who were physically active for at least 60 minutes on each of the past seven days has seen little change in Oklahoma, decreasing from 33.1% in 2011 to 29.2% in 2019 (Figure 5). Oklahoma's 2017 percentage of 29.5% was not statistically different than the US average of 26.1% in 2017. Oklahoma did see improvement in the percentage of students who watched three or more hours of TV on an average school day, which decreased significantly from 36.7% in 2003 to 22.3% in 2019. However, the percentage of students who played video or computer games for three or more hours per day on an average school day increased significantly from 19.1% in 2007 to 48.0% in 2019. In 2019 in Oklahoma, 37.9% of public high school students attended PE class on one or more days during an average school week and 28.1% attended PE on all 5 days during an average school week.

**Figure 5. The percentage of students who were physically active for at least 60 minutes per day for all seven of the past seven days: Oklahoma and the US, YRBS 2011-2019**



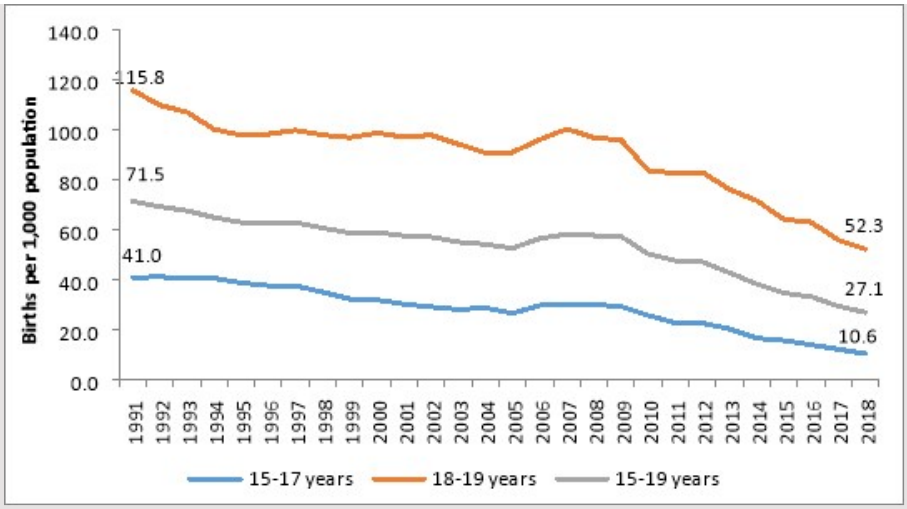

***Adolescent preventative medical visit.*** Access to health care is an important component of safeguarding the health of children. Health care can include the prevention, treatment, and management of illness and the promotion of emotional, behavioral, and physical well-being. While most children are healthy, many health problems can go unnoticed until a condition becomes severe. It is therefore essential to identify and treat health conditions early to prevent or mitigate the impact on a child's overall health and development.

Uninsured children are more likely than insured children to have unmet medical needs, to delay seeing a doctor, and, when hospitalized, have higher rates of morbidity and mortality than children with insurance.[1] Additionally, underinsured children are less likely to receive timely and appropriate care, to have a medical home, or to receive necessary referrals. Data from the National Survey of Children's Health (NSCH) show that in 2016 and 2017, 10.2% of children ages 0-17 years did not have health insurance or a health coverage plan at the time of the survey, which was statistically significantly higher than the 6.1% observed nationwide. Additionally, 9.4% did not have continuous insurance coverage during the 12 months before the survey. Sample sizes were too small to look at other factors, such as race, gender, or age groups.

Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. Preventive medical visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening patients for suicide, mood disorders, and substance abuse and dependence. Data from the 2016 and 2017 NCHS show that during the 12 months before the survey 74.2% of children ages 6-11 years had one or more preventive visits and 73.5% of adolescents ages 12-17 years had one or more preventive visits. By income level 72.1% of children in households with an income 0-99% of the Federal Poverty Level (FPL) had one or more preventive visits whereas 86.5% of children in households with an income 400% or greater FLP one or more preventive visits.

**Teen Pregnancy**. Related to health care access, teen pregnancy has been a long standing public health concern. Teens have higher rates of unplanned pregnancy and enter later into prenatal care than older mothers. Babies born to teenage mothers are at elevated risk of poor birth outcomes, including higher rates of low birth weight, preterm birth, and death in infancy. Teen birth rates are at historic lows in Oklahoma and decreased 59% from 71.5 births per 1,000 females ages 15-19 years in 1991 to 29.6 in 2017. However, Oklahoma's teen birth rate has declined at a slower pace (59%) than the national average, which decreased 70% during the same time span, Figure 6.

**Figure 6. Teen Birth Rates by Age of Mother: Oklahoma, 1991 to 2018**




Compared to other states in the nation, including the District of Columbia, Oklahoma's teen birth rates ranked the 5th highest for 15-19 year olds, the 3rd highest for 18-19 year olds, and the 7th highest for 15-17 year olds. Racial and ethnic disparities exist among teen births in Oklahoma. In 2018, Hispanics had the highest teen birth rate at 36.7 births per 1,000 females ages 15-19, followed by NH-Blacks at 33.8, NH-American Indians at 31.1, whites at 23.4, and NH-Asian Pacific Islanders at 10.4.

Repeat teen births continue to be an important public health concern. In 2017, nearly one in five births (17.5%) was to teen females with one or more previous live births. One in five (20.9%) females ages 18-19 years had one or more previous live birth(s) and one in twelve (8.4%) females ages 15-17 years had one or more previous live birth(s).

MCH has continued the administration and monitoring of the following state and federally funded teen pregnancy prevention (TPP) programs/services: Oklahoma Healthy YOUth (OHY), Personal Responsibility Education Program (PREP), and Pregnancy Assistance Fund (PAF). PREP funds supported implementation of adolescent pregnancy prevention projects through contractual agreements with the city-county health departments in Oklahoma City and Tulsa.

The number of state-funded adolescent pregnancy prevention projects in local county health departments supported by MCH totaled five administrator areas in 24 counties. Coverage areas were determined and prioritized through analysis of county-level teen birth rate data. MCH supported projects continued to use evidence-based programs (EBPs).

***Bullying.***

In Oklahoma, the prevalence of having been bullied on school property during the 12 months before the 2019 survey was 19.4%, a statistically significant increase from 17.5% in 2009. The prevalence of having been bullied electronically during the 12 months before the survey was 14.5% in 2019, which shows no statistical change from 15.6% in 2011 (Table 3).

**Table 3. Trends in the prevalence of bullying: Oklahoma YRBS, 2009-2019**

| | 2009 | 2011 | 2013 | 2015 | 2017 | 2019 |
|---|---|---|---|---|---|---|
| Bullied on school property in the past 12 months | 17.5 | 16.7 | 18.6 | 20.4 | 21.3 | 19.4 |
| Bullied electronically in the past 12 months | - | 15.6 | 14.3 | 14.5 | 16.1 | 14.5 |

Females were more than 1.5 times as likely as males to have been bullied on school property at 24.5% and 14.3%, respectively. Females were twice as likely as males to have been bullied electronically at 19.2% and 9.7%, respectively.

**Table 4. Prevalence of bullying by gender: Oklahoma YRBS 2019**

| | Female | Male |
|---|---|---|
| Bullied on school property in the past 12 months | 24.5 | 14.3 |
| Bullied electronically in the past 12 months | 19.2 | 9.7 |

Additionally, data from the YRBS 2019 show that students who were bullied on school property or bullied electronically were more likely than students who had not been bullied to report signs of depression, suicidal ideation, and current use of alcohol.

MCH works with the Oklahoma Department of Mental Health and Substance Abuse Services, and the Oklahoma State Department of Education providing 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.

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

Children and youth with special health care needs (CSHCN) is defined by MCHB as children who “have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.” Exact estimates for the number of CSHCN in Oklahoma is difficult to establish due to this broad definition. The complexity of the child’s condition is widely variable when defining CSHCN. Additionally, different survey data may not include the same CSHCN when describing who these children are. Other than primary health care, children and youth with special health care needs and their families often require additional support. Areas of additional support include, but are not limited to, social services, transition, education, and mental health.

According to NSCH 2017-2018, it is estimated that there were 217,565 children with special health care needs in Oklahoma. This equates to about 23 percent of children in Oklahoma. The majority (73%) of children with special health care needs in Oklahoma are aged 6 or older (n=158,877). According to OKDHS Adult and Family Services, there were 16,685 medical children receiving SSI from October 2018 to September 2019. As such, less than ten percent of the children with special health care needs were receiving medical SSI. There is much work to be done to reach the children with special health care needs in the state of Oklahoma.

| Race/Ethnicity of all CSHCN in OK | Number of all CSHCN in OK | % of all CSHCN in OK |
|---|---|---|
| Hispanic | 33,649 | 15% |
| White, Non-Hispanic | 106,853 | 49% |
| Black, Non-Hispanic | 26,614 | 12% |
| Other, Non-Hispanic | 50,449 | 23% |

Through the Title V Block Grant, since 2018, partners have provided direct/enabling services to 5,365 children or families of children with special health care needs (see below). This year alone, partners have provided direct/enabling services to 886 children or families of children with special health care needs. Types of direct services provided by Title V partners include: Coordinated Family Advocacy, Behavioral/Mental Health Services, Education Consultation, Respite Services, Physical Services (such as Medical or Allied Health Services), Healthcare Transition Services, Sib Shops and others.

**MEDICAL HOME:**

Data from the 2017-2018 National Survey of Children’s Health indicated that, among children ages 0-17 years with special health care needs, more than half (56%) in Oklahoma had care which did not meet medical home criteria. Similarly, 57.3% of children with special health care needs in United States had care, which did not meet medical home criteria. Differences by age in Oklahoma were not statistically significant.

Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, provides a variety of services in an attempt to assist in meeting the immense need for Medical Homes in Oklahoma. OHCA provides the Patient-Centered Medical Home managed delivery system, called Soonercare Choice Program, in which contracted partners are required to offer care coordination, such as assisting with referrals for specialty care. According to OHCA's May 2020 Fast Facts, 12,099 children with special health care needs were enrolled in SoonerCare Choice with a little over half, approximately 59%, residing in urban areas of the state.

Not all children in Oklahoma with special health care needs are on Medicaid (Soonercare). For those children who are not currently on Medicaid or who do not meet the financial criteria for Medicaid, Oklahoma CSHCN currently has several contracted programs in place to help provide some level of care that meets the Medical Home definition. CSHCN currently partners with the Oklahoma Infant Transition Program (OITP) at OUHSC. OITP provides family support for newborns in the NICU which includes training, information, and emotional support activities while the child is in the NICU. Other community partners who currently provide care with a medical home approach include the Oklahoma Family Network (OFN), Sooner SUCCESS, Family Partners, and Oklahoma Family Support 360 Center (OKFS360°).

**TRANSITION TO ADULT HEALTH CARE:**
Data from the 2017-2018 National Survey of Children's Health indicated that, among children ages 12-17 in Oklahoma, more than three-fourths (78.2%) did not receive services necessary for transition into adult health care. This is compared with 81.1% nationwide; however, the difference was not statistically significant.

Oklahoma CSHCN contracts with Sooner SUCCESS at the Oklahoma University Health Sciences Center (OUHSC). Sooner SUCCESS has been charged with addressing Healthcare Transition in the state of Oklahoma. Sooner SUCCESS is currently conducting a pilot study with selected clinics at the OUHSC in order to establish standard policies and procedures for healthcare transition and increase the number of families at these pilot sites who are aware of and/or report receiving healthcare transition.

Oklahoma CSHCN also partners with the Sickle Cell Clinic at OUHSC. The Sickle Cell Clinic enrolls all patients with Sickle Cell Disease ages 13-21 into the Sickle Cell Transition Program and then follows them at least 2x per year. The Sickle Cell Clinic creates transition summaries for all patients in the transition age group and provides those summaries to the patients transitioning from pediatric to adult care. The Sickle Cell Clinic plans to establish better tracking to identify and reach out to those patients who have been lost to follow-up.

**ACCESS TO SERVICES FOR BEHAVIORAL HEALTH NEEDS:**
Data from the 2017-2018 National Survey of Children's Health indicated that, among children ages 3-17 in Oklahoma who have been diagnosed by health care provider with a mental/behavioral condition, 56.6% received mental health treatment or counseling.

According to the Oklahoma Department of Mental Health and Substance Abuse Services, for Fiscal Year 2019 there were 88,676 children aged 0-17 served by a Mental Health program in Oklahoma.

All of the current CSHCN Title V partnerships in Oklahoma either provide some type of direct trainings or assistance for mental and/or behavioral health or they provide information and referral to the families to help educate and encourage them to seek out assistance.

### III.C.2.b.ii. Title V Program Capacity

### III.C.2.b.ii.a. Organizational Structure

In Oklahoma, state health and human services are organized under the Cabinet Secretary of Health and Mental Health and the Cabinet Secretary of Human Services and Early Childhood Initiatives, offices which are appointed by the state's governor. Kevin Corbett is the Cabinet Secretary of Health and Mental Health and Justin Brown serves as the Cabinet Secretary of Human Services and Early Childhood Initiatives. Health and human services agencies include the Oklahoma State Department of Health, Oklahoma Human Services, Oklahoma Department of Mental Health and Substance Abuse

Services, Department of Rehabilitation Services, Office of Juvenile Affairs, Oklahoma Health Care Authority, and the Oklahoma Commission on Children and Youth. The Oklahoma Commission on Children and Youth (OCCY) has responsibility with planning and coordinating children's services in the state, along with providing oversight for juvenile services. The agency heads of the major agencies serving children are appointed to serve on the OCCY.

Oklahoma administers the Title V MCH Block Grant through two separate state agencies, the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (OKDHS). As the state's health agency, OSDH is authorized to receive and disburse Title V MCH Block Grant funds under the provisions for public health of Oklahoma Statute Title 63, Sections 1-105 through 1-108. These sections created the OSDH, and originally charged the Commissioner of Health to serve under the Board of Health, and outlined the Commissioner of Health's duties as "general supervision of the health of citizens of the state." In 2018, new legislation was enacted making the Board of Health an advisory body to the Commissioner of Health, who is now appointed by the state's governor. Title 10 of the Oklahoma Statutes, Section 175.1 et.seq., grants the authority to administer the CSHCN Program to the OKDHS.

Organizationally, the Title V MCH Program is located in Family Health Services, under the Community Health Services branch, at the OSDH. Joyce Marshall, MCH Director, is directly responsible to the Assistant Deputy Commissioner of Family Health Services, Tina Johnson, who in turn reports to Keith Reed, Deputy Commissioner of Community Health Services. Deputy Commissioner Reed reports directly to the Interim Commissioner of Health, Lance Frye, MD. Tamela Hamilton, MD, is the Chief Medical Officer for the OSDH, reporting to Deputy Commissioner Reed of Community Health Services. MCH Service is structured with three divisions: Child and Adolescent Health (CAH), Perinatal and Reproductive Health (PRH), and MCH Assessment. Each division is supervised by an Administrative Program Manager with more than 15 years of public health experience. The respective staffs of these three divisions are highly trained with many years of experience in MCH programming.

Programs or projects administered by Title V funds, at least in part, include *Preparing for a Lifetime, It's Everyone's Responsibility*; Preconception IM CoIIN; MCH Cribs Safe Sleep Project; Pregnancy Risk Assessment Monitoring System (PRAMS); the Oklahoma Toddler Survey (TOTS); the Youth Risk Behavior Survey (YRBS); teen pregnancy prevention projects; positive youth development projects; bullying prevention; youth suicide prevention; the State Systems Development Initiative (SSDI); fetal and infant mortality review; school health, including school nurses; child passenger safety training; maternal mortality review; *Becoming Baby Friendly*; and other MCH-related programs and initiatives. MCH was awarded a State Maternal Innovation Program Grant which collaborates closely with Title V to achieve mutual goals and objectives.

The Title V CSHCN Program is located in the Adult and Family Services Division under Adult Services Director Kristi Blackburn, Adult and Family Services Director Patrick Klein and Deputy Director for Programs Linda Cavitt. Carla McCarrell-Williams is the Director of the CSHCN Title V Program. Ms. Blackburn reports to Justin Brown, the DHS Director. Mr. Klein reports to Ms. Blackburn. Mrs. Cavitt reports to Mr. Klein and Mrs. McCarrell-Williams reports to Mrs. Cavitt.

The CSHCN Program oversees the provision of social services to children receiving Supplemental Security Income (SSI) by providing training and guidance to the social services specialists throughout the state, who are responsible for developing and monitoring service plans for children who receive SSI and other services through the OKDHS. CSHCN program information can be accessed via the social services specialists and the OKDHS website. Contracts are in place with the Oklahoma Family Network, Comprehensive Pediatric Sickle Cell Clinic, Family Support 360°, Oklahoma Infant Transition Program, Family Partners, Sooner SUCCESS, and the JD McCarty Center to provide high quality, family-centered services to Oklahoma's CYSHCN.

Brief bio-sketches for key MCH and CSHCN staff are attached and can be obtained by contacting MCH at (405) 271-4480 or paulaw@health.ok.gov. Related organizational charts are also attached.

**III.C.2.b.ii.b. Agency Capacity**

Oklahoma Title V maintains the capacity to assure that services are available throughout the state for all five population health domains. MCH, CSHCN and the Oklahoma Family Network (OFN) work collaboratively to provide services and

technical assistance for service providers and families statewide.

MCH continues to be involved in the work of the Oklahoma Perinatal Quality Improvement Collaborative, the Child Health Group, Child Death Review Board, Suicide Prevention Council, Bullying Prevention Coalitions, Home Visiting Advisory Group, Child Care Advisory, Children's State Advisory Work Group, Sooner SUCCESS Advisory Group, among others, to improve the well-being of women, infants, and children throughout the state, including CSHCN. Oklahoma's MCH Service continues to lead *Preparing for a Lifetime, It's Everyone's Responsibility*, the statewide infant mortality initiative launched in 2009 to reduce infant death overall and to eliminate the racial/ethnic disparities in infant death.

MCH has developed and maintained close working relationships with state-level programs and with regional directors of the county health departments. Multiple and various opportunities exist to engage in activities with OSDH leadership to promote and advocate for Title V programs, including regular meetings for Deputy Commissioners, Directors, and Managers. The Title V MCH Director attends standing meetings with all Family Health Service Directors, providing opportunities to discuss crosscutting activities. MCH routinely collaborates with other OSDH programs to address issues of mutual interest, including preconception care, health across the life span, family planning, maternal mood disorders, breastfeeding, tobacco cessation, obesity, injury prevention, immunizations, newborn screening, adolescent pregnancy prevention, school health, infant safe sleep, family resource and support services, child care, early childhood, and social determinants of health.

MCH population-based services are provided through county health departments, professional service agreements, vendor, sub-recipient and state agency contracts, requests for proposals, and invitations-to-bid. Despite being administratively separate from the OSDH system, the Oklahoma City-County Health Department and the Tulsa Health Department are essential MCH partners, providing services and/or administering projects through direct contracts with the MCH Service.

The Oklahoma CSHCN Program at OKDHS oversees service provision to children receiving Title XVI Supplemental Security Income (SSI) through training and guidance to over 95 Social Service Specialists. These Specialists are responsible for writing, implementing, and monitoring plans for all children receiving SSI benefits and other services, via OKDHS. Families of children receiving SSI, but not Medicaid, are contacted to assure they are aware of services available through the CSHCN Program. Title V funds non-Medicaid compensable inpatient behavioral and psychological services to children in OKDHS custody. The CSHCN Program contracts with clinics to provide care to neonates in the Tulsa and Oklahoma City metropolitan areas. The CSHCN Program also contracts with community-based programs that provide education, information, referral, advocacy and resource navigation to families of children with special health care needs statewide.

CSHCN continues to develop relationships with various state and local agencies, and divisions within those agencies, in order to educate them about the CSHCN population and advocate for this population. CSHCN continues to be involved on the Sooner SUCCESS Interagency Council, Healthcare Transition Committee, Oklahoma Caregiver Coalition and Respite Subcommittee, Oklahoma Transition Council, and Joining Forces Committee, among others.

Title V funds are used to support program collaboration and coordination, and community activities across the state. To assure families have a voice in MCH and CSHCN programs and activities both MCH and CSHCN contract with the Oklahoma Family Network (OFN). OFN has created a statewide network of families which enables state Title V programs to engage with families at the individual and community levels on MCH-related issues. The MCH Title V Director, the CSHCN Title V Director, and the OFN Executive Director attend monthly MCH/CSHCN program meetings for strategic planning purposes and to review and discuss progress of relevant initiatives.

**III.C.2.b.ii.c. MCH Workforce Capacity**

Title V MCH Block Grant funds 37 full-time equivalent (FTE) positions. Of those employed by MCH, 9 have more than 10 years' experience working in MCH, 13 have 5-10 years' experience and 11 staff members have less than 5 years with the program. The CSHCN Program consists of two staff funded in part by Title V dollars, including the Title V CSHCN Director and one program staff, both with more than 10 years' experience at Oklahoma Department of Human Services working with populations with special needs. Both entities contract with the Oklahoma Family Network which has more than 20 years' experience providing a family voice to programs and agencies serving children and youth across the state.

A more detailed description of the training conducted for the development of Oklahoma's MCH-related workforce can be found in Section III.E.2.b.i. of the block grant narrative, Workforce Development. Brief biographies of key Title V staff who serve in lead MCH and CSHCN-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities are attached.

### III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Oklahoma's Title V programs have strong relationships with state and community-based public and private partners, and emphasize through these relationships the goal of promoting and protecting the health of MCH populations. The MCH Title V Director, CSHCN Director, and the OFN Executive Director are members of the Child Health Group and have provided continuing input into the formulation of statewide efforts to address health needs in the child and adolescent population.

Stakeholder input into Title V programming and activities is sought via a variety of mechanisms. These include regular meetings, opportunities for collaboration on supplemental grant applications, surveys, staff participation in projects, and in more informal ways during networking opportunities. MCH consults with the OSDH tribal liaison when tribal participation is key to the work being discussed and works with the OSDH Office of Minority Health, to assure those communities who need to be part of the planning and implementation process are included.

Table III.C.2.b.iii.1 highlights key partner programs and agencies that Oklahoma Title V and OFN collaborate with to improve health across the five domains: women/maternal, perinatal/infant, child, adolescent, and CYSHCN.

**Table III.C.2.b.iii.1. Key Partnerships with Oklahoma Title V**

| | | | | | |
|---|---|---|---|---|---|
| Chickasaw Nation | Cheyenne Arapaho Nation | Southern Plain Inter-tribal Health Board | Cherokee Nation | Choctaw Nation | Muscogee (Creek) Nation |
| Indian Health Service | Sooner SUCCESS | WIC | Go Red for Women | John 3:16 Mission, Tulsa | OK Child Care Resource and Referral Association |
| Oklahoma City County Health Department | OK Department of Mental Health and Substance Abuse Services | Families | Northeastern Oklahoma Tribal Health System | Oklahoma State Department of Education | Central Oklahoma Healthy Start |
| Head Start State Collaboration Office | Family Support and Prevention Services (OSDH) | March of Dimes | Youth Services Tulsa | Child Death Review Board | OU Department of Pediatrics (OKC) |
| Oklahoma Development Disabilities Council | Oklahoma Healthcare Authority | Oklahoma City-County and Tulsa Fetal and Infant Mortality Review Teams | Oklahoma Institute for Child Advocacy | Head Start State Collaboration Office | Tulsa Healthy Start Projects |
| County Health Departments | Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV,OADDH) | OU Health Science Center Child Study Center | Oklahoma Primary Care Association | Oklahoma Commission on Children and Youth | OU Health Sciences Center |
| Healthy Schools Oklahoma | Screening and Special Services (OSDH) | Oklahoma Turning Point | Oklahoma Partnership for School Readiness (OPSR) | OU Children's Medical Center | Safe Kids Oklahoma |

| | | | | | |
|---|---|---|---|---|---|
| Immunization Service (OSDH) | Child Care Services (OHS) | Center for Health Statistics (OSDH) | OU College of Social Work | OU College of Nursing and School of Medicine | The Oklahoma Transition Institute |
| Oklahoma Suicide Prevention Council | Oklahoma Partnership for School Readiness (OPSR) | Injury Prevention Service (OSDH) | Oklahoma Highway Safety Office | Oklahoma Tribal Child Care Association (OTCCA) | Child Care Advisory Committee |
| Oklahoma Mother's Milk Bank (OMMB) | Oklahoma Hospital Association | Perinatal Center of Oklahoma | Oklahoma Family Network | George Kaiser Family Foundation | American College of Nurse Midwives |
| Association of Women's Health, Obstetrics and Neonatal Nurses | The Parent Child Center of Tulsa | Community Service Council (Tulsa) | Child Guidance (OSDH) | Oklahoma Perinatal Quality Improvement Collaborative | OSU-Tulsa |
| OU Medical Center Women's Services | Center for the Advancement of Wellness (OSDH) | Oklahoma Autism Network | Center for Early Childhood Professional Development (CECPD) | Kirkpatrick Family Foundation | Tulsa Health Department |
| Little Dixie Healthy Start | Coalition of Oklahoma Breastfeeding Advocates (COBA) | SoonerStart (OSDH) | Oklahoma State Medical Association (OSMA) | Variety Health Center | Emergency Preparedness and Response Service (OSDH) |
| Oklahoma Breastfeeding Resource Center (OBRC) | Oklahoma Center for Poison and Drug Information | THRIVE | AMPLIFY | Maternal Health Task Force | Maternal Mortality Review |

**III.C.2.c. Identifying Priority Needs and Linking to Performance Measures**

The identification and selection of Oklahoma Title V priority needs were based on the results of a public input survey, tribal listening sessions, analyses of state data, a capacity assessment of Title V and MCH-related programs, recognition of ongoing and emerging issues, and the expertise of MCH and CSHCN professionals. While not exhaustive of all possible assessments, combined these efforts afforded a rich and varied examination of strengths and needs of pregnant women, mothers and infants, and children in the state of Oklahoma.

After the data were collected and analyzed, the Title V Block Grant Coordinator held a series of guided discussions for each domain using the information from the listening sessions, state data, survey input and staff and family expertise. Contractors, MCH and CSHCN staff and family representatives participated and worked to identify priorities and emerging needs. These selected priorities (eight to ten per domain) were used to guide the selection of the final eight Oklahoma Title V priorities by the MCH/CSHCN leadership team.

Using a multi-voting technique and the PEARL (Propriety, Economics, Acceptability, Resources, Legality) test, MCH/CSHCN leadership discussed and voted on the potential priorities and then determined which met the PEARL test criteria for Title V programs. Table III.C.2.c1 shows the potential priorities considered by Oklahoma Title V for inclusion in the top priorities for the state.

Table III.C.2.c1 List of Potential Title V Priorities for Oklahoma

| Women/Maternal | Perinatal/Infant | Child and Adolescent | CSHCN |
|---|---|---|---|
| Preconception/Interconception care | Breastfeeding | Bullying | Mental/behavioral health |
| Mental/behavioral health | Food Insecurity | Unintentional injury/child safety | Respite care |
| Maternal mortality | Mental/behavioral health | Health disparities | Chronic health conditions |
| Prenatal/postpartum Care | Infant Mortality | Mental/behavioral health | Developmental screenings |
| Access to quality care | Attachment | Sexual health education | Specialty care/ Necessary therapies |
| Overweight/obesity | Postpartum Depression and mood disorders | Life skills | Health Equity |
| Nutrition/food insecurity | Racism and Provider Bias | Health education | Poverty/Basic Needs |
| Substance Abuse | Safe sleep | Access to care | Transportation |
| Social workers/social supports | Child abuse/neglect | Chronic disease prevention | Food Insecurity/ Nutrition |
| Unplanned pregnancy | Need for social workers | Trauma-informed care | Transition to adult care |
| Chronic health conditions | Car seat safety | Substance use | Family/caregiver-centered programs |
| | | Healthy Relationships | Family support navigators |
| | | | Out of school time/child care |

Resources and Title V capacity were kept in mind when selecting priority needs. The final Title V Priority Needs were chosen as a result of needs assessment findings, existing capacity, and potential for improvement (See Table III.C.2.c2).

Table III.C.2.c2 Oklahoma Title V Priority Needs 2021-2025

| Priority Need | Need Type | Rationale |
|---|---|---|
| Reduce infant mortality | Continued | State and national priority. Oklahoma compares poorly to the US and other states, ranking near the bottom with a high IMR. Racial disparities in IMR are marked and persistent. |
| Improve the health of reproductive age individuals | New | Chronic conditions (diabetes, hypertension, obesity) remain high for Oklahoma women and men. A leading cause of infant death in 2018 was newborn affected by maternal conditions during pregnancy. Data for Oklahoma Maternal Mortality Review support the finding that a high proportion of maternal deaths are affected by chronic conditions. |
| Improve access to social workers and support systems throughout the state | New | At every listening session and within every program the overwhelming need identified across almost all population groups was assistance in accessing services and the importance of social supports. Research supports enhancing social supports to improve health outcomes. |
| Improve quality health education for children and youth | New | Oklahoma remains one of the few states in the nation without health education mandates in school. The state remains in the top five for teen birth rates in the country. Listening sessions and survey data reinforce the need for life skills training, comprehensive and high quality health education, sexual health education, and safety. |
| Improve the mental and behavioral health of the MCH population | Continued | Needs Assessment findings support the need for programs and services to address mental and behavioral health across population groups to include bullying, substance use/misuse (opiates), mood disorders, and postpartum depression. There is a notable lack of providers in rural locations and inpatient bed availability is lacking across the state. |
| Improve access to family-centered programs via family support navigators | New | Families with access to family-centered programs and navigators to assist in service provision are better prepared to meet their needs. Discussions with families and programs during listening sessions highlighted the need for more families and caregivers to have access to navigators, due to complicated health and social welfare systems. |
| Increase quality health care access for the MCH population | New | Needs Assessment findings highlight the importance of health care across all domains. Disparities in preconception and interconception health highlight the need for quality and access to health care across the lifespan. Listening sessions and survey results reinforced that access and quality are important to improving health outcomes. |
| Increase health equity for the MCH population | New | Disparities in health, particularly by race/ethnicity, are persistent across many birth outcomes and risk behaviors. |

The following performance measures in Table III.C.2.c3 were selected based upon the findings from our current five-year needs assessment and alignment to selected Title V priorities. Oklahoma Title V elected to continue the three State Performance Measures from the previous Needs Assessment cycle, due to their continued importance in improving the health and well-being of the MCH/CSHCN population and their relationship to current priorities. Specific rationale is listed in the third column for each performance measure selected along with the Oklahoma MCH Title V Priorities impacted by each measure.

| Table III.C.2.c3 State Performance Measures Selected for Oklahoma, by Population Domain | | |
|---|---|---|
| **Domain** | **Performance Measure** | **Priorities Impacted and Rationale** |
| **Maternal** | NPM: Percent of women, ages 18 through 44, with a preventive medical visit in the past year | MCH Priorities Impacted: Health of Reproductive Age Individuals, Health Equity, Infant Mortality, Behavioral and Mental Health, Health Education, Quality Health Care Access<br><br>Rationale: Impacts 6 of 8 Title V/MCH Priorities as listed above. |
| | SPM: Rate of Maternal Mortality | MCH Priorities Impacted: Health of Reproductive Age Individuals, Health Equity, Social Workers and Support, Infant Mortality, Behavioral and Mental Health, Quality Health Care Access<br><br>Rationale: Impacts 6 of 8 Title V/MCH Priorities as listed above. |
| **Perinatal** | NPM: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months | MCH Priorities Impacted: Health Equity, Social Workers and Support, Infant Mortality, Quality Health Care Access, Family Support Navigators, Health Education<br><br>Rationale: Impacts 6 of 8 Title V/MCH Priorities as listed. |
| | NPM: 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 | MCH Priorities Impacted: Health Equity, Social Workers and Support, Infant Mortality, Health Education, Family Support Navigators<br><br>Rationale: Impacts 5 of 8 Title V/MCH Priorities as listed. |
| | SPM: Rate of Infant Mortality | MCH Priorities Impacted: Health of Reproductive Age Individuals, Health Equity, Family Support Navigators, Social Workers and Support, Infant Mortality, Behavioral and Mental Health, Quality Health Care Access<br><br>Rationale: Impacts 7 of 8 Title V/MCH Priorities as listed. |
| **Child** | NPM: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day | MCH Priorities Impacted: Health Equity, Health Education, Social Workers and Support, Behavioral and Mental Health, Quality Health Care Access<br><br>Rationale: Impacts 5 of 8 Title V/MCH Priorities as listed above. |
| **Adolescent** | NPM: Percent of adolescents, ages 12 through 17, who are bullied or who bully others | MCH Priorities Impacted: Health Equity, Health Education, Social Workers and Support, Behavioral and Mental Health<br><br>Rationale: Impacts 4 of 8 Title V/MCH Priorities as listed above. |
| | NPM: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. | MCH Priorities Impacted: Health Equity, Health Education, Health of Reproductive Age Individuals, Social Workers and Support, Behavioral and Mental Health, Quality Health Care Access |

The above referenced state and national performance measures were chosen as those that best represented the needs of the Oklahoma maternal and child health population through extensive surveys and listening sessions conducted throughout the state resulting in MCH Priority areas identified. These measures were also selected based upon data trends and health impact upon residents.

### III.D. Financial Narrative

| | 2018 | | 2019 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $6,967,164 | $7,056,875 | $6,956,304 | $7,049,999 |
| State Funds | $5,285,582 | $4,725,532 | $5,217,228 | $5,988,318 |
| Local Funds | $0 | $1,304,765 | $219,826 | $1,189,061 |
| Other Funds | $0 | $0 | $0 | $0 |
| Program Funds | $4,050 | $1,195 | $32,970 | $0 |
| SubTotal | $12,256,796 | $13,088,367 | $12,426,328 | $14,227,378 |
| Other Federal Funds | $4,787,937 | $4,787,937 | $4,890,970 | $6,599,270 |
| Total | $17,044,733 | $17,876,304 | $17,317,298 | $20,826,648 |

| | 2020 | | 2021 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $7,407,455 | $7,215,434 | $7,215,434 | |
| State Funds | $5,578,263 | $6,120,077 | $5,411,576 | |
| Local Funds | $0 | $1,220,999 | $0 | |
| Other Funds | $0 | $0 | $0 | |
| Program Funds | $1,196 | $0 | $0 | |
| SubTotal | $12,986,914 | $14,556,510 | $12,627,010 | |
| Other Federal Funds | $5,361,987 | $7,771,094 | $8,147,585 | |
| Total | $18,348,901 | $22,327,604 | $20,774,595 | |

| | 2022 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $7,215,434 | |
| **State Funds** | $5,411,576 | |
| **Local Funds** | $0 | |
| **Other Funds** | $0 | |
| **Program Funds** | $0 | |
| **SubTotal** | $12,627,010 | |
| **Other Federal Funds** | $8,025,771 | |
| **Total** | $20,652,781 | |

**III.D.1. Expenditures**

See Forms 2, 3a, and 3b

The Oklahoma State Department of Health (OSDH) MCH value for parts A, B, and C is determined through the OSDH time and effort reporting system in which all state and local staff code their daily time to program activities. Non-personnel expenses are made as direct charges to the appropriate program budgets. State funds include state and county appropriations for local health departments. Other contributions include in-kind monies. Program income includes fee revenues from Medicaid. The OSDH is audited each year by the state auditor's office following the federal guidelines applicable to the MCH Title V Block Grant. All appropriate fiscal records are maintained to ensure audit compliance. It should be noted that the required breakdown of expenditures by types of services and individuals served, along with specific funding sources has necessitated some of these numbers to be estimated through the agency's current budgeting system. All should be moved from estimates to actual expenditure numbers once the agency's new financial system is in place.

The Oklahoma Department of Human Services (OKDHS) CSHCN value is determined through the Random Moment Time Study (RMTS) and based on employees' responses specifically related to the CSHCN Program. All Adult and Family Services staff that work multi-funded programs are sampled in the RMTS. RMTS sampling is a federally approved technique for estimating the actual distribution of worker time to various activities when numerous federal funding sources exist. The percentage of employees' responses to CSHCN-related tasks compared to responses to all other federal and/or state programs in the RMTS constitutes the value of costs directly charged quarterly to the CSHCN Program. Payroll, benefits, travel, etc., for RMTS participants are allocated proportionately based on RMTS responses.

The Oklahoma Title V Program continually looks for opportunities to realign funding for core enabling services and public health services and systems, while assuring critical gap-filling direct health care services are maintained. Expansion of Medicaid coverage up to 138% federal poverty level for Oklahomans between the ages of 19-64 begins July 1, 2021. Enrollment for this expanded coverage begins June 1$^{st}$. These efforts will not only assist the MCH population in accessing necessary services and care, but will also assist the Title V Program in further accomplishing critical realignments. These realignments will benefit Oklahoma by providing needed data and evaluation for policy and services decisions, quality improvement activities, training for health care providers, public education, and improved coordination among health and human services agencies.

Form 2 indicates Title V federal, state and local dollars remained fairly level when comparing 2019 to 2020 numbers, which was an accomplishment in itself considering the many historical challenges faced in 2020. While there were difficulties with staffing, due to the flexibility of Title V to utilize funds for COVID-19 dire needs in the MCH population, staffing and funding issues did not reach the severity they may have otherwise. Additionally, moving to gap-filling prenatal care and child health services in local county health departments and mobile units was delayed due to COVID-19 urgencies with hotline, testing, vaccination pods, etc. However, if things continue to improve as they have in recent weeks, these services should be able to begin by early summer 2021 in four pilot districts.

Form 3a documents expenditures by the MCH types of individuals served. For FFY 2020, total funding for children 1-21 increased by approximately 10% and funding for infants/infant mortality reduction program increased by 42%. At the same time, funding for pregnant women and CSHCN decreased by 24% and 15% respectively. This shift in funds in these areas was due in large part to enhanced efforts in regard to our infant mortality reduction initiative: *Preparing for a Lifetime: It's Everyone's Responsibility.* The infant mortality funding increase nicely complimented additional funds from the SMHIP grant that MCH utilized for pregnant women through innovative maternal health

initiatives such as: a special clinic for pregnant women with substance use disorder, tribal maternal-fetal medicine services, High Risk OB Project ECHO, and implementation of a new maternal safety bundle for Oklahoma Mothers and Newborns affected by Opioids, to name a few. Additionally, enhancements to grow the teen pregnancy prevention and positive youth development programs, health education, and epidemiology/analytical services in all districts in the state over the next year should assist in data-driven decisions and better outcomes for children with and without special health care needs.

Form 3b documents shifts that occurred within the categories of direct health care services, enabling services, and public health services and systems. Direct health care service expenditures utilized mostly for mental health treatment services for children with special health care needs remained flat from 2019 to 2020. Enabling services expenditures decreased by approximately 17% and public health systems and services increased by 9% in 2019. The shift to more population-based systemic services to address pandemic immediate and resulting needs, along with working with hospitals and partners in relation to best practices implementation in the areas of maternity, infant mortality reduction, and child health to address the need of the Oklahoma MCH population were demonstrated in 2020 expenditures.

With these changes, it should be noted that the Oklahoma Title V Program is very thoughtful in its process of looking at the priority needs of the MCH population and realigning funds and resources to meet those needs. As opportunities present with changes in national, Medicaid and state policies; state and county Title V staff; and Title V contractual services; the Title V Program will assure that the funds available are used for appropriate and quality services to optimize health outcomes for mothers, infants, children, and their families in Oklahoma. The Oklahoma Title V program is grateful to the HRSA Maternal and Child Health Bureau for the flexibility and support to adapt funding and services to the needs of our MCH population, as was particularly necessary and evident in the pandemic year of 2020.

**III.D.2. Budget**

**Maintenance of effort from 1989:**
For 1989 the OSDH administered 77.5 percent of the MCH Title V Block Grant funds and the OKDHS administered 22.5 percent of the funds. Even with this split, 1/3 of the available dollars were spent on CSHCN activities. The amount of the award for 1989 was $5,980,100. The OSDH share was $4,634,578 and the OKDHS received $1,345,522.

The OSDH expenditure reports indicate that a total of $4,634,578 of MCH Title V Block funds was expended during the grant period October 1, 1988 through September 30, 1989. For that period, a total $4,109,415 of the OSDH and county health department resources were expended for Block Grant activities. The amount of state/local expenditures exceeded the required match of $3,475,932 by an amount of $633,483.

Summary – Federal Fiscal Year (FFY) 1989 Block Grant Expenditures

| | State Health Department | Department of Human Services | Total |
|---|---|---|---|
| **Title V** | $4,634,578 | $1,345,522 | $5,980,100 |
| **Match** | $3,475,932 | $1,061,546 | $4,537,478 |
| **Overmatch** | $146,839 | $0 | $146,839 |
| **Income** | $250,000 | $0 | $250,000 |
| **Local/Other** | $236,644 | $0 | $236,644 |
| **Total** | $8,743,993 | $2,407,068 | $11,151,061 |

**Special consolidated projects:**
MCH Title V Block Grant funds continue to be used to carry out safe sleep activities and the CSHCN Supplemental Security Income-Disabled Children's Program (SSI-DCP). Safe sleep activities include public education and technical assistance along with resource provision (e.g. cribs, sleep sacks) at the community level. The Public Health Social Work Coordinator in MCH is responsible for coordination of Safe Sleep and sudden infant death syndrome (SIDS) related activities. The CSHCN SSI-DCP uses funds to provide formula, durable medical equipment, supplies and services that would otherwise not be available to children with special health care needs.

**State matching funds:**
In 2009, the OSDH made a policy decision to provide cost sharing in grant applications based on the requirements in each specific grant. For the MCH Title V Block Grant, cost sharing is based on the three state dollars for each four federal dollars as well as the requirement to meet the maintenance of effort set in 1989.

**Federal 30/30 requirement:**
For FFY 2021, 33% of the federal Title V Block Grant funds are designated for programs for preventative and primary care services for children, 30% for services for children with special health care needs, and 10% for administrative costs.

**State provides a reasonable portion of funds to deliver services:**

The OSDH uses MCH funds towards programs of priority for state and local needs. Assistance is provided to state and local agencies to: 1) identify specific MCH areas of need; 2) plan strategies to address identified needs; and 3) provide services to impact needs. Allocation of resources to local communities will continue to be based on factors such as: the identified need and scope of the particular health problem; community interest in developing service(s)/implementing evidenced-based practice(s) to eliminate the problem, including the extent and ability to which local resources are made available; ability to recruit the specialized staff which are often needed to carry out the proposed service; the cost effectiveness of the service to be provided; coordination with existing resources to assure non-duplication of services; and periodic evaluation to determine if resources have impacted the problem.

The OKDHS administers the CSHCN Program through Adult and Family Services (AFS). AFS also administers the SSI-DCP for SSI recipients under age 18. Other components of the CSHCN Program include a project that supports neonates and their families; support of the Sooner SUCCESS toll-free information and referral system for CYSHCN; a project that provides sickle cell services; respite care services for medically fragile children; medical, psychological and psychiatric services to the CSHCN population in the custody of the OKDHS; a project that is establishing an integrated community-based system of services for children with special health care needs in several communities in the state; funding for a statewide mentorship program for families of children with special needs; and, funding of a parent advocate on a team that provides multi-disciplinary services to children in the autism clinic. Coordination continues between the AFS and the Oklahoma Health Care Authority (OHCA) to assure services are not duplicated and policies and procedures are in compliance with federal and state mandates. The AFS continues to utilize Title V funding to assure the development of community-based systems of services for children with special health care needs and their families.

**Other federal programs or state funds within MCH to meet needs and objectives:**
The State Systems Development Initiative (SSDI), a grant funded by the Maternal and Child Health Bureau (MCHB), supports activities to link maternal, infant, and child health data (including birth and death certificates) with Medicaid eligibility and claims data. This compliments and strengthens MCH's activities to link relevant program services to existing MCH databases including the Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) surveillance systems. These linkages enable the state to generalize the results to Oklahoma's population of pregnant women (or new mothers) and young children.

The Pregnancy Assistance Fund (PAF), a grant funded by the Office of Adolescent Health, is a competitive grant program that funds states and tribal entities, including Oklahoma, so they can provide a seamless network of support services to expectant and parenting teens, women, fathers, and their families, with the goal of improving the health, educational, social, and economic outcomes of this special population. The Pregnancy Assistance Fund ended in December 2020.

The Pregnancy Risk Assessment Monitoring System (PRAMS), funded by the Centers for Disease Control and Prevention (CDC) and MCH, provides population-based data on maternal and infant health issues. This information is used to educate health care providers on maternal and infant health issues; recommend health care interventions; monitor health outcomes; and provide support for state policy and services changes.

The State Maternal Health Innovation Program is funded by HRSA to meet the needs of Oklahoma women and reduce maternal mortality and morbidity utilizing a multi-pronged approach. Through the OSDH MCH Service, the Oklahoma Maternal Health Task Force, and well-established partnerships throughout the state, the following are areas of focus for impacting and improving maternal health in Oklahoma: addressing racial disparities and implicit bias; increasing access to prenatal and postpartum care; addressing maternal morbidity through education and healthcare; addressing substance abuse and misuse in pregnant and postpartum women; increasing awareness

and access to treatment for maternal mood disorders; and, increasing access to telehealth services for high risk obstetric, substance use/abuse services and maternal mood disorders in rural Oklahoma.

Federal funds are received from the CDC to support ongoing administration of the Youth Risk Behavior Survey (YRBS). This survey provides Oklahoma with information on risk-taking behaviors of high school youth that is utilized to educate providers and public on current issues and recommended interventions.

Targeted state and general revenue funds are received to support key MCH activities such as: gap-filling maternity and child health clinical services; outreach to vulnerable and disparate populations; infant mortality reduction program activities including preconception and interconception care and education; preterm birth initiatives using evidence-based practices to reduce premature births; support of mothers and health care providers with breastfeeding information, education, and a statewide 24 hour 7 day per week breastfeeding hotline and texting services, Fetal and Infant Mortality Review (FIMR) projects; Maternal Mortality Review (MMR); adolescent pregnancy prevention and positive youth development efforts; childhood injury prevention; school health to include funding of school nurses in priority areas of the state; Oklahoma's Center for Poison and Drug Information; health education in public schools; Oklahoma Perinatal Quality Improvement Collaborative; birthing hospital safe sleep programs; Period of Purple Crying; *Every Mother Counts* maternal morbidity reduction program and related initiatives; and, data matching and analysis. Medicaid administrative match funds are received to support FIMR and data matching and analysis. The OSDH/MCH continued to receive funds this year for state- and community-based infant mortality reduction activities from the Governor and Legislature for key prevention and priority activities.

State funds, county funds, Medicaid revenue, fees, and Title X federal funds support the provision of family planning services through county health departments and contract clinic sites. These funds are also used to provide a variety of educational programs targeted at decreasing unintended pregnancies; postponing sexual activity in teens; preventing sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS); and, increasing knowledge of human sexuality.

The Oklahoma State Department of Health was designated as the state agency to receive funding from the Administration on Children, Youth, and Families (ACYF), Family and Youth Services Bureau (FYSB) to continue a Personal Responsibility Education Program (PREP). Funds are used to implement projects in the two large metropolitan areas of Oklahoma City and Tulsa through contractual agreements with the two independent city-county health departments. These projects focus on educating adolescents on both sexual risk avoidance and contraception to prevent pregnancy and STDs, including HIV/AIDS, and adulthood preparation (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, healthy life skills).

**Budget Documentation:**
Overall budget preparation and monitoring are provided through administrative support under the direction of the OSDH Chief Financial Officer. Agency budgeting, grants, and contract acquisition staff meets routinely with program areas. The MCH Director is responsible for overall program budget oversight and, along with each individual Division Administrative Program Manager, is responsible for compliance with program standards and federal and state requirements.

The OSDH receives an annual independent audit of program and financial activities. The state's Office of the State Auditor and Inspector conducts this annual statewide single audit. The OSDH maintains an internal audit staff that reviews county health departments and subcontractors for compliance with contract fiscal matters relating to OSDH support. Additionally, MCH performs onsite program reviews with county health departments and contractors to assure programmatic compliance for both Title V and Title X.

The comptroller for the Adult and Family Services prepares and oversees the budget for the CSHCN Program. The CSHCN Director is responsible for compliance with federal and state requirements. CSHCN program staff monitors the budget and meet regularly to insure financial awareness within each budgeted area. CSHCN performs yearly onsite reviews with each contracted entity to insure program compliance. Each contractor also undergoes an independent audit. The state's Office of the State Auditor and Inspector conducts an annual audit of the CSHCN Program to assure compliance and accountability.

The Title V Grant application documents a proposed budget on Forms 2, 3a, and 3b, inclusive of Title V federal funds, state dollar match, local dollars, and anticipated income to be received from Medicaid. This budget is the base for services at the beginning of the grant period. As the year passes, the OSDH may make available more state and local funded resources (e.g., staff, supplies, travel) as available for provision of MCH services as an agency priority. This results in increased funding reported as expended on Forms 2, 3a, and 3b, compared to budget requirements. It is understood each year that these additional state and local funded resources are fluid and may be redirected at any time by the Commissioner of Health based on state and/or agency priorities, or in the event of a state health event, emergency or disaster needing to be addressed. An example of this is the recent COVID-19 pandemic, as all funds and resources possible needed to be diverted to these response efforts. The OSDH appreciates Title V's understanding and willingness to utilize Title V funds and personnel to meet the health needs of Oklahoma's moms, babies, children and families in the state during this critical time period.

Federal MCH block grant funds complement non-federal Title V funds in supporting essential MCH programs and services to meet Oklahoma's maternal and child health population needs. Both federal and non-federal Title V MCH Block Grant funds are vital to the state's capacity to address these needs.

## III.E. Five-Year State Action Plan

### III.E.1. Five-Year State Action Plan Table

**State: Oklahoma**

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

### III.E.2. State Action Plan Narrative Overview

#### III.E.2.a. State Title V Program Purpose and Design

Oklahoma administers the MCH Title V Block Grant through two state agencies, the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (DHS). The OSDH, as the state health agency, is authorized to receive and disburse the MCH Title V Block Grant funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108. These sections create the OSDH and outline the Commissioner of Health's duties as "general supervision of the health of citizens of the state." Title 10 of the Oklahoma Statutes, Section 175.1 et.seq., grants the authority to administer the CSHCN Program to the DHS.

The OSDH MCH Service manages programs and services for pregnant women, mothers and infants, children and adolescents, while the CSHCN Program oversees those for children and youth with special health care needs. OSDH, as the state health agency, receives federal Title V Block Grant funds and then transfers funds designated for CSHCN to DHS. OSDH and DHS formulate a memorandum of agreement (MOA) which directs the administration and funds for the CSHCN Program. The MOA is attached.

The MCH Title V Program is located in the OSDH within Family Health Services (FHS). The FHS is organizationally placed under Keith Reed, Community Health Services Deputy who reports to the Commissioner of Health. Joyce Marshall, Director of MCH, is directly responsible to the Assistant Deputy Commissioner of the FHS, Tina Johnson, who is directly responsible to the Community Health Services Deputy. Dr. Marny Dunlap is currently serving as Medical Director for the Child and Adolescent Health Division and Dr. Pamela Miles is Medical Director for the Perinatal and Reproductive Health Division.

The Title V CSHCN Program is located in the Adult and Family Services Division under Adult and Family Services Director Patrick Klein, Adult and Family Services Assistant Director for Program Operations Shawn Franks, and Deputy Director for Programs Linda Cavitt. Carla McCarrell-Williams is the Director of the CSHCN Title V Program. Mr. Klein reports to Justin Brown, DHS Director. Mr. Franks reports to Mr. Klein. Mrs. Cavitt reports to Mr. Franks and the CSHCN Director reports to Mrs. Cavitt. The organizational charts for MCH, OSDH and CSHCN are attached.

Programs administered in some part with Title V funds include: *Preparing for a Lifetime, It's Everyone's Responsibility* Infant Mortality Reduction Initiative*;* the Collaborative Improvement and Innovation Network on Preconception/Interconception Health; *Every Mother Counts* Maternal Mortality and Morbidity Reduction Initiative; Period of PURPLE Crying program; PRAMS, TOTS and YRBS surveillance programs; Teen Pregnancy Prevention Projects throughout the state; State Systems Development Initiative; Fetal Infant Mortality Review; school health programs in the two major metropolitan areas*; Becoming Baby Friendly Oklahoma;* and other-related programs and initiatives.

MCH and CSHCN contract with the Oklahoma Family Network (OFN) to assure family input is incorporated into the planning, development, and evaluation of Oklahoma's Title V programs. OFN has created a statewide network of families which enables state Title V programs to engage with families at the individual and community levels on MCH-related issues. The MCH Title V Director, the CSHCN Title V Director, and the OFN Executive Director attend monthly MCH/CSHCN program meetings for strategic planning purposes and to review and discuss progress of relevant initiatives.

Oklahoma's Title V programs enjoy strong relationships with state and community-based public and private partners, and emphasize through these relationships the goal of promoting and protecting the health of MCH populations. MCH, OFN and CSHCN participate in the Oklahoma Child Health Group. MCH serves as the lead for the state's

infant mortality reduction initiative, *Preparing for a Lifetime, It's Everyone's Responsibility,* with several MCH leadership staff leading topical workgroups (i.e., maternal mood disorders, preconception care, infant safe sleep, breastfeeding, injury prevention) in the initiative. MCH continues to be integrally involved with the work of the Oklahoma Perinatal Quality Improvement Collaborative and the Oklahoma Maternal Health Task Force, which aim to improve the care of women, mothers, and infants throughout the state.

MCH has close working relationships with state level programs and with the Regional Directors of the county health departments. There are multiple opportunities to engage in activities with OSDH leadership to communicate about Title V, including the monthly meeting held by the Assistant Deputy Commissioner of the FHS and regular meetings with the Commissioner and Cabinet Secretary. These meetings provide a space for agency updates, sharing program activities, and networking. In the former, the MCH Title V Director interacts with all FHS Directors, affording an opportunity to discuss crosscutting activities. MCH routinely collaborates with other OSDH programs to address issues of mutual interest, including maternal health, preconception care, family planning, maternal depression, breastfeeding, tobacco use prevention, dental care, obesity, injury prevention, immunizations, newborn hearing and metabolic screening, adolescent pregnancy prevention, school health, family resource and support services, child care, and early childhood.

The provision of services for MCH populations are accomplished through county health departments, professional service agreements, vendor and state agency contracts, requests for proposals, and invitations to bid. Although administratively separate, the Oklahoma City-County Health Department and the Tulsa Health Department are essential MCH partners, providing services or administering projects via direct contracts. Some examples include the Fetal Infant Mortality Review (FIMR) projects, Pregnancy Assistance Fund (PAF) program, the Personal Responsibility Education Program (PREP) projects, MCH Outreach and School Health programs.

Bullying and youth suicide prevention are priority focus areas in work accomplished with the Oklahoma State Department of Education (OSDE) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). MCH has committed to assist in further building community level infrastructure for recognizing and intervening to prevent youth suicide across the state by assuring staff working with youth provide evidence-based trainings in their areas.

The CSHCN Program oversees the provision of social services to children receiving Supplemental Security Income (SSI) by providing training and guidance to approximately 95 Social Services Specialists throughout DHS, who are responsible for developing and monitoring service plans for children who receive SSI and other services through the DHS. The provision of high quality, coordinated, comprehensive and family-centered systems of services to Oklahoma's CYSHCN is accomplished through several contracts DHS has in place which include the Oklahoma Family Network, Comprehensive Pediatric Sickle Cell Clinic, Family Support 360°, Oklahoma Infant Transition Program, Family Partners, Sooner SUCCESS, and the JD McCarty Center. The CYSHCN related services above can be accessed via the Social Services Specialists and on the DHS website.

In Oklahoma, the Title V program utilizes a life course framework for needs assessment, program planning and performance reporting at the state and local levels. Trainings, data, and activities are structured to emphasize the importance and effectiveness of reducing risk factors and increasing protective factors early in life to reduce poor health and social outcomes later in adolescence and adulthood. The most prominent examples of this are the *Preparing for a Lifetime, It's Everyone's Responsibility* infant mortality reduction initiative led by MCH and the life course work accomplished with families through OFN.

The Oklahoma CSHCN Program utilizes federal funds for specialty services to children and youth with special health care needs and their families. Services include neonatal services, specialty services for children with sickle cell

anemia, durable medical supplies and respite care. The monies enable family partner programs to assist families in finding community-based resources, participate in Title V partnership and decision-making and attend family-professional partnership trainings, like the Association of Maternal and Child Health Programs (AMCHP) Conference. This helps assure families have a voice in MCH and CSHCN services.

MCH works with partner organizations to develop or promote innovative and evidence-based approaches. Examples include partnership with the Parent Child Center of Tulsa and their barbershop program and the Maternal Health Innovation grant's usage of the CHESS Health app to assist providers working with pregnant women with addiction issues. The CSHCN Director regularly meets with Adult and Family Services Program Managers as well as DHS and OHCA leadership which provides an opportunity to discuss cross-cutting issues that impact the health status of the CSHCN population and their families.

The core public health functions of assessment, assurance, and policy development are integral to Title V's approach to programs in Oklahoma. All programs, projects and contractors are required to submit data and performance indicators and to assess effectiveness and reach. This is in addition to the on-going efforts of the Title V Needs Assessment and data collection activities in the MCH Assessment Division. Quality assurance processes are put into place by several MCH programs, using data collected during assessments and surveys. Although COVID-19 halted some progress in implementing quality improvement processes into a wider array of programming. MCH and CSHCN are active participants in multiple work groups, boards, and councils designed to influence and improve policy for the MCH population, from Medicaid/Soonercare to Child Death Review Board to Sooner SUCCESS and the Oklahoma Family Network and many more in-between. Staff assist with items like drafting and reviewing the Health Education Standards created by the Oklahoma State Department of Education and writing rules for promulgation on OSDH-related legislation, most recently midwifery and school vision screening.

### III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

#### III.E.2.b.i. MCH Workforce Development

Title V MCH Block Grant funds 36 full-time equivalent (FTE) positions. Of those employed by MCH, 13 have more than 10 years' experience working in MCH, 8 have 5-10 years' experience and 12 staff members have less than 5 years with the program; 3 positions are vacant. The CSHCN Program consists of two staff funded in part by Title V dollars, including the Title V CSHCN Director (recently made vacant) and one program staff, with more than 10 years' experience at Oklahoma Department of Human Services working with populations with special needs. Both entities contract with the Oklahoma Family Network which has more than 20 years' experience providing a family voice to programs and agencies serving children and youth across the state. Brief biographies of key Title V staff who serve in lead MCH and CSHCN-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities are attached.

MCH adheres to the Oklahoma State Department of Health (OSDH) administrative policies and procedures regarding recruitment and retention of qualified, competent and diverse applicants to fill vacant positions. All MCH positions are posted on the Office of Management and Enterprise Services online employment center. MCH works in partnership with leadership, human resources, supervisors and current employees to attract, screen, evaluate and hire individuals with the appropriate qualifications, education and skills to succeed. Job descriptions are designed to align with the vision, mission and values of OSDH, MCH essential services and the mission of OSDH Maternal and Child Health Service. Requirements and priorities of program funders also inform the development of job descriptions.

Recent staff additions to MCH resulted in a full-staff complement. Employee retention is accomplished through orientation, mentoring, administrative support, professional development and opportunities for transition and advancement. Agency supports such as a generous benefits package, employee assistance program, health and wellness activities, and partnerships with other OSDH programs contribute to employee satisfaction and retention.

All new MCH employees must complete trainings required by OSDH, including data security, HIPAA, cultural competency, ethics, safety, and supervisory (if indicated). In addition, the MCH New Employee Orientation Checklist must be completed during their first few months, which includes Human Subjects Research Training, MCH Navigator website review and trainings, Title V Block Grant and Needs Assessment Review, Title X Grant and Needs Assessment Review, the Oklahoma Health Improvement Plan review, and a site visit to both the Oklahoma Family Network and a county health department.

Based on the results of an annual needs assessment process, trainings are provided by MCH to staff in county health departments, OSDH central office, and contract staff. These trainings include required content such as child abuse identification and reporting, and sexual coercion, including human trafficking. Training for SFY 2021 includes chronic diseases impacting reproductive health, child abuse, neglect, and human trafficking, updates on OSDH programs supporting the prevention of infections in pregnancy and immunizations for maternal and infant health, outreach and community participation, family planning and maternity program update, preconception/interconception health, domestic/interpersonal violence, adolescent health issues, women's and men's health priorities. Each topic includes conversations and recommendations with a health equity approach. These trainings are recorded and distributed to staff in county health departments serving the maternal and child population.

MCH continues to provide the Life Course Approach training for new and current employees, highlighting the significance of adverse childhood experiences as they impact health outcomes into adulthood. Nursing students, interns and partners are also provided the training. Due to COVID-19 these trainings were placed on hold.

Beginning in 2020, recruitment began for an Epidemiologist, an Adolescent Health Specialist, and a MCH Social Worker for each Health Department District throughout the state. Although COVID-19 paused most recruitment and hiring for these positions, as of April 2021, many Districts renewed the process of searching for applicants.

Title V CSHCN is located at the Department of Human Services (DHS) in the Adult and Family Services (AFS) Division and consists of two state-level program staff: the Title V CSHCN Director and a Title V Programs Field Representative. These two staff are responsible for overseeing the provision of services to children under the age of 18 who receive Supplemental Security Income (SSI) by providing training and guidance to approximately 95 AFS eligibility workers statewide located in 26 districts in Oklahoma; districts being comprised of one or more counties. Eligibility workers in the districts complete requests and monitor services provided to children who receive SSI through the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Services provided through SSI-DCP are supplemental formula, adaptive equipment which aids in accessibility and mobility, interaction and integration services aimed at strengthening the child physically and mentally, and respite care. All services must be pre-approved by the state level staff.

Newly hired AFS eligibility workers attend a New Worker Academy within their first year of employment. New workers receive instruction on all AFS services including a brief overview of Title V regulations, the SSI-DCP Program, and children who receive SSI. Tenured staff, as well as those leaving New Worker Academy, continue to receive instruction in the field regarding Title V services through online tutorials (QUEST) and the AFS Eligibility Handbook on the Agency's Infonet. Assistance on Title V services is also available through the DHS State Office Health Related & Medical Services Outlook Mailbox (HRMS Mailbox).

DHS AFS continues to operate under the model of First Contact Resolution (FCR). The goals of FCR are to interview the same day of application, determine eligibility no later than the next business day, reduce steps in the process, eliminate hand-offs, obtain all verification while the client is present, and avoid delaying the decision. These guiding principles help to reduce variation and provide consistency which assist in staff training and provide more timely benefits to our CSHCN population.

Over the last year, DHS AFS began rebuilding the caseload distribution process so that work is shared over a region rather than over districts or individual counties. All but one of the regions in Oklahoma encompass multiple districts, which means that with redistribution, the caseloads for individual workers are more evened out across the state. The ultimate goal for caseload redistribution is to share work on a statewide level. This newly created regional redistribution process was constructed so that all workers, both urban and rural, would be able to maximize their ability to engage the customer beyond just performing eligibility tasks for benefits to better help to meet the customer's basic needs. Additionally, AFS workers are being imbedded into the local communities with various community partners, to meet the customer where they are. This aligns with DHS's True North AFS goal of "improving access to all available services and supports through collaboration with community partners and other state agencies."

CSHCN continues to partner with three programs at the University of Oklahoma Health Sciences Center Section on Developmental and Behavioral Pediatrics of the Department of Pediatrics; the Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND), the Developmental-Behavioral Pediatric Fellowship, and the Sooner State Unified Children's Comprehensive Exemplary Services for Special Needs (Sooner SUCCESS) Program. These programs offer a variety of workforce development opportunities across multiple disciplines.

Oklahoma LEND offers interdisciplinary leadership education programs for advanced graduate or postgraduate students in Audiology, Autism Spectrum Disorders (ASD), Child and Adolescent Psychiatry, Genetic Counseling, Nursing, Nutrition, Occupational Therapy, Pediatric Medicine, Physical Therapy, Psychology, Public Health, Social

Work and Speech-Language Pathology. Community members in Parent-Family Perspective and Self-advocacy are also included as trainees. Training is provided through classroom, clinical/community-based experiences and research activities related to children-youth with neurodevelopmental and related disabilities and their families. Training highlights the core principles of Family-centered/Person-centered services, Cultural Competence, Interdisciplinary Teaming, and Inclusive Community-Based Practices. The program has expanded over the last few years to include trainees from Tulsa, Stillwater, and rural communities of Oklahoma. Included in the expansion is the ability to offer more short- and medium-term training opportunities to an increased number of learners, in addition to those receiving the traditional long-term training.

The fellowship training in Developmental-Behavioral Pediatrics (DBP) is a three-year program, accepting one fellow each year. Like the LEND training, it provides interdisciplinary education experiences through didactic, clinical/community and research activities focused on the core principles of Family-Centered/Person-Centered Care, Cultural Competence, Interdisciplinary Teaming, Life Course and Inclusive Community-Based Practices on behalf of children and youth with Autism Spectrum Disorders (ASD) and other Developmental Disabilities (DD) and their families. The funding for the program will continue through the Department of Pediatrics. There are three board-certified DBP physicians in Oklahoma. LEND and DBP fellows and pediatric residents are all provided training and observations of the JumpStart Interdisciplinary Team, which includes the Family Partner role funded by Title V.

Sooner SUCCESS works to advance a comprehensive, unified system of health, social and educational services for Oklahoma Children and Youth with Special Needs through community-based resource coordination. Sooner SUCCESS County Coordinators help coalitions identify, plan, and educate key stakeholders to reduce gaps in services in their communities. Health Care Transition continues to remain a priority focus area. Sooner SUCCESS has been conducting a pilot study in partnership with the Child Study Center, Sickle Cell Clinic and Sooner Pediatrics to learn how to effectively improve health care transition as well as implement a formal process to improve the transition from pediatrics to adult health care. Sooner SUCCESS, LEND and the Child Study Center Medical team are formally training LEND trainees, DBP fellows, and pediatric residents/faculty to improve how patients transition from pediatric to adult health care services.

**III.E.2.b.ii. Family Partnership**

The Oklahoma Family Network (OFN), Oklahoma's Family-to-Family Health Information Center, assures family involvement in Title V work at the direct care, organizational, governance and policymaking levels. The OFN utilizes a statewide network of families to engage families as partners and connects them to opportunities to share their voice. MCH has a multi-year agreement with the OFN to ensure family involvement at the state and local levels through family participation and engagement in Title V activities. Family members are hired as paid staff or consultants for CSHCN via contractors, including OFN. OFN staff members work closely with the Title V MCH Director and Title V CSHCN Director attending monthly planning meetings, participating in quarterly calls of Region VI Title V Directors and Region VI Health and Human Services Administration (HRSA) partners, as well as participating in multiple state level efforts as part of Oklahoma Title V. Financial support (financial assistance, technical assistance, travel, and child care) is offered for parent activities, parent groups, youth leadership activities and sibling support groups.

Family members are involved in both the CSHCN and MCH elements of the MCH Title V Block Grant application process. OFN participated in the planning, information gathering activities, and prioritization process for the 2016-2020 Title V Needs Assessment and the ongoing 2021-2025 Assessment. OFN staff members also attend the annual review for the block grant, providing valuable insight into programmatic activities, family needs, challenges, and participation opportunities.

Family and youth leaders participate in advisory roles statewide and OFN offers training, mentoring, coaching and reimbursement, when appropriate. Some of the committees and advisory councils include: hospitals serving children across the state; Oklahoma Department of Human Services (DHS) Developmental Disabilities Services; Oklahoma Commission for Children and Youth; Interagency Coordinating Council for SoonerStart; Oklahoma State Department of Health (OSDH) *Preparing for a Lifetime* Breastfeeding Work Group and Maternal Mood Disorder Work Group; Screening and Special Services and Newborn Screening Advisory Groups; Children with Special Needs and Child Health Advisories; Oklahoma Perinatal Quality Improvement Collaborative and their leadership team; Oklahoma Department of Rehabilitation Services Deaf and Hard of Hearing Advisory; Oklahoma Transition Council; Oklahoma Department of Mental Health and Substance Abuse Systems of Care State Advisory Team and Children's State Advisory Work Group and multiple county coalitions; Oklahoma Health Care Authority Member Advisory Task Force and Medical Advisory Committee; and, Child Welfare activities to reduce the number of children in custody and to develop HOPE Centers to meet the needs of children during days they were not in a traditional school setting during the COVID public health crisis.

Additional activities that OFN has and will continue to provide includes podcasts which include a family sharing their story of parenting a child with special needs while sharing connections to resources for a number of MCH and CSHCN topic areas. All podcasts are highlighted in the quarterly OFN newsletter, promoted on OFN Facebook pages and are available on the OFN You Tube Channel and website.

OFN impacts the workforce of those in public and private health service by providing training on topics such as: supporting families of children/youth with special needs and disabilities, family centered care, OFN overview of services, LifeCourse Tools, Care Notebook, Parent-Nurse Communications Class, and LEND participation and feedback activities as well as LEND mentoring from a family's perspective. Tribal and Hispanic families are involved to promote culturally respectful service delivery. Service area trainings for CSHCN staff and providers are given by family members. Trainings on Charting the LifeCourse, family-centered care, the importance of family/professional partnerships, and family involvement at every level of decision-making have been given to state MCH staff and home-based visitation staff, the University of Oklahoma (OU) College of Social Work, OU College of Nursing and School of Medicine, Oklahoma Health Care Authority, Oklahoma Autism Network, The Oklahoma Transition Institute,

Autism Symposiums, various early intervention and school district staff, and other professionals across the state.

Family and youth leaders across the state attend community county coalitions and advisories, comprised of multiple state agency staff, community leaders, clinic and hospital staff, school personnel, law enforcement and many others. Their voice is meaningful as it drives the work of the coalitions to meet the needs of families in their counties. Some counties have youth advisory councils, which provide a venue for youth: to review services being provided, attend health literacy training, learn of opportunities for raising awareness regarding bullying and mental health in their communities, along with other important advocacy efforts.

OFN staff, family leaders and youth leaders have impacted state policy and governance by coaching families to share their stories at the capitol, during public comment hearings, at state agency boards and committees, by participating in Newborn Hearing Screening Impact Statements, and by having a presence on state level advisories for: State Department of Education Part C, Mental Health and Substance Abuse Services, State Department of Health Child Health Workgroup and Perinatal Quality Improvement Collaborative and Leadership Team, the consumer advisory of the Medicaid agency, the Child Health Workgroup (which leads efforts at the state level to meet gaps in behavioral healthcare for children and their families) and a host of others. Participating in other state-level meetings with Title V partners as well as hosting and participating in advocacy events in communities across the state and at the capitol are all forms of family and youth advocacy in Oklahoma.

For 14 years, OFN has hosted Joining Forces: Supporting Family Professional Partnerships Conference. Almost 300 families and professionals attended the conference, focused on family professional partnerships as we foster belonging: Joining Forces to Support Ordinary Needs of Families.

OFN trainings are available in Spanish. During the Family Track of the 2021 Virtual Children's Behavioral Health Conference, OFN provided all sessions translated in Spanish. The families were offered child care reimbursement and three family leaders without proper electronics to access the virtual conference were provided tablets. In collaboration with Heartland Regional Genetics Network, OFN now has most documents for the Care Notebook Training available in Marshallese. The partnership has also successfully completed videos to help families who speak Spanish understand genetics and to know what to expect during a genetics appointment. In collaboration with Family Voices, OFN has provided telemedicine training to families and professionals in English and Spanish. An effort has been made by American Indian staff and families to assure OFN trainings are agreeable to families from their culture. All trainings consider aspects of other cultures, beyond race and ethnicity, such as single moms, military families, rural and urban families, disability-specific, child welfare experience, etc.

OFN staff communicated with various Title V and other partners to create NICU Folders for families with multiple resources including OFN information, breastfeeding, safe sleep, and NICU tip sheets in English and Spanish. Staff are working on developing similar folders for genetic referrals, including newborn screening information.

**III.E.2.b.iii. MCH Data Capacity**

**III.E.2.b.iii.a. MCH Epidemiology Workforce**

The Maternal and Child Health Assessment Division (MCH Assessment) has responsibility for building data capacity and all data related functions relevant to advancing MCH priorities, including data collection, data management, analysis and reporting, and program evaluation. MCH Assessment is comprised of 13 positions (11 FTEs), which include epidemiologists, biostatisticians, and project managers, along with support staff who carry out administrative and operations functions within the unit. Analytic staff is assigned to support program areas or grant projects. MCH Assessment has accountability for the performance of Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), and the State Systems Development Initiative (SSDI), the main surveillance systems and data capacity initiatives in the MCH Service. Furthermore, the unit is a heavy user of birth certificate and death certificate data, as well as the Public Health Oklahoma Client Information System (PHOCIS), OSDH's internal data system that captures information about client caseload and service utilization with respect to care provided in county health departments and contract sites.

MCH Assessment is led by Paul Patrick, Administrative Program Manager (1.0 FTE), who holds a Master's of Public Health in Biostatistics and has more than 20 years of public health experience, the majority of which has been in MCH. Mr. Patrick serves as the data contact for the Title V MCH Block Grant and has responsibility for drafting key sections of the application and annual report. His duties include supervision of MCH Assessment staff; design and oversight of the Title V Five-Year Needs Assessment; Data Liaison for the Collaborative Improvement and Innovation Networks (CoIIN) to improve infant mortality, safe sleep, and preconception care; including the completion of grant applications and performance reports. Mr. Patrick also has responsibility for preparing and overseeing Institutional Review Board applications as needed for MCH projects. Funding for the Administrative Program Manager is drawn from the Title V Block Grant.

The Senior Biostatistician position (1.0 FTE) with MCH Assessment is held by Binitha Kunnel, MS. In her role, Ms. Kunnel serves as the lead statistical and epidemiologic resource for the MCH Service, providing leadership in interpreting results of analyses and advising MCH leadership in translating results into actionable programming. She has responsibility for performing analysis of PRAMS and TOTS surveillance data, assuring that these data are incorporated into building Title V data capacity. Ms. Kunnel has supervision over the MCH Medicaid Analyst (described below) and assists with directing priority analyses of the OHCA/MCH Medicaid Shared-Data Workgroup. She has 10 years of experience in MCH. Ms. Kunnel's FTE position is funded by the Title V Block Grant, PRAMS, and the State Maternal Health Innovation Program (SMHIP) grant.

The MCH Medicaid Analyst (1.0 FTE) position within MCH Assessment is presently vacant; the incumbent having resigned in October 2020. Recruitment is ongoing at this time. This position has responsibility for linking and analyzing birth certificate and Medicaid administrative records.

Two epidemiologists (2.0 FTEs) are employed by MCH Assessment. One, the Child and Adolescent Health Epidemiologist position, is held by Thad Burk, MPH. Mr. Burk has 18 years of employment in MCH as an epidemiologist. He has responsibility for supporting the Child and Adolescent Health (CAH) Division within the MCH Service, providing technical expertise on data analysis and reporting. Likewise, MCH Assessment has a second epidemiologist (Dana Coles, MPH) who provides support for the Perinatal and Reproductive Health (PRH) Division. Ms. Coles has greater than 10 years employment experience with MCH, primarily focused on family planning program support. However, she supports the submission of the Title V Block Grant and has co-coordinated the completion of the Five-Year Needs Assessment with previous Oklahoma grant submissions. Funding to support these positions is combination of Title V, YRBS, PREP, SMHIP, and Title X funds.

Susan Harman, DrPH, holds the position of State System Development Initiative (SSDI) Analyst (1.0 FTE) in MCH Assessment. In that role, she served as the Five-Year Needs Assessment Coordinator for the 2021-2025 Title V Block Grant. Ms. Harman has primary responsibility for advancing MCH data capacity to include partnering with internal and external entities to develop new datasets, topic-specific analyses, and reporting dashboards. She has five years of experience working in MCH, but has been a professor in academia and served as an analyst for the Tribal Epidemiology Center for the Oklahoma City Area Tribal Health Board, now known as the Southern Plains Tribal Health Board. Principally, Ms. Harman is funded with SSDI grant funds (90%), the remainder coming from Title V dollars.

Remaining staff (5.0 FTEs) within MCH Assessment consist of an Administrative Assistant, PRAMS-TOTS Programs Manager, PRAMS-TOTS Data Manager, and four temporary, half-time positions employed as phone surveillance staff. Each of these positions serves to support the data capacity, analysis, and evaluation activities performed in MCH Assessment. Funding for positions is allocated from Title V and PRAMS grants.

MCH Assessment continues to collect surveillance data via PRAMS, TOTS, and YRBS, and seeks to develop improved reporting mechanisms, primarily through Tableau dashboards and retooled data products designed for social media presentation. Through SSDI activities, MCH Assessment aims to partner with internal service areas (e.g., Screening, WIC) to develop linked data systems for analyses. Recruitment for the MCH Medicaid Analyst will continue to such time as the position is filled with a qualified candidate. Once filled and the new hire is trained, MCH Assessment and the OHCA/MCH Medicaid Data Workgroup will resume linkages and analyses of birth and Medicaid records. This work is vital to creating a better understanding of health outcomes and health care use patterns among the Medicaid population in Oklahoma.

**III.E.2.b.iii.b. State Systems Development Initiative (SSDI)**

The Oklahoma SSDI project, funded by the MCHB, is used to support the MCH Service, setting three goals to this end: 1) to build and expand MCH data capacity to support the Title V MCH Block Grant activities and to contribute to data-driven decision making as it relates to assessment, planning, and evaluation of MCH programs; 2) to advance the development and utilization of linked MCH-related data systems; and 3) to provide data support in state quality improvement activities. The SSDI project contributes to addressing the state's need for improved availability, timeliness, and utilization of population-based, administrative, and program data to inform Title V programs.

*(i) Progress in building and supporting timely and linked MCH data systems*
In FY2020, with SSDI's ability to manage volumes of MCH associated datasets, coupled with the promise of robust information through data linkage, data used are to inform MCH Service and OSDH leadership to improve the health and well-being of women, children, and their families. The available linked datasets include infant deaths to births, Medicaid administrative records to births, births to Pregnancy Risk Assessment Monitoring System (PRAMS), and births to the Oklahoma Toddler Survey (TOTS).

Infant deaths to birth data. Oklahoma SSDI has consistent data access to vital records on a daily basis. Generally, the lag time for accessing finalized datasets for births and deaths range from 6-8 months for birth datasets to 8-10 months for death datasets after the end of the calendar year. However, due to coronavirus pandemic the finalization of 2019 data was delayed into 2021. These data were obtained from the Office of Vital Records, the state's authority for recording vital events, and the Center for Health Statistics (CHS), a unit responsible for preparing statistical datasets for analysis and reporting. The first step to linking the infant deaths to birth certificate records is accomplished by CHS, who then gives permission to the SSDI Analyst to access to the linked infant death/birth data. The SSDI Analyst has responsibility for standardizing the linked data for use in detailed infant mortality assessment.

Medicaid records to birth data. The Medicaid Data Sharing Workgroup is a joint project of the Oklahoma Health Care Authority and the MCH Service. MCH data capacity is also expanded by the work of the MCH Medicaid Analyst who is responsible for linking and analyzing birth certificate records and Medicaid administrative data. The workgroup, staffed by MCH and OHCA personnel, directs the linking and analysis efforts. To date, data for years 2015 to 2018 have been linked and used in analyses of neonatal substance withdrawal, the use of 17P (17 alpha hydroxyprogesterone caproate) among Medicaid enrollees, and infant mortality.

Newborn screening records to the birth defects surveillance system. SSDI is focused on expanding the data capacity by collaborating with internal partner Screening and Special Services (SSS) and has access to NewSTEPS 360, a national newborn screening resource center. The SSS newborn metabolic screening linkage to birth certificate has been slowed due to the coronavirus pandemic. The data linkage will be resumed in FY2022.

PRAMS and TOTS data to birth records. PRAMS data are directly linked to birth certificate data. These data are used as baseline data for assessments across the Title V programming. As a follow-back study of PRAMS, TOTS data are linked to PRAMS and births by design. These MCH surveillance projects provide a wealth of data on diverse health topics - preconception care, safe sleep, maternal smoking, breastfeeding, and intimate partner violence to name a few.

*(ii) SSDI role in enabling Title V program assessment, monitoring, and reporting*
The role of SSDI is to develop, enhance, and expand MCH data capacity and provide epidemiologic support for the Oklahoma Title V program. Organizationally, the Oklahoma SSDI is positioned in the MCH Service, within Family Health Services at OSDH. The MCH Director, MCH Assessment Administrative Program Manager, SSDI Project Analyst, and the MCH Medicaid Analyst comprise the key positions listed on the SSDI grant. The SSDI grant funds

most of the salary of the SSDI Project Analyst.
SSDI provides data and statistical analyses for MCH and CSHCN staff to use in making data driven decisions, which may include areas to concentrate effort, potential projects to initiate or implement, and where services are needed for new and existing clients.

Developing tools for collecting and analyzing data to carry out the ongoing reporting needs of the MCH population is another responsibility of SSDI. The SSDI project reports on important MCH public health indicators in order for disparities to be assessed and compared over time.

During FY2020, as part of the Title V Five-Year Needs Assessment process, the SSDI performed data collection, analyses, and reported results from a public input survey, tribal listening sessions, and a key informant survey that supported the data driven decisions utilized in planning the Title V Block Grant Five-Year Action Plan. SSDI took part in the CDC directed surveillance of Oklahoma women who tested positive for COVID-19 during their pregnancy in calendar year 2020. Further, the SSDI Project continued to develop and refine Tableau dashboards for displaying provisional vital records data, core/minimum data sets, and the national performance and outcome measures.

*(iii) Description of key SSDI program activities*
In FY2020, SSDI time and effort was focused on the Five-Year Needs Assessment, completing and cataloging MCH dashboards, the surveillance of Oklahoma women testing COVID-19 positive during pregnancy, and real time reporting of vital records for births and infant deaths.

Five-Year Needs Assessment
The SSDI coordinated the Title V MCH Five-Year Needs Assessment and played a supporting role in the preparation and submission of the Needs Assessment section in the 2021 Title V MCH Block Grant Application and 2019 Annual Report. In FY 2020, the coordination of the 2021-2025 MCH Title V Needs Assessment was the final year of a two-year process of engaging partners; planning and organizing grant activities; collecting, analyzing, interpreting, and reporting data; and writing and rewriting narratives.

- The SSDI developed and disseminated the Oklahoma Public Input Survey online using web-based Qualtrics software. Responses were compiled and a condensed report highlighted the respondents' top three priorities under each of the MCH domains.
- Listening Sessions. The SSDI Project Manager served as a scribe at the listening sessions with seven tribes/tribal entities, African American community, and families with CYSHCN. A Microsoft Access database of responses was developed from all events and dashboard reports were created in Tableau for the Needs Assessment Advisory Working Group. In addition, a summary report of the seven tribal listening sessions has been drafted for the Oklahoma AI/AN community that includes the outstanding themes addressed by the tribal listening session participants.
- Key Informant Interview Survey. The SSDI developed and disseminated the Oklahoma Key Informant Interview Survey online using web-based Qualtrics software. Responses were compiled and a summary report was made available to the Needs Assessment Advisory Working Group.
- SSDI analysts developed narratives providing a descriptive view of relevant MCH indicators within each of the MCH domains.

Five-Year State Action Plan.
SSDI developed reports from multiple sources to guide public health recommendations that are data-driven and cost effective for use in developing the Oklahoma Five-Year State Action Plan. Information was utilized from the public input surveys, the seven tribal listening sessions, the African American community listening session, the CYSHCN listening session, and key informant survey, areas that provided access to timely, reliable data so that partners can

use this information in their own efforts to advance equity.

Minimum/Core Datasets.

During FY2020, the SSDI updated the minimum/core indicators with the most current publicly available data in an Excel spreadsheet provided with the *Minimum/Core Dataset Implementation Guide* supplied by Maternal Child Health Bureau. Where publicly available data were not available, data requests were sent to various OSDH divisions including Screening and Special Services, Injury Prevention, and Health Care Information. The SSDI Project received the most current data available from these divisions. Dashboards were developed with real-time provisional birth and infant death data for timely action at the state level for advancing evidence-based decision-making in maternal and child health programs.

The SSDI also constructed interactive dashboards that provide real-time provisional data reporting for births, preterm births, infant deaths, and SUIDs and are run on a weekly basis and reported monthly. The SSDI developed a dashboard catalogue for documenting data definitions, source files, programming, and file locations to ensure quality reporting and repeatable results among analysts.

The dashboards provide end users a tool for keeping abreast of the various indicators and are aimed at providing data visualizations reflecting current provisional data reporting for action at the state level. Continued training is being undertaken for utilizing the interactive features built in the Tableau software. Dashboards have also been populated with elements designated as a National Outcome Measure (NOM) and/or a National Performance Measure (NPM) to make comparisons to the United States and other states. The dashboards include graphs and charts to provide a snapshot of the Oklahoma population and surrounding states.

The MCH dashboards attempt to put these indicators into broader context and to use this information for evaluating programs and policies. The county-specific population information includes population socioeconomic status information, and trends of pregnancy outcomes and infant deaths.

**III.E.2.b.iii.c. Other MCH Data Capacity Efforts**

Additional efforts to expand MCH data capacity include building a data catalog for the Innovative Technology and Data Systems Work Group (ITDSW) of the Maternal Health Task Force. The ITDSW requested that an environmental scan of existing data sets be performed to document and learn what data are available for the study of maternal health in Oklahoma. MCH Assessment is taking the lead in this endeavor. A list of data systems has been compiled with staff beginning to investigate the parameters of each system. Compiled information will be used to build a searchable database which can be employed by the ITDSW and others to identify where topics of interest can be found. The use of the database extends beyond the MHTF and will be shared as appropriate with other partners.

Another effort includes work described in the section for the Needs Assessment Update, on the CDC's COVID-19 Pregnancy Module. Here, MCH staff have been involved in collecting pregnancy and neonate information from pregnant women who tested positive for COVID-19 in 2020. Collected data are submitted to the CDC for analysis and research publication. MCH Assessment will also perform an assessment of the data to be used in informing Title V programs.

It should be noted here that much of the data capacity building carried out by MCH Assessment to further Title V goals and objectives is funded from sources other than those awarded by the SSDI grant. Primarily, funds are drawn from the Title V Block Grant but staff time devoted to efforts that expand data capacity (data collection, management, analysis, reporting, data linking and so forth) are additionally funded by YRBS, PREP, PRAMS,Title X, and SMHIP. Those efforts have been described elsewhere in the application.

**III.E.2.b.iv. MCH Emergency Planning and Preparedness**

MCH participates in the OSDH Continuity of Operations Plan (COOP), which contains information pertaining to the deployment, mobilization, and tactical operations of MCH in response to emergencies and includes a listing of critical functions that would need to be carried out in the event of a disaster. It also lists the critical MCH staff involved to carry out the functions. Staff review the plan twice per year for revisions/updates. It has been in place for approximately fifteen years.

MCH also was an active participant, prior to the COVID-19 pandemic, in the Emergency Preparedness and Response Service's (EPRS) Senior Advisory Committee (SAC), comprised of senior staff from OSDH and multiple external partner agencies. The SAC is the advisory body that guides administration and implementation of the Centers for Disease Control and Prevention (CDC) Public Health Emergency Preparedness (PHEP) cooperative agreement, and the Assistant Secretary of Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) cooperative agreement. The SAC has been given the authority to make recommendations related to strategic direction and implementation of these grants in Oklahoma. The SAC also serves as an advisory committee for the Oklahoma Office of Homeland Security (OKOHS) and the Oklahoma Department of Emergency Management (OEM).

Members of the SAC include representatives of:

- The Oklahoma Medical Reserve Corps
- Oklahoma Department of Agriculture
- The Oklahoma Department of Corrections
- The Oklahoma Center for Poison and Drug Information
- Oklahoma City County Health Department
- Tulsa Health Department
- Oklahoma Primary Care Association
- Oklahoma Office of Homeland Security
- OUHSC OK Emergency Medical Services for Children
- Office of Chief Medical Examiner
- Oklahoma School Security
- Oklahoma State Department of Health (OSDH), includes MCH Service and Screening and Special Services
- Office of Communications
- Public Health Lab
- Operation Flu Fight

MCH staff participated in multiple activities for virus mitigation during the COVID-19 pandemic, although not directly a member of the leadership team for the Incident Command for COVID-19. Staff participated in the COVID-19 Hotline, assisted in data collection on women with recent pregnancies or live births, worked in the Strategic National Stockpile Warehouse preparing and distributing orders of Personal Protective Equipment (PPE), provided support in testing and vaccine pods, and, assisted in information dissemination.

Title V CSHCN was challenged during the COVID-19 pandemic in its delivery of services in two areas. One area centered around the distribution of supplemental formula through the Supplemental Security Income – Disabled Children's Program (SSI-DCP). The warehouse where the formula was stored was part of a series of unexpected building and county office closures. CSHCN staff were tasked with rapidly establishing a new method of delivery after many years of utilizing the same vendor. CSHCN utilized an already existing finance system for creating vouchers that could be provided to families to purchase the formula themselves at a vendor of their choosing in their

local community. Even with an existing foundational system in place, it took approximately four months for Oklahoma's IT state agency to establish specific coding for the formula tied to the Title V funds. The new system functioned well for approximately two months before it had to paused to clear up incorrect budget coding in the system. The voucher system is now working properly and families are being contacted and assisted in finding local vendors to provide the formula. Unfortunately, there was a gap in consistent formula services for these families while the new process was being created and subsequent issues resolved.

A second area of challenge regarding service delivery for CSHCN was centered around policy for respite providers. Pre-pandemic rules did not allow respite providers to reside in the home with the caregiver and care recipient. Leadership from several divisions within DHS who administered respite were brought to the table and it was determined that an exception to policy could be made during the Public Health Emergency to allow the respite provider to be another adult who resides in the home with the caregiver and care recipient. Informing eligible recipients about this temporary change in policy in a timely manner was challenging. However, both CSHCN staff at DHS and Title V contracted partners informed families through one-on-one interactions and through various virtual trainings and meetings with other programs and agencies to help spread the word.

Oklahoma Family Network met with a number of challenges as well. All services and supports were shifted to be provided via Zoom or by phone/text. OFN was able to provide Care Notebook Training individually as well as in groups online or by mailing the notebook with materials and calling the individuals. The Care Notebook includes a Portable Medical Summary, which includes all medical information (health history, medication list, hospitalization list, etc.) one might need if accessing a medical provider that does not have the individual's records or during an emergency when access to records may not be immediate. OFN was also able to provide outreach to and direct families to providers offering COVID testing as well as COVID vaccinations. OFN and disability-related partners, in collaboration with the Oklahoma City-County Health Department, assisted more than 250 families in providing registration for COVID vaccines where special assistance was being provided to individuals with disabilities and other special needs.

**III.E.2.b.v. Health Care Delivery System**

**III.E.2.b.v.a. Public and Private Partnerships**

Oklahoma Title V has excellent relationships with partners throughout the state and this assists programs in assuring access to quality health care and needed services for the Oklahoma MCH population. Title V CSHCN has an ongoing commitment to build, sustain and expand partnerships. CSHCN collaborates and coordinates with various other MCH-serving organizations to accomplish respective missions and to identify priority needs.

Other system partners include: Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Perinatal Quality Improvement Collaborative (OPQIC), Oklahoma Hospital Association, Oklahoma March of Dimes, Oklahoma American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Chapters, Oklahoma State Medical Association (OSMA), Southern Plains Tribal Health Board, Indian Health Service, tribal nations, birthing hospitals, universities, county health departments, physicians, and other public health organizations and agencies. Examples of some of these collaborations include:

- *AIM/Every Mother Initiative* to reduce severe maternal morbidity and maternal mortality through evidence-based safety bundles;
- *Focus Forward Oklahoma* to reduce unintended pregnancies and teen births through education, counseling, and increased access to long acting reversible contraceptives;
- *OPQIC Maternal Opioid Use Disorder and Neonatal Abstinence Syndrome Work Group* to decrease maternal opioid use and infants affected with NAS;
- *OPQIC Preterm Birth Initiative* to promote best practices with providers to reduce preterm births;
- *The Child Health Group* to improve overall child health outcomes;
- *Sooner SUCCESS Health Care Transition Team/Advisory Board* to advise on services for CYSHCN and transition to adult care services;
- *Oklahoma Caregiver Coalition*, comprised of approximately ten subcommittees, to share information about various community resources and services, including but not limited to respite, psychosocial supports, transportation and legal services, for caregivers of all ages, including families of CYSHCN. Oklahoma Caregiver Coalition Respite Subcommittee members from several agencies and DHS sub-divisions, including Title V, continued to provide quarterly updates to inform families and professionals about services available during the COVID-19 National Emergency and any temporary relaxed requirements for eligibility for these programs.
- *Waiting in Oklahoma* to provide status updates about the DDS Wait List in Oklahoma and to provide families the opportunity to ask questions, seek support, and talk about issues families are having that those in the group may be able to help with.
- *Child Death Review Board, Fetal and Infant Mortality Review Teams, and Maternal Mortality Review Committee* to review maternal, fetal, infant, and child deaths and make recommendations in relation to prevention and best practices;
- Choctaw Nation Medical Center pilot to improve breastfeeding and safe sleep practices;
- *Preconception CoIIN* to improve Women's Health awareness and assessment during Preconception/Interconception phases;
- *Oklahoma Maternal Health Task Force* working together to improve maternal health services, programs and outcomes in Oklahoma through four main priorities including access to adequate care and maternal health programs; improved maternal mental health, behavioral health and social services; innovative technology and data systems; and reduced racial disparities and implicit biases.
- *Cribs and Safe Sleep Participation Projects* to assure safe sleep education and tools (including portable cribs and sleep sacks) to Oklahoma newborns and families throughout the state;
- *Oklahoma Family Network Advisory Committee* to advise the Oklahoma Family Network in relation to

services and resources for Oklahoma families of CYSHCN and to identify gaps and potential service providers to fill those gaps ; and the

- *SoonerCare Member Advisory Task Force (Medicaid Member Advisory)* to provide perspectives and recommendations of SoonerCare members and their parents to the Oklahoma Health Care Authority for quality improvement and program development; and
- *Continuum of Care (COC) Communication Workgroup* to implement a communication plan at DHS to ensure feedback among internal and external stakeholders throughout the continuum of services to better meet the needs of children and youth at risk in Oklahoma.

The Oklahoma Family Network (OFN) is a contracted provider of the OSDH and DHS and assists in obtaining valuable family input on how best to provide Title V services to families in need. OFN outreach services include:

- Assisting and informing families regarding online SoonerCare (Medicaid) enrollment and connecting them with their local DHS office in cases of CYSHCN;
- Providing Adult Medicaid Expansion promotion as well as information regarding upcoming shift to Medicaid Managed Care agencies.
- Hosting regional parent institutes and family/professional partnerships conferences across the state to support identifying and navigating services, managing challenging behaviors and the effects of trauma. Family/professional partnerships were promoted;
- Hosting Trauma-Informed Summertime Professional Development Summit for teachers and school-based professionals in the second largest school district in Oklahoma;
- Hosting the *14th Annual Joining Forces: Supporting Family Professional Partnerships* conference by Zoom (due to COVID-19) with nearly 300 participants. Drs. Jennifer Jones and Kami Guller shared research and engaged the audience in ensuring underserved and marginalized citizens feel they belong, and how to increase feelings of belonging and being heard and seen;
- Hosting virtual and in-person (when possible) booths at conferences, trainings, health fairs, walks, etc. to share information regarding access to Medicaid and other services – events such as Coffee Chats at the Capitol for legislators, Mental Health, Rare Disease and Developmental Disabilities Awareness events (primarily via social media due to COVID-19) across the state, Heartland Regional Genetics Network Trainings, and other MCH-related events;
- Continuing to provide SoonerCare, TEFRA and private duty nursing information and access on Facebook pages (public and private), in quarterly OFN newsletters, during parent support, etc.;
- Serving as a family voice regarding *Preparing for a Lifetime: It's Everyone's Responsibility* events and programming;
- Providing training and supporting families completing TEFRA, respite, SSI and other applications;
- Partnering with OHCA to assist in identifying barriers and improving access to TEFRA and SoonerCare in general via the OHCA Member Advisory Task Force;
- Partnering with Managed Care Organizations to promote access to information and support they will provide beginning October, 2021 and,
- Promoting and sharing information to families and policy makers regarding financing of waivers and state plan services.

Other services relating to financing and policy decision-making include: providing *Telling Your Story* and *Sitting on Boards and Committees* Trainings at Family Leadership Institutes, during Zoom trainings and individually to ensure the family voice and experience is available and valued to improve financing of essential services and better access to health care for CYSCHN and their families. OFN Family Leaders serve as members of the OKDHS Developmental Disability Services Policy Committee, OHCA Member Advisory Task Force, OSDH *Preparing for a*

*Lifetime* and other Maternal and Child Health committees, Screening and Special Services committees, and Mental Health and Substance Abuse Services State Advisory Team for Systems of Care and State Advisory Workgroup for Children's Behavioral Health, to name a few. The OFN provides stipends to family leaders for their involvement in these important decision-making groups and for attendance at coalition meetings to ensure family voice.

This last year delivery of services was challenged by the COVID-19 pandemic. Having these established relationships with partners throughout the state eased the burden as we all worked together to meet the immediate needs of Oklahomans throughout the state. Under the Governor's and legislative charge, the state health department led these efforts throughout the state, and state agencies, organizations, and individuals pitched in to do whatever was needed to mitigate the spread of the virus throughout the state. Title V and MCHB were very flexible with allowing both grant funds and personnel to be utilized as needed for these events, including utilization of current staffing for the coronavirus hotline, strategic national stockpile, epidemiology hotline, symptoms check tables, and COVID-19 testing and vaccination pods, caring vans, and clinics. Oklahoma is grateful to Title V and MCHB for this as it assisted programs greatly in providing necessary personnel and funds when and where required for all Oklahomans.

**III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)**

A close working relationship with the State's Medicaid Agency, the Oklahoma Health Care Authority (OHCA), is of high value to Title V to the degree that representation and involvement from OHCA can be found in most all Title V initiatives undertaken.

OSDH MCH works together with the OHCA to recruit and enroll eligible applicants to Medicaid through the county health departments. MCH and OHCA are working together to implement gap-filling maternity and child health services in local county health departments and mobile health units. Additionally, staff from both entities work together to implement evidence-based and best practices in the Oklahoma Maternal Health Task Force, Oklahoma Perinatal Quality Improvement Collaborative, The Child Health Group and Maternal Mortality Review Committee.

Other unique collaborative efforts between the OHCA and MCH are the Shared Data Work Group and analyst position. The OHCA and MCH have a leadership team that meets monthly to address shared MCH topics of interest through linked data. The analysis is accomplished by a shared analyst position (paid 50% from OHCA Medicaid and 50% from the MCH) who links both data systems and gathers critical data and information to further inform efforts to critical MCH areas of concern such as Neonatal Abstinence Syndrome and prenatal care. OHCA and OSDH are also working together to implement the new Health Information Exchange to integrate electronic health records and data systems throughout the health care network to coordinate and improve care in our state.

Additionally, Oklahoma has a Family Planning State Planning Amendment (SPA) in place which covers family planning services for males and females including examination, lab, contraceptive supplies, sterilizations, and Gardasil. Funds received from the SPA are matched funds used to pay for staff, contraceptive supplies, and medications under the program name SoonerPlan. These funds assist in reducing unintended pregnancies and teen births by sustaining access to the family planning program for priority populations.

Two Medicaid Health Service Initiatives began in October 2018 and continued through September 2020. These impacted two MCH Title V focus areas, unintended pregnancy and infant safe sleep. The OHCA provided 78% of the costs for these projects with MCH Service funding the remainder. One project provided long acting reversible contraceptive methods to reduce unintended pregnancies and teen births in the counties and the other expanded the Cribs Project to reduce infant deaths and racial disparities through improvements in infant safe sleep practices with culturally sensitive educational materials, portable cribettes and sleep sacks for those in need.

The OHCA and DHS have an agreement to assure cooperation and collaboration in performance of their respective duties to provide health care to persons eligible under Titles V, XIX, XXI of the Social Security Act; including, but not limited to, children in state custody and Title V recipients.

OHCA and DHS collaborate to provide both organizational and programmatic support to the other, as outlined in the MOU. An interagency steering committee comprised of executive management staff from both agencies meet to ensure coordination of responsibilities, including establishment of a strategic plan for both agencies.

Waivers or state plan amendments which influence health care delivery for the MCH population, particularly CYSHCN, are the 1915 (c) home and community-based waivers and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). DHS medical programs have the responsibility for the operation and allowable OHCA administrative activities of approved 1915 (c) home and community-based waivers. Developmental Disabilities Service Division, a division of DHS, serves individuals who are three years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for individuals with intellectual disabilities. OHCA and DHS coordinate all mutual policy issues related to the operation of

all waivers and state plan amendments.

TEFRA is a state plan option available for a certain population of CYSHCN. Under Section 134 of TEFRA, (P.L.97-248), states have the option to make Medicaid benefits available to children with physical or mental disabilities who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parent's income or level of resources being too high. In these cases, only the child's income and resources are used in determining financial eligibility. Under Oklahoma's Medicaid program, TEFRA allows children who are eligible for institutional services to be cared for in their homes (they don't have to be in an institution). The cost of care at home compared to the cost in an institutional setting is also used in determining eligibility. DHS determines the financial eligibility and OHCA establishes the medical eligibility for the TEFRA program.

DHS, in collaboration with OHCA, recently came into full compliance from a business processes vantage point regarding annual Title XIX eligibility determinations. The eligibility renewal process was automated for Title XIX and all associated medical program benefits for all persons, including CYSHCN, who receive SSI. The newly created automated renewal system for SSI recipients will enhance healthcare delivery as it will remove the barrier of benefits being incorrectly closed for CYSHCN which created gaps in service and hardships for families trying to remedy the closure.

### III.E.2.c State Action Plan Narrative by Domain

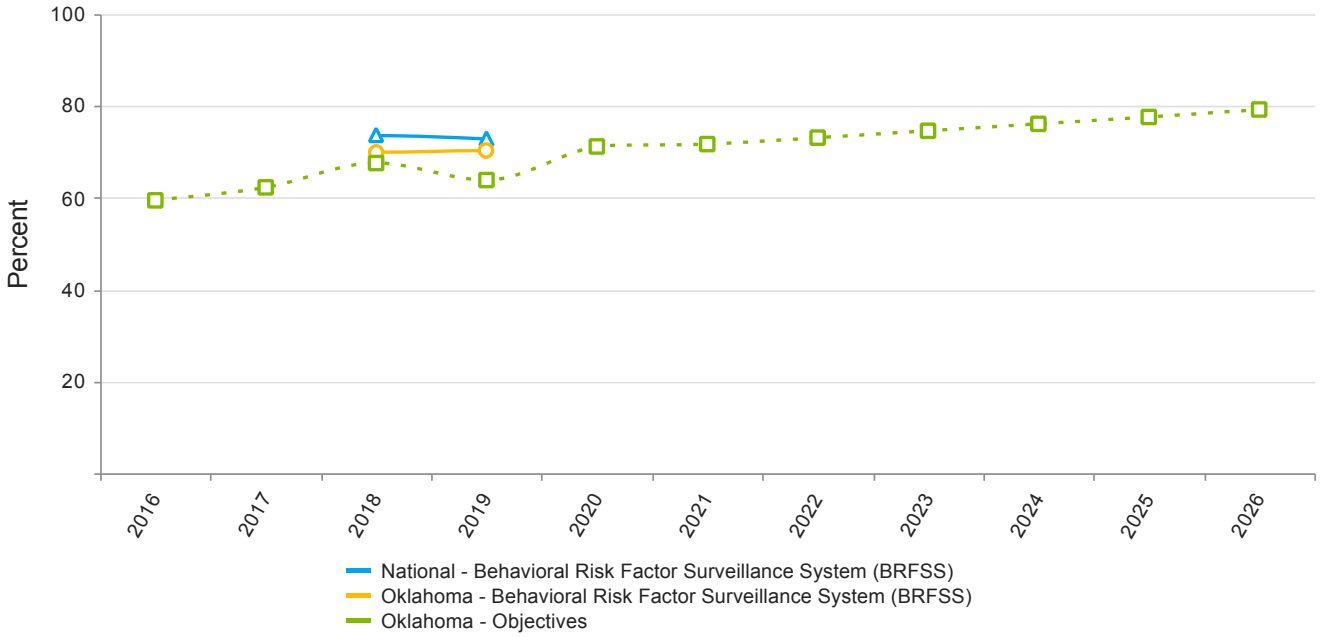
**Women/Maternal Health**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations | SID-2018 | 73.0 | NPM 1 |
| NOM 3 - Maternal mortality rate per 100,000 live births | NVSS-2015_2019 | 23.5 | NPM 1 |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) | NVSS-2019 | 8.2 % | NPM 1 |
| NOM 5 - Percent of preterm births (<37 weeks) | NVSS-2019 | 11.5 % | NPM 1 |
| NOM 6 - Percent of early term births (37, 38 weeks) | NVSS-2019 | 30.6 % | NPM 1 |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2018 | 6.5 | NPM 1 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2018 | 7.1 | NPM 1 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2018 | 4.3 | NPM 1 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2018 | 2.8 | NPM 1 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2018 | 198.8 | NPM 1 |
| NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy | PRAMS-2015 | 5.0 % | NPM 1 |
| NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations | SID-2018 | 5.7 | NPM 1 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2019 | 27.4 | NPM 1 |
| NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth | PRAMS-2017 | 15.0 % | NPM 1 |

## National Performance Measures

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year**
**Indicators and Annual Objectives**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | | | 71.1 |
| Annual Indicator | | | | 69.7 | 70.3 |
| Numerator | | | | 471,074 | 463,707 |
| Denominator | | | | 675,608 | 659,936 |
| Data Source | | | | BRFSS | BRFSS |
| Data Source Year | | | | 2018 | 2019 |

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 71.6 | 73.0 | 74.5 | 76.0 | 77.5 | 79.1 |

**Evidence-Based or –Informed Strategy Measures**

**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**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 95 | 100 | 100 | 105 |
| Annual Indicator | 91 | 90 | 95 | 95 | 95 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | PHOCIS | PHOCIS | PHOCIS | PHOCIS | PHOCIS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 100.0 | 105.0 | 110.0 | 115.0 | 120.0 | 125.0 |

**State Performance Measures**

**SPM 1 - Maternal mortality rate per 100,000 live births**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 17.4 | 20.8 | 24.1 | 22.3 |
| Annual Indicator | 20.1 | 23.7 | 24.9 | 23.5 | 23.5 |
| Numerator | 32 | 37 | 38 | 35 | 35 |
| Denominator | 159,025 | 155,953 | 152,607 | 148,949 | 148,949 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2017-2019 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 23.0 | 22.6 | 22.1 | 21.7 | 21.2 | 20.8 |

**State Action Plan Table**

| State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Improve the health of reproductive age individuals | |
| **NPM** | |
| NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year | |
| **Objectives** | |
| 1. Increase the number of women returning for the postpartum visit from 87.3% in 2016-2018 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 15.0% in 2018 to 20.0% in 2025. | |
| **Strategies** | |
| 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. | |
| **ESMs** | **Status** |
| 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 | Active |

NOMs

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

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

## State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 2

### Priority Need

Increase quality health care access for the MCH population

### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

### Objectives

Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births from 29.3% in 2016-2018 to 25.0% by 2025.

### Strategies

Promote the importance of reproductive life planning through utilization of the Women's Health Assessment/new 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.

| ESMs | Status |
| --- | --- |
| 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 | Active |

NOMs

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

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

## State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 3

### Priority Need

Increase health equity for the MCH population

### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

### Objectives

Create a Communication and Dissemination Plan to educate reproductive age males and females on being healthy before and between pregnancies in areas of the state with the highest infant and maternal mortality rates by December 2021.

### Strategies

Distribute preconception/interconception health materials at community events (Farmer's Markets, Community Baby Showers, etc.).

Create and provide targeted preconception health information to populations in need of the information as identified by PRAMS and other data sources.

Continue to assist all clients visiting a county health department for a preventive health visit with development of a reproductive life plan.

Develop social media messages and expand social media venues to reach reproductive age females and males.

| ESMs | Status |
| --- | --- |
| 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 | Active |

NOMs

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

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

## State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 4

### Priority Need

Improve the mental and behavioral health of the MCH population

### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

### Objectives

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 2022.

### Strategies

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.

| ESMs | Status |
| --- | --- |
| 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 | Active |

NOMs

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

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

## State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 5

### Priority Need

Increase health equity for the MCH population

### NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

### Objectives

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.

### Strategies

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.

| ESMs | Status |
| --- | --- |
| 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 | Active |

NOMs

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

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

## State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 6

### Priority Need

Improve the health of reproductive age individuals

### SPM

SPM 1 - Maternal mortality rate per 100,000 live births

### Objectives

Reduce maternal mortality rate from 24.9 maternal deaths per 100,000 live births in 2016-2018 to 17.5 by 2025.

### Strategies

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.

**NPM: Percentage of women with a past year preventive medical visit**

**Objective 1. Increase the number of women returning for the postpartum visit from 87.3% in 2016-2018 to 95.0% in 2020.**

**Data:**
According to the most recent Pregnancy Risk Assessment Monitoring System (PRAMS) data (2016-2019), 88.0% of new mothers in Oklahoma attended their postpartum visit with the postpartum visit rate increasing slightly from 87.3% in 2016-2018. White mothers reported a higher postpartum visit rate (90.0%) than Black mothers at 85.2%, Native American mothers at 83.8% and mothers who reported their race as other at 84.3%. With global billing and reimbursement for obstetric services, claims data were not available to support this self-reported percentage. As in previous years, based on anecdotal information, these numbers may be inflated by recall or social desirability bias, as mothers may have been aware they were expected to return for the postpartum visit but did not actually attend the visit.

**Successes:**
PRAMS data were used to create the Oklahoma Maternal and Child Health Data Review. Preconception and chronic health data in the review indicated that Oklahoma women reported higher rates of diabetes (3.5%) and depression (16.4%) than the national rates of 3.1% and 12.8%, higher rates of smoking in the three months prior to pregnancy (23.4% Oklahoma, 17.7% nationally) and higher rates of obesity (31.8% Oklahoma, 25.3% nationally). Oklahoma mothers also reported higher rates of postpartum depression (15.2% vs. 12.5%). These data supported the need for preventive medical visits as an opportunity for preconception counseling and the importance of the postpartum visit for follow-up and intervention if needed.

The Soon-To-Be-Sooners Medicaid plan continued in the state but was a limited benefit plan with coverage ending at delivery; therefore, the postpartum visit was not covered. Consequently, women who qualified for this package may not have returned for their postpartum visit and health care providers were not motivated to encourage these mothers to return in the absence of medical conditions requiring follow-up.

County health department staff continued to encourage women to return to their delivering provider for a postpartum visit. For those women who refused to return to the delivering provider, the advanced practice nurse in the county health department conducted a postpartum visit, follow-up or referral for follow-up on any health conditions that developed during pregnancy (i.e. gestational diabetes, hypertension) and encouraged the use of the moderately or most effective methods of contraception as indicated through client-centered counseling.

Within OSDH, the Family Support and Prevention Service provided oversight for all of the home visiting programs under the parentPro umbrella. parentPro remained a resource that connected parents and caregivers with free, voluntary family support in their community in the comfort of their own home. Pregnant women and parents with children birth to kindergarten, could enroll in the program best suited to meet their needs. MCH staff assisted in training the parentPro staff on medical norms for the pregnancy and postpartum periods. In the Parents as Teachers (PAT) program, the parent educator first ensured that the family had a medical home (whether the mother was pregnant or postpartum). This included a primary care provider (PCP) for the mother and baby. In addition, the parent educator helped mothers to understand the importance of maternal health, what to expect during a postpartum visit, and questions she may want to ask her health care provider. The parent educator supported the mother by helping her make timely postpartum appointments and provided transportation, if needed.

The PAT curriculum contained lessons that addressed the postpartum period called “Normal Postpartum Adjustment”. In addition, the parent educator had access to handouts that addressed adjusting to the birth of the baby and signs and symptoms of postpartum depression. Parent educators performed the Patient Health Questionnaire (PHQ9) to screen for postpartum depression which was administered by the 4th home visit or if the mother was pregnant, in her 36th week. It was administered again when the infant was between 4-6 months, at 12 months, and then annually. Also, it could be administered at any time if the parent educator suspected depression.

At the beginning of SFY 2021, with the continuing uncertainty of the pandemic health crisis, PAT made allowances to complete home visiting services using virtual platforms and Group Connections. Virtual service delivery refered to services both through interactive video conferencing technology and phone calls. Virtual visits through an interactive video conferencing platform allowed there to be two-way, real-time, audio-visual communication between the home visitor and parent(s), guardians, or primary caregivers and their child(ren). These visits were delivered using a device, preferably a tablet or computer (laptop) and a secure video conferencing platform. Virtual visits through telecommunication were visits completed via audio phone calls.

Children First (C1), Oklahoma's Nurse-Family Partnership, continued to provide a voluntary family support program that offered home visitation services to mothers expecting their first child. Upon enrollment, a public health nurse worked with the mother in order to increase her chances of delivering a healthy baby. The nurses addressed life course development (including Personal Health, Environment, Family and Friends, and Maternal Role) with the client in the prenatal period. During the C1 postpartum visit, the nurse asked when the client’s next appointment with the delivery provider was to occur. Visits from the C1 nurse were scheduled weekly during the first 4 visits and during the first six weeks postpartum. Mothers were also asked, up to 12 weeks postpartum, if they had returned for a postpartum visit. These questions provided a natural segue way to encourage the client to attend the postpartum exam. In SFY 2019, the county health departments were able to post and hire positions vacated during the SFY 2018 budget crisis. Nurses worked diligently to rebuild the program to capacity. However, the pandemic significantly impacted the ability to provide home visitation services. In March 2020, as a result of the Coronavirus, Children First nurses were required to begin providing home visitation via telephone for their safety and for the safety of the clients. In addition, the majority of nurse home visitors, as Public Health Nurses, were required to assist with emergency response efforts. Children First Nurses worked to maintain relationships with their clients despite spending as much as 80% of their time working the pandemic response. As a result, the caseloads for the Children First Program significantly dropped across the state.

In October 2017, the University of North Carolina received new funding to reduce infant mortality and improve birth outcomes by advancing the status of women's preconception health particularly for low-income women and women of color in some of the country's most underserved communities. Oklahoma was chosen to participate in this grant opportunity based on work with previous Collaborative Improvement and Innovation Network (CoIIN) teams focused on preconception health. MCH recruited seven partners for this team: two family planning clinics, all four Healthy Start Projects in the state, and a Federally Qualified Health Center (FQHC). The FQHC dropped out of the project but the remaining six sites remained engaged. A new preconception/interconception screening tool was developed through the Human-Centered design process and piloted in all sites. The pilot was completed in September and all sites have incorporated the tool into their protocol. Family planning clinics and home visitation programs both restricted in person visits due to COVID and utilization of the tool with feedback from clients was limited. Two of the Healthy Start projects involved in this team developed guidelines to use the tool to prepare clients for their postpartum or well-women visit. The tool was made available in five languages: English, Spanish, Burmese, Marshallese, and Zomi.

**Challenges:**

The Oklahoma State Department of Health, in conjunction with partners at the Oklahoma Health Care Authority (OHCA, the State’s Medicaid agency) and private insurers, have been unsuccessful in attempts to change the rate

methodology for reimbursement for obstetrical services, splitting out the postpartum visit from the global package. Consequently, it remained difficult to determine how many women actually returned for their postpartum visit. Current information on postpartum visits was obtained from PRAMS, which relied on the mother's recall and ability to have completed the postpartum visit at the time of the survey.

During the grant time period, Oklahoma remained a state without Medicaid expansion. The limited benefit package for some Medicaid recipients (Soon-to-be-Sooners), did not cover the postpartum visit, limiting the ability of some mothers to even schedule a visit. The lack of health care providers in rural areas made it difficult for some women to attend a postpartum visit due to limitations of time and transportation. The large percentage of working mothers without paid leave forced new mothers to return to work early, making it difficult to attend postpartum and newborn health care visits.

The biggest challenge this year was the impact of COVID-19 on access to in person health care visits, restriction of family members from health care visits with pregnant women, changing the focus to telehealth visits, and access to telehealth visits in rural areas of the state without quality wireless connections. Many providers, including OSDH family planning clinics, restricted services to what could be provided curbside, through phone conversations, or through telehealth visits where available. Acute care became the priority for healthcare provider visits over preventive care. Additionally, women were afraid to come into a healthcare provider office or a hospital for fear of contracting COVID from another patient/client.

**Objective 2. Improve birth intention by increasing the usage of the most effective methods of contraception among women with Medicaid and at risk for unintended pregnancy from 12.0% in 2014 to 15.5% in 2020.**

**Data:**
Baseline data (state fiscal year (SFY) 2014) indicated 8.5% of females ≤ 18 year olds, 16.3% of 19-24 year olds, and 14.7% of females ≥ 25 with Medicaid-funded health care relied on long acting reversible contraception (LARC) methods. Calendar year (CY) 2018 data show 3% of females under 15, 6% of females ≤ 19 years old, 14% 20-24 year olds, 15% of 25-29 year olds, 14% of 30-34 year olds, 12% of 35-39 year olds, 10% of 40-44 and 7% of females 45 years or older with SoonerCare relied on a LARC method. This provided an overall LARC utilization rate of 15.0% for SoonerCare members in CY 2018.

**Successes:**
The Oklahoma Health Care Authority (OHCA) continued provision of family planning services through SoonerPlan, the state plan amendment (SPA). SoonerPlan provided coverage for uninsured men and women 19 years of age or older who were United States citizens or qualified aliens, residents of Oklahoma, not eligible for regular Medicaid, and who met the income standard. Services provided included: physical exams related to family planning, birth control information, methods, and supplies; laboratory tests including pap smears and screening for sexually transmitted diseases (STDs); pregnancy tests; tubal ligations for females age 21 and older; and, vasectomies for males age 21 and older.

OSDH continued to support eligibility staff in all county health departments trained to assist clients with the online enrollment process to help link clients with services (including contraception). Eligibility was determined (for any Medicaid program including Title XIX, SoonerPlan, Insure Oklahoma) at the time of application and clients were immediately provided with a Medicaid ID number to use in covering the cost of services for that day, as well as, setting up appointments if referrals were indicated. As of September 30, 2020, SoonerPlan provided coverage to 39,485 enrollees accounting for 4.36% of Medicaid enrollment which is up from 28,444 enrollees and 3.60% of

Medicaid enrollment in the previous year.

Family planning services were provided through county health departments and contract clinics. Services included medical histories; physical exams; laboratory services; methods education and counseling; provision of contraceptive methods; STD/human immunodeficiency virus (HIV) screening and prevention education; pregnancy testing; immunizations; and preconception health education. OSDH continued promoting the CDC/HHS guidelines for providing Quality Family Planning Services (QFP), requiring client centered contraceptive counseling and presenting information on the most effective methods of contraception first depending on the client's desire to prevent or achieve pregnancy in the next year.

The Family Planning Annual Report (FPAR) for calendar year 2020 indicated 7.6% of clients relied on intrauterine devices/systems and 12.2% of clients relied on the implant for contraception. This equates to 14.0% of all users and 19.8% of clients choosing a hormonal method of contraception relying on a LARC method. Family planning services were provided to a total of 28,508 females and males of reproductive age for calendar year 2020 (down from 35,958 in CY 2019). Of the 28,508 clients, 5,225 relied on public insurance and 18,840 were considered uninsured (SoonerPlan clients were included in the uninsured category for the purposes of FPAR since benefits are limited to only family planning related services).

Historically, only Title X funds were utilized to purchase LARCs for the OSDH clinics creating long waiting lists. With additional Children's Health Insurance Program (CHIP) funding from Medicaid to purchase LARCs for clients less than 19 years old, most clients could receive their method of choice on their date of service.

Through the collaborative Focus Forward Oklahoma Initiative, the Oklahoma Health Care Authority (OHCA) led efforts to recruit and train health care providers across the state on contraceptive counseling and LARC procedures. The Focus Forward Oklahoma (FFO) Program operated under three primary strategies for addressing barriers to access of the most effective methods of contraception. These included: policy change, education, and communication. Since its inception, the program has removed restrictions on LARC (Long Acting Reversible Contraceptive) devices for SoonerCare members from the Oklahoma State Plan for Medicaid, and more recently focused policy efforts on explorations of access at health departments and Federally Qualified Health Centers (FQHCs). In particular, in partnership with OSDH, the program was able to get a Health Service Initiative through the Children's Health Insurance Program approved to increase the number of LARC devices available to uninsured women under 19. This past year, policy work focused on creating a LARC carve out for FQHCs so that they could be reimbursed for LARC outside of the prospective payment system. Education efforts have focused on provider workforce development to increase the number of providers who provide LARC to patients. Since 2017, 29 training sessions focused on best practices in patient centered counseling and hands-on LARC procedures skills have been hosted at no cost to the trainees.

A total of 334 providers from across the state have been trained in the curriculum. Sixty-eight percent of providers were from the two major metropolitan areas of Oklahoma (Oklahoma City/Tulsa) and 32% were from rural areas in Oklahoma. Five provider types have attended the training sessions: 1) Physician MD, 41%; 2) Physician DO, 16%; 3) Physician Assistant, 10%; 4) Advanced Practice Registered Nurse/Certified Nurse Practitioner, 31%; 5) Certified Nurse Midwife, 1%. Four specialties were represented at the training sessions: 1) Family Practice/Primary Care, 72%; 2) Obstetrics/Gynecology, 15%; 3) Pediatrics, 8%; 4) Other (e.g. Internal Medicine, Emergency Medicine), 4%. In 2019, clinical and administrative staff training sessions were added to the program to better support provision of the full range of contraceptive options. The program maintained a website to house information related to the program and resources for patients, providers, and community partners. FFO staff also continued to conduct outreach to the provider and patient community. Two MCH staff became trainers for Merck this year to assist with Nexplanon training for new OSDH staff and as part of the Focus Forward program.

**Challenges:**
The biggest challenge this year was the impact of COVID-19 on access to in person health care visits. LARC insertion requires a face-to-face visit with a healthcare provider and many providers restricted visits to curbside or telehealth visits only.

Three additional major challenges continued to impede progress towards reaching this goal: education, religiously affiliated hospital systems, and access to providers in rural areas of the state.

Reaching and educating busy physicians and other health care providers remained a challenge and became almost impossible this year. The OSDH, OHCA, and Oklahoma Perinatal Quality Improvement Collaborative all attempted to educate health care providers and promote LARCs – including postpartum LARC insertion. However, some providers were still hesitant to counsel on and insert the most effective methods, especially immediate postpartum LARCs. In addition, national attention has been drawn to the fact that some populations feel LARCs are being promoted to them as a method of population control and rather than a response to their contraceptive desires. LARC trainings were all provided in Oklahoma City and Tulsa. No training was provided for clinicians in the western half of the state. This was due to financial resources, availability of trainers, access to simulators for training, and the temporary suspension of trainings during the pandemic.

Religiously affiliated hospital systems managed a large number of smaller hospitals and physician practices and LARCs could not be provided immediately postpartum in those hospitals. Frequently, they could not be provided in the physician offices either for physicians associated with those hospital systems. Clients were referred to another provider when they chose a LARC method for contraception, erecting significant barriers especially in rural areas of the state. Oklahoma's large rural population primarily relies upon local public health department clinics to provide publicly supported family planning services. According to the 2015 Oklahoma Health Work Force Data Book, 66 of Oklahoma's 77 counties were designated as health professional shortage areas.

Smaller hospitals, physician practices, and some Federally Qualified Health Centers faced financial barriers in purchasing LARCs and having them available for same day insertion. Some hospitals and providers were still unaware that LARCs could be placed immediately postpartum and billed separately from the global delivery charge.

**Objective 3: Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births from 33.5% in 2014 to 31.8% by 2020.**

**Data:**
PRAMS data were used to monitor unintended pregnancy within Oklahoma. For 2016-2019 births, 52.3% of mothers reported an intended pregnancy (a slight decrease from previous reporting period at 52.9%), 30.6% reported an unintended pregnancy (previously 29.3%), and 17.1% (previously 17.9%) reported they were not sure what they wanted. This does not reflect significant changes from the previous reporting period.

**Successes**:
OHCA continued provision of family planning services through SoonerPlan, the state plan amendment (SPA). See Objective 2 for more information on this program.

OSDH continued to support eligibility staff in all county health departments trained to assist clients with the online enrollment process to help link clients with services (including contraception). Eligibility was determined (for any Medicaid program including Title XIX, SoonerPlan, Insure Oklahoma) at the time of application and clients were

immediately provided with a Medicaid ID number to use in covering the cost of services for that day, as well as, setting up appointments if referrals were indicated. As of September 30, 2020, SoonerPlan provided coverage to 39,485 enrollees accounting for 4.36% of Medicaid enrollment which is up from 28,444 enrollees and 3.60% of Medicaid enrollment in the previous year.

Family planning services were provided through county health departments and contract clinics. Services included medical histories; physical exams; laboratory services; methods education and counseling; provision of contraceptive methods; STD/human immunodeficiency virus (HIV) screening and prevention education; pregnancy testing; immunizations; and preconception health education. All family planning clients seen for an initial or annual exam were asked if they intend to be pregnant within one year, greater than one year from the visit or never. Contraceptive counseling was then focused on the options to best meet their reproductive plans.

See Objective 1 for information on the Preconception CoIIN project.

See Objective 2 for a discussion about LARC activities, supplemental funding, and professional training opportunities.

Staff employed in MCH administered both the Title V and Title X federal programs and the PREP funds. Many activities between these programs overlapped to prevent unintended pregnancies.

MCH continued to receive funding through the federal Personal Responsibility Education Program (PREP) grant to maintain teen pregnancy prevention efforts. PREP funds continued to support projects in the Oklahoma City County Health Department (OCCHD) and Tulsa Health Department (THD). Both projects continued to build connections with schools even during the pandemic. Due to local health department staff being largely re-assigned to COVID mitigation efforts and schools being either online-only or closed to visitors, the evidence-based curricula: "Making a Difference!", "Making Proud Choices!", “Love Notes”, “Positive Prevention Plus” and “Power through Choices” were not facilitated for most of this grant year. Projects did provide some limited online content, including curriculum, but the reach was not very large.

Staff development opportunities were provided throughout the year based on the MCH annual staff development training needs assessment as well as federal Title V and Title X Family Planning priorities and key issues. These trainings included anticipatory guidance and family participation for adolescents seeking family planning services; intimate partner violence and sexual coercion; human trafficking; infections and reproductive health; recommended immunizations; and substance use and misuse in pregnancy. Only a few of the scheduled trainings were provided due to staff being reassigned to emergency response activities.

**Challenges:**
The biggest challenge this year was the impact of COVID-19 on access to in person health care visits, restriction of family members from health care visits (especially adolescents involving family in their decision to seek contraception), changing the focus to telehealth visits, and access to telehealth visits in rural areas of the state without quality wireless connections. Many providers, including OSDH family planning clinics restricted services to what could be provided curbside, through phone conversations, or through telehealth visits where available.

The long standing challenge remained in relation to changing the paradigm for men and women of reproductive age to value preventive health visits more than intervention (sick) visits and to understand the importance of creating a reproductive life plan to help them meet personal and professional goals. With the pandemic, acute care became the priority for healthcare provider visits over preventive care visits. Additionally, clients were afraid to come into a

healthcare provider office or a hospital for fear of contracting COVID from another patient/client.

The lack of standard health education curriculum in schools across the state continued to leave many adolescents without access to accurate health and sexual health related information.

Access to care continued to be an issue especially in the rural areas. Based on data from the March of Dimes 2018 report on maternity care deserts, only 14 of Oklahoma's 77 counties had access to maternity care. An additional 22 counties had limited access, however, the remaining 41 counties met the designation of a maternity care desert. This designation was determined by the number of hospitals offering maternity care, the number of OB/GYN and CNM providers per 100,000 population, and the proportion of women 16-64 without health insurance. A lack of these health care providers erected significant barriers in access to contraception to prevent unintended pregnancies. Only 27 out of 77 counties had a hospital capable of delivering infants.

Oklahoma's large rural population primarily relied upon local public health department clinics to provide publicly supported family planning services with 66 of Oklahoma's 77 counties designated as health professional shortage areas. Federally Qualified Health Centers (FQHC) also provided services in most areas of the state, however, there was very limited access to FQHCs in the southwest area of the state. Due to the negotiated reimbursement rate for long acting reversible contraception (LARC) in the state, many of these sites either do not offer LARCs or offer a limited number. Although effective at preventing unintended pregnancies, the upfront cost of LARC methods continued to be prohibitive for some health care providers. The Focus Forward Program continued to work towards making the methods more accessible through additional providers across the state.

**Objective 4: Create a Communication and Dissemination Plan to educate reproductive age males and females on being healthy before and between pregnancies in areas of the state with the highest infant and maternal mortality rates by December 2017.**

**Data:**
The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health (OSDH) or any alternative tool remained constant this year. Every county health department utilized the Women's Health Assessment/Client Engagement Tool with clients being seen for an initial or annual exam and all clients with a negative pregnancy test desiring pregnancy.

**Successes:**
County health departments continued to assess preconception health with the 28,273 female clients in the clinic for preventive health check-ups and pregnancy tests. Healthy Start projects and Healthy Women, Healthy Futures continued to provide preconception information to clients as long as they were able to continue face-to-face visits.

PRAMS data were used to develop the Oklahoma Maternal and Child Health Data Review fact sheet with information on preconception health indicators including chronic conditions, birth rate, teen birth rate, smoking in the three months prior to pregnancy, alcohol use in the three months prior to pregnancy, multivitamin/folic acid use, and obesity. Oklahoma's rates were worse than national rates for all indicators except birth control use postpartum (79.6 to 77.0 respectively) and multivitamin use (41.9 to 40.4).

See Objective 1 for information about the UNC-led Preconception CoIIN work on the patient engagement tool.

The Perinatal and Reproductive Health Division (PRHD) also maintained a web page under the *Preparing for a Lifetime Initiative* page on preconception health entitled "Before and Between Pregnancy" with information on living

a healthy lifestyle, making healthy food choices, getting regular health check-ups, emotional wellness and support, knowing health and pregnancy risks and provided a list of free resources.

A public service announcement (PSA) entitled “Measure Up” was available on the website for use on television and radio. The PSA promoted the importance of being healthy prior to pregnancy and planning for pregnancy.

**Challenges:**
Due to COVID response efforts, Office of Communications staff were focused on presenting up to date information on the status of COVID-19 infections, testing and recommendations in place of preconception health information for Women’s and Men’s Health Weeks. In previous years, information was shared through a press release, social media, and PSAs run during May and June.

MCH staff was not able to share preconception health and prematurity information at the annual March of Dimes Walk or any other community health fairs this year due to COVID restrictions.

Changing the paradigm from reactive to proactive with emphasis on establishing a reproductive health plan and taking steps to ensure reproductive goals are reached resulting in healthy, intended pregnancies remained a challenge. Prior to COVID, health care providers were busy and often did not have time for counseling and planning. A multitude of resources were available to assist with preconception health counseling; however, busy providers did not have time to review and assess all the resources available in order to choose a resource that would work best for each of them. During the pandemic, in-person visits were reduced to medically necessary visits, limiting the opportunities to share preconception health information. The sites piloting the new CollN tool did experience significantly more buy-in and discussion regarding health behaviors and risks before the preventive visits suspended.

**SPM 2 Maternal mortality rate per 100,000 live births**

**Objective 5: Reduce maternal mortality rate from 19.4 maternal deaths per 100,000 live births in 2013-2015 to 17.5 by 2020.**

**Data:**
Maternal death continued to be the international standard by which a nation’s commitment to women’s status and their health could be evaluated. The Maternal Mortality Rate (maternal deaths within 42 days of termination of pregnancy per 100,000 live births) for Oklahoma from 2017-2019 among women aged 10-59 years was 20.8 maternal deaths per 100,000 live births (down from 24.9 for 2016-2018). The goal of Healthy People 2020 was to reduce the Maternal Mortality rate to no more than 11.4 per 100,000 live births. This measure was based on a three-year rate of those deaths occurring within forty-two days from termination of pregnancy to assure the availability of comparable data to other state and national rates. For confidentiality reasons, MCH policy for reporting Oklahoma maternal mortality rates required that only three-year rolling averages could be released.

**Successes:**
MCH continued to provide leadership for the Maternal Mortality Review. Oversight was provided by the Perinatal and Reproductive Health Division (PRHD) Administrative Program Manager (APM) and one of the Advanced Practice Nurses continued in the project manager role. With the passage of HB 2334, the Maternal Mortality Review Committee became a statutory committee with expanded access to additional records vital for accurate case review. The Maternal Mortality Review Committee (MMRC) remained an essential community process used to enhance and improve services to women, infants and their families. Qualitative, in-depth reviews investigated the

causes and circumstances surrounding each maternal death. Through communication and collaboration, the MMRC served as a continuous quality improvement system that resulted in a better understanding of the maternal issues. The overall goal of the MMR was prevention through understanding of causes and risk factors. The list of maternal deaths, obtained from the Vital Records Division, was reviewed by the APM and the PRH Medical Director to determine which cases would be reviewed by the committee. All possible pregnancy-related and pregnancy-associated deaths were reviewed for women who died while they were pregnant or within 365 days of the end of the pregnancy. The APM, three nurse practitioners, and the nurse manager abstracted cases for review. HB2334 defined the make-up of the committee with 18 permanent positions representing various organizations and disciplines, as well as seven community positions appointed by the Commissioner of Health. The committee reviewed three to four cases at quarterly meetings in October and January to identify gaps in services or possible system level changes to prevent future maternal deaths. The top causes of death were cardiovascular, sepsis, non-cardiovascular, and hemorrhage.

MCH continued to work with the CDC as the transition to the network-based Maternal Mortality Review Information Application (MMRIA) database was completed to help states collect and report comparable data. Cases are now abstracted directly into this database.

The Council on Patient Safety in Women's Health Care continued to provide leadership for the program "Alliance for Innovation on Maternal Health (AIM): Improving Maternal Health and Safety". The national goal is to prevent 100,000 severe complications during delivery hospitalizations and 1,000 maternal deaths over the course of the funding period. AIM collaborated with public, private, and professional organizations to focus on the areas of obstetric hemorrhage, severe hypertension, venous thromboembolism, reduction of primary cesarean births, and reduction of racial disparities during pregnancy contributing to maternal morbidity and mortality. Oklahoma was the first AIM state based on infrastructure and activities put in place through the Every Mother Counts Initiative in 2014. The Office of Perinatal Quality Improvement (OPQI) continued to provide leadership for these efforts providing technical assistance for participating hospitals on data entry, policy development, and emergency drills. The participating Oklahoma birthing hospitals worked on postpartum hemorrhage and/or hypertension. Information on outcome measures was entered into the database through the Vital Records Division. Process measure information was entered by individual hospital staff. Hospitals were recognized as "Spotlight Hospitals" for establishing protocols and entering data into the AIM data portal, in addition to meeting other criteria. During the summit in 2019, the tool kit for the *Obstetric Care for Women with Opioid Use Disorder* bundle was presented to hospital staff to kick-off work on this bundle. Fifteen hospitals agreed to participate in this bundle, however, hospital staff were diverted to acute care with the pandemic and opioid bundle activities were suspended in the spring. Plans are to resume as soon as staff can transition back to regular duties and responsibilities.

The Infant Mortality Alliance (IMA) began focusing on preventing maternal mortality as well as infant mortality. At the October 2019 Summit, Dr. Malawa provided guidance on "Naming the Elephant in the Room" in order to start the conversation on racism and its effects on infant and maternal mortality. In July, the IMA hosted a panel discussion with a senator, representative and two city council members to discuss current events, policy implications and insights for reducing infant and maternal mortality in Oklahoma County. Plans were made to host a webinar series in place of the 2020 annual summit with Dr. Joia Crear-Perry as the first speaker in October.

**Challenges**:
COVID restrictions prevented the MMRC from meeting in April and July. The committee met and approved the first annual report in October but was unable to review cases. Many members could not access the cases for review prior to the meeting despite the cases being available through several virtual yet secure options. With multiple options available for virtual meetings/document sharing and differing agency restrictions on platform utilization, staff experienced difficulty orienting outside partners to the OSDH approved Teams platform.

Although Oklahoma's maternal mortality rates remained high, the relatively small number of cases each year and small number of cases reviewed this year made it challenging to identify system level interventions to improve morbidity and prevent mortality.

Transition to the new MMRIA database occurred this year but since hospitals restricted access to records during the pandemic, staff were not able to fully utilize and become familiar with the database.

Continued challenges related to preconception health and pregnancy intention were identified as contributing factors for many maternal deaths. To date, the MMRC reviewed 126 cases with at least one of the following contributing factors listed for the majority of cases reviewed: obesity (BMI listed as high as 53.5), chronic hypertension, diabetes (not gestational diabetes), cardiac problems, and asthma/pulmonary issues.

**Objective 6: Increase the percent of new mothers screened for postpartum depression at county health departments and partner agencies, from 44.5% in 2015 to 46.7% in 2020.**

**Data:**
According to data from the 2015-2017 The Oklahoma Toddler Survey (TOTS), 48.7% of new mothers were screened for postpartum depression, exceeding the 2020 goal. Almost 14.3% of mothers with toddlers indicated they had been diagnosed with postpartum depression (PPD) sometime after their toddler was born.

**Successes:**
In this timeframe, MCH worked to unify the screening for postpartum depression across programs, asking each clinic to utilize the PHQ-9 Patient Health Questionnaire. By having each area (WIC, family planning, child guidance) utilize the same screening tool more uniform data were collected and program staff could better determine trends in their communities. These screenings continued with the county health department clinics throughout the state, and with partners in the Tulsa and Oklahoma City County Health Departments.

The primary goals of the *Preparing for a Lifetime* Maternal Mood Disorders Work Group continued to be ongoing reduction in stigma, increased awareness, and provision of education both to the general public and to medical providers throughout the state. Despite the COVID-19 pandemic restricting in-person gatherings, educational opportunities were found in places critical for this education. The co-lead of the Maternal Mood Disorders Work group trained home visiting staff in the southeastern area of Oklahoma in recognizing Perinatal Mood and Anxiety Disorders (PMADs) as well as how they could best educate their clients on the symptoms to look for, give their own overview to their clients, and tools for prevention and intervention.

Planning and registration was completed for the Postpartum Support International (PSI) Components of Care and Advanced Psychotherapy virtual trainings coming to Oklahoma for perinatal behavioral health providers. These trainings will be a vital tool to both increase substantive education in detail on perinatal mental health for mental health clinicians throughout the state as well as a tool to increase resources for OB/GYN, pediatrician, and other medical providers. Although originally scheduled for June 2020, the trainings were postponed due to concerns about coronavirus as the event was originally designed to be in-person. The event was rescheduled for virtual implementation in December 2020.

**Challenges:**
As with many programs and sectors of public health, COVID-19 had impacts on maternal mental health and the mitigation efforts of the *Preparing for a Lifetime* Maternal Mood Disorders Work Group. Perhaps one of the most

unfortunate impacts was the drop in screenings for postpartum depression across the state at health departments and contract sites. At both local county health departments and partner sites at independent health departments the Tulsa Health Department (THD) and Oklahoma City-County Health Department (OCCHD) the overall number of screenings from October 1, 2019 to September 30, 2020, decreased by 22.1% over the previous report to 1,673. This is most likely due to the decreased number of women who came into family planning clinics, WIC offices, or county health departments for other needs because of provider restrictions or anxieties about the virus. Unfortunately, the need for screening and treatment was possibly as great or greater due to the impacts of COVID-19 on the mental health of mothers, fathers, and families.

Awareness and education remained a challenge for Oklahoma, as many women consulted who have recently been or are currently pregnant reported anecdotally that there continued to be a lack of education regarding PMADs.

The number of outpatient treatment providers who were willing and available to treat maternal mood disorders continued to be small; and there were still no dedicated inpatient facilities in Oklahoma for mothers (or fathers) with a need for intensive treatment especially in regards to postpartum psychosis.

**Women/Maternal Health - Application Year**

**NPM 1 Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

**Objective 1. Increase the number of women returning for the postpartum visit from 88.0% in 2016-2019 to 96.0% in 2025.**

OSDH and OHCA hope to fill the vacant position so that data matching and analysis between Medicaid claims and birth certificate data will resume. The joint OSDH/Oklahoma Health Care Authority (OHCA) work group will work on determining the most effective use of the data and publications utilizing this information.

Staff in the county health departments will continue providing postpartum care for those women choosing not to return to their delivering provider for a postpartum visit.

The home visitation programs will educate and encourage new moms to make and attend postpartum appointments and MCH staff will continue to assist in training new parentPro staff. The Healthy Start projects will continue to utilize the new client engagement tool to encourage attendance at the postpartum visit and prepare women for their postpartum/annual health care visits and utilization of the tool will expand to all OSDH family planning clinics.

MCH will continue to establish projects with Maternal Health Innovation Grant funding to improve access to quality health care and reduce maternal and infant mortality. This grant is closely tied with Title V priorities utilizing the following baseline priorities: Percentage of women covered by health insurance, percentage of women who receive an annual well woman visit, percent of pregnant women who receive prenatal care in the first trimester, percent of women attending a postpartum visit, percent of women screened for perinatal depression, rate of maternal mortality, and rate of severe maternal morbidity. Grant activities are linked to: State Performance Measure (SPM) #1: Reducing infant mortality, SPM #2: Reducing maternal mortality, and National Performance Measure #1: Percent of women with a past year preventive medical visit.

OSDH will resume prenatal care and child health services within the county health departments to improve access to care for pregnant women and infants. Some care will be provided on mobile units to address barriers to service including lack of transportation and lack of providers in rural areas. Memorandums of Understanding will be signed for transfer of care for prenatal clients around 36 weeks gestation.

**Objective 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 15.0% in 2018 to 20.0% in 2025.**

The OSDH and OHCA will continue to work together to promote long-acting reversible contraception (LARC) utilization with public and private providers through the Focus Forward Initiative. A sustainable education model will provide skills training to current and future health care providers for LARC insertion utilizing staff from two major institutions of higher learning in partnership with the OHCA. Frontline staff and billing staff will continue to be trained to assist with provision of accurate information, assistance with scheduling, and education on accurate billing for maximum reimbursement. MCH staff will continue to train new OSDH staff and assist with the Focus Forward trainings for Nexplanon insertion.

OHCA will implement Medicaid expansion starting October 1, 2021 (enrollment began in July). OHCA benefits will maintain coverage for a broad range of contraceptives including the LARC methods. OSDH and OHCA will continue collaboration through the HSI project to increase access to LARCs for Title X Family Planning clients.

**Objective 3. Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births from 29.3% in 2016-2018 to 25.0% by 2025.**

The OSDH will continue to administer the family planning program through county health departments and contract clinics including assistance with SoonerCare enrollment, reproductive life planning and client centered counseling, and provision of LARC methods. OSDH will maintain family planning services at all county health departments for both insured and uninsured clients. MCH will distribute LARCs purchased with additional funding to ensure same day access in county health departments.

Plans to host youth councils, facilitated by the Adolescent Health Specialists, were in place for the 2020-2021 school year. These plans were put on hold due to the pandemic response activities required of OSDH staff and natural attrition. Facilitators trained in both positive youth development and youth-adult partnership frameworks will use this knowledge to provide leadership for the councils when they can safely resume.

**Objective 4. Create a Communication and Dissemination Plan to educate reproductive age males and females on being healthy before and between pregnancies in areas of the state with the highest infant and maternal mortality rates by December 2021.**

MCH will work with community partners (OHCA, March of Dimes, Oklahoma Perinatal Quality Improvement Collaborative, Federally Qualified Health Centers, etc.) to identify ways to promote preconception health messages. Through a contract with Southern Plain Tribal Health Board (SPTHB) and the Maternal Health Innovation Grant, MCH will work with SPTHB to create and disseminate culturally appropriate preconception and pregnancy related messages to improve quality of care and reduce infant and maternal morbidity and mortality.

**Objective 5. 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 2022.**

MCH will continue to provide technical assistance and training to assist county health departments with the PHQ-9 implementation.

**Objective 6. 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.**

The Maternal Mood Disorders Work Group will continue work towards the creation of a representative collection of PSA (public service announcement) videos; working specifically to obtain videos from African-American and Native American mothers who represent a disproportionate amount of Oklahoma's mothers impacted by maternal mental health concerns. The primary goal of these videos will continue to be showcasing the diversity in population and experience for those individuals impacted by these diagnoses in the state. There are plans for a Postpartum Support International (PSI) "Climb Out of the Darkness" awareness event for the upcoming year, and an additional event using fitness apps to "map" personal or team "blue dots" on maternal mental health awareness week.

Although modified for a "virtual" version, the Postpartum Support International (PSI) Components of Care and Advanced trainings still brought a new level of trained behavioral health clinicians trained in perinatal mental health to the state in 2020. Planning is in place to expand this training by the end of 2022 to train even more professionals

throughout the state.  In addition, breakout work groups have been formed to facilitate the top priority projects of an outreach team to OBGYN offices to coordinate staff and patient education, patient education modules for hospitals and staff, and a work group tasked with outreach to pediatrician offices to assist with the integration of Perinatal Mood and Anxiety Disorders (PMADs) education, screening, and referrals.

**SPM 1 Maternal mortality rate per 100,000 live births**

MCH will continue to provide leadership and financial support for the Maternal Mortality Review Committee (MMRC) under the new statutory requirements. Staff will disseminate an annual report with data that is comparable to other states. As part of the new Maternal Health Innovation Grant, MCH will continue the new Maternal Health Task Force to assist with implementing recommendations from the MMRC.

MCH will remain active in the Alliance for Innovation on Maternal Health (AIM) activities through the OPQI hospital level interventions to reduce maternal mortality and morbidity, addressing priority activities related to postpartum hemorrhage, hypertension, and opioid use/abuse. MCH will partner with the STAR (Substance Use, Treatment and Recovery) clinic through the Oklahoma Health Science Center to address the needs of pregnant women with substance use disorders.

MCH will look at analyzing Pregnancy Risk Assessment Monitoring System (PRAMS) data and disseminating information through a Pregnancy PRAMS Brief or a PRAMSgram on some aspect of preconception health and counseling information obtained from the PRAMS surveys. Women will be surveyed through PRAMS regarding utilization of postpartum visits and preconception health issues – especially those associated with maternal deaths in Oklahoma.

**Perinatal/Infant Health**

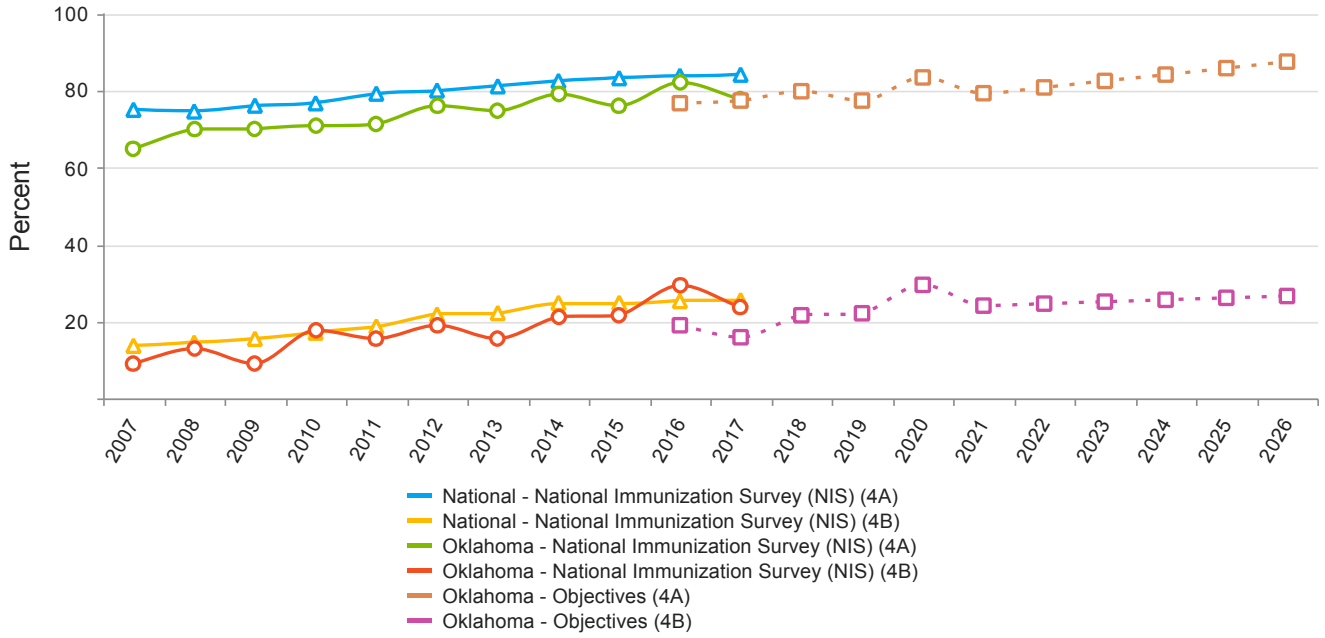
**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2018 | 7.1 | NPM 4<br>NPM 5 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2018 | 2.8 | NPM 4<br>NPM 5 |
| NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2018 | 168.7 | NPM 4<br>NPM 5 |

## National Performance Measures

### NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

### Indicators and Annual Objectives




### NPM 4A - Percent of infants who are ever breastfed

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 76.7 | 77.4 | 79.8 | 77.4 | 83.4 |
| Annual Indicator | 74.7 | 79.2 | 75.9 | 82.2 | 77.7 |
| Numerator | 38,593 | 41,230 | 38,194 | 38,328 | 34,343 |
| Denominator | 51,646 | 52,032 | 50,306 | 46,652 | 44,223 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 79.3 | 80.8 | 82.5 | 84.1 | 85.8 | 87.5 |

**NPM 4B - Percent of infants breastfed exclusively through 6 months**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 19.1 | 16 | 21.7 | 22.2 | 29.6 |
| Annual Indicator | 15.7 | 21.3 | 21.6 | 29.6 | 23.7 |
| Numerator | 7,715 | 10,883 | 10,756 | 13,540 | 10,126 |
| Denominator | 49,145 | 51,056 | 49,712 | 45,739 | 42,737 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 24.2 | 24.7 | 25.2 | 25.7 | 26.2 | 26.7 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 4.1 - The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2019 | 2020 |
| Annual Objective | | |
| Annual Indicator | 1,707 | 1,957 |
| Numerator | | |
| Denominator | | |
| Data Source | Breastfeeding Hotline | Breastfeeding Hotline |
| Data Source Year | FY2019 | FY2020 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 2,055.0 | 2,158.0 | 2,265.0 | 2,378.0 | 2,497.0 | 2,622.0 |

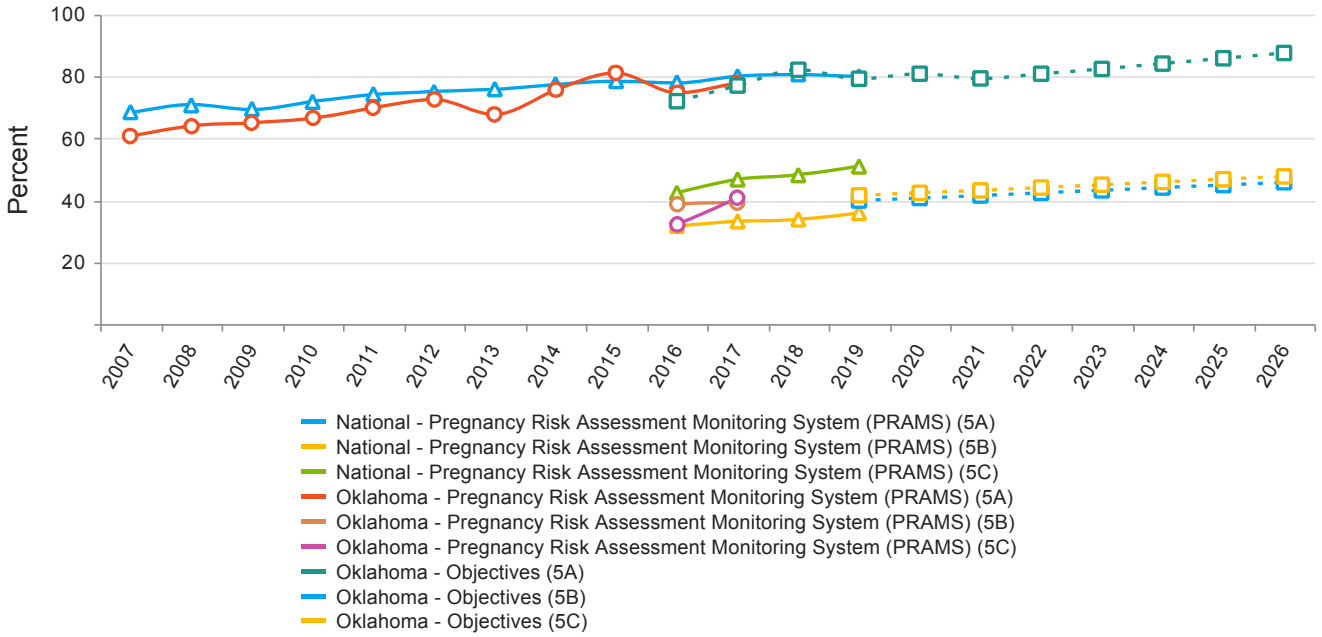
**ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 15.6 | 16 | 23.3 | 34.7 |
| Annual Indicator | 12.5 | 15.2 | 22.6 | 33.4 | 31.9 |
| Numerator | 6,590 | 7,598 | 11,247 | 15,926 | 14,540 |
| Denominator | 52,607 | 50,008 | 49,787 | 47,664 | 45,526 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 36.4 | 38.2 | 40.1 | 42.1 | 44.2 | 45.1 |

**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 Indicators and Annual Objectives**




**NPM 5A - Percent of infants placed to sleep on their backs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 71.9 | 76.9 | 82 | 79.1 | 80.7 |
| Annual Indicator | 75.4 | 81.2 | 77.6 | 77.6 | 77.6 |
| Numerator | 37,018 | 40,173 | 36,090 | 36,090 | 36,090 |
| Denominator | 49,130 | 49,458 | 46,523 | 46,523 | 46,523 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2017 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 79.2 | 80.7 | 82.3 | 84.0 | 85.7 | 87.4 |

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | |
| | **2018** | **2019** | **2020** |
| Annual Objective | | 39.9 | 40.7 |
| Annual Indicator | 39.2 | 39.2 | 39.2 |
| Numerator | 17,658 | 17,658 | 17,658 |
| Denominator | 45,065 | 45,065 | 45,065 |
| Data Source | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2017 | 2017 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 41.5 | 42.4 | 43.2 | 44.1 | 44.9 | 45.8 |

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | |
| | **2018** | **2019** | **2020** |
| Annual Objective | | 41.6 | 42.4 |
| Annual Indicator | 40.8 | 40.8 | 40.8 |
| Numerator | 18,485 | 18,485 | 18,485 |
| Denominator | 45,328 | 45,328 | 45,328 |
| Data Source | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2017 | 2017 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 43.2 | 44.1 | 45.0 | 45.9 | 46.8 | 47.7 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 5.1 - The percentage of infants delivered at birthing hospitals participating in the sleep sack program**

| Measure Status: | | | | | Active |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 70.6 | 71.2 | 75.3 | 80.6 |
| Annual Indicator | 63.4 | 69.5 | 73.8 | 81.7 | 77.3 |
| Numerator | 33,346 | 34,913 | 36,756 | 38,948 | 35,171 |
| Denominator | 52,607 | 50,214 | 49,787 | 47,664 | 45,526 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| **Annual Objectives** | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 82.2 | 83.8 | 85.5 | 87.2 | 89.0 | 90.8 |

**State Performance Measures**

**SPM 2 - Infant mortality rate per 1,000 live births**

| Measure Status: | Active | | | | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 7.3 | 7.5 | 7 | 6.7 |
| Annual Indicator | 7.4 | 7.7 | 7.1 | 7 | 7 |
| Numerator | 391 | 387 | 352 | 344 | 344 |
| Denominator | 52,607 | 50,214 | 49,787 | 49,143 | 49,143 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 6.5 | 6.3 | 6.2 | 6.1 | 5.9 | 5.8 |

**State Action Plan Table**

| State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 1 | |
|---|---|
| **Priority Need** | |
| Reduce infant mortality | |
| **NPM** | |
| 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 | |
| **Objectives** | |
| 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. | |
| **Strategies** | |
| 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. | |
| **ESMs** | **Status** |
| ESM 5.1 - The percentage of infants delivered at birthing hospitals participating in the sleep sack program | Active |

NOMs

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

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 2

### Priority Need

Increase health equity for the MCH population

### NPM

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

### Objectives

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 2022.

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 2022.

### Strategies

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, 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.

| ESMs | Status |
|---|---|
| ESM 5.1 - The percentage of infants delivered at birthing hospitals participating in the sleep sack program | Active |

### NOMs

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

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 3

### Priority Need

Reduce infant mortality

### NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

### Objectives

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 355 sites in 2020 to 365 sites in 2021.

### Strategies

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 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.

| ESMs | Status |
| --- | --- |
| ESM 4.1 - The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs. | Active |
| ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly | Active |

| NOMs |
| --- |
| 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 |

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 4

### Priority Need

Increase health equity for the MCH population

### NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

### Objectives

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.

2. Increase partners for outreach to ethnically diverse populations from 37.5% to 44.4% by 2021.

### Strategies

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.

2a. 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.

2b. 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.

2c. Increase the number of mothers with WIC who are exposed to at least seven of the Ten Steps to Successful Breastfeeding.

2d. Promote free bilingual online prenatal education training through state, community, and national partnerships.

| ESMs | Status |
|---|---|
| ESM 4.1 - The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs. | Active |
| ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly | Active |

NOMs

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

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 5

### Priority Need

Improve access to social workers and support systems throughout the state

### NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

### Objectives

Develop information and guidelines for food pantries, shelters, regarding supporting breastfeeding in emergency situations.

### Strategies

Share guidelines for supporting breastfeeding families in emergency situations with food pantries, professionals, and families.

| ESMs | Status |
| --- | --- |
| ESM 4.1 - The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs. | Active |
| ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly | Active |

### NOMs

| |
| --- |
| 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 |

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 6

### Priority Need

Increase quality health care access for the MCH population

### SPM

SPM 2 - Infant mortality rate per 1,000 live births

### Objectives

Screen 100% of newborns in Oklahoma and maintain timely follow-up to definitive diagnosis and clinical management for infants with positive screens.

### Strategies

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.

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 7

### Priority Need

Increase quality health care access for the MCH population

### SPM

SPM 2 - Infant mortality rate per 1,000 live births

### Objectives

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.

### Strategies

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.

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 8

### Priority Need

Reduce infant mortality

### SPM

SPM 2 - Infant mortality rate per 1,000 live births

### Objectives

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 2022.

2. Reduce nonfatal motor vehicle injuries in children ages 0 to 19 from 394 in 2013 to 366 by 2025.

### Strategies

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. Utilize existing resources and available partners to distribute materials and provide community education.

2a. Continue to utilize the MCH staff member who is a certified CPS technician to assist Injury Prevention Services and Safe Kids Oklahoma with a minimum of two car seat checkup events per month and four car seat training sessions annually.

2b. Provide support and technical assistance to families and caregivers with car seat questions and concerns.

## State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 9

### Priority Need

Increase health equity for the MCH population

### SPM

SPM 2 - Infant mortality rate per 1,000 live births

### Objectives

1. Evaluate and revise the Preparing for a Lifetime, It's Everyone's Responsibility statewide infant mortality reduction initiative to address present issues impacting infant health.

2. Increase stakeholders for Preparing for a Lifetime, It's Everyone's Responsibility from 30 in 2020 to 35 in 2022.

3. Increase awareness of perinatal and infant health issues by attending and presenting at 3 conferences by 2022.

### Strategies

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.

1b. Determine if there are emerging issues that need to be addressed by the initiative, including health equity.

1c. Update the Preparing for a Lifetime, It's Everyone's Responsibility statewide report, fact sheets and online resources to reflect current activities, issues and data.

2. Find ways to engage new stakeholders in the Preparing for a Lifetime activities and meetings, more specifically nontraditional partners.

3a. Create new health equity tools for public education and awareness on the factors related to infant mortality in the state.

3b. Develop and implement health equity and implicit bias training for healthcare professionals and stakeholders.

**NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

**Objective 1: Increase the percent of mothers who breastfeed their infant at hospital discharge from 81.3% in 2017 to 84.0% by 2020.**

**Objective 2: Increase the percent of mothers who exclusively breastfeed their infant through 6 months of age from 21.6% in 2015 to 25% by 2020.**

**Data:**
In 2018, Oklahoma Vital Statistic data showed 80.4% of new mothers were breastfeeding at hospital discharge, an increase from 75.0% in 2013, but a slight decrease from 2017 (81.3%). The Oklahoma Toddler Survey (TOTS) provided data to monitor feeding at six months duration. According to 2014-2016 TOTS data, 41.4% of women reported breastfeeding their infants to six months of age, an increase from the 34.7% rate for 2012-2014. National Immunization Survey (NIS) 2016 data showed that 29.6% of Oklahoma mothers exclusively breastfed through six months of age, exceeding the goal for 2020. Maternal and Child Health Service (MCH) monitored breastfeeding initiation, duration, and exclusivity using Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children Supplemental Nutrition Program (WIC), NIS, and TOTS. This information was shared with state policymakers, health care providers, families, and community groups.

**Successes:**
One hundred twenty-five participants attended the *8th Annual Becoming Baby-Friendly in OK (BBFOK) Summit* with leadership teams from 20 hospitals and 26 organizations. Presenters Kimberly Seals-Allers, SHIFT Strategic Communications; Trish MacEnroe, Baby-Friendly USA; and Becky Mannel, OK Breastfeeding Resource Center (OBRC) discussed: Fact vs. Fibs - Countering Misinformation and Fear-Based Campaigns; Communities Matter - Effective Engagement Strategies to Build Supportive Communities; Baby-Friendly USA - Revisions to the Guidelines and Evaluation Criteria; Safe Implementation of Baby-Friendly Practices; and Breastfeeding State of the State.

The Summit included a Baby-Friendly Panel discussion with professionals and recognition of Oklahoma's newest Baby Friendly Hospital, The Children's Hospital at OU Medicine, bringing the state's total to ten. An update on OK's Breastfeeding Hotline (OBH) and online trainings closed the Summit. The evening before, Ms. Seals-Allers spoke with a group of advocates at the OK Mothers' Milk Bank (OMMB), followed by a fundraising reception.

Due to the pandemic, in-person trainings and conferences were cancelled or postponed. MCH worked with OBRC and WIC to ensure updated Oklahoma, national, and World Health resources were posted to appropriate websites. One hundred and seventy-seven individuals attended an OBRC webinar featuring COVID-19 Breastfeeding Recommendations. Panelists included Kate Arnold, MD, OB/GYN, Variety Care; Doug Drevets, MD, University of OK Health Sciences Center (OUHSC); Malinda Webb, MD, Stillwater Medical Center/Breastfeeding Coordinator, OK Chapter American Academy of Pediatrics; and Rebecca Mannel, OBRC Director and OMMB Executive Director.

Responding to requests to provide online patient education, OBRC created and posted free prenatal breastfeeding education modules in English and Spanish, which were shared in meetings, newsletters, websites, and social media. Hospitals and WIC provided the links to clients. OBRC conducted an online Breastfeeding Orientation for the OK Perinatal Nurses Forum and converted a two-day class for hospital, clinic, home visiting staff, doulas, and peer

counselors to a virtual format.

OMMB maintained operations during the pandemic with staggered staffing while continuing to screen donors, pick up raw milk, pasteurize and dispense. Some staff teleworked when possible. Donor recruitment and involvement actually increased!

OBRC revised the 15-hour online Baby-Friendly training for health care staff. Comanche County Memorial Hospital achieved Re-Designation and three hospitals continued designation efforts. OBRC surveyed 37 delivering hospitals to learn interest in joining BBFOK and discover what help was needed to initiate or maintain the Ten Steps. The survey resulted in requests in 19 areas from 17 hospitals, including 8 not yet committed to the project.

Workgroup members reviewed, updated, and worked to condense the Preparing for a Lifetime (PFL) Breastfeeding Website pages incorporating the new OK state website format, including a revised *Nursing Your Newborn* Fact Sheet. Breastfeeding Friendly Worksites rose to 259 recognized semi-annually through meetings and websites. One hundred and twenty of those were health care facilities and 248 were Gold Star Worksites. WIC's Breastfeeding Task Force (WBTF) including MCH, OBRC, COBA, Indian Tribal Organizations, and partners, promoted the World Breastfeeding Week (WBW) theme, National Breastfeeding Month (NBM), and Black Breastfeeding Week (BBW) through state and community news releases, websites, and social media and WBW materials. WIC sponsored the Online Breastfeeding Educator Course for staff providing WIC services, led by Alabama's Glenda Dickerson, MSN, RN, IBCLC, and WIC's Breastfeeding Peer Counselor (BFPC) Program continued in 17 counties and 29 clinic sites, with 33 WIC BFPCs.

COBA leadership worked closely with the U.S. Breastfeeding Committee, Centers for Disease Control, MCH and WIC services to monitor and share COVID-19 recommendations and changes in accessing lactation support. Several policy positions and statements on current affairs and existing laws and policies hindering support efforts were developed and posted. Members supported the passage of two senate bills: one requiring state agencies to provide paid break time to use a designated lactation room; the other requiring state owned public buildings to provide a sanitary place (not a bathroom) with chair, working surface, and electric outlet, shielded from view and free from intrusion, to express milk or breastfeed. COBA's online annual meeting featured a short business update and education topic.

MCH support continued for the OK Breastfeeding Hotline (OBH), providing information and referrals for 1,957 mothers and health care providers, and for the Hospital Breastfeeding Education (HBEP), BBFOK, and OMMB projects. The OBH launched a secure texting portal allowing users to text hotline IBCLCs, increasing contacts to 98%. Calls and texts were received from families delivering at 39 different hospitals, representing over three-fourths of OK's birthing hospitals.

OMMB celebrated its seventh anniversary, serving all seven level III neonatal intensive care units (NICUs). Expanding to twenty-one depots with five in county health departments, OMMB served rural level II NICUs and special care nurseries and supported seven out-of-state hospitals without milk banks and four other milk banks with shortages. The Silas Murphy Memorial Tree was launched with over 80 plaques representing the baby of a bereaved mother who donated milk in her baby's memory.

MCH promoted breastfeeding duration through OPQIC and PFL meetings, and National Nutrition Month activities. Work groups representing a variety of partners received updates and met virtually to promote activities and worksite recognition. Thirteen Area Coordinators in five statewide regions were available to assist employers to create policies, establish mothers' rooms, and receive recognition. MCH coordinated with WIC and OBRC to update and reformat the Breastfeeding Support Fact Sheet, sharing OK's rates and Maternity Practices in Infant Nutrition and

Care (mPINC) Surveys, key outcomes and activities with legislators, health care providers, students, advocates, funders, and websites. Based on the August CDC Breastfeeding Rates Update, OK increased in three Healthy People 2020 Objectives, and equaled the national average in mPINC Rooming-In scores.

**Objective 3: Increase the percent of Hispanic, Black, and American Indian mothers who exclusively breastfeed their infant to 8 weeks or more from 41.0%, 44.5%, and 47.6% in 2017 to 43.1%, 46.7%, and 50.0% by 2020.**

**Data:**
According to Pregnancy Risk Assessment data for 2016-2018 the rates for Hispanic, Black and American Indian mothers exclusively breastfeeding for 8 weeks or more were 39.6%, 45.9%, and 46.4% respectively. Individual year data for 2018 was not available due to not meeting the response threshold for weighting.

**Successes:**
Efforts to address disparities focused on featuring communities of color in staff recruitment, training materials, and in selection of topics and speakers. The state's multicultural population was reflected in brochures, websites, posters, and PSA's.
The BBFOK Summit featured Baby-Friendly videos with stories from an African American mom and nurse. NBM celebrations targeted disparities and shared resources for communities of color. Tulsa's Black Breastfeeding Week's Online Celebration was led by a former COBA chair representing communities of color, as were many of COBA's leadership and WIC BFPCs. A new nonprofit, For The Village, Inc., was formed to improve maternal and infant outcomes in the Black community by raising awareness, developing Black birth workers, and providing birth services. Queens Village, a Cincinnati group fighting high infant mortality rates disproportionately affecting Black mothers, was featured in an OK Infant Mortality Alliance Webinar. COBA members and partners supported the passage of a Senate Resolution declaring April 11-17 Black Maternal Health Week.

**Challenges**:
COVID-19 presented many challenges. Staff teleworked, conducted online meetings, and developed virtual webinars and trainings. Hospital priorities were redirected to manage the changes required to train staff, obtain supplies, and care for COVID-19 patients, so many were unable to join or participate in the BBFOK project. Multiple OSDH statewide staff operated the COVID-19 Hotline, answering questions and referring callers to available resources and services. Competing priorities and staff reductions made recruiting and retaining active work group members difficult. The state coalition worked to recruit and train members to develop leadership, communication, and financial skills to maintain and promote ongoing and new projects. OSDH's move to a different location in the midst of a pandemic created additional challenges.

**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.**

**Objective 1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 28 in 2020 to 30 in 2022.**

**Objective 2. Increase the number of trainings given to providers and professional organizations on infant safe sleep from 4 in 2020 to 5 in 2022.**

**Objective 3. Increase the number of community outreach activities by Safe Sleep Work Group members**

**from 10 in 2015 to 15 in 2022.**

**Objective 4. Increase the number of hits for the *Preparing for a Lifetime* website and MCH Facebook page from 236 in 2020 to 500 hits by 2022.**

**Objective 5. Increase the percent of American Indian and African American births in hospitals participating in the Safe Sleep Sack Program, from 61.1% in 2019 to 65% in 2022.**

**Objective 6. Reduce infant mortality rate due to unsafe sleep practices for American Indian infants from 2.7 in 2018 to 2.5 by 2022 and from 3.9 in 2018 to 3.5 for African American infants by 2022.**

**Data:**
Between October 1, 2019 and September 30, 2020, approximately 34,920 sleep sacks were provided to families upon discharge from the 28 participating Oklahoma birthing hospitals. Among those participating hospitals, 87.6% of 2019 births were to African American women and 61.1% to American Indian women, a slight decrease from 90.1% for African American women and 63.3% for American Indian women in 2018.

The percent of infants who were placed to sleep on their backs was 77.9% in 2018. This was an increase from 76.1% in 2016-2017. However, 64.6% of African American mothers reported placing their infants to sleep on their backs, compared to 80.2% of white mothers and 80.1% of American Indian mothers in 2016-2018.

**Successes:**
The Infant Safe Sleep Work Group continued to work on the work plan goals and objectives outlined in the group's work plan under the MCH supported statewide initiative *Preparing for a Lifetime, It's Everyone's Responsibility*. This umbrella coalition, designed to reduce infant mortality and promote the health of the MCH population, was comprised of representatives from the Central Oklahoma and Tulsa Fetal Infant Mortality Review (FIMR) programs, Oklahoma MIECHV, Oklahoma Child Death Review Board, Oklahoma SAFE KIDS Coalition, Oklahoma Health Care Authority, the University of Oklahoma Health Sciences' Office of Perinatal Quality Improvement (OPQI), local urban and rural hospitals (such as the Children's Hospital at OU Medical Center and the Chickasaw Nation Medical Center) as well as additional community and state agencies.

The Oklahoma State Department of Health (OSDH) portable crib and sleep sack distribution projects were both able to complete some expansion efforts despite the difficulties of having hospital, public health, and affiliated staff focused on COVID-19 treatment, education, and mitigation. In its fifth year in FFY 2019, the portable crib project added Hillcrest Medical Center (the first hospital expansion into the Tulsa metro area) and Chickasaw Nation Medical Center, the largest hospital for patients primarily from the local American Indian community. These new partners were added to the program's original distribution partners; home visitation programs, the Oklahoma City Indian Clinic, the OU Children's Hospital, Mercy Hospital Oklahoma City, and Mercy Hospital Ardmore. The portable cribs continued to be distributed with culturally specific materials to qualified families on safe sleep education, along with sleep sacks. Two hundred and sixty-four portable cribs were distributed to families in need as of September 30, 2020.

The Chickasaw Nation Medical Center was also added to the list of birthing hospitals participating in the hospital sleep sack distribution program. The OPQI was a key partner in enrolling this hospital in the program. Hospital staff was trained in infant safe sleep, implemented written safe sleep hospital policies, signed the Infant Safe Sleep Hospital Participation Agreement, and, began distribution.

Despite COVID-19 hampering many other components of the projects and initiatives to bolster infant safe sleep and education across the state, the Maternal and Child Health outreach workers at the Oklahoma City-County Health Department (OCCHD) and Tulsa Health Department (THD) programs, and the Infant Safe Sleep Work Group co-lead continued to provide safe sleep education. Central Oklahoma FIMR provided train-the-trainer Infant Safe Sleep virtual sessions that resulted in approximately 431 total participants from across the state. The Tulsa Health Department (THD) FIMR group trained 57 caregivers directly in infant safe sleep, and also partnered with the Tulsa Police Department in promoting infant safe sleep in the homes where they had interactions. Finally, the Infant Safe Sleep Work Group co-lead provided education to a home for teen mothers in rural Oklahoma, home visitors in one of the rural health department clinics, and the Choctaw Nation home visiting staff.

Due, at least in part, to an increase in promotional campaigns and social media postings, the *Preparing for a Lifetime* Facebook page saw a rise in “hits” to 2,975 individuals in this period.

**Challenges:**
As with many other programs in this timeframe, COVID-19 was a significant hurdle due to time and resources pulled away from all public health projects to bolster COVID-19 education, mitigation, and treatment. The hospital partners key to these efforts were most often overwhelmed with pandemic-related tasks and as such almost any project that was not directly related to COVID-19 was placed on pause in many organizations.

Unfortunately, while community baby showers were a great opportunity for bringing education and resources to Oklahoma women and their partners in prior years, those that occurred annually were cancelled due to COVID-19 concerns. *Preparing for Lifetime* Infant Safe Sleep Work Group partners, the Oklahoma City-County Health Department (OCCHD) and Tulsa Health Department (THD) were unable to hold many community events, and did not host a community baby shower unlike previous years.

Unrelated to COVID-19 but still a persistent obstacle to equity is the continued racial/ethnic disparity for both safe sleep and infant mortality in the state. African Americans continued to place their babies on their back to sleep at a significantly lower rate than their white counterparts. The disparity of African American parents who shared a sleep space with their infants was also disproportionately higher. However, the back-to-sleep placement gap between the American Indian community and the white community shrank to almost no difference. When looking at co-sleeping data, although the disparity continued to persist between American Indian and white parents, it was much smaller than in the prior years measured. The infant mortality rate disparity did not improve significantly, with the White Infant Mortality Rate at 1.3, Black at 3.0, and American Indian at 2.6.

Despite interest from three birthing hospitals and dialogue about entering into the sleep sack distribution program, only one of those completed the requirements for participation due to COVID-19.

Another significant shift was the reduction in distribution of crib kits among almost all partners. When examining this shift from home visitors, this was likely due to the COVID-19 protocol ceasing all in-home visits. The reduction in hospital distribution may have also been another unfortunate circumstance of the staff being focused on COVID-19 treatment response with less time allowed for other discharge activities.

**SPM 1: Infant Mortality Rate per 1,000 live births**

**Objective 1. Reduce the rate of preterm births (births < 37 weeks gestation) from 10.8 in 2012 to 9.1 by 2020.**

**Data:**
Prematurity remained the second leading cause of infant mortality in Oklahoma; rates continued the upward trend from 10.6% in 2016, 11.1% in 2017, 11.4% for 2018, and 11.5% for 2019 births. This was significantly higher than the Healthy People 2020 goal of 8.1%. Disparities remained evident with Black women having a preterm birth rate of 15.8% compared to white women at 10.9%, American Indian/Alaska Natives women at 11.3%, Hispanic women at 11.0% and Asian at 10.3% and Other/Pacific Islander at 10.7%.

**Successes:**
The Preconception/Interconception Work Group of the *Preparing for a Lifetime* initiative to reduce infant mortality focused on educating women about planning for pregnancy and the importance of early and appropriate prenatal care. Work group members and county health department staff distributed preconception health information at health fairs and community baby showers across the state prior to March 2020. Activities and opportunities to share information were very limited for the remainder of the year due to restrictions on activities and priorities for staff and partners to assist with emergency response activities.

In October 2017, the University of North Carolina received new funding to reduce infant mortality and improve birth outcomes by advancing the status of women's preconception health particularly for low-income women and women of color in some of the country's most underserved communities. Oklahoma was chosen to participate in this grant opportunity based on work with previous Collaborative Improvement and Innovation Network (CoIIN) teams focused on preconception health. MCH recruited seven partners for this team: two family planning clinics, all four Healthy Start Projects in the state, and a Federally Qualified Health Center. The federally qualified health center dropped out of the project this year but the other six sites remained engaged. A new preconception/interconception screening tool was developed through the human-centered design process and piloted in all sites. The pilot was completed in September and all sites have incorporated the tool into their protocol. Family planning clinics and home visitation programs both restricted in-person visits due to COVID and utilization of the tool with feedback from clients was limited. Two of the Healthy Start projects involved in this team developed guidelines to use the tool to prepare clients for their postpartum or well-women visit. The tool is available in five languages: English, Spanish, Burmese, Marshallese, and Zomi.

Through the collaborative Focus Forward Oklahoma Initiative, the Oklahoma Health Care Authority (OHCA) led efforts to recruit and train health care providers across the state on contraceptive counseling and LARC procedures. The Focus Forward Oklahoma (FFO) Program maintained three primary strategies for addressing barriers to access of the most effective methods of contraception. These included: policy change, education, and communication. Since its inception, the program has removed restrictions on LARC (Long Acting Reversible Contraceptive) devices for SoonerCare members from the Oklahoma State Plan for Medicaid, and more recently focused policy efforts on explorations of access at health departments and Federally Qualified Health Centers (FQHCs). In particular, in partnership with OSDH, the program was able to get a Health Service Initiative through the Children’s Health Insurance Program approved to increase the number of LARC devices available to uninsured women under 19. This past year policy work has focused on creating a LARC carve out for FQHCs so that they can be reimbursed for LARC outside of the prospective payment system. Education efforts have focused on provider workforce development to increase the number of providers who provide LARC to patients. Since 2017, 29 training sessions focused on best practices in patient centered counseling and hands-on LARC procedures skills have been hosted at no cost to the trainees.

A total of 334 providers from across the state have been trained in the curriculum. Sixty-eight percent of providers were from the two major metropolitan areas of Oklahoma (Oklahoma City/Tulsa) and 32% were from rural areas in Oklahoma. Five provider types have attended the training sessions: 1) Physician MD, 41%; 2) Physician DO, 16%;

3) Physician Assistant, 10%; 4) Advanced Practice Registered Nurse/Certified Nurse Practitioner, 31%; 5) Certified Nurse Midwife, 1%. Four specialties were represented at the training sessions: 1) Family Practice/Primary Care, 72%; 2) Obstetrics/Gynecology, 15%; 3) Pediatrics, 8%; 4) Other (e.g. Internal Medicine, Emergency Medicine), 4%. In 2019, clinical and administrative staff training sessions were added to the program to better support provision of the full range of contraceptive options. The program has a website that houses information related to the program and resources for patients, providers, and community partners. FFO staff also continued to conduct outreach to the provider and patient community. Two MCH staff became trainers for Merck this year to assist with Nexplanon training for new OSDH staff and as part of the Focus Forward program. Birth certificate data appeared to indicate a decrease in the number of births in 2017, 2018 and 2019. Increased access to LARCs could be contributing to these changes and possibly impact the premature birth rate for unintended pregnancies in mothers with risk factors for preterm births.

The Office of Perinatal Quality Improvement (OPQI) continued work on quality improvement activities with birthing hospitals, including the continued monitoring of elimination of elective, non-medically indicated inductions and scheduled cesarean sections prior to 39 weeks of gestation. The “Every Week Still Counts” initiative provided birthing hospitals with support to maintain reduced rates for elective deliveries prior to 39 weeks. Activities for the “Every Week Counts” collaborative ended 12/31/14 as hospitals transitioned to reporting these numbers to the Centers for Medicare and Medicaid Services for The Joint Commission’s PC-01 measure “Patients with elective vaginal deliveries or elective cesarean sections at $\geq$ 37 weeks and < 39 weeks of gestation.” Oklahoma saw a 96% decrease from baseline data in Quarter 1, 2011 for elective scheduled deliveries prior to 39 weeks in 2014. From Quarter 1, 2019 – Quarter 4, 2019, Oklahoma hospitals maintained an average PC-01 rate of 2% that equaled the national average however, the percentage of deliveries at 36-38 weeks gestation deliveries started increasing in 2019. In 2020 this increase was sustained with a rate of 35.9% of deliveries occurring between 36 and 38 weeks during the 4$^{th}$ quarter. Some of the increase may be result of changes in recommendations and the addition of some “indicated” conditions for early deliveries. OPQI staff also propose that rising rates of preterm births may be due to lack of enforcement of hard stop policies for scheduling inductions and cesarean sections before 39 weeks without a medical indication, documentation not reflecting appropriate medical indications, and improper coding of medical indications. The Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) addressed perinatal issues identified by providers and continued to serve as the link between providers and policy-makers. MCH provided funding for the OPQIC to facilitate the collaborative, including funding the OPQIC Medical Director position and MCH staff who served as members of the leadership team for the collaborative. Reducing preterm deliveries remains a priority for this group.

Oklahoma continued to experience an alarming increase in the number of congenital syphilis cases. Mothers can transmit the infection to their baby before birth or through the birthing process causing miscarriage, stillbirth, death shortly after birth, prematurity and birth defects. Early testing and treatment remained the most effective method for getting ahead of the epidemic, to help ensure optimal birth outcomes. MCH staff joined the Congenital Syphilis Task Force in 2019, which advocated for testing pregnant women in the first and third trimesters. Task Force members also worked to educate Oklahomans on the risk of syphilis in pregnancy and the importance of getting treatment if caught early in pregnancy to prevent congenital transmission. While OSDH Sexual Health and Harm Reduction staff continued to track cases and educate providers, task force activities were temporarily suspended due to COVID emergency response activities.

Financial support of the FIMR projects at the THD and the OCCHD remained a priority. Accomplishments included conducting full case reviews of fetal, neonatal and infant deaths and community action activities.

The Healthy Start projects in Oklahoma and Tulsa counties and the home visiting programs under the umbrella of parentPro (Maternal, Infant, and Early Childhood Home Visiting programs [MIECHIV], Children First, Parents as

Teachers) received technical assistance and support from MCH. These projects and programs provided in-home support to pregnant females and their families. The Fetal and Infant Mortality Case Management project at OHCA provided phone support to decrease infant morbidity and mortality, including education on the signs and symptoms of pregnancy complications and where to seek prompt medical attention. Some visits were accomplished virtually this year but most in-home visits were suspended in March due to COVID restrictions.

OSDH was awarded the State Maternal Health Innovation Program Grant (SMHIP) in 2019 to augment Title V activities in relation to maternal health and prenatal care. These funds are to be used to improve access to prenatal care for high risk minority populations including tribal health members and Black women across the state. With improved access to prenatal care, health care providers may be able to identify more women at risk for preterm births and ensure appropriate care is provided to help prevent additional premature births. See objective #2 for information on expanded services.

MCH maintained a close collaborative relationship with contractors and community partners, ensuring that developed tools and information were available to health care providers across the state through the OSDH website, the OPQIC website, the OHCA website, and OPQIC quarterly meetings.

**Challenges**:
Challenges included the rising preterm birth rate at 11.5% and the fall to an “F” on the March of Dimes grade card in 2021 despite all the work of OSDH and community partners. This is the highest preterm birth rate for Oklahoma in the last 10 years. Although collaborative partners continually review the data, no obvious causes for the increase were identified making it difficult to determine how to address the increase.

Additional issues included identifying causes of spontaneous preterm birth, especially in the Black population; and identifying and addressing the impact of social and racial inequities on prematurity. Disparities continued to exist in Oklahoma with the preterm birth rate among Black women 36% higher than the rate among all other women. However, the disparities are slightly better than 2019 when the Black rate was 38% higher than other women. Social determinants of health, such as income, health insurance status and prenatal care access, provided a context that could be linked to inequities in maternal and infant health outcomes.

**Objective 2. Increase the number of women who receive prenatal care in the first trimester of pregnancy from 68.5% in 2013 to 71.9% by 2020.**

**Objective 3. Reduce the prevalence of substance-exposed newborns.**

**Data:**
In 2015, the number of births to Oklahoma females who began prenatal care during the first trimester of pregnancy reached a high of 70.2% then dipped in 2016 and 2017. The 2018 data indicate prenatal care in the first trimester was up again to 70.4%.

According to Oklahoma hospital discharge data, 7.0 infants per 1,000 hospital births were diagnosed with neonatal abstinence syndrome in 2018, compared with 5.0 in 2014 and 6.2 in 2016.

**Successes:**
According to the Oklahoma Health Care Authority State Fiscal Year 2020 Annual Report, 27,828 deliveries or 57.4% of all births in Oklahoma were paid for by the Medicaid programs SoonerCare or Soon-To-Be-Sooners (STBS). The Medicaid program STBS continued to provide health care benefits through the State Children's Health Insurance

Program for the unborn children of pregnant females who would not otherwise qualify for SoonerCare benefits due to their citizenship status and those women with incomes between 133% of Federal Poverty Level (FPL) and 185% FPL. MCH continued to have a strong partnership with staff at the Oklahoma Health Care Authority (OHCA), the state agency that administers the Medicaid program.

County health department (CHD) staff continued to assist individuals and families to apply for Medicaid benefits through the online enrollment process. Eligibility was determined at the time of application and clients were immediately provided with a Medicaid ID number to use in setting up appointments with providers which assisted pregnant females in obtaining earlier access to prenatal care. Dr. Stevens, from Warren Clinic in Tulsa, continued providing prenatal care at the Creek County Health Department.

The OPQIC addressed issues identified by providers and continued to serve as the link between providers and policy-makers.

As part of the MCH Comprehensive Program Reviews conducted with county health departments and routine site visits to contractors, MCH assessed community issues related to access to prenatal care. Clinic records were audited to ensure females with positive pregnancy tests were counseled on the need to initiate care with a maternity health care provider within 15 days. County health departments and contract providers were expected to keep current resource lists and to link clients with maternity providers. Comprehensive Program Review visits were suspended in March due to COVID restrictions.

County health departments and contract providers served as safety net providers for maternity clinical services. Clinics served as the point of entry for 15,4008 females for pregnancy testing and linkage with appropriate services depending on pregnancy test results. This reflects a 22.0% decrease from the previous year, most likely due to COVID restrictions on in-person clinic visits. With the continuation of STBS as a Medicaid option for health care coverage, many pregnant women were eligible for coverage for prenatal care and delivery. However, STBS continued to be a limited benefit package. Through OPQIC meetings and partnerships it was apparent that access to care was still an issue for many women due to distance and provider availability, especially in rural areas of the state.

MCH continued to promote the Office of Population Affairs and the CDC's guidelines for "Providing Quality Family Planning Services" (4/2014). The QFP provided recommendations for evidence-based practice and encouraged health care providers to treat every visit as a preconception health visit, providing targeted preconception and interconception health counseling to every client. The OSDH continued utilizing these guidelines in the provision of family planning and reproductive health care services, including preconception health care in county health departments and contractor clinics through the Title X grant. All female clients were strongly encouraged to complete the Women's Health Assessment Tool/Client Engagement Tool to assist in identifying risk factors, provide related education on risks identified, and promote reproductive health planning. For those seeking pregnancy within the next year, counseling included the importance of early prenatal care. Screening for a history of premature birth is included in pregnancy test counseling to help educate women with a prior preterm delivery on the importance of early prenatal care.

Due to the high rates of opioid use and increasing rates of newborns diagnosed and treated for neonatal abstinence syndrome, the OMNO (Oklahoma Mothers and Newborns Affected by Opioids) Work Group was established last year. Opioid prescribing guidelines for pregnant and postpartum women were developed and distributed to family practice, obstetric, and pediatric health care providers. The guidelines are available online at: https://opqic.org/omno/maternal/. A toolkit was developed for hospitals choosing to implement the *Obstetric Care for Women with Opioid Use Disorder* Patient Safety bundle as part of the Alliance for Innovation on Maternal Health

(AIM) Initiative. The toolkit included the prescribing guidelines, examples of universal screening tools, information on Screening, Brief Intervention and Referral to Treatment (SBIRT), information on Medication Assisted Treatment (MAT), behavioral health resources and evidence-based resources. The toolkit and the safety bundle were launched at the joint Oklahoma Perinatal Quality Improvement Collaborative/*Preparing for a Lifetime* Summit held September 20, 2019. There were 15 hospitals participating in the pilot group. Activities were suspended for a few months due to competing priorities for hospital staff dealing with COVID, but plans are to resume in the spring.

The OSDH was awarded the new SMHIP grant to address maternal morbidity and mortality in innovative ways for the next five years in 2019. This grant started October 1, 2019 with projects to address the lack of access to quality prenatal care for minority, tribal and rural women, substance use/abuse in pregnant and postpartum women, maternal morbidity, and telehealth linkages to high risk obstetrical care. Due to COVID responses and changes in staff at OSDH, contracts were delayed. However, several contracts were established including Project ECHO, Cherokee Nation, STAR clinic and CHESS Health. Contracts were put in place to establish a High Risk OB ECHO (Extension for Community Healthcare Outcomes) which provides didactic information for local OB providers on high risk conditions and case review with input from the hub team on standards of care and recommendations for quality care and referral. OSDH also contracted with Cherokee Nation to expand Maternal Fetal Medicine access within the Cherokee Nation health system. Another contract was initiated with the Oklahoma University Health Science Center Maternal Fetal Medicine STAR clinic to expand services for pregnant women with substance use disorders. A contract was also initiated with CHESS Health for the e-intervention application to make a warm handoff through the application for pregnant women with substance use and/or mental health needs.

The Maternal Health Task Force was established in partnership with the Oklahoma Perinatal Quality Improvement Collaborative through the Maternal Health Innovation Grant. A strategic map was developed with the goal of improving maternal health through comprehensive health care, both preventative and reactive, for women of childbearing age –including preconception, pregnancy, childbirth, postnatal and inter-conception care. Four priorities were identified with access to appropriate care and maternal health programs identified as priority A.

**Challenges:**
The biggest challenge this year was the impact of COVID-19 on access to in-person health care visits, restriction of family members from health care visits with pregnant women, changing the focus to telehealth visits, and access to telehealth visits in rural areas of the state without quality wireless connections.

The Soon-to-be-Sooners (STBS) program was created to provide insurance coverage for women who were excluded from full Medicaid benefits due to citizenship status and consequently offered a limited benefit package which only included prenatal care services that benefited the infant. Insurance coverage for this population ended at hospital discharge. Three years ago, STBS changed eligibility requirements to include those similar benefits for all women between 133% and 185% FPL, regardless of citizenship status, which continued to leave a large percentage of pregnant women with limited prenatal care coverage.

Another major barrier to access was the continued lack of obstetric providers in the state and, consequently, transportation issues, which prevented women from accessing available care. Only 46 hospitals continued to provide delivery services in 28 of the state's 77 counties.

Legislation was once again introduced in this legislative session for full practice authority for advanced practice nurses, however, it did not pass out of committee. This legislation would have removed the requirement for advanced practice nurses to have a physician signature for prescriptive authority. Each practicing physician can only sign for two full-time APRNs creating a significant barrier to accessing services especially in rural areas of the state where

there is a shortage of all health care professionals. This year, the Oklahoma State Medical Association agreed to allow practicing physicians to sign for prescriptive authority for more than two APRNs, however, the physicians have to apply, get scheduled on the agenda for an Oklahoma State Medical Association (OSMA) executive committee meeting, and attend the meeting either virtually or in-person to receive approval to sign for additional APRNs.

Oklahoma continued to be a state without Medicaid expansion during this time period, which impacted access to care as Medicaid benefits were threatened or reduced, reimbursement remained low, physician offices closed, and rural hospitals either closed or stopped providing obstetric services.

**Objective 3. Screen 100% of newborns in Oklahoma and maintain timely follow-up to definitive diagnosis and clinical management for infants with positive screens.**

**Data:**
All newborns born in Oklahoma hospitals in 2019 (latest data available) were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU) and other amino acid disorders; congenital hypothyroidism; galactosemia; sickle cell disease; other hemoglobinopathies; cystic fibrosis (CF); congenital adrenal hyperplasia; medium chain acyl-CoA dehydrogenase deficiency (MCAD) and other fatty acid disorders; organic acid disorders; biotinidase deficiency, and severe combined immunodeficiency (SCID). One hundred percent of newborns received short-term follow-up (STFU) services for diagnosis and 100% of affected newborns were referred to long-term follow-up (LTFU) for care coordination services.

In 2019, all 647 newborns with sickle cell trait and hemoglobin C trait received educational material regarding trait status and were referred for genetic counseling. Many of the families also received trait counseling from their child's primary physician when seen for well child visits, as both families and physicians on record were sent screening results. The NSP offered families an opportunity to discuss long-term life and family planning issues with a genetic counselor and 53 families received counseling with a board-certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (71 of the 74 received counseling). All cases of confirmed diagnosis for other newborn screening disorders were referred for genetic counseling and 18 received genetic counseling.

**Successes**:
Title V funding continued to support the newborn screening activities statewide. The NSP, housed within the Screening and Special Services Division of the OSDH, continued activities to educate providers and hospitals about the need for newborn screening and procedural issues regarding collecting and submitting the specimens to the Public Health Laboratory for testing. NSP also maintained the Oklahoma Birth Defects Registry (OBDR), an active, population-based public health surveillance system. The mission of the OBDR remained to identify opportunities to prevent, optimize early detection of birth defects, and reduce infant mortality. In addition, educational sessions were provided to county health department nurses, Children First nurses (the State’s Nurse Family Partnership program), and medical personnel about the NSP and OBDR.

The NSP started the work of expanding to the four additional core conditions (Mucopolysaccharidosis Type 1 (MPS 1), Pompe, Spinal Muscular Atrophy (SMA), and X-Linked Adrenoleukodystrophy (X-ALD) legislatively approved in 2020. However, progress was halted due to resources being diverted to support COVID-19 relief efforts.

Long-term follow-up activities continued to include family education, and other public and stakeholder education, such as schools and transition committees. LTFU was expanded to include a second genetics clinic in OKC. The NSP and Public Health Laboratory (PHL) continued partnering with the Oklahoma Hospital Association and the

Office of Perinatal Quality Improvement on the quality improvement program, “Every Baby Counts,” to address delays in newborn screening. The overall goal of the QI program was to improve timeliness of newborn screening through collaboration with birthing hospitals and the contracted courier service to improve transit time (the time it took for specimens to arrive at the PHL from the time of collection). The QI program included providing educational Web-Ex sessions for all birthing hospitals, development and dissemination of monthly transit time reports to birthing hospitals and continued monitoring of provided courier services, as well as, work on reducing the number of unsatisfactory specimens submitted to the PHL.

Staff from Screening and Special Services actively collaborated with MCH on several projects, including the *Preparing for a Lifetime, It’s Everyone’s Responsibility* infant mortality reduction initiative, the OPQI and the Oklahoma Fetal and Infant Mortality Review (FIMR) projects.

The NSP continued to provide trainings on the topics of newborn screening and genetics for other statewide programs such as Children First, Healthy Start, Oklahoma Partnership for School Readiness, Oklahoma Parents as Teachers (OPAT), the Maternal, Infant, Early Childhood Home Visiting (MIECHV) program, the Child Abuse Training and Coordination (CATC) Program, and the Home Visitation Leadership Advisory Council (HVLAC).

**Challenges**:
Challenges related to improving newborn screening timeliness included staff being diverted to the COVID-19 response as well as difficulty with hospital engagement due to COVID-19.

Capacity, an additional challenge related to the number of medical specialists in the state, remained inadequate to serve the population of the state as many specialty services were located only in the two large metropolitan cities, requiring families to travel long distances for appropriate care. Another challenge included linking to birth certificate data to capture home births for screening and follow-up activities.

**Objective 4. MCH will evaluate and revise the *Preparing for a Lifetime, It’s Everyone’s Responsibility* statewide infant mortality reduction initiative, as it approaches its 15th year.**

**Data:**
Partner feedback was obtained from work group participants on potential ways to increase participation and visibility of the initiative. Ideas included more in-depth discussion on timely topics from partners, redesign of the initiative’s marketing, and social media outreach, expansion of non-traditional stakeholders to invite to meetings, and movement towards a virtual platform to engage stakeholders across the state.

**Successes:**
At the suggestion of the stakeholder workgroups, it was decided to redesign the marketing and educational components of the initiative. The redesign included a new contract with Cox Media in developing and streaming updated campaigns through cable television, social media platforms, and radio spots; including satellite radio. Stakeholders began providing input on the new website design to ensure that information could be presented in an easy to acquire manner and understandable by various audiences across the state. During this time of COVID-19, stakeholders were able to continue the work of the initiative by participating in virtual meetings and inviting non-traditional partners to the table.

**Challenges:**
The primary challenge remained assuring that the partners and stakeholders needed at meetings were those in attendance. Although access to the meetings was improved due to the virtual format, COVID-19 created challenges

for more participation in the stakeholders and community members due to reassignment of duties to respond to the pandemic.

### NPM 4 A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Breastfeeding rates will be monitored through PRAMS, WIC, TOTS, and NIS data. Information will be shared with state policymakers, health care providers, families, and community groups.

Mothers' Lounge and worksite policy information will be shared on the agency intranet, websites, and trainings, serving as models for state and community agencies and worksites. Efforts to promote and increase Recognized Breastfeeding Friendly Worksites including schools and child care centers will continue.

MCH will work with the WBTF Indian Tribal Organizations to plan and promote joint conferences and trainings through combined efforts. The Task Force will provide input for WBW activities, promotion and duration materials for county health departments and area clinics, help identify expansion sites for BFPC, and promote duration through news releases and PSAs. OSDH-PFL, OBRC, and COBA websites will serve as statewide resources.

MCH will partner with OUHSC to support and promote the 24-hour OBH through a variety of outlets and settings. With others, MCH will continue to fund the OMMB to provide donor human milk for preterm and fragile infants. OMMB's Director will lead a USBC group discussing national issues related to donor milk.

Through a MCH contract, OBRC will offer in-person or virtual evidence-based education with staff trainings, train-the-trainer sessions, ongoing technical support, and resources.

MCH will collaborate with WIC, COBA, the OK Health Care Authority (OHCA), the OK Hospital Association, the OUHSC Office of Perinatal Quality Improvement (OPQI), the OPQIC, and the OBRC to promote Baby-Friendly designation for birthing hospitals.

MCH and partners will work to promote COBA's strategic plan to build capacity, network, educate, promote public awareness and workplace laws, and advocate for OK's breastfeeding families.

### 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

In addition to continuing efforts with the Oklahoma City-County and Tulsa FIMR programs, Healthy Start programs, the Infant Safe Sleep Work Group will seek out novel partners to educate women on the importance of infant safe sleep practices, preconception health, early prenatal care, and importance of postpartum visits to improve both maternal and infant outcomes and reduce infant mortality.

Eliminating disparities in safe sleep practices will be a key area of focus for the workgroup moving forward. Finding champions within these communities will be critical to assist in promoting the messages of back-to-sleep and the importance of separate infant safe sleep spaces.

The largest venue to reach new parents will remain Oklahoma birthing hospitals, and as such, work to expand the number of hospitals participating in the infant safe sleep education and sleep sack distribution program will be on-going.

Staff will work to take the portable crib distribution project into new venues for distribution, with a prominent focus in areas to reach the underserved African-American and Native American populations. These new venues may include new partnerships such as Federally Qualified Health Centers (FQHCs), tribal home visiting programs, or potentially county health departments.

**SPM 2 Infant mortality rate per 1,000 live births**

Continue to provide funding and technical assistance to Screening and Special Services for screening and follow-up services statewide.

Prematurity will remain a focus for OSDH and community partners. The Oklahoma State Department of Health, the Oklahoma Health Care Authority, the March of Dimes, and OPQI will continue to support the activities of the Oklahoma Perinatal Quality Improvement Collaborative in addressing perinatal quality of care issues in Oklahoma. MCH staff will continue to support March of Dimes activities to address prematurity and participate in the March of Dimes annual walk when possible.

Preconception/Interconception Care and Education and Tobacco Cessation, two work groups with the *Preparing for a Lifetime* initiative, will continue activities to impact the number of preterm births by decreasing smoking rates during pregnancy and to promote reproductive life planning to address preconception health risks prior to pregnancy through dissemination of preconception information at community events when possible and through social media messaging through Cox Media.

MCH will continue to provide contraceptives through the Title X Family Planning Grant. Emphasis will continue to be on client centered counseling and the promotion of long-acting reversible forms of contraception when appropriate to reduce the number of unintended pregnancies, adolescent pregnancies, and closely spaced pregnancies, all of which contribute to the preterm birth rate.

County health department (CHD) staff will continue to assist individuals and families to apply for Medicaid benefits through the online enrollment process.

The Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) will continue to work with prenatal care providers to address issues identified by providers and will continue to serve as the link between providers and policy-makers.

When MCH Comprehensive Program Reviews resume, staff will continue to assess community issues related to access to prenatal care, audit records to assure females with positive pregnancy tests are counseled on the need to initiate care with a maternity health care provider within 15 days, and ensure resource lists and links with maternity providers are kept current. MCH will continue to work on identifying barriers to access for prenatal care and looking for innovative solutions.

County health departments and contract providers will serve as safety net providers for maternity clinical services and continue providing evidence-based preconception health care and counseling to assist clients in achieving a healthy pregnancy and in accessing early prenatal care.

OSDH, ODMHSAS, and OPQIC will continue working together to address opioid use/abuse in pregnant women and increasing rates of newborns diagnosed and treated for neonatal abstinence syndrome through implementation of the *Obstetric Care for Women with Opioid Use Disorder* Patient Safety bundle as part of the AIM Initiative and

through support for the STAR (Substance, Treatment and Recovery) clinic with funds from the Maternal Health Innovation Grant assisting pregnant women with substance use disorders. OSDH will continue to fund a contract with CHESS Health for access to the e-intervention application to assist staff in linking pregnant women with substance abuse and mental health disorders to the most appropriate health care provider to meet their needs.

Collaborative efforts will continue with the home visiting programs, Healthy Start projects, and FIMR to educate women on the importance of preconception health, early prenatal care, and importance of postpartum visits to improve both maternal and infant outcomes and reduce infant mortality.

MCH will continue to establish projects with Maternal Health Innovation Grant funding to improve access to quality health care and reduce maternal and infant mortality. Through this grant, the plan is to establish prenatal care clinics to address access to early and adequate prenatal care in disparate and rural populations with a focus on tribal women and African American women.

Efforts will continue to maintain the number of PURPLE hospitals implementing with fidelity, and MCH will work with partners in non-participating hospitals' communities to assist in describing the need for this program. Innovative practices will be reviewed to determine if avenues outside hospitals might be more impactful for program expansion.

CLICK hats will be tagged and distributed to PURPLE participating hospitals and the 2021 CLICK Campaign will be planned.

MCH will continue to partner with Injury Prevention Service (IPS) to support the installation of car seats and booster seats for families of young children available at no cost to families that qualify. Two car seat check events will be held each month through a collaborative relationship with the University of Oklahoma's Children's Hospital and Safe Kids Metro. The MCH Early Childhood Coordinator will maintain Child Passenger Safety (CPS) certification status to participate with car seat events and educate caregivers and professionals on child passenger safety.

County health departments with certified CPS Technicians will continue to support families in their communities with car seats and car seat installation and education.

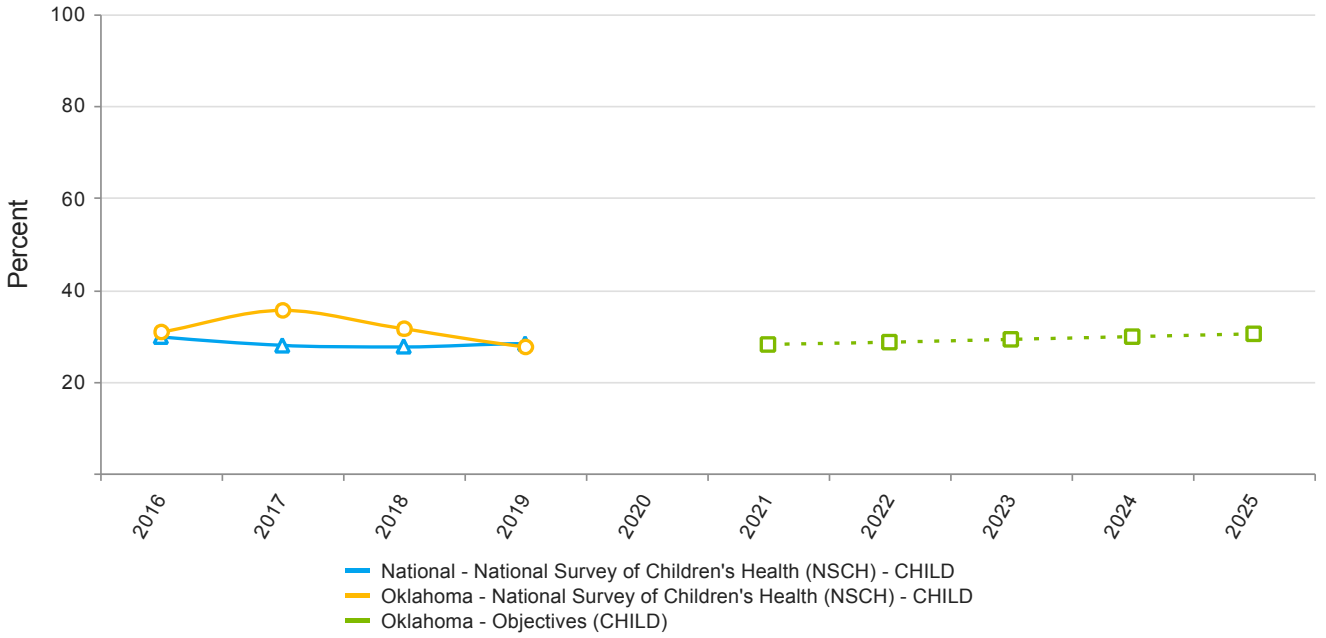
**Child Health**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000 | NVSS-2019 | 22.1 | NPM 7.1 |
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 | NVSS-2019 | 41.9 | NPM 7.1 |
| NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 | NVSS-2017_2019 | 16.6 | NPM 7.1 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 | NVSS-2017_2019 | 17.8 | NPM 7.1 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2018_2019 | 87.9 % | NPM 8.1 |
| 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) | NSCH-2018_2019 | 18.8 % | NPM 8.1 |
| 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) | WIC-2018 | 13.8 % | NPM 8.1 |
| 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) | YRBSS-2019 | 17.6 % | NPM 8.1 |

## National Performance Measures

**NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**
**Indicators and Annual Objectives**




| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | |
| | **2019** | **2020** |
| Annual Objective | | |
| Annual Indicator | 31.4 | 27.5 |
| Numerator | 93,110 | 89,475 |
| Denominator | 296,779 | 325,093 |
| Data Source | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | 2017_2018 | 2018_2019 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 28.1 | 28.6 | 29.2 | 29.8 | 30.4 | 31.0 |

**Evidence-Based or –Informed Strategy Measures**

**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.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2019 | 2020 |
| Annual Objective | | |
| Annual Indicator | 125 | 101 |
| Numerator | | |
| Denominator | | |
| Data Source | Child and Adolescent Health, MCH program data | Child and Adolescent Health, MCH program data |
| Data Source Year | 2019 | 2020 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 110.0 | 120.0 | 130.0 | 140.0 | 150.0 | 160.0 |

**State Action Plan Table**

| State Action Plan Table (Oklahoma) - Child Health - Entry 1 |
| --- |
| Priority Need |
| Improve quality health education for children and youth |
| NPM |
| NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day |
| Objectives |
| 1. Via the Oklahoma Center for Poison and Drug Information, provide poisoning prevention education to at least 24,000 preschool and elementary school students across the state annually. |
| 2. Provide staff support to assist the Oklahoma Partnership for School Readiness (OPSR) in implementing their five-year strategic plan for creating an equitable and sustainable system for improving developmental and academic outcomes for young children. |
| 3. Serve at least 58,000 students statewide Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD) by 2022. |
| 4. Identify areas in need of evidence-based health education in the state and develop a plan to help address the need. |
| 5. Reduce the number of absences during the school year from an average of 8.7 per student in 2018 to 7.2 per student in schools with an MCH-funded school nurse by 2022. |

## Strategies

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.

2a. Provide input into the strategic plan for OPSR and staff the following committees: Family and Community Engagement, Quality Improvements and Professional Development.

2b. Continue to participate in various advisory boards, committees and partnerships to promote best practices in early childhood care and education.

3a. 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.

3b. 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.

3c. Provide in partnership with Oklahoma's Learn the Signs: Act Early Team developmental screening training, as well as autism specific screening, to county health departments providing child health services. [New]

4a. 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. [New]

4b. Identify community partners that can assist in providing evidence-based health education and training for staff in their local schools.

5a. Continue to fund the rural school health nurses to provide evidence-based health education and services in their school districts.

5b. Provide in-services for school staff on the importance of students having an evaluation by the school nurse prior to being sent home related to illness or behavior issues, including technical assistance on COVID-19-related illnesses.

| ESMs | Status |
|---|---|
| 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. | Active |

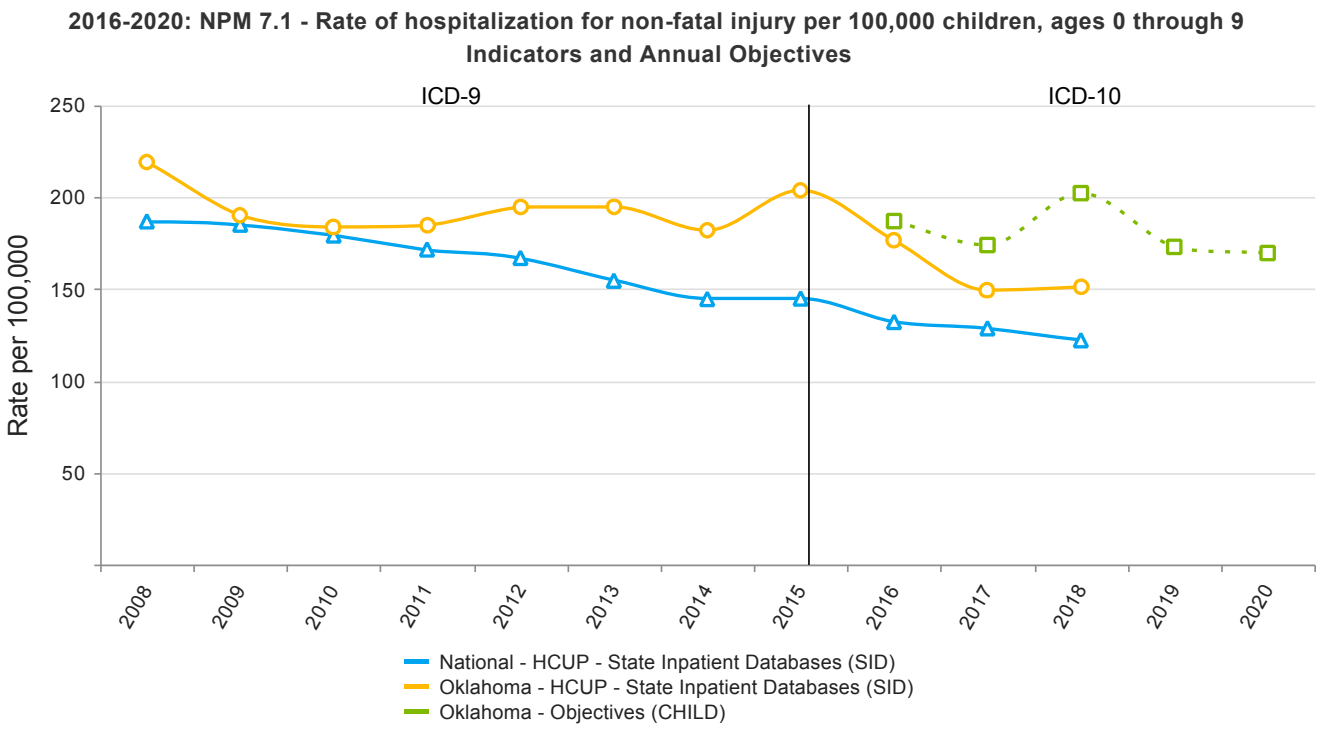
## NOMs

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)

| State Action Plan Table (Oklahoma) - Child Health - Entry 2 | |
|---|---|
| Priority Need | |
| Increase health equity for the MCH population | |
| NPM | |
| NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day | |
| Objectives | |
| 1. Require 100% of MCH contractors working in schools to have training in trauma-informed care and the impact of ACES on development by 2022. | |
| 2. Reinstate Child Health Clinics in pilot County Health Department Clinics for mobile and traditional settings by 2022. | |
| Strategies | |
| 1. Provide training on trauma-informed care and ACES to contractors or find acceptable online alternatives. | |
| 2a. Work with county staff to develop clinic practices and materials, including ways to increase client base and successfully promote clinics in underserved areas. | |
| 2b. Host monthly Pediatric Review sessions for clinical staff to share best practices and provide opportunities for networking and instruction from the MCH Medical Director. | |
| ESMs | Status |
| 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. | Active |
| NOMs | |
| 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) | |

**2016-2020: National Performance Measures**




Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: HCUP - State Inpatient Databases (SID)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 186.8 | 173.8 | 201.9 | 172.8 | 169.4 |
| Annual Indicator | 177.3 | 203.9 | 176.4 | 148.9 | 150.9 |
| Numerator | 951 | 823 | 948 | 793 | 797 |
| Denominator | 536,332 | 403,600 | 537,475 | 532,642 | 528,226 |
| Data Source | SID-CHILD | SID-CHILD | SID-CHILD | SID-CHILD | SID-CHILD |
| Data Source Year | 2014 | 2015 | 2016 | 2017 | 2018 |

**2016-2020: Evidence-Based or –Informed Strategy Measures**

**2016-2020: ESM 7.1.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum**

| **Measure Status:** | | | | **Active** | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 86.5 | 88 | 86.9 | 88.7 |
| Annual Indicator | 81.8 | 84.1 | 85.2 | 89.5 | 84.6 |
| Numerator | 43,013 | 42,224 | 42,425 | 42,643 | 38,537 |
| Denominator | 52,607 | 50,214 | 49,787 | 47,664 | 45,526 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

**Objective 1: Increase the number of delivering hospitals participating in the Period of PURPLE Crying Abusive Head Trauma curriculum from 39 in 2015 to 42 by 2020.**

**Data:**
The number of participating hospitals was 39 as of September 30, 2020; the program lost one participating hospital because it stopped delivering infants.

**Successes:**
The Injury Prevention Work Group of *Preparing for a Lifetime* continued to meet quarterly, albeit virtually, to discuss projects, including the Period of PURPLE Crying. PURPLE provides evidence-based information via a booklet, DVD or app, and nurse education to inform new parents and caregivers about the patterns of infant crying in an effort to reduce abusive head trauma. Hospitals had the option to request the PURPLE application (or app) for families, in addition to the DVD in English or Spanish. For those needing additional languages, Arabic, Vietnamese, Chinese, French or Burmese, only DVDs were available.

Presentations were given by staff and partners during this time on the Period of PURPLE Crying, abusive head trauma (AHT) and the crying curve, as well as the barbershop project to state social workers, the state's Head Start Health Managers and at the International Conference on Shaken Baby Syndrome/Abusive Head Trauma.

COVID put a hard stop on any in-person trainings or presentations. The barbershop project in Tulsa had to pause due to COVID protocols. Where possible virtually, community groups in the Tulsa area were provided information via The Parent Child Center, a member of the Injury Prevention Work Group and partner in the PURPLE program.

Injury Prevention workgroup members worked with the National Center to Prevent Shaken Baby Syndrome to plan data-driven training and distribution based on app use by delivery hospitals. MOUs with participating facilities were updated to include data tracking and were sent and signed by most delivery hospitals.

**Challenges:**
Program participation looked a little different for most of 2020 due to COVID-19. Most mothers were allowed only one or, at times during the pandemic, zero support persons in the delivery room, so often the mother was the only recipient of the information. In some hospitals, due to COVID rules, education was provided in take-home packets and not face-to-face, which for PURPLE is not best practice.

**Objective 2. Continue CLICK for Babies outreach activities, and expand project to 2 new community partners by 2020.**

**Data:**
CLICK provided handmade, purple knit hats to participating PURPLE hospitals in an effort to provide parents and caregivers with a visual reminder of the PURPLE crying techniques. The hats were given out during November, December, and January. This year's CLICK Campaign in Oklahoma netted over 1,000 knitted caps sent to MCH to add to the approximately 20,000 remaining from a previous year's campaign. Due to COVID, caps were not tagged prior to being sent to hospitals in September, so that they could be washed at the facility.

**Successes:**
The small number of cap donations for the year was due to limited marketing and outreach for CLICK efforts. Most caps came from knitting groups and individuals who had participated in the past and reached out to MCH staff.

Because MCH stored a large number of caps from a previous year's success, there was limited need for additional caps to meet all of the hospitals' needs.

MCH and Injury Prevention Work Group members responded to a few email requests, providing information about CLICK, knitting patterns, crying patterns for infants, abusive head trauma, and ways to support new parents. Staff also created washing and drying guidelines for caps to provide to volunteers to assure that hats sent to birthing facilities were sanitized appropriately.

**Challenges:**
None to report, although it is unknown how many hospitals were able to wash, tag and distribute caps due to the pandemic.

**Objective 3. Provide, via Adolescent Health Specialists, a total of 3 trainings in communities on adolescent distracted driving and graduated drivers licensing each year.**

**Data:**
OSDH Child and Adolescent Health (CAH) and Injury Prevention Service (IPS) staff partnered to hold a training over concussion prevention and a teen distracted driving program, Countdown2Drive, in January 2020 for nurses, health educators (HEs), and Adolescent Health Specialists (AHS).

IPS staff provided the existing Graduated Driver Licensing (GDL) brochures to CAH staff for distribution to AHS in the rural counties.

**Successes:**
A total of five AHS were hired for the state-level teen pregnancy prevention project, Oklahoma Healthy YOUth (OHY), between October 2019 and June 2020 for Pittsburg County, Jackson County, Carter County, and Ottawa County. MCH continued to rebuild the project and plans were made to train new staff on responsibilities related to distracted driving and graduated drivers licensing.

The AHS worked towards developing partnerships with local schools and community organizations in hopes of re-establishing and/or building Public Health Youth Councils (PHYCs) in their district. The Jackson County AHS partnered with a local public library that had an existing youth group to hold a Countdown2Drive event, unfortunately it was postponed indefinitely due to the COVID-19 pandemic.

MCH, Injury Prevention Service, and the Oklahoma Child Death Review Board, continued to participate in the Child Safety Learning Collaborative to focus on reducing motor vehicle injuries and fatalities among children and adolescents in Oklahoma until it ended in April 2020. Teen driving safety was still the top priority to address this issue. Five counties in Oklahoma previously identified for having the highest teen crash rates were still used to focus efforts of the collaborative.

**Challenges:**
The OHY project was still in the process of rebuilding after the 2018 Reduction in Force (RIF) and experienced turnover among the AHS throughout this grant year. Three AHS resigned, greatly impacting adolescent health activities in three districts. Additionally, the COVID-19 pandemic caused a statewide shut down in March, lasting through June 2020. This reduced ability to conduct trainings, develop PHYCs, deliver presentations, and host events. During the pandemic, all AHS and many MCH staff were re-assigned to the pandemic response and assisted with COVID-19 testing, employee screening, and case management. AHS had limited time for planning and participation

in adolescent health activities.

**Objective 4. Reduce nonfatal motor vehicle injuries in children ages 0 to 19 from 394 in 2013 to 366 by 2020**.

**Data:**
Due to the availability of data as reported by OSDH Injury Prevention, the data for this Objective is described in rates instead of by number. The rate of hospitalizations for nonfatal motor vehicle injuries for children ages 0-14 years in 2018 of 13.0 hospitalizations per 100,000 population was a decrease from 19.8 in 2010. Similarly, the rate of hospitalizations for nonfatal motor vehicle injuries for children ages 15-19 years in 2018 of 56.8 hospitalizations per 100,000 population was a decrease from 105.9 in 2010. Although the change over time for both age groups appears statistically significant, due to coding changes from the ICD-9-CM to the ICD-10-C, changes in rates should be interpreted with caution.

**Successes:**
The Early Childhood Coordinator, in the Child and Adolescent Health (CAH) Division of MCH, continued to provide support as a Certified Child Passenger Safety (CPS) Technician and Instructor. The Early Childhood Coordinator accepted appointments two to three days per week to check car seats, provide car seats for low-income families that did not have a safe seat, and educate the parent or caregiver about proper use and installation of the seats.

From October 1, 2019 through mid-March 2020, the Early Childhood Coordinator educated caregivers on the installation and appropriate use of approximately 64 child safety seats through individual appointments. On February 19, 2020 the Early Childhood Coordinator taught a one-day Child Passenger Safety course for home visitors. The Early Childhood Coordinator also participated in four community car seat events. On March 23, 2020 the Governor issued Statewide stay-at-home orders for all non-essential businesses and restricted public gatherings due to the rapidly spreading COVID-19 virus. Individual appointments and car seat events were suspended.

Individual car seat appointments resumed in June 2020, with the CPS technician wearing a gown and mask, and careful screening and instructions for the families. The Early Childhood Coordinator completed approximately 30 individual appointments from June 11, 2020 through September 30, 2020. In addition, MCH and Injury Prevention Service teamed up with OU Children's Hospital to hold twice per month car seat check events for families. All CPS technicians and families wore masks and the families learned how to install their car seats outside in a practice seat. The family members then installed the car seats into their own vehicles with supervision from the CPS technicians.

The MCH Early Childhood Coordinator maintained the Certified CPS Technician Instructor status and assisted in one National CPS Certification Technician Training Class with the newly revised curriculum September 28 – 30, 2020.

**Challenges:**
There continued to be a higher need by families than there were services available with trained CPS technicians across the state. The outbreak of the COVID-19 virus reduced the number of qualified families who received car seats and the number of families who received assistance in proper installation by a CPS Technician.

**Objective 5. Maintain an average minimum of 3,300 calls per month to the Poison Control Hotline through December 2020.**

**Data:**

For the calendar year 2020, the Poison Control Hotline received an average of 3,196 calls per month, a decrease from the 3,300 minimum calls per month. The calls included both confirmed exposures and confirmed non-exposures to humans and animals along with informational calls requesting identifications of medications and risk of exposure to the medication.

**Successes:**
The Oklahoma Center for Poison and Drug Information continued to provide clinical training opportunities for physician, pharmacy and nursing students, including pivoting to Zoom trainings after March 2020. Educational trainings for elementary schools, child care providers and the children in their programs were also provided virtually. Staff provided radio and television interviews on topics related to prevention of poisonings as requested. They also provided educational opportunities to parent groups, senior citizen clubs and community-based organizations. Technical assistance was given to emergency response personnel on potential poisoning episodes and to hospital emergency rooms treating patients with possible poisonings.

The services provided by the Oklahoma Center for Poison and Drug information continued to be invaluable during the COVID-19 pandemic as evidenced by the slight increase of calls after March 2020, compared to the previous year. The services provided were vital in keeping Oklahoma children safe, providing education and technical support.

COVID-19 highlighted the need for necessary changes to serve the citizens of Oklahoma. Staff transitioned to working from home using the Virtual Desk Interface which included web-based information, resources, links, and the capability to communicate via a video window with a toxicologist and other staff. The 2-day HAZMAT Life Support Course was held via Zoom during this time and participants and facilitators stated it was as successful as an in-person training without a drop in attendance.

**Challenges:**
The COVID-19 pandemic created challenges for the Center in that the back-up plan had to be reconfigured from the previous pattern of utilizing other states in an emergency, as all Poison Centers nationwide were in the same situation. Since March 2020, there has not been a need for many in-person educational presentations, as schools were either out or virtual. Not being in-person also drastically reduced the number of pamphlets and other items distributed with the Hotline number. Some presentations and trainings continued to be held virtually, but the request for educational programs dropped significantly during this time to almost zero.

Staff time and funding continued to limit the number of presentations and outreach that could be accomplished for prevention and educational activities.

Although there has been a decrease in the number of calls from the public, the Center continued to experience an increase in the number of calls from medical professionals, including emergency room providers and other medical clinics. This was similar to trends across the country. Calls from medical entities were more labor-intensive; therefore, the staff spent additional time taking care of more complex patient situations.

**Objective 6. Reduce the percentage of children 0-17 years experiencing two or more adverse family experiences from 26.6% in 2016 to 23.9% by 2020.**

**Data**:
According to 2018 and 2019 National Survey of Children's Health, among children ages 0-17 years in Oklahoma, 49.8% had no adverse childhood experiences, 25.1% had one adverse childhood experience, and 25.1% had two or

more adverse childhood experiences.

**Successes**:
Adverse Childhood Experiences (ACEs) occurred frequently among Oklahomans and accumulated over time, contributing to short- and long-term personal, familial, and societal outcomes, including early death. ACEs continued to include such things as family and neighborhood violence, mental illness and substance abuse in the family, divorce, incarceration of a family member, death of a parent/guardian, poverty, and being the victim of abuse. Such experiences caused stress responses in a child's developing brain, including extreme fear and helplessness. Continued stress responses over a prolonged period created a buildup of high levels of stress hormones in the body, interrupting normal physical and mental development – even changing the brain's architecture.

The Oklahoma Partnership for School Readiness (OPSR) held the OKFutures Moving Forward Professional Development Conference on November 2, 2019 in nine locations across the state. There was a total of 837 participants and one of the topics to choose from was Trauma-Informed Care: How to Support Children and Families Who Come from Hard Places. MCH staff, partners, and contractors assisted in the planning process for these events.

On January 30 & 31, 2020, the OPSR offered Conscious Discipline training to almost 200 early childhood professionals. The training took place in Midwest City, Oklahoma. This training was funded by the Preschool Development Grant Birth through Five from the U.S. Departments of Health and Human Services & Education. It featured Mara Spencer who has over 20 years of experience in early childhood. Each attendee received copies of the book "Conscious Discipline: Building Resilient Classrooms," Conscious Discipline is a comprehensive, evidence-based self-regulation program that integrates social-emotional learning, classroom management, and discipline. Conscious Discipline helps build resilient classrooms by giving educators seven powers to see conflict differently. These powers include: perception, attention, unity, free will, love, acceptance and intention. Each of these powers encourages a positive response from children and promotes skills like composure, encouragement and empathy.

The Oklahoma Professional Development Registry through the Center for Early Childhood Professional Development continued to offer formal training for early childhood professionals online and in the classroom on these ACEs topics from October 2019 through September 2020:

- Responding to Young Children Who Have Been Through Adverse Childhood Experiences
- Adverse Childhood Experiences: Building Resilience
- Addressing ACEs with Brain-based Approaches in Trauma-Informed Care
- Self-Care for ECE Professionals Who Care for Children Impacted by ACEs
- Foster and Adoptive Families: Supportive Strategies
- Understanding Adverse Childhood Experiences
- Promoting Equity Through Early Childhood Interventions

In the summer of 2020 approximately 150 professionals participated in a pilot group that received training in the Pyramid Model. The Pyramid Model is a research-based framework for promoting healthy social and emotional development in children. The model provides education, guidance, and coaching for early childhood professionals and families to promote the best practices in social and emotional engagement that support positive behavioral outcomes in children.

The OSDH Child Guidance program remained uniquely positioned in public health settings to provide evidence-based programs that enhance protective factors and reduce risk factors for families. Child Guidance teams located

in county health departments consist of master's degree level clinicians in child development, behavioral health and speech/language pathology. Through a multidisciplinary approach, the Child Guidance Program continued to provide a continuum of services that supports development and parenting of children from birth to age 13 years. MCH and OSDH staff referred families to Child Guidance professionals for services in the county health departments.

MCH continued to work collaboratively with the Oklahoma Family Network. Oklahoma Family Network focused on supporting families of children and youth with special needs via emotional support, resource navigation, and ensuring quality health care for all children and families through strong and effective family/professional partnerships.

During the MCH Title X Comprehensive Site Review visits to county health departments, MCH staff members checked for community involvement in child abuse prevention efforts, health education provided in the schools and at community events, and appropriate resources and referrals for those dealing with mental health issues, needing treatment for substance abuse, and help for those experiencing homelessness, hunger, poverty and domestic violence. Due to COVID-19, only a few site visits were conducted prior to lockdown in March 2020.

The MCH Early Childhood Coordinator continued to serve on the Oklahoma Head Start Early Childhood Collaboration Advisory Board and attended the meetings. The Advisory Board was established to provide input to and receive updates on the strategic plan of work and activities of the Oklahoma Head Start State Collaboration Office (HSSCO).

The Board met according to schedule, three times per year, with ongoing communication between meetings, pivoting to virtual after March 2020. The membership of the advisory board continued to be composed of representatives of these priority areas: Health and Mental Health Care; Child Care; Education; Professional Development/Higher Education; Welfare (TANF); Child Welfare; Community Services; Family and Financial Literacy Services and Reading Readiness Programs; Activities related to Children with Limited English Proficiency; Activities related to Children with Disabilities; and Services to Children who are Homeless.

OPSR did not receive a second year of funding for OKFutures, the federal Preschool Development Grant Birth through Five by the U.S. Department of Health and Human Services, Administration for Children and Families, but they finalized the Oklahoma Early Childhood Strategic Plan. OPSR, as the State Early Childhood Advisory Council continued to lead efforts in collaborative, diversely representative decision-making through strategic plan implementation and continuous review processes. OKFutures stakeholders established a common agenda and developed shared measures for the OKFutures vision and desired outcomes and the MCH Early Childhood Coordinator served on the Family and Community Workforce Team.

The MCH Early Childhood Coordinator continued participating in the Oklahoma Tribal Child Care Association (OTCCA) meetings. The OTCCA remained a representative of American Indian and Alaska Native organization serving the 36 tribal Child Care Development Fund (CCDF) grantees that represent Tribal communities across Oklahoma. At the December 2019 meeting and the March 2020 meetings, the MCH Early Childhood Coordinator provided information and resources on safety, health, and nutrition for the tribal child care entities to share with the child care programs and families they serve. Due to COVID-19 restrictions the June and September 2020 meetings were cancelled.

**Challenges**:
Due to the COVID-19 pandemic, there was increased concern and challenges for all families and children in tolerating the increased adverse experiences created by the COVID-19 pandemic and sheltering at home.

There remained an identified need for more training on adverse family experiences for all who work with children and

families, and for the families themselves.

**Objective 7. Develop guidelines, with the assistance of the MCH-funded school nurses, and provide in-services for school staff on the importance of students having an evaluation by the school nurse prior to being sent home related to illness or behavior issues.**

**Data:**
During the 2019-2020 school year, MCH continued to assist the Oklahoma State Department of Education with funding for eleven school nurses in nine rural school districts. The school nurses returned 6,528 students back to class to finish the day following an evaluation by the school nurse, up from 4,253 students the previous year. The school nurses sent 1,052 students home following the school nurse evaluation, which was up from 601 sent home the previous year. The 9 school districts had attendance rate of 93% or greater with total absences of 6,906 with 6,429 students enrolled (or an average of 1.1 absences per student). Compared with 2018-2019 numbers, Coronavirus-19 (COVID-19) appeared to have increased the number of students' visits with the school nurse as well as a slight increase in the number of students sent home due to caution and mitigation practices. The nurses were following the CDC guidelines for signs and symptoms of COVID-19 until school ceased to meet in person in mid-March 2020.

**Successes:**
The MCH-funded school nurses (in 9 districts) continued to educate staff on the guidelines for their school districts to ensure that students were evaluated by the school nurse prior to being sent home for self-reports of illness or injury. Having guidelines in place to have each student evaluated by the school nurse prior to being sent home for illness reduced unnecessary absences and assisted in maintaining attendance rate for the school district. The school nurse followed evidence-based nursing principles and communicable disease guidelines, including the new COVID-19 guidelines, to determine if the student's signs and symptoms warranted being sent home related to illness or injury. If deemed unnecessary, the students were returned to class to continue learning and limit the number of absences in the district as well as increased the student's learning time at school. The districts' access to a school nurse continued to keep the unnecessary absences to a minimum, even during a pandemic.

The School Health Coordinator worked with all state school nurses in creating and disseminating COVID-19 mitigation efforts, policies, procedures and guidance. Most Oklahoma schools did not return in-person following Spring Break March 2020. School guidance regarding picking up medication and other important items from school were created and sent out to Oklahoma school nurses and districts in April 2020. Algorithms and easy to follow flow sheets were developed for staff to discern the need for evaluation by the nurse versus the need to manage care in the classroom.

Once schools began returning in person, school nurses worked with their local county health department offices for contract tracing to reduce the spread of illness. The nurses also continued to provide necessary health education in a variety of ways including videos and working with the students virtually. Guidance and protocols were sent out to school nurses and other school staff as it was written and vetted through the OSDH process. Work on the Emergency Guide for School Nurses was written with the assistance of School Nurse Leaders around the state. This was accomplished while the School Health Coordinator also worked several shifts per week on the statewide COVID-19 Hotline. The crafting of the various COVID-19 related policies, procedures, and guidelines created the need for several meetings each week with school nurses, OSDE, and OSDH, which strengthened the working relationship with OSDE, MCH, and school districts around the state.

Successful creation of the mandated Diabetes Management Training for School Staff in a virtual setting was accomplished during this time by the School Health Coordinator in collaboration with OSDE. The trainings were held

in the fall of 2020. School nurses around the state volunteered to assist with the completion of the training by providing needle skill trainings for other districts in their areas without a school nurse. This, in turn, created a stronger network of school nurses for the School Health Coordinator.

School nurses were able to complete their mandatory vision screenings, health education, social emotional learning, and nursing duties using COVID-19 mitigation strategies to keep their schools as healthy and safe as possible.

**Challenges:**
COVID-19 created many challenges including not being in-person at school, schools working on a hybrid schedule of both in-person and virtual learning. The nurses were stretched to manage typical chronic illness, acute illness or injury, in addition to COVID-19 mitigation, contact tracing, testing, etc. Sometimes the school nurse was the only person in their district directly responsible for pandemic mitigation and there were many associated stressors.

Due to the Pandemic, the MCH-funded nurses halted data collection in March 2020. A system for each district had to be developed to count students as absent and the differences may skew the data numbers as each district's policy was slightly different. The pandemic created the need for most of the original guidelines, policies, and programs to be placed on hold through the period of March 2020-October 2020. During this time, the school nurse's focus was turned to contact tracing, mitigation, and development of new procedures and policies. Changes also occurred to policies regarding sending students to school nurse, and new guidance was developed to assist staff on when to send to the nurse and when to manage in the classroom. Some districts created a small kit for each classroom that contained items such as bandages and nail clippers to keep the student in the classroom, reducing time in the hall, office, or nurse's office. The nurses had to adapt, lead, and support their district, community, and surrounding school districts during this challenging time.

**Child Health - Application Year**

**NPM 8.1 Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

**Objective 1. Via the Oklahoma Center for Poison and Drug Information, provide poisoning prevention education to at least 24,000 preschool and elementary school students across the state annually.**

MCH will continue to partner with The Oklahoma Center for Poison and Drug Information (OCPDI) hotline to support presentations around the state to preschool and elementary school students to reduce the number of annual poisonings and enhance skills for medical professionals.

**Objective 2. Provide staff support to assist the Oklahoma Partnership for School Readiness (OPSR) in implementing their five-year strategic plan for creating an equitable and sustainable system for improving developmental and academic outcomes for young children.**

The Early Childhood Coordinator will continue to participate as a member of the Department of Human Service's Child Care Advisory Committee, providing information and resources regarding health, safety and nutrition for children participating in child care programs.

In addition, the Early Childhood Coordinator will assist the Oklahoma Partnership for School Readiness (OPSR) as they work to achieve objectives from the OKFutures Strategic Plan, with a focus on improving the coordination and quality of existing early childhood services and increasing families' knowledge and capacity to support their children, birth through five years old. The Early Childhood Coordinator will continue to serve on the OPSR Family and Community Workforce Team.

**Objective 3. Serve at least 58,000 students statewide Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD) by 2022.**

MCH will continue to provide funding and contract monitoring for Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD). The programs will provide skill-based health education and social emotional learning. The school health programs will continue to address school wellness, physical activity, and bullying prevention.

**Objective 4. Identify areas in need of evidence-based health education in the state and develop a plan to help address the need.**

The School Health Coordinator and School Health Consultant will work with the Oklahoma State Department of Education to map the areas where health education is being provided with data from OSDE. MCH will continue to identify community partners that can provide evidence-based health education in local areas around the state.

Staff will assist the OSDE with guidance and support for the implementation of the new mandatory health education legislation.

MCH will continue to attend the Oklahoma Whole School, Whole Community, Whole Child (OKWSCC) workgroup, Collaboration of OK Resilience in Education (CORE) meetings to work with partners and increase the strength of ACES, trauma-informed care in OK school districts, and skill-based health education.

MCH will continue to form and strengthen school health partnerships around the state.

**Objective 5. Reduce the number of absences during the school year from an average of 8.7 per student in 2018 to 7.2 per student in schools with an MCH-funded school nurse by 2022.**

MCH will continue to fund the 11 rural school health nurses in the 9 districts to provide evidence-based health education and services in their school districts. The School Health Coordinator will continue to provide technical assistance and annual site visits to each district.

The School Health Coordinator will continue to work with the rural school district nurses on the importance of a student evaluation prior to being sent home from school related to illness or behavior issues, including COVID-19 related illness, to maintain the absences below 4% for the year by 2023. The rural school nurses will continue to collect appropriate data regarding health education provided at their district for the year sending a report at the end of the school year.

The School Health Coordinator will provide an annual school nurse meeting for school nurses around the state either virtually or a combination of in-person and virtually to provide training along with technical assistance.

**Objective 6. Require 100% of MCH contractors working in schools to have training in trauma-informed care and the impact of ACES on development by 2022.**

Staff will create and provide ACES trainings for school nurses and require contractors to document their participation in trauma-informed trainings during annual site visits.

**Objective 7. Reinstate Child Health Clinics in pilot County Health Department Clinics for mobile and traditional settings by 2022.**

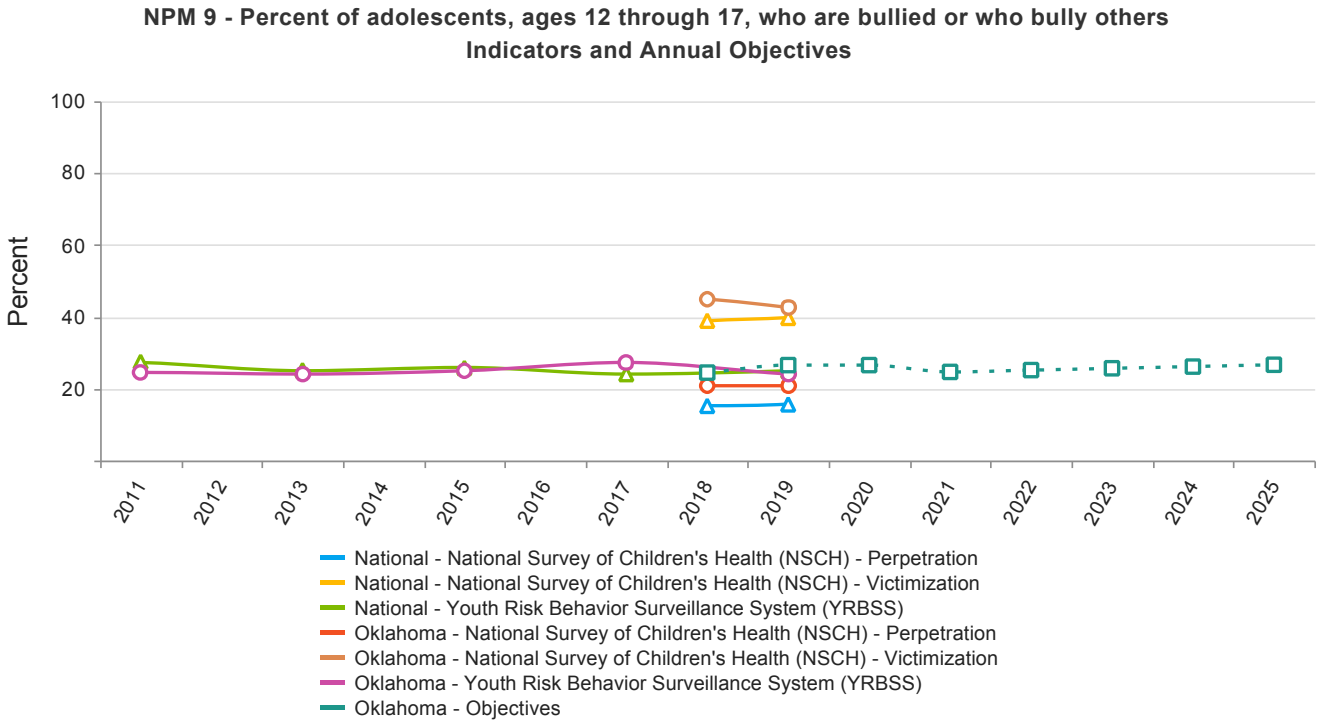
MCH will provide funding and technical support for the four pilot county health department clinics reinstating well and sick child health services. These services will be provided by APRNs in high need areas in the Southeast, Central and Southwest parts of the state. All clinics will follow the AAP's Bright Futures Guidelines and will use the Bright Futures forms.

**Adolescent Health**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 | NVSS-2019 | 41.9 | NPM 9<br>NPM 10 |
| NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 | NVSS-2017_2019 | 16.6 | NPM 10 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 | NVSS-2017_2019 | 17.8 | NPM 9<br>NPM 10 |
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system | NSCH-2018_2019 | 16.0 % | NPM 10<br>NPM 12 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2018_2019 | 56.4 % | NPM 10 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2018_2019 | 87.9 % | NPM 10 |
| 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) | NSCH-2018_2019 | 18.8 % | NPM 10 |
| 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) | WIC-2018 | 13.8 % | NPM 10 |
| 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) | YRBSS-2019 | 17.6 % | NPM 10 |
| NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza | NIS-2019_2020 | 59.5 % | NPM 10 |
| NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine | NIS-2019 | 65.6 % | NPM 10 |
| NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine | NIS-2019 | 88.0 % | NPM 10 |
| NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine | NIS-2019 | 77.3 % | NPM 10 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2019 | 27.4 | NPM 10 |

## National Performance Measures




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 23.9 | 23.6 | 24.5 | 26.6 | 26.6 |
| Annual Indicator | 25.0 | 25.0 | 27.2 | 27.2 | 24.2 |
| Numerator | 44,898 | 44,898 | 49,239 | 49,239 | 43,594 |
| Denominator | 179,440 | 179,440 | 180,854 | 180,854 | 180,410 |
| Data Source | YRBSS | YRBSS | YRBSS | YRBSS | YRBSS |
| Data Source Year | 2015 | 2015 | 2017 | 2017 | 2019 |

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Perpetration** | | | | |
| | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 26.6 | 26.6 |
| Annual Indicator | | | 20.9 | 20.9 |
| Numerator | | | 71,345 | 68,450 |
| Denominator | | | 341,223 | 328,275 |
| Data Source | | | NSCHP | NSCHP |
| Data Source Year | | | 2018 | 2018_2019 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Victimization** | | | | |
| | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 26.6 | 26.6 |
| Annual Indicator | | | 45.0 | 42.7 |
| Numerator | | | 153,408 | 140,343 |
| Denominator | | | 341,223 | 328,882 |
| Data Source | | | NSCHV | NSCHV |
| Data Source Year | | | 2018 | 2018_2019 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 24.7 | 25.2 | 25.7 | 26.2 | 26.7 | 27.3 |

**Evidence-Based or –Informed Strategy Measures**

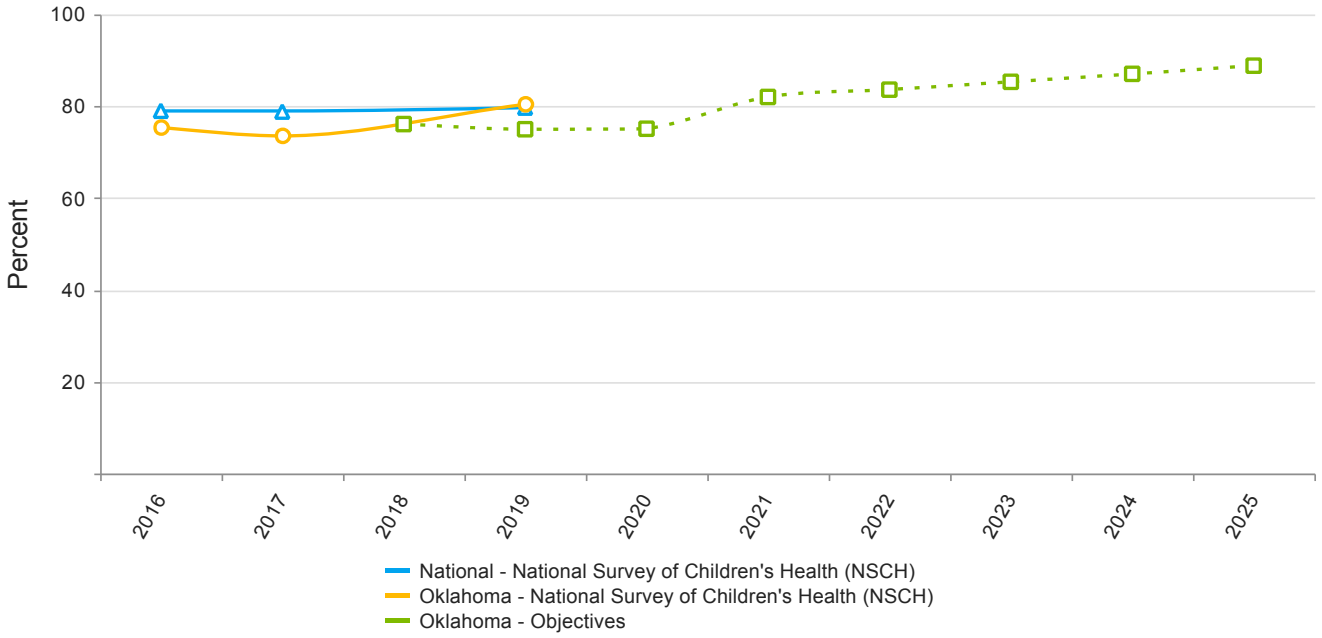
**ESM 9.1 - The number of trainings provided to school and community staff on bullying prevention**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 4 | 5 | 6 | 7 |
| Annual Indicator | 3 | 3 | 1 | 2 | 1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | MCH Training Log | MCH Training Log | MCH Training Log | MCH Training Log | MCH Training Log |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 5.0 | 8.0 | 11.0 | 14.0 | 17.0 | 20.0 |

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**
**Indicators and Annual Objectives**




| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 76 | 74.9 | 75 |
| Annual Indicator | | 75.2 | 73.5 | 73.5 | 80.3 |
| Numerator | | 229,371 | 225,282 | 225,282 | 252,941 |
| Denominator | | 304,952 | 306,365 | 306,365 | 314,972 |
| Data Source | | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2016_2017 | 2019 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 81.9 | 83.5 | 85.2 | 86.9 | 88.7 | 90.4 |

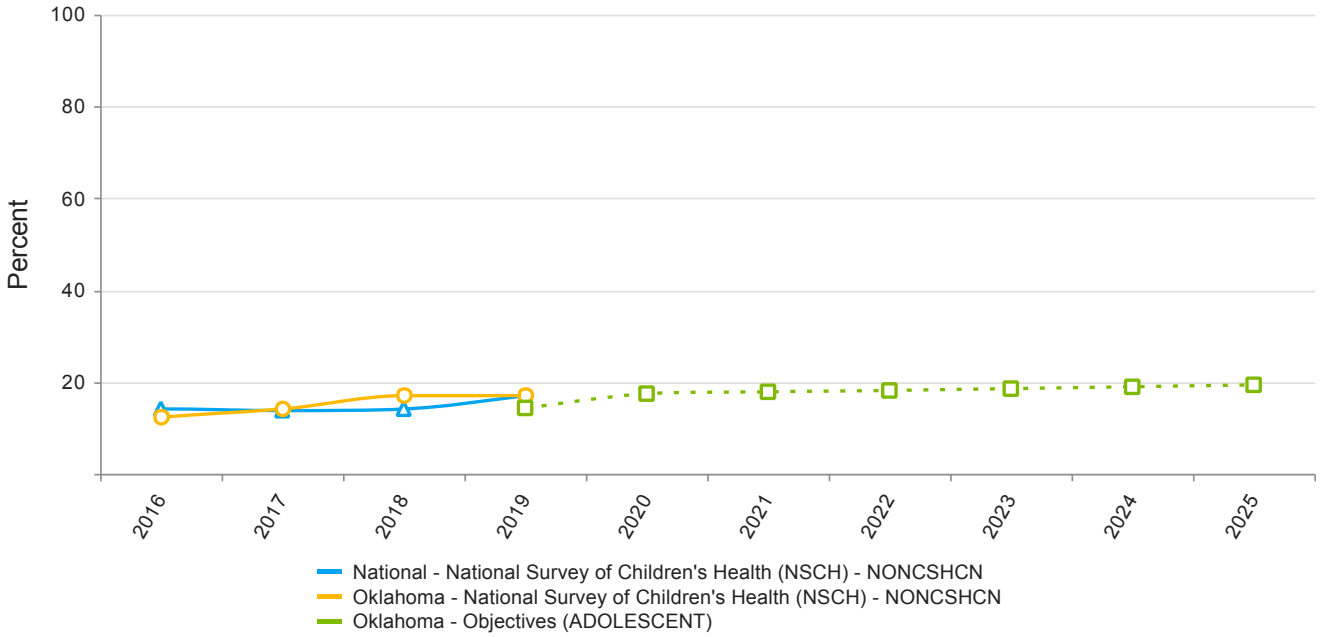
**Evidence-Based or –Informed Strategy Measures**

**ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 4,300 | 4,500 | 4,400 | 4,900 |
| Annual Indicator | 3,350 | 4,389 | 4,204 | 4,651 | 4,092 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | MCH PREP Program | MCH PREP Program | MCH PREP Program | MCH PREP Program | MCH PREP Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 4,400.0 | 4,700.0 | 5,000.0 | 5,300.0 | 5,600.0 | 5,900.0 |

**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**
**Indicators and Annual Objectives**




**NPM 12 - Adolescent Health - NONCSHCN**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - NONCSHCN** | | | | |
| | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 14.4 | 17.5 |
| Annual Indicator | 12.5 | 14.2 | 17.2 | 17.2 |
| Numerator | 26,234 | 31,388 | 41,549 | 40,910 |
| Denominator | 210,453 | 220,834 | 241,098 | 237,455 |
| Data Source | NSCH-NONCSHCN | NSCH-NONCSHCN | NSCH-NONCSHCN | NSCH-NONCSHCN |
| Data Source Year | 2016 | 2016_2017 | 2017_2018 | 2018_2019 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 17.9 | 18.2 | 18.6 | 19.0 | 19.4 | 19.8 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - The number of providers who address transition to adult health care in their practice**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 170 | 170 | 175 |
| Annual Indicator | 94 | 164 | 164 | 164 | 77 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | Sooner Success | Sooner Success | Sooner Success | Sooner Success | Sooner Success |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 80.0 | 85.0 | 90.0 | 95.0 | 100.0 | 105.0 |

**State Action Plan Table**

| State Action Plan Table (Oklahoma) - Adolescent Health - Entry 1 |
| --- |
| Priority Need |
| Improve the mental and behavioral health of the MCH population |
| NPM |
| NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others |
| Objectives |
| 1. Increase the number of annual trainings provided by MCH staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with adolescents from 1 in 2020 to 8 by 2025. |
| 2. Increase the number of local Public Health Youth Councils across the state from 1 in 2019 to 5 by 2025 that will provide input regarding adolescent health issues, including suicide prevention and bullying, to MCH, CSHCN, as well as other programs within and outside of OSDH. |
| 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 eight schools as a stand-alone presentation by December 2022. |
| 4. Will 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 December 2022. [New] |

## Strategies

1. Provide training and TA to county health departments and other youth-serving organizations in evidence-based methods following appropriate best practices.

2a. Train council facilitators, recruit youth, provide education to council members on adolescent health issues, and prepare some members to be peer facilitators.

2b. Work with local groups and agencies to spread evidence-based teen driver safety training to counties with the highest teen driver crash rates.

2c. Provide annual training, TA, and materials to Adolescent Health Specialists (AHS) on suicide prevention, bullying, and distracted driving.

3a. Work with the state Rape Prevention Education (RPE) program to provide consent training for new health educators working in schools and AHS.

3b. Monitor fidelity logs for documentation of consent education before, during, or after administration of evidence-based teen pregnancy prevention curricula, as required by law.

4a. 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.

4b. Develop a manual and train county health department health educators in bullying-prevention curriculum and social emotional learning to assist in training school staff and communities on this issue.

4c. Recruit the two school districts for the Olweus bullying prevention program and begin implementation. [New]

| ESMs | Status |
|---|---|
| ESM 9.1 - The number of trainings provided to school and community staff on bullying prevention | Active |

## NOMs

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

## State Action Plan Table (Oklahoma) - Adolescent Health - Entry 2

### Priority Need

Improve quality health education for children and youth

### NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

### Objectives

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).

2. Increase the number of adolescent family planning clients aged 15 to 19 who choose Long Acting Reversible Contraception (LARC) methods from 8.0% in 2013 to 10.2% by 2020.

3. Provide training for evidence-based teen pregnancy prevention curricula to project staff yearly or on an as-needed basis.

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 12 in 2019 to 30 by 2025.

5. Develop and host an annual Adolescent Health Summit to provide education and resources for professionals working with youth by 2022.

| Strategies |
| --- |
| 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, teachers, school nurses, health educators, adolescent health specialists, community leaders, and parents who are advocates for evidence-based education. |
| 2a. Continue to educate on the most effective methods of contraception first. |
| 2b. Increase adolescent education in the community about available methods. |
| 3. Coordinate training on evidence-based curricula for new PREP and state-funded teen pregnancy prevention staff and interested partners annually. |
| 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. |
| 4d. Adapt or create presentations to fit virtual format delivery. |
| 5a. After the Summit, evaluate the planning and implementation process based on participant and planning group feedback. |
| 5b. Develop and/or adapt existing planning tools to be used with similar MCH events. |

| ESMs | Status |
| --- | --- |
| ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum | Active |

NOMs

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

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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

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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## State Action Plan Table (Oklahoma) - Adolescent Health - Entry 3

### Priority Need

Increase quality health care access for the MCH population

### NPM

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

### Objectives

1. Collaborate with the Oklahoma Health Care Authority to provide transition information and at least 1 training to their provider network by 2022.

2. Develop, in partnership with Sooner SUCCESS, 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 2022.

### Strategies

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. Meet quarterly with OHCA to provide relevant transition information for provider newsletter, social media pages, and create meaningful transition training for providers.

2b.Incorporate transition information into presentations, activities of Adolescent Health Specialists and Adolescent Health staff.

2a. Partner with Sooner SUCCESS to determine needs for transition education for all youth and families, irrespective of health condition and build on their existing toolkit to create Guidelines document for all youth.

2b.Incorporate transition information into presentations, activities of Adolescent Health Specialists and Adolescent Health staff.

| ESMs | Status |
| --- | --- |
| ESM 12.1 - The number of providers who address transition to adult health care in their practice | Active |

### NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## State Action Plan Table (Oklahoma) - Adolescent Health - Entry 4

### Priority Need

Increase health equity for the MCH population

### NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

### Objectives

Increase the number of annual trainings provided by MCH staff related to health equity, trauma-informed practices, and inclusivity for contractors and staff working with youth from 0 in 2020 to 3 by 2022.

### Strategies

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 equitable and inclusive programming and services.

Provide annual health equity trainings to staff via PREP/TPP semi-annual meetings, quarterly meetings, and/or Title X meetings.

Create training documentation tool for educators to complete and submit annually to ensure completion of mandatory and optional trainings.

Provide trauma-informed ACES training for school nurses and staff. [New]

| ESMs | Status |
| --- | --- |
| ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum | Active |

NOMs

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

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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

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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## State Action Plan Table (Oklahoma) - Adolescent Health - Entry 5

### Priority Need

Improve quality health education for children and youth

### NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

### Objectives

Aid school-based staff in preparing for online delivery of classroom training by providing education, COVID-related resources, and technical assistance, as requested.

### Strategies

Continue to refine and adapt created online presentations as needed.

| ESMs | Status |
| --- | --- |
| ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum | Active |

NOMs

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

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

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

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

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

**NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

**Objective 1: Increase the number of annual trainings provided by MCH staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with adolescents from 0 in 2020 to 3 by 2022.**

**Data**:
The suicide death rate among youth 15-19 years old saw essentially no increase over the last 30 years going from 14.8 deaths per 100,000 youth ages 15-19 in 1989 to 14.8 in 2018. In 2018, disparities were observed by gender as males had a suicide rate twice that of females at 19.9 and 9.4, respectively. However, data from the 2019 Youth Risk Behavior Survey (YRBS) indicated that females were significantly more likely than males to have:

- Experienced sadness or hopelessness (48% vs 30%)
- Considered attempting suicide (28% vs 17%)
- Made a plan to attempt suicide (21% vs 15%)
- Attempted suicide (15% vs 9%)

MCH did not provide any suicide prevention trainings in 2020 due to the COVID-19 pandemic and staffing re-assignments related to mitigation efforts.

**Successes**:
A total of five Adolescent Health Specialists (AHS) were hired for the state-level teen pregnancy prevention project, Oklahoma Healthy YOUth (OHY), between October 2019 and June 2020 for Pittsburg County, Jackson County, Carter County, and Ottawa County. All AHS, pre-existing and recently hired, attended webinars on suicide prevention and engaged in other mental health and/or suicide prevention activities in their respective coverage areas. See Objective 2 for more detailed information.

Even though they did not provide any trainings, MCH staff engaged in suicide prevention and positive youth development (PYD) activities for professional development, such as webinars, trainings, and/or conferences. In 2020, staff attended the following virtual conferences: Annual Turning Point Conference, Missouri Suicide Prevention Conference, and the Oklahoma Public Health Association (OPHA) Conference.

Child and Adolescent Health (CAH) staff worked on activities for Suicide Prevention Month in September 2020. Staff highlighted adolescent mental health amid the COVID-19 pandemic on Facebook, as well as created and posted suicide prevention Facebook content. CAH staff also collaborated on a Teen Depression and Mental Health report based on 2019 YRBS data.

MCH and Child Guidance staff participated in the State Advisory Team and the Children's State Advisory Work (CSAW) Group to support and collaborate with mental health providers.

The Oklahoma State Health Department (OSDH) continued to participate in the National Violent Death Reporting System, collecting detailed surveillance data that was used to help develop a state strategic plan for suicide prevention and community-based suicide prevention efforts.

MCH staff continued participation with the Youth Prevention Summit Taskforce, a working group led by the OSDH Injury Prevention Service (IPS). This taskforce was initially created to aid in planning and implementation of a prevention summit for youth, but the goal was later changed to develop a prevention toolkit for schools to utilize to

host their own mini prevention summits. Intended prevention topics were mental health, sexual health promotion/teen pregnancy prevention, sexual violence prevention, and bullying prevention. In July 2020 the taskforce was discontinued due to conflicting commitments from members.

MCH organized and facilitated a sexual health community of practice (CoP) for program staff and partners whose work falls within teen pregnancy prevention, sexual health education, and violence prevention. The CoP served to exchange ideas, concerns, resources, and best practices for providing services and programming to schools and communities, including those related to mental health and positive youth development. The CoP was initiated in July 2020 and monthly meetings were held, led by the CAH Healthy Youth Consultant.

The CAH Adolescent Health Coordinator continued to serve on the Oklahoma Suicide Prevention Coalition and MCH staff also attended coalition meetings.

MCH began planning for the division's first Adolescent Health Summit, to be held in 2021 on a virtual platform. The intended purpose of the summit was designed to provide youth-serving professionals with interdisciplinary training and tools to improve the health of adolescents in their communities. MCH formed a planning committee involving various agency and community partners, and held monthly meetings starting in July 2020. The objectives of the Summit were aligned with Title V priorities and incorporated Injury Prevention Service's Adolescent Climate Survey results. Specifically, planning committee members were asked to focus on mental health for adolescent males, bullying prevention, healthy relationships, sexual health, LGBTQIA+ inclusivity, parent-teen communication, and youth involvement and engagement. Sub-committees were developed to focus on specific aspects of the Summit, such as; logistics, marketing, speakers, and youth voice.

MCH staff regularly attended the Oklahoma Prevention Leadership Committee (OPLC) quarterly meetings and participated in subcommittees. The CAH Healthy Youth Consultant served on the Advisory Board for OPLC.

**Challenges**:
Due to the COVID-19 pandemic all in-person trainings were either cancelled or moved a virtual format, and school districts across the state closed for the remainder of the 2019-2020 academic year then slowly transitioned to virtual learning platforms for the 2020-2021 academic year. Schools were overwhelmed and prioritized adapting core curriculum for virtual learning; many did not allow external programming. Existing suicide prevention materials were not formatted for virtual use, and many of the individuals who would have received the training(s) such as clinic nurses, AHS, Health Educators (HEs), and other staff were re-assigned to the COVID-19 pandemic response and had little-to-no time for adolescent health activities.

**Objective 2: Increase the number of local Public Health Youth Councils across the state from 3 in 2015 to 7 by 2020 that will provide input regarding adolescent health issues, including suicide prevention and bullying, to MCH, CSHCN, as well as other programs within and outside of OSDH.**

**Data:**
Due to AHS turnover and the COVID-19 Pandemic, there were no active Public Health Youth Councils (PHYCs) during this timeframe.

**Successes**:
The Jackson County AHS served as a resource for schools and provided suicide prevention materials for events, as well as participated in the Elk City Suicide Prevention Coalition meetings.

The Latimer County AHS partnered with a local high school to conduct a presentation on teen depression for high school students and facilitated QPR gatekeeper trainings for school staff and county health department supervisors in her region. The AHS also planned suicide prevention activities for local churches and schools for Spring 2020 but had to cancel due to COVID-19 pandemic.

CAH and IPS staff partnered together for a training on concussion prevention and the distracted driving program, Countdown2Drive, in January 2020 for nurses and AHS. IPS staff supplied Graduated Driver Licensing (GDL) brochures for attendees to provide at distracted driving events.

The CAH Healthy Youth Consultant routinely provided the AHS with materials and/or resources for PYD, which included a self-paced PYD 101 training course to complete in preparation for building PHYCs.

The AHS worked towards developing partnerships with local schools and community organizations in hopes of re-establishing and/or building PHYCs in their district. The Jackson County AHS partnered with a local public library that had an existing youth group to begin a healthy relationship series, a teen mental health event, and a distracted driving event. The Seminole County AHS attended local Providers and Teens Communicating for Health (PATCH) Youth Subcommittee meetings and planned to host a teen panel with the group. Additionally, the Seminole County AHS held meetings with school administration at a local high school regarding establishing a PHYC. Unfortunately, all of the aforementioned activities were postponed indefinitely due to the COVID-19 pandemic.

**Challenges**:
The OHY project was still in the process of rebuilding after the 2018 Reduction in Force (RIF) and subsequent turnover among the AHS. Three AHS resigned during this report's timeframe, greatly impacting adolescent health activities in three districts. Additionally, the COVID-19 pandemic caused school closures from March through the remainder of the academic year and a statewide shut down, reducing ability to conduct trainings, develop PHYCs, implement curricula, and deliver presentations. The start of the 2020-2021 school year was also impacted by the pandemic, schools were either not doing traditional learning (in-person) or not allowing outside visitors to limit the virus spread. AHS-led virtual instruction and/or training was a challenge due to limited student access to technology and/or connectivity issues in rural parts of the state. As all AHS were re-assigned to the COVID-19 pandemic response and assisted their districts with COVID testing and case management, there was limited time for participation in adolescent health activities.

**Objective 3: Among county health departments, increase from 5% to 50% the sites that have the Suicide Prevention Lifeline Number displayed in their lobby by 2020.**

**Data:**
Five AHS maintained posters with the Suicide Prevention Lifeline number in their main county health department (CHD) for staff and clients, which was approximately 83% of the home-base clinic sites occupied by AHS.

**Successes:**
The CAH Healthy Youth Consultant ordered free Lifeline resources and distributed to the AHS to provide to CHDs in their district and suicide prevention events. All AHS maintained visible Lifeline materials in their home-base clinic, provided clinic nurses with suicide prevention resources to keep in the exam rooms, and gave clerks materials to post in the front area and to hand out to clients.

The Seminole County AHS continued partnership with Seminole State College and maintained a stock of suicide prevention resources for their student resource room.

Three AHS actively participated in local suicide prevention coalitions and/or adolescent health coalitions within their respective districts prior to the pandemic.

CAH staff promoted International Adolescent Health Week (IAHW), formerly known as Teen Health Week, in March, and provided suicide prevention resources to the public via a resource table at OSDH prior to the COVID-19 lockdown. Additionally, staff highlighted adolescent mental health during the COVID-19 pandemic on Facebook, as well as created and posted content for Suicide Prevention Month in September 2020, which included the National Suicide Prevention Lifeline, 1-800-273-TALK (8255).

**Challenges**:
AHS turnover limited the ability for suicide prevention materials to be distributed to all CHDs within a district. See Objective 2 for discussion of other challenges related to the OHY project.

**Objective 4**: **Increase the number of the Safe Schools Committees reported to the Oklahoma State Department of Education mandated by School Safety and Bullying Prevention Act from 1,775 in 2016 to 1,807 sites by 2020.**

**Data:**
For the 2019-2020 and 2020-2021 school years, due to decreased funding to schools and the COVID-19 pandemic, the legislature allowed schools to defer the requirements for Safe Schools Committees and for Healthy and Fit School Committees without penalty.

**Successes:**
The School Health Educator attended monthly meetings focused on school health such as the Anti-Bullying Coalition in Tulsa, OKPTA Cultivate (a group focused on multiple child health issues including bullying prevention), Collaborative for Oklahoma in Resilience Education (CORE, created the basis for a trauma-informed school toolkit for school staff, parents and communities), CSAW, OPLC, and Oklahoma Whole School, Child, Community (OKWSCC) Work Group.

The School Health Educator became certified in the research-based OLWEUS Bullying Prevention Program (OBPP). Upon certification, the Health Educator developed and uploaded a Bullying Prevention Resource Guide for families and CAH professionals to the agency's website, as well as, uploaded bullying awareness and prevention materials to the MCH social media page. The Health Educator partnered with the CAH Epidemiologist to present a poster on "Adverse Childhood Experiences (ACEs) and the Relationship with Flourishing and Bullying" at the OPHA in 2019. Contributions to publications on the agency's website such as the bullying and obesity reports utilizing 2019 YRBS data were also made.

The School Health Educator position was vacant from February 2020 to August 2020, as the former employee left to work on bullying prevention at the Oklahoma State Department of Education (OSDE) strengthening MCH's partnership at that agency. With the transition of new staff, the School Health Educator became classified as a School Health Consultant, and continued the work of the School Health Educator. The School Health Consultant became certified in the research-based OLWEUS Bullying Prevention Program (OBPP) and attended the YRBS training series through the Centers for Disease Control and Prevention (CDC). The School Health Consultant continued to produce and provide materials for social media and increased partnerships with the Oklahoma State Department of Education as well as Oklahoma City County Health Department (OCCHD), Tulsa Health Department (THD), Healthy Schools of Oklahoma and other community agencies.

CAH staff met with the CDC 1801 Grant administrators virtually at least 1 time per month and with OSDE staff as needed minimally 1 time per month. Staff also attended the virtual meetings with OKWSCC at least once every quarter and met with the 21st Century Program Coordinator to discuss how best to incorporate bullying prevention into afterschool programs.

The School Health Coordinator (SHC) supervised the bullying prevention work and provided technical assistance and training throughout the state for MCH-funded school nurses, school nurses in other districts, district administrators, and other school staff. TA consisted of the development of policies, procedures, district required training, and resources using the Whole School, Whole Community, Whole Child (WSCC) framework. The SHC worked with outside partners and attended the Oklahoma WSCC Working Group, the CORE initiative to develop trauma-informed tools for schools and communities. Since March 2020 and the spread of the COVID-19 Pandemic, work on CORE has slowed and there were only two meetings during this time. OKPTA, a local collaborative to reduce health risks among school-aged youth, continued to work closely with OSDE and MCH, albeit virtually.

MCH continued to fund eleven school nurses in nine districts around the state who provided bullying prevention training for their district staff. They provided resources and education for parents and the communities in which they served. The school nurses also provided social emotional learning and bullying prevention classes to the students in these districts. They used various methods of evidence-based trainings and presentations. Prior to March 2020, many of the districts partnered within their communities, with county health departments, and the Cherokee, Choctaw, Creek, and Citizen Potawatomi tribal nations, to provide evidence-based bullying prevention programs to the students attending those schools. From March 2020 through September 2020 this work decreased because students were out of school or participating via remote learning due to the COVID-19 Pandemic. Presentations that occurred after March 2020 were completed via a virtual platform or recorded videos. Additionally, the School Health Coordinator and school nurses around the state worked on the safe retrieval of items such as medication or needed school supplies from the buildings and the safe return to school policies and procedures starting in April 2020.

OCCHD provided health education in nine schools within the Oklahoma City Public Schools (OKCPS) via their Health at School (HAS) Program. The programs provided follow the WSCC model and placed children in the center as the main focus. The programs used for elementary schools included social emotional learning (SEL). HAS provided 5,300 students with SEL and bullying prevention curriculum and worked with 527 school staff during the 2019-2020 school year. During the COVID-19 pandemic, OCCHD worked on contract tracing and had staff members at the COVID pods full-time working with the telephone helpline,assisting with technology and scheduling COVID tests and vaccines.

THD's It's All About Kids (IAK) school health program served a total of 15,130 students utilizing 202 health education presentations and 488 sessions during the 2019-2020 school year. IAK staff provided a variety of health education programs: Bully Busters Assembly, Bully Prevention, Class Cohesion, Conflict Resolution, Don't Bug Me, Drugs and Your Heart, Fitness in the Classroom, Head Lice, Human Growth and Development, Hygiene, Mindfulness, Responsible Decision Making, Stress Management, Teambuilding, Tobacco Prevention. IAK followed the WSCC model placing children in the center as the main focus. IAK provided health education in 39 schools within six Tulsa area school districts throughout the school-year, and social emotional learning was part of the curriculum presented. At the beginning of the COVID-19 pandemic, THD staff were assisting with COVID-19 response one day each week. This gradually increased to four days per week during the peak of the virus with any free time spent on IAK activities and planning.

**Challenges:**

Due to competing issues and funding constraints and the COVID-19 pandemic, a limited number of Health

Educators in the county health departments delivered bullying prevention in schools. THD and OCCHD conducted annual surveys for the schools starting in the summer and concluding in the fall to plan what programming was needed in the districts they serve. Some schools did not perceive a need for bullying prevention or SEL in their schools when surveyed for school improvement. In addition to the changes to the programs in the schools, the Chris Harris Jr.'s Annual Underdog Football Camp in Bixby Oklahoma in collaboration with the Anti-Bullying Coalition in Tulsa, was cancelled due to the COVID-19 pandemic as well as the IAK and Tulsa Drillers partnership to host an Anti-Bullying Day celebration at ONEOK Field. The Pandemic changed the way programs were presented for the staff and students. Programs became innovative and created videos that could be viewed at any time or used a live virtual platform to work in schools. Because there were many in-person cancellations and pivots to virtual events, THD and OCCHD took their entire School Health team and reallocated them to the COVID-19 work, including testing, contract tracing, running childcare programs for front line staff, and assisting with vaccine clinics.

**Objective 5. Implement a Bullying Awareness Poster and Video Contest with state middle and high school students.**

**Data:**
Due to system limitations to receive large digital files at the OSDH, the contest was limited to posters only. The poster contest was developed; however, the rollout was significantly delayed and further hampered by COVID-19 and staff turnover to get responses returned to OSDH.

**Successes:**
The School Health Educator, MCH staff, and external partners successfully put in place the procedures, marketing materials and began the process to roll out the Bullying Awareness Poster Contest.

**Challenges:**
Due to the COVID-19 pandemic, programs in schools stopped completely to focus on mitigation of spread and OSDH staff were reassigned to assist in various COVID-19 efforts.

**NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

**Objective 1: Increase by 5% annually the number of adolescents participating in state or federally funded evidence-based teen pregnancy prevention programs (Baseline: 4,145 adolescents for the 2014-2015 school year).**

**Data:**
A report from the National Center for Health Statistics found that the 2019 birth rate for Oklahoma teens, defined as the number of births per 1,000 adolescent females aged 15-19, was 27.4 and was significantly higher than the national average of 16.7. Older teens in Oklahoma, aged 18-19 years, had the highest birth rate at 52.1, followed by teens aged 15-17 years at 11.0. Compared to other states in the nation, including the District of Columbia, Oklahoma had the 4th highest teen birth rate for 15-19 year olds, the 4th highest teen birth rate for 18-19 year olds, and the 4th highest teen birth rate for 15-17 year olds. Although Oklahoma continued to rank among the top states with the highest teen birth rates, it is important to note the state's teen birth rates are improving.

**Successes:**
MCH continued the administration and monitoring of the Personal Responsibility Education Program (PREP) grant from the Administration of Children, Youth, and Families and Family and Youth Services Bureau (FYSB). The federal funds supported the implementation of teen pregnancy prevention (TPP) projects through contractual agreements

with the OCCHD and the THD. Target populations remained with youth 11-19 years of age in the middle, high, and alternative schools in the Oklahoma City and Tulsa metropolitan statistical areas (MSAs). PREP projects continued to use evidence-based curriculum from the Health and Human Services (HHS) approved list. Due to the pandemic, reach was significantly impacted as curriculum was only able to be held online and only with one contractor for a brief time.

MCH continued the administration and monitoring of the Pregnancy Assistance Fund (PAF), a federally funded grant that focused on providing education, resources, and case management services to adolescent pregnant and parenting youth in the Oklahoma City and Tulsa metro areas, as well as adolescents involved with the Oklahoma Office of Juvenile Affairs (OJA) correctional system. Through the THD and OCCHD, PAF provided Love Notes to PAF participants, an evidence-based program (EBP) that focuses on healthy relationships, sexual health, and teen parents. In addition to improving educational and parenting goals, the projects sought to reduce rapid repeat pregnancies among the youth served. The OJA youth were provided case management and parenting education via Nurturing Parents (Teen Edition). The primary successes were improved parenting skills and feeling like they could provide for their children.

In May 2020, MCH applied for and received a No Cost Extension for the PAF grant for two of the sub-awardees for this grant, OJA and OCCHD, to complete their PAF programs. December 31, 2020 was the official end of the PAF grant. This program served 3,864 PAF participants and their families. Each year the number of participants increased, with the pregnant and parenting youth bringing their significant others and sometimes their parents to classes. Much of the increase in participants was due to participants talking to their peers about the benefits of the program and encouraging them to join.

MCH, PAF, PREP, and several partner agencies participated in the following trainings for evidence-based curriculum: Love Notes in November 2019, Making a Difference (MAD), Making Proud Choices (MPC) in March and June 2020, and Positive Prevention PLUS (P3) in July 2020. ETR curriculum developers approved virtual implementation for MAD and MPC, and provided resources and materials for program staff to utilize.

CAH staff highlighted sexual health messages on Facebook for National Teen Pregnancy Prevention Month in May 2020.

A total of 2,782 students participated in TPP curricula in the Oklahoma City and Tulsa MSAs through PREP during the 2019-2020 school year. A total of 497 students participated curricula in the rural areas through the Oklahoma Healthy YOUth project in the same period.

**Challenges:**
The COVID-19 pandemic caused school closures from March through the remainder of the 2019-2020 academic year. Schools were still impacted at the start of the 2020-2021 academic year, with many opting for full-time virtual learning or hybrid learning (part time virtual, part time in person). Many schools served by OCCHD and THD PREP, and the OHY project prioritized core studies to compensate for the impacts the COVID-19 pandemic caused, which significantly reduced TPP programming. OCCHD and AHS with the OHY project were unable to serve schools in their districts, however, Tulsa Public Schools allowed a limited amount of PREP Curriculum to be provided virtually by THD.

Many of the MCH, OCCHD, and THD staff were re-assigned to COVID-19 response activities such as testing pods, screening employees as they entered the building, operating the state-level COVID-19 hotline, and conducting pregnancy and neonate calls to residents who were diagnosed with COVID while pregnant.

**Objective 2: Increase the number of adolescent family planning clients aged 15 to 19 who choose Long-Acting Reversible Contraception (LARC) methods from 8.0% in 2013 to 10.2% by 2020.**

**Data:**
Between October 1, 2019 and September 30, 2020, 6,540 clients ages 15-19 were seen in family planning clinics in rural county health departments and the two city-county health departments. This is a decrease of 14.0% from October 1, 2018 to September 30, 2019, but not unexpected due to clinic closures at the height of the pandemic. Of those, 11.0% chose a LARC method.

**Successes:**
County health departments and contract facilities continued to provide family planning clinical services to adolescents during the months before COVID-19 restrictions and limited services after those restrictions were lifted. These services included a comprehensive physical examination, preventive education on HIV and STD transmission, education on contraceptive methods (including abstinence), provision of a method when appropriate, and encouragement of parental involvement.

**Challenges:**
Clinic closures and limited availability due to the COVID-19 pandemic impacted the number of appointments that were available for all family planning clients in the state.

**Objective 3: Maintain the number of available trainers statewide who have completed a training of trainers (TOT) in Oklahoma's selected evidence-based teen pregnancy prevention curricula at 12.**

**Data:**
MCH staff held one training of trainers (TOT) for contractors and other partners in 2020; 14 educators and program staff received TOT certification for MAD and MPC in June.

The number of available trainers statewide with a TOT certification increased from 12 to 26.

**Successes:**
MCH, OCCHD, and THD staff partnered to co-facilitate a Love Notes training of educators (TOE) in November 2019 for program staff and partner agencies. A total of 14 people received certification to implement the Love Notes curriculum.

OCCHD PREP staff facilitated a TOE for MAD and MPC in March 2020. A total of 9 people received certification to implement the curriculum.

Amplify Tulsa, the backbone organization for TPP work in Tulsa County and one of MCH's partners, held a TOE for P3 in July of 2020. Three AHS with the OHY project and three PREP staff received certification.

**Challenges:**
Turnover among program staff resulted in a loss of educators with TOT and/or TOE certification. By the time new staff were hired, trainings were already held. The COVID-19 pandemic also made it difficult to provide EBP trainings since materials would need to be adapted for virtual use. Additionally, most of the program staff were re-assigned to the pandemic response.

**Objective 4: Expand coverage of state and federally funded, age-appropriate, evidence-based teen**

**pregnancy prevention projects in rural counties with teen birth rates higher than the national average from 24 in 2015 to 30 by 2020.**

**Data:**
There were eight AHS on staff for the OHY project during the timeframe of this report, three of which resigned between December 2019 and August 2020.

Six AHS were active in 11 rural counties in Oklahoma. Four AHS implemented EBPs in their respective coverage area; two schools received Love Notes, six schools received MAD, and one school received MPC. A total of 497 students participated in TPP curriculum.

**Successes:**
Hired five AHS between October 2019 and June 2020. All newly hired AHS received EBP training; two received TOE certification for MAD, MPC, and Love Notes, three received TOE certification for P3**,** and two received TOT certification for MAD and MPC.

New staff received training for curricula as well as reporting documents and tools. MCH continued to provide guidance, oversight, and technical assistance to the OHY project. MCH staff coordinated semi-annual training for PREP and OHY staff in January and July of 2020. In January, training focused on child abuse prevention, trauma-informed strategies, body autonomy, and self-care. July training consisted of classroom management strategies, program protocols, fidelity, and mandatory reporting. Additionally, staff engaged in numerous professional development activities (webinars, trainings, self-paced modules, and conference) throughout the time frame of this report.

AHS developed and/or maintained partnerships with local schools and/or colleges, coalitions, community organizations, and health educators (HEs) in their counties to ensure TPP, positive youth development (PYD), suicide prevention, and other adolescent health issues were priorities in their areas. The Ottawa County AHS joined a task force in their region to assist in a community needs assessment regarding sexual health education and resources.

AHS delivered STD/HIV presentations to middle and high schools in their counties to help schools fulfill the HIV/AIDS Prevention Education state mandate. Additionally, they provided presentations on sexual consent, contraception, family planning services, and other adolescent health issues.

The Seminole County AHS continued partnership with Seminole State College to have a resource room on campus where students could obtain sexual health resources such as brochures and condoms. The AHS also provided HIV/STD presentations to students.

MCH staff collaborated with Child Guidance and OCCHD PREP for Let’s Talk Month in October, a national campaign to encourage parent-child communication about sexuality and relationships. This working group created social media content for the MCH Facebook and printed materials for distribution in the public lobby of OSDH and schools across the state.

The Jackson County AHS highlighted Teen Dating Violence Awareness Month (TDVAM) in February on their county's Facebook page with a series of healthy relationship posts, as well as printed TDVAM stickers and organized a day at their clinic site for staff to wear orange to raise awareness and show support for victims of dating violence.

The Seminole County AHS engaged in community awareness activities for IAHW, formerly known as Teen Health Week, in March and Sexual Assault Awareness Month in April by posting information at their local county health department.

**Challenges:**
OSDH issued a statewide district reorganization in November 2019, which expanded the AHS coverage areas and, in some cases, resulted in an AHS losing an active county. AHS turnover reduced adolescent health activities in the counties due to vacancies and/or lack of training for EBPs for new hires. Due to the COVID-19 pandemic, schools closed in March 2020 through the rest of the academic year, interrupting EBP implementation at three schools. OHY project staff in the counties were reassigned to pandemic response activities indefinitely and were unable to engage in adolescent health activities in their districts. The lack of a comprehensive sexual education state mandate meant that the adolescent pregnancy prevention curricula used by MCH remained optional for schools. This continued to be a barrier for project implementation in some high need areas. Oklahoma remained one of the only states in the nation without mandatory health education in public schools as well as one of 21 states without mandated sexual health education.

**Objective: Increase activities and public awareness on the topic of transition to adulthood for all youth in Oklahoma. Establish at least 10 contacts with providers by 2020.**

**Data:**
A partnership with Oklahoma Health Care Authority (OHCA) was established to train Medicaid-funded providers on transition.

**Successes:**
CAH staff met with OHCA monthly. The intent was to find ways to improve and increase the number of adolescents who receive transitional care from their provider(s) as they age out of the pediatric care setting. Several activities and best practices were reviewed and MCH connected OHCA with OCCHD staff who oversaw Teen Friendly Clinics and the PATCH program to create a webinar and tool kit for providers.

**Challenges:**
After March 2020, all work on this objective was placed on hold as staff involved were asked to assist in COVID-19 mitigation duties.

**Adolescent Health - Application Year**

**NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.**

The School Health Consultant will provide the Olweus Bullying Prevention Program model to support the Oklahoma State Department of Education and schools statewide in training and implementation.

MCH will support OSDE efforts to implement the new statewide health education mandate, which includes social emotional learning, providing technical assistance and guidance as needed.

MCH will continue to attend the Collaboration of OK Resilience in Education (CORE) meeting to work with partners and increase the strength of ACES and trauma-informed care in OK school districts.

MCH staff will conduct and/or share opportunities for evidence-based trainings quarterly or as needed as they relate to adolescent mental health and positive youth development (PYD) for professionals working with youth. MCH will continue to monitor COVID-19 and will modify trainings to be conducted virtually as needed.

The Oklahoma Suicide Prevention Coalition will promote the 2020-2025 State Strategy for Suicide Prevention and MCH will continue to have a presence on the Coalition. The Coalition will provide strategic direction and technical assistance in the field of suicide prevention and intervention, including responsible media reporting, community involvement, and promoting trainings.

Child and Adolescent Health (CAH) staff will continue to highlight teen suicide prevention messages in September for Suicide Prevention Awareness Month and throughout the year.

MCH staff will strengthen partnership with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and OSDH Injury Prevention Service (IPS) on suicide prevention activities, such as joining any existing workgroups, supporting trainings, assisting with material development, etc.

MCH will strengthen interests in Public Health Youth Councils (PHYCs) among OSDH leadership at all levels and staff once new Adolescent Health Specialists (AHS) are hired in areas of need.

MCH will continue to collaborate with local county health departments to establish, support, and sustain local PHYCs. Training for facilitating PHYCs will be held for all AHS once posted positions are filled.

Provision of technical assistance will continue for AHS in evidence-based teen driving safety programs, PYD, suicide prevention, and other adolescent health issues identified by PHYC members.

MCH will continue to monitor the COVID-19 pandemic. If the pandemic continues to affect the ability for PHYC activities to occur in-person, staff will ensure that PHYC materials can be downloaded as fillable documents (as necessary) and will provide any TA for facilitators to hold virtual activities (interviews, meetings, etc.)

Staff will continue to monitor compliance of consent instruction via educator's fidelity logs, as well as provide TA and resources to staff and community partners; MCH will encourage teen pregnancy prevention (TPP) project staff to offer virtual consent presentations if schools are not permitting outside visitors due to COVID-19.

MCH staff will work with Rape Prevention Education (RPE) staff and educators to conduct consent and sexual violence prevention training for all new AHS and other staff as needed. Staff will also continue to provide consent

materials and resources to AHS for use with schools and communities.

MCH will continue to highlight consent and healthy relationship messages via national observances throughout the year.

The CAH Healthy Youth Consultant will continue to facilitate the sexual health CoP with community partners, meetings will be held quarterly.

**NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

MCH will continue to support comprehensive reproductive and sexual health education in schools so teens can have access to medically accurate information in order to make informed decisions. This information will include affirmative consent as required by state legislation.

MCH will continue to support Adolescent Health Specialists (AHS) throughout Oklahoma by providing and/or connecting them with trainings for each of the approved evidence-based curricula as needed. MCH will assist AHS with gaining entry into their local school districts.

MCH will continue to ensure all teen pregnancy prevention (TPP) project staff receive training for evidence-based TPP curricula, and provide support and guidance as needed. This will either be accomplished by MCH staff or partner agencies.

MCH will continue to promote awareness of teen birth rates and provide resources and/or technical assistance to county health departments that have identified reducing teen births as a quality improvement measure or who have established or are interested in establishing a TPP project.

MCH will continue to collaborate with tribal partners and additional stakeholders to strengthen TPP and positive youth development (PYD) efforts across the state of Oklahoma.

Child and Adolescent Health (CAH) staff will continue to monitor the COVID-19 pandemic and will ensure that TPP materials can be utilized for virtual implementation in the event that schools do not allow outside visitors during the 2021-2022 school year.

CAH staff will collaborate to create materials that highlight teen pregnancy prevention efforts across the state, as well as develop a strategic marketing plan to increase awareness.

MCH will hire AHS to fill existing district vacancies. All new staff will receive training for EBPs and project implementation.

MCH will continue to highlight sexual health promotion messages via national observances throughout the year.

MCH will evaluate the planning and implementation process for the Adolescent Health Summit to aid in planning for the next event. Connections and collaborations will be maintained and will be built upon each year.

MCH will provide training opportunities related to health equity, trauma-informed practices, and inclusivity for program staff via PREP/TPP semi-annual meetings, AHS quarterly meetings, and/or Title X trainings. Existing partnerships with OSDE, Office of Minority Health, and other community agencies may be utilized.

CAH staff will continue to monitor the COVID-19 pandemic and provide materials, resources, and technical assistance to program staff related to virtual implementation as needed.

MCH will contract with OFN to assure youth partnership and youth voice in projects, utilizing stipends and other mechanisms to obtain youth input.

**NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.**

MCH will strengthen their relationship and collaboration with the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency.

MCH will collaborate with CSHCN partners and Adolescent Health Specialists (AHS) an to develop a comprehensive Adolescent Transition Guide, available in electronic form. This guide will address health literacy, how to make an appointment, what to know about insurance coverage, health maintenance guidance, and resources for adolescents who may need specialized care.

MCH will work with County Health Departments interested in hiring additional Family Nurse Practitioners to assist with well child visits, with an emphasis on increasing awareness of and access to adolescent well visits.

**Children with Special Health Care Needs**

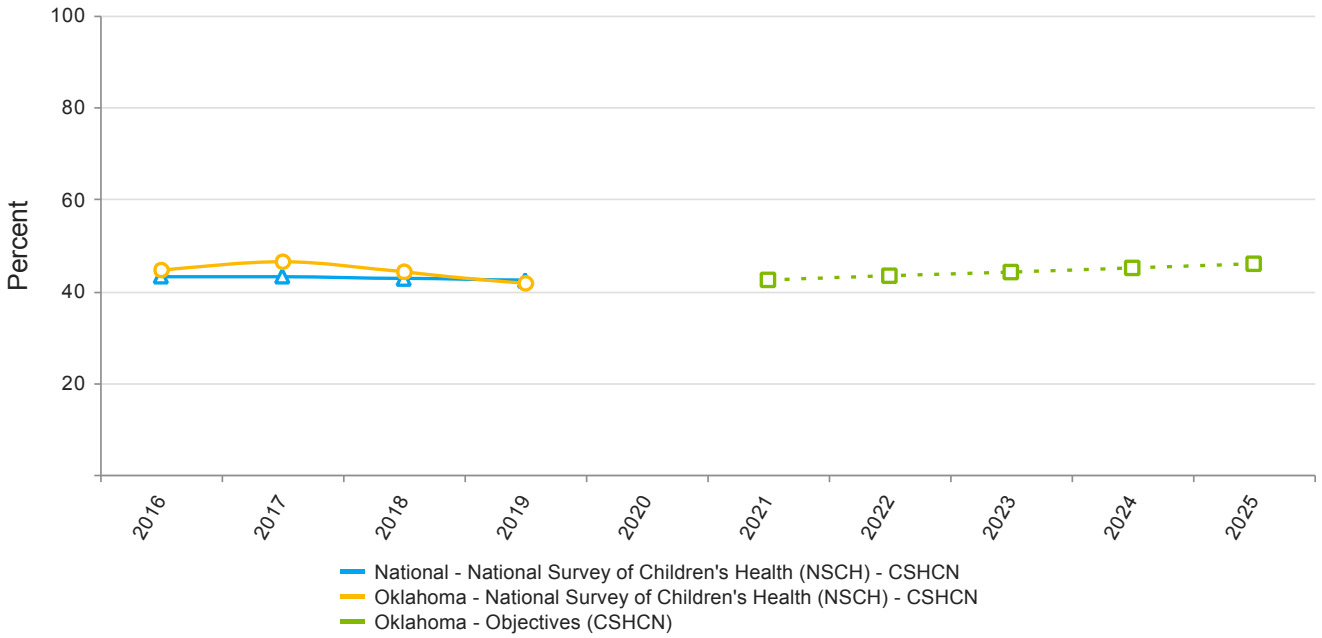
**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system | NSCH-2018_2019 | 16.0 % | NPM 11<br>NPM 12 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2018_2019 | 56.4 % | NPM 11 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2018_2019 | 87.9 % | NPM 11 |
| NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year | NSCH-2018_2019 | 2.2 % | NPM 11 |

## National Performance Measures

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

**Indicators and Annual Objectives**




**NPM 11 - Children with Special Health Care Needs**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | |
| | **2019** | **2020** |
| Annual Objective | | |
| Annual Indicator | 44.0 | 41.6 |
| Numerator | 95,790 | 91,264 |
| Denominator | 217,565 | 219,136 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2017_2018 | 2018_2019 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 42.4 | 43.3 | 44.1 | 45.0 | 45.9 | 46.8 |

**Evidence-Based or –Informed Strategy Measures**

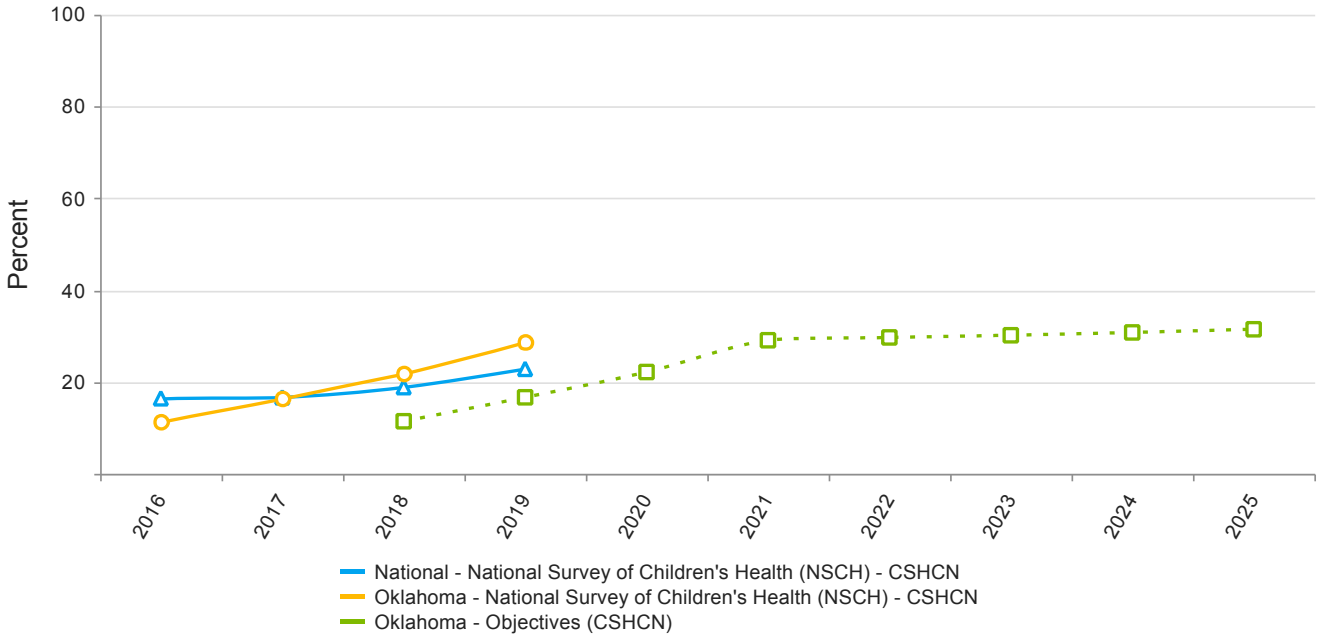
**ESM 11.1 - Number of CYSHCN who received care coordination services from Title V CSHCN contract providers in the past year.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2019 | 2020 |
| Annual Objective | | |
| Annual Indicator | 39.7 | 41.6 |
| Numerator | | |
| Denominator | | |
| Data Source | National Survey of Childrens Health | National Survey of Childrens Health |
| Data Source Year | 2018 | 2018-2019 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 42.4 | 43.3 | 44.1 | 45.0 | 45.9 | 46.8 |

**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**
**Indicators and Annual Objectives**




**NPM 12 - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 11.5 | 16.7 | 22.2 |
| Annual Indicator | | 11.3 | 16.4 | 21.8 | 28.5 |
| Numerator | | 10,795 | 14,252 | 18,388 | 26,312 |
| Denominator | | 95,220 | 87,022 | 84,532 | 92,174 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 | 2018_2019 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 29.1 | 29.7 | 30.2 | 30.8 | 31.5 | 32.1 |

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - The number of providers who address transition to adult health care in their practice**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 170 | 170 | 175 |
| Annual Indicator | 94 | 164 | 164 | 164 | 77 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | Sooner Success | Sooner Success | Sooner Success | Sooner Success | Sooner Success |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 80.0 | 85.0 | 90.0 | 95.0 | 100.0 | 105.0 |

**State Performance Measures**

**SPM 3 - The percent of families who are able to access services for their child with behavioral health needs**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 61.9 | 63.2 | 64.2 | 57.7 |
| Annual Indicator | 60.7 | 60.7 | 62.9 | 56.6 | 56.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Survey of Childrens Health | National Survey of Childrens Health | National Survey of Childrens Health | National Survey of Childrens Health | National Survey of Childrens Health |
| Data Source Year | 2011/12 | 2016 | 2017 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 57.5 | 58.7 | 59.9 | 61.0 | 62.3 | 64.1 |

**State Action Plan Table**

State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve access to family-centered programs via family support navigators

NPM

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

Objectives

1. Build upon existing Healthcare Transition Toolkit by adding ten additional family specific resources by 2023. [New]

2. Increase number of families who are aware of need for provision of transition services from 32% in 2017 to 35% in 2022.

3. Increase number of families of CYSHCN who report receiving transition services from 21.8% in 2017-2018 to 24.4% in 2025.

4. Expand ongoing pilot study between Sooner SUCCESS and selected clinics at OUHSC to establish a system to help collect, analyze and report data from the pilot study by 2023. [New]

5. Complete a minimum of two provider trainings on Healthcare Transition by 2023. [New]

Strategies

1a. Identify additional family specific resources within the state to address transition to adult health care. [New]

1b. Maintain comprehensive HCT Toolkit and update, as needed, based on feedback received and ongoing research.

2. Continue a work group of Title V partners 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 through 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]

5a. Determine requirements needed to provide CMEs in order to encourage provider trainings. [New]

5b. Develop provider training that meets CME requirements. [New]

| ESMs | Status |
| --- | --- |
| ESM 12.1 - The number of providers who address transition to adult health care in their practice | Active |

| NOMs |
| --- |
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system |

## State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 2

### Priority Need

Increase health equity for the MCH population

### NPM

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

### Objectives

Develop a plan to increase healthcare transition awareness among the CYSHCN population, to include addressing health disparities for CYSHCN, by 2022.

### Strategies

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.

| ESMs | Status |
| --- | --- |
| ESM 12.1 - The number of providers who address transition to adult health care in their practice | Active |

### NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 3

### Priority Need

Increase quality health care access for the MCH population

### NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

### Objectives

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. Develop at least 2 trainings for health care providers to improve care integration and cross provider communication using evidence-based tools by 2022.

### Strategies

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.

1c. Develop family-centered educational materials for parents regarding a medical home for use across programs.

2a. Develop outreach materials for pediatricians who are caring for discharged patients from hospital NICUs.

2b. Educate health care providers on the use and benefits of telemedicine and how to implement strategies to increase usage, including billing.

| ESMs | Status |
|---|---|
| ESM 11.1 - Number of CYSHCN who received care coordination services from Title V CSHCN contract providers in the past year. | Active |

### NOMs

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 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

## State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 4

### Priority Need

Improve the mental and behavioral health of the MCH population

### SPM

SPM 3 - The percent of families who are able to access services for their child with behavioral health needs

### Objectives

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.

### Strategies

Collaborate with all Title V CSHCN partners to connect families with behavioral and mental health services.

Identify all infant and early childhood mental health coalitions and other related activities in the five Oklahoma counties with the greatest need for 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.

**Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.**

**Objective 1: Develop a toolkit for primary care providers by 2020.**

**Data:**
The Health Care Transition Toolkit has been developed and placed online. Sooner SUCCESS continued to work towards adding additional resources for families. During FFY20, Sooner SUCCESS provided psychosocial support and resources to the families of 810 children between 12 to 18 years of age.

**Successes:**
The Oklahoma Department of Human Services Title V program continued to collaborate with Sooner SUCCESS on Health Care Transition (HCT) with the ultimate goal being to provide the essential services required to assist the adolescent population with health care transition and the development of a toolkit for primary care physicians and families. Development and distribution of a toolkit to providers, partners and families will increase awareness of standard practices of health care transition in due time, fundamentally increasing the percentage of youth with special health care needs receiving necessary services to make transition to all aspects of life, including health care, work and independence. The HCT toolkit is available at the following link:
**https://ouhscsoonersuccess.github.io/ok-hct-toolkit.github.io/**

In FFY20, Sooner SUCCESS continued in the development/maintenance phase of the toolkit for primary care physicians and families of children between 12 years and 22 years of age. The knowledge periodically attained through utilization of appropriate resources helped to inform updates needed to the existing toolkit. During 2019-2020, Sooner SUCCESS also began distribution. Posters, brochures and flyers were handed out at doctor's offices, conferences and workshops. Academic posters highlighting the resources were also presented.

The section on providers included resources such as readiness assessment tools, diagnoses fact sheets, relevant webinars and recently published yearly reports on health care transition. Other topics included provider billing and procedure manuals. The section on "Finding Health Care" included links for finding providers across different specialties from multiple organizations within Oklahoma. Under the "Provider Information Brief" domain, multiple topics with links to resources were included to help physicians and providers navigate families through HCT and connect them to community-oriented services in their community.

In early 2020, Sooner SUCCESS got an opportunity to receive guidance from Dr. Patience White from the National Alliance to Advance Adolescent Health. Based on her recommendations, Sooner SUCCESS revised the HCT toolkit as they procured more resources. Sooner SUCCESS also collaborated with Got Transition® for organized implementation of their HCT tools such as readiness assessments for youth and caregivers and tracking tools for progress documentation through the process of HCT. Implementation began for three pilot clinics at University of Oklahoma Health Sciences Center – Child Study Center, Sickle Cell Clinic and Sooner Pediatrics. Collaboration with other entities continued to provide means for further integration of variety of advanced topics surrounding HCT in the toolkit.

In FFY20, Sooner SUCCESS collaborated with a doctoral student from Health Promotion Sciences in the College of Public Health (COPH) at OUHSC to conduct a sub-study with Sooner SUCCESS families for assessment of their perception of the extent to which their children's chronic health conditions were being managed in the current health

care system. Once those results become available, they will significantly add to the family section of the HCT toolkit.

Sooner SUCCESS continued to coordinate and conduct quarterly Health Care Transition committee meetings where several community partners and representatives from clinics in the Children's Hospital at OUHSC attended. Stakeholders from this group helped provide input regarding resources, new and revised, that needed to be included in the family section of the toolkit. Topics such as legal guardianship and decision-making, foster care, health insurance and SSI were included.

Oklahoma Family Support 360° (OKFS360°), a contractor for CSHCN, continued to participate at the quarterly Health Care Transition subcommittee meetings to give a voice to the Hispanic/Latino population perspective.

OKFS360° continued the conversation with pediatric residents during their practicum with CLL/OKFS360°/OUHSC (Center for Learning and Leadership/Oklahoma Family Support 360°/Oklahoma University Health Sciences Center).

Sickle Cell Clinic gave an annual educational presentation to first year medical students with participation of patients/families to provide a 'face' for sickle cell disease. Sickle Cell Clinic staff continued to provide educational talks to adult health care providers at the Stephenson Cancer Center.

As part of the contract with CSHCN, Sickle Cell Clinic also provided education and resources to the medical students, residents/fellows in training, nurses and nursing students as well as to Physician Assistant (PA) and Nurse Practitioner (NP) students during comprehensive sickle cell clinics and inpatient rotations. Sickle Cell Clinic developed sickle cell disease awareness materials and educational handouts were printed and distributed to Jimmy Everest Center (JEC) staff.

**Challenges:**
Sooner SUCCESS reported that the varying complexity of scenarios where adolescents prepare and then transtion into aduthood requires coordination of multiple services. A variety of these needs were medical and many more were based in the community. Sooner SUCCESS reported that providng guidance and education to streamline a well-coordianted system of service navigation within and outside of medical world required discipline, organization and collaboration that is incentivized which was a difficult process to achieve given limitations posed by family dynamics and present resource availability. This included threats of sudden loss of services resulting from termination of benefits as adolescents became adults and came off of their parent's health insurance plans. Sooner SUCCESS, with the help of its county coordinators and community partners, was able to find solutions to challenges such as this.

The COVID-19 pandemic slowed down usual business practices and the pace at which Sooner SUCCESS expected to further build on the HCT toolkit.

Oklahoma Family Support 360° (OKFS360°) reported a continued lack of communication about transitional services from medical providers to families and youth with developmental disabilities.

OKFS360° challenges included the COVID-19 pandemic and the deficit of information in their clientele's primary language, Spanish. The pandemic produced a series of issues for families, which included basic needs, food, shelter, etc. Clinics cancelled visits that could wait for their current patients; however, most of the information was delivered in English so many Hispanic/Latino families were, again, without needed information.

Sickle Cell Clinic struggled with identifying and distributing educational materials/handouts to primary care providers. Sickle Cell Clinic collaborated with Oklahoma American Academy of Pediatrics (AAP) chapter to seek out their

assistance.

**Objective 2: Increase number of families who are aware of need for provision of transition services from 32% in 2017 to 35% in 2020.**

**Data:**
Since October 2015, LEAD (Listen. Empower. Advocate. Database.) reports compiled by Sooner SUCCESS show that 3,127 children and youth with special health care needs (CYSHCN) have been supported through direct navigations efforts. Sooner SUCCESS County Coordinators continued to make efforts across time to survey families of CYSHCN's in order to assess their level of awareness around timely preparation for transition of health care for their children. During FFY20, 144 HCT surveys were completed with children between 12 and 21 years of age. Thirty-four of the 144 (24%) report having a plan for transition.

**Successes:**
Oklahoma Family Support 360° (OKFS360°) brought opportunities for learning about health care transition and services for a successful health care transition for all, including the Hispanic community, to the Hispanic support groups. The FS360° Center provided individualized information to families with children age 12 to adulthood enrolled at the Center. OKFS360° developed a solid relationship with an adult medical provider to bring awareness of health care transition to the Hispanic/Latino community served.

OKFS30° finalized the one page bilingual document for families and youth about health care transition, including information on different agencies that support this effort in the state of Oklahoma.

Oklahoma Family Network (OFN) staff participated in the Sooner SUCCESS Health Care Transition quarterly subcommittee meetings by providing input on resources and experiences related to transition to adult health care.

Sickle Cell Clinic Transition Coordinator participated in Healthcare Transition Committee meetings. Transition Coordinator was able to attend the meetings more regularly due to fact that the meetings were conducted via Zoom, after March 2020.

Another CSHCN contractor, the Oklahoma Infant Transition Program hosted two successful family activities weekly. One activity was a family luncheon where speakers provide inspirational or self-help topics. The speaker topics focused on transitioning home. OITP taught families to prepare for the transition home and what to expect once discharged. Parents also shared what they have learned. A total of 671 lunches were served which was a 62% increase. The second activity was a scrapbooking class where parents gathered and shared NICU experiences, tips for other parents or just pictures of their baby. Parents became a support system for other NICU families experiencing stress and anxiety. OITP hosted 535 family members in our scrapbooking class which was a 64% increase.

**Challenges:**
Oklahoma Family Support 360° (OKFS360°) continued to face a language barrier with their clientele and a lack of communication from medical providers to families about health care transition. The Public Health Emergency added to the difficulties faced by the Hispanic population as the delivery of services and supports for the families served changed to social distancing and virtual platforms. Many families served by OKFS360° did not have the technology or the knowledge to access opportunities of learning and awareness through these routes of delivery. OKFS360° worked with the families to access services virtually or by phone. OKFS360° attempted to teach the families about Zoom and other technologies. Clinics cancelled non-emergency appointments for patients, making basic care

harder for families.

Oklahoma Family Network (OFN) reported that the cessation of in-person meetings, as a result of COVID-19, was challenging.

OITP outgrew their space for the family luncheons and scrapbooking class activities. OITP worked with the hospital to identify additional space that is close to the NICU. The COVID 19 pandemic limited OITP's access to families in the NICU. The family luncheons shifted to a "Grab & Go" box lunch. OITP was still able to give parents printed information about available resources. OITP staff called NICU parents to reinforce the need for resources and assess any needs they had in order to offer appropriate resources.

**Objective 3: Increase number of families of CYSHCN who report receiving transition services from 22.5% in 2017 to 23% in 2020.**

**Data:**
The combined 2018-2019 National Survey of Children's Health found that 28.5% of Oklahoma adolescents with special health care needs, age 12 to 17 years, received the services necessary for making the transition to adult health care. This rate is higher than the national average of 22.9%.

**Successes:**
During FFY20, Sooner SUCCESS introduced 6-core principals of health care transition at two pilot sites at Oklahoma University Health Sciences Center (OUHSC). These two clinical sites included Child Study Center (CSC) located in the section on Developmental and Behavioral Pediatrics (DBP) and Sooner Pediatrics. There was one other pilot clinic at Pediatric Hematology/Oncology Clinic in the Children's Hospital.

Sooner SUCCESS signed an agreement with Got Transition to be able to use their HCT implementation tools, including the caregivers and youth readiness assessment tools and patients progress recording and reporting tools. These tools were used at all three pilot sites.

To date, the CSC has been at the center of most of the efforts around healthcare transition for the pilot. A written policy for HCT was developed for CSC. Additionally, readiness assessments were developed using REDCap and providers started the process of intake with their patients. Shortly into this intake process, providers realized it was better for children and their caretakers to complete the readiness assessments at the clinic on iPads prior to the visit.

The Sooner SUCCESS team began working with Dr. Demvihin Ulhyembe to design an HCT module on the Electronic Medical Record (EMR) for patient's monitoring and recording purposes. Module development remained in process.

All three participating pilot clinics were made aware of each other's appointments and patients' management procedures through the healthcare transition subcommittee meetings and created a great collaborative learning opportunity for clinic staff.

The Pediatric Hematology/Oncology Clinic has conducted health care transition for their patients for several years. During FFY20, this Clinic began using iPads for completing readiness assessments with their patient population.

In FFY20, 26.6% of the children enrolled in the Oklahoma Family Support 360° (OKFS360°) program were able to

apply for the support and transitional services, including but not limited to, Developmental Disability Services, Supplemental Security Income and State Supplemental Payment.

Oklahoma Family Network (OFN) assisted Sooner SUCCESS (the lead) on this strategy by providing training around Health Care Transition (HCT). OFN trained 56 families and 71 professionals during FFY20 by providing a presentation of 75 slides that included resources intended to assist with young adults transitioning to adulthood. OFN also provided Transition Care Notebook and other transition related training to 25 families and 24 professionals. One hundred forty-one individuals downloaded the Transition Care Notebook documents from the OFN web site.

OFN collaborated with the Children's Hospital at Saint Francis in Tulsa to webcast the Houston Chronic Illness and Disability Transition Conference for 5 families and 4 professionals. A number of good resources were shared during that event.

OFN played a role in planning and executing the statewide OK Transition Institute.

Sickle Cell Clinic continued Sickle Cell Disease transition program with identified transition coordinator. During this grant year, the Sickle Cell Clinic implemented a database to identity patients lost to follow-up.

OITP increased the number of families receiving services from 528 infants in FY 2019 to 535 in FY20. This was a 10% increase.

OITP staff offered NICU tours to families that had a high-risk pregnancy in which the baby, once delivered, might be admitted into the NICU. These tours included explanation of equipment, visitation, and procedures. They also included self-care practices for parents. OITP provided 72 tours beginning November 2019 up through April 2020 when they became virtual due to COVID precautions and the NICU limiting visitors.

OITP added several diagnoses to the criteria for services. These diagnoses include infants with hypoxic brain injuries and infants with complex cardiac disease.

OITP initiated and hosted individual care conferences for babies whose length of stay in the NICU was greater than 90 days. OITP would notify the neonatologist and family to see what topics needed to be covered and what the barriers were to discharging home. In each care conference, the attending neonatologist, nursing leadership, primary care nurses, specialist, family members and OITP staff assigned to the infant as well as other members of the baby's care team were invited to discuss a plan for discharge. The team made sure the family was comfortable with the infant's plan of care and OITP continued to facilitate a smooth transition home. Care conferences increased by 50% from 2018.

OITP facilitated a weekly developmental clinic for NICU graduates at 1 and 2 years of age. OITP provided a Bayley developmental assessment at the clinic. After the assessment was completed, the physical therapist and neonatologist reviewed the assessment and made recommendations for care during the next transition to childhood and beyond. The child's PCP was notified of the Bayley results and recommendations so they could follow up during the child's next visit. Therapists completed 62 Bayley exams.

**Challenges:**
The Sooner SUCCESS family study conducted with LEAD families cannot necessarily be generalized to all families of CYSHCN's in the state of Oklahoma. Families were either reached in person or efforts were made to contact them via phone calls and emails. Many voicemail messages were left where connections were not made after several

attempts. Many voicemails and emails were not returned. In some case, families were not interested in completing the survey. Other factors included invalid phone numbers, no English speaking family member or no contact information available after a move. Additionally, Sooner SUCCESS serves many families anonymously who are referred by service providers who only request coordination of services without giving any demographic information.

For Sooner SUCCESS, the COVID-19 pandemic posed some new challenges where both families and providers were faced with uncertainties and stress at a taxing level. This may have affected routine flow of service navigation and interpersonal coordination. The necessity of social distancing, quarantines and fear associated with the pandemic could also have been implicating factors.

Oklahoma Family Support 360° (OKFS360°) reported that some of the programs and/or agencies lacked bilingual professionals to assist with transition services. Additionally, some of the programs had long waiting lists for services.

Oklahoma Family Network (OFN) recognized from the collaboration with Saint Francis that physicians, other health care providers and families have historically not been open to attending a multi-day conference on health care transition, via webcast. More work needs to be done to increase awareness of the importance of health care transition among families and professionals alike. It was evident that a different method of generating awareness and knowledge needs to be identified in order to reach more individuals.

Sickle Cell Clinic limited in-person visits during the 2nd quarter of 2020 due to COVID. Sickle Cell Clinic had a high no show rate/lost to follow-up, which increased due to COVID.

OITP has increased patient load for each social worker by approximately 20 patients per year without increasing staff size.

OITP added several diagnoses to the criteria for services which included medically fragile infants needing a smooth transition from the hospital to home. The additional diagnoses increased the need for family dynamic counseling, education on medical needs of infant and depression and anxiety reducing methods for the entire family. OITP staff needed on-going education/training to meet the needs of the families who may be experiencing increased anxiety/depression.

OITP continually tries to seek out additional resources for families who are making the transition from hospital to medical home and beyond as their child grows. The challenge is to find resources that are culturally sensitive, age appropriate and available to this population.

**Objective 4: Develop a plan to increase healthcare transition awareness among the CYSHCN population, to include addressing health disparities for CYSHCN, by 2020.**

**Data:**
Oklahoma Family Support 360° Center, in conjunction with the Oklahoma Family Network, provided dissemination and translation support to the OKmama support group for Spanish speaking families. In response to the COVID-19 pandemic, all OKmama meetings went virtual. The OKmama private/closed Facebook group platform distributed information from respected sources to help teleworking families access services and resources that they needed. The Facebook group saw an increase of 15% over the last year with the total friends (parents, guardians and professionals) rounding out to 204 by the end of FFY20.

**Successes:**

Oklahoma Family Support 360° (OKFS360°) provided information in Spanish to parents and caregivers about activities, trainings and awareness about transition to adulthood.

An OKFS360° Coordinator supported the Oklahoma Transition Institute by presenting “Charting the LifeCourse” and by contacting bilingual speakers to present at the conference. This was the first time the OTI had several sessions in Spanish throughout their conference for families of transitional youth. Those activities were aimed at reducing health disparities specific to the Hispanic community. The trainings were made available on the OTI website as well.

OKFS360° partnered with the Developmental Disabilities Council of Oklahoma to share and promote the Youth Leadership Forum program which increased the involvement of youth from the Hispanic community.

OKFS360° continued to share information in Spanish provided by the Got Transition project through their website, www.gottransition.org.

Sickle Cell Clinic continued Sickle Cell Disease transition program with identified transition coordinator. Sickle Cell Clinic had a social worker available to all patients with sickle cell disease to facilitate referrals to outside community resources/services.

Sickle Cell Clinic increased Sickle Cell Disease awareness and transition awareness by providing resources and educational materials to the families. Due to COVID, Sickle Cell Clinic was not able to host any in-person educational events for patients/families; however, materials and resources were still provided.

Approximately 25% of all deliveries at OU Medical Center were to adolescents. Many of the adolescent mothers experienced the anxiety of their baby admitted to the NICU at The Children’s Hospital. OITP provided services to these adolescent mothers along with education and counseling regarding transitioning from hospital-based care to home care for not only their infant but for themselves. These adolescent mothers were making the developmental transition into adulthood with a medically fragile baby, adding stress and anxiety to their family unit. OITP staff educated these adolescent parents on how to use family support systems and to advocate for themselves and their baby. Many of the adolescent mothers had transportation issues. OITP helped these young women to access transportation resources so they could continue to bond with their infant and learn the necessary skills to transition home.

OITP provided services for one adolescent mother who delivered premature triplets. The mother had a difficult time transitioning from the NICU to a medical home. Each of her three children had special healthcare needs; such has oxygen dependency, immature feeding skills and decreased muscle tone. At two months of age, her family members who had been helping with the care of her children began to leave and she was left caring for the triplets alone. OITP followed up with her in the follow-up clinic. The young mother was not sleeping and had very little funds so she was not eating. OITP helped the mother with services in her home and provided parenting classes and respite care.

OITP learned during one of the follow-up clinics that a teen parent with a child dependent on oxygen was in danger of having the electricity in their home disconnected due to lack of payment. OITP staff contacted the electric company and was able to keep her power from being disconnected. OITP also helped her to develop a budget to keep this from becoming a problem in the future.

OITP staff were members of and participated in the Oklahoma Family Support Focus Group to advise and find appropriate resources for the needs of families in transition from the NICU to a medical home. OITP was also a member of the Children’s Health Group for the State of Oklahoma, Transition Services Committee and Fetal/Infant Mortality Review Committee, which addresses the disparity of services for CYSHCN.

**Challenges:**
Oklahoma Family Support 360° (OKFS360°) addressed priorities, such as basic needs like food and shelter, for the Hispanic community during the pandemic because Hispanic families are often unaware of the services and tools that support children and youth at transition age. Information in Spanish about the virus and how to access protections and to keep their family and children with disabilities safe was not readily available.

Sickle Cell Clinic challenges included patients/families difficulties in following up and/or coming to clinic for their appointments.

OITP continued to be challenged in continuing education for staff and having the funding to attend seminars and conferences that would increase knowledge to provide services to the adolescent parent.

**SPM 3: The percent of families who are able to access services for their child with behavioral health needs.**

**Objective 1: Increase the number of children who receive behavioral and mental health services from 67.7% in 2017 to 68.5% by 2020.**

**Data:**
The combined 2018-2019 National Survey of Children's Health found that 56.4% of children in Oklahoma, ages 3 through 17, with a mental/behavioral condition received treatment or counseling.

**Successes:**
During FFY20, Oklahoma Family Support 360° (OKFS360°) Center connected enrolled families who were in need of behavioral or mental health services with information and referral for evaluation, diagnosis and treatment, as needed. OKFS360° collaborated with a bilingual representative from the Oklahoma Department of Mental Health and Substance Abuse Services to provide information about their services through the Hispanic Support Group.

Oklahoma Family Network (OFN) supported 1,296 families in FFY20 by providing one-to-one peer support, matching them with other families and connecting them with training and behavioral health resources.

OFN continued partnering with the National Alliance on Mental Illness (NAMI) Oklahoma Parents Helping Parents as a project of Oklahoma Mental Health and Substance Abuse and the Children's Behavioral Health Network (CBHN). OFN provided connections to support and resources for families who have children with behavioral health concerns/diagnoses. OFN and other CBHN partners were actively engaged in community coalitions, which included three infant mental health coalitions. OFN furnished stipends to family leaders in order to provide a family voice during meetings.

OFN hosted 29 family leaders, 22 of which received all registration and travel expenses,
to attend the National Federation of Families for Children's Mental Health Conference in Phoenix, AZ during FFY20. This group, which includes members from across the state, had quarterly encouragement and leadership training, received emails and shared opportunities and encouragement via their private Facebook group. Additionally, OFN hosted a Family Leaders' Facebook page with 113 members. Posts were made with leadership opportunities and training.

OFN hosted the Virtual Children's Behavioral Health Conference on June 10, 2020.

OFN provided conference packets with resource information to 34 parents and 15 young adults. Both conferences allowed families to realize that they are not alone in caring for a child with mental health concerns and they learned skills for their own child and to share with other families in their area.

OFN held the Joining Forces:  Supporting Family/Professional Partnerships Conference via Zoom in March 2020 with 403 in attendance. Dr. Chan Hellman, author of "*Hope Rising: How the Science of Hope Can Change Your Life*" was the keynote speaker with a gathering of 84 families following.

The Family Partner in the JumpStart Developmental Clinic provided assistance to a total of 127 families in accessing behavioral and mental health services for FFY20. This was an increase from the 120 families in the previous federal fiscal year.

The JumpStart Family Partner participated in team evaluation/feedback sessions with 110 families at the JumpStart Clinic during FFY20. The Family Partner provided direct resource navigation for many families, particularly Spanish speaking families, for other clinical programs at the Child Study Center as well, including the multidisciplinary A Better Chance Prenatal Substance Exposure Clinic. The Family Partner saw follow-up JumpStart and other patients and families in the Developmental-Behavioral Medical Clinic. Services were provided for 17 families in these other clinics at Child Study Center. All families seen at the JumpStart Clinic in FFY20 were provided with a diagnosis/diagnoses (e.g. autism spectrum disorder, global developmentally delayed milestones, intellectual disability, mixed receptive expressive language disorder, anxiety, disruptive behavior disorder, ADHD) and with a plan of action, referral recommendations, and resources. These services were maintained even during virtual visits, which were necessitated by the COVID pandemic. Families were encouraged to call back after the appointment with any questions, further explanation, or if additional help was needed. Additionally, the Family Partner contacted several families after the visit to discuss further follow-up concerns. The Family Partner role was enriched as it is a combination half-time position with JumpStart Clinic and half-time position as Oklahoma County Coordinator with Sooner SUCCESS, another Title V partner.

The Family Partner at JumpStart Clinic assisted with scheduling 6-month follow-ups with the Developmental Behavioral Pediatrics (DBP) physician to check in and to allow the DBP to determine if additional assistance was needed in accessing behavioral/mental health, school, medical, and/or other community services/resources.

The JumpStart Family Partner developed and hosted a monthly Zoom support session for Spanish-speaking families whose children were seen in JumpStart or other clinics. This meeting became known as *Community Talk*. In this forum, families discussed what helped them and how they could help each other.

The JumpStart Family Partner shared a success story about one of the families she served during FFY20. A parent brought in her toddler for an Autism evaluation. The parent already had a teenage child with Autism. The parent was Spanish speaking and could not read or write in her own language. The Family Partner and team took extra time to explain the process and assessment. The toddler was ultimately diagnosed with Autism as well. The parent was extremely thankful for the assistance and happy to know there would be an interpreter at the clinic who could help meet her needs. The parent was able to not only obtain service navigation information in her own native language for her toddler but also for her teenage child.

Sickle Cell Clinic continued to employ a licensed counselor to provide counseling services to patients with sickle cell disease, as well as a psychologist. The psychologist and licensed counselor were available to all patients with sickle cell disease for counseling services and met with patients at least annually. They provided behavioral and mental health services to the Sickle Cell Clinic patients and families and provided referrals for neuropsychological testing, counseling services, cognitive behavioral therapies and psychiatry. A Sickle Cell Clinic social worker was available

to all patients/families to provide resources and referrals.

The Sickle Cell Clinic database helped to identify and track patients who were lost to follow-up so that staff could reach out to them to identify barriers and to increase clinic visit rate in order to increase psychology and behavioral services provided.

J.D. McCarty Center provided respite services for children aged birth to 21 years of age through a partnership with Title V CSHCN. The respite program remained a valuable program that provided caretakers the opportunity to seek out support for mental health care. In FFY20, J.D. McCarty provided respite services for six families – one family in October 2019, three families in November 2019, two families in December 2019 and no families from January 2020 through September 2020 due to the pandemic.

J.D. McCarty Center provided free therapeutic services screenings to families in Oklahoma that has a child that they believed may be in need of services for intellectual or developmental disabilities. J.D. McCarty Center assessed the needs of the children screened, as well as their families, and identified any correlating services that were available in the state of Oklahoma to assist the child and/or their family, including any necessary mental health services. In FFY20, J.D. McCarty served 82 families with therapeutic screenings.

J.D. McCarty Center kicked off a separate pilot program in March 2020 primarily in Cleveland County where staff visited with a defined population of children and their families out in the community rather than having the families come into the facility. Staff were able to engage with 206 families to discuss not only their services, such as respite care, but also help the families to find other needed services, such as mental health care. J.D. McCarty Center's recent past challenges have included a lack of awareness by families in Oklahoma about their services and this new program has been a successful marketing tool to make families aware, at least in the local vicinity for now, of their respite program and the need for mental health.

OITP added multiple layers to the mental health services for NICU families. OITP screened for maternal mood disorders in the follow-up clinics at one month and one-year post discharge from the NICU. OITP developed a resource kit for families needing mental health care.

OITP was a member of the Maternal Mood Disorder Work Group in conjunction with the Oklahoma Department of Health.

OITP continued to recognize that it is not just mothers who need mental health assistance. During a one-year follow-up, a single dad with a child with special health care needs expressed feelings of helplessness and depression. OITP helped the father with online and in-person resources along with respite resources. OITP found that one year later, the single father was coping with his child's special needs and was able to keep his depression from ruling his life.

**Challenges:**
A challenge OKFS360° faced was families having limited understanding and knowledge of what behavioral health is or how it can help them or their family. Additionally, there was a lack of bilingual behavioral specialists as well as materials in Spanish for families of children with behavioral needs or dual diagnoses.

OKFS360° was unable to carry out partnerships with Advanced Behavioral Solutions due to a conflict of the trainer and the sudden close of the clinic due to the COVID-19 pandemic.

Oklahoma Family Network (OFN) lost several staff over FFY20, and prior, due to the need for a higher rate of pay, health insurance and retirement. In September 2020, a staff member from a frontier area resigned due to the struggle of caring for her children and teaching them at home during COVID-19. Other staff had difficulty working the number of hours needed to support families in their regular fashion. This was, and continues to be, a strain on the organization as valuable wisdom was lost and the remaining staff were over-taxed.

The JumpStart Family Partner position continued to be part-time (20 hours/week). Follow-up with all individual families seen in the JumpStart Clinic was challenging given the limited time constraints and other responsibilities. This challenge worsened as resource navigation for families of children with Autism substantially increased due to Applied Behavioral Analysis (ABA) recently becoming a covered service under Soonercare (Oklahoma's Medicaid program). These families were often overwhelmed in navigating the options for ABA in the community, ensuring insurance coverage, and identifying an agency with availability that was suitable to the family's needs and safety, particularly in the face of COVID.

The JumpStart Family Partner's capacity to assist families increased over the last FFY and families and other interested parties became more aware of that. However, the availability to serve all potential families in the full clinic remained limited by time constraints and other responsibilities. There was no dedicated case manager position to follow-up with families.

The JumpStart Family Partner had challenges related to the COVID pandemic, especially as related to Internet/technological connectivity difficulties during attempted family support interactions.

Sickle Cell Clinic reported that some patients continued to be lost to follow-up and the no show rate continued to be high.

The COVID pandemic was the most prevalent challege that J.D. McCarty Center encountered over FFY20. J.D. McCarty Center had difficulty retaining Direct Care Staff to provide care during respite services because no new respite admissions were allowed after January 2020 in order to keep the current, vulnerable inpatient population safe.

The free therapeutic services screenings to families in Oklahoma that have a child they believed may be in need of services for intellectual or developmental disabilities were down 56.6% (from 145 in FFY19 to 82 in FFY20) due to the COVID pandemic. Part of this was due to families who were concerned about taking the child out of the home for the screening and partly due to the facility taking more precautions to keep both families and staff safe.

Many NICU families had a knowledge deficit regarding behavioral and mental health needs. OITP stressed the importance of mental health to the whole family unit but many families were unwilling to acknowledge need for services due in part to the stigma associated with mental health needs.

**NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.**

**Objective 1: Publish Healthcare Transition Toolkit on Sooner SUCCESS website by 2022.**

Sooner SUCCESS will prepare and publish a separate toolkit for families (the current one is provider-focused) and have both the Providers and Families toolkits published on the Sooner SUCCESS website. Sooner SUCCESS will record the number of times toolkits are accessed from the website. Sooner SUCCESS will also make HCT toolkits available to stakeholders at the request of providers, community partners and families and the number of requests will be recorded.

Sooner SUCCESS will continue to host quarterly Healthcare Transition subcommittee meetings so that collaborators, community partners and families get an opportunity to hear about the work that Sooner SUCCESS is doing around healthcare transition. These partners will continue to be encouraged to speak about their own experiences and about identified service gaps in the community. Any additional recommendations on how they they can be part of Sooner SUCCESS efforts will continue to be welcomed. Any new resources mentioned or discussed will be acknowledged and added to the toolkits if and when they represent existing needs and service gaps in both health care services and community.

Sooner SUCCESS will continue to get guidance from Dr. Patience White at The National Alliance to Advance Adolescent Health in Washington DC.

Procedures undertaken via Sooner SUCCESS' pilot project will help determine the count and percentages of children in participating organizations approached who received services necessary to transition from adolescent to adult health care.

Sooner SUCCESS county coordinators will continue to navigate services for Oklahoma families to assist with health care transition for their kids.

Oklahoma Family Support 360° (OKFS360°) will continue to be part of the quarterly Health Care Transition subcommittee meetings hosted by Sooner SUCCESS to bring the Hispanic perspective to the group.

OKFS360° will continue to offer Quick Tips to Medical Transition sheet to families. This sheet will also be offered to Sooner SUCCESS to add to their toolkit for publication on their website.

Sickle Cell Clinic will continue the sickle cell disease transition program with the transition coordinator and social worker meeting with patients/families twice per year.

Sickle Cell Clinic will maintain a list of patients with sickle cell disease in the transition program database and will generate electronic reports for all transition visits/patients.

Sickle Cell Clinic will give sickle cell disease specific toolkits to all patients upon entering the transition program and again at age 18.

**Objective 2: Increase number of families who are aware of need for provision of transition services from 32% in 2017 to 35% in 2022.**

Oklahoma Family Support 360° (OKFS360°) will continue to increase awareness for transitional services for the Spanish speaking community across the state of Oklahoma through outreach at support groups, workshops, social media and trainings for families and communities. Information will be provided virtually and will transition to in-person outreach when it is safe to do so. OKFS360° will also collaborate with other Title V programs to improve supports for transitional services.

Oklahoma Family Network (OFN) will continue to have a presence in and participate in the Sooner SUCCESS Health Care Transition work group.

OFN will promote health care transition sessions for the Oklahoma Transition Institute.

Sickle Cell Clinic will continue to participate in the Title V partners meetings and incorporate new tools and resources into the program.

Sickle Cell Clinic will continue to identify and track eligible patients to provide education for provision of transition of transition services.

OITP plans on adding additional parent activities for major holidays and adding videos to its Facebook page. The OITP Facebook page has 199 families following and receiving insightful information as resources.

OITP will meet with parents prior to discharge to ensure they have needed resources in the home and will call after discharge to help parents solve any problems that may arise once home.

OITP will continue to develop an “Early Birds” chapter hosted by OITP. Early Birds is a school readiness program for parents-to-be and parents of children from birth to five. Early Birds covers five core areas:  developmental milestone, parent/child activities, everyday learning, purposeful parenting and family health and wellness. Parents will receive activities, educational toys and books to stimulate their child’s development and learning. This program will focus on NICU graduates from Children’s Hospital.

**Objective 3:  Increase number of families of CYSHCN who report receiving transition services from 21.8% in 2017-2018 to 24.4% in 2025.**

Sooner SUCCESS county coordinators will continue to coordinate with families, physicians, health service providers, managers, administrators, guardians and human service agencies to brainstorm the best possible solutions integrating cumulative needs of individual families while appreciating the diversity of Oklahoma families. Sooner SUCCESS will continue to acknowledge the role of their community partners, both providers and family representatives, in complementing their efforts.

Sooner SUCCESS will continue to collaborate with multiple coalitions throughout Oklahoma in order to identify large-scale gaps across different counties. Small-scale efforts will then be initiated at several levels depending upon the resources available to bridge the existing identified gaps, including healthcare transition.

Sooner SUCCESS will continue to collaborate with faculty, students and specialists on and outside of Oklahoma University Health Sciences Center (OUHSC) campus. This will include the current collaboration with Health Promotion Sciences doctoral students at OUHSC College of Public Health to distribute surveys to Sooner SUCCESS client population to assess the extent to which their children’s chronic health conditions are successfully

managed by Oklahoma health care providers. This collaboration will help to identify service gaps and barriers, such as distances families have to travel to access needs for CYSHCN.

Sooner SUCCESS will continue to meet quarterly to provide updates on completed and continuing efforts for Oklahoma families, note concerns provided by partners, share resources and discuss future steps. Sooner SUCCESS will improvise from current efforts after group discussions with collaborators.

OKFS360° will provide information and coordinated care to each family with children and adolescents in the transitional age who are enrolled at the Center. Coordinated care will be patient-centered/family-centered and focus on inclusion and self-determination to improve transition to adulthood for our members.

OKFS360° will share information with medical professionals to help bring awareness regarding the uniqueness and complexity of the Hispanic community.

OFN will maintain five regions of staff members who have children/adults with behavioral health and other special health care needs and disabilities to provide family-to-family support, resource information, and training and opportunities for advocacy and leadership development. OFN will continue to consider the family's culture as core to effective support. Staff will have diverse backgrounds and experiences to help better meet the needs of the families, including the need of those transitioning youth to adult health care services.

Sickle Cell Clinic will continue the sickle cell disease transition program with the transition coordinator and social worker meeting with patients/families twice per year to provide transition education during comprehensive sickle cell clinic visit.

Sickle Cell Clinic will use the newly formed database to identify patients who have been lost to follow-up, in clinic and in the transition program, so that attempts can be made to identify reasons for missed follow-ups and resources can be provided to bring them back to clinic.

OITP will expand the role of our family advocate to assist parents to coordinate care for their medically fragile child during their transition to home based care. The family advocate will offer community based resources with the unique perspective of a parent who has had a child in the NICU.

**Objective 4: 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 patient population, in accordance with six core elements of health care transition.**

Sooner SUCCESS will take the written Health Care Transition (HCT) policy that was developed for the Child Study Center (CSC) and share it with families and other providers at the Clinic.

Sooner SUCCESS will install iPad stands at CSC to hold and thus ensure the safety of the iPads used for the readiness assessments prior to the visit.

The Sooner SUCCESS team will continue to work with Dr. Demvihin U Ihyembe to design an HCT module on the Electronic Medical Record (EMR) for patient's monitoring and recording purposes. Module development still in process.

The Sooner SUCCESS team will brainstorm and consult on individual clinics HCT procedures, depending upon

individual patients' and administrative needs and priorities, to further help them ease into the HCT implementation procedures without any further strains and burdens on the system and exhaustion of the staff involved.

Sooner SUCCESS will assist participating pilot sites with the introduction of a written policy and sharing that policy with families that have children between the ages of 12-22 years of age and the staff (both pediatricians and administrative) at both clinics. Sooner SUCCESS will encourage providers to track and monitor transition progress and to conduct transition readiness assessments with youth and parents/caregiver. Sooner SUCCESS will encourage providers to develop a plan of care, emergency care plan, medical summary, condition fact sheet, care checklist and transfer letter. The ultimate goal will be to achieve the transfer completion for families in collaboration with an adult provider.

Readiness assessments for families will be monitored on REDCap by Maleeha Shahid (research analyst) at Sooner SUCCESS and attending physicians to pediatric population. Resulting data will be collected on REDCap, a database that is HIPPA compliant. Required analysis will be done using R- software. Electronic web-based reports for aggregated results will be published using a wide variety of analytics tools.

OKFS360° will continue to support the HCT subcommittee and bring the voice of Hispanic families. Additionally, FS360° staff will continue to collaborate with the Center for Learning and Leadership (CLL) and with Oklahoma Family Network's Pediatric Residents' Advocacy rotation to bring awareness to the challenges families face with healthcare transition.

OFN will partner with The Children's Hospital at Saint Francis in Tulsa and OSU-Center for Health Sciences Psychiatry and Behavioral Sciences Department to promote and assist in establishing health care transition goals for their institutions and their patient populations.

Sickle Cell Disease Program will continue to participate in pilot studies as needed or requested.

Both of the OITP clinics – Oklahoma Transition Clinic and PremieR Clinic host fellows, residents, and students as they complete their pediatric clinical requirements. OITPS plans to increase their exposure and allow them a unique look at the needs and resources available for the families making the transition to a medical home.

OITP will continued expanding developmental testing at three, six and nine months for patients who have experienced neuro trauma and/or hypothermic cooling.

OITP will initiate a parent questionnaire to determine mental health needs, unique family coping behavior, financial needs (if applicable), transportation needs, childcare needs, etc. Once the data is collected, OITP will determine the needs of the family prior to leaving the clinic and develop discharge or post discharge education.

**Objective 5: Develop a plan to increase healthcare transition awareness among the CYSHCN population, to include addressing health disparities for CYSHCN, by 2022.**

OKFS360° will continue to share information about activities that promote self-care, independence and self-determination for transitioning youth, particularly Hispanic youth. OKFS360° will make referrals to programs like The Youth Leadership Forum. OKFS360° will continue to help bring awareness about transition services and tools to Hispanic CYSCHN, such as the Got Transition website and the Sooner SUCCESS toolkit when available.

OKFS360° will continue to share the one-page Quick Tips to Healthcare Transition bilingual document developed by

OFFS360°/CLL to share with families enrolled at the Center. The Quick Tips one-page document will be posted to the OKF360° webpage within the Center for Learning and Leadership's website. OKFS360° will track and report visits through Google analytics for data purposes.

OFN will support the Title V lead (Sooner SUCCESS) in this area by identifying families to be involved.

The Sickle Cell Disease social worker will help to identify families who may be able to help develop a plan to address health disparities.

OITP will consider becoming a "Early Bird" center. OITP will need funds to provide the literature and developmental toys for the NICU families that participate. OITP will need $2000 to start the program and space within the OUHSC campus to hold classes. Two of the OITP staff have begun training.

**NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.**

**Objective 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.**

OKFS360° will continue to be a one stop for Spanish speaking families by providing the one on one supports they need. OKFS360° Center is located at the Oklahoma University Health Sciences Center and is a block away from the OU Children's Hospital and specialty clinics. This location makes it accessible for Spanish speaking families with CSHCN who are in need of care coordination and family advocacy.

OKFS360° will continue to build capacity within the families served in order to help them become more self-sufficient and better equipped to make wiser choices for their children and youth by providing opportunities for learning through trainings such as health care notebook, ABA for families and advocacy for families.

OFN will support a minimum of 100 participants in preparing Health Care Notebooks; OFN will provide the Joining Forces: Supporting Family Professional Partnerships Conference for a minimum of 150 participants; OFN will provide advocacy/leadership training for a minimum of 50 participants; OFN will provide 1:1 support to a minimum of 300 families and 75 professionals.

OFN will develop a family-centered educational tool for parents regarding a medical home for use in Neonatal and Pediatric Intensive Care Units and for those accessing health care services via Medicaid.

Sickle Cell Clinic will continue to help patients/families identify a medical home (primary care provider), especially prior to transition to adult hematology provider.

Sickle Cell Clinic will continue to provide resources, educational materials and treatment summaries to help in coordination of care.

OITP will coordinate with case management and physicians to identify patients and families a week prior to discharge to assess knowledge base of infant's disease process and resources needed to transition to a medical home.

OITP will develop online videos for discharge teaching that can be accessed by parents prior to discharge and after

discharge as a reference during the transition to home based care. Topics may include oxygen use at home, CPR refresher, troubleshooting the home monitors as well as mental health topics, as parents are usually stressed once home and caring for their child 100%.

**OBJECTIVE 2: Develop at least 2 trainings for health care providers to improve care integration and cross provider communication using evidence-based tools by 2022.**

Oklahoma Family Support 360° Center (OKFS360°) will create and evaluate a training for Family Medicine residents if the opportunity arises.

OITP will set guidelines for telemedicine/virtual visits and begin to train physicians in the use of telemedicine. OITP will coordinate with the billing department to train physicians in the correct billing for telemedicine.

OITP will be adding transition clinic services to Comanche County Hospital (Lawton) via telemedicine

**SPM 3: The percent of families who are able to access services for their child with behavioral health needs.**

**Objective 1: 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.**

OKFS360° will continue to bring awareness to the families enrolled at the Center and to the Hispanic support groups in the community about mental health and the benefits of behavioral health support.

OKFS360° will continue partnering with service medical providers, including Advanced Behavioral clinic, to provide information and trainings to Hispanic families about mental health. The information will be provided in their primary language to better support their children. Additionally, OKFS360° will support families with referrals for evaluations and treatment and connect them with behavioral and mental health services.

OFN will connect 100 or more families with behavioral health services through Regional Family Support Partners and will provide leadership and partnership skills education to at least 25 families with children with behavioral health needs to ensure family voice at all levels of their decision making process.

OFN will work together with at least three school districts in partnership with behavioral health providers in their area to provide added supports to families of children in their school districts experiencing behaviors, anxiety and other mental health concerns.

OFN will actively engage in five counties' infant or early childhood activities and/or coalitions.

The JumpStart Family Partner plans to expand the newly developed Community Talk Zoom sessions for Spanish-speaking families by hosting a similar meeting for all families to help assist or navigate services.

Family Partners will work towards the goal of more fully implementing regular follow-ups with all families after their initial visit. The plan is to utilize a simplified questionnaire to obtain feedback by phone from families approximately 4-6 weeks after their appointment. If implemented, this will allow the team to 1) obtain family input about their JumpStart evaluation and feedback session, 2) discern what recommended resources/services they have already accessed as a result of the JumpStart evaluation and 3) elicit any further areas of resource access/other concerns

with which the Family Partner or other JumpStart team members can assist.

The JumpStart Family Partner/Sooner SUCCESS Oklahoma County Coordinator will continue to be staffed by someone bilingual in Spanish and English with experience in serving as an interpreter for developmental assessments. The plan is to explore specific strategies to improve strengthening communication and connection between Child Study Center and the Latino Community Development Agency to provide more direct, comprehensive follow-up services for Spanish-speaking families seen in JumpStart.

The JumpStart Family Partner/Sooner SUCCESS Oklahoma County Coordinator will collaborate with JumpStart and other clinical, research, and training programs in DBP Section as needed to strengthen support of families throughout our programs.

JumpStart Clinic and Oklahoma LEND program are developing a new Mobile Autism Clinic designed to increase outreach to families in underserved communities and the plan is to engage the JumpStart Family Partner in the planning process.

The Sickle Cell Disease Social Worker will continue to meet with all patients/families at least twice per year. Sickle Cell Clinic will continue to make a psychologist and licensed counselor available to all patients with sickle cell disease for counseling services. They will meet with patients at least annually. They will continue to provide behavioral and mental health services to the Clinic patients and families as well as to provide referrals for neuropsychological testing, counseling services, cognitive behavioral therapies and psychiatry.

Sickle Cell Clinic will continue to work to increase the number of patients receiving counseling and psychology services.

J.D. McCarty Center plans to continue providing respite care services and free therapeutic services screenings to as many children and their families as possible. There are strict guidelines and screenings for all staff in order to help keep patients safe but as the COVID 19 numbers decline, J.D. McCarty will begin lifting some of the guidelines and screening restrictions. This should help bring more Direct Care Staff to the Center. Additionally, recruiting will begin to help bring in more staff once the pandemic starts to subside.

OITP will continue to develop discussion groups for parents in the NICU to discuss and receive resources and/or counceling for behavioral health issues that parents may be experiencing as part of a family with a medically fragile infant. Family education regarding the importance of family behavioral health and maternal mood disorder will be included in the discussion groups. OITP will develop resources and interactive play for siblings in a family of a medically fragile child.

OITP will help parents recognize the signs of sibling stress and behavoiral issues that may arise in the family of a medically fragile child. OITP will allow parents to discuss behavorial issues with behavorial counselors who can help parents and the entire family cope with the stress of a child with special needs.

**Cross-Cutting/Systems Building**

**State Action Plan Table**

| State Action Plan Table (Oklahoma) - Cross-Cutting/Systems Building - Entry 1 |
|---|
| Priority Need |
| Improve access to social workers and support systems throughout the state |
| Objectives |
| Implement a fatherhood initiative project in at least three new counties by 2023. |
| Strategies |
| 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. |
| Utilize reporting from counties in the project to inform the design and implementation of the expansion of the fatherhood project. |

**Objective: Implement a fatherhood initiative project in at least three pilot counties.**

**Data:**
One pilot county was able to begin implementation. Although due to COVID-19, activities were halted before curriculum completion.

**Successes:**
The MCH fatherhood initiative pilot project was set to begin in three counties with an expansion into a new county that had not yet been engaged in this initiative. As in prior years, the goals in each area were to locate and identify fathers at the county level who wanted to enhance their capacities as fathers. Additionally, there was a desire to empower fathers to increase their level of engagement and increase the quality of co-parenting with the mother of their child(ren) or another primary caregiver.

The design of the project continued to be a partnership between a county health educator or other qualified community engagement professional with a representative of a local community coalition. In each of the three counties there was a health department employee and community partner trained as a team. The pilot project was structured as a state-county partnership with a disbursement of funds from the state office to county-level applicants for administration of the project. In two of the three counties, the project leads did not change from the year prior and so were already trained. The assessment instruments for the project did change, utilizing feedback collected from the prior year's project, so that they were simpler and more compact for participant use and comprehension.

In the one county that had not yet implemented the project, the MCH project lead (also a certified trainer of the evidence-based *On My Shoulders* fatherhood curriculum) trained facilitators for the curriculum on-site in January 2020. The new facilitators were also trained in the documentation and reporting structure. These reporting documents included a local needs assessment, Fatherhood Engagement, Co-parenting Relationship, and the forms for participant and facilitator feedback at the end of the 14-unit curriculum.

All pilot sites engaged in the planning and process, but only the new county was able to conduct outreach into their community, obtain project participants, and host several meetings. This site utilized participants from the community and hosted their project at a local community center. Although only 2 of the 14 units could be completed, due to operations ceasing after COVID-19 began to spread, the facilitators reported their participants were very engaged in the project and were eager to continue.

**Challenges:**
The effect that the COVID-19 virus had in halting implementation during this cycle cannot be overstated. Each county that had agreed to continue or host new facilitators of the project was placed on hold by the end of March 2020 due to concern over participant and facilitator safety. Identifying and retaining participants for the project had been a consistent challenge in the past, and COVID stopped two of the three projects before they could even start enrolling participants. Unlike other MCH projects, this one remained difficult to facilitate for several reasons. First, the recruitment phase of the project presented difficulties for engaging participants who were not in a congregant setting as this required in-person community engagement. Secondly, the congregant settings were some of the largest places of virus transmission, and as such were not safe spaces. Potentially, the most important reason was that this project did not have an easily transferrable virtual version, because the curriculum was designed to be facilitated in-person with pen and paper workbooks and assessment instruments. And, lastly, because our facilitators were health department employees they were redirected to COVID-19 response and were unavailable to staff this project after March 14, 2020.

**Cross-Cutting/Systems Building - Application Year**

**Objective: Implement a fatherhood initiative project in at least three pilot counties.**

The fatherhood project will continue, although due to continued COVID-19 response taking priority with all of the trained facilitators it is likely that the project will be postponed until the majority of the vaccine rollout in the state has been completed. The configuration of the project will have to be built on the currently trained facilitators as resources will not be available to expand trained facilitators beyond those who have already been trained.

The bi-monthly newsletter, begun in March 2021 and well received by facilitators, will continue and plans to grow distribution to increase the engagement of the target participant population will be made.

Discussions to expand the project's operation and scope beyond the current counties will continue, pending additional funding in 2022.

### III.F. Public Input

Input into the Maternal and Child Health Services (MCH) Title V Block Grant (needs assessment, priorities, programs, and activities) is typically sought on a routine basis. The Oklahoma Title V Program engages families, consumers, public and private sector organizations, and other stakeholders at the state and community levels in continuous processes to assure the needs of the maternal and child health population are identified and addressed.

Oklahoma provides access for public input to the MCH Title V Block Grant throughout the year via an active link to the federal Maternal and Child Health Bureau (MCHB), Title V Information System (TVIS) website. This active link titled, Title V Program, is found on the MCH web page, https://www.ok.gov/health/Family_Health/Maternal_and_Child_Health_Service/index.html, on the Oklahoma State Department of Health's (OSDH) website. Information on how the public may forward input on the grant is provided on the MCH web page under the active link. A one-page description of the MCH Title V Block Grant and the Title V priorities in the state has also been created and is available on the MCH web page. The CSHCN, Oklahoma Department of Human Services (OKDHS), has a link to the OSDH MCH web page on the CSHCN web page, http://www.okdhs.org/services/health/Pages/default4.aspx on the OKDHS website, with a request for public comment. Hard copies and pdfs of the MCH Title V Block Grant are also provided on request to MCH.

Public input via e-mail and telephone calls was received intermittently throughout the year. To date, calls and e-mails have been received requesting more program information about MCH and several seeking details on COVID-19 information for schools and programs, infant mortality, maternal mortality, access to healthcare, and midwifery, from parents, media and other public health professionals. Questions were answered and contact information was given for follow-up with the appropriate program or data person. MCH and CSHCN use these calls and e-mails to determine better ways to seek feedback from the public, and for the evaluation, planning, and development of policies, procedures, and services that are reported and described in the MCH Title V Block Grant annual report and application.

Due to the pandemic, many of the ways MCH and CSHCN collect public input (customer surveys, listening sessions, public meetings and trainings) were not feasible. Efforts to mitigate the COVID-19 virus became the primary focus of communication for many months. Staff in the county health departments were working the front lines of the pandemic and almost all MCH Central Office staff assisted in pandemic response as well.

With current rates of virus transmission in the state, it is hoped that more interaction with the public can occur and input into needs and priorities for the MCH population can be actively sought once again. In the meantime, staff will continue to assist in pandemic response efforts, program activity where possible and engaging with the public using online forums and social media.

A new communication campaign (TV, radio, internet and Facebook ads) highlighting pregnancy and maternal health care has shown promising results in getting the public to call and review the MCH website for more information. This campaign will continue with a variety of topics, teen pregnancy prevention, infant safety, bullying prevention, over the next year with the hopes of educating and engaging the public. Information gleaned from the campaign and its successes and challenges will be used to inform our MCH priorities and strategies moving forward.

### III.G. Technical Assistance

At this time, Oklahoma is not requesting technical assistance. The assistance Oklahoma received from MCHB for the planning and coordination of the 2021 Virtual Adolescent Health Summit was invaluable in planning a meaningful and interactive, youth-centered conference for youth-serving professionals.

## IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - DHS_OSDH_Medicaid agreements combo.pdf

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MCH_CSHCN MOA FFY22.pdf

Supporting Document #02 - Acronyms_2021 OK.pdf

Supporting Document #03 - Title V Bio Sketches OK.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Charts for Title V OK.pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: Oklahoma**

| | FY 22 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 7,215,434 | |
| A. Preventive and Primary Care for Children | $ 2,381,094 | (33%) |
| B. Children with Special Health Care Needs | $ 2,164,631 | (30%) |
| C. Title V Administrative Costs | $ 721,542 | (10%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 5,267,267 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 5,411,576 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 0 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 5,411,576 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 4,684,317 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 12,627,010 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | |
| 10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9) | $ 8,025,771 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 20,652,781 | |

| OTHER FEDERAL FUNDS | FY 22 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 655,696 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS) | $ 100,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 160,020 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program | $ 2,010,055 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 5,000,000 |

| | FY 20 Annual Report Budgeted | | FY 20 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 7,407,455 | | $ 7,215,434 | |
| A. Preventive and Primary Care for Children | $ 2,476,336 | (33.4%) | $ 2,353,217 | (32.6%) |
| B. Children with Special Health Care Needs | $ 2,222,237 | (30%) | $ 2,166,556 | (30%) |
| C. Title V Administrative Costs | $ 740,745 | (10%) | $ 719,616 | (10%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 5,439,318 | | $ 5,239,389 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 5,578,263 | | $ 6,120,077 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | | $ 1,220,999 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 1,196 | | $ 0 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 5,579,459 | | $ 7,341,076 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 4,684,317 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 12,986,914 | | $ 14,556,510 | |
| 9. OTHER FEDERAL FUNDS<br>Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2. | | | | |
| 10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9) | $ 5,361,987 | | $ 7,771,094 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 18,348,901 | | $ 22,327,604 | |

| OTHER FEDERAL FUNDS | FY 20 Annual Report Budgeted | FY 20 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 653,167 | $ 653,167 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS) | $ 100,000 | $ 100,000 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 100,000 | $ 100,000 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 3,500,000 | $ 5,000,000 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 157,500 | $ 157,500 |
| Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens | $ 851,320 | $ 761,320 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program | | $ 999,107 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **4. LOCAL MCH FUNDS** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Funds are based on Contractor contributions, which can change from year to year are no longer required for some categories. | |
| 2. | **Field Name:** | **6. PROGRAM INCOME** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Actual expenditures have decreased due to less revenue generated at the state level. There was no program income recognized in FY20. | |

**Data Alerts: None**

## Form 3a
## Budget and Expenditure Details by Types of Individuals Served

**State: Oklahoma**

### I. TYPES OF INDIVIDUALS SERVED

| IA. Federal MCH Block Grant | FY 22 Application Budgeted | FY 20 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 784,282 | $ 795,506 |
| 2. Infants < 1 year | $ 1,163,885 | $ 1,180,539 |
| 3. Children 1 through 21 Years | $ 2,381,094 | $ 2,353,217 |
| 4. CSHCN | $ 2,164,631 | $ 2,166,556 |
| 5. All Others | $ 0 | $ 0 |
| Federal Total of Individuals Served | $ 6,493,892 | $ 6,495,818 |

| IB. Non-Federal MCH Block Grant | FY 22 Application Budgeted | FY 20 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 142,528 | $ 218,339 |
| 2. Infants < 1 year | $ 971,937 | $ 1,488,912 |
| 3. Children 1 through 21 Years | $ 2,493,253 | $ 3,819,418 |
| 4. CSHCN | $ 1,803,858 | $ 1,814,407 |
| 5. All Others | $ 0 | $ 0 |
| Non-Federal Total of Individuals Served | $ 5,411,576 | $ 7,341,076 |
| Federal State MCH Block Grant Partnership Total | $ 11,905,468 | $ 13,836,894 |

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

None

**Data Alerts: None**

## Form 3b
## Budget and Expenditure Details by Types of Services

**State: Oklahoma**

### II. TYPES OF SERVICES

| IIA. Federal MCH Block Grant | FY 22 Application Budgeted | FY 20 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 2,153,804 | $ 2,153,804 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 484,326 | $ 484,326 |
| B. Preventive and Primary Care Services for Children | $ 0 | $ 0 |
| C. Services for CSHCN | $ 1,669,478 | $ 1,669,478 |
| 2. Enabling Services | $ 1,502,451 | $ 1,502,451 |
| 3. Public Health Services and Systems | $ 3,559,179 | $ 3,559,179 |
| 4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 19,603 |
| Physician/Office Services | | $ 0 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 1,544,803 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 105,072 |
| Laboratory Services | | $ 484,326 |
| Direct Services Line 4 Expended Total | | $ 2,153,804 |
| **Federal Total** | $ 7,215,434 | $ 7,215,434 |

| IIB. Non-Federal MCH Block Grant | FY 22 Application Budgeted | FY 20 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 1,708,832 | $ 2,318,117 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 748,699 | $ 1,015,648 |
| B. Preventive and Primary Care Services for Children | $ 58,908 | $ 79,912 |
| C. Services for CSHCN | $ 901,225 | $ 1,222,557 |
| 2. Enabling Services | $ 3,102,052 | $ 4,208,091 |
| 3. Public Health Services and Systems | $ 600,692 | $ 814,868 |
| 4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 14,788 |
| Physician/Office Services | | $ 438,227 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 1,128,504 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 79,265 |
| Laboratory Services | | $ 657,333 |
| Direct Services Line 4 Expended Total | | $ 2,318,117 |
| **Non-Federal Total** | $ 5,411,576 | $ 7,341,076 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

## Form 4
## Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

**State: Oklahoma**

**Total Births by Occurrence: 49,143** **Data Source Year: 2019**

**1. Core RUSP Conditions**

Aggregate Data Not Available

**2. Other Newborn Screening Tests**

| Program Name | (A) Total Number Receiving at Least One Screen | (B) Total Number Presumptive Positive Screens | (C) Total Number Confirmed Cases | (D) Total Number Referred for Treatment |
|---|---|---|---|---|
| Phenyketonuria | 49,143 (100.0%) | 7 | 3 | 3 (100.0%) |
| Congenital Hypothyroidism | 49,143 (100.0%) | 62 | 33 | 33 (100.0%) |
| Galactosemia | 49,143 (100.0%) | 9 | 0 | 0 (0%) |
| Sickle Cell Disease | 49,143 (100.0%) | 23 | 20 | 18 (90.0%) |
| Congenital Adrenal Hyperplasia | 49,143 (100.0%) | 4 | 3 | 3 (100.0%) |
| Biotinidase Deficiency | 49,143 (100.0%) | 6 | 5 | 5 (100.0%) |
| Cystic Fibrosis | 49,143 (100.0%) | 11 | 11 | 11 (100.0%) |
| Sickle Cell Trait | 49,143 (100.0%) | 187 | 187 | 0 (0.0%) |
| Very Long-Chain Acyl-CoA Dehydrogenase Deficiency | 49,143 (100.0%) | 6 | 2 | 2 (100.0%) |
| Medium-Chain Acyl-CoA Dehydrogenase Deficiency | 49,143 (100.0%) | 7 | 6 | 6 (100.0%) |
| Short-Chain Acyl-CoA Dehydrogenase Deficiency/Glutaric Aciduria Type II | 49,143 (100.0%) | 7 | 5 | 0 (0.0%) |

| Program Name | (A) Total Number Receiving at Least One Screen | (B) Total Number Presumptive Positive Screens | (C) Total Number Confirmed Cases | (D) Total Number Referred for Treatment |
|---|---|---|---|---|
| Citrullinemia/Argininosuccinic Acidemia | 49,143 (100.0%) | 8 | 2 | 2 (100.0%) |
| Tyrosinemia | 49,143 (100.0%) | 12 | 0 | 0 (0%) |
| Proprionic/Methylmalonic Acidemia | 49,143 (100.0%) | 4 | 0 | 0 (0%) |
| Glutaric Aciduria Type I | 49,143 (100.0%) | 3 | 2 | 2 (100.0%) |
| "3-methylcrotonyl-CoA carboxylase (3MCC) deficiency (infant or mother); 3-hydroxy-3-methylglutaryl ( | 49,143 (100.0%) | 4 | 1 | 1 (100.0%) |
| Carnitine Palmitoyltransferase I Deficiency | 49,143 (100.0%) | 5 | 0 | 0 (0%) |
| Carnitine Uptake Defect | 49,143 (100.0%) | 0 | 0 | 0 (0%) |
| Homocystinuria | 49,143 (100.0%) | 1 | 0 | 0 (0%) |
| Isovaleric Acidemia | 49,143 (100.0%) | 1 | 0 | 0 (0%) |
| Maple Syrup Urine Disease | 49,143 (100.0%) | 0 | 0 | 0 (0%) |
| Carnitine Acylcarnitine Translocase Deficiency (CACT) | 49,143 (100.0%) | 7 | 0 | 0 (0%) |
| Malonic Aciduria | 49,143 (100.0%) | 3 | 0 | 0 (0%) |
| Severe Combined Immunodeficiency | 49,143 (100.0%) | 8 | 0 | 0 (0%) |

**3. Screening Programs for Older Children & Women**

None

### 4. Long-Term Follow-Up

The Oklahoma Newborn Screening Program (NSP) provides contracted services for long-term follow-up for infants identified with a metabolic, endocrine, dietary management and transition for hemoglobinopathies. The NSP collaborates with nurses who provide long-term management for cystic fibrosis and hemoglobinopathies that are funded by other entities. Children diagnosed through newborn screening continue to receive long-term follow-up services until 21 years of age, except for children identified with congenital hypothyroidism who are followed up through age five. Care coordination services include education to families, establishing and maintaining children in a medical home, addressing barriers to care, monitoring morbidity and mortality of referred children. Information collected includes diagnosis, genetic counseling, service referrals, barriers to care, annual performance assessments, growth development, ER visits, and compliance with medication regimen.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Aggregate Data Not Available** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Aggregate Data Not Available Notes** |
| | **Field Note:** Aggregate data unavailable for core conditions. Data are entered individually for conditions screened by Oklahoma's newborn screening program. | |
| 2. | **Field Name:** | **Sickle Cell Disease - Total Number Referred For Treatment** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** Individuals identified with Sickle Cell C disease do not require treatment. | |
| 3. | **Field Name:** | **Sickle Cell Trait - Total Number Referred For Treatment** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** Sickle cell trait individuals are identified as carriers for sickle cell disease; therefore, they do not exhibit symptoms or have the disease. These results are never considered presumptive results as the result does not indicate possible disease status, only carrier status. | |
| 4. | **Field Name:** | **Short-Chain Acyl-CoA Dehydrogenase Deficiency/Glutaric Aciduria Type II - Total Number Referred For Treatment** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Other Newborn** |
| | **Field Note:** Precautions only were taken for those not referred for treatment. | |

**Data Alerts: None**

## Form 5
## Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

**State: Oklahoma**

**Annual Report Year 2020**

### Form 5a – Count of Individuals Served by Title V
### (Direct & Enabling Services Only)

| | | Primary Source of Coverage | | | | |
|---|---|---|---|---|---|---|
| Types Of Individuals Served | (A) Title V Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private / Other % | (E) None % | (F) Unknown % |
| 1. Pregnant Women | 49,143 | 51.0 | 0.0 | 47.0 | 2.0 | 0.0 |
| 2. Infants < 1 Year of Age | 49,143 | 51.0 | 0.0 | 47.0 | 2.0 | 0.0 |
| 3. Children 1 through 21 Years of Age | 69,279 | 36.0 | 0.0 | 56.0 | 8.0 | 0.0 |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | 2,076 | 58.0 | 0.0 | 34.0 | 8.0 | 0.0 |
| 4. Others | 512 | 9.0 | 0.0 | 77.0 | 14.0 | 0.0 |
| Total | 168,077 | | | | | |

### Form 5b – Total Percentage of Populations Served by Title V
### (Direct, Enabling, and Public Health Services and Systems)

| Populations Served by Title V | Reference Data | Used Reference Data? | Denominator | Total % Served | Form 5b Count (Calculated) | Form 5a Count |
|---|---|---|---|---|---|---|
| 1. Pregnant Women | 49,143 | No | 76,172 | 80.0 | 60,938 | 49,143 |
| 2. Infants < 1 Year of Age | 47,667 | No | 49,143 | 100.0 | 49,143 | 49,143 |
| 3. Children 1 through 21 Years of Age | 1,120,063 | Yes | 1,120,063 | 35.0 | 392,022 | 69,279 |
| 3a. Children with Special Health Care Needs 0 through 21 years of age^ | 267,588 | Yes | 267,588 | 22.0 | 58,869 | 2,076 |
| 4. Others | 2,788,466 | Yes | 2,788,466 | 10.0 | 278,847 | 512 |

^Represents a subset of all infants and children.

**Form Notes for Form 5:**

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Number of pregnant women reflects those delivering a live birth in Oklahoma in 2019.<br>Source: Oklahoma vital statistics, 2019. | |
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Figure reflects the number of live births in Oklahoma in 2019.<br>Source: Oklahoma vital statistics, 2019. | |
| 3. | **Field Name:** | **Children 1 through 21 Years of Age** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Enumeration reflects program efforts in Period of Purple Crying, The Oklahoma Toddler Survey, Youth Risk Behavior Survey, Personal Responsibility Education Program, MCH school health activities, child safety seat installations, county teen pregnancy prevention. | |
| 4. | **Field Name:** | **Children with Special Health Care Needs 0 through 21 Years of Age** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Estimate obtained via FFY2020 Partner Survey, indicating 2,076 CSHCN were served by Title V programs. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>MCH Title V programs provide services to small percentage of individuals through maternity services and the Fatherhood Initiative. | |

**Field Level Notes for Form 5b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>For the denominator, the number of pregnant women in the state is estimated by multiplying the number of live births by an inflation factor of 1.55. This inflation factor is based on CDC methodology. | |
| 2. | **Field Name:** | **InfantsLess Than One Year** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>MCH holds that all infants in Oklahoma are served by the Title V Program. Service is provided through newborn screening, safe sleep programs, becoming baby-friendly initiatives, and infant injury prevention efforts (period of purple crying). | |
| 3. | **Field Name:** | **Children 1 Through 21 Years of Age** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Enumeration reflects program efforts for Period of Purple Crying, The Oklahoma Toddler Survey, Youth Risk Behavior Survey, Personal Responsibility Education Program, MCH school health activities, child safety seat installations, and county teen pregnancy prevention. | |
| 4. | **Field Name:** | **Children with Special Health Care Needs 0 through 21 Years of Age** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Reflects services from OSDH and partner agencies, including Sooner SUCCESS, Oklahoma Family Network, Oklahoma Family Support 360, Oklahoma Infant Transition Program, Sickle Cell Clinic, Family Partners, and JD McCarty. In addition, children received enabling services through TEFRA and children received population-based services through Supplemental Security Income (SSI).<br>Title V representatives continue to encourage partners to reach out to families in under-served populations by speaking at family support groups, attending local health conferences that address children with special health care needs, and handing out family-informed brochures that provide information about Title V services and resources. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2020** |
| | **Field Note:**<br>Figure reflects male family planning clients and those participating in the MCH fatherhood initiative. | |

**Data Alerts:**

| | |
|---|---|
| 1. | Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count. |

## Form 6
## Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

**State: Oklahoma**

**Annual Report Year 2020**

### I. Unduplicated Count by Race/Ethnicity

| | (A) Total | (B) Non-Hispanic White | (C) Non-Hispanic Black or African American | (D) Hispanic | (E) Non-Hispanic American Indian or Native Alaskan | (F) Non-Hispanic Asian | (G) Non-Hispanic Native Hawaiian or Other Pacific Islander | (H) Non-Hispanic Multiple Race | (I) Other & Unknown |
|---|---|---|---|---|---|---|---|---|---|
| 1. Total Deliveries in State | 49,143 | 27,367 | 4,093 | 7,776 | 4,652 | 1,474 | 0 | 0 | 3,781 |
| Title V Served | 49,143 | 27,367 | 4,093 | 7,776 | 4,652 | 1,474 | 0 | 0 | 3,781 |
| Eligible for Title XIX | 32,119 | 17,020 | 3,029 | 6,057 | 3,337 | 761 | 0 | 0 | 1,915 |
| 2. Total Infants in State | 49,143 | 29,412 | 4,932 | 7,768 | 5,450 | 1,573 | 0 | 0 | 8 |
| Title V Served | 37,667 | 22,366 | 3,699 | 5,826 | 4,088 | 1,682 | 0 | 0 | 6 |
| Eligible for Title XIX | 28,012 | 16,764 | 2,811 | 4,428 | 3,107 | 897 | 0 | 0 | 5 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2. Total Infants in State** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Total** |

**Field Note:**
Numbers reflect live births for the years 2019. Enumeration of Non-Hispanic Asian infants includes Non-Hispanic Native Hawaiian or Other Pacific Islander.
Source: Oklahoma vital statistics

## Form 7
## State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

**State: Oklahoma**

| A. State MCH Toll-Free Telephone Lines | 2022 Application Year | 2020 Annual Report Year |
|---|---|---|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (877) 362-1606 | (877) 362-1606 |
| 2. State MCH Toll-Free "Hotline" Name | Heartline 2-1-1 Oklahoma | Heartline 2-1-1 Oklahoma |
| 3. Name of Contact Person for State MCH "Hotline" | Margi Preston | Margi Preston |
| 4. Contact Person's Telephone Number | (405) 840-9396 | (405) 840-9336 |
| 5. Number of Calls Received on the State MCH "Hotline" | | 162,351 |

| B. Other Appropriate Methods | 2022 Application Year | 2020 Annual Report Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | 2-1-1 Helpline Oklahoma | 2-1-1 Helpline Oklahoma |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | 156,436 |
| 3. State Title V Program Website Address | www.oklahoma.gov/health/family-health/maternal-and-child-health-services.html | www.oklahoma.gov/health/family-health/maternal-and-child-service.html |
| 4. Number of Hits to the State Title V Program Website | | 3,121 |
| 5. State Title V Social Media Websites | www.facebook.com/OKMaternalAndChildHealth | www.facebook.com/OKMaternalAndChildHealth |
| 6. Number of Hits to the State Title V Program Social Media Websites | | 437 |

**Form Notes for Form 7:**

None

## Form 8
## State MCH and CSHCN Directors Contact Information

**State: Oklahoma**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | Joyce Marshall |
| Title | MCH Title V Director |
| Address 1 | 123 Robert S Kerr |
| Address 2 | |
| City/State/Zip | Oklahoma City / OK / 73102 |
| Telephone | (405) 426-8113 |
| Extension | |
| Email | joycem@health.ok.gov |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Carla McCarrell-Williams |
| Title | CSHCN Title V Director |
| Address 1 | 2400 N Lincoln |
| Address 2 | |
| City/State/Zip | Oklahoma City / OK / 73117 |
| Telephone | (580) 471-1990 |
| Extension | |
| Email | Carla.McCarrell-Williams@okdhs.org |

| 3. State Family or Youth Leader (Optional) | |
|---|---|
| Name | Joni Bruce |
| Title | Executive Director |
| Address 1 | Oklahoma Family Network |
| Address 2 | 800 NE 15th St |
| City/State/Zip | Oklahoma City / OK / 73104 |
| Telephone | (405) 203-8745 |
| Extension | |
| Email | joni-bruce@oklahomafamilynetwork.org |

**Form Notes for Form 8:**

None

## Form 9
## List of MCH Priority Needs

**State: Oklahoma**

**Application Year 2022**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Reduce infant mortality | Continued |
| 2. | Improve the health of reproductive age individuals | Continued |
| 3. | Improve access to social workers and support systems throughout the state | Continued |
| 4. | Improve quality health education for children and youth | Continued |
| 5. | Improve the mental and behavioral health of the MCH population | Continued |
| 6. | Improve access to family-centered programs via family support navigators | Continued |
| 7. | Increase quality health care access for the MCH population | Continued |
| 8. | Increase health equity for the MCH population | Continued |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 9 State Priorities – Needs Assessment Year – Application Year 2021**

| No. | Priority Need | Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period) |
|---|---|---|
| 1. | Reduce infant mortality | Continued |
| 2. | Improve the health of reproductive age individuals | New |
| 3. | Improve access to social workers and support systems throughout the state | New |
| 4. | Improve quality health education for children and youth | New |
| 5. | Improve the mental and behavioral health of the MCH population | New |
| 6. | Improve access to family-centered programs via family support navigators | New |
| 7. | Increase quality health care access for the MCH population | New |
| 8. | Increase health equity for the MCH population | New |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

## Form 10
## National Outcome Measures (NOMs)

**State: Oklahoma**

**Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.**

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 76.1 % | 0.2 % | 36,988 | 48,613 |
| 2018 | 75.1 % | 0.2 % | 36,572 | 48,723 |
| 2017 | 74.2 % | 0.2 % | 36,389 | 49,046 |
| 2016 | 72.8 % | 0.2 % | 37,411 | 51,405 |
| 2015 | 74.6 % | 0.2 % | 38,719 | 51,929 |
| 2014 | 72.8 % | 0.2 % | 37,398 | 51,352 |
| 2013 | 69.1 % | 0.2 % | 34,413 | 49,834 |
| 2012 | 68.7 % | 0.2 % | 34,280 | 49,900 |
| 2011 | 66.6 % | 0.2 % | 32,996 | 49,577 |
| 2010 | 65.5 % | 0.2 % | 33,170 | 50,613 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

**NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 73.0 | 4.0 | 333 | 45,618 |
| 2017 | 76.5 | 4.1 | 356 | 46,515 |
| 2016 | 65.9 | 3.7 | 320 | 48,535 |
| 2015 | 63.9 | 4.2 | 234 | 36,612 |
| 2014 | 64.1 | 3.7 | 308 | 48,041 |
| 2013 | 59.0 | 3.5 | 285 | 48,339 |
| 2012 | 60.0 | 3.5 | 293 | 48,843 |
| 2011 | 62.5 | 3.6 | 303 | 48,453 |
| 2010 | 52.6 | 3.3 | 259 | 49,274 |
| 2009 | 55.7 | 3.3 | 282 | 50,672 |
| 2008 | 49.2 | 3.1 | 249 | 50,585 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 2 - Notes:**

None

**Data Alerts: None**

**NOM 3 - Maternal mortality rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015_2019 | 23.5 | 3.0 | 60 | 254,871 |
| 2014_2018 | 22.4 | 2.9 | 58 | 259,067 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts: None**

**NOM 4 - Percent of low birth weight deliveries (<2,500 grams)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 8.2 % | 0.1 % | 4,045 | 49,112 |
| 2018 | 8.3 % | 0.1 % | 4,115 | 49,771 |
| 2017 | 8.1 % | 0.1 % | 4,085 | 50,193 |
| 2016 | 7.8 % | 0.1 % | 4,110 | 52,547 |
| 2015 | 7.9 % | 0.1 % | 4,172 | 53,066 |
| 2014 | 8.0 % | 0.1 % | 4,238 | 53,307 |
| 2013 | 8.1 % | 0.1 % | 4,297 | 53,341 |
| 2012 | 8.0 % | 0.1 % | 4,200 | 52,697 |
| 2011 | 8.5 % | 0.1 % | 4,431 | 52,242 |
| 2010 | 8.4 % | 0.1 % | 4,458 | 53,206 |
| 2009 | 8.4 % | 0.1 % | 4,558 | 54,453 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 4 - Notes:**

None

**Data Alerts: None**

**NOM 5 - Percent of preterm births (<37 weeks)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 11.5 % | 0.1 % | 5,646 | 49,121 |
| 2018 | 11.4 % | 0.1 % | 5,670 | 49,774 |
| 2017 | 11.1 % | 0.1 % | 5,592 | 50,187 |
| 2016 | 10.6 % | 0.1 % | 5,597 | 52,555 |
| 2015 | 10.3 % | 0.1 % | 5,485 | 53,082 |
| 2014 | 10.3 % | 0.1 % | 5,492 | 53,284 |
| 2013 | 10.6 % | 0.1 % | 5,625 | 53,284 |
| 2012 | 10.9 % | 0.1 % | 5,710 | 52,555 |
| 2011 | 10.8 % | 0.1 % | 5,639 | 52,121 |
| 2010 | 11.2 % | 0.1 % | 5,919 | 53,017 |
| 2009 | 10.9 % | 0.1 % | 5,907 | 54,294 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 5 - Notes:**

None

**Data Alerts: None**

**NOM 6 - Percent of early term births (37, 38 weeks)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 30.6 % | 0.2 % | 15,013 | 49,121 |
| 2018 | 29.5 % | 0.2 % | 14,660 | 49,774 |
| 2017 | 28.7 % | 0.2 % | 14,410 | 50,187 |
| 2016 | 28.2 % | 0.2 % | 14,825 | 52,555 |
| 2015 | 27.4 % | 0.2 % | 14,570 | 53,082 |
| 2014 | 27.6 % | 0.2 % | 14,699 | 53,284 |
| 2013 | 27.8 % | 0.2 % | 14,834 | 53,284 |
| 2012 | 29.2 % | 0.2 % | 15,325 | 52,555 |
| 2011 | 30.1 % | 0.2 % | 15,702 | 52,121 |
| 2010 | 31.9 % | 0.2 % | 16,929 | 53,017 |
| 2009 | 33.5 % | 0.2 % | 18,191 | 54,294 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts: None**

**NOM 7 - Percent of non-medically indicated early elective deliveries**

**Data Source: CMS Hospital Compare**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019/Q1-2019/Q4 | 2.0 % | | | |
| 2018/Q4-2019/Q3 | 2.0 % | | | |
| 2018/Q3-2019/Q2 | 2.0 % | | | |
| 2018/Q2-2019/Q1 | 2.0 % | | | |
| 2018/Q1-2018/Q4 | 2.0 % | | | |
| 2017/Q4-2018/Q3 | 2.0 % | | | |
| 2017/Q3-2018/Q2 | 2.0 % | | | |
| 2017/Q2-2018/Q1 | 2.0 % | | | |
| 2017/Q1-2017/Q4 | 2.0 % | | | |
| 2016/Q4-2017/Q3 | 2.0 % | | | |
| 2016/Q3-2017/Q2 | 2.0 % | | | |
| 2016/Q2-2017/Q1 | 2.0 % | | | |
| 2016/Q1-2016/Q4 | 1.0 % | | | |
| 2015/Q4-2016/Q3 | 2.0 % | | | |
| 2015/Q3-2016/Q2 | 2.0 % | | | |
| 2015/Q2-2016/Q1 | 3.0 % | | | |
| 2015/Q1-2015/Q4 | 3.0 % | | | |
| 2014/Q4-2015/Q3 | 3.0 % | | | |
| 2014/Q3-2015/Q2 | 3.0 % | | | |
| 2014/Q2-2015/Q1 | 3.0 % | | | |
| 2014/Q1-2014/Q4 | 4.0 % | | | |
| 2013/Q4-2014/Q3 | 5.0 % | | | |
| 2013/Q3-2014/Q2 | 5.0 % | | | |
| 2013/Q2-2014/Q1 | 6.0 % | | | |

**Legends:**

**NOM 7 - Notes:**

None

**Data Alerts: None**

**NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 6.5 | 0.4 | 325 | 49,946 |
| 2017 | 6.5 | 0.4 | 326 | 50,338 |
| 2016 | 7.0 | 0.4 | 372 | 52,773 |
| 2015 | 6.2 | 0.3 | 329 | 53,260 |
| 2014 | 7.0 | 0.4 | 377 | 53,483 |
| 2013 | 5.8 | 0.3 | 309 | 53,519 |
| 2012 | 6.9 | 0.4 | 363 | 52,916 |
| 2011 | 6.2 | 0.3 | 324 | 52,420 |
| 2010 | 6.0 | 0.3 | 318 | 53,388 |
| 2009 | 6.2 | 0.3 | 341 | 54,715 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts: None**

**NOM 9.1 - Infant mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 7.1 | 0.4 | 353 | 49,800 |
| 2017 | 7.8 | 0.4 | 391 | 50,214 |
| 2016 | 7.5 | 0.4 | 393 | 52,592 |
| 2015 | 7.3 | 0.4 | 389 | 53,122 |
| 2014 | 8.2 | 0.4 | 438 | 53,339 |
| 2013 | 6.7 | 0.4 | 359 | 53,369 |
| 2012 | 7.5 | 0.4 | 397 | 52,751 |
| 2011 | 7.3 | 0.4 | 380 | 52,272 |
| 2010 | 7.5 | 0.4 | 399 | 53,238 |
| 2009 | 7.9 | 0.4 | 431 | 54,553 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.1 - Notes:**

None

**Data Alerts: None**

**NOM 9.2 - Neonatal mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 4.3 | 0.3 | 213 | 49,800 |
| 2017 | 5.0 | 0.3 | 252 | 50,214 |
| 2016 | 4.5 | 0.3 | 237 | 52,592 |
| 2015 | 4.4 | 0.3 | 233 | 53,122 |
| 2014 | 5.3 | 0.3 | 283 | 53,339 |
| 2013 | 4.0 | 0.3 | 212 | 53,369 |
| 2012 | 4.6 | 0.3 | 243 | 52,751 |
| 2011 | 4.4 | 0.3 | 231 | 52,272 |
| 2010 | 4.2 | 0.3 | 223 | 53,238 |
| 2009 | 4.4 | 0.3 | 242 | 54,553 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.2 - Notes:**

None

**Data Alerts: None**

**NOM 9.3 - Post neonatal mortality rate per 1,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 2.8 | 0.2 | 140 | 49,800 |
| 2017 | 2.8 | 0.2 | 139 | 50,214 |
| 2016 | 3.0 | 0.2 | 156 | 52,592 |
| 2015 | 2.9 | 0.2 | 156 | 53,122 |
| 2014 | 2.9 | 0.2 | 155 | 53,339 |
| 2013 | 2.8 | 0.2 | 147 | 53,369 |
| 2012 | 2.9 | 0.2 | 154 | 52,751 |
| 2011 | 2.9 | 0.2 | 149 | 52,272 |
| 2010 | 3.3 | 0.3 | 176 | 53,238 |
| 2009 | 3.5 | 0.3 | 189 | 54,553 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts: None**

**NOM 9.4 - Preterm-related mortality rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 198.8 | 20.0 | 99 | 49,800 |
| 2017 | 284.8 | 23.9 | 143 | 50,214 |
| 2016 | 235.8 | 21.2 | 124 | 52,592 |
| 2015 | 244.7 | 21.5 | 130 | 53,122 |
| 2014 | 313.1 | 24.3 | 167 | 53,339 |
| 2013 | 211.7 | 19.9 | 113 | 53,369 |
| 2012 | 265.4 | 22.5 | 140 | 52,751 |
| 2011 | 170.3 | 18.1 | 89 | 52,272 |
| 2010 | 174.7 | 18.1 | 93 | 53,238 |
| 2009 | 229.1 | 20.5 | 125 | 54,553 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

**NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 168.7 | 18.4 | 84 | 49,800 |
| 2017 | 153.3 | 17.5 | 77 | 50,214 |
| 2016 | 136.9 | 16.2 | 72 | 52,592 |
| 2015 | 148.7 | 16.7 | 79 | 53,122 |
| 2014 | 155.6 | 17.1 | 83 | 53,339 |
| 2013 | 149.9 | 16.8 | 80 | 53,369 |
| 2012 | 164.9 | 17.7 | 87 | 52,751 |
| 2011 | 155.0 | 17.2 | 81 | 52,272 |
| 2010 | 182.2 | 18.5 | 97 | 53,238 |
| 2009 | 154.0 | 16.8 | 84 | 54,553 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015 | 5.0 % | 0.8 % | 2,517 | 50,387 |
| 2014 | 7.0 % | 1.1 % | 3,498 | 50,017 |
| 2013 | 3.9 % | 0.8 % | 1,957 | 50,172 |
| 2012 | 5.6 % | 0.9 % | 2,817 | 50,068 |
| 2011 | 5.3 % | 1.0 % | 2,611 | 49,664 |
| 2010 | 5.3 % | 0.9 % | 2,715 | 50,867 |
| 2009 | 4.6 % | 0.8 % | 2,365 | 51,960 |
| 2008 | 6.1 % | 0.9 % | 3,150 | 51,928 |
| 2007 | 4.8 % | 0.8 % | 2,516 | 51,975 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 5.7 | 0.4 | 259 | 45,170 |
| 2017 | 6.6 | 0.4 | 308 | 46,818 |
| 2016 | 6.2 | 0.4 | 303 | 48,502 |
| 2015 | 5.7 | 0.4 | 210 | 36,974 |
| 2014 | 5.0 | 0.3 | 244 | 48,638 |
| 2013 | 3.9 | 0.3 | 189 | 48,559 |
| 2012 | 2.8 | 0.2 | 136 | 48,974 |
| 2011 | 2.5 | 0.2 | 122 | 48,454 |
| 2010 | 1.7 | 0.2 | 85 | 49,516 |
| 2009 | 1.2 | 0.2 | 62 | 50,928 |
| 2008 | 1.2 | 0.2 | 62 | 50,506 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 13 - Notes:**

None

**Data Alerts: None**

**NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 11.8 % | 1.2 % | 106,043 | 902,456 |
| 2017_2018 | 12.3 % | 1.5 % | 111,385 | 902,066 |
| 2016_2017 | 12.7 % | 1.5 % | 113,586 | 892,246 |
| 2016 | 13.0 % | 1.9 % | 115,261 | 887,430 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

**NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

| Multi-Year Trend | | | | |
|---|---|---|---|---|
| **Year** | **Annual Indicator** | **Standard Error** | **Numerator** | **Denominator** |
| 2019 | 22.1 | 2.2 | 105 | 474,998 |
| 2018 | 21.3 | 2.1 | 102 | 477,873 |
| 2017 | 22.7 | 2.2 | 109 | 480,765 |
| 2016 | 24.7 | 2.3 | 120 | 485,066 |
| 2015 | 28.0 | 2.4 | 136 | 485,290 |
| 2014 | 26.7 | 2.4 | 129 | 482,492 |
| 2013 | 29.1 | 2.5 | 140 | 481,170 |
| 2012 | 25.2 | 2.3 | 120 | 475,436 |
| 2011 | 29.9 | 2.5 | 142 | 474,448 |
| 2010 | 27.4 | 2.4 | 129 | 471,513 |
| 2009 | 29.3 | 2.5 | 136 | 464,479 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts: None**

**NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

| Multi-Year Trend | | | | |
|---|---|---|---|---|
| **Year** | **Annual Indicator** | **Standard Error** | **Numerator** | **Denominator** |
| 2019 | 41.9 | 2.8 | 224 | 535,055 |
| 2018 | 39.3 | 2.7 | 210 | 534,250 |
| 2017 | 44.6 | 2.9 | 237 | 531,803 |
| 2016 | 43.8 | 2.9 | 231 | 527,872 |
| 2015 | 43.4 | 2.9 | 228 | 525,456 |
| 2014 | 42.7 | 2.9 | 222 | 520,233 |
| 2013 | 44.0 | 2.9 | 228 | 517,639 |
| 2012 | 44.4 | 2.9 | 229 | 515,384 |
| 2011 | 45.8 | 3.0 | 237 | 517,435 |
| 2010 | 43.0 | 2.9 | 223 | 518,148 |
| 2009 | 51.8 | 3.2 | 268 | 517,003 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

**NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2019 | 16.6 | 1.5 | 132 | 792,875 |
| 2016_2018 | 17.3 | 1.5 | 137 | 790,067 |
| 2015_2017 | 18.3 | 1.5 | 144 | 786,893 |
| 2014_2016 | 19.2 | 1.6 | 150 | 780,627 |
| 2013_2015 | 19.6 | 1.6 | 152 | 774,912 |
| 2012_2014 | 19.8 | 1.6 | 152 | 769,486 |
| 2011_2013 | 20.3 | 1.6 | 157 | 772,259 |
| 2010_2012 | 22.3 | 1.7 | 174 | 780,352 |
| 2009_2011 | 24.3 | 1.8 | 192 | 790,954 |
| 2008_2010 | 28.6 | 1.9 | 228 | 796,647 |
| 2007_2009 | 30.0 | 1.9 | 239 | 797,110 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

**NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2019 | 17.8 | 1.5 | 141 | 792,875 |
| 2016_2018 | 16.2 | 1.4 | 128 | 790,067 |
| 2015_2017 | 16.3 | 1.4 | 128 | 786,893 |
| 2014_2016 | 15.0 | 1.4 | 117 | 780,627 |
| 2013_2015 | 14.5 | 1.4 | 112 | 774,912 |
| 2012_2014 | 14.9 | 1.4 | 115 | 769,486 |
| 2011_2013 | 14.0 | 1.4 | 108 | 772,259 |
| 2010_2012 | 12.8 | 1.3 | 100 | 780,352 |
| 2009_2011 | 10.7 | 1.2 | 85 | 790,954 |
| 2008_2010 | 10.4 | 1.1 | 83 | 796,647 |
| 2007_2009 | 9.9 | 1.1 | 79 | 797,110 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 22.9 % | 1.6 % | 219,136 | 955,383 |
| 2017_2018 | 22.7 % | 1.7 % | 217,565 | 958,493 |
| 2016_2017 | 22.6 % | 1.6 % | 216,392 | 958,306 |
| 2016 | 22.0 % | 1.9 % | 210,529 | 957,402 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 16.0 % | 2.9 % | 35,014 | 219,136 |
| 2017_2018 | 16.7 % | 3.6 % | 36,285 | 217,565 |
| 2016_2017 | 15.7 % | 3.3 % | 33,766 | 215,000 |
| 2016 | 14.5 % | 3.0 % | 30,123 | 207,744 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 3.2 % | 0.8 % | 26,236 | 807,521 |
| 2017_2018 | 2.9 % | 0.7 % | 23,193 | 796,508 |
| 2016_2017 | 2.7 % | 0.6 % | 21,091 | 790,433 |
| 2016 | 1.9 % | 0.5 % | 15,058 | 796,277 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 10.2 % | 1.2 % | 81,534 | 797,519 |
| 2017_2018 | 10.3 % | 1.5 % | 81,522 | 788,136 |
| 2016_2017 | 11.3 % | 1.5 % | 88,841 | 784,005 |
| 2016 | 11.4 % | 1.7 % | 89,620 | 787,609 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 56.4 % | 5.0 % | 64,311 | 114,039 |
| 2017_2018 | 56.6 % | 5.2 % | 65,093 | 115,010 |
| 2016_2017 | 57.7 % | 4.9 % | 66,122 | 114,548 |
| 2016 | 51.9 % | 6.3 % | 56,340 | 108,482 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 87.9 % | 1.4 % | 839,648 | 954,805 |
| 2017_2018 | 88.4 % | 1.5 % | 847,211 | 958,493 |
| 2016_2017 | 89.2 % | 1.4 % | 851,745 | 954,862 |
| 2016 | 90.5 % | 1.4 % | 859,741 | 950,514 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**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)**

**Data Source: WIC**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018 | 13.8 % | 0.2 % | 4,129 | 29,940 |
| 2016 | 13.1 % | 0.2 % | 4,528 | 34,486 |
| 2014 | 13.8 % | 0.2 % | 4,518 | 32,754 |
| 2012 | 14.8 % | 0.2 % | 5,158 | 34,770 |
| 2010 | 15.4 % | 0.2 % | 5,838 | 37,849 |
| 2008 | 14.9 % | 0.2 % | 4,206 | 28,285 |

**Legends:**

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 17.6 % | 1.0 % | 29,918 | 169,652 |
| 2017 | 17.1 % | 1.4 % | 28,805 | 168,245 |
| 2015 | 17.3 % | 1.5 % | 29,753 | 172,023 |
| 2013 | 11.8 % | 1.0 % | 18,331 | 154,860 |
| 2011 | 16.7 % | 1.4 % | 27,690 | 165,875 |
| 2009 | 14.0 % | 1.4 % | 23,553 | 168,736 |
| 2007 | 14.6 % | 0.9 % | 24,000 | 164,638 |
| 2005 | 15.1 % | 1.0 % | 24,960 | 165,310 |

**Legends:**

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 18.8 % | 2.5 % | 78,152 | 414,639 |
| 2017_2018 | 18.0 % | 2.5 % | 72,478 | 402,468 |
| 2016_2017 | 18.7 % | 2.5 % | 72,279 | 386,649 |
| 2016 | 18.1 % | 2.9 % | 69,168 | 381,285 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

**NOM 21 - Percent of children, ages 0 through 17, without health insurance**

**Data Source: American Community Survey (ACS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 7.8 % | 0.5 % | 74,000 | 950,362 |
| 2018 | 7.5 % | 0.5 % | 71,237 | 955,521 |
| 2017 | 7.3 % | 0.5 % | 69,633 | 959,932 |
| 2016 | 7.0 % | 0.4 % | 67,244 | 962,141 |
| 2015 | 8.2 % | 0.4 % | 78,467 | 959,160 |
| 2014 | 8.7 % | 0.5 % | 82,190 | 950,023 |
| 2013 | 10.5 % | 0.5 % | 98,940 | 947,160 |
| 2012 | 9.9 % | 0.5 % | 92,887 | 936,722 |
| 2011 | 10.9 % | 0.6 % | 101,812 | 934,009 |
| 2010 | 10.4 % | 0.5 % | 96,671 | 932,723 |
| 2009 | 11.1 % | 0.6 % | 102,685 | 921,695 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months**

**Data Source: National Immunization Survey (NIS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 63.8 % | 3.3 % | 34,000 | 53,000 |
| 2015 | 64.8 % | 3.6 % | 35,000 | 54,000 |
| 2014 | 65.4 % | 4.2 % | 35,000 | 54,000 |
| 2013 | 68.8 % | 4.2 % | 37,000 | 54,000 |
| 2012 | 61.8 % | 4.0 % | 33,000 | 53,000 |
| 2011 | 68.2 % | 3.4 % | 36,000 | 53,000 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

**NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza**

**Data Source: National Immunization Survey (NIS) – Flu**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019_2020 | 59.5 % | 1.6 % | 535,263 | 899,601 |
| 2018_2019 | 56.0 % | 1.4 % | 503,249 | 898,017 |
| 2017_2018 | 55.0 % | 1.7 % | 493,936 | 897,824 |
| 2016_2017 | 53.6 % | 1.9 % | 478,533 | 892,286 |
| 2015_2016 | 52.3 % | 2.2 % | 463,253 | 886,608 |
| 2014_2015 | 54.4 % | 2.2 % | 482,493 | 886,773 |
| 2013_2014 | 55.2 % | 2.1 % | 480,374 | 870,847 |
| 2012_2013 | 50.1 % | 2.6 % | 438,541 | 875,876 |
| 2011_2012 | 53.2 % | 2.9 % | 453,126 | 851,398 |
| 2010_2011 | 50.4 % | 3.1 % | 423,271 | 839,823 |
| 2009_2010 | 43.7 % | 2.3 % | 379,503 | 868,427 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

**NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 65.6 % | 3.0 % | 174,808 | 266,384 |
| 2018 | 59.1 % | 3.1 % | 156,370 | 264,584 |
| 2017 | 58.5 % | 3.2 % | 154,955 | 264,827 |
| 2016 | 56.9 % | 3.7 % | 149,757 | 263,262 |
| 2015 | 55.5 % | 3.4 % | 144,818 | 261,148 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**

**NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 88.0 % | 1.9 % | 234,395 | 266,384 |
| 2018 | 87.1 % | 2.3 % | 230,373 | 264,584 |
| 2017 | 86.7 % | 2.2 % | 229,657 | 264,827 |
| 2016 | 89.6 % | 2.3 % | 235,981 | 263,262 |
| 2015 | 84.4 % | 2.5 % | 220,371 | 261,148 |
| 2014 | 82.6 % | 2.4 % | 213,323 | 258,140 |
| 2013 | 78.1 % | 2.5 % | 200,795 | 257,188 |
| 2012 | 77.1 % | 2.9 % | 198,246 | 257,165 |
| 2011 | 66.0 % | 3.2 % | 168,949 | 256,171 |
| 2010 | 54.8 % | 3.3 % | 135,997 | 248,051 |
| 2009 | 35.1 % | 2.9 % | 86,620 | 246,600 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

**NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 77.3 % | 2.7 % | 205,853 | 266,384 |
| 2018 | 72.9 % | 2.9 % | 192,939 | 264,584 |
| 2017 | 71.1 % | 3.0 % | 188,169 | 264,827 |
| 2016 | 73.6 % | 3.3 % | 193,766 | 263,262 |
| 2015 | 68.1 % | 3.3 % | 177,924 | 261,148 |
| 2014 | 70.8 % | 2.9 % | 182,853 | 258,140 |
| 2013 | 66.2 % | 2.7 % | 170,300 | 257,188 |
| 2012 | 63.8 % | 3.4 % | 164,130 | 257,165 |
| 2011 | 55.3 % | 3.4 % | 141,605 | 256,171 |
| 2010 | 42.6 % | 3.3 % | 105,757 | 248,051 |
| 2009 | 29.5 % | 2.8 % | 72,731 | 246,600 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2019 | 27.4 | 0.5 | 3,520 | 128,687 |
| 2018 | 27.2 | 0.5 | 3,492 | 128,203 |
| 2017 | 29.7 | 0.5 | 3,793 | 127,864 |
| 2016 | 33.4 | 0.5 | 4,250 | 127,118 |
| 2015 | 34.9 | 0.5 | 4,391 | 125,886 |
| 2014 | 38.6 | 0.6 | 4,802 | 124,485 |
| 2013 | 42.9 | 0.6 | 5,310 | 123,737 |
| 2012 | 47.3 | 0.6 | 5,844 | 123,473 |
| 2011 | 48.1 | 0.6 | 6,025 | 125,333 |
| 2010 | 50.7 | 0.6 | 6,496 | 128,156 |
| 2009 | 57.4 | 0.7 | 7,451 | 129,709 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

**NOM 23 - Notes:**

None

**Data Alerts: None**

**NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 15.0 % | 1.4 % | 7,087 | 47,155 |
| 2016 | 14.7 % | 1.2 % | 7,325 | 49,738 |
| 2015 | 16.1 % | 1.4 % | 8,098 | 50,425 |
| 2014 | 16.4 % | 1.6 % | 8,240 | 50,128 |
| 2013 | 15.9 % | 1.5 % | 8,026 | 50,459 |
| 2012 | 14.9 % | 1.5 % | 7,494 | 50,174 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year**

**Data Source: National Survey of Children's Health (NSCH)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2018_2019 | 2.2 % | 0.5 % | 21,264 | 954,542 |
| 2017_2018 | 2.0 % | 0.5 % | 18,631 | 954,827 |
| 2016_2017 | 2.7 % | 0.6 % | 26,004 | 952,125 |
| 2016 | 3.1 % | 0.8 % | 29,586 | 951,285 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 25 - Notes:**

None

**Data Alerts: None**

## Form 10
## National Performance Measures (NPMs)

**State: Oklahoma**

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | | | 71.1 |
| Annual Indicator | | | | 69.7 | 70.3 |
| Numerator | | | | 471,074 | 463,707 |
| Denominator | | | | 675,608 | 659,936 |
| Data Source | | | | BRFSS | BRFSS |
| Data Source Year | | | | 2018 | 2019 |

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 71.6 | 73.0 | 74.5 | 76.0 | 77.5 | 79.1 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 4A - Percent of infants who are ever breastfed**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 76.7 | 77.4 | 79.8 | 77.4 | 83.4 |
| Annual Indicator | 74.7 | 79.2 | 75.9 | 82.2 | 77.7 |
| Numerator | 38,593 | 41,230 | 38,194 | 38,328 | 34,343 |
| Denominator | 51,646 | 52,032 | 50,306 | 46,652 | 44,223 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 79.3 | 80.8 | 82.5 | 84.1 | 85.8 | 87.5 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 4B - Percent of infants breastfed exclusively through 6 months**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 19.1 | 16 | 21.7 | 22.2 | 29.6 |
| Annual Indicator | 15.7 | 21.3 | 21.6 | 29.6 | 23.7 |
| Numerator | 7,715 | 10,883 | 10,756 | 13,540 | 10,126 |
| Denominator | 49,145 | 51,056 | 49,712 | 45,739 | 42,737 |
| Data Source | NIS | NIS | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 | 2016 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 24.2 | 24.7 | 25.2 | 25.7 | 26.2 | 26.7 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 5A - Percent of infants placed to sleep on their backs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 71.9 | 76.9 | 82 | 79.1 | 80.7 |
| Annual Indicator | 75.4 | 81.2 | 77.6 | 77.6 | 77.6 |
| Numerator | 37,018 | 40,173 | 36,090 | 36,090 | 36,090 |
| Denominator | 49,130 | 49,458 | 46,523 | 46,523 | 46,523 |
| Data Source | PRAMS | PRAMS | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2014 | 2015 | 2017 | 2017 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 79.2 | 80.7 | 82.3 | 84.0 | 85.7 | 87.4 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | |
| | **2018** | **2019** | **2020** |
| Annual Objective | | 39.9 | 40.7 |
| Annual Indicator | 39.2 | 39.2 | 39.2 |
| Numerator | 17,658 | 17,658 | 17,658 |
| Denominator | 45,065 | 45,065 | 45,065 |
| Data Source | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2017 | 2017 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 41.5 | 42.4 | 43.2 | 44.1 | 44.9 | 45.8 |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Figure reflects the percentage of infants who are placed to sleep in a crib.

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)** | | | |
| | **2018** | **2019** | **2020** |
| Annual Objective | | 41.6 | 42.4 |
| Annual Indicator | 40.8 | 40.8 | 40.8 |
| Numerator | 18,485 | 18,485 | 18,485 |
| Denominator | 45,328 | 45,328 | 45,328 |
| Data Source | PRAMS | PRAMS | PRAMS |
| Data Source Year | 2017 | 2017 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 43.2 | 44.1 | 45.0 | 45.9 | 46.8 | 47.7 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CHILD** | | |
| | **2019** | **2020** |
| Annual Objective | | |
| Annual Indicator | 31.4 | 27.5 |
| Numerator | 93,110 | 89,475 |
| Denominator | 296,779 | 325,093 |
| Data Source | NSCH-CHILD | NSCH-CHILD |
| Data Source Year | 2017_2018 | 2018_2019 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 28.1 | 28.6 | 29.2 | 29.8 | 30.4 | 31.0 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: Youth Risk Behavior Surveillance System (YRBSS)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 23.9 | 23.6 | 24.5 | 26.6 | 26.6 |
| Annual Indicator | 25.0 | 25.0 | 27.2 | 27.2 | 24.2 |
| Numerator | 44,898 | 44,898 | 49,239 | 49,239 | 43,594 |
| Denominator | 179,440 | 179,440 | 180,854 | 180,854 | 180,410 |
| Data Source | YRBSS | YRBSS | YRBSS | YRBSS | YRBSS |
| Data Source Year | 2015 | 2015 | 2017 | 2017 | 2019 |

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Perpetration** | | | | |
| | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 26.6 | 26.6 |
| Annual Indicator | | | 20.9 | 20.9 |
| Numerator | | | 71,345 | 68,450 |
| Denominator | | | 341,223 | 328,275 |
| Data Source | | | NSCHP | NSCHP |
| Data Source Year | | | 2018 | 2018_2019 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - Victimization** | | | | |
| | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 26.6 | 26.6 |
| Annual Indicator | | | 45.0 | 42.7 |
| Numerator | | | 153,408 | 140,343 |
| Denominator | | | 341,223 | 328,882 |
| Data Source | | | NSCHV | NSCHV |
| Data Source Year | | | 2018 | 2018_2019 |

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 24.7 | 25.2 | 25.7 | 26.2 | 26.7 | 27.3 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 76 | 74.9 | 75 |
| Annual Indicator | | 75.2 | 73.5 | 73.5 | 80.3 |
| Numerator | | 229,371 | 225,282 | 225,282 | 252,941 |
| Denominator | | 304,952 | 306,365 | 306,365 | 314,972 |
| Data Source | | NSCH | NSCH | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 | 2016_2017 | 2019 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 81.9 | 83.5 | 85.2 | 86.9 | 88.7 | 90.4 |

**Field Level Notes for Form 10 NPMs:**

None

**NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs**

| Federally Available Data | | |
|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | |
| | **2019** | **2020** |
| Annual Objective | | |
| Annual Indicator | 44.0 | 41.6 |
| Numerator | 95,790 | 91,264 |
| Denominator | 217,565 | 219,136 |
| Data Source | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | 2017_2018 | 2018_2019 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 42.4 | 43.3 | 44.1 | 45.0 | 45.9 | 46.8 |

**Field Level Notes for Form 10 NPMs:**

None

**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 - Children with Special Health Care Needs**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 11.5 | 16.7 | 22.2 |
| Annual Indicator | | 11.3 | 16.4 | 21.8 | 28.5 |
| Numerator | | 10,795 | 14,252 | 18,388 | 26,312 |
| Denominator | | 95,220 | 87,022 | 84,532 | 92,174 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 | 2017_2018 | 2018_2019 |

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 29.1 | 29.7 | 30.2 | 30.8 | 31.5 | 32.1 |

**Field Level Notes for Form 10 NPMs:**

None

**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 - Adolescent Health - NONCSHCN**

| Federally Available Data | | | | |
|---|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - NONCSHCN** | | | | |
| | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | | 14.4 | 17.5 |
| Annual Indicator | 12.5 | 14.2 | 17.2 | 17.2 |
| Numerator | 26,234 | 31,388 | 41,549 | 40,910 |
| Denominator | 210,453 | 220,834 | 241,098 | 237,455 |
| Data Source | NSCH-NONCSHCN | NSCH-NONCSHCN | NSCH-NONCSHCN | NSCH-NONCSHCN |
| Data Source Year | 2016 | 2016_2017 | 2017_2018 | 2018_2019 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 17.9 | 18.2 | 18.6 | 19.0 | 19.4 | 19.8 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

**State: Oklahoma**

**2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

| Federally Available Data | | | | | |
|---|---|---|---|---|---|
| **Data Source: HCUP - State Inpatient Databases (SID)** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | 186.8 | 173.8 | 201.9 | 172.8 | 169.4 |
| Annual Indicator | 177.3 | 203.9 | 176.4 | 148.9 | 150.9 |
| Numerator | 951 | 823 | 948 | 793 | 797 |
| Denominator | 536,332 | 403,600 | 537,475 | 532,642 | 528,226 |
| Data Source | SID-CHILD | SID-CHILD | SID-CHILD | SID-CHILD | SID-CHILD |
| Data Source Year | 2014 | 2015 | 2016 | 2017 | 2018 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: Oklahoma**

### SPM 1 - Maternal mortality rate per 100,000 live births

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 17.4 | 20.8 | 24.1 | 22.3 |
| Annual Indicator | 20.1 | 23.7 | 24.9 | 23.5 | 23.5 |
| Numerator | 32 | 37 | 38 | 35 | 35 |
| Denominator | 159,025 | 155,953 | 152,607 | 148,949 | 148,949 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2017-2019 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 23.0 | 22.6 | 22.1 | 21.7 | 21.2 | 20.8 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The data reported for SPM #2, maternal mortality rate per 100,000 live births, reflect multi-year data for years 2014-2016. Data for year 2016 are provisional pending final closeout of that year's death data.

Annual Objectives have been revised to reflect improvement in the maternal mortality rate.

| | | |
|---|---|---|
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The data reported for SPM #2, maternal mortality rate per 100,000 live births, reflect multi-year data for years 2015-2017.

| | | |
|---|---|---|
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The data reported for SPM #2, maternal mortality rate per 100,000 live births, reflect multi-year data for years 2016-2018. Data for reporting year 2018 are provisional pending final closeout of that year's death data.

Annual Objectives have been revised to reflect current status of the maternal mortality rate.

| | | |
|---|---|---|
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The data reported for SPM #1, maternal mortality rate per 100,000 live births, reflect multi-year data for years 2017-2019.

| | | |
|---|---|---|
| 5. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
The data reported for SPM #1, maternal mortality rate per 100,000 live births, reflect multi-year data for years 2017-2019. Data for reporting year 2020 are provisional pending final closeout of that year's death data.

Annual Objectives have been revised to reflect current status of the maternal mortality rate.

**SPM 2 - Infant mortality rate per 1,000 live births**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 7.3 | 7.5 | 7 | 6.7 |
| Annual Indicator | 7.4 | 7.7 | 7.1 | 7 | 7 |
| Numerator | 391 | 387 | 352 | 344 | 344 |
| Denominator | 52,607 | 50,214 | 49,787 | 49,143 | 49,143 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2019 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 6.5 | 6.3 | 6.2 | 6.1 | 5.9 | 5.8 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
Final data for 2020 are unavailable at this time. Provisional data for 2020 are too incomplete to report. Final data for 2019 are repeated for 2020 as a placeholder until such time that final data for 2020 are released.

**SPM 3 - The percent of families who are able to access services for their child with behavioral health needs**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 61.9 | 63.2 | 64.2 | 57.7 |
| Annual Indicator | 60.7 | 60.7 | 62.9 | 56.6 | 56.4 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | National Survey of Childrens Health | National Survey of Childrens Health | National Survey of Childrens Health | National Survey of Childrens Health | National Survey of Childrens Health |
| Data Source Year | 2011/12 | 2016 | 2017 | 2017-2018 | 2018-2019 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 57.5 | 58.7 | 59.9 | 61.0 | 62.3 | 64.1 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |

**Field Note:**
With the 2016 NSCH, there is no comparable survey item to provide a comparable measurement for State Performance Measure #3 as originally defined. For this reporting, the previous indicator from 2011/12 NSCH is carried forward as an estimation.Future reporting will address this gap in timely information.

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESMs)

**State: Oklahoma**

**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**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 95 | 100 | 100 | 105 |
| Annual Indicator | 91 | 90 | 95 | 95 | 95 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | PHOCIS | PHOCIS | PHOCIS | PHOCIS | PHOCIS |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 100.0 | 105.0 | 110.0 | 115.0 | 120.0 | 125.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 4.1 - The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2019 | 2020 |
| Annual Objective | | |
| Annual Indicator | 1,707 | 1,957 |
| Numerator | | |
| Denominator | | |
| Data Source | Breastfeeding Hotline | Breastfeeding Hotline |
| Data Source Year | FY2019 | FY2020 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 2,055.0 | 2,158.0 | 2,265.0 | 2,378.0 | 2,497.0 | 2,622.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 15.6 | 16 | 23.3 | 34.7 |
| Annual Indicator | 12.5 | 15.2 | 22.6 | 33.4 | 31.9 |
| Numerator | 6,590 | 7,598 | 11,247 | 15,926 | 14,540 |
| Denominator | 52,607 | 50,008 | 49,787 | 47,664 | 45,526 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 36.4 | 38.2 | 40.1 | 42.1 | 44.2 | 45.1 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect final 2016 live births occurring at facilities classified as baby-friendly - Cherokee Nation W.W. Hastings Hospital, Integris Baptist Medical Center, Integris Health Edmond, St. Anthony Hospital, Comanche County Memorial Hospital. | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect final 2017 live births occurring at facilities classified as baby-friendly - Cherokee Nation W.W. Hastings Hospital, Integris Baptist Medical Center, Integris Health Edmond, St. Anthony Hospital, Comanche County Memorial Hospital, Chickasaw Nation Medical Center. | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect provisional 2018 live births occurring at facilities classified as baby-friendly - Bailey Medical Center, Cherokee Nation W.W. Hastings Hospital, Claremore Indian Hospital, Comanche County Memorial Hospital, Integris Baptist Medical Center,<br>St. Anthony Hospital, St. Anthony Shawnee Hospital, Chickasaw Nation Medical Center, Duncan Regional Hospital, Hillcrest Medical Center, St. Francis Hospital South. | |

**ESM 5.1 - The percentage of infants delivered at birthing hospitals participating in the sleep sack program**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 70.6 | 71.2 | 75.3 | 80.6 |
| Annual Indicator | 63.4 | 69.5 | 73.8 | 81.7 | 77.3 |
| Numerator | 33,346 | 34,913 | 36,756 | 38,948 | 35,171 |
| Denominator | 52,607 | 50,214 | 49,787 | 47,664 | 45,526 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| **Annual Objectives** | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 82.2 | 83.8 | 85.5 | 87.2 | 89.0 | 90.8 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the percent of births delivered at Oklahoma birthing hospitals participating in the sleep sack distribution program. Source of final data is Oklahoma Vital Statistics, 2016. | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the percent of births delivered at Oklahoma birthing hospitals participating in the sleep sack distribution program. Source of final data is Oklahoma Vital Statistics, 2017. | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the percent of births delivered at Oklahoma birthing hospitals participating in the sleep sack distribution program. Source of provisional data is Oklahoma Vital Statistics, 2018. | |

**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.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2019 | 2020 |
| Annual Objective | | |
| Annual Indicator | 125 | 101 |
| Numerator | | |
| Denominator | | |
| Data Source | Child and Adolescent Health, MCH program data | Child and Adolescent Health, MCH program data |
| Data Source Year | 2019 | 2020 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 110.0 | 120.0 | 130.0 | 140.0 | 150.0 | 160.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 9.1 - The number of trainings provided to school and community staff on bullying prevention**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | 4 | 5 | 6 | 7 |
| Annual Indicator | 3 | 3 | 1 | 2 | 1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | MCH Training Log | MCH Training Log | MCH Training Log | MCH Training Log | MCH Training Log |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 5.0 | 8.0 | 11.0 | 14.0 | 17.0 | 20.0 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum**

| Measure Status: | | | | Active | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 4,300 | 4,500 | 4,400 | 4,900 |
| Annual Indicator | 3,350 | 4,389 | 4,204 | 4,651 | 4,092 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | MCH PREP Program | MCH PREP Program | MCH PREP Program | MCH PREP Program | MCH PREP Program |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** |
| Annual Objective | 4,400.0 | 4,700.0 | 5,000.0 | 5,300.0 | 5,600.0 | 5,900.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Number reflects the total who initiated or attended at least one session for the 2017 academic year, August 2016 to July 2017. | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Number reflects the total who initiated or attended at least one session for the 2017-2018 academic year. | |
| 3. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Reported figure reflects the number of youth served during the period August 1, 2018 through July 1, 2019. | |

**ESM 11.1 - Number of CYSHCN who received care coordination services from Title V CSHCN contract providers in the past year.**

| Measure Status: | Active |
|---|---|

| State Provided Data | | |
|---|---|---|
| | 2019 | 2020 |
| Annual Objective | | |
| Annual Indicator | 39.7 | 41.6 |
| Numerator | | |
| Denominator | | |
| Data Source | National Survey of Childrens Health | National Survey of Childrens Health |
| Data Source Year | 2018 | 2018-2019 |
| Provisional or Final ? | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 42.4 | 43.3 | 44.1 | 45.0 | 45.9 | 46.8 |

**Field Level Notes for Form 10 ESMs:**

None

**ESM 12.1 - The number of providers who address transition to adult health care in their practice**

| Measure Status: | Active |
|---|---|

| State Provided Data | | | | | |
|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 |
| Annual Objective | | | 170 | 170 | 175 |
| Annual Indicator | 94 | 164 | 164 | 164 | 77 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | Sooner Success | Sooner Success | Sooner Success | Sooner Success | Sooner Success |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 |
| Annual Objective | 80.0 | 85.0 | 90.0 | 95.0 | 100.0 | 105.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Rather than providers data reflect the number of practices who address transition. Collecting data at the provider-level has been problematic. Oklahoma may look to change this measure in future reporting. | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Rather than providers data reflect the number of practices who address transition. Collecting data at the provider-level has been problematic. Oklahoma may look to change this measure in future reporting. | |
| 3. | **Field Name:** | **2020** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Number is reflective of the pilot initiated with 3 clinics at OUHSC (Child Study Center, Sickle Cell and Sooner Pediatrics). More concrete numbers on providers will be possible once established parameters for study objectives has been achieved.<br><br>Targets revised based on current reporting. | |

## Form 10
## Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

**2016-2020: ESM 7.1.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum**

| **Measure Status:** | | | | **Active** | |
|---|---|---|---|---|---|
| **State Provided Data** | | | | | |
| | **2016** | **2017** | **2018** | **2019** | **2020** |
| Annual Objective | | 86.5 | 88 | 86.9 | 88.7 |
| Annual Indicator | 81.8 | 84.1 | 85.2 | 89.5 | 84.6 |
| Numerator | 43,013 | 42,224 | 42,425 | 42,643 | 38,537 |
| Denominator | 52,607 | 50,214 | 49,787 | 47,664 | 45,526 |
| Data Source | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics | Oklahoma Vital Statistics |
| Data Source Year | 2016 | 2017 | 2018 | 2019 | 2020 |
| Provisional or Final ? | Final | Final | Final | Final | Provisional |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the number and percent of births delivered at Oklahoma birthing facilities participating in the Period of Purple Crying program. Source of final data is Oklahoma Vital Statistics, 2016. | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the number and percent of births delivered at Oklahoma birthing facilities participating in the Period of Purple Crying program. Source of final data is Oklahoma Vital Statistics, 2017. | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the number and percent of births delivered at Oklahoma birthing facilities participating in the Period of Purple Crying program. Source of data is Oklahoma Vital Statistics, 2018. | |
| 4. | **Field Name:** | **2019** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:**<br>Data reflect the number and percent of births delivered at Oklahoma birthing facilities participating in the Period of Purple Crying program. Source of provisional data is Oklahoma Vital Statistics, 2019. | |

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: Oklahoma**

**SPM 1 - Maternal mortality rate per 100,000 live births**
**Population Domain(s) – Women/Maternal Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To reduce the maternal mortality rate |
| **Definition:** | **Unit Type:** Rate<br>**Unit Number:** 100,000<br>**Numerator:** The number of deaths related to or aggravated by pregnancy and occurring within 42 days of the end of the pregnancy<br>**Denominator:** The number of live births |
| **Data Sources and Data Issues:** | Oklahoma Vital Statistics, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health |
| **Significance:** | According to CDC data from 2005-2010, the rate of maternal deaths related to childbirth in Oklahoma (29.9 deaths per 100,000 live births) is highest among all states, with the rate increasing in recent years. There are significant racial disparities with Black/African American women being more likely that white women to experience maternal death. |

**SPM 2 - Infant mortality rate per 1,000 live births**
**Population Domain(s) – Perinatal/Infant Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To reduce the number of infant deaths |
| **Definition:** | **Unit Type:** Rate<br>**Unit Number:** 1,000<br>**Numerator:** The number of deaths to infants from birth through 364 days of age<br>**Denominator:** The number of live births |
| **Data Sources and Data Issues:** | Oklahoma Vital Statistics, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health |
| **Significance:** | The Oklahoma infant mortality rate (IMR) has declined substantially over the last three decades, down from 12.3 in 1980 to 8.1 in 2014. Significant racial disparities persist despite this improvement in the overall infant mortaltiy rate. The non-Hispanic Black IMR (13.3 deaths per 1,000 live births in 2014) is nearly two times the rate for non-Hispanic Whites (7.0), while the IMR in American Indians (12.0) is more than one and a half times the rate of non-Hispanic Whites. The IMR for Hispanic infants was 7.4 in 2014. Infant mortality continues to be an extremely complex health issue with many medical, social, and economic determinants, including race/ethnicity, maternal age, education, smoking and health status. |

**SPM 3 - The percent of families who are able to access services for their child with behavioral health needs**
**Population Domain(s) – Children with Special Health Care Needs**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To improve the behavioral health of children with special health care needs |
| **Definition:** | <table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of families who are able to access services for their child with behavioral health needs</td></tr><tr><td>**Denominator:**</td><td>The number of families who have a child needing behavioral health services</td></tr></table> |
| **Data Sources and Data Issues:** | National Survey of Children's Health |
| **Significance:** | Mental health has a complex interactive relationship with a child's physical health and their ability to succeed in school, at work and in society. All children and youth have the right to happy and healthy lives and deserve access to effective care to prevent or treat any mental health problems that they may develop. However, there is a tremendous amount of unmet need, and health disparities are particularly pronounced for children and youth living in low-income communities, ethnic minority youth or those with special needs. |

## Form 10
## State Outcome Measure (SOM) Detail Sheets

**State: Oklahoma**

No State Outcome Measures were created by the State.

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

**State: Oklahoma**

**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**
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of service sites utilizing the new preconception health tool</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>200</td></tr>
<tr><td>Numerator:</td><td>The number of service sites utilizing the new preconception health assessment tool developed by the Oklahoma State Department of Health CoIIN team</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Public Health Oklahoma Client Information System (PHOCIS), Oklahoma State Department of Health and Oklahoma Health Care Authority (OHCA) practice facilitation data</td></tr>
<tr><td>Significance:</td><td>Improved health before conception will improve birth outcomes for both mother and infant. Preconception health care is “the medical care a woman or man receives from the doctor or other health professionals that focuses on the parts of health that have been shown to increase the chance of having a healthy baby. Preconception care seeks to reduce the risk of adverse effects for women and infants by optimizing women's health and knowledge before planning and conceiving a pregnancy."<br><br>Recommendations to Improve Preconception Health and Health Care - United States. MMWR 55 (RR06); 1-23. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm</td></tr>
</table>

**ESM 4.1 - The number of women receiving in-person, telehealth, or telephonic breastfeeding support Title V-funded services by IBCLCs.**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of women served by Title V-funded breastfeeding support services |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 10,000<br>**Numerator:** Number of women receiving in-person, telehealth, or telephonic breastfeeding support<br>**Denominator:** |
| **Data Sources and Data Issues:** | Contractor reports |
| **Significance:** | Breastfeeding, specifically exclusive breastfeeding, is known to provide immediate benefits to infants and mothers and long-term protection from chronic health problems that lead to morbidity and mortality. Achieving the Baby-Friendly designation is an evidence based practice that has been shown to increase breastfeeding initiation and duration.<br><br>Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. 2016 revision. Baby-Friendly USA, Inc. |

**ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of Oklahoma birthing hospitals that are Baby-Friendly |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of births occurring at Baby-Friendly hospitals<br>**Denominator:** The number of resident live births |
| **Data Sources and Data Issues:** | Vital Statistics Data, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health and Baby-Friendly USA |
| **Significance:** | Breastfeeding, specifically exclusive breastfeeding, is known to provide immediate benefits to infants and mothers and long-term protection from chronic health problems that lead to morbidity and mortality. Achieving the Baby-Friendly designation is an evidence based practice that has been shown to increase breastfeeding initiation and duration.<br><br>Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. 2016 revision. Baby-Friendly USA, Inc. |

**ESM 5.1 - The percentage of infants delivered at birthing hospitals participating in the sleep sack program**
**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**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of birthing hospitals participating in the safe sleep program |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** The number of births occurring at birthing hospitals participating in the sleep sack program<br>**Denominator:** The number of resident live births |
| **Data Sources and Data Issues:** | Vital Statistics Data, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health and MCH Sleep Sack Program |
| **Significance:** | Providing a consistent message about infant sleep safety is essential to reducing sleep-related infant deaths. Hospital-based programs provide opportunities to give accurate and consistent infant safe sleep information to hospital staff and enable modeling of safe sleep practices. Increasing the number of birthing hospitals participating in the safe sleep program will directly increase the number of parents and caregivers receiving infant safe sleep education and the number of babies utilizing sleep sacks. This in turn will lead a reduction in infant deaths related to unsafe sleep conditions.<br><br>Safe to Sleep Campaign. Eunice Kennedy Shriver National Institute of Child Health and Human Development. U.S. Department of Health and Human Services. |

**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.**
**NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of schools participating in activities related to improved physical activity for students. |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 1,000<br>**Numerator:** Number of schools<br>**Denominator:** |
| **Data Sources and Data Issues:** | Reports from contractors and Title V-funded staff working with schools |
| **Significance:** | Improve quality health education for children and youth which includes physical activity, to improve the health across the lifespan for Oklahoma's youth. Increased physical activity during the school week has the potential to reduce obesity rates, assist in managing chronic health issues, and improve sleep and classroom behaviors. |

**ESM 9.1 - The number of trainings provided to school and community staff on bullying prevention**
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the knowledge and preparedness of school staff with respect to bullying prevention |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 100<br>**Numerator:** The number of trainings provided by MCH staff annually on bullying prevention<br>**Denominator:** |
| **Data Sources and Data Issues:** | MCH bullying prevention training log |
| **Significance:** | Trainings using the evidence-based curriculum will increase the knowledge of school staff on the recognition of bullying and appropriate intervention measures, assist schools in meeting state regulations, and decrease the number of students feeling unsafe at school as measured by the Youth Risk Behavior Survey. (http://www.cdc.gov/violenceprevention/youthviolence/bullyingresearch/index.html, http://www.cdc.gov/healthyyouth/data/yrbs/index.htm) |

**ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To empower adolescents to make responsible, healthy decisions to enable them to better transition into adulthood |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 10,000<br>**Numerator:** The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum<br>**Denominator:** |
| **Data Sources and Data Issues:** | MCH sessions data recording tool completed by PREP staff, Adolescent Health Specialists, Health Educators, and School Health Nurses |
| **Significance:** | Research has shown that youth who possess a greater number of health assets/protective factors are less likely to engage in high-risk behaviors such as sexual activity, illicit drug use, and alcohol use. Evaluations from the trainings capture each participant's opinion of the training as it pertains to how well they feel the training prepared them for resisting or saying no to peer pressure, knowing how to manage stress, forming friendships that keep them out of trouble, making health decisions about drugs and alcohol, etc.<br><br>Goesling B, Colman S, Trenholm C. Programs to Reduce Teen Pregnancy, Sexually Transmitted Infections, and Associated Sexual Risk Behaviors: A Systematic Review, Mathematica Policy Research. ASPE Working Paper. Department of Health and Human Services. |

**ESM 11.1 - Number of CYSHCN who received care coordination services from Title V CSHCN contract providers in the past year.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | The goal is to increase the number of CYSHCN who have received assistance through Title V programming to find, via case management and care coordination, a medical home. |
| **Definition:** | **Unit Type:** Percentage<br>**Unit Number:** 100<br>**Numerator:** Number of clients assisted with care coordination services from contractor reports<br>**Denominator:** N/A |
| **Data Sources and Data Issues:** | National Survey of Children's Health |
| **Significance:** | The key elements of the medical home are based on recognized standards of child and adolescent health care. They are documented in policies and best practice guidelines by recognized professional organizations, such as the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). |

**ESM 12.1 - The number of providers who address transition to adult health care in their practice**
**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**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the number of providers who address transition to adult health care in their practice |
| **Definition:** | **Unit Type:** Count<br>**Unit Number:** 300<br>**Numerator:** The number of providers who address transition to adult health care in their practice<br>**Denominator:** |
| **Data Sources and Data Issues:** | CSHCN Program, Oklahoma Department of Human Services & SoonerSuccess |
| **Significance:** | Health care transition planning is important as all teens should receive quality health care that is appropriate for their age. Teens should not go through a period of time without a primary care provider. Losing access to primary care, even for a short time, can affect the long-term health of a teen with special health care needs.<br><br>Center for Health Care Transition Improvement, Maternal and Child Health Bureau and the National Alliance to Advance Adolescent Health. |

## Form 10
## Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

**2016-2020: ESM 7.1.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum**
**2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the number of infants who experience abusive head trauma</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of infants delivered in birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum</td></tr>
<tr><td>Denominator:</td><td>The number of resident live births</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Vital Statistics Data, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health and Preparing for a Lifetime Injury Prevention Work Group</td></tr>
<tr><td>Significance:</td><td>The Period of Purple Crying is an evidence-based curriculum shown to have a positive impact on providing new parents with an effective technique for calming the baby and reducing abusive head trauma.<br><br>The Period of Purple Crying. National Center on Shaken Baby Syndrome.http://dontshake.org/purple-crying</td></tr>
</table>

## Form 11
## Other State Data

### State: Oklahoma

The Form 11 data are available for review via the link below.

Form 11 Data

## Form 12
## MCH Data Access and Linkages

**State: Oklahoma**

**Annual Report Year 2020**

| | Access | | | | Linkages | |
|---|---|---|---|---|---|---|
| Data Sources | (A) State Title V Program has Consistent Annual Access to Data Source | (B) State Title V Program has Access to an Electronic Data Source | (C) Describe Periodicity | (D) Indicate Lag Length for Most Timely Data Available in Number of Months | (E) Data Source is Linked to Vital Records Birth | (F) Data Source is Linked to Another Data Source |
| 1) Vital Records Birth | Yes | Yes | Daily | 0 | | |
| 2) Vital Records Death | Yes | Yes | Daily | 0 | Yes | |
| 3) Medicaid | Yes | Yes | Annually | 8 | Yes | |
| 4) WIC | Yes | Yes | Daily | 1 | No | |
| 5) Newborn Bloodspot Screening | Yes | No | Annually | 12 | No | |
| 6) Newborn Hearing Screening | Yes | No | Annually | 12 | No | |
| 7) Hospital Discharge | Yes | Yes | Annually | 12 | No | |
| 8) PRAMS or PRAMS-like | Yes | Yes | Daily | 18 | Yes | |

**Form Notes for Form 12:**

None

**Field Level Notes for Form 12:**

| | |
|---|---|
| **Data Source Name:** | **2) Vital Records Death** |
| | **Field Note:**<br>The linkage of birth and death data reflects only infant deaths/births. |
| **Data Source Name:** | **3) Medicaid** |
| | **Field Note:**<br>Linked Medicaid/birth data are developed through an agreement between OHCA, the state's Medicaid agency, and the OSDH. MCH employs a Medicaid analyst who has responsibility for linking and analyzing these data. This position is jointly funded by OSDH/MCH and OHCA. |
| **Data Source Name:** | **4) WIC** |
| | **Field Note:**<br>WIC data may be accessed through Public Health Oklahoma Client Information System (PHOCIS), OSDH's client services data system. |
| **Data Source Name:** | **5) Newborn Bloodspot Screening** |
| | **Field Note:**<br>Newborn bloodspot screening data are available upon request in aggregate form. |
| **Data Source Name:** | **6) Newborn Hearing Screening** |
| | **Field Note:**<br>Newborn hearing screening data are available upon request in aggregate form. |
| **Data Source Name:** | **7) Hospital Discharge** |
| | **Field Note:**<br>Hospital discharge data are available in aggregate form via OK2SHARE, the online data query system used by OSDH. MCH does request the public use data file of hospital discharge data. This provides de-identified record level data for MCH use. |