Maternal and Child Health Services Title V Block Grant

Oklahoma

FY 2023 Application/ FY 2021 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

July 28, 2022

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, 2020 through September 30, 2021, and the Annual Plan for October 1, 2022 through September 30, 2023.

For further information regarding this application, please contact Joyce Marshall at 405-301-1027 or JoyceM@health.ok.gov ; or Bethany Ledel at BethanyL@health.ok.gov .

Sincerely,

Joyce Marshall
Joyce Marshall (Jul 28, 2022 13:46 CDT)

Joyce Marshall, MPH
Director, Title V/Maternal and Child Health Service
Oklahoma State Department of Health

Bethany Ledel

Bethany Ledel
Grants and Reporting Director
Grants and Reconciliation, Financial Services
Authorizing Official
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Health.Ok.gov

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 2021, 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 2019, MCH analysts collected data on 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, and the second held in conjunction with the Joining Forces Conference convened by the OFN. 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 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, Its Everyone's Responsibility, infant mortality reduction initiative led by MCH, and the life-course 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 (OCCHD) and the Tulsa Health Department (THD) 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) and the Oklahoma Maternal Health Task Force (OMHTF), which aim to improve the care of women and infants throughout the state and the Children's State Advisory Work Group, which brings together multi-disciplinary professionals in child-serving agencies focused on improving mental and behavioral health for children and youth in the state. CSHCN Title V has contracts in place with the Comprehensive Pediatric Sickle Cell Clinic, Parent Promise Community HOPE Center, JumpStart Clinic, Family Support 360°, the Oklahoma Infant Transition Program, OFN, Sooner SUCCESS, and the JD McCarty Center to provide high quality, family-centered CYSHCN services.

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, media campaigns, health equity activities, and other-related programs and initiatives.

Maternal/Women:

Accomplishments:

- Began open enrollment on June 1 for newly expanded Medicaid eligibility to adults ages 19-64 whose income was 138% (133% with a 5% disregard) of the federal poverty level or lower.
- Continued Maternal Mortality Review (MMR) and the OMHTF, completing the second Maternal Morbidity and Mortality Annual Report.
- Assisted in training the parentPro home visiting staff on medical norms for the pregnancy and postpartum periods.
- Created and ran public service announcements on streaming services with messages regarding preconception health and healthy pregnancies.

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 health.
- 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 via the six new maternity clinics.

Perinatal:

Accomplishments:

- 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 Project (HBEP) and Becoming Baby-Friendly in Oklahoma (BBFOK) Project.
- Distributed 226 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 the 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.
- Continued support for Child Passenger Safety (CPS) activities, including staff time for the installation of car seats to families in need and providing staff for community training and technical assistance on child passenger safety.
- Continue work with the OPQIC and partners to address opioid use/abuse in pregnant women and the increasing rates of newborns diagnosed and treated for neonatal abstinence syndrome.

Child:

Accomplishments:

- Provided funding for the Oklahoma Poison Control Hotline for training and technical assistance to families, students, health care providers and child care programs.
- Participated in the Oklahoma State Obesity Plan Stakeholders Group, serving on the early childhood and school age working groups.
- Assisted in the planning, funding and implementation of the new Parent Warmline for Oklahoma families, 1-888-574-5437.
- Maintained school health contracts to support physical and social emotional health activities in the state's two largest school districts and in one statewide school health organization.
- Implemented Child Health well and sick care visits in pilot health department districts across the state.

Plans:

- Promote bullying prevention and suicide prevention trainings in schools across the state.
- 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 (OSDE) in planning implementation for the new Health Education requirement for public schools.

Adolescent:

Accomplishments:

- Supported eight state-funded adolescent pregnancy prevention projects in local county health departments,

and administered the Personal Responsibility Education Program (PREP) grant for OCCHD and THD.
- Hosted the first Adolescent Health Summit, a two-day virtual event for interdisciplinary youth-serving professionals across the state of Oklahoma in June 2021. Topics included: youth mental health, inclusivity, bullying prevention, positive youth development, and youth connectedness.
- Participated in the OSDE work group to update existing Oklahoma Academic Standards for Health Education.
- 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 (PHYCs) 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.
- Host the second Adolescent Health Summit.
- 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 parent-to-parent support, sibling support, training, and opportunities for family leadership via OFN.
- Continued funding the Oklahoma Infant Transition Program (OITP), Sooner SUCCESS, 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, Parent Promise, Family Support 360°, and the Sickle Cell Clinic to further work in the state for the families of CYSHCN.
- Promote 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. More recently, these funds are supporting new child health and maternity care clinics. 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.

Federal Title V funding 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, supplemental formula for weight gain, specialized formula supplements for PKU 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 Joining Forces and the Association of Maternal and Child Health Programs (AMCHP) Conference. This helps assure families have a voice in MCH and CSHCN services.

Although somewhat lessened for FFY23, Title V-funded staff continue to provide assistance for the COVID-19 pandemic. This includes county health department and central office staff working on multiple aspects of pandemic response, from 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 continue to respond to COVID-19 related needs for the families they serve, and to alumni families as needed. The community partners assist families in procuring necessary personal protective equipment (PPE) as well as accommodate families technologically in order to help them access benefits, medical visits, and trainings. Spanish speaking families are provided important COVID-related information and updates in Spanish. One Title V CSHCN community partner has recently added a staff member dedicated to serving the Black/African American community with information, training and resources, both COVID and non-COVID related, in order to reduce health disparities.

III.A.3. MCH Success Story

In September 2021, the Oklahoma Family Network (OFN) hosted the first Family Matters Virtual Conference with funding from the Oklahoma Department of Human Services (DHS) CSHCN Title V Program. The goals of the conference were to help build families' knowledge of services, to discover additional support for their children, and to help families manage the many challenges of caring for a child/young adult with special health care needs, behavioral health needs or disabilities.

The Family Matters Conference also focused on the promotion of participant self-care, honing leadership and partnership skills and assisting families with understanding how to belong and participate in micro- and macro- level communities. A variety of sessions were provided in English and Spanish, including topics such as advocacy (neighborhood to legislation), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), health care transition, caregiver nutrition/stress evaluation, and understanding the sibling perspective.

Conference materials included items and resource materials from partnering agencies, and self-care items, each reflective of the conference topic and goals. OFN mailed 258 conference boxes of materials to those who met the registration deadline.

With the support of OFN's community and agency partners, the conference will become an annual event, with sessions to remind families that they are not alone. Of the 376 registrants, 208 different participants attended. Conference evaluations indicated that 97% of the participants were satisfied or highly satisfied, 89% said their skills had increased, 87% said their understanding of family professional partnerships had increased, 83% indicated they would use the skills they learned in their personal life and 82% would use them with their family. Additional feedback from participants included these narrative statements: "I came to the conference as a professional in Child Care Licensing not really knowing what to expect. But I gained so much information that I can use in my personal life as well as a parent of a child with Autism and a liver disease", "Conference was very informative. Looking forward to more in the future" and "I needed this."

The Family Matters Conference sessions were made available on OFN's YouTube channel: https://www.youtube.com/channel/UC5KMi7XSNF65Kof2QRu-juQ

III.B. Overview of the State

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

Demographics

In the 2020 Census, 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 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 17% (681,000 residents) of the state's population. About 100 miles to the northeast is Tulsa, a city accounting for 10% (413,000 residents) of the state's population. Nearly 90 miles southwest of the capital, sits Lawton, a city consisting of 90,000 residents, or 2.3% of Oklahoma's population.

Nearly a quarter (24.1%, 953,000) of the Oklahoma population is less than 18 years of age. Individuals aged 65 years and older make up 16.4% of the population, and roughly 61% of the population is between 18 and 64 years of age. The male-female ratio is about 1:1, with slightly more females (2.0 million) than males (1.97 million). Females of childbearing age (15-44 years) number 781,000, about 20% of the total population. The number of females aged 15-19 years account for 128,700, about 16% of childbearing age females. The number of women aged 30-34 has increased by nearly 12% between 2010 and 2020, rising from 118,800 to 132,500.

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 2020, 77% of Oklahoma's population was classified as white, while American Indians represented 11% and African Americans comprised 9% of the state's population. Approximately 3% of the population was categorized as Asian or Pacific Islander. The Hispanic population has grown from 8% (302,000) of the total population in 2010 to 11% (452,500) in 2020, a growth of 50% over the time period. Oklahoma is home to the largest number of federally recognized American Indian tribal governments (38).

Data from the U.S. Bureau of Economic Analysis indicate that Oklahoma's per capita personal income was $53,156 in 2021, ranking 42nd among all states, and representing about 84% of the national average of $63,444. U.S. Census Bureau data show that 15.3% (606,000 people) of Oklahoma residents were living in poverty in 2020, an increase from 15.2% the previous year. Females (16.5%) were more likely to be living in poverty than were males (14.0%). Among children less than 18 years of age, 20.7% lived in poverty in 2020. Poverty status was more likely in minority populations when compared to the white population, with Native Hawaiian or Other Pacific Islanders (33.1%) having the highest percentage of residents in poverty, followed by African Americans (26.2%) and American Indians (20.0%).

Oklahoma's birth rate was 12.0 births per 1,000 total population in 2020, ranking 41st among other states, and about 9% higher than the comparable U.S. birth rate (11.4). Since 2010, the birth rate has decreased by 15%, with the state averaging about 51,500 births per year. Similarly, the fertility rate has decreased from 71.9 births per 1,000 females aged 15-44 years to 60.9 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 2020, Oklahoma's teen birth rate for females ages 15-19 was 25.0 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 (69,000 employees, military and civilian) and Walmart Associates, Inc. (38,500). In the health sector, INTEGRIS Health has 9,600 employees, followed by Saint Francis Hospital (6,400), Mercy Health and the University of Oklahoma Health Sciences Center (5,900 each), OU Medical Center (5,200), St. Anthony/SSM Health Hospital (4,000), and St. John's Medical Center (3,800).

Oklahoma's real gross domestic product (GDP), the output of all goods and services produced by the economy in current dollars, totaled $195.0 billion in 2021, according to data from the U.S. Bureau of Economic Analysis, up by 2.5% from 2015 ($190.2 billion). The private sector comprises 85% of Oklahoma's real GDP, with government making up the remainder (15%). As a percentage of GDP, the industry share in the economy was led by natural resources and mining (20%), the FIRE sector (i.e., finance, insurance, and real estate) (13%), manufacturing and information (12%), trade (10%), education and health services (7%), and transportation and utilities (6%).

Gaming (lotteries and casinos) continue to be a major contributor to the state's economy. The state of Oklahoma collected over $163 million in tribal gaming exclusivity fees in fiscal year 2021, a 32.5% increase from the fiscal year 2020. Those fees were based on $2.74 billion in tribal gaming revenue. Exclusivity fees were distributed to the Education Reform Revolving Fund ($143.2 million), the General Revenue Fund ($19.5 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 2021 showed that annual average unemployment rate for Oklahoma was 3.8%, ranking the state 13th nationally and approximately 28% lower than the US unemployment rate at that time. Of the state's 77 counties, 39 counties had an unemployment rate less than the state average, 36 counties had a rate in excess of the state average, and 2 counties had the same unemployment rate for 2021. County unemployment rates ranged from 1.7% (Beaver County, located in the state's panhandle) to 7.3% (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 58.3 in 2021, slightly lower than the national rate (58.4).

Urbanization

Approximately 61% of the Oklahoma population resides in the metropolitan statistical areas (MSAs) of Oklahoma City (1,441,647; 36%) and Tulsa (1,023,988; 25%), while a much smaller proportion of the state's citizens lives in the Lawton MSA (127,543; 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 was modest between 2020 and 2021, increasing by 0.9%. 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 just 0.7% between 2020 and 2021. With similar rate of growth, the Lawton MSA, made up of Comanche and Cotton counties, grew by 0.7% over the same time period.

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 the Oklahoma State Department of Health (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 past and current state and national efforts as well, including the Maternal Health Innovation Program, CoIIN to Reduce Infant Mortality, the Oklahoma Perinatal Quality Improvement Collaborative, the Period of Purple Crying Program, the MCH Safe Sleep Project, and 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 (DHS), the Oklahoma Commission on Children and Youth (OCCY), 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 four reporting years 2016 through 2019, the state observed an increase in preterm birth rate, similar to the nation's, rising from a low of 10.3% in 2015 to 11.5% in 2019. In 2020, Oklahoma did observe improvement in preterm birth with the rate falling to 11.2%. Despite still having the 4th highest birth rate among teens aged 15-19, Oklahoma has experienced significant declines in the last two decades. In 2020, the teen birth rate for this population group was 25.0 births per 1,000 female population, a decrease of 8.8% over the recorded rate of 27.4 in 2019. While Oklahoma's 2020 teen birth rate was still much higher than the comparable national rate (15.4), 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 (IMR) has decreased from 8.6 per 1,000 live births in 2007 to 6.0 in 2020, a relative decrease of 30% 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, 2020. From the onset of the pandemic through mid-April 2022, more than 1,038,224 known cases and 15,815 provisional COVID-19 deaths have been recorded in the state. Oklahoma's governor, Kevin Stitt, issued Executive Order 2020-7 on March 15, 2020, declaring 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 2.2 million individuals have been fully vaccinated with more than 5.8 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 were 9,700 Oklahoma business locations which 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 steadily declined to 4.2% by March 2021. The annual average unemployment rate for Oklahoma in 2021 was 3.8%, nearly back to the level observed prior to the onset of the coronavirus pandemic.

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, DHS, ODMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, OHCA, 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. OSDH programs and services are configured under three Deputy Commissioner areas: Community Health Services, Quality Assurance and Regulatory Services, and Health Preparedness. Community Health Services (CHS) is comprised of the county health departments, Family Health Services, Personal Health Services, Nursing Services, and Records and Community Health Systems. 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. Services comprising Personal Health include Community Development, Chronic Disease Service, Injury Prevention Service, and Immunization Service.

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

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, Mendy Spohn. Ms. Spohn reports directly to the Commissioner of Health, Keith Reed, who was appointed by Governor Stitt upon the resignation of Lance Frye, MD, in October 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 DHS 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 Deborah Smith. Title V CSHCN provides funding for respite through periodic vouchers to caregivers and through short-term inpatient stays and camps 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 (OUHSC) 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), Family Partners JumpStart Clinic (developmental and behavioral screening services), Sooner SUCCESS (comprehensive system of health and educational services), the Comprehensive Sickle Cell Pediatric Clinic (healthcare transition services) and the Oklahoma Infant Transition Program (family support for newborns in the NICU). Parent Promise Community Hope Center and Center for Children and Families, Inc. (CCFI) Community Hope Center recently began receiving funding to lift up families of CSHCN through social service network navigation and assistance with securing concrete supports. The Community Hope Centers (CHC's) infuse the science of Hope and promote self-sufficiency and resilience. 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 223,770 children in Oklahoma with a special health care need in 2019-2020.

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, 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 693 active pediatricians in the state in July 2022.

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 OHCA, 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. In March 2022, Oklahoma had 974

children 18 years and under accessing SoonerCare via TEFRA. Additionally, 18,091 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 OHCA 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. Eligible enrollees began signing up for the program on June 1, 2021. 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. More than 291,000 individuals have benefited from expanded eligibility in the last year. In 2022, Oklahoma passed legislation that privatizes Medicaid for certain populations, implementing a managed care structure that administers services through capitated payment plans, to begin October 1, 2023.

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 session of the 58th legislature (2022). SB indicates a Senate bill, HB, a House bill.

Abortion
SB 612, signed by Governor Stitt on April 22, 2022, prohibits the performance of an abortion in the state, except to save the life of a pregnant woman in a medical emergency. Violation of this law is a felony with a person convicted of performing an abortion subject to up to a $100,000 fine and confinement in the Oklahoma Department of Corrections, not to exceed 10 years.

SB 1503, immediately in effect upon passage by Governor Stitt on May 3, 2022, creates the Oklahoma Heartbeat Act, a measure providing that a physician my not knowingly perform or induce an abortion unless it has been determined there is no detectable fetal heartbeat. The Act requires the physician to perform a certain test with specified criteria and that certain information be included in the medical record of the pregnant woman. The measure does not apply should the physician believe a medical emergency exists, thus, preventing compliance with the Act.

HB 4327, immediately in effect upon passage by Governor Stitt on May 26, 2022, authorizes individuals to take civil

action against those who perform abortions or help a person obtain an abortion. The woman seeking an abortion cannot be sued under this legislation. The law contains exceptions for abortions performed to save the life of the mother in a medical emergency, and provides an exception in cases of rape or incest reported to law enforcement.

Suicide Prevention
On April 21, 2022, Governor Stitt signed into law SB 1307, which requires school districts and charter schools serving students in grades 7th through 12th to issue student ID cards with the National Suicide Prevention Lifeline and the Crisis Text Line. Further, the bill allows for institutions within the Oklahoma State System of Higher Education and private institutions of higher education in the state to issue student ID cards with the telephone number for the National Suicide Prevention Lifeline, the Crisis Text Line, and the campus police or security telephone number. Law becomes effective July 1, 2023.

CPR and First Aid
SB 1462, which became Ava's Law following the governor's signature on April 21, 2022, requires that all persons licensed to practice medicine and surgery in Oklahoma; as well as Advance Practice Registered Nurses and those who provide prenatal, delivery, infant care services, provide resources and information about CPR and basic first aid to women who are pregnant or plan to have a baby. The OSDH is charged with compiling educational resources on infant cardiopulmonary resuscitation and basic first aid to include contact information for training programs and to make this information available on its webpages. Law becomes effective November 1, 2022.

State Commissioner of Health
SB 709 exempted potential candidates for the position of Commissioner of Health from existing qualifications. Prior to the passage of this bill, candidates for the position had to meet at least one of the following criteria: possess a doctor of medicine degree and a license to practice medicine in Oklahoma; possess an osteopathic medicine degree and a license to practice medicine in Oklahoma; possess a doctoral degree in public health or public health administration; or possess a master of science degree and at least five years of supervisory experience in the administration of health services. SB 709 stipulates that the Commissioner of Health serves at the pleasure of the governor and shall be exempt from the above qualifications if they possess at least a master's degree and has experience in management of state agencies or large projects. This bill was enacted into law as of April 26, 2022.

Vital Records
SB 1100 limits the biological sex designation on a birth certificate to either male or female and shall not be nonbinary or any symbol representing a nonbinary designation. Bill was enacted into law immediately upon the governor's signature dated April 26, 2022.

Vision Screening
HB 3823 specifies that licensed optometrists and ophthalmologists may perform vision screening for children enrolling in kindergarten, first and third grade. The bill exempts these professionals from the standards and training requirements created by the Infant and Children's Health Advisory Council. Governor Stitt signed HB 3828 on April 29, 2022, and the bill will be enacted into law on November 1, 2022.

Tobacco Use Prevention
HB 3315 removes the fine associated with persons under 21 who purchase tobacco, nicotine, or vapor products, and requires them to complete an education or tobacco use cessation program approved by the OSDH. The law removes language permitting cities and towns to enact and municipal police officers to enforce ordinances prohibiting and penalizing the purchase or possession of such products by a person less than 21 years of age. Governor Stitt signed HB 3315 on May 16, 2022, and the law will become effective November 1, 2022.

Congenital Anomalies

Signed by Governor Stitt on April 29, 2022, SB 1203, to be enacted as Courtney's Law in November 2022, requires any health care facility, health care provider, or genetic counselor providing prenatal care, postnatal care, or genetic counseling upon receipt of a positive result for a chromosomal disorder test, will provide the parents with specific disorder information as prepared by the OSDH. Information will be culturally appropriate for woman or family in question.

Medicaid Program

SB 1337, signed into law by Governor Stitt in May 26, 2022, allows private health care providers to be awarded contracts to managed Medicaid for patients in Oklahoma. The law requires the OHCA to issue request for proposals (RFP) for all Medicaid services other than dental services for certain Medicaid populations – pregnant women, children, newborns, parents and caretaker relatives, and the expansion population. OHCA must specify covered and not covered services in the RFPs and to implement the program by October 1 2023, pending approval by the Centers for Medicare and Medicaid Services (CMS).

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

Ongoing needs assessment activities
Assessment staff continued 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 continued to collect data but has been facing significant 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 2020; unfortunately, the response rate was insufficient for weighted data, marking the second consecutive year with this result. Collection cycle for 2021 shows promise with provisional response rates above the 50% threshold currently in use by PRAMS projects. This improvement is driven by the implementation of Amazon gift cards ($10 value) as a reward for survey participation. The PRAMS project applied and received funding ($25,000) from the Council for State and Territorial Epidemiologists to implement a COVID-19 Vaccine Supplement for a portion of the year. With this funding, the gift card value was increased to $20. Data for the 2021 collection cycle should become available in late 2022. MCH Assessment published two reports using PRAMS data in 2021 – *Social Support Among Oklahoma Mothers* and *Preconception Health Disparities and Birth Outcomes among Foreign-Born and Native-Born Hispanic Women in Oklahoma*.

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 reasonably 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 school semester. Administration of the survey was successful with nearly all MCH staff taking part. As previously reported, the 2021 survey includes the 16 questions on adverse childhood experiences. Cycle 2021 data should become available mid-year 2022. YRBS publications using the latest cycle data available (2019) were published during 2021, focusing on mental health, unsafe driving, alcohol use, sleep health, nutrition, dating violence, and adolescent suicide.

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 was on hiatus for 2021 due to the extended period of time for which

the Medicaid Analyst position was vacant. The incumbent resigned in late 2020 and while recruitment was underway throughout the year a qualified candidate was not hired in 2021. Fortunately, in July 2022, Assessment was able to hire a master's trained epidemiologist to fill the position. Rakel Cleveland will assume the position in August. After that time, the project will resume activity of linking and analyzing Medicaid and birth data.

Assessment continued its participation 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 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 were abstracted with collected data then submitted to CDC for analysis and research publication.

Changes in health status and needs of 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.

The state has observed improvements in select health indicators. The rate of infant mortality decreased sharply, down 14% from 7.0 infant deaths per 1,000 live births in 2019 to 6.0 in 2020. However, provisional data for 2021 indicate a return to a rate (7.0) similar to that in 2019. Still, Oklahoma has made progress in reducing infant mortality as the trajectory of the rate over a longer period of time shows a downward trend. Teen birth rates have continued to decline across all age groups between 2015 and 2020 – ages 15-17 down 37% to 10.1 births per 1,000 population, ages 18-19 down 25% to 48.1, and ages 15-19 down 28% to 25.0. These downward trends in teen childbearing were observes for all race and ethnic groups.

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, before falling to 11.1% in 2020. 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 8.2% in 2018, and then rising yet again to 8.3% in 2020. Maternal mortality has increased as well, rising from 18.9 maternal deaths per 100,000 live births in 2014-2016 to 29.5 in 2017-2019, and then sliding back to 25.2 in 2018-2020.

Changes in state's Title V program capacity

Oklahoma's Title V programs have experienced staffing changes. The Perinatal and Reproductive Health Division added an Advanced Practice Registered Nurse, Amy Foster, to its staff to support maternity clinics and the Maternal Health Innovation Program grant. Likewise, the Child and Adolescent Health Division hired an Advanced Practice Registered Nurse, Misty Hammons to provide technical assistance and support to Child Health clinical staff and assist with nurse and APRN trainings. As previously reported, the Assessment Division lost a staff analyst (Medicaid Analyst) to resignation in October 2020. Recruitment for the position was prolonged but a qualified candidate was hired in early July 2022 with a start data set for August 1, 2022. Rakel Cleveland (MS, Epidemiology) will join the Assessment team as the Medicaid Analyst, performing linking and analysis of Medicaid/birth records. In March 2022, a long serving PRH Epidemiologist, Dana Coles, resigned. Assessment has been successful in recruiting and hiring a replacement in short order. Jenna Bellantoni (MPH, Epidemiology) began her employment on July 6, 2022. Her responsibilities as the PRH Epidemiologist will be to support program activities in the PRH Division, including

primary support for the Title X and State Maternal Health Innovation Program grants. Ms. Cleveland and Ms. Bellantoni also will provide support for the Title V Block Grant Application/Annual Report and the Five-Year Needs Assessment. Lastly, Susan Harman, who held the SSDI Analyst position in Assessment, retired at the end of 2021. Assessment has hired Cynthia Bates (MPH, Epidemiology) to serve as the new SSDI Analyst, beginning in May 2022.

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. While COVID as abated in recent months, MCH continues to do much of its collaborative work virtually on TEAMS and Zoom calls.

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
Lance Frye, MD, who was confirmed as the Commissioner of Health in April 2021, resigned his post in October 2021. Following Frye’s resignation, Governor Kevin Stitt appointed Keith Reed as the Interim Commissioner of Health at the Oklahoma State Department of Health (OSDH). Mr. Reed is a long serving OSDH employee and has since been confirmed as the agency’s lead. OSDH has experienced several organization changes in the last year. Health services are split across three areas led by Deputy Commissioners for Community Health Services, Quality Assurance and Regulatory Services, and Health Preparedness. Community Health Services encompasses the county health departments, Family Health Services, Personal Health Services, Nursing Services, and Records and Community Health Systems. Quality Assurance and Regulatory Services is comprised of Long Term Care, Medical

Facilities, Health Resources Development Service, and Consumer Health Services. Health Preparedness includes the Public Health Laboratory (now located in Stillwater, Oklahoma), Emergency Preparedness and Response Service, Acute Disease, Sexual Health and Harm Reduction Services, Center for Health Statistics, and Vital Records. Also, Health Preparedness is home to the Office of the State Epidemiologist and the Chief Science Officer.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,956,304	$7,049,999	$7,407,455	$7,215,434
State Funds	$5,217,228	$5,988,318	$5,578,263	$6,120,077
Local Funds	$219,826	$1,189,061	$0	$1,220,999
Other Funds	$0	$0	$0	$0
Program Funds	$32,970	$0	$1,196	$0
SubTotal	$12,426,328	$14,227,378	$12,986,914	$14,556,510
Other Federal Funds	$4,890,970	$6,599,270	$5,361,987	$7,771,094
Total	$17,317,298	$20,826,648	$18,348,901	$22,327,604

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,215,434	$7,310,479	$7,215,434	
State Funds	$5,411,576	$6,193,837	$5,411,576	
Local Funds	$0	$1,082,489	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$12,627,010	$14,586,805	$12,627,010	
Other Federal Funds	$8,147,585	$7,506,294	$8,025,771	
Total	$20,774,595	$22,093,099	$20,652,781	

	2023	
	Budgeted	Expended
Federal Allocation	$7,310,479	
State Funds	$5,482,860	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$12,793,339	
Other Federal Funds	$7,737,047	
Total	$20,530,386	

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 labor 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 began July 1, 2021. This expansion 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. The expansion of Medicaid will enable more women and men of childbearing age to receive full health care services, thus improving their preconception health and ultimately health across the lifecourse.

For FFY 2021, the 30/30/10 requirement was met; 32% of the federal Title V MCH Block Grant funds were designated for programs for preventive and primary care services for children, 32% for services for children with special health care needs, and, 8% for administrative costs. Form 2 indicates Title V federal and overall state match dollars remained fairly level when comparing 2020 to 2021 numbers, which is considered an accomplishment in light of the extensive pandemic challenges in 2021. It should be noted that although local dollars decreased by 11% due to pandemic needs and requirements, state dollars were slightly increased allowing the overall state match to remain at a flat level while continuing to exceed the federal matching requirements. Due to the flexibility of MCHB and Title V to utilize funds for COVID-19 needs in the MCH population, difficulties with staffing and funding issues did not reach the severity they could have otherwise. The on-going pandemic delayed the move to gap-filling prenatal care and child health services in local county health departments and mobile units, as staff were detailed to COVID-19 urgent needs such as the hotline, testing, vaccination pods, etc. However, services for child health were made available in several pilot sites throughout the state during FFY 2021. Maternity and prenatal care services were not able to begin until February 2022.

Form 3a documents expenditures by types of individuals served. For FFY 2021, total funding for infants/infant mortality reduction program increased 11% and funding for children with special health care needs by 5.4%. At the same time, funding for children 1-21 was flat, and funding for pregnant women decreased by 30%, as SMHIP dollars were utilized for new maternal health programs. The shift in funds in these areas was done thoughtfully due to enhanced efforts to focus on CSHCN and the infant mortality reduction initiative: *Preparing for a Lifetime: It's Everyone's Responsibility*. The infant mortality funding increase complimented additional funds from the SMHIP grant that MCH utilized for pregnant women through maternal health initiatives such as: a clinic for pregnant women with substance use disorders, tribal maternal-fetal medicine services, High Risk OB Project ECHO, maternal safety bundle for Oklahoma mothers and newborns affected by opioids, and launching the innovative Delivery Decision Initiative's Team Birth program to improve delivery, postpartum and equity care. Funds for children focused on maintaining the teen pregnancy prevention and positive youth development programs, school and community-based health education, child health clinics and epidemiology/analytical services in districts throughout the state.

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 relatively flat from 2020 to 2021, as did enabling and public health systems and services. This was due in large part to the effect of the continuing pandemic and the manner in which services were accessed during this time. Thus, the shift to more population-based services to address immediate and resulting pandemic needs, along with working with organizations and partners in relation to best practices implementation in the areas of maternity, child health, and infant mortality reduction continued into 2021.

With these changes, it should be noted that the Oklahoma Title V Program remained 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 the MCH population as was critically necessary in the continued pandemic year of 2021.

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 DHS 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 DHS 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 2023, 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.

DHS 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 DHS; 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 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 disorder 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. A supplemental grant was

received to fund adding specific ACES questions to the survey beginning in the 2021-2022 school year.

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 infections (STIs), 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 administration of the 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 STIs, 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 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, although these were on hold during FFY 2021 due to the pandemic. Site visits resumed in the spring of 2022.

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) 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. 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 greatly 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 Mendy Spohn, 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 Deborah “Deb” Smith, 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. Mrs. Smith reports to Justin Brown, DHS Director. Mr. Franks reports to Mrs. Smith. 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; maternity and child health clinics in rural county health departments; 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 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 weekly meeting held by the Assistant Deputy Commissioner for the FHS Directors 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, 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). Training and guidance are provided to approximately 600 Family Services Specialists (FSS) throughout DHS, who are responsible for disseminating information about the Supplemental Security Income-Disabled Children's Program (SSI-DCP) and other services through DHS. FSS make appropriate referrals to the divisions and staff responsible for developing and monitoring service plans. 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, Sooner SUCCESS, Oklahoma Family Support 360° Center, Comprehensive Pediatric Sickle Cell Clinic, Oklahoma Infant Transition Program, Family Partners/JumpStart Clinic, JD McCarty Center, Parent Promise Community Hope Center and the Center for Children and Families, Inc. (CCFI) Community Hope Center. The CYSHCN related services above can be accessed via the Family 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, supplemental formula, 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 Joining Forces and 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 the Maternal Health Innovation grant's usage of the CHESS Health app to assist providers working with pregnant women with mental health and 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 the State Obesity Plan to reduce obesity across the lifespan for Oklahomans and reviewing MCH-related legislation for potential impact to agency programs, budgets and staff for the legislative liaison.

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 34 full-time equivalent (FTE) positions. Of those employed by MCH, 13 have more than 10 years' experience working in MCH, 7 have 5-10 years' experience and 12 staff members have less than 5 years with the program. Two vacancies currently exist. The Child and Adolescent Health Division is undergoing reorganization to provide valuable coverage throughout its programs. 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. 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.

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, customer service, 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, and a site visit to both the Oklahoma Family Network and a county health department (when possible due to COVID-19 restrictions).

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 2022 includes: chronic diseases impacting reproductive health, child abuse, neglect, 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, adverse childhood experiences, adolescent health issues, and 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 in person trainings were placed on hold, but have been presented to state universities interested in a virtual forum.

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, in April 2021, many Districts renewed the process of searching for applicants. Recruitment has also begun for gap-filling Maternity and Child Health APRNs for Health Department Districts throughout the state.

The Title V CSHCN program 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 (PFR). 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 600 AFS eligibility workers statewide. Eligibility workers disseminate information about the Supplemental Security Income-Disabled Children's Program (SSI-DCP) to the families of SSI children that they serve on their caseloads. Families who are interested in these services are then referred to the Title V PFR to complete the requests and monitor services, as SSI-DCP is moving toward centralization. Services provided through the SSI-DCP are supplemental formula, adaptive equipment which aid in accessibility and mobility, interaction and integration services aimed at strengthening the child physically and mentally, and respite care.

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 and information in the field regarding Title V services through online tutorials (QUEST) on the Agency's Infonet. Assistance on Title V services is also available through a DHS State Office Health Related & Medical Services Outlook Mailbox. Additionally, a Microsoft Teams channel dedicated strictly to Health Related & Medical Services (HR&MS) was recently established in order to provide timely one-way communication to AFS field staff about important updates and reminders.

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 are designed to help to reduce variation and provide consistency which assist in staff training and provide more timely benefits to our CSHCN population.

The caseload distribution process for AFS field staff was transitioned over the last year from a regional process to a statewide work share model. This newly updated statewide assignment process was established 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. AFS staff were trained on the 'Be A Neighbor' platform, a statewide initiative, in order to connect families to Oklahoma's non-profits, faith-based groups and community organizations across the state's 77 counties. Additionally, more AFS workers were imbedded into the local communities with various community partners, to meet the customer where they are.

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

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 working on a Health Care Transition Provider Training webinar series. Additionally, 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, Developmental-Behavioral Pediatrics (DBP) fellows, and pediatric residents/faculty to improve how patients transition from pediatric to adult health care services.

A Family Partner for Jumpstart Clinic at Child Study Center is a parent who has first-hand experience with a child, or children, with a developmental disability. The Family Partner works with families who come to the clinic by assisting them in accessing resources and services, gaining knowledge and experience about their child's needs, and guiding them to build their advocacy skills.

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, Developmental-Behavioral Pediatric (DBP) 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 DBP fellowship training is a three-year program housed in the Section of DBP at the University of Oklahoma Health Sciences Center. 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 ASD and other Developmental Disabilities (DD), and their families. The funding for the program will continue through the Department of Pediatrics. 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.

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 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 (OKDHS) Developmental Disabilities Services; 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 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 and Office of Juvenile Affairs activities to reduce the number of children in custody and to support HOPE Centers.

OFN has and will continue to provide podcasts which include a family story about parenting a child with special needs and the sharing of resources for a number of MCH and CSHCN topic areas. All podcasts are highlighted in the quarterly OFN newsletter, promoted on OFN Facebook pages, are available on the OFN Podcast Platform, entitled "We Saved You a Seat." Podcasts can be accessed through the listener's favorite podcast listening app, and are linked to the OFN website. The podcasts have also enabled providers to share information and resources about important topics like maternal mental health, breastfeeding, and other specific topics from agencies who partner with families. OFN has published 74 episodes with more than 5,500 total downloads, from at least 19 different countries in the last 24 months. Currently, the podcast has 94 followers through the Podbean platform. There is a long list of families who have expressed a desire to share their story to encourage and support others, as well as advocates, agencies, and community partners willing to share information. Podcasts have been proven to bring awareness, conversation, education, and support to others as they listen to family stories and hear about community and agency resources.

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, Charting the LifeCourse (CtlC), 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 advisory groups, 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 efforts, and by having a presence on state level advisories. Some of those advisories include: State Department of Education Part C, Mental Health and Substance Abuse Services, State Department of Health Information and Education Committee, the Oklahoma Perinatal Quality Improvement Collaborative and Leadership Team, the consumer advisory of the Medicaid agency and 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 15 years, OFN has hosted Joining Forces: Supporting Family Professional Partnerships Conference. In 2022, a hybrid platform was provided allowing for over 300 families and professionals to attend either in-person or virtually. Through the online platform, attendees were able to interact before, during and after the conference, sharing resources, discussion boards and networking. The focus was on family engagement and family/professional partnerships provided by Eileen Forlenza with seven breakout sessions, including one hosted by Title V Leadership to gather public input for the Title V MCH Block grant. Sessions were available in Spanish and ASL interpretation was also provided. The annual conference contributes to activities that serve to strengthen and advance family partnerships throughout the state and in multiple programs and systems, including Title V.

OFN trainings are provided statewide in various formats and are available in Spanish and ASL interpretation upon request. During the Family Track of the 2021 Virtual Children's Behavioral Health Conference, OFN provided translation for all sessions in Spanish. The families were offered child care reimbursement and three family leaders without proper electronics were provided tablets to access the virtual conference. 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 what to expect during a genetics appointment. Additionally, the Care Notebook documents are now available on an app for ease of use. 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, maternal mental health education, and NICU tip sheets in English and Spanish. Staff are working on developing similar folders for genetic referrals, including newborn screening information.

OFN staff assist in identifying youth for participation and leadership to provide consultation for MCH related activities. Youth leadership and input into Title V is becoming more and more vital to efforts to best serve youth and their families. These efforts assist MCH in marketing efforts, planning conferences with content relevant to youth and engaging youth to become advocates for public health work. Stipends are provided through OFN for participation.

OFN staff partner with community leaders to help bring awareness and conversation to maternal mental health and perinatal mood disorders through the Postpartum Support International (PSI) walk, Climb Out of The Darkness (COTD), which is held in June each year. This walk provides awareness and raises funds to support the community and those experiencing a perinatal mood and anxiety disorder.

To maintain strong and engaged hospital partnerships through strict COVID-19 policies and no in-person family engagement, OFN supported families and community hospital staff by providing care packages and notes of encouragement. In April 2022, OFN returned to in-person support in hospitals and reestablished key partnerships to provide support for families experiencing a Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU) hospital admit with their child. OFN also resumed in-person emotional support, resource navigation and in-person support groups. OFN has organized families to provide unique support to hospital staff during Nurse Appreciation Week and other special occasions.

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

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

The MCH Assessment Division (Assessment) has the responsibility for building data capacity and all analysis-related functions in advancing MCH priorities, including the collection, management, statistical analysis, and reporting of data. Assessment is comprised of 13 positions (11 FTEs), which include epidemiologists, a biostatistician, and project managers, as well as support staff who perform administrative and operational duties within the division. Assessment administers the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), and the State Systems Development Initiative (SSDI). These projects serve as the main surveillance activities and data capacity enhancements in the Assessment unit. In addition, Assessment is an extensive user of birth and death certificate data and that of the Public Health Oklahoma Client Information System (PHOCIS), the Oklahoma State Department of Health's data system which captures client information with respect to caseload and service utilization as experienced in contract sites and county health departments.

Paul Patrick, Administrative Program Manager (1.0 FTE), serves as the division supervisor for the Assessment Division. Mr. Patrick holds a Master's of Public Health in Biostatistics and has greater than 20 years of public health experience with the majority of his career spent in MCH. He serves as the data contact for the Title V MCH Block Grant and has responsibility for writing key sections of the annual report and application. Mr. Patrick's responsibilities include supervision of Assessment staff, design and oversight of the Title V MCH Five-Year Needs Assessment, and completion of grant applications and performance reports. Mr. Patrick prepares and oversees Assessment's Institutional Review Board applications for surveillance projects. Funding for the Assessment Administrative Program Manager comes from the Title V MCH 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 and the SSDI Analyst positions in Assessment. She also assists with directing priority analyses of the OHCA/MCH Medicaid Shared-Data Workgroup. She has more than 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 Assessment had been vacant since October 2020. In August 2022, Assessment hired Rakel Cleveland (MS, Epidemiology) as the Medicaid Analyst. This position has responsibility for linking and analyzing birth certificate and Medicaid administrative records. Funding for the position is shared by OSDH/MCH and the Oklahoma Health Care Authority, the state's Medicaid agency.

Cynthia Bates, MPH in Epidemiology, holds the position of State System Development Initiative (SSDI) Analyst (1.0 FTE) in Assessment, beginning her employment in April 2022. In her role as SSDI Analyst, Ms. Bates serves as the Five-Year Needs Assessment Coordinator for the Title V program. Ms. Bates 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. Principally, Ms. Bates is funded with SSDI grant funds (90%), the remainder coming from Title V dollars.

Two other epidemiologists (2.0 FTEs) are employed by Assessment. One, the Child and Adolescent Health Epidemiologist position, is held by Thad Burk, MPH. Mr. Burk has greater than 15 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, Assessment has a second epidemiologist (Jenna Bellantoni, MPH) who provides support for the Perinatal and Reproductive Health (PRH) Division. Ms. Bellantoni is a new hire for Assessment with her employment beginning in early July 2022. Her work in MCH will focus primarily on family planning program support and developing enhanced reporting and analysis of maternal mortality and severe maternal morbidity. However, Ms. Bellantoni also will support the preparation of the Title V Block Grant Annual Report and Application, along with the completion of the Five-Year Needs Assessment. Funding to support these positions is a combination of Title V, YRBS, PREP, SMHIP, and Title X funds.

Remaining staff (5.0 FTEs) within 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 Assessment. Funding for positions is allocated from Title V and PRAMS grants.

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, Assessment aims to develop a MCH data portal which will serve as the central online location for all MCH-related data reporting and analytic results. Now that the SSDI Analyst, the Medicaid Analyst and the PRH Epidemiologist positions have been hired, Assessment's analytic staff is at capacity. While orientation and training of new staff will take some time, it is anticipated that given the quality and experience of the staff, full production of analysis and reporting is anticipated in short order. MCH is expected to enhance and build data capacity to further understanding of health outcomes and health care use patterns among the women, infants and children in Oklahoma.

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

Under current SSDI grant guidance, the Oklahoma SSDI project supports MCH service area priorities with three goals in mind: 1) build and expand MCH data capacity in support of Title V MCH Block Grant activities and contribute to data-driven decisions relevant to assessment, planning, and evaluation of programs; 2) advance the development and use of electronically linked data systems; and 3) provide data in support of state quality improvement efforts. The SSDI project contributes by addressing the state's need for improved availability, timeliness, and use of administrative, population-based, and program service data to inform Title V programs.

i. Progress in building and supporting accessible, timely and linked MCH data systems

The Oklahoma SSDI project has routine access to record level vital statistics data (e.g., births, deaths, and fetal deaths). Access is mediated through a signed Data Use Agreement, which grants permission to the SSDI Analyst to perform analysis on and linking with data collected via vital events registration. With ongoing, daily access to vital statistics data, the SSDI Analyst has the ability to conduct near contemporary assessment of the birth and death experience among women, infants, and children in Oklahoma. Further, these data sets are regularly linked to build a more comprehensive measurement of the health and well-being of MCH populations. Birth records can be linked to infant deaths, Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance data, the Oklahoma Toddler Survey (TOTS), and Medicaid administrative data.

The Oklahoma SSDI project consistently has access to vital statistics data, updated daily for provisional data sets. Final or closed data sets for prior years of registration are available as well and regularly accessed by staff to fulfill data requests, perform analyses, or reporting on study findings. In general, the availability of a final data set for a given year will occur 6-8 months after the close of the year for births and 8-10 months for deaths. However, delays may occur due to system changes, registration processes, and, for 2020 and 2021, the impact of the COVID-19 pandemic. MCH Assessment, the division home to the SSDI project, develops standardized birth and infant death analytic files for staff to use. The SSDI Analyst plays a role in reviewing and creating SAS programming to create these analytic files, within 60 days following release of final birth and death files. Linking infant deaths to live births is carried out by staff in the Center for Health Statistics with resulting analysis files made available to the SSDI Analyst and other MCH analysts via Data Use Agreements.

Joining Medicaid administrative data to birth records is performed by the MCH Medicaid Analyst, a position jointly funded by the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, and MCH Title V. The Medicaid Analyst has regular access to Medicaid eligibility and claims records, which are electronically linked through deterministic and probabilistic matching methods. Access to records is determined by a schedule within the agency mega-agreement that outlines permissions for covered staff. Records are obtained using Business Objects software, saved locally for data management and linkages, and then standardized for analysis purposes. Linked Medicaid/birth data are prepared on an annual basis. This linking and analysis work is directed by OHCA and MCH staff who are members of the Medicaid Data Sharing Work Group, which meets regularly to plan and discuss priority analysis efforts. This work was suspended due to the vacancy in the position of Medicaid Analyst. Work will resume now that the position is filled.

PRAMS data, along with the follow-back survey TOTS which surveys PRAMS mothers at the time her infant reaches the age of two years old, are linked directly to live birth records as a result of the methodology used to draw the PRAMS and TOTS samples. Surveillance data from PRAMS and TOTS are frequently used as a source of baseline data for MCH and Title V performance measures, including breastfeeding, safe sleep behaviors, tobacco use, and preconception health topics. Availability of these data lag several months after the closeout of a surveillance cycle. For example, PRAMS data for a calendar year of surveillance do not become available until late in the year following the calendar year in question; that is, say, 2020 data generally will not become available until the fall of 2021. Timing

depends on efficient closeout of surveillance activities, submission of data to the CDC, the completion of data management and weighting procedures carried out by CDC personnel, and the return of weighted analysis data sets to the state. TOTS is similar in the closeout procedures with the exception that all steps are performed locally by MCH Assessment staff.

Access to other data systems is done through official data requests submitted to recognized authorities over targeted data. Data from newborn screening, WIC, and hospital discharge are obtained through data requests to respective OSDH departments. However, some aggregated WIC data can be accessed through the PHOCIS data system (Public Health Oklahoma Client Information System), and MCH Assessment does possess public use data files for some years of the hospital inpatient discharge data system. These data systems have been used in ad hoc fashion to respond to specific questions submitted to MCH. A more thorough approach, particularly for hospital discharge records, is anticipated as MCH Assessment has now hired personnel to fill related analytic positions (e.g., Perinatal & Reproductive Health Epidemiologist, Medicaid Analyst).

ii. SSDI role in enabling ongoing Title V program assessment, monitoring and reporting

The role of SSDI is to develop, enhance, and expand data capacity and to provide statistical and epidemiologic support for Oklahoma's Title V programs. Organizationally, the SSDI project is housed in the MCH Assessment division of the MCH Service. Key personnel for the project include the SSDI Analyst, the Medicaid Analyst, the Senior Biostatistician, the MCH Assessment Administrative Program Manager, and the MCH Service Director. SSDI grant funds are used to support most of the salary of the SSDI Analyst; the other positions are funded in kind by other federal grant funds, primarily Title V Block Grant dollars. The SSDI project is responsible for providing data management, statistical analyses, and reporting for MCH and CSHCN programming to assure that personnel have the latest information available to drive decision-making when allocating and organizing Title V resources to meet the needs of women, infants, and children, including those with special health care needs.

Further, the SSDI Analyst has the assigned responsibility for coordinating and supporting the completion of the Title V Five-Year Needs Assessment. This work includes convening meetings, developing tools for collecting input from the general public and stakeholders, and performing analysis and reporting. Essential to these tasks is collaborating with MCH staff, OSDH personnel in other departments having MCH-related goals and objectives, and external valued partners for community organizations, state agencies, families, as well as the general public.

iii. Description of key SSDI program activities

In FY2021, the SSDI project focused principally on developing Tableau dashboards to visually display key health measures relevant to Title V and MCH priorities. The SSDI Analyst created dashboards for child and adolescent health measures, data published in the Federally Available Data documentation, CoIIN measures, and the core/minimum data sets, which were made available but not fully finalized prior to the retirement of the then SSDI Analyst. Work on these dashboards is ongoing with plans to integrate into a MCH Data Portal, which will serve as a resource for MCH personnel and internal and external partners. A new SSDI Analyst was hired in April 2022.

The SSDI Analyst played a supporting role in the preparation and submission of the Needs Assessment section in the 2022 Title V MCH Block Grant Application and 2020 Annual Report. The new analyst will begin orientation and early preparation for the next cycle of the needs assessment in FY2023.

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

Further expansion of MCH data capacity, as previously reported, includes the creation of a maternal health data catalog requested by the Innovative Technology and Data Systems Workgroup (ITDSW) of the Maternal Health Task Force. This work was assigned to the Assessment Division of the MCH Service and initially was built out in an MS Excel workbook. Essentially this tool provides metadata on public health and socioeconomic data systems which contain data elements specific to women of childbearing age. Those data elements include demographics, risk behaviors, service utilization, health outcomes, and morbidity measures. Once the Excel workbook was created, the ITDSW partnered with staff from the Kaiser Family Foundation to transfer the metadata and its basic structure to a web-friendly production environment with full navigational features, as well as a key word search component. Following this migration, and review and testing by ITDSW members, the data catalog was relocated to a public facing website hosted by the Oklahoma Perinatal Quality Improvement Collaborative.

MCH has continued to participate in the CDC's COVID-19 Pregnancy Module in which data were collected on pregnant women who had tested positive for the coronavirus in calendar year 2020. At the beginning of this effort, MCH staff contacted women to gather pregnancy and neonate data which were securely submitted electronically to the CDC. However, once the pandemic surged in Oklahoma, the volume of cases was too great for existing MCH resources. Working with the CDC, MCH developed a sampling design to select 10% of cases for the purpose of medical record abstraction. MCH compiled these records over a period of months for submission to the CDC to use in analysis and results publication.

Currently, the Assessment Division is in the process of developing and deploying web-based data portal to include dashboards and static reporting. All data products designed for public dissemination will be housed on the site. As appropriate, previously released reports will be included and organized to comply with the configuration of the data portal. It is anticipated that the data portal will serve as the central location for MCH-related data important to the expansion of Title V data capacity, as well as those data relevant to the needs of internal and external MCH partners.

A challenge faced in the past year has been the vacancies in the Assessment analytic staff. Recruitment and hiring have been necessary for three positions – the State Systems Development Initiative (SSDI) Analyst, the MCH Medicaid Analyst, and the Perinatal and Reproductive Health Epidemiologist. These positions have key responsibilities in data management, analysis, and reporting, along with their roles in providing support to program areas. Fortunately, Assessment has recruited quality candidates to fill these positions with start dates in June and July, 2022. A second challenge, related to filling the vacancies, is the time needed to train new staff for their positions. This is particularly difficult when deadlines are coming due on active grants, allowing little time to ease into new roles. Existing staff must shoulder greater responsibilities outside their normal range of activity. Again, MCH has been fortunate in that these staff are remarkably resilient and willing to take on extra work to help their peers and teammates. Lastly, although much less than during the height of the pandemic, COVID-19 continues to pose challenges to the workforce. Telework now is commonplace with meetings occurring in virtual mode. While useful, these virtual meetings can pose logistical challenges and place staff at remote distance, sometimes preventing or slowing progress on projects.

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

MCH participates in the OSDH Emergency Response Plan, which contains information pertaining to the deployment, mobilization, and tactical operations of the agency in response to emergencies and includes a listing of critical functions that would need to be carried out in the event of a disaster or emergency situation.

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.

DHS Risk and Safety Management utilizes safety and security inspections, drills and simulations, and annual safety trainings, primarily through local leadership, to help mitigate the impact of an emergency on a person, office or facility. Personnel trained through these processes include, but are not limited to, staff who work with CYSHCN and their families.

Title V CSHCN encountered a few challenges throughout the COVID-19 pandemic.
One such challenge centered on the distribution of supplemental nutritional formula available through the

Supplemental Security Income - Disabled Children's Program (SSI-DCP). CSHCN was compelled to abandon a previous multi-years long process for handling the supplemental formula distribution after there were unexpected and permanent closures of multiple county offices and buildings because of COVID-19. CSHCN transitioned the formula to an already established DHS voucher process. However, it took several months in order to get the new formula process up and going for this service (from a systems standpoint). Once the voucher process became fully functional, it allowed CSHCN families to obtain the formula locally through a vendor of their choosing. The voucher system allowed a bit of flexibility that had not been present previously but there were also additional challenges to overcome in working with vendors in the community. More recently, it has become necessary to procure a more sustainable process for the formula distribution as DHS works to improve outdated technology and systems, which will ultimately lead to the elimination of the voucher process all together. CSHCN is presently collaborating with a current Title V Community Based Organization (CBO) to provide the formula for the families in a more direct and efficient manner and to move away from the voucher process through DHS. The Title V CBO has both the capacity and the reach to inform more families statewide about this social service and to increase participation in the program, which has dwindled, for various reasons, by approximately two-thirds the number of participants pre-COVID.

A second challenge during the pandemic centered on respite care and the families that utilize this service. Several divisions within DHS provide respite vouchers to those families that qualify. Respite vouchers are provided through the SSI-DCP for CSHCN under the age of 18 who receive SSI. Leadership for CSHCN (in the Adult & Family Services division), in conjunction with Leadership from other DHS divisions who also administer respite vouchers, previously allowed a policy exception for the Respite Provider to be another adult member of the Care Provider/Care Receiver's household.
This policy exception has continued, and will continue, throughout the Public Health Emergency (PHE). This policy exception has allowed many families peace of mind in knowing that someone who is already in the child's living environment could care for the child while the Caregiver took a break. Informing families about this policy exception was challenging at the outset, but CSHCN staff at DHS as well as Title V-contracted partners were able to spread the word quickly through one-on-one interactions and through various virtual trainings and meetings with other programs and agencies.
Long term, DHS is actively working to digitize the outdated paper respite voucher process so that families, including those with CYSHCN, will have better access, more reliable and immediate information, and timely processing of payments for the providers.

Oklahoma Family Network (OFN) 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 Maternal Health Task Force (OMHTF), 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 neonatal abstinence syndrome.
- *OPQIC Preterm Birth Initiative* to promote best practices with providers to reduce preterm births.
- *The Child State Advisory Workgroup* to improve overall child health outcomes with a special focus on behavioral and mental health.
- *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 multiple subcommittees, to share information about various community resources and services, including but not limited to, respite; psychological supports; transportation; and legal services, for caregivers of all agers, including families of CYCHCN.
- *Waiting in Oklahoma* to provide status updates about the Developmental Disabilities Services Wait List in Oklahoma and to provide families the opportunity to ask questions, seek support, and talk about issues families are having that may be addressed by others in the group.
- *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.
- *Obesity State Plan Stakeholders* to improve physical activity and nutrition and reduce obesity throughout the life course.
- *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.
- *SAFER (Safely Advocating for Families Engaged in Recovery) Initiative* to advocate for women and

families in recovery and to implement family care plans from prenatal to postpartum stages.
- *THRIVE Advisory Committee* to reduce teen pregnancies and births throughout the state utilizing a collective impact framework.
- *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.
- *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.
- *Continuum of Care (COC) Communication Workgroup* to implement a communication plan at OHS 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 OHS 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 OHS 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.
- Hosting Trauma-Informed Summertime Professional Development Summit for teachers and school-based professionals in the second largest school district in Oklahoma.
- For 15 years, OFN has hosted Joining Forces: Supporting Family Professional Partnerships Conference. In 2022, a hybrid platform was provided allowing for over 300 families and professionals to attend either in-person or virtually.
- 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.
- Promoting and sharing information to families and policy makers regarding financing of waivers and state plan services.
- Providing podcasts, which include families sharing their stories of parenting a child with special needs while sharing connections to resources for several MCH and CSHCN topic areas, such as maternal mental health, breastfeeding, specific health care or genetic conditions.
- Partner with families and organizations to provide sessions of CPR training and telemedicine training.

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 and the OFN Family Matters Conference. These trainings were also available on Zoom and individually to ensure the family voice and experience is available and valued. OFN Family Leaders serve as members of the OHS Developmental Disability Services Policy Committee, OHCA Member Advisory Task Force and Medical Advisory Committee, OSDH *Preparing for a Lifetime* and other Maternal and Child Health committees, Screening and Special Services committees, and ODMHSAS 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.

During these last two years, service delivery has been challenged by COVID-19. Having established relationships with partners throughout the state, eased the burden as all worked together to meet the immediate needs of Oklahomans throughout the state. Title V and MCHB were very flexible with allowing both grant funds and personnel to be utilized as needed for COVID-19 mitigation efforts, including utilization of current staffing for the coronavirus hotline, strategic national stockpile, epidemiology hotline, symptoms check tables, and COVID-19 testing for 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.

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. 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, and Maternal Mortality Review Committee.

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 priority areas, unintended pregnancy and infant safe sleep. OHCA provided 78% of the costs for these projects and MCH Service funded 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 Department of Human Services (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 Memorandum of Understanding. 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. 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 high level of resources. 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 do not 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, continue to work on being in full compliance on annual Title XIX eligibility determinations by utilizing a recently initiated systems automated eligibility renewal process for all persons, including CYSHCN, who receive SSI. The automated renewal system for SSI recipients enhances healthcare delivery by removing the barrier of incorrectly closed benefits for CYSHCN, which creates gaps in service and hardships for families trying to remedy the closure.

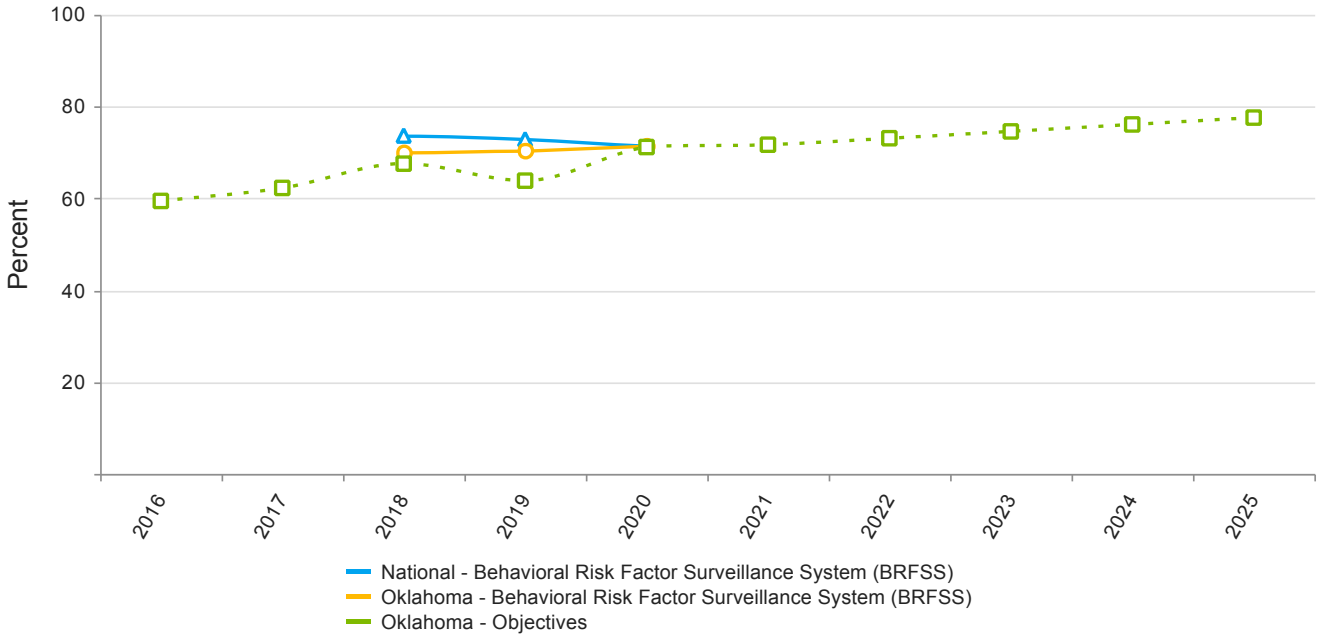
Oklahoma expanded Medicaid coverage to adults between the ages of 18 and 65, with incomes at 133% of the federal poverty level or below, on July 1, 2021. The Oklahoma State Department of Health has collaborated with OHCA to assist in enrolling newly eligible Oklahomans to receive this critical coverage.

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

Women/Maternal Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				71.1	71.6
Annual Indicator			69.7	70.3	71.1
Numerator			471,074	463,707	465,393
Denominator			675,608	659,936	654,197
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS 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 with 2018 survey data.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	73.0	74.5	76.0	77.5

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					
	2017	2018	2019	2020	2021
Annual Objective	95	100	100	105	100
Annual Indicator	90	95	95	95	95
Numerator					
Denominator					
Data Source	PHOCIS	PHOCIS	PHOCIS	PHOCIS	PHOCIS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	105.0	110.0	115.0	120.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	17.4	20.8	24.1	22.3	23
Annual Indicator	26.3	28.8	29.5	25.2	25.2
Numerator	41	44	44	37	37
Denominator	155,953	152,623	149,158	146,561	146,561
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2015-2017	2016-2018	2017-2019	2018-2020	2018-2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.8	24.4	24.0	23.6

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 preconception health client engagement tool and My Life. My Plan for adolescents.

Disseminate the client engagement tool for reproductive health planning through the Maternal Health Task Force.

Promote LARCs to prevent unintended pregnancies and closely spaced pregnancies in county health departments and Medicaid recipients.

See activities to reduce teen pregnancy in the Adolescent Health Plan.

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

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 2025.

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 4

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 5

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 28.8 maternal deaths per 100,000 live births in 2016-2018 to 23.6 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 96.0% in 2025.

Data:
According to the latest available Oklahoma 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 was used to create a report on Tobacco Use During Pregnancy Among SoonerCare (Oklahoma's Medicaid program) Mothers. Smoking during pregnancy has been associated with many adverse health outcomes both during and after pregnancy. At the time of the survey, nearly 35% of mothers covered by SoonerCare reported using tobacco in the last two years, compared to 15% reported by non-SoonerCare mothers. From 2016-2018, 25.9% of Oklahoma mothers reported smoking in the last two years and out of these, 12% of mothers reported smoking during pregnancy (in the last three months of pregnancy). Postpartum, 25% of SoonerCare mothers and 7% of non-SoonerCare mothers reported smoking. Medicaid covered approximately 56% of live births in Oklahoma. These data support the need for continued education about preventive medical visits prior to pregnancy, early prenatal care, and attendance at postpartum visits

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. With encouragement from the Oklahoma Perinatal Quality Improvement Collaborative, the Maternal Health Task Force, and the Medicaid Postpartum Affinity Workgroup, the Oklahoma Health Care Authority (OHCA) started looking into unbundling the postpartum visit for SoonerCare. Previously, the effort to unbundle all services failed but staff began exploring again the possibility of unbundling only the postpartum visit.

On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income was 138% (133% with a 5% disregard) of the federal poverty level or lower. Enrollment opened June 1, 2021 and by August 2, an additional 154,316 individuals were approved for benefits through this expansion. Of these new enrollees, 82,211 were reproductive age women between the ages of 19 and 34. Expansion offered the full benefit package for women before, during and after pregnancy.

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 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 resources 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 and during the postpartum period (1-8 weeks). It was administered again when the infant was between 4-6 months, at 12 months, and then annually. It could also be administered if the parent educator suspected depression at any time. Parent Educators also administered a Prenatal/ Postpartum Record which gathered information about prenatal care, type of delivery, and screens for anxiety and depression.

PAT personal visits and Group Connections were completed using a hybrid of in-person and virtual platforms. In-person visits were conducted based on the comfort level of the Parent Educator and the family. These visits were completed in the home, or an alternative location such as a park or library. Virtual service delivery referred to services both through interactive video conferencing technology and phone calls. Virtual visits through an interactive video conferencing platform enabled a two-way, real-time, audio-visual communication between the home visitor and parent(s), guardians, or primary caregivers and their child(ren). 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 assessed clients in six domains during the prenatal period: Personal Health, Environment, Family and Friends, Life Course Development, Maternal Role, and Health and Human Services. 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 to encourage the client to attend the postpartum exam. In state fiscal year (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 following the budget crisis. However, March 2020 through July 2021, C1 nurses were required to begin providing home visitation via telephone or telehealth for their safety and for the safety of the clients due to COVID-19. In addition, the majority of nurse home visitors, as Public Health Nurses, were required to assist with emergency response efforts. C1 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 C1 program significantly dropped across the state. The majority of C1 sites across the state have been able to re-build capacity to around 60-80% since July 2021.

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). A new preconception/interconception screening tool was developed through the Human-Centered design process. During this year, all family planning clinics switched to using this tool. Two of the team's Healthy Start projects 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. Funding for this project ended in September 2021.

On April 23, 2021, MCH staff provided training for county health department staff on policies and procedures for maternity services to kick off the return of prenatal care in county health departments. These gap-filling services were introduced to improve access to quality care closer to home and improve attendance at both prenatal visits and the postpartum visit.

MCH staff participated in the Postpartum Affinity Work Group led by OHCA with the goals of improving attendance at postpartum visits and the quality of the visits for individuals whose pregnancy was covered by Medicaid. The group worked through a multi-pronged approach which included: 1) developed a survey of new mothers to determine if they attended a postpartum visit and if not, what barriers/attitudes prevented them from attending, 2) a care coordination pilot with five women of color with comorbidities, 3) developed a newsletter for postpartum moms, and 4) explored the option of unbundling the postpartum visit from global billing. The survey elicited interesting responses but did not reach a significant response rate for generalization of data and the care management team had difficulty reaching and engaging the five women with co-morbid conditions. Due to significant turnover in staff at OHCA, the group was not able to move forward on the other activities by the end of the grant reporting year.

Challenges:
OSDH, in conjunction with partners at the OHCA and private insurers, were 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 first half of the grant 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 continued to be the impact of COVID-19 on access to in-person health care visits, restriction of family members from health care visits with pregnant women, the continued focus on telehealth visits, and access to telehealth visits in rural areas of the state without quality wireless connections. As COVID-19 numbers waxed and waned, healthcare providers, including OSDH family planning clinics, restricted services and visitors and then allowed visitors and increased appointments only to restrict appointments and visitors again when positive cases increased and/or staff were out sick. Acute care visits still took priority for healthcare providers and for individuals, priority over preventive care. Additionally, women were sometimes afraid to come into a healthcare

provider office or a hospital for fear of contracting COVID-19 from another patient. Hospitals and clinics remained understaffed and over worked.

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 15.0% in 2018 to 20.0% in 2025.

Data:
Baseline data for SFY 2014 indicated 8.5% of females ≤ 18 years, 16.3% of 19-24 years, and 14.7% of females ≥ 25 with Medicaid-funded health care relied on long-acting reversible contraception (LARC) methods. Staff and reporting methods changed during this reporting period and consequently, current data were not comparable to the baseline data. Calendar year (CY) 2019 data showed 4.3% of 15-20 year-old females and 3.8% of 21-44 year-old with SoonerCare, relied on a LARC method. This provided an overall LARC utilization rate of 4.1%, down from 4.6% for SoonerCare members in CY 2018. Overall, 28.2% of members chose an FDA-approved most or moderately effective method of contraception.

Successes:
The 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 infections (STIs); pregnancy tests; tubal ligations for females age 21 and older; and vasectomies for males age 21 and older. Enrollment opened June 1, 2021 for Medicaid expansion, and by August 2, 154,316 additional individuals were approved for benefits. Of these new enrollees, 82,211 were reproductive age women between the ages of 19 and 34. Expansion offered the full benefit package for women before, during and after pregnancy.

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, or 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. In June of 2021, SoonerPlan covered 5.64% of enrollees. As of September 30, 2021, individuals being moved from the limited benefit package to the full benefit package and SoonerPlan, provided coverage to 13,109 enrollees accounting for only 1% of Medicaid enrollment while expansion provided coverage for 181,747 individuals accounting for 16.36% of enrollees.

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; STI/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 2021 indicated 6.6% of clients relied on intrauterine devices/systems and 10.1% of clients relied on the implant for contraception. This equates to 16.7% of all users and 23.1% of clients choosing a hormonal method of contraception relying on a LARC method. Family planning services

were provided to a total of 23,641 females and males of reproductive age for calendar year 2021 (down from 28,508 in CY 2020). Of the 23,641 clients, 4,700 relied on public insurance and 15,305 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. OHCA and OSDH continued the partnership through the Health Services Initiative, matching CHIP funds and state dollars.

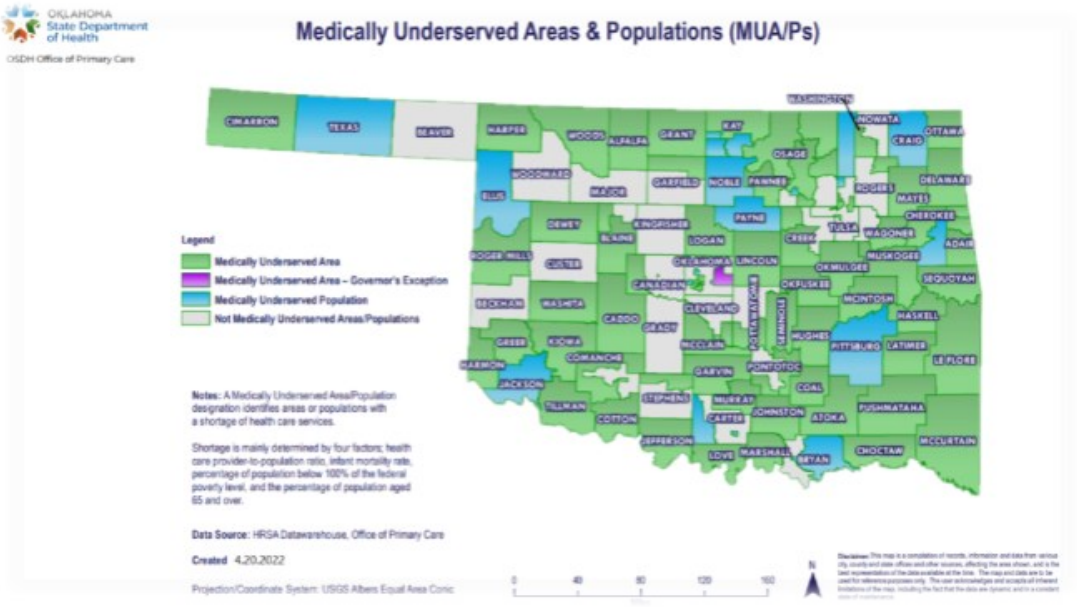
Through the collaborative Focus Forward Oklahoma Initiative, OHCA led efforts to recruit and train health care providers across the state on contraceptive counseling and LARC procedures. The Focus Forward Oklahoma (FFO) Program operated under three primary strategies for addressing barriers to access 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, worked in partnership with OSDH to develop a Health Service Initiative through CHIP to increase the number of LARC devices available to uninsured women under 19, and created a LARC carve-out for FQHCs so that they can be reimbursed for LARCs outside of the prospective payment system. Efforts to best address inventory management for LARC are underway this year. Education efforts have focused on provider workforce development to increase the number of providers who provide LARCs to patients. Since 2017, 32 training sessions focused on best practices, "in-patient"-centered counseling and hands-on LARC procedure skills have been hosted at no cost to the trainees. A total of 384 providers from across the state have been trained in the curriculum. Sixty-seven percent of providers were from the two major metropolitan areas of Oklahoma (Oklahoma City/Tulsa) and 33% were from rural areas in Oklahoma. Five provider types have attended the training sessions: 1) Physician MD, 39%; 2) Physician DO, 17%; 3) Physician Assistant, 10%; 4) Advanced Practice Registered Nurse/Certified Nurse Practitioner, 34%; and 5) Certified Nurse Midwife, 1%. Four specialties were represented at the training sessions: 1) Family Practice/Primary Care, 71%; 2) Obstetrics/Gynecology, 15%; 3) Pediatrics, 9%; 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 FFO program.

Challenges:
The biggest challenge this year remained 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 only and/or continued to restrict the number of appointments available due to staff assigned to other duties.

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 almost impossible this year. In addition, national attention was drawn to the fact that some populations felt they were being coerced into choosing LARCs based on their socioeconomic status 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 COVID-19.

Religiously affiliated hospital systems managed a large number of smaller hospitals and physician practices where LARCs could not be provided immediately postpartum in the hospital. Frequently, LARCs could not be provided during a physician office visit if the physician was associated with these hospital systems. Clients were referred to another provider if 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 Office of Primary Care, all but 4 of Oklahoma's 77 counties were designated as health professional shortage areas due to either a low-income population or a shortage of primary care providers for the entire population of the service area. See the OSDH Map below for green areas indicating Medically Underserved Areas & Population.



Smaller hospitals, physician practices, and some FQHCs 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 29.3% in 2016-2018 to 25.0% by 2025.

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). Medicaid expansion became effective July 1, 2021. See Objective 2 for more information on these programs.

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, or 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. In June of 2021, SoonerPlan covered 5.6% of enrollees. As of September 30, 2021, individuals were being moved from the limited benefit package to the full benefit package and SoonerPlan provided coverage to 13,109 enrollees, accounting for only 1% of Medicaid enrollment, while Medicaid expansion provided coverage for 181,747 individuals accounting for 16.4% of enrollees.

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; STI/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 (i) pregnant within one year, (ii) greater than one year from the visit or (iii) 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 the administration and monitoring of the Personal Responsibility and Education Program (PREP) grant from the Administration of Children, Youth, and Families and Family and Youth Services Bureau (FYSB). PREP funds continued to support projects in the Oklahoma City County Health Department (OCCHD) and Tulsa Health Department (THD). COVID-19 continued to have an impact on both projects and limited programming with schools; reach was significantly impacted as many schools restricted external visitors and only allowed for virtual instruction for an extended period of time during the 2020-2021 academic year. A total of 863 students participated in the evidence-based curricula implemented by the PREP projects. Additionally, project staff were re-assigned to COVID-19 mitigation efforts that held priority over PREP project activities.

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, strategies in youth engagement in mental health and live discussions with a youth panel, strategies and considerations for successful counseling of adolescents and young adults, child abuse and neglect reporting, human trafficking, intimate partner violence, trauma informed work with youth, and preconception health.

Challenges:
The biggest challenge this year remained 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), and access to telehealth visits in rural areas of the state without quality wireless connections. Many providers, including OSDH family planning clinics limited in-person visits that required exams/procedures and restricted other services to what could be provided curbside, through phone conversations, or through telehealth visits where available.

In the midst of COVID-19, 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 COVID-19, acute care remained the priority for healthcare provider visits over preventive care visits. Additionally, clients were still afraid to come into a healthcare provider office or a hospital for fear of contracting COVID-19 from another 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 Certified Nurse Midwife (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 from contraception to prevention of unintended pregnancies. Only 27 out of 77 counties had a hospital capable of delivering infants. According to the Office of Perinatal Quality Improvement (OPQI), these conditions remained in 2021 as there were only 46 delivering hospitals in the state.

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. FQHCs 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 LARCs in the state, many of these sites either did not offer LARCs or offered 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 was successful at getting Medicaid to adopt a carve out for FQHCs to receive better reimbursement for LARCs which hopefully will make these methods more accessible 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 2021.

Data:
The number of service sites utilizing the Women's Health Assessment Tool developed by the OSDH or any alternative tool remained constant this year. Every county health department utilized the Women's Health Assessment/Preconception Health Assessment Tool with clients 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 23,406 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 when they were able to continue face-to-face visits.

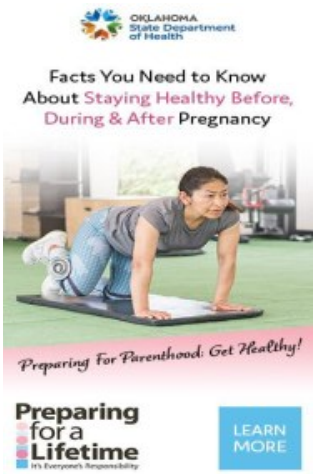
A PRAMSgram was published this year on *Preconception Health Disparities and Birth Outcomes among Foreign-Born and Native-Born Hispanic Women in Oklahoma*. A PRAMSBrief also provided information on *Social Support Among Oklahoma Mothers: 2016-2019.*

See Objective 1 for information about the UNC-led Preconception CoIIN work on the Preconception Health Assessment Tool.

The Perinatal and Reproductive Health Division (PRHD) 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.

Through a new contract with Cox Media, MCH ran creative ads on streaming services with messages regarding preconception health and healthy pregnancies July – September, see two examples below. The previously created public service announcements, Measure Up (preconception health) and Caring Dads (secondhand smoke and newborns) were also run on the streaming services.



Challenges:
Due to COVID-19 response efforts, OSDH 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 unable 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-19 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. Maternal mortality data for Oklahoma clearly indicated that obesity, tobacco use, and chronic health conditions played a major role in both maternal morbidity and mortality. However, 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 COVID-19, in-person visits were reduced to medically necessary visits, limiting the opportunities to share preconception health information.

Objective 5: Increase the number of county health department sites appropriately utilizing the PHQ-9 tool and the new codes for positive and negative screening from 61 sites in 2020 to 90 sites in 2022.

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.

Data:
According to data from the 2018-2019 The Oklahoma Toddler Survey (TOTS), 54% of new mothers were screened for postpartum depression, exceeding the 2022 goal. A little over 14% of mothers with toddlers indicated they had been diagnosed with postpartum depression (PPD) sometime after their toddler was born.

Due to COVID-19, the traditional process of auditing charts for the county health department sites was not possible. Therefore, it was not clear as to whether or not the health department sites were utilizing PHQ-9 “positive” and “negative” codes appropriately; therefore, data could not be run to determine rates for OSDH clients.

There were consistent efforts to locate local women and men impacted by Perinatal Mood and Anxiety Disorders (PMADs) for participation in public service announcement videos, from partnering with local mental health providers, to conversations with local non-profit organizations centered in some of the communities disproportionately impacted by PMADs. However, finding individuals who were at the intersection of having been diagnosed with, or have had symptoms of PMADs who were not currently experiencing acute symptoms and were willing and able to share their stories on video was difficult, therefore, no one has yet been identified.

Successes:
In service of increasing awareness and education of throughout the state, the Maternal Mood Disorders Work Group worked on and completed a printed and digital version of a Postpartum Plan template. This template was designed to bring awareness to new mothers of some questions that they may not have considered impacting PMADs such as, “Would you like visitors at the hospital?”, “Who can bring you meals, and when?”, and “My partner will support me at night by…”. There were ongoing efforts to partner with hospital systems, OB/GYN clinics, and Pediatric clinics to distribute these throughout the state as resources for new parents.

In working toward connecting with and assessing the needs of Oklahoma medical providers such as OB/GYNs and Pediatricians, the Oklahoma Maternal Mood Disorders Work Group developed a survey. The survey was distributed to the membership of the Oklahoma Medical Board newsletter (which covers the majority of MDs throughout the state) as well as members of the Oklahoma Osteopathic Association (of which the majority of Oklahoma DOs are members). It was a short, nine question assessment which asked questions regarding how they integrated PMADs awareness and screening in their practice with questions such as, “What is the protocol for conducting screenings for postpartum depression in your clinic?”, “How could the OSDH help you in bringing education on PMADs to your office”, and “What treatment barriers exist that prevent you from providing the best care to your patients?” The responses received were reviewed and will be a powerful tool in formulating the future efforts of the Oklahoma Maternal Mood Disorders Work Group towards reducing stigma, raising awareness, and increasing resources for those impacted by PMADs throughout the state.

Another unforeseen benefit of hosting the Maternal Mood Disorders work group meetings virtually, was the fact that more individuals attended from throughout the state who could not typically drive in to Oklahoma City to attend in-person. Having more individuals, and a greater variety of stakeholders at the table for these discussions, was a benefit that will carry forward into the future to allow the most diversity as possible in the work group composition.

Challenges:
Almost certainly, the reduced numbers in the number of clients reported as seen at the OCCHD and THD during the reporting timeframe impacted by COVID-19. However, because of the extremely low reported numbers (69 screenings reported at OCCHD and 72 screenings at THD), there were likely other issues as well, such as reporting inconsistencies, that cannot be ruled out until chart audits are completed.

Anecdotal conversations with women in the perinatal-period screened during this time have indicated that there continued to be a need for education regarding PMADs, with reports that OBGYN and Pediatric providers were not consistent in providing education on this topic.

In addition, although the state continued to grow the number of mental health providers who have been educated on treatment for perinatal health concerns, these numbers need additional growth; especially in more rural areas. There remained no in-patient facility in Oklahoma specifically devoted for mothers (or fathers) with a need for intensive treatment in regards to postpartum psychosis.

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

Objective 1: Reduce maternal mortality rate from 28.8 maternal deaths per 100,000 live births in 2016-2018 to 21.0 by 2025.

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 2018-2020 among women aged 10-44 years was 25.2 maternal deaths per 100,000 live births (a decrease from 29.5 for 2017-2019). 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 Committee. Oversight was provided by the Perinatal and Reproductive Health Division Administrative Program Manager (APM) and one of the Advanced Practice Nurses who continued in the project manager role. With the passage of House Bill (HB) 2334, the Maternal Mortality Review Committee (MMRC) became a statutory committee with expanded access to additional records vital for accurate case review. The 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 MMRC 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 Oklahoma Commissioner of Health. The MMRC reviewed three to five cases at quarterly meetings in April and July to identify gaps in services or possible system level changes to prevent future maternal deaths. Due to the continuing effects of COVID-19, no cases were reviewed in January or September. The

top causes of death were cardiovascular, sepsis, non-cardiovascular, and hemorrhage.

MCH completed the transition to the network-based Maternal Mortality Review Information Application (MMRIA) database to help states collect and report comparable data. Cases began to be abstracted directly into this database and reviewed prior to the meetings. Committee members came prepared to discuss the cases which allowed the committee to complete more cases during each meeting.

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 was 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 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 and hospitals started reporting on the bundle addressing opioid use disorder. The Oklahoma Mothers and Newborns Affected by Opioids (OMNO) initiative provided data and technical support for this initiative. 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 annually during the OPQIC summit. However, the summit was cancelled in 2021 with the hopes of returning to an in-person format in 2022.

The Infant Mortality Alliance (IMA) began focusing on preventing maternal mortality as well as infant mortality at the October 2019 summit. 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. Monthly newsletters highlighted the risks of COVID-19 for pregnant women and infants and the importance of getting vaccinated and the benefits of the Build Back Better Act nationally, which included provisions aimed at improving maternal health and covered the effects of tobacco on maternal health, including the link to cardiovascular disease, the leading cause of maternal deaths in Oklahoma.

The Oklahoma Maternal Health Task Force, created in connection with the State Maternal Health Innovation Grant, finalized the strategic profile for 2020-2024, defined maternal health, and established work groups for the four priority pillars: Improve Access to Appropriate Care and Maternal Health Programs; Expand Mental Health, Substance Use and Social Services; Implement Innovative Technology and Data Systems; and Address Racial Disparities.

The second annual Oklahoma Maternal Health, Morbidity, and Mortality Report was released in September 2021. This report included definitions for mortality and morbidity, top causes of death and socioeconomic and health related contributing factors, an overview of women's health in Oklahoma, data from the Maternal Mortality Committee case reviews, and recommendations from the committee to improve maternal health and help prevent future maternal deaths. This report can be found at: https://oklahoma. gov/content/dam/ok/en/health/health2/aem-documents/family-health/maternal-and-child-health/maternal-mortality/maternal-morbidity-mortality-annual-report-2021.pdf.

Challenges:
COVID-19 restrictions prevented the MMRC from meeting in January and contributed to not meeting quorum in September. The committee met and approved the second annual report in October 2020 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. The meeting was still held virtually and staff attempted to share the screen for the committee to review cases, but this did not prove to be an effective solution. For the September 2021 meeting, several members ended up with COVID-19 or being exposed and could not attend the in-person meeting.

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

Continued challenges related to preconception health and pregnancy intention were identified as contributing factors for many maternal deaths. To date, the MMRC reviewed 134 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.

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 will work with the new staff person so that data matching and analysis between Medicaid claims and birth certificate data will resume. The joint OSDH/OHCA work group will work on determining the most effective use of the data and publications utilizing this information. This critical position, difficult to refill and vacant for an entire year, was recently hired with a start date of August 1, 2022.

OSDH will continue to expand prenatal care services in the CHDs with the hopes of encouraging more women to attend the postpartum visit, either with the delivery provider or at the health department. Staff in the CHDs will continue providing postpartum care for those women scheduling a family planning visit that have chosen 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 encourage attendance at the postpartum visit and prepare women for their postpartum/annual health care visits.

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.

OSDH will expand prenatal care and child health services within the CHDs to additional districts and sites 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 or agreements put in place for transfer of care for prenatal clients around 36 weeks gestation.

MCH will continue to collaborate with partners at the OHCA to monitor Medicaid expansion for enrollment statistics as well as utilization of services once individuals have enrolled. Enrollment does not always equal access to quality care and/or access to preventive health care.

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.

MCH will continue to collaborate with partners at the OHCA to monitor Medicaid expansion for enrollment statistics as well as utilization of services once individuals have enrolled. OHCA benefits will maintain coverage for a broad range of contraceptives including the LARC methods. OSDH and OHCA will continue collaboration to increase access to LARCs for Title X Family Planning clients. MCH will work with OHCA to determine if the carve-out for LARCs that was approved this year, assists FQHCs in increasing access to these methods.

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 CHDs and contract clinics including assistance with SoonerCare enrollment, reproductive life planning, 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 CHDs.

The Family Planning Information and Education Committee continues to seek input from youth in reviewing reproductive health materials to ensure information is appropriate for adolescents and easy to understand in an effort to share information on preventing unintended pregnancies.

Public Health Youth Councils, facilitated by the Adolescent Health Specialists in rural areas of the state, will resume recruitment and begin meeting during the 2022-2023 school year.

MCH will work with community partners (OHCA, March of Dimes, OPQIC, Federally Qualified Health Centers, etc.) to identify ways to promote preconception health messages. Staff will work with the OSDH Chronic Disease Division and Office of Communications, as well as, Cox Media to create preconception health messages to be disseminated through social media and/or streaming services. Through a contract with Southern Plains 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.

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 Maternal Health Innovation Grant, MCH will continue leading the Maternal Health Task Force to assist with implementing recommendations from the MMRC. Due to COVID restrictions and difficulty in providing a secure option for reviewing deaths, the MMRC fell behind in reviewing cases during 2020 and 2021. Next year, the committee will work to catch up in order to be able to review deaths that occurred more recently and make relevant recommendations to improve care.

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 issues associated with maternal morbidity and mortality in Oklahoma.

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

Objective 1. Increase the percent of county health department sites appropriately utilizing the PHQ-9 tool for screening and the new codes for positive and negative screening from 61 sites in February 2020 to 90 sites by 2025.

MCH will conduct additional trainings and provide technical assistance at site visits to assist with the utilization of the PHQ-9 and new codes for screening.

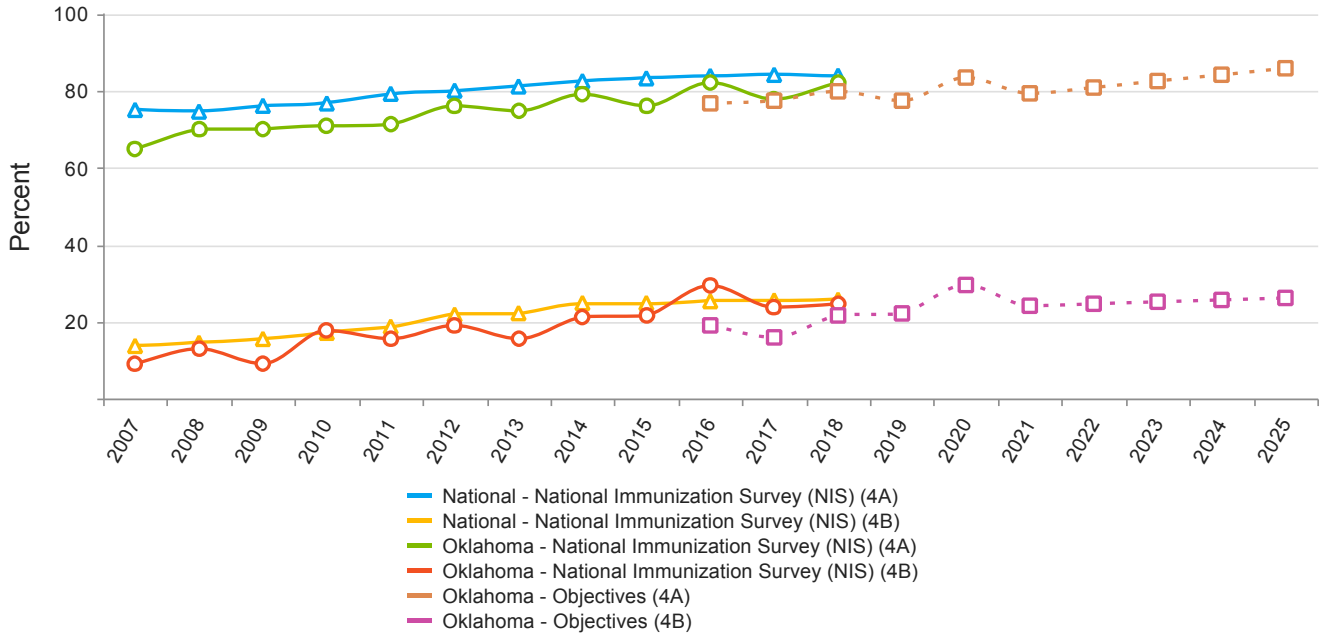
Objective 2. Create culturally competent public service announcements (PSAs) and messages on maternal mental health that are representative of African-American, Native, and Latinx women and men impacted by Perinatal Mood and Anxiety Disorders (PMADs) by 2025.

Recruitment for representatives to assist with the PMADS PSAs will continue.

Perinatal/Infant Health

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	77.4	79.8	77.4	83.4	79.3
Annual Indicator	79.2	75.9	82.2	77.7	82.1
Numerator	41,230	38,194	38,328	34,343	40,689
Denominator	52,032	50,306	46,652	44,223	49,582
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	80.8	82.5	84.1	85.8

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	16	21.7	22.2	29.6	24.2
Annual Indicator	21.3	21.6	29.6	23.7	24.7
Numerator	10,883	10,756	13,540	10,126	11,666
Denominator	51,056	49,712	45,739	42,737	47,187
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	24.7	25.2	25.7	26.2

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	2021
Annual Objective			2,055
Annual Indicator	1,707	1,957	1,957
Numerator			
Denominator			
Data Source	Breastfeeding Hotline	Breastfeeding Hotline	Breastfeeding Hotline
Data Source Year	FY2019	FY2020	FY2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2,158.0	2,265.0	2,378.0	2,497.0

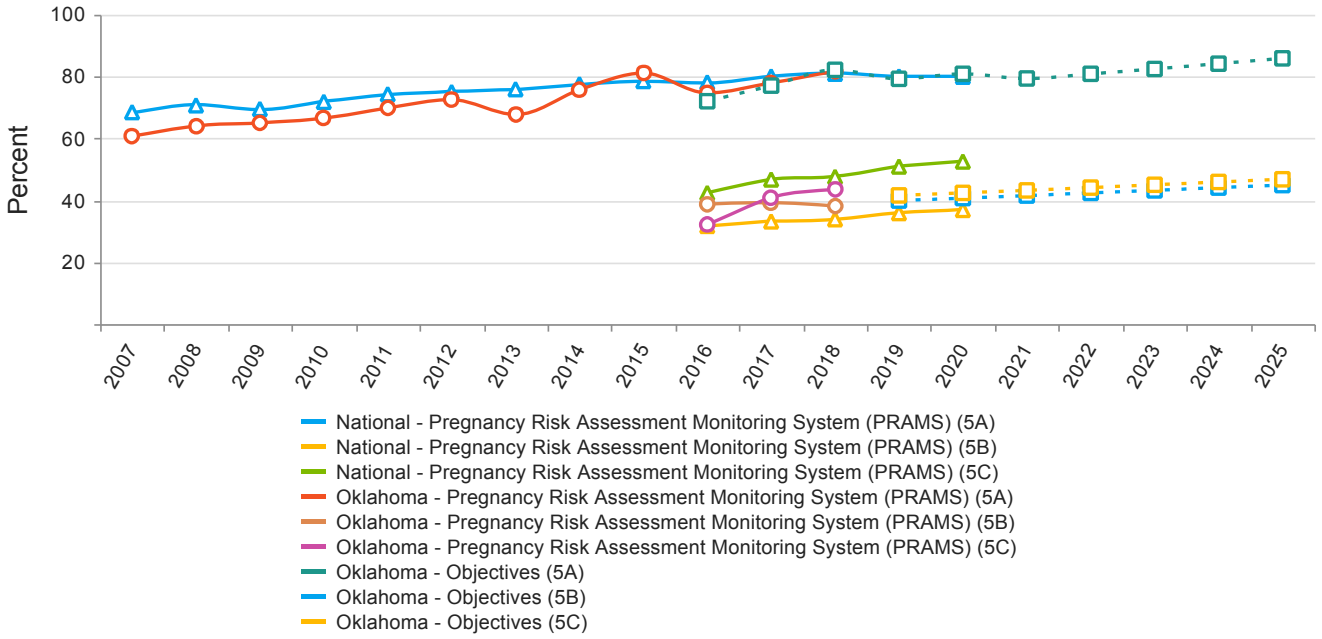
ESM 4.2 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	15.6	16	23.3	34.7	36.4
Annual Indicator	15.2	22.6	33.4	30.3	30.6
Numerator	7,598	11,247	15,926	14,439	14,702
Denominator	50,008	49,787	47,664	47,617	47,978
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	38.2	40.1	42.1	44.2

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	76.9	82	79.1	80.7	79.2
Annual Indicator	81.2	77.6	77.6	77.6	81.6
Numerator	40,173	36,090	36,090	36,090	37,866
Denominator	49,458	46,523	46,523	46,523	46,392
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2017	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	80.7	82.3	84.0	85.7

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**	**2021**
Annual Objective		39.9	40.7	41.5
Annual Indicator	39.2	39.2	39.2	38.3
Numerator	17,658	17,658	17,658	17,190
Denominator	45,065	45,065	45,065	44,880
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.4	43.2	44.1	44.9

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**	**2021**
Annual Objective		41.6	42.4	43.2
Annual Indicator	40.8	40.8	40.8	43.7
Numerator	18,485	18,485	18,485	19,921
Denominator	45,328	45,328	45,328	45,571
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	44.1	45.0	45.9	46.8

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	70.6	71.2	75.3	80.6	82.2
Annual Indicator	69.5	73.8	81.7	80.8	75.7
Numerator	34,913	36,756	38,948	38,484	36,342
Denominator	50,214	49,787	47,664	47,617	47,978
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	77.2	78.8	80.3	81.9

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	7.3	7.5	7	6.7	6.5
Annual Indicator	7.7	7.1	7	6	7
Numerator	387	352	344	285	336
Denominator	50,214	49,787	49,143	47,617	47,978
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.9	6.7	6.6	6.5

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 2025.

2. Increase the number of hospitals and other facilities serving American Indian and African American families participating in the Cribs Project, distributing pack-n-plays and safe sleep tools and education for families, from 5 in 2020 to 8 by 2025.

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 380 sites in 2022 to 400 sites in 2025.

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.

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.

1c. Support COBA's efforts to promote breastfeeding among African American mothers and families through building partnerships with ethnically diverse organizations, such as Black Nurses Associations.

1d. Target outreach to communities with low breastfeeding rates through community baby showers, health fairs, family partners, and local schools to increase education on breastfeeding guidelines and practices.

1e. Increase the number of mothers with WIC who are exposed to at least seven of the Ten Steps to Successful Breastfeeding.

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 2023.

2. Reduce the rate of fatal motor vehicle injuries in children ages 0 to 5 from 3.2 per 100,000 in 2018 to 2.9 by 2024.

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. Begin work on a grandparent training toolkit for infant care and safety.

2a. Continue to utilize the MCH staff member who is a certified CPS technician to assist Injury Prevention Services and Safe Kids Oklahoma with 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. Revise the Preparing for a Lifetime annual report and one-pager on the initiative to educate the community and policymakers on topics impacting infant health by December 2024. [New]

2. Develop and implement two new marketing campaigns focused on diversity and equity in addressing infant health, including mortality and morbidity, by December 2023. [New]

3. Develop and implement a train-the-trainer program to educate 50 professionals and community liaisons on health disparities, implicit bias, and birth equity impacting infant health by December 2023. [New]

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. Engage workgroups and stakeholders on contributions to the annual report and community education. [New]

2a. Determine if there are emerging issues that need to be addressed by the initiative, including health equity and disparities.

2b. Collaborate with the marketing team to develop messages on emerging issues and disperse them among social media, television, streaming applications, and radio. [New]

3a. Complete train-the-trainer program facilitator and participant guides and have reviewed by work group leaders and professional researchers for efficacy. [New]

3b. Train at least 10 professionals to deliver the training to their organizations. [New]

3c. Develop a tracking system to record the number of professionals and community liaisons trained on health disparities, implicit bias, and birth equity. [New]

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 35 in 2025.

Objective 2: Increase the number of trainings and community outreach activities by the Infant Safe Sleep Work Group members for providers and professional organizations on infant safe sleep from 10 in 2020 to 20 in 2025.

Objective 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.

Objective 4: Increase the percent of American Indian and Black births in hospitals participating in the Safe Sleep Sack Program, from 73.3% in 2018 to 80% in 2022.

Objective 5: Increase the number of hospitals and other facilities serving American Indian and Black families participating in the Cribs Project, distributing pack-n-plays and safe sleep tools and education, from 5 in 2020 to 10 by 2025.

Data:
Between October 1, 2020 and September 30, 2021, approximately 37,488 sleep sacks were provided to families upon discharge from the 29 participating Oklahoma birthing hospitals. Among those participating hospitals, 62.8% of births were to American Indian women, which is a slight increase from the 2019 births. Among Black women, 86.5% gave birth in facilities participating in the sleep sack program, a decrease from 87.6% in 2019.

The percent of infants placed to sleep on their backs was 77.6% according to 2016-2019 data. This was an increase from 76.1% in 2016-2017. However, 65% of Black mothers reported placing their infants to sleep on their backs, compared to 80.1% of white mothers and 79.6% of American Indian mothers in 2016-2019.

The number of hospitals and other facilities serving American Indian and Black families has not increased since 2020. There were conversations with two birthing hospitals regarding joining the program, but due in part to internal staffing changes in these facilities, and due to the continued influence of COVID-19 on the hospital's resources and interest in launching new projects; neither of these facilities were able to join the project.

Successes:
The alliance of partners that comprise the Infant Safe Sleep Work Group continued to be robust, with the University of Oklahoma Health Sciences' Office of Perinatal Quality Improvement, the Oklahoma Health Care Authority, Oklahoma SAFE KIDS Coalition, Oklahoma Child Death Review Board, Oklahoma MIECHV, and representatives from the Central Oklahoma and Tulsa area Fetal Infant Mortality Review (FIMR) programs. The work group and its partners continued to work towards the goals of increasing infant safe sleep education, empowering medical providers with the most up-to-date information on infant safe sleep, and the reduction of infant sleep-related death overall.

At the Oklahoma State Department of Health (OSDH), the two largest projects related to the promotion of infant safe sleep continued to be the hospital partnerships with Oklahoma birthing hospitals in distributing sleep sacks, along with infant safe sleep education; and the partnership between the OSDH and the Oklahoma Health Care Authority on distributing portable cribs and education to families in need of a safe sleep space. The hospital safe sleep sack project saw several important partners added to the list of participating hospitals. The Cherokee Nation WW Hastings Hospital and the Choctaw Nation Healthcare Center both joined the list of hospitals distributing sleep sacks along with infant safe sleep education, and committed to engaging in these practices within their facilities. These hospital partners were especially important as they primarily served members of the tribal nations they were situated within; furthering the goal of targeting these communities, disproportionately impacted by infant safe sleep disparities. The crib kits were distributed with infant safe sleep education, a fitted sheet, a pacifier, an educational board book and a sleep sack. Two hundred and twenty-six portable cribs were distributed to families in need during the grant reporting period through September 30, 2021.

The Infant Safe Sleep Work Group co-lead conducted a train-the-trainer event with 23 rural health educators and nurses on infant safe sleep, and provided an interview on infant sleep safety with a local news station to raise awareness during Sudden Unexpected Infant Death (SUID) awareness month. Although COVID-19 response continued to be a primary focus of the public health system in Oklahoma, the Oklahoma City County Health Department (OCCHD) and Tulsa Health Department (THD) maternal outreach programs along with the Infant Safe Sleep Work Group co-lead, continued to provide safe sleep education. Central Oklahoma Fetal and Infant Mortality Review (FIMR) provided train-the-trainer Infant Safe Sleep virtual sessions that resulted in approximately 477 total participants from across the state. Due to the THD FIMR group's re-assignments for emergency COVID-19 response until late summer 2021, they were unable to conduct the infant safe sleep training.

The racial disparity in the infant mortality rate remained but began trending smaller. For this reporting period, the infant mortality rate disparity was improved with the White Infant Mortality Rate at 0.7, Black at 1.5, and American Indian rate at 1.6.

Due, at least in part, to an increase in promotional campaigns and social media postings, the *Preparing for a Lifetime* Facebook page saw a significant gain in the numbers reached; 8,179 individuals from October 1, 2020 to September 30, 2021, compared to 2,975 for the previous fiscal year.

Challenges:
While there was success in adding additional partners to the infant sleep sack distribution project, the hope that the portable crib distribution project could add partners did not come to fruition. Hospital partnerships were particularly difficult to originate due to COVID-19 overwhelming resources and personnel.

One of the primary components for hospital partners that joined the OSDH sleep sack distribution program was becoming certified through Cribs for Kids as a safe sleep bronze, silver, or gold level hospital. Certification remained important because it showed a commitment to (at a minimum) a hospital or system-wide Infant Safe Sleep Policy, ensured that staff were trained in infant safe sleep, and provided safe sleep education to family/caregivers of infants less than one-year-old. This process was placed "on hold" for all partners due to the continued overwhelming need to respond to COVID-19.

The most recent data on percentage of infants sleeping alone was not as high as prior years, with the overall percentage being 55%, Non-Hispanic White at 59.8%, Non-Hispanic American Indian 50.4%, and Non-Hispanic Black infants at 35.8%. The percentage of black infants sleeping alone is especially concerning.

Although there was a small increase from the prior year, broadly there continued to be a lesser amount of crib kit

distributions during this period than in prior years. At least part of the source for this reduction was fewer home visitors engaging with families due to modified COVID-19 home visiting protocols.

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 80.4% in 2018 to 85.0% by 2025.

Objective 2: Increase the percent of mothers who exclusively breastfeed their infant through 6 months of age from 29.6% in 2016 to 35% by 2025.

Data:
In 2020, Oklahoma Vital Statistic data showed 81.1% of new mothers were breastfeeding at hospital discharge, a slight increase from 2018 (80.4%). The Oklahoma Toddler Survey (TOTS) provided data to monitor feeding at six months duration. According to 2018-2019 TOTS data, 46.4% 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) 2018 data showed that 24.7% of Oklahoma mothers exclusively breastfed through six months of age. 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 eighty-five participants attended the *9th Annual Becoming Baby-Friendly in OK (BBFOK) Summit,* a virtual Summit due to the COVID-19 pandemic, with leadership teams from 21 hospitals and 76 other organizations. Keynote speaker Jane Morton, MD, First Droplets Founder and former Director of Breastfeeding Medicine Program at Stanford Medical Center discussed "A Mother-centric Approach to Reduce Early Breastfeeding Cessation" in two sessions and Becky Mannel, Director, OK Breastfeeding Resource Center (OBRC) outlined "Oklahoma's State of the State – Unprecedented".

The Summit included two panel discussions with professionals and breastfeeding moms: "Systemic Racism and Health Disparities in Oklahoma and their Impact on Breastfeeding" and "Mothers' Stories: Support is Critical". Comanche County Memorial Hospital received recognition as Oklahoma's second baby-friendly hospital to achieve redesignation, maintaining the state's total of ten designated and redesignated hospitals in the midst of numerous hospital and statewide changes due to COVID-19. Also featured, sessions on "Full Breasts, Empty Arms: Perinatal/Infant Loss & Lactation" and "Maternal Mental Health & Breastfeeding: Perinatal Mood and Anxiety Disorders and their Impacts".

Interspersed throughout the day were short informational videos from Community and State Partners: Coalition of Oklahoma Breastfeeding Advocates (COBA), Oklahoma Mothers' Milk Bank (OMMB), OK Perinatal Quality Improvement Collaborative (OPQIC), Oklahoma Breastfeeding Hotline (OBH), OU Health Physicians Breastfeeding Clinic, OK WIC, and PSAs from eight Preparing for a Lifetime (PFL) Infant Mortality Reduction Initiative Work Groups.

Due to the ongoing pandemic, in-person trainings, conferences and hospital assessments were cancelled, postponed, or moved to a virtual format. MCH worked with OBRC and WIC to ensure updated Oklahoma, national, and world health resources were posted to appropriate websites.

Links to OBRC's free interactive online prenatal education modules (in English and Spanish) were shared widely with the public and OBRC contacts including OUHSC departments of OB/GYN, Pediatrics and Family Medicine and OBRC's Lactation Clinic as well as Oklahoma hospitals and WIC, all who shared same online modules with their prenatal clients. OBRC communicated with 35 delivering hospitals to determine their interest in joining BBFOK and/or implementing some of the Ten Steps to Successful Breastfeeding. In addition, they joined a nationwide collaborative of other state programs who are also attempting to get more hospitals to work toward Baby-Friendly designation.

Work group members continued to review, update, and condense the PFL breastfeeding website pages in the revised OK state website format, and updated the *Nursing Your Newborn* Fact Sheet. Breastfeeding friendly worksites rose to 367 recognized semi-annually through meetings and websites. 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 continued online applications and education and sponsored the Virtual Breastfeeding Educator Course for staff providing WIC services, led by Alabama's Glenda Dickerson, MSN, RN, IBCLC. WIC's Breastfeeding Peer Counselor (BFPC) Program continued in 14 counties and 27 clinic sites, with 31 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. Four additional policy positions and statements on current affairs and existing laws and policies hindering support efforts were developed and posted, bringing the total to seven. Members promoted the passage of a senate bill requiring school districts to provide lactating employees paid breaks and a private, secure, sanitary location to express milk or breastfeed a child.

MCH support continued for OBH, providing information and referrals for 2,116 mothers and health care providers, and for the Hospital Breastfeeding Education (HBEP), BBFOK, and OMMB projects. Since the launch of the texting capability, allowing users to text hotline IBCLCs, call volume has increased 20%. Calls and texts were received from families delivering at 31 different hospitals, representing over 66% of Oklahoma's 47 birthing hospitals.

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

Celebrating its eighth anniversary, OMMB served all five level III and both level IV neonatal intensive care units (NICUs). Twenty-one depots, with seven in-county health departments, were maintained, and OMMB continued to recruit and serve rural level II NICUs and special care nurseries, and supported seven out-of-state hospitals without milk banks and two other milk banks with shortages. The bereavement program continued with over 100 plaques representing babies of bereaved mothers who donated milk in their baby's memory. OMMB contracted with University Hospitals Authority and Trust and sought funds to renovate space in Garrison Tower to expand operations and double the physical space, and promoted legislation to provide Medicaid coverage of donor milk for babies in the community with a medical need.

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. MCH continued to share on its website the *Breastfeeding Support Fact Sheet*, which included Oklahoma's breastfeeding rates and Maternity Practices in Infant Nutrition and Care (mPINC) Surveys, key

outcomes, and activities; all helpful information for legislators, health care providers, students, advocates, and funders. Based on the August CDC Breastfeeding Rates Update, Oklahoma increased in every category.

Challenges:
Due to physician opposition, Integris Edmond Health decided not to re-designate. OBRC staff successfully converted interactive, in-person trainings to virtual trainings; however, this required more staff time and additional expertise to develop and manage polls, break out rooms, and the chat box while conducting trainings.

Objective 3: Increase the number of breastfeeding friendly worksites, including schools and childcare centers from 355 sites in 2020 to 365 sites in 2021.

Data:
Oklahoma recognized breastfeeding friendly hospitals increased to 367 in 2021. One hundred and eighteen of those were health care facilities and 280 were Gold Star Worksites.

Successes:
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 develop policies, establish mothers' rooms, and receive recognition. MCH continued to share on its website the *Breastfeeding Support Fact Sheet*, including Oklahoma's breastfeeding rates and Maternity Practices in Infant Nutrition and Care (mPINC) surveys, key outcomes and activities; all helpful information for legislators, health care providers, students, advocates, and funders. Based on the August CDC breastfeeding rates update, Oklahoma increased in every category.

Challenges:
Competing priorities and staff reductions made recruiting and retaining active work group members and efforts to increase recognized breastfeeding friendly worksites challenging.

Objective 4: 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.

Objective 5: Increase partners for outreach to ethnically diverse populations from 37.5% to 44.4% in 2021.

Data:
According to Pregnancy Risk Assessment data for 2016-2019, the rates for Black and American Indian mothers exclusively breastfeeding for 8 weeks or more were 46.9% and 48.2%, respectively. Individual year data for 2020 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, PSAs and in social media posts. Two Baby-Friendly videos featured stories from a Black mom and a nurse and were shared on the OBRC website. NBM celebrations targeted disparities and shared resources for communities of color. Tulsa's BBW's online celebration was led by a former COBA chair representing communities of color. For The Village, Inc., a nonprofit formed to improve maternal and infant outcomes in the Black community by raising awareness, developing Black birth workers, and providing birth services, continued activities. Work group and COBA membership included representation from communities of color and sought to increase input from a variety of

ethnic and racial groups. MCH, COBA members and partners promoted Black Maternal Health Week during April 11-17.

COBA's virtual annual meeting featured a panel discussion, *Systemic Racism and its Effects on Health Disparities in Oklahoma* that included Noor Jihan Abdul-Haqq, MD, Peace of Mind Pediatrics; Maggie Green, LCSW, Greenwercs Coaching Counseling Consulting Services; and Jillian Whitaker, Better Black News. This panel discussion was again presented at the BBFOK Summit. *How Good Policy Can Change Health Outcomes* was the topic for COBA's Spring Virtual Meeting's panel discussion and included Oklahoma legislators, Senator Carri Hicks (OKC), Representative John Waldron (Tulsa) and Senator Jessica Garvin (Duncan).

Challenges:
COVID-19 continued to present 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. MCH staff continued to operate 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 challenging. COBA continued to recruit and train members to develop leadership, communication, and financial skills to maintain and promote ongoing and new projects. OSDH employees continued to adjust to the many changes brought about by the move to a different location while the pandemic continued.

Objective 6: Develop information and guidelines for food pantries and shelters, regarding supporting breastfeeding in emergency situations.

Successes:
MCH shared information on supporting breastfeeding in emergencies on the OSDH website including links to the OBH, the American Academy of Pediatrics and CDC's Infant Feeding in Disasters and Emergencies websites with links to fact sheets/infographics, as well as, links to the International Lactation Consultant Association's and United States Breastfeeding Committee's Breastfeeding in Emergencies webpages. Links to COVID-19 information and guidelines were also included on OSDH, COBA, and OBRC breastfeeding websites.

COBA members developed, promoted, and posted on the website a position statement on *Infant & Young Child Feeding During Emergencies*, calling for organizations and shelters to screen families with infants and young children for their preferred feeding methods. The statement included providing lactation support if needed, such as alternate methods of milk removal (pumps or education on methods of hand expression to empower mothers to express breast milk).

SPM 2 Infant mortality rate per 1,000 live births

Objective 1. Screen 100% of newborns in Oklahoma and maintain timely follow-up to definitive diagnosis and clinical management for infants with positive screens.

Data:
According to the latest data available, all newborns born in Oklahoma hospitals in 2020 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.

For 2020, all 609 newborns with sickle cell trait and hemoglobin C trait received educational material regarding trait status and 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 41 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. Title V funding also supported 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. Additionally, education was provided at health fairs and community baby shower events across the state.

In 2021, the NSP added four core conditions (Mucopolysaccharidosis Type 1 (MPS 1), Pompe, Spinal Muscular Atrophy (SMA), and X-Linked Adrenoleukodystrophy (X-ALD) that were legislatively approved in 2020.

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 the partnership with the Oklahoma Hospital Association and OPQI on the quality improvement program, "Every Baby Counts", to address delays in newborn screening. The overall goal of the QI program remained to improve timeliness of newborn screening through collaboration with birthing hospitals and the contracted courier service to improve transit time (the time it takes for specimens to arrive at the PHL from the time of collection). The QI program included providing virtual educational sessions for all birthing hospitals that requested additional training. Due to staff changes and challenges with the public health lab move to Stillwater, monthly hospital reporting did not continue in 2021. During the time that the NSP was unable to provide monthly reports to facilities, staff worked on developing a Tableau dashboard so that hospitals would have access to retrieve their monthly reports.

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, 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, difficulty with hospital engagement due to COVID-19, as well as staff turnover and challenges related to the PHL move.

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 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. 2018 data indicated prenatal care in the first trimester was on the rise again and according to most recent data available, in 2020 reached another high at 70.9%.

According to Oklahoma hospital discharge data, 6.3 infants per 1,000 hospital births were diagnosed with neonatal abstinence syndrome in 2019, compared with 6.6 in 2017.

Successes:
According to the Oklahoma Health Care Authority State Fiscal Year 2020 Annual Report (latest report available), 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 applying 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.

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

Traditionally, 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. However, no site visits were completed this year due to COVID-19. Family planning clients with a positive pregnancy test continued to be 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.

CHDs and contract providers served as safety net providers for maternity clinical services. 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 (QFP) 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. 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 was 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. Opioid prescribing guidelines for pregnant and postpartum women were developed and distributed to family practice, obstetric, and pediatric health care providers. The guidelines were made 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, launched in September 2019, 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. Activities were suspended for a few months due to competing priorities for hospital staff dealing with COVID-19. Once normal activities began resuming, 10 hospitals began reporting data. The most common substances of use/abuse reported were amphetamines, cannabinoids, heroin, buprenorphine and methadone.

The OSDH was awarded the five-year State Maternal Health Innovation Program (SMHIP) grant to address maternal morbidity and mortality in innovative ways in 2019. This grant, which began in October 2019, continued with projects to address the lack of access to quality prenatal care for women in ethnic and racial minorities, or tribally-affiliated, and/or lived in rural areas. Additional projects included substance use/abuse in pregnant and postpartum women, maternal morbidity, and telehealth linkages to high-risk obstetrical care. Contracts were maintained with Oklahoma State University (OSU) for the Project ECHO, Cherokee Nation, the STAR clinic, Southern Plains Tribal Health Board and CHESS Health. Through the contract with OSU, a High-Risk OB ECHO (Extension for Community Healthcare Outcomes) continued monthly, providing 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 access to Maternal Fetal Medicine both within the Cherokee Nation health system and through telehealth visits. Another contract continued with the Oklahoma University Health Science Center Maternal Fetal Medicine STAR clinic to expand services for pregnant women with substance use disorders. Data indicated that most mothers enrolled in this program are discharged after delivery with their infant. Through the contract with Southern Plains Tribal Health Board, media messages began to be updated, making them more culturally appropriate and inviting for the Native American population. SPTHB also conducted a survey to assess resources and gaps in services and identify contacts for some of the smaller tribes in the state. MCH also continued a contract 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. Access to CHESS Health was expanded statewide this FFY for all family planning, child health and maternity clients.

The Maternal Health Task Force continued in partnership with OPQIC through the SMHIP Grant. A strategic map (OMHTF Strategic Profile 2020-2024r.pdf (oklahoma.gov) 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 interconception care. Four priorities were identified with access to appropriate care and maternal health programs identified as priority. The strategic map was updated this year and each work group identified activities to reach the goals. The Access to Care work group focused on developing consistent, evidence-based messages for pregnant women and their families and expanding access to care through the development of recommended guidelines for the safe provision of telehealth visits.

Challenges:
The biggest challenge this year continued to be the impact of COVID-19 on access to in-person health care visits, restriction of family members from health care visits with pregnant women. Some providers lifted restrictions on masks and visitors while many maintained strict safety procedures. Telehealth visits were established with some providers, however, access to telehealth visits in rural areas of the state without quality wireless connections continued to provide challenges.

The STBS program, created to provide insurance coverage for women who were excluded from full Medicaid benefits due to citizenship status, continued to offer a limited benefit package, which only included prenatal care services. Insurance coverage ended at delivery hospital discharge. Four 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. Plans were on the table to move the current Medicaid reimbursement system to a managed care model as Medicaid expansion became available in July. However, it was determined that this plan was in not accordance with state statutes and the plan was dropped. Prior to this, MCH staff had met with the managed care leadership in relation to quality improvement options for access to care for pregnant women.

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 the 2021 legislative session for full practice authority for advanced practice nurses, however, legislative leadership refused to hear any legislation on this topic. This legislation would have removed the requirement for advanced practice nurses to have a physician signature for prescriptive authority. Each practicing physician could only sign for two full-time APRNs creating a significant barrier to accessing services especially in rural areas of the state. This year, the Oklahoma State Medical Association agreed to allow practicing physicians to sign for prescriptive authority for up to six APRNs. To supervise more than six, physicians had 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.

Medicaid expansion became effective during this time period and many people signed up for coverage, however with the shortage of physicians in the rural areas, some new enrollees were assigned to a Primary Care Provider (PCP) in a different county.

Infant Mortality 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 2022.

Data:
The number of participating hospitals was 39 as of September 30, 2021; the program neither added nor lost hospitals in FFY21.

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

During this time, virtual presentations were given by OSDH staff and partners on PURPLE Abusive Head Trauma (AHT) and the crying curve. Presentations were made to state social workers, the state's Head Start Health Managers, the Southern Plains Inter-Tribal Health Board's annual conference, and staff and program managers at The Parent Child Center of Tulsa and OSDH.

COVID-19 put a hard stop on any in-person trainings or presentations. The barbershop project in Tulsa had to pause due to COVID protocols. When 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.

During the spring 2021 semester, the Injury Prevention Work Group hosted an intern, who developed a practicum project around PURPLE implementation in the state. She performed an environmental scan, conducted a survey and several in-depth interviews with key personnel to better understand the barriers and benefits of the current project. Training and process improvements were also identified and shared with the Injury Prevention Work Group and the National Center on Shaken Baby Syndrome.

In April 2021 (Child Abuse Prevention Month) Child and Adolescent Health (CAH) staff and the Injury Prevention Work Group assisted MCH's media contractor with developing a series of web and streaming ads on the norms of crying and the PURPLE program.

Injury Prevention Work Group members provided consultation with a contractor from the Hawaii Department of Health interested in the statewide approach of the work group.

The Dad postcard, created in 2019, was updated with the new statewide toll-free Child Warm Line information, available to families across the state. Additionally, the website for the Injury Prevention Work Group was updated.

Challenges:
PURPLE program participation looked a little different for much of 2021 due to COVID-19. Most mothers were allowed only one support person in the delivery room; hence, the mother and her partner were often the only recipients of the information. In some hospitals, due to COVID-19 rules, education was provided in take-home packets and not face-to-face; which is not best practice for PURPLE. These challenges do not even touch on the hardship some new parents faced, as they dealt with situations where they could not call upon grandparents and extended family to provide respite care and support.

Infant Mortality Objective 2. Reduce nonfatal motor vehicle injuries in children ages 0 to 19 from 321 in 2016 to 230 by 2025.

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 2019 of 10.6 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 5.8 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 CAH Division of MCH, continued to provide support as a Certified Child Passenger Safety (CPS) Technician and Instructor. The Early Childhood Coordinator participated in regularly-scheduled car seat check-up events, assisted Safe Kids Oklahoma in teaching a short child passenger safety class for parents at Variety Care Clinics that ended with a car seat check for the families, and conducted a few private appointments.

From October 1, 2020 through September 30, 2021, the Early Childhood Coordinator assisted Safe Kids Oklahoma with four classes for parents and car seat check-up events held at the Variety Care clinics, and participated in 28 car seat check-up events held at OU Children's Hospital in a partnership with OSDH Injury Prevention Service, OU Children's Hospital, and Safe Kids Metro. The Early Childhood Coordinator also helped five individual families at private car seat appointments. During every car seat check, parents were educated about the dangers of backing over children and leaving children in hot cars.

MCH and Injury Prevention Service continued to team up with OU Children's Hospital to hold car seat check-up events two times per month, with the CPS technicians and families following COVID-19 Safety Protocols:

- All persons (CPS Technicians, volunteers, and family members) must wear a mask.
- Driver and passengers must remain in the vehicle until called to the inspection station.
- Drivers and passengers will exit the vehicle only at inspection and practice social distancing guidelines.

When possible, family members learned how to install the 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 earned Continuing Education units by participating in the virtual 14th Annual Martha Collar Tech Reunion CPST Conference April 21, 2021.

Challenges:
Due to some of the restrictions caused by COVID-19 and the increase in COVID-19 cases, proper car seat installation by a certified CPS Technician was lower than desired across the state for families qualified to receive car seats and in need of assistance.

Health Equity Objective 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.

Data:
Stakeholders completed a review of areas impacting infant mortality and compared it with recent state data to establish the efficacy of the initiative's focus.

Successes:
Current statewide data was presented at the Stakeholders' quarterly meeting, and new initiatives from the work groups were developed. The creation and production of various media campaigns provided a platform of diversity and inclusion among birthing families, offering more opportunities to extend education and access to services. The overall IMR decreased over the past few years, to the lowest it has been since the 1980s.

Challenges:
The impact of state programming under the Preparing for a Lifetime initiative was effective, but the challenge remained that Oklahoma continued to rank higher than many other states, ranking 42nd highest out of 50, for IMR. A racial disparity between Blacks and Hispanics (when compared to the white population) continued in the state.

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

Data:
The goal of increasing stakeholders was placed on hold due to the COVID-19 response and the virtual nature of the quarterly meetings.

Successes:
Stakeholders were able to participate in work group meetings and stakeholder meetings via Microsoft Teams and Zoom. This provided more engagement of current stakeholders regarding participation.

Challenges:
Because the meetings were virtual, engaging nontraditional partners in innovative and interactive ways was a challenge.

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

Data:
Stakeholders and agency leads were able to complete a minimum of three community and professional engagements on MCH-related topics, including perinatal and infant health.

Successes:
Presentations were offered during 2021 Black Maternal Health Week addressing perinatal and infant health; a presentation for college students was completed via Zoom, and an e-Learning program was offered to address implicit bias and racial disparities.

Challenges:
Due to COVID-19, the opportunity to present at perinatal and infant health conferences was minimal**.**

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

The Infant Safe Sleep workgroup will continue to look for partnerships throughout the state to disseminate accurate and up-to-date infant safe sleep education, especially those that operate within the American Indian and Black communities. Key partners in this effort will continue to be the Oklahoma City County Health Department FIMR program, Tulsa Health Department FIMR program, Oklahoma birthing hospitals, faith communities, and the tribal nations throughout Oklahoma.

Workgroup lead and members will continue to interface with Oklahoma birthing hospitals to provide infant safe sleep resources. Infant sleep sacks will continue to be distributed through partner hospitals, and work will continue to expand the reach; especially in areas with higher-needs populations.

Distributing portable crib kits will continue and work will resume to increase the number of partner organizations assisting in this effort.

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 an 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 Oklahoma 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 OSDH Community Analysis and Linkages will coordinate with OBRC to use additional funding received from the National Association of Chronic Disease Directors Special Breastfeeding Project to reimburse Baby Friendly Hospitals for re-designation fees and staff training.

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.

SPM 2 Infant mortality rate per 1,000 live births

Objective 1. Screen 100% of newborns in Oklahoma and maintain timely follow-up to definitive diagnosis and clinical management for infants with positive screens.

Continue to provide partial funding for birth defects education and the Oklahoma Birth Defects Registry. Family Planning clinics will distribute information on exposure to CMV (cytomegalovirus) and related birth defects to all clients with a positive pregnancy test. In an effort to continue to prevent neural tube defects, county health departments will distribute multivitamins with 400mcg of folic acid to women of childbearing age.

Continue to provide partial funding for the Oklahoma Childhood Lead Poisoning Prevention Program (OCLPPP). The OCLPPP will provide case management to families of children with elevated lead levels through education, community referrals, environmental investigations, along with reminders and guidance on follow-up.

Objective 2. 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.

Objective 3. Reduce the prevalence of substance-exposed newborns from 6.2 per 1,000 in 2016 to 5.0 in 2025.

Prematurity will remain a focus for OSDH and community partners. OSDH, OHCA, the March of Dimes, and OPQI will continue to support the activities of the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) 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. This will be accomplished in part 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, including the new Community Health Workers across the state, will continue to assist individuals and families to apply for Medicaid benefits through the online enrollment process.

The 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.

CHDs 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. The STAR (Substance, Treatment and Recovery) clinic, with funds from the Maternal Health Innovation Grant, will continue to assist 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 health department clients, including pregnant persons, 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.

Infant Mortality Objective 1: Increase the number of delivering hospitals participating in the Period of PURPLE Crying Abusive Head Trauma curriculum from 40 in 2020 to 42 by 2023.

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.

Work will begin to develop a toolkit for trainers to provide education to grandparents across the state about newborn safety and injury prevention, including the norms of infant crying, infant safe sleep and breastfeeding support.

Infant Mortality Objective 2. Reduce fatal motor vehicle injuries in children ages 0 to 5 from 3.2 per 100,000 in 2018 to 2.9 by 2024.

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 Oklahoma Children's Hospital OU Health and Safe Kids Metro. The MCH Early Childhood Coordinator will continue to work with Safe Kids Oklahoma at their community car seat education classes and installation events. The 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.

During every car seat event, CPS technicians will continue to educate families about the dangers of backing over children and leaving children in hot cars.

The MCH Early Childhood Coordinator will maintain CPS Certification through participating in continuing education training and fulfilling the community education requirements.

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

Health Equity Objective 1. Revise the Preparing for a Lifetime annual report and one-pager on the initiative to educate the community and policymakers on topics impacting infant health by December 2024. [New]

Health Equity Objective 2: Develop and implement two new marketing campaigns focused on diversity and equity in addressing infant health, including mortality and morbidity, by December 2023. [New]

Health Equity Objective 3. Develop and implement a train the-trainer program to educate 50 professionals and community liaisons on health disparities, implicit bias, and birth equity impacting infant health by December 2023. [New]

Work will begin on a revised annual report and one-pager.

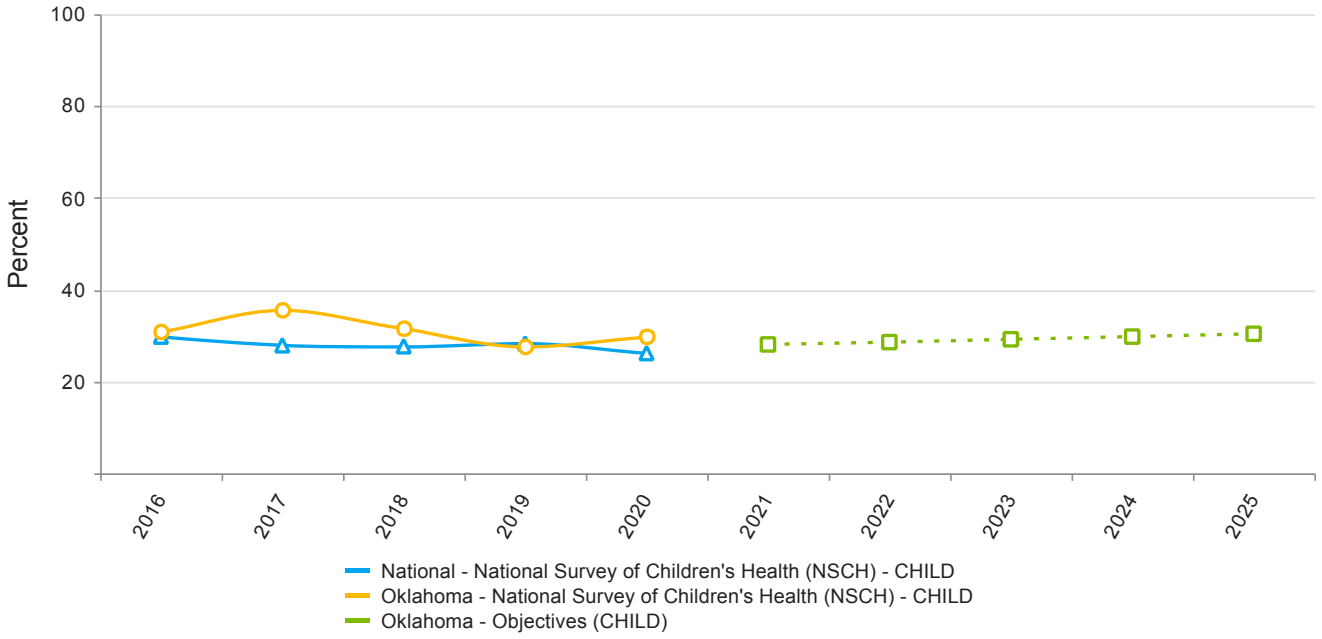
Quarterly meetings and work groups will continue and work to increase reach and stakeholder involvement.

A work group will be convened to develop the train-the-trainer program and assist with the recruitment of partners to commit to the training.

Child Health

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**	**2021**
Annual Objective			28.1
Annual Indicator	31.4	27.5	29.9
Numerator	93,110	89,475	96,949
Denominator	296,779	325,093	324,556
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	28.6	29.2	29.8	30.4

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	2021
Annual Objective			110
Annual Indicator	125	101	112
Numerator			
Denominator			
Data Source	Child and Adolescent Health, MCH program data	Child and Adolescent Health, MCH program data	Child and Adolescent Health, MCH program data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	120.0	130.0	140.0	150.0

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, expertise, and consultation by participating in and attending 80% of the meetings of the DHS Child Care Advisory Committee, the State Obesity Planning Group, Safe Kids Oklahoma, OPSR and the Oklahoma Tribal Child Care Association.
3. Complete the updates and revisions to the Good Health Handbook by 2023.
4. Serve at least 58,000 students statewide Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD) by 2024.
5. Identify areas in need of evidence-based health education and develop one lesson for Health Educators in the state by 2023.
6. 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 2023.
7. Provide at least 6 vision screening and 12 diabetes management trainings for school staff annually.

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.

2. Continue to participate in advisory boards, committees and partnerships such as the Oklahoma DHS Child Care Advisory Committee, the Oklahoma State Obesity Planning Team, Safe Kids Oklahoma, the Oklahoma Partnership for School Readiness (OPSR), and the Oklahoma Tribal Child Care Association to promote best practices in early childhood care and education.

3. Revise and update The Good Health Handbook: A Guide for Those Caring for Children.

4a. Continue to provide funding and contract monitoring for the Healthy Schools OK, It's All About Kids (THD), and Health at Schools (OCCHD) for the provision of social emotional learning, skills-based health education, nutrition education, and bullying prevention.

4b. Establish partnerships with tribal organizations and with county health departments to collaborate on professional development activities and service provision for evidence-based health education activities in their jurisdictions.

5a. Assist the Oklahoma State Department of Education and partners, as requested, as they begin planning for the new health education mandate for Oklahoma public schools to begin in 2023-2024.

5b. Identify community partners that can assist in providing evidence-based health education and training for staff in their local schools.

6a. Continue to fund the rural school health nurses to provide evidence-based health education and services in their school districts.

6b. 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. Create and distribute school nurse resources.

6c. Plan and host an Annual School Nurse Summit. Assist in Planning the OKWSCC Annual Conference. Work with the OSDE Nurse Cadre to provide trainings to school nurses.

7. Facilitate in-person and virtual trainings in partnership with school nurses and OSDE.

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/PACES on development by 2023.

2. Strengthen Child Health Clinics in pilot County Health Department Clinics for mobile and traditional settings by 2023.

Strategies

1. Provide training on trauma-informed care and ACES to contractors or find acceptable online alternatives.

2a. Work with county staff to foster clinic practices and materials, including ways to increase client base and successfully promote clinics in underserved areas.

2b. Host a minimum of quarterly Pediatric Review sessions or hands-on training 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)

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.

Data:
The Oklahoma Center for Poison and Drug Information (OCPDI) remained committed to reducing unintentional poisonings and educating the public about their services. From October 1, 2020 through September 30, 2021, OCPDI provided educational presentations and materials to 18,107 elementary and pre-school students across the state of Oklahoma. The purpose of the presentations was to reduce the risk of exposure to toxic substances.

Successes:
The OCPDI continued to be a resource for Oklahoma families, educators, child care facilities, and medical professionals around the state of Oklahoma. They continued to provide information on potential exposures to medications, toxic plants, poisonous snakes/insects, and other potential toxins to which humans or animals were exposed. Services assisted in identification of medications or potential toxins 365 days per year, with an average of 3,027 phone calls per month. The opportunity for medical, pharmacy, and nursing students, to obtain knowledge from a clinical rotation throughout the year, continued to be provided. Educational presentations were given throughout the year for pharmacy students, medical students, and others in the medical field. OCPDI staff also provided articles for publication, radio, and TV interviews as requested.

On February 19, 2021, the 4th Annual Toxicology Education Day, a single day conference was held. The conference was geared toward healthcare providers that were involved in the care of patients of possible overdoses and other toxic exposures. Resources for educators, emergency medical service personnel, and community members were provided to assist in the work of educating the public on potential risks of toxic exposures.

Due to the ongoing pandemic, staff trainings and meetings continued virtually thus allowing staff to work safely from remote locations, mitigating the spread of COVID-19. Staff continued to use the electronic resources and equipment obtained during the beginning of the pandemic; and, they continued to be a valuable resource for Oklahomans. Obtaining information from OCPDI has reduced the number of emergency room visits and saved millions of dollars in cost. A large percentage of the calls received come from healthcare workers. Call services for other states continued to be part of the work performed by the staff in the event that the state was unable to provide services for a short time, such as in local natural disaster situations or power outages.

Challenges:
The COVID-19 pandemic continued to create challenges with providing in-person presentations to elementary and pre-school students along with other public presentations. There was a decline in the number of students attending presentations from the 24,000-student benchmark set for previous years. Schools not allowing outside presenters into the building and the virtual school setup provided obstacles that were sometimes impossible to overcome.

Due to loss of some additional OCPDI funding sources, staff and time allocations were reduced, particularly for outreach efforts.

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.

Data:
MCH staff has participated in 100% of OPSR board meetings and trainings.

Successes:
The Director of MCH participated in the OPSR board meetings representing OSDH. The Early Childhood Coordinator in the CAH Division of MCH attended all quarterly OPSR Board meetings virtually during this federal fiscal year. The Early Childhood Coordinator participated in the final meeting for the Family, Community, and Workforce Team virtually on March 31, 2021, and attended the OPSR Zoom meeting held to introduce the Oklahoma Clearinghouse on August 27, 2021. The Oklahoma Clearinghouse for Early Childhood Success (Clearinghouse) was built to contain a collection of research-based and practice-based resources for a broad range of audiences, including parents, relatives who care for children, early childhood teachers, and child care providers.

The Early Childhood Coordinator continued to serve on the Oklahoma Department of Human Services (DHS) Child Care Advisory Committee and attended quarterly meetings, promoting best practices in early childhood care. The Early Childhood Coordinator participated in the DHS Roundtable Review meetings to revise child care center requirements from January through May 2021 and the meetings for revising family child care requirements in June and July 2021. There were two follow-up Zoom meetings to review the final revisions in September 2021.

Additionally, the Early Childhood Coordinator served as a member of the Learn the Signs. Act Early. (LTSAE) Oklahoma Act Early COVID Response Team. The project partnered with the CDC's Learn the Signs. Act Early, to promote the four steps of Early Identification, and identify barriers and opportunities during COVID-19 through:

- Parent-engaged developmental monitoring;
- Developmental and autism screening; and
- Referral for early intervention services.

The Early Childhood Coordinator participated in the monthly Oklahoma Act Early Response Team virtual meetings from October 2020 through September 2021. The leaders of the Oklahoma LTSAE presented an overview during the OSDH Pediatric Review meeting with the county health department pediatric and family nurse practitioners on August 27, 2021. They explained the importance of developmental monitoring of young children and discussed the resources that the CDC Learn the Signs Act Early offers. They also shared the free Milestone Tracker App and answered questions.

The Oklahoma State Obesity Plan Stakeholders Group began state obesity prevention planning meetings in July 2021 and asked several staff from MCH to participate and serve on subcommittees. The Early Childhood Coordinator participated in the Early Childhood State Obesity Plan Subcommittee, which began working on measurable goals and Objectives to address the high prevalence of obesity among the Oklahoma population.

In the spring of 2021, the Early Childhood Coordinator, Title V Director and the Administrative Program Manager for Child and Adolescent Health assisted with the planning for a parent warmline and the accompanying media campaign. The Oklahoma Warmline (1-888-574-5437 with the tagline "because kids don't come with instructions") was an expansion of an existing warmline for child care providers. The expansion opened the warmline up to all parents and child care providers with children 0-13 years of age. Title V funds were utilized to partially fund the Behavioral Health Consultant hired in July 2021 to field those parent calls.

Challenges:

OPSR experienced many changes and challenges over the past year. The executive director of over ten years resigned in February 2021. There was an interim executive director serving from March 2021 through August 2021, and a new executive director was hired in September 2021. Staff turnover was also high during this time and the office moved to a new location. The work groups that the Early Childhood Coordinator served on stopped meeting, and OPSR seemed to change focus slightly. The COVID-19 pandemic conditions and stress may have contributed to some of the challenges.

With a high staff turnover and no in-person meetings, it was difficult for the Early Childhood Coordinator to provide support in implementing the strategic plan for creating an equitable and sustainable system for improving developmental and academic outcomes for young children.

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

Data:
It's All About Kids (THD) served 6,062 students across 35 schools in the Tulsa metro with 129 health education presentations and 290 other sessions during the 2020-2021 school year.

Health at School (OCCHD) served 104 students in the 2020-2021 school year; staff were only able to conduct 3 presentations and 2 interventions due to COVID-19 and staff reassignment.

Healthy Schools OK served 23,989 students in the 2020-2021 school year.

Successes:
Healthy Schools OK, It's All About Kids (THD), and Health at School (OCCHD) continued to provide services with alternative approaches to in-person lessons. Health at School (OCCHD) provided some health education across nine schools within the Oklahoma City Public School district and supported the community by responding to referrals from schools. It's All About Kids stayed active in the Tulsa metro with in-person and virtual programs. Social emotional learning (SEL) was part of the curriculum utilized as well as the Whole School, Child, Community (WSCC) model. In July 2021, Healthy Schools OK became part of the Bethany Children's Health Center. Bethany Children's Health Center remained a leader in the field of pediatric rehabilitation and 24-hour complex care. The hospital offered inpatient and outpatient services for children (ages 0-21) and remained the only inpatient pediatric rehabilitation facility in Oklahoma. Healthy Schools OK became part of their efforts to enhance community health, including ATV Ride Safe and Safe Kids Oklahoma.

Healthy Schools OK continued to support participating schools through the continuation of the COVID-19 pandemic. The annual Summer Health Institute was held in-person in July 2021 with social distancing restrictions and over 60 teachers from 53 elementary schools attended the 2-day event. Healthy Schools OK continued to provide in-person and virtual trainings to schools for various projects, including Tower Gardens and Action Based Learning (ABL) labs. The Tower Garden programs reached over 30 schools and fruit and vegetable tasting parties were held at participating schools.

Challenges:
The goal to serve at least 58,000 students was not met due to the rise in COVID-19 outbreaks. THD had to cancel several events and pivot to virtual or prerecorded videos. Some events were unable to be rescheduled like the Bully Busters assembly and Drugs and Your Heart assembly. OCCHD continued to reallocate staff to the COVID-19 outbreak, therefore many of the programs were canceled or postponed until spring. Healthy Schools OK were unable

to conduct fitness testing due to COVID-19 restrictions within schools. Virtual learning, along with school staff stress, caused disruptions in planned events forcing rescheduling for multiple lessons.

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

Data:
OSDE collected data during the 2019-2020 school year on health education classes provided in the state. They continued to have 543 independent school districts; of these, 331 (62.1%) had students enrolled in at least 1 of 5 health education subjects. Some districts provided an occasional health education class or curriculum that was not captured in these data. Oklahoma was one of the last states to mandate health education in school. During this FFY, there were no requirements for health education and enrollment was voluntary.

Among public school districts the five health education topics included:

- Health/Nutrition in 169 districts (31.2%) with students enrolled in 74 elementary schools (7.7%), 75 middle schools (30%), 13 junior high schools (22%) and 7 charter schools (10.9%);
- Health in 216 districts (39.9%), with 5 middle schools (2%), 6 junior high schools (10.2%), 195 high schools (43.2%), and 10 charter schools (15.6%);
- Comprehensive Health in 11 districts (2%) with 11 high schools (2.4%);
- Human Growth and Development in 129 districts (23.8%), 2 junior high schools (3.4%) and 127 high schools (28.2%);
- Lifetime Nutrition and Wellness in 114 districts (21.1%), 1 junior high school (1.7%) and 113 high schools (25.1%).

Successes:
During the 2021 Legislative Session, Senate Bill 89 passed and was signed into law in April 2021 by Governor Stitt, requiring schools to teach health education in multiple grades statewide beginning in the 2023-24 school year.

MCH staff participated in OSDE-led work groups to revise and update Health Education standards for Oklahoma public schools. Staff also participated in work groups to plan trainings for Oklahoma educators on skills-based health education.

Challenges:
New data were not collected during the 2020-21 school year due to COVID-19 decreasing the number of outside guests allowed in schools and the staff needed to finalize data. Without the state mandate to teach health education in the schools in place, many districts were not providing consistent health education or did not prioritize it as a needed curriculum.

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.

Data:
During the 2020-2021 school year, MCH continued to provide OSDE funding for the salaries of eleven school nurses in nine rural school districts throughout the state. During the FFY, 6,230 students were enrolled in these districts and had 6.5 absences per student, meeting the goal of less than 7.2 absences per student. The school nurses provided assessments and evaluated students' ability to safely return to class, be sent home for care or be examined by a medical provider. During the 2020-2021 school year, 6,482 nurse visits occurred resulting in 5,015 students returning

to the classroom for continued learning and,1,467 students sent home for care or medical examination. The number of students sent home increased by 415 compared to the previous year. COVID-19 played a part in the increase of students sent home during the 2020-2021 school year. The school nurses followed nursing judgment, CDC COVID-19 guidelines, COVID-19 testing guidance, and the guidance on safely reopening schools provided by the OSDH to help make those determinations.

Successes:
Despite the COVID-19 pandemic, absences remained below the goal of 7.2 per student. The percentage of students returned to class was higher due to the school nurse assessment prior to a decision for a student to return home. The School Health Coordinator provided technical assistance (TA) and training for the school nurses throughout the year. The partnership with the 11 nurses and the districts continued to strengthen with regular contact and distribution of resources. COVID-19 information was distributed to school nurses upon OSDH leadership and Acute Disease Service approval. This enabled the schools to follow the most current protocols and to make rapid decisions.

The School Health Coordinator worked with the COVID-19 Reopening Schools Team providing valuable resources for all districts. The mandated diabetes management training for school staff continued to be provided through virtual outlets, with the hands-on needle skills portion provided through school nurses around the state with guidance from the School Health Coordinator. An in-person Diabetes Management Training was held twice, as COVID numbers subsided. Vision screening training was adapted to a virtual format and provided to school nurses and other school staff responsible for those mandated screenings. The trainings received positive feedback related to the ease of attendance and being able to provide the mandated services in their districts.

A School Nurse Summit was held August 6, 2021 in a hybrid fashion. Attendees were given the option to attend either in-person or virtually. The Oklahoma Board of Nursing presented on issues that arise in a school regarding care and being a licensed nurse in the school. Additionally, a presentation on Trauma-Informed Care and the Impact of Adverse Childhood Experiences (ACEs) on Development was presented by the OSDH Child and Adolescent Health Consultant. COVID-19 reporting was demonstrated and presented during the Summit as well.

Monthly meetings for Oklahoma's Whole Child, Whole School, Whole Community (OKWSCC), were attended by the Child and Adolescent Health Consultant and the School Health Coordinator. Both also attended planning meetings for a summer OKWSCC conference held in June, 2021. Education and training on the CDC's WSCC model for implementation in Oklahoma schools was provided. Meetings started during July, 2021 for Obesity State Plan Stakeholders and were attended by the School Health Coordinator along with other OSDH staff. CAH staff also promoted to school partners the Adolescent Health Summit held on June 23 and 24, 2021, which, received rave reviews from attendees.

In May 2021 the School Health Coordinator (SHC) began working with a variety of professionals from around the state on health and physical education standards; the OSDE led the process. Partnerships were strengthened with other agencies and community partners, for the CAH team. The meetings attended during the grant period were either in-person or virtual, to strengthen the school health community.

Challenges:
Related to the COVID-19 mitigation strategies, there were times that schools or classes met virtually and not in-person. Virtual class days created issues with data collection and accuracy of absence numbers therefore the total absences and the average absence numbers may be somewhat skewed on virtual days. The number of COVID-19 cases increased the number of nurse visits, the number of students sent home for illness, and the number of absences. Being in contact with a positive case also increased the absentee rates and the number of students sent

home as the districts followed the CDC guidelines for contact investigation.

With school districts closed to outside volunteers or partners, interactions and learning that occurred with the students from valuable community partners decreased. The reduction of partners in the schools was also limited by virtual days. Providing training virtually takes planning and adaptation, and there were times that the pivot was not suited for the curriculum or materials.

Health Equity Objective 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.

Data: One hundred percent of the 11 contracted school nurses completed the required Trauma-Informed Care and the Impact of ACEs on Development training. THD, OCCHD, and Healthy Schools OK staff all participated in ACES training or provided documentation that they had received ACEs training.

Successes: The Child and Adolescent Health Consultant developed and presented Trauma-Informed Care and the Impact of Adverse Childhood Experiences (ACEs) on Development training at the School Nurse Summit in August 2021. Many of the nurses were familiar with ACEs from completing other trainings. All contractors with MCH participated in the training and documented that they were up to date with this requirement.

Challenges: The hybrid nature of the conference created some difficulty with technical issues for the Summit. Although recorded, the file was too large to easily send to those who missed the original presentation, an alternative training was suggested.

Health Equity Objective 2: Reinstate Child Health Clinics in pilot County Health Department Clinics for mobile and traditional settings by 2022.

Data:
As of September 30, 2021, four (out of ten) County Health Department Districts had reinstated Child Health Clinic in at least one of their counties, in either a brick and mortar traditional setting or with a mobile unit.

Successes:
CAH manuals and forms were updated for the reinstated Child Health Clinic pilot between December 2020 and February 2021. The pilot sites were selected based on community need and the training planned to onboard sites once COVID-19 subsided. A CAH Medical Director was contracted in March to assist with implementation and oversight.

A training was held on April 23, 2021 to provide an overview of the Bright Futures forms, manuals, basic structure and expectations for the clinics. The CAH Medical Director also provided an overview of pediatric primary care. CAH created an intra-agency TEAMS page for all staff participating in, supporting or supervising the Child Health clinic pilot. This resource became a place to ask questions, post training materials and videos, and share information across clinics and providers.

To assist staff with ongoing training needs and to provide a forum for peer learning and programmatic Q & A, CAH developed a training series dubbed “Pediatric Reviews”. Approximately, every other month various topics were presented via TEAMS for anyone affiliated with a pilot site. The first review centered on vision screening and was presented virtually in June 2021. It served as a refresher on state mandates and provided the information needed to successfully provide vision screenings during well child visits or school physicals. The second Pediatric Review was

held in August with the Oklahoma Learn the Signs, Act Early Campaign on the importance of developmental monitoring and screening during well child visits. Reviews were well attended and afforded county health department staff an opportunity to ask questions of the presenters, CAH program staff and/or the CAH Medical Director.

Promotional materials were created to assist counties with promoting their clinics, including modifiable flyers and advertisements on social and streaming media.

Challenges:
The pilot sites experienced delays beginning client care, due to rapid changes in the COVID-19 pandemic. Not long after many began seeing patients, the delta variant closed or limited clinic site availability as staff had to once again shift gears to assist with vaccines and testing.

Recruiting patients to county clinic sites was also a challenge, multiple discussions were held about where and how best to recruit clients during Pediatric Reviews and in other meetings. Ideas included talking to local school nurses and with area head starts to assist in well child checks and necessary physicals.

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 students across the state annually.

MCH will continue to fund the Oklahoma Center for Poison and Drug Information (OPDI) to allow them to provide services 365 days per year through the hotline. Continuation of support will also allow OPDI the opportunity to provide educational presentations and materials to 24,000 or more pre-school and elementary students throughout the state.

Objective 2: Provide staff support, expertise, and consultation by participating in and attending 80% of the meetings of the DHS Child Care Advisory Committee, the State Obesity Planning Group, Safe Kids Oklahoma, OPSR and the Oklahoma Tribal Child Care Association.

Objective 3. Complete the updates and revisions to the Good Health Handbook by 2023.

The Early Childhood Coordinator will work on developing a closer working relationship with the OPSR as they 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 participate on the Oklahoma State Obesity Plan Stakeholders Group, attending quarterly meetings and serving on the Early Childhood State Obesity Plan Subcommittee. The state obesity plan will include measurable goals and objectives that will address the high prevalence of obesity among the Oklahoma population over time.

In addition, the Early Childhood Coordinator will continue to participate as a member of the Department of Human Service's Child Care Advisory Committee and the Oklahoma Tribal Child Care Association, providing information and resources regarding health, safety and nutrition for children participating in child care programs, including the Good Health Handbook.

Objective 4. Serve at least 58,000 students statewide Healthy Schools OK, It's All About Kids (THD), and Health at School (OCCHD) by 2024.

MCH will continue to provide funding and contract monitoring for Healthy Schools OK, It's All About Kids (THD), and Health at School (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 5. Identify areas in need of evidence-based health education and develop one lesson for Health Educators in the state by 2023.

The Child and Adolescent Health Educator will continue to partner with OSDE, OK WSCC, and other community health education partners to assist in the development of technical assistance for school and community staff providing health education and develop at least one lesson for new health educators.

Objective 6. Reduce the number of absences during the school year from an average of 8.7 per student in 2018 to 7.1 per student in schools with an MCH-funded school nurse by 2024.

Objective 7. Provide at least 6 vision screening and 12 diabetes management trainings for school staff annually.

MCH will continue to fund eleven school nurses providing health education and services in rural school districts. The nurses will be encouraged to work with OSDE and OSDH to provide in-services on chronic illnesses and evidence-based health education, in an effort to reduce absenteeism due to illness.

Vision screening and diabetes management trainings will be scheduled and provided both in-person and virtually to assure those in need can access them.

Health Equity Objective 1. Require MCH contractors working in schools to have trauma-informed care and the impact of ACES/PACES on development training completed at minimum once every other year.

MCH staff will continue to provide ACES/PACES training for school nurses and contractors providing services in the schools. School nurses and contractors may provide proof of attending other approved ACES/PACES trainings, in lieu of the MCH training.

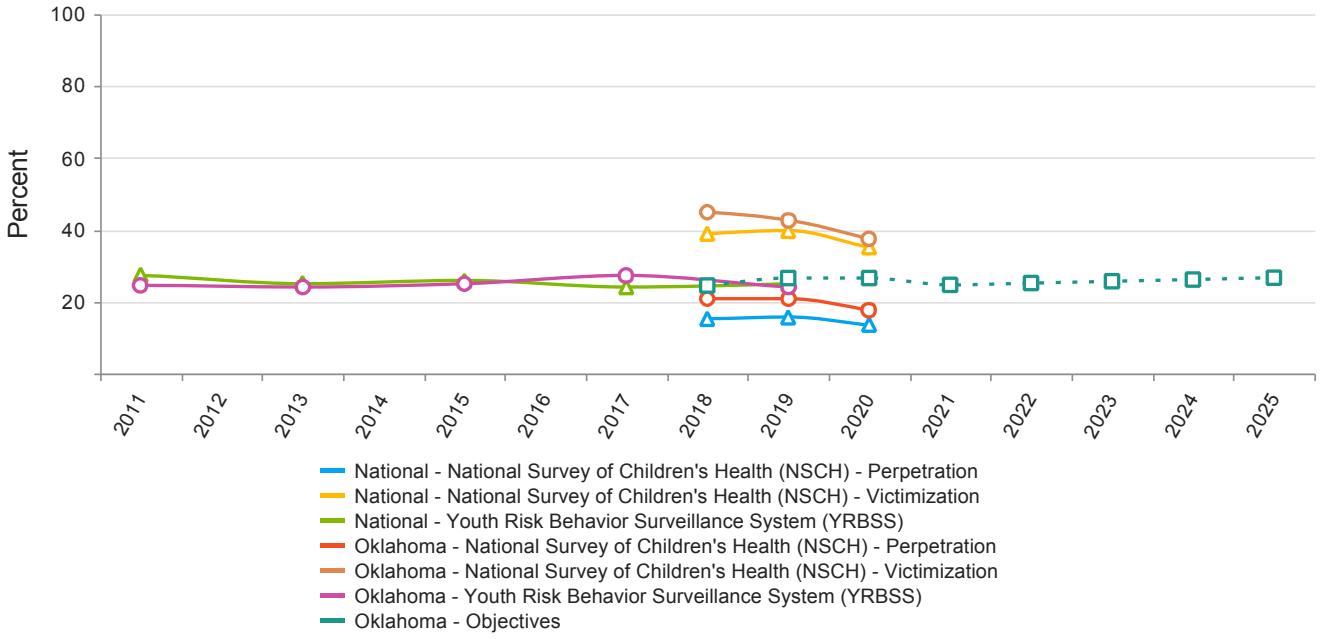
Health Equity Objective 2: Strengthen Child Health Clinics in pilot County Health Departments, in both mobile and traditional settings by 2023.

Trainings and funding will be provided to all ten districts in the state for Child Health Clinics. The new Child Health APRN Consultant in MCH will be tasked with assuring that all clinics are following Bright Futures Guidelines and using the forms appropriately by conducting site visits and chart audits. Pediatric Reviews will continue to be provided on a bi-monthly basis on requested topics. The CAH Medical Director will continue to provide consultation and technical assistance, as needed.

Adolescent Health

National Performance Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23.6	24.5	26.6	26.6	24.7
Annual Indicator	25.0	27.2	27.2	24.2	24.2
Numerator	44,898	49,239	49,239	43,594	43,594
Denominator	179,440	180,854	180,854	180,410	180,410
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2017	2017	2019	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			26.6	26.6	24.7
Annual Indicator			20.9	20.9	17.8
Numerator			71,345	68,450	55,986
Denominator			341,223	328,275	315,365
Data Source			NSCHP	NSCHP	NSCHP
Data Source Year			2018	2018_2019	2019_2020

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**	**2021**
Annual Objective			26.6	26.6	24.7
Annual Indicator			45.0	42.7	37.4
Numerator			153,408	140,343	118,300
Denominator			341,223	328,882	315,972
Data Source			NSCHV	NSCHV	NSCHV
Data Source Year			2018	2018_2019	2019_2020

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				
2022	**2023**	**2024**	**2025**	
Annual Objective	25.2	25.7	26.2	26.7

Evidence-Based or –Informed Strategy Measures

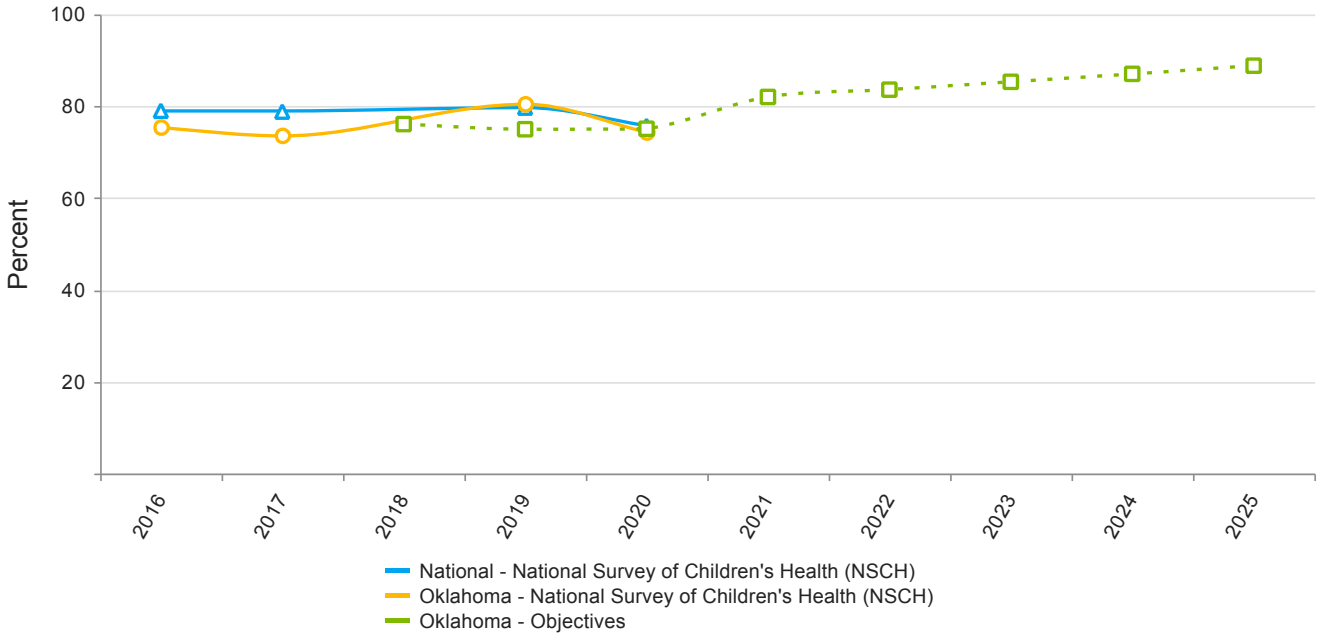
ESM 9.1 - The number of trainings provided to school and community staff on bullying prevention

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	4	5	6	7	5
Annual Indicator	3	1	2	1	1
Numerator					
Denominator					
Data Source	MCH Training Log	MCH Training Log	MCH Training Log	MCH Training Log	MCH Training Log
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	5.0	7.0	9.0	11.0

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		76	74.9	75	81.9
Annual Indicator	75.2	73.5	73.5	80.3	74.3
Numerator	229,371	225,282	225,282	252,941	236,394
Denominator	304,952	306,365	306,365	314,972	318,014
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	83.5	85.2	86.9	88.7

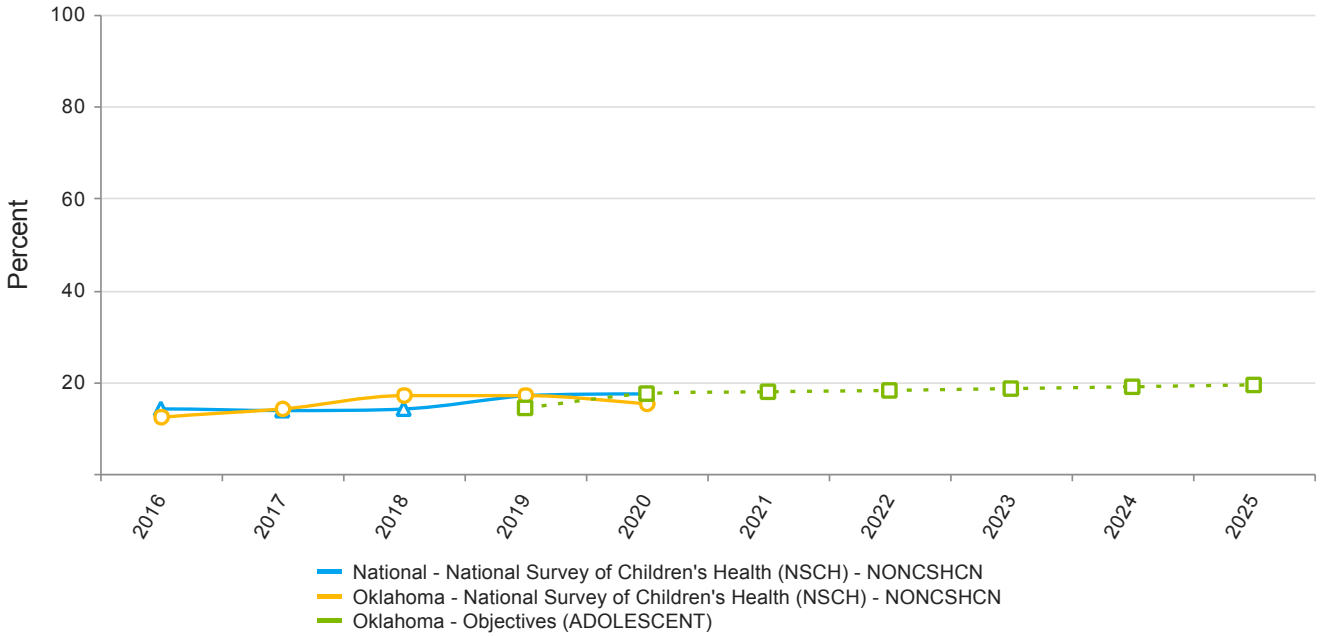
Evidence-Based or –Informed Strategy Measures

ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	4,300	4,500	4,400	4,900	4,400
Annual Indicator	4,389	4,204	4,651	4,092	459
Numerator					
Denominator					
Data Source	MCH PREP Program	MCH PREP Program	MCH PREP Program	MCH PREP Program	MCH PREP Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	4,700.0	5,000.0	5,300.0	5,600.0

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**	**2021**
Annual Objective			14.4	17.5	17.9
Annual Indicator	12.5	14.2	17.2	17.2	15.2
Numerator	26,234	31,388	41,549	40,910	35,470
Denominator	210,453	220,834	241,098	237,455	233,632
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	18.2	18.6	19.0	19.4

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		170	170	175	80
Annual Indicator	164	164	164	77	31
Numerator					
Denominator					
Data Source	Sooner Success	Sooner Success	Sooner Success	Sooner Success	Sooner Success
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	85.0	90.0	95.0	100.0

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-funded staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with or care for adolescents from 1 in 2020 to 10 by 2025.
2. Conduct youth-informed public health activities with youth across the state regarding adolescent health issues, including teen pregnancy prevention, suicide prevention and bullying by 2024. [New]
3. Work with county health departments, Oklahoma State Department of Education, and local school districts to provide Olweus training and technical assistance with at least two school districts by December 2024.
Strategies
1a. Provide training and TA to county health departments and other youth-serving organizations in evidence-based methods following appropriate best practices.
1b. Refer MCH-funded staff to suicide prevention and positive youth development trainings, as appropriate, annually. [New]
2a. Identify and work with existing youth groups in the Oklahoma Healthy YOUth coverage areas on adolescent health activities to build a Public Health Youth Council infrastructure. [New]
2b. Strengthen the MCH Youth Consultant project in partnership with the Oklahoma Family Network, and recruit at least two youth annually to provide input regarding adolescent health issues to MCH, CSHCN, and other programs within and outside of OSDH. [New]
2c. Provide TA and materials to Adolescent Health Specialists (AHS) on suicide prevention, bullying, positive youth development, and other adolescent health topics.
2d. In partnership with youth, design a toolkit for 2023 National Adolescent Health Month. [New]
3a. Strengthen partnerships and work with the Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma State Department of Education to provide training to parents and community members to understand the pervasiveness and the damaging effects of bullying, learn the signs of bullying and how to help schools and communities implement effective strategies to prevent the continuation of bullying in the community.
3b. Develop a manual and train county health department health educators in social emotional learning to assist in training school staff and communities on this issue.
3c. Recruit the two school districts for the Olweus bullying prevention program and begin implementation.

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. Work with local agencies and healthcare professionals to deliver training on how to provide youth-friendly, high-quality services to expectant and parenting teens by 2024. [New]

3. Consent education will be provided at least once to all participants in the evidence-based teen pregnancy prevention curricula classes, and to at least 14 schools as a stand-alone presentation by December 2023.

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 56 by 2023.

5. Develop and host the 2nd bi-annual Adolescent Health Summit to provide education and resources for professionals working with youth by 2023.

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.
1d. Coordinate and/or provide training on evidence-based curricula for new PREP and state-funded teen pregnancy prevention staff and interested partners annually or as needed. [New]
2. Work with local healthcare providers and agencies to review and adapt (as needed) the Expectant and Parenting Teens training developed by the Mississippi State Health Department and Teen Health Mississippi. [New]
3a. Collaborate with state and community partners on teen pregnancy prevention and sexual violence prevention activities. [New]
3b. Monitor fidelity logs for documentation of consent education provided before, during, or after implementation of evidence-based teen pregnancy prevention curricula, as required by law. [New]
4a. Identify areas of highest need based on most current data available.
4b. Partner with county health department regional directors in the areas of highest need to begin targeted prevention efforts.
4c. Establish partnerships with tribal organizations and collaborate on professional development activities and service provision to adolescents in their jurisdictions.
5a. Convene a workgroup to assist in planning and implementation of the 2023 Summit. [New]
5b. Develop and/or adapt existing planning tools and materials for the Summit.
5c. After the Summit, evaluate the planning and implementation process based on participant and planning group feedback. [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 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 2023.

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 2024.

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. Establish a relationship with OCHA to provide relevant transition information for provider newsletter, social media pages, and create meaningful transition training for providers.

2a. Work on partnership 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 health equity, trauma-informed practices, and inclusivity trainings provided by MCH-funded staff from 1 in 2021 to 3 by 2023.

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 trainings to MCH staff, contractors, and project staff working with youth via PREP/TPP semi-annual meetings, MCH general staff meetings, and/or Title X meetings.

Provide trauma-informed ACES and PACES training for school nurses and staff.

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 1 in 2020 to 8 by 2025.

Data:
The suicide death rate among youth 15-19 years old had essentially no increase over the last 30 years going from 14.8 deaths per 100,000 youth 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%)

Successes:
MCH successfully held the division's first Adolescent Health Summit, a two-day virtual event for interdisciplinary youth-serving professionals across the state of Oklahoma in June 2021. The objectives of the Summit aligned with Title V priorities and incorporated results from a school climate survey administered by the Oklahoma State Department of Health (OSDH) Injury Prevention Service (IPS). The Summit had ten presenters, four of which addressed youth mental health, suicide prevention, bullying prevention, and positive youth development (PYD). For more information regarding the Adolescent Health Summit, see NPM 10, Objective 5.

In addition to the Adolescent Health Summit, MCH staff participated in professional development opportunities such as webinars, trainings, and conferences. Staff attended the following conferences and webinars: Missouri Suicide Prevention Conference; *Thwarting Suicide: Advanced Trauma-Informed Strategies*; *Addressing Suicide in Schools: Covid-19 Update*; and, *Youth-Adult Partnership: Strategies for Presenting Together*.

In December 2020, MCH staff conducted a virtual presentation for MCH and Title X staff working in county health departments regarding counseling adolescent clients on how to resist sexual coercion.

Child and Adolescent Health (CAH) staff continued to highlight adolescent health topics on the MCH Facebook page. Staff created content and/or used existing content created by other entities for mental health, suicide prevention, bullying prevention, teen dating violence, child-adult communication, nutrition, physical activity, and STI prevention. The majority of the content aligned with Teen Dating Violence Awareness Month in February, International Adolescent Health Week in March, STI Prevention Month in April and Suicide Prevention Awareness Month in September.

MCH funded eight Adolescent Health Specialists (AHS) for the state-level teen pregnancy prevention project, Oklahoma Healthy YOUth (OHY), in the following counties: Blaine, Ottawa, Jackson, Seminole, Muskogee, Carter, and Pittsburg. The AHS for Jackson County was a re-hire, who served in the position during the previous year and returned to the project in May 2021. Vacancies for Blaine and Muskogee were filled in June and July 2021. 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. New AHS were required to complete an online self-paced training for PYD. See Objective 2 for more detailed information.

The sexual health community of practice (CoP) meetings for program staff and community partners continued from October 2020 – July 2021. Initially, the meetings were monthly as schools were closed or virtual only, and then moved to quarterly at the start of 2021 due to dwindling participation as schools re-opened to external partners. The CAH Healthy Youth Consultant created a newsletter for the CoP as an additional method for communicating with partners and sharing resources and information. After July 2021, the CoP meetings were discontinued due to low participation, and the newsletters were distributed in place of the meetings. Four newsletters were distributed to CoP members between April and September 2021.

MCH staff continued partnership with the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and the OSDH IPS by participating on coalitions and committees. The CAH Adolescent Health Coordinator served on the Oklahoma Suicide Prevention Coalition and attended the coalition meetings regularly, which were conducted virtually by ODMHSAS. MCH staff regularly attended the Oklahoma Prevention Leadership Committee (OPLC) quarterly meetings, facilitated virtually by the OSDH IPS, and participated in bi-weekly subcommittee meetings. The CAH HYC continued to serve on the Advisory Board for OPLC.

Challenges:
The COVID-19 pandemic had a steady impact on programming and training for staff. All meetings and trainings were conducted virtually, including the Adolescent Health Summit. Materials typically used for in-person trainings had to be adapted for virtual use. Many MCH and County Health Department (CHD) staff continued their re-assignment to COVID-19 response activities.

Objective 2: Increase the number of local Public Health Youth Councils across the state from 3 in 2015 to 7 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.

Data:
Due to AHS turnover and COVID-19, there were no active Public Health Youth Councils (PHYCs) during this timeframe.

Successes:
The OHY AHS participated in suicide prevention activities in their respective districts, as well as attended trainings/webinars for professional development. The AHS attended *Talk Saves Lives*, a suicide prevention and referral training in June 2021, and the Missouri Suicide Prevention Conference in July 2021.

The Jackson County AHS attended community health fairs and provided education and resources regarding tobacco and vaping use prevention/cessation, suicide prevention and mental health, teen driving safety, teen pregnancy prevention, and STIs. Additionally, the same AHS partnered with a local public career and technology center and provided a series of presentations over tobacco use prevention/cessation, sexual consent, and healthy relationships. As a result of this partnership, one of the students shadowed the AHS to learn about different careers in public health.

The Blaine County AHS created a presentation for Let's Talk Month, for use in October with parents/caregivers of adolescents.

The CAH HYC continued to provide the OHY AHS with information and resources for PYD, which included a required self-paced PYD 101 training for all new AHS. Additionally, existing PHYC materials were being adapted for virtual

use as schools re-opened with restrictions for external visitors.

Challenges:
The OHY project was still in the process of rebuilding after the 2018 Reduction in Force (RIF) and subsequent turnover among the AHS. Four AHS resigned during the timeframe of this report. The Pittsburg County AHS transitioned into a new role at their CHD and the Latimer County AHS absorbed additional clinic duties that made them unavailable to participate in adolescent health activities in July 2021. In September 2021, the Muskogee County AHS resigned due to personal reasons, and the Ottawa County AHS transitioned into a Health Educator (HE) role for their district.

Prior to the resignations, four of the eight AHS on staff for the OHY project were still new and had not yet been able to build relationships with their communities before COVID-19 interrupted programming. When schools re-opened for the 2020-2021 academic year, they were either using hybrid-learning models or held in-person learning with restrictions for non-school employees due to COVID-19. AHS continued to be re-assigned to the COVID-19 pandemic response and assisted their districts with COVID-19 testing, case management, and other activities.

Objective 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.

Data:
Consent education was provided as a stand-alone presentation to one school during the timeframe of this report.

Successes:
The Jackson County AHS partnered with a local public career and technology center and provided a series of presentations, which included education on sexual consent. The same AHS also scheduled consent presentations with schools that received evidence-based programs (EBPs); however, those presentations took place after the timeframe of this report.

The Ottawa County AHS virtually attended the 2020 Healthy Teen Network conference in November, held over the course of three days. The conference's theme was centered around adolescent sexuality and technology, and provided knowledge and resources for promoting healthy digital relationships.

OHY and the PREP grant educators participated in professional development activities related to sexual health, human sexuality, relationships, and consent. Staff attended the following trainings and/or events: The MCH Adolescent Health Summit; *Spotlight on Domestic Violence*; *Positive Conversations with Young People about Sexual Decisions*; *Understanding and Addressing Digital Dating Abuse*; and, *Why Teens Hook Up: Relationship Skills in Today's Teens*.

Additionally, AHS and the CAH HYC attended a virtual training series hosted by the OSDH IPS in July 2021 that addressed intersectional health, sexual decision-making, the connection between gender roles and rape culture, and sexual consent.

Challenges:
See Objective 2, above.

Objective 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.

Data: In August 2021, the Child and Adolescent Health Consultant, in conjunction with the Bullying Prevention Specialist at Oklahoma State Department of Education (OSDE), provided OLWEUS training to Coyle Public Schools in Coyle, OK. Thirty-five staff members attended the training, to the benefit of the 310 students enrolled Pre-Kindergarten through 12th grade in the district.

Successes:
The Child and Adolescent Health Consultant attended monthly meetings focused on school health such as the Anti-Bullying Coalition in Tulsa, Oklahoma; OKPTA Cultivate (a group focused on multiple child health issues including bullying prevention); Oklahoma Whole School, Child, Community (OKWSCC) Coalition; and, the 1801 Evaluation Services work group.

The Child and Adolescent Health Consultant continued training in the research-based OLWEUS Bullying Prevention Program (OBPP) and assisted in the planning and administration of the YRBS. Contributions to the agency's website and social media page were made, including information on school health, bullying prevention and COVID-19 in schools. Partnerships were strengthened with the OSDE, as well as the Oklahoma City County Health Department (OCCHD), Tulsa Health Department (THD), Healthy Schools of Oklahoma and other community agencies. The Child and Adolescent Health Consultant developed and provided training on Adverse Childhood Experiences (ACEs) at the School Nurse Summit in August 2021.

CAH staff met with the Centers for Disease Control and Prevention (CDC) 1801 Grant administrators virtually at least one time per month and with OSDE staff as needed. 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) continued to supervise 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. Technical assistance consisted of the development of policies, procedures, district required training, and resources using the Whole School, Whole Community, Whole Child (WSCC) framework.

MCH continued to fund eleven school nurses in nine districts around the state who facilitated 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 trainings to the students in these districts. They used various methods of evidence-based materials and presentations. Many of the districts continued to partner 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. The COVID-19 pandemic caused in-person work to decrease because students were out of school or participating via remote learning. Some completed presentations via a virtual platform or recorded videos during the 2020-2021 school year. Additionally, the SHC and school nurses around the state continued to work on the safe return to school policies and procedures as the pandemic changed throughout the school year.

OCCHD planned to provide health education in nine schools within the Oklahoma City Public Schools (OKCPS) via their Health at School (HAS) Program. The programs were designed to follow the WSCC model and place children in the center as the focus. The programs planned for implementation in elementary schools included social emotional

learning (SEL). However, during the continuous COVID-19 pandemic, all HAS staff were reassigned to assist with vaccination Points of Dispensing (PODs) and contact tracing, all while reviewing programmatic activities and trainings in school health components. HAS prepared interventions, materials, and staff wellness challenges for teachers, completed training in School Health Index and Total Wellness, and fine-tuned work plans for the 2021-2022 school year. The HAS Social Services team began receiving referrals and working cases in fall 2021. The social services team received 42 referrals from all 9 schools in the program and completed 25 pathways serving 50 individuals. These services included food assistance, insurance navigation, clothing assistance, SNAP assistance, tax, and utility assistance. HAS Health Promotion Specialists began implementation of a holiday weight maintenance challenge with staff in partner schools. There were 14 participants in the weight loss challenge.

THD's It's All About Kids (IAK) school health program served 6,062 students during the 2020-2021 school year. IAK provided health education in 35 schools within 7 Tulsa area school districts throughout the school year. Social emotional learning was part of the curriculum presented, and the WSCC model remained the primary focus with hope to gain more school partners next year. IAK staff provided a variety of health education programs: Bullying Prevention, Class Cohesion, Conflict Resolution, Fitness in the Classroom, Human Growth and Development, Handwashing, Hygiene, Mindfulness, Responsible Decision Making, Stress Management, Teambuilding in PE, Tobacco Prevention, and Vaping Prevention. Virtual Nutrition in the Classroom included topics of Food Groups, Food Labels, Little Bite Nutrition Breaks, and MyPlate. Staff members continued to provide virtual lessons for all topics. Employee wellness continued and 14 schools participated in IAK School Health Readiness Assessment. The participants had various challenges through an app called MoveSpring, an easy-to-use step and activity challenge platform. During the school year, there were 10 challenges available and 445 participants overall. All IAK activities were impacted by the COVID-19 outbreak and the variety of learning options offered in schools across the Tulsa metro. Social Media communication increased with 218 Facebook posts, 57 Instagram posts, 74 Twitter tweets and 7 YouTube video postings for a total of 356 posts as well as, maintenance on the IAK website that received 6,652 page views.

Challenges:
The COVID-19 pandemic changed the way programs were presented for staff and students. Programs continued to stay innovative and videos were used when in-person events switched to virtual. Because there were many in-person cancellations and pivots to virtual events, OCCHD continued to reallocate their entire School Health team to COVID-19 work which included answering phone calls, testing, contact tracing and assistance with vaccination PODs. The OCCHD HAS team received permission to work in schools again starting in October 2021.

Due to the COVID-19 pandemic and various disruptions in the school schedules across the Tulsa metro area, there were limited activities during the 2020-2021 fiscal year. Family engagement and community involvement activities were severely impacted.

As a result of the COVID-19 pandemic, both OKPTA and Collaborative for Oklahoma in Resilience Education (CORE) discontinued meetings.

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: 4,856 adolescents for the 2019-2020 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 ages 15-19, was 27.4 and significantly higher than the national average of 16.7. Older teens in Oklahoma, ages 18-19 had the highest birth rate at 52.1, followed by teens ages 15-17 at 11.0. Compared to other states in the nation, including the District of Columbia, Oklahoma had the 4th highest teen birth rate for teens ages 15-19; the 4th highest teen birth rate for teens ages 18-19; and the 4th highest teen birth rate for teens ages 15-17. 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 were improving.

A total of 863 students participated in teen pregnancy prevention (TPP) curricula in the Oklahoma City and Tulsa metropolitan statistical areas (MSAs) through PREP during the timeframe of this report. In the same period, 186 students participated in TPP curricula in the rural counties through the OHY project. More information about the OHY activities can be found in Objective 4.

The Oklahoma Pregnancy Assistance Fund (PAF) program served 3,864 PAF participants and their families over the two-year grant period before funding ended in March 2021.

Successes:
MCH staff and internal OSDH partners worked to develop a report on adolescent sexual health, which was published in June 2021. The report addressed adolescent sexual behavior, teen birth rates, STIs, health care coverage and services, strategies and activities, and recommendations, Oklahoma Adolescent Sexual Health Report 2021.pdf.

MCH continued the administration and monitoring of the PREP grant from the Administration of Children, Youth, and Families and Family and Youth Services Bureau (FYSB). The federal funds supported the implementation of TPP projects through contractual agreements with the OCCHD and the THD. Target populations remained youth 11-19 years of age in the middle, high, and alternative schools in the Oklahoma City and Tulsa MSAs. PREP projects continued to use evidence-based curriculum from the Health and Human Services (HHS) approved list.

THD PREP obtained a Memorandum of Understanding (MOU) with Tulsa Public Schools (TPS) through the Amplify Youth Health Collective, the lead agency in the county's collaboration, which instructed all EBPs to be delivered virtually because the school district could no longer create and/or enforce mask mandates. THD PREP delivered Positive Prevention PLUS High School (P3) virtually to 4 high schools during the timeframe of this report, reaching 769 participants. OCCHD PREP delivered Making Proud Choices (MPC) in-person to one school during the timeframe of this report, reaching 94 participants. The MCH Adolescent Health Coordinator conducted observations as required.

THD PREP staff monitored their Facebook page and posted content related to sexual and reproductive health, and highlighted national health observances such as Mental Health and Suicide Prevention and Awareness months. Additionally, information about Safe Place and Crisis Text Line for youth was posted regularly. PREP staff also utilized their website to provide adolescents, caregivers, and schools with medically accurate and age-appropriate sexual health information.

OCCHD and THD PREP staff continued partnership with their county's respective sexual health and/or health education collaboration, Thrive and Amplify, and attended meetings regularly. In collaboration with Thrive and the Oklahoma City metro library system, OCCHD PREP staff created a sexual health presentation for teens and delivered it virtually via Zoom.

PREP staff attended the sexual health CoP meetings facilitated virtually by MCH staff when they were able; additionally, MCH and PREP staff attended regular PREP technical assistance (TA) meetings.

MCH completed the administration and monitoring of PAF, which was 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 MSAs, as well as adolescents involved with the Oklahoma Office of Juvenile Affairs (OJA) correctional system. MCH received a No Cost Extension (NCE) for OJA and OCCHD to complete their PAF programs, which were impacted by COVID-19. Prior to the NCE ending in March 2021, OCCHD provided Love Notes virtually to PAF participants at a local university, and OJA completed the Nurturing Parents (Teen Edition) curriculum with expectant and parenting youth. After funding for the PAF grant ended, OJA decided to continue to provide case management and parenting education using Nurturing Parents via a similar program due to its success with their families. Access to the child-friendly family visiting spaces was also planned post-COVID.

MCH staff coordinated a semi-annual meeting for PREP and OHY staff in January 2021, and the Adolescent Health Summit in June 2021 took the place of the summer semi-annual meeting. See Objective 5 for more information about the Adolescent Health Summit. For the January meeting, THD PREP staff conducted a presentation over their experiences implementing curriculum the previous fall, detailing their school strategies, online data collection and management, fidelity monitoring, and challenges and successes. THD PREP staff also conducted a virtual demonstration of some of the P3 curriculum activities. MCH staff facilitated a fidelity and protocol training for PREP and OHY staff in July 2021.

MCH, PREP, and OHY staff participated in numerous professional development opportunities related to sexual health, sexuality, relationships, trauma-informed care, and other adolescent health topics. Additionally, staff participated in EBP training for Making a Difference! (MAD), MPC, and P3; THD PREP staff served as trainers.

Oklahoma passed a bill that mandated health education in public schools in July 2021, to begin in the 2023-2024 school year. MCH and THD PREP staff participated on the OSDE's revision committee for existing health education standards. Staff attended regular Zoom meetings to aid in the revision process.

Challenges:
Due to COVID-19, reach was significantly impacted, as schools were restricting outside visitors for an extended period during the 2020-2021 academic year. Attendance of students for the OCCHD PREP programming was an ongoing challenge due to the quarantine protocols set by Oklahoma City Public Schools. For the THD PREP virtual programming, TPS did not require program participants to attend live Zoom sessions, which created challenges for accurately tracking attendance and completing fidelity logs. Additionally, participants experienced multiple factors related to virtual learning that affected attendance.

Many schools served by PREP and the OHY project prioritized core studies to compensate for the impacts of COVID-19, which significantly reduced TPP programming. Partnership with the schools returned to some level of normalcy at the start of the 2021-2022 academic year, however many of the OCCHD, THD, and OHY staff were re-assigned to COVID-19 response activities that held priority over implementation.

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, 2020 and September 30, 2021, 6,601 clients ages 15-19 were seen in family planning clinics in rural county health departments and the two city-county health departments. This was an increase of 1% from the previous FFY, likely due to increased clinic availability during the second half of 2021. Of those clients, 14.5% chose a LARC

method, exceeding the target of 10.2%.

Successes:
County health departments and contract facilities continued to provide family planning clinical services to adolescents when staff were not otherwise detailed for COVID-19 response. These services included a comprehensive physical examination, preventive education on HIV and STI 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: Provide training for evidence-based teen pregnancy prevention curricula to project staff yearly or on an as-needed basis.

Data:
Three AHS with the OHY project were certified to facilitate the approved EBPs in June and July 2021. All other AHS with OHY and PREP were previously certified in all EBPs and did not require training.

Successes:
Through an MOU with a community partner, Amplify, the OHY AHS were able to attend EBP trainings hosted by Amplify at no cost. The Jackson County and Blaine County AHS received training for P3 High School and Middle School. The Ottawa County AHS received training for MAD and MPC.

The CAH HYC continued to provide TA and support to the AHS regarding curricula.

MCH purchased additional curricula sets for MAD and MPC, which came with subscriptions for virtual training that could be attended more frequently.

Challenges:
The Muskogee AHS was hired after the summer EBP trainings occurred in June and July 2021, and there were no additional trainings planned in the near future. The EBP trainings were held virtually via Zoom, which limited interaction and engagement for the AHS as some of them experienced issues with technology and/or did not have all of the necessary equipment such as a microphone or webcam.

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 12 in 2019 to 30 by 2025.

Data:
According to the Center for Health Statistics, the top 5 counties in Oklahoma with the highest teen birth rates were Hughes (61.7), Adair (58.4), Atoka (56.2), Okfuskee (51.9), and Harmon (51.0).

There were eight AHS on staff for the OHY project during the timeframe of this report, four of which resigned between July 2021 and September 2021. Turnover had an impact on active projects within the aforementioned counties with high teen birth rates.

There was a 72.7% increase in the number of active project areas since the previous report; 5 AHS were active in 19 rural counties in Oklahoma. Two AHS implemented EBPs in their respective coverage area; one school received Love Notes, one school received MAD, one school received P3 High School, and one school received P3 Middle School. A total of 186 students participated in TPP curriculum. The CAH HYC conducted one observation at each implementation site.

Successes:
OHY hired three AHS between May 2021 and July 2021. Two of the newly hired AHS received certification for P3, and a long-standing AHS received certification for MAD and MPC. New staff also received training on the OHY reporting documents and tools. The CAH HYC continued to provide guidance, oversight, and TA to the OHY project.

OHY project staff engaged in numerous professional development activities (webinars, trainings, self-paced modules, and conferences) related to adolescent sexual health, relationships, and mental health throughout the period of this report.

AHS developed and/or maintained partnerships with local schools, colleges, coalitions, community organizations, and HEs in their counties to ensure TPP, PYD, suicide prevention, and other adolescent health issues were priorities in their areas. AHS delivered HIV and STI presentations to middle and high schools in their counties to help schools fulfill the HIV/AIDS Prevention Education state mandate. Additionally, presentations were provided on sexual consent, healthy relationships, puberty, and tobacco and vaping prevention/cessation. A total of 24 sites received stand-alone presentations on the aforementioned adolescent health topics: 2 higher-education institutions, 13 high schools, 8 middle schools, and 1 youth-serving community agency.

MCH contracted with Cox Media to create materials for National Teen Pregnancy Prevention Month in May 2021; 4 graphics and a 30-second video were created, and staff collaborated to ensure that the materials were inclusive. Additionally, the Blaine County AHS created and posted content on Facebook for Sexual Health Awareness Month in September.

Challenges:
Oklahoma did not have a mandate for comprehensive sexual education, which continued to be a barrier for project implementation as the EBPs used by the OHY project remained optional for schools. See NPM 9, Objective 2 for additional challenges.

Objective 5: Develop and host an annual Adolescent Health Summit to provide education and resources for professionals working with youth by 2022.

Data:
MCH successfully held the division's first Adolescent Health Summit for youth-serving professionals in Oklahoma in June 2021. A total of 229 people registered for the Summit, the majority of which represented 60 cities and 43 (out of 77) counties across the state of Oklahoma. Six of the registrants were from outside Oklahoma, from Maryland, Colorado, Pennsylvania, Washington DC, Oregon, and one international attendee in Nigeria. Of the 229 registrants, 192 attended the Summit via the live stream.

Successes:
MCH facilitated regular planning committee meetings via Zoom leading up to the Summit, which was comprised of internal and community partners, family members and students. The planning committee was divided into three subcommittees led by OSDH staff: presenters, marketing and logistics, and the youth panel. The presenter

subcommittee was responsible for the coordination of presenters; members selected and confirmed presenters, handled correspondence with presenters, collected biographies and photos, reviewed presentations, and drafted the Summit agenda. The marketing and logistics committee was responsible for marketing the event; members created a Save the Date and worked with the OSDH Communications team to create graphics and a landing page on the MCH website. Marketing for the Summit was done via social media, distribution lists, and the MCH website. The youth panel subcommittee was led by staff from the OSDH IPS and was comprised of youth leaders who were members in various youth leadership groups. The youth panel provided input throughout the planning process, developed and administered electronic surveys to adolescents and adults to learn more about perceptions around sexual health, dating violence, and mental health; as well as barriers youth face concerning those topics, what youth need, and how adults can support youth. The data from these surveys were used to guide the youth panel's presentation for the Summit and their call-to-action video.

MCH received TA from MCHB to collaborate with an external TA team for the Summit as it was the first virtual statewide conference MCH had ever attempted. The TA team created planning tools (email templates, scripts, FAQ docs, timeline, run of show, etc.), as well as created the registration form and tracked registrants, developed the Summit booklet, held rehearsals with presenters, coordinated Zoom links for the Summit sessions, and sent all correspondence to the registered participants. Additionally, the TA team created a Google Drive to house all of the materials for the registered participants to access during the Summit. MCH staff in charge of the Summit had regular meetings with the TA team via Zoom.

The Summit was held virtually on Zoom on June 23rd and June 24th, and occurred in the afternoon for 4 hours each day. A total of 229 people registered for the Summit, majority of which represented 60 cities and 43 counties across the state of Oklahoma. Six of the registrants represented Maryland, Colorado, Pennsylvania, Washington DC, Oregon, and Nigeria. Registrants represented a variety of roles: project coordinators, social workers, nurses, health educators, AHS, program managers, consultants, epidemiologists, advocates, directors, counselors, teachers, child welfare specialists, case managers, parents and students. Of the 229 registrants, a total of 192 people attended the Summit live. As an incentive to attend the Summit, registered attendees were able to receive continuing education units (CEUs) for CHES and Social Work (SW). All attendees received a certificate of attendance.

There were nine individual presenters and a panel of seven high-school and college-age youth that presented at the Summit. MCH had paid contracts with four of the presenters, two of which were national and/or international presenters and served as the keynote and plenary speakers. The topic areas for the Summit were bullying prevention, healthy relationships, LGBTQ+ inclusivity, youth engagement, sexual health, and mental health. These topics were identified using data from a school climate survey developed by the OSDH IPS and administered to public high school students in Oklahoma by OSDE.

Several MCH staff and internal OSDH partners (IPS and AHS) served on the planning committee, as well as community and federal partners who also provided services at no cost. These partners included: Amplify Youth Health Collective, Association of Maternal and Child Health Program (AMCHP), CHDs, Empowered Voices, MCHB, the MCH section of the Oklahoma Public Health Association (OPHA), Northeastern State University, OCCHD, ODMHSAS, Oklahoma Family Network (OFN), OSDE, Operation Aware of Oklahoma Inc., Teen emPower Inc., THD, University of Central Oklahoma, University of Oklahoma, Variety Care, Youth Advisory Subcommittee of OPLC, Youth Advising Youth, and the YWCA.

MCH staff had a debriefing meeting at the conclusion of the Summit to reflect on the planning and implementation process and reviewed the planning tools created by the TA team, for use at future events.

Challenges:

Many of the planning committee members were splitting their time between other responsibilities and projects, therefore there was a drop in regular attendance at meetings as the process continued.

The Summit had to be held virtually due to COVID-19, which limited interaction. There were also logistical limitations on Zoom; the main room served as the room for the keynote, youth panel, and plenary sessions and breakout rooms were used for the remaining sessions that attendees could choose from. If a session was being held in a breakout room, that room could not form an additional breakout for group work. Additionally, the Summit was held in the afternoon and ended at the end of the workday; as 5pm approached, some attendees left before the session ended.

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.

Objective 1: Collaborate with the Oklahoma Health Care Authority to provide transition information and at least one training to their provider network by 2022.

Objective 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.

Data:
There were no trainings or guides developed during this timeframe.

Successes:
MCH staff held regular meetings with a contact at the Oklahoma Health Care Authority (OHCA) to work towards strengthening partnership and developing transition materials for providers.

Challenges:
OHCA experienced major organizational changes that took priority over the transition project. After the changes, MCH lost its project contact and the project was placed on hold with both OHCA and Sooner SUCCESS.

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Health Equity Objective 1: 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.

Data:
Three unique presentations were provided by MCH staff or contractors on the issue of ACEs or inclusivity in 2021.

Successes:
The Child and Adolescent Health Consultant developed and provided training on trauma-informed care and ACEs for contractors that work with youth in schools as stated in the Child Health Objective 1. Most in attendance were familiar with ACEs and had completed other trainings related to ACEs and the impact on development of the students they work with.

The HYC disseminated professional development opportunities related to health equity and inclusivity to TPP project

staff. Some of the following webinars, conferences, and workshops were attended by both MCH and TPP project staff: Promoting Educational Equity through SEL; Reproductive Health Equity and Anti-Racism; Advancing Racial Equity: The Time is Now; Health, Equity and Social Justice Conference; and Reducing Inequalities between LGBTQ Adolescents and Cisgender, Heterosexual Adolescents.

Additionally, MCH brought in speakers for the 2021 Adolescent Health Summit to address these topics. The opening keynote speaker and one of the breakout session speakers addressed LGBTQ inclusivity. The speakers covered LGBTQ basic concepts such as definitions and a breakdown of the community's acronym, provided a general scope of health disparities within the population, and introduced evidence-based strategies for supporting LGBTQ+ youth. More information about the Summit can be found in the within Objective 5 within this domain.

Challenges:
Although many activities with the schools and youth-serving organizations returned to some level of normalcy during the beginning of the 2021-2022 academic year, multiple partner, contractor, and county health department staff remained on COVID-19 detail that limited their participation and requests for additional training.

Health Equity Objective 2. Aid School-based staff in preparing for online delivery of classroom training by providing education, COVID-related resources, and technical assistance, as requested.

Data:
The School Health Coordinator developed a contact list for many school nurses serving school districts around the state to assist in material and resource distribution. Additionally, the HYC facilitated a CoP for teen pregnancy prevention and healthy relationship skills staff to exchange ideas, information and training opportunities related to virtual online curriculum implementation.

Successes:
The School Health Coordinator worked with several groups, partners, and other agencies to disseminate new materials as they were developed. The information was emailed out in a timely manner and on several occasions, added to OSDE newsletters. Materials were also added to websites, as needed.

A group from OSDH/OSDE worked with the CDC on the Reopening Schools Grant Program, Project 723. The group worked to provide policies, procedures, protocols, and testing supplies to school districts throughout the state. The School Nurse Organization of Oklahoma (SNOO) worked with school nurses to compile a database to assist in dissemination of important time sensitive material for school nurses to utilize. Another group that worked on dissemination of information was the OSDE School Nurse Cadre group, formed to utilize 1801 CDC grant funds. The cadre group leader organized presentations and encouraged all to share the information with their districts and other school nurses. The contact list of school nurses grew, enabling information to be sent out to a larger number of nurses statewide. The agencies' time-sensitive materials and resources were developed and disseminated, which increased mitigation practices and positive results, which kept staff and students safe.

During the School Nurse Summit in August 2021 the developer of the COVID-19 reporting system for OSDH presented the step-by-step process of reporting positive COVID-19 cases tested at school. Other school staff also had access to the reporting system for the districts without a school nurse. OSDH and OSDE staff had access to the reporting program necessary for their job functions.

Frequent TA was utilized by school nurses and other district staff from the School Health Coordinator and the Health and PE Coordinator at OSDE. Through the course of the COVID-19 emergency declaration, the agencies worked as

partners on many overlapping projects and work groups, strengthening the partnership with OSDE/OSDH.

The sexual health CoP meetings, facilitated by the CAH HYC, for TPP program staff and community partners, continued from October 2020-July 2021. During the November CoP meeting, Tulsa PREP staff served as spotlight speakers and conducted a presentation over how to make virtual presentations and/or instruction more interactive. For more information regarding the CoP, see NPM 9, Objective 1.

Additionally, TA and guidance for delivering EBPs virtually was provided at the January 2021 PREP/OHY semi-annual meeting. Tulsa PREP staff provided a demonstration for how they conducted virtual implementation and successes and/or challenges they encountered.

Healthy Schools Oklahoma was able to use creativity in producing virtual trainings and videos for schools and PE teachers. MCH authorized an adjustment to their budget, assisting in the purchase of materials for filming lessons for virtual learning. These virtual lessons were then shared with partner schools and uploaded to the Healthy Schools Oklahoma YouTube channel. Travel and other expenses were limited during this time due to in-person events pivoting to virtual, enabling the budget reallocation.

Challenges:
An incomplete database of school nurses and their email addresses made the dissemination of materials more difficult, delaying some distribution of materials. Materials distributed from agency leadership to school district administrators, such as superintendents, were not always passed on to school nurses, further delaying the flow of communication. School staff turnover also created a delay in the dissemination of valuable materials.

Adolescent Health - Application Year

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-funded staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with adolescents from 1 in 2020 to 10 by 2025.

The School Health Consultant will provide the Olweus Bullying Prevention Program model to support the Oklahoma State Department of Education (OSDE) and schools statewide in training, implementation, and technical assistance (TA).

MCH will support OSDE efforts to implement the statewide health education standards, which include social emotional learning, providing TA and guidance as needed.

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 TA 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 continue to highlight consent and healthy relationship messages via national observances throughout the year (Teen Dating Violence Awareness Month, National Teen Pregnancy Prevention Month, Let's Talk Month, etc.).

Objective 2: Conduct youth-informed public health activities with youth across the state regarding adolescent health issues, including teen pregnancy prevention, suicide prevention and bullying by 2024. [New]

MCH will strengthen interests in Public Health Youth Councils (PHYCs) among OSDH leadership at all levels and staff. The Adolescent Health Coordinator will identify MCH staff interested in serving on the PHYC Advisory Board.

MCH will continue to collaborate with local county health departments (CHDs) to establish, support, and sustain local PHYCs and identify existing youth groups to build infrastructure.

The existing training PowerPoint for PYD and PHYCs will be recorded and provided to any new Adolescent Health Specialists (AHS). MCH will continue to provide TA for establishing and implementing PHYCs.

Provision of TA 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 and will provide any TA for facilitators to hold virtual activities (interviews, meetings, etc.).

MCH will recruit and maintain at least two Youth Consultants. Staff will work towards developing and/or completing all on-boarding items for future Youth Consultants. MCH staff will include the Youth Consultant(s) in meetings and/or projects that impact adolescents. MCH will continue to contract with the Oklahoma Family Network (OFN) to ensure youth partnership and youth voice in projects, utilizing stipends and other mechanisms to obtain youth input.

Objective 3: Work with county health departments, Oklahoma State Department of Education, and local school districts to provide Olweus training and technical assistance with at least two school districts by December 2024.

Staff will partner with OSDE 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.

The CAH Consultant will develop a manual and train county health department health educators in social emotional learning to assist them in their work with schools.

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: 4,856 adolescents for the 2019-2020 school year).

MCH will continue to support comprehensive reproductive and sexual health education in schools via PREP and Oklahoma Healthy YOUth so that 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.

CAH staff will continue to monitor COVID-19 and will ensure that TPP materials can be utilized for virtual implementation in the event that schools revert to limiting external visitors.

MCH will continue to collaborate with partners to create and/or distribute materials that highlight TPP efforts across the state and sexual health promotion messages via national observances throughout the year (Teen Dating Violence Awareness Month, National Teen Pregnancy Prevention Month, Let’s Talk Month, etc.).

Objective 2: Work with local agencies and healthcare professionals to deliver training on how to provide youth friendly, high-quality services to expectant and parenting teens by 2024. [New].

Staff will work to identify and adapt an appropriate training such as the Mississippi Expectant and Parenting Teens training to implement across the state with youth-serving entities.

Objective 3: Consent education will be provided at least once to all participants in the evidence-based teen pregnancy prevention curricula classes, and to at least 14 schools as a stand-alone presentation by

December 2023.

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 (Teen Dating Violence Awareness Month, National Teen Pregnancy Prevention Month, Let's Talk Month, etc.).

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 12 in 2019 to 56 by 2023.

MCH will seek to fill any existing district vacancies for the Oklahoma Healthy YOUth (OHY) project. All new AHS will receive training for evidence-based curricula and project implementation within the first six months of hire.

MCH will continue to support AHS serving on TPP projects 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 collaborate with tribal partners and additional stakeholders to strengthen TPP and PYD efforts across the state of Oklahoma.

Objective 5: Develop and host the 2023 Adolescent Health Summit to provide education and resources for professionals working with youth by July 2023.

MCH will convene a planning committee for the 2023 Adolescent Health Summit and will utilize the connections and collaborations established from the previous Summit. The committee will consist of work groups to assist with logistics, marketing, speaker identification and youth voice.

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: Collaborate with the Oklahoma Health Care Authority to provide transition information and at least one training to their provider network by December 2023.

Objective 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 2024.

MCH will strengthen their relationship and collaboration with the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency and Sooner SUCCESS to further both objectives.

The Child Health Clinic APRN position will become responsible for transition projects and collaborating with OHCA, once the on-boarding process is complete.

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Health Equity Objective 1: 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 1 in 2021 to 3 by 2023.

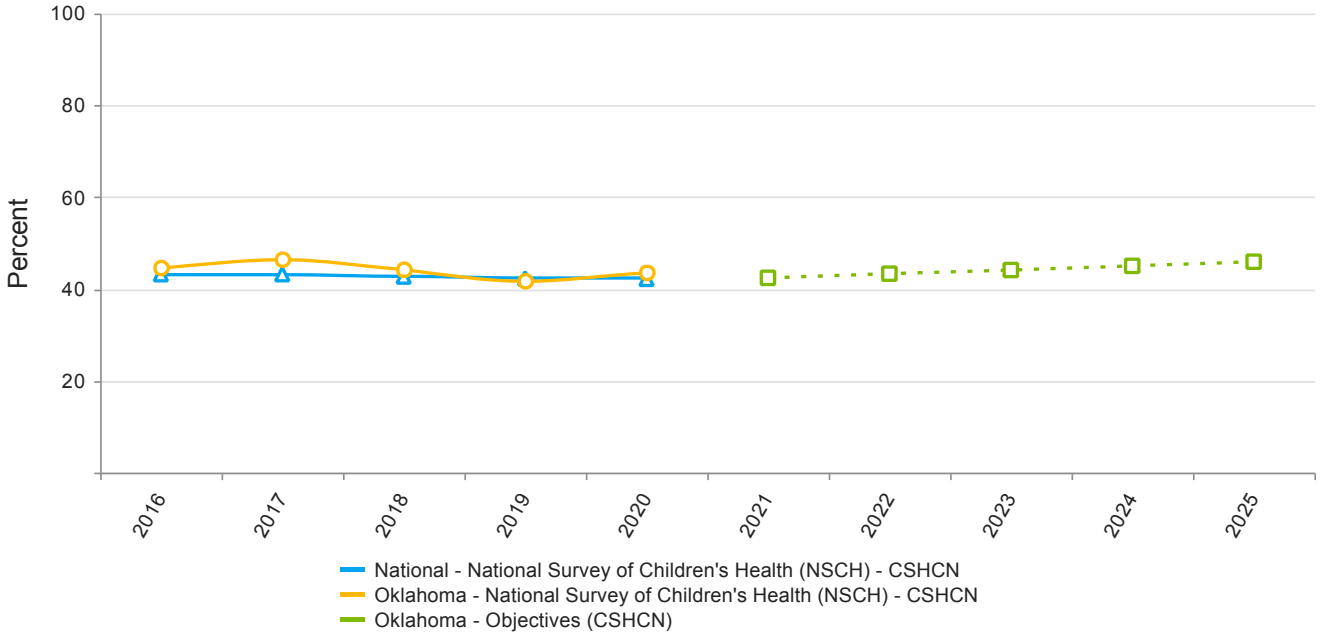
MCH will continue to work with state and community partners to increase the quality and accessibility of ACEs, trauma-informed care, and inclusivity trainings for contractors and youth-serving staff across the state.

Children with Special Health Care Needs

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**	**2021**
Annual Objective			42.4
Annual Indicator	44.0	41.6	43.6
Numerator	95,790	91,264	97,601
Denominator	217,565	219,136	223,770
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	43.3	44.1	45.0	45.9

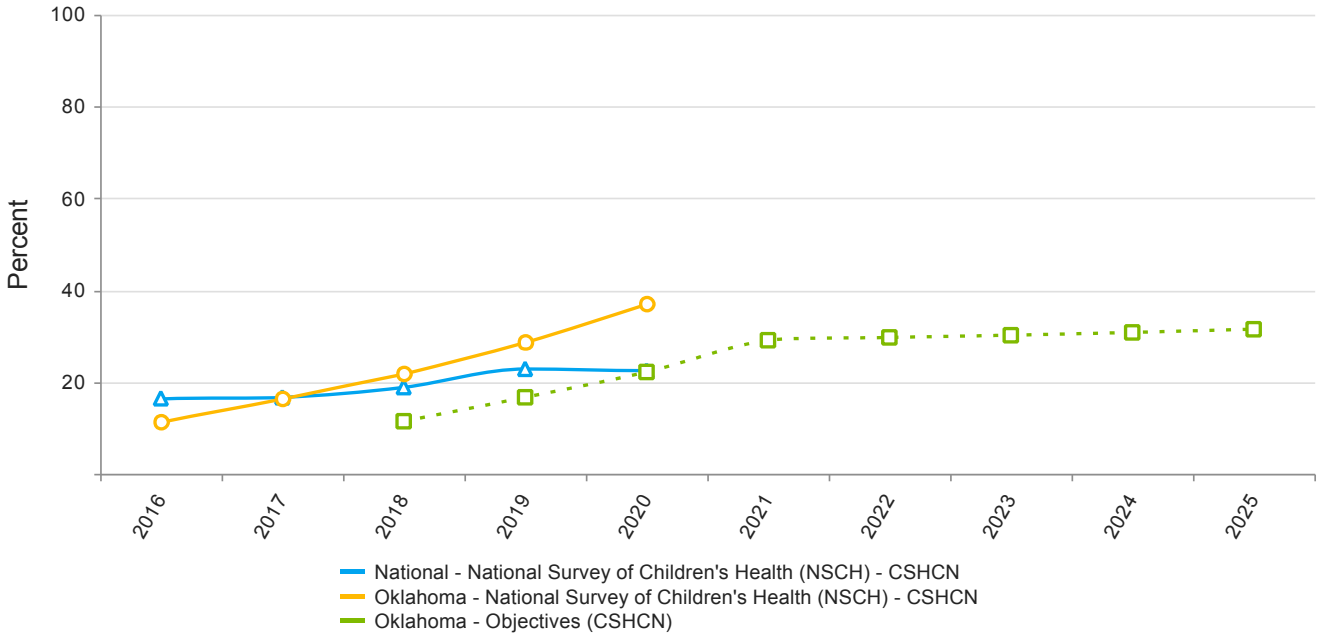
Evidence-Based or –Informed Strategy Measures

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**	**2021**
Annual Objective			42.4
Annual Indicator	39.7	41.6	43.6
Numerator			
Denominator			
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	43.3	44.1	45.0	45.9

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		11.5	16.7	22.2	29.1
Annual Indicator	11.3	16.4	21.8	28.5	37.0
Numerator	10,795	14,252	18,388	26,312	31,935
Denominator	95,220	87,022	84,532	92,174	86,423
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	29.7	30.2	30.8	31.5

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		170	170	175	80
Annual Indicator	164	164	164	77	31
Numerator					
Denominator					
Data Source	Sooner Success	Sooner Success	Sooner Success	Sooner Success	Sooner Success
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	85.0	90.0	95.0	100.0

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					
	2017	2018	2019	2020	2021
Annual Objective	61.9	63.2	64.2	57.7	57.5
Annual Indicator	60.7	62.9	56.6	56.4	56.5
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	2016	2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	58.7	59.9	61.0	62.3

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. Maintain the Healthcare Transition Toolkit by continuing to update specific resources for families and providers by 2025.
2. Increase the number of families who are aware of the need for transition services from 37% in 2019-2020 to 40% in 2025.
3. Increase number of families of CYSHCN who report receiving transition services from 21.8% in 2017-2018 to 24.4% in 2025.
4. Continue to expand the ongoing initiative between Sooner SUCCESS and selected clinics at OUHSC, as well as other urban and rural clinics across the state, to establish a formal health care transition policy by 2025.
5. Complete a minimum of two provider trainings on Healthcare Transition by 2023.

Strategies
1a. Promote research-based health care transition resources on the Sooner SUCCESS website and social media platforms. [New]
1b. Continue to address ongoing feedback from families and providers by creating a HCT Provider Directory, flyers and other resources specific to Oklahoma. [New]
2. Continue quarterly HCT committee of Title V partners, providers, and families of CYSHCN to improve ongoing efforts related to health care transition.
3. Provide families of CYSHCN with information and support to access and navigate ongoing, culturally effective, community-based, coordinated, comprehensive care which includes health care transition.
4a. Identify primary care physicians, specialty providers, interns and students at health care institutions throughout Oklahoma to help them establish health care transition goals both for the institution and their patient population.
4b. Continue to assist primary care and specialty providers at a major state health care institution in establishing health care transition goals both for the institution and their specific patient population, in accordance with the six core elements of health care transition. [New]
4c. Disseminate information to families and providers in both urban and rural clinics across the state on health care transition.
5a. Determine requirements needed to provide CMEs in order to encourage provider trainings.
5b. Develop provider training that meets CME requirements.

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 2025.

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. Continue to improve care integration and cross-provider communication for healthcare providers using evidence-based tools by 2025.

3. Educate health care providers on the use and benefits of telemedicine and how to implement strategies to increase usage, including billing, by 2025. [New]

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. Distribute current outreach material to pediatricians. [New]

2b. Establish a survey for pediatricians around the state, including rural providers and family providers, to determine knowledge deficits regarding the care of their patients who have discharged from hospital NICUs. [New]

2c. Revise outreach materials for pediatricians who are caring for discharged patients from hospital NICUs to incorporate feedback from the survey. [New]

3a. Define the type of patient that would be a candidate for a NICU follow-up telemedicine visit. [New]

3b. Develop parent information regarding telemedicine usage. [New]

3c. Create a system where discharging neonatologists can utilize the established Zoom platform to provide a handoff for complex patients to the child's pediatrician. [New]

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.

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.

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.

Objective 1: Build upon existing Healthcare Transition Toolkit by adding ten additional family specific resources by 2023.

Data:
The Health Care Transition (HCT) Toolkit remained on the Sooner SUCCESS website.

In FFY21, three additional family specific resources were added to the HCT webpage. Data indicated that the HCT webpage was accessed 506 times.

Successes:
Sooner SUCCESS staff maintained the existing HCT Toolkit during FFY21 on the Sooner SUCCESS website. Content was added or updated based on newly identified resources and feedback received from providers and family members. During the FFY, three additional resources were identified that were specifically designed for families**.**

Oklahoma Family Network (OFN) staff participated in the Sooner SUCCESS HCT quarterly meetings by providing input on resources and experiences related to transition to adult health care. OFN staff shared transition resources received through national partners and other Family to Family Organizations with Sooner SUCCESS staff, families, and other professionals.

The Oklahoma Family Support 360°Center (OK FS360) collaborated with Sooner SUCCESS during the quarterly HCT committee meetings. OK FS360 staff actively attended the HCT committee meetings to bring expertise and the family voice of the Latinx/Spanish-speaking population and served as a liaison between families and the research team.

The Oklahoma Infant Transition Program (OITP) took a small toolkit for NICU parents and expanded it into a comprehensive toolkit specifically designed with approximately 18 resources for families in the NICU and those transitioning to a medical home. OITP worked on developing a website for NICU parents to use with up-to-date information and resources, as well as information about medical homes and frequently asked questions. The website was maintained by OITP staff to modify information as needed.

The Sickle Cell Clinic Disease Transition Program (comprised of a transition coordinator, social worker and psychologist) continued to meet with patients/families twice per year. During the FFY, the Sickle Cell Clinic added a second full time psychologist to assist with the Sickle Cell Disease Program. A Sickle Cell Disease specific toolkit was given to all patients upon entering the Transition Program and to all patients when they turned 18. Sickle Cell Clinic continued sickle cell disease educational activities at the Stephenson Cancer Center (where most patients transition to for adult care).

One new CSHCN grantee began providing services. Parent Promise was awarded a grant by CSHCN Title V beginning in August 2021. This funding supported a Community HOPE Center with a Family Services Navigator specifically focused on the CYSHCN population.

Challenges:

A limited number of minority voices attended the quarterly HCT committee meetings.

OITP worked with the University of Oklahoma (OU) and OU Physicians Information Technology Department for website approval. However, it took longer to make progress than anticipated, as OITP had to comply with the OU and OU Physician's guidelines for branding and format.

OITP was limited on the number of families that could meet for the parent lunches and scrapbooking. Both have been excellent vehicles for information gathering and disbursement from/to parents in the past. Normal activities were slow to resume due to COVID-19 restrictions.

The Sickle Cell Clinic reported that there continued to be a lack of true Adult Sickle Cell Disease programs to transition adolescents to once they reached adulthood.

Objective 2: Increase number of families who are aware of need for provision of transition services from 32% in 2017 to 35% in 2022.

Data:
The 2019-2020 National Survey of Children's Health data state 37% of families were aware of the need for transition services in Oklahoma. Sooner SUCCESS County Coordinators surveyed families of transition age CYSHCN in order to assess their level of awareness around timely preparation for transition of health care for their children. For FFY21, Sooner SUCCESS surveyed 142 families of which 30 (21%) of those families surveyed reported having a plan for transition.

Successes:
Sooner SUCCESS continued to host quarterly HCT committee meetings where collaborators, community partners and families had an opportunity to hear about Sooner SUCCESS' work around health care transition. The attendees shared their own experiences and identified service gaps in the community. Sooner SUCCESS encouraged attendees to be part of the program's efforts whenever possible. Any new resources mentioned or identified as meeting community needs were added to toolkits. OFN and OK FS360 both contributed to these meetings.

OK FS360 continued to bring opportunities of learning about adult health care transition to the families served through the Center and to the Spanish-speaking support groups in the area. OK FS360 provided individualized information, care coordination and family support to families with children 12 to adulthood. OK FS360 was the one stop center housed at the Center for Learning and Leadership, Oklahoma's University Center for Excellence in Developmental Disabilities (UCEDD).

For FFY21, the OK FS360 Center distributed the one-page bilingual document created by the OK FS360 Center staff about health care transition, which included specific state resources that the families could utilize when helping their children transition from pediatric to adulthood medical services.

OITP provided weekly activities for the NICU families. Written and verbal information was provided relating to transitioning from care in the NICU to care in a medical home. This information included community resources, facts on transitioning care for their child, mental health and stress management. Parent lunches and scrapbooking sessions, when able to be held due to COVID-19, were well attended and provided an excellent forum for parents to ask questions and OITP staff to provide information.

As a result of parent feedback, OITP developed a "caregiver box" for the NICU families from out-of-town who did not

bring much with them in terms of needed personal items when they were rushing to the hospital. The “caregiver box” included a toothbrush and toothpaste, ear buds, an electronic battery charger, deodorant, eye mask and ear plugs for sleeping, notebook and pen and a children’s book to read to their child in the NICU. This family success story was provided related to the caregiver boxes: *OITP had one father from a rural Oklahoma town who followed Medi Flight in from the delivering hospital to OU Health. The father came with only the clothes he was wearing. OITP gave him a “caregiver box” and he expressed to staff that it was “a life saver”. He called his wife and expressed how glad he was that his baby was at a hospital that cared for the family as much as the baby.*

The Sickle Cell Clinic encouraged the representation of families with Sickle Cell Disease to be on the Oklahoma Children’s Hospital Family Advisory Board and Jimmy Everest Center (JEC) Advisory Board.

Challenges:
OFN reported that families lacked understanding of the importance of beginning transition skills early. This lack of understanding limited OFN’s ability to gain their attention for attendance at trainings, conferences and other events promoting health care transition skills. Additionally, families were overwhelmed due to the last two years of virtual school, lack of in-home supports/services and trying to juggle it all.

During FFY21, the Saint Francis Family Advisory Council recommended educational handouts be provided to youth, ages 16 and over, with emergency room (ER) visits to educate parents and youth on the upcoming transition to the adult ER. Caregivers would be encouraged to speak with pediatricians and specialists on the importance of providers discussing the transition with their children. The group tasked with addressing transition from the Saint Francis Children’s ER to the adult ER did not meet because of a change in leadership and COVID-19 precautions.

OK FS360 continued to report challenges surrounding the COVID-19 Public Health Emergency and its effect on the families OK F360 served during FFY21. OK FS360 reported that many families had challenges accessing services due to a lack of knowledge, experience and technology in accessing the distance learning opportunities.

OITP reported some parents were hesitant about meeting in a large group due to their infant being immunocompromised. OITP provided information to these parents on a one-on-one basis. However, it was difficult to schedule time with each family.

Objective 3: Increase number of families of CYSHCN who report receiving transition services from 21.8% in 2017-2018 to 24.4% in 2025.

Data:
The combined 2019-2020 National Survey of Children’s Health found that 37% 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 is an increase from the 28.5% just over a year prior (2018-2019). This rate is higher than the national average of 22.5%.

Successes:
Sooner SUCCESS continued to host quarterly HCT committee meetings where collaborators, community partners and families had an opportunity to hear about Sooner SUCCESS’ work around health care transition. The attendees shared their own experiences and identified service gaps in the community. Sooner SUCCESS encouraged attendees to be part of the program’s efforts whenever possible. Any new resources that mentioned or discussed and that met identified community needs were added to toolkits.

Sooner SUCCESS County coordinators continued to navigate services for Oklahoma families to assist with health care transition for their kids. County coordinators reached out specifically to families who have transition age children to ensure that they had considered healthcare transition and were developing an effective transition plan.

The OK Transition Institute (OTI) was held October 26-28, 2021, and hosted online for 525 attendees. OFN promoted the OTI in multiple ways to increase family participation and there was no registration fee. Three OFN staff presented sessions which included Charting the LifeCourse (80 participants), Charting the LifeCourse in Spanish (10 participants) and Preparing Students to Transition to Adult Wellness (84 participants). Two OFN staff were on the planning committee for the OTI and were very involved with the planning and implementation. They remained on the planning committee for 2022 and attended all meetings.

OFN reported that Health Transition Training was also provided to 15 individuals during a Poteau young adult summer summit. OFN promoted the Houston Medical Transition Conference to families and professionals virtually.

OK FS360 reported that 30% of the children served in the program during FFY21 were able to apply for support and transitional services. Some examples included the Developmental Disabilities Services, Supplemental Security Income and State Supplemental Payment. That percentage was up by 4% from the previous fiscal year.

OITP scheduled and staffed weekly Oklahoma Transition Clinics (Clinics) for infants discharged from the NICU with special health care needs. OITP had 70 clinic days and reached 234 patients in NICU follow-up clinics. The neonatologist assigned to the NICU Follow-Up Clinic addressed any health care needs the infant may have had due to the NICU stay or any health care needs that the infant may have encountered since discharge. An OITP social worker performed a needs assessment for the infant and family. Referrals were made for any infant who needed additional services and the importance of the referral for the infant was discussed with the family. Referrals included SoonerStart, speech therapy, physical therapy, and/or referrals to other specialty physicians or clinics. Additionally, OITP social workers tracked the mother's PHQ-9 score obtained during the NICU stay and compared the first PHQ-9 score to the score obtained after discharge in the follow-up clinic. Comparing the PHQ-9 scores allowed the team to assess the mother's needs for additional mental health resources and counseling.

The Sickle Cell Clinic held the 1st Annual Sickle Cell Disease Patient/Family Networking Event for patients/families. Past patients who had successfully transitioned and current patients and their families attended the event. Educational sessions were held on disease modifying strategies, curative options (including bone marrow transplant), COVID-19 and Sickle Cell Disease, keys to successful transition, psychosocial impact of Sickle Cell Disease, genetic counseling, and life lessons learned in living with Sickle Cell Disease. The event was recorded for those who could not attend in person.

The Parent Promise Family Services Navigator worked on the creation of a community needs assessment outline seeking feedback to determine resource and service needs by the families of the CYSHCN population.

Challenges:
Health care transition remained a topic frequently not addressed by families until the actual transition point approaches.

OFN was not able to track the number of Oklahoma families who attended the Houston Medical Health Care Transition Conference.

OK FS360 reported that families continued to struggle with access to information in Spanish during FFY21. Many of

the agencies that families relied upon lacked sufficient bilingual personnel. Some of the agencies did have translation services but not all staff were aware of those translation services to assist the families. Additionally, many agency websites were not available in other languages. All of this made it difficult for families to not only access the services but also to learn about the services that their child might benefit from.

COVID limited in-person meeting opportunities for the Sickle Cell Clinic.

Objective 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.

Data:
Sooner SUCCESS worked with three clinics at OUHSC as part of their Pilot Study. The three clinics were the Child Study Center, Sooner Pediatric Clinic and the Sickle Cell Clinic. Sooner SUCCESS reported unforeseen challenges in FFY21 with the Pilot Study due to COVID-19. The Child Study Center was able to make some progress by implementing an HCT policy and setting a goal that all patients,16 and older, would complete the HCT readiness assessment so that providers could review and discuss results. The Sooner Pediatric Clinic had little progress and the Sickle Cell Clinic advanced their HCT policy and procedures. Sooner SUCCESS reported there were future plans in place to remain on track to report data by 2023.

Successes:
Sooner SUCCESS reported that procedures undertaken, via the pilot study, helped determine the count and percentages of children in participating organizations who received services necessary to transition from adolescent to adult health care.

Sickle Cell Clinic staff continued to provide support for any sickle cell disease related concerns to providers on the adult side, other sub-specialties and primary care physicians.

Challenges:
Sooner SUCCESS reported that the implementation of the pilot study was slower than expected due to COVID-19 protocols, which included increased telehealth visits instead of in-person visits**.**

The Sickle Cell Clinic continued to await transition to a new Electronic Health Record (EHR) system (for incorporation of standardized forms and templates, educational materials, order sets and algorithms used in practice) at an institutional level.

Objective 5: Complete a minimum of two provider trainings on Healthcare Transition by 2023.

Data:
A series of HCT provider trainings was developed (three modules per series) in order to provide training in the fall 2021. However, provider training could not be scheduled until May 2022 due to increased COVID-19 cases, staffing issues and difficulties obtaining Continuing Medical Education (CME) approval.

Successes:
Sooner SUCCESS successfully navigated the CME approval process and gained CME approval for three separate HCT provider training sessions in partnership with Dr. Terence Gipson.

OITP is affiliated with the University of Oklahoma School of Medicine and regularly hosted residents in both OITP

clinics to allow future providers a specialized look into the need and mechanics of transitioning from the NICU to a medical home. Many residents cared for these infants in the NICU and in OITP follow-up clinics giving them the unique advantage of both inpatient and outpatient care and education.

Sickle Cell Clinic completed numerous provider training activities throughout the institution, all of which included at least some information on health transition for youth with sickle cell disease. Provider training included medical students, residents, fellows, Nurse Practitioner (NP) and Physician Assistant (PA) students, nursing staff, emergency room, pharmacists and providers.

Parent Promise Family Services Navigator attended Family Matters Virtual Conference on September 21, 2021 and September 23, 2021. This conference provided an opportunity for parents, caregivers, and service providers to build knowledge on how to support children and better manage challenges when caring for a child and/or young adult with special health care needs, behavioral health needs, or disabilities.

Challenges:
Sooner SUCCESS reported that the CME approval process required more time than originally anticipated which delayed the HCT provider training sessions initially scheduled for the fall. Part of the delays were due to the program waiting on OUHSC Marketing to develop and approve publicity materials.

OITP staff had a limited number of hours to have the resident care for NICU graduates in follow-up clinics. Residents cared for approximately 4-5 outpatients weekly.

One challenge for the Sickle Cell Clinic with provider training was the absence of a standardized program and the limited ability to offer CME credits for training.

Health Equity Objective 1: Develop a plan to increase healthcare transition awareness among the CYSHCN population, to include addressing health disparities for CYSHCN, by 2025.

Data:
OK FS360, in partnership with the Center for Learning and Leadership (CLL), created a step-by-step video in Spanish to assist families in applying for, renewing, and monitoring their benefits from the Oklahoma Human Services (DHS) agency. This included instructional assistance concerning SoonerCare for children receiving SSI.

Successes:
OK FS360 provided information in Spanish to parents and caregivers who were enrolled for their services. Information included activities, trainings and opportunities to learn about transition and adulthood. One of the major forms of assistance provided by OK FS360 was supporting the families for the continuation of benefits while they transitioned.

As a result of family inquiries, OITP scheduled and provided care conferences for families who had a child with complex medical issues (length of stay > 90 days or as requested by the physician) in the NICU. The care conferences began after 60 days, with consulting physicians invited to attend. Barriers to discharge were evaluated by a care team and plans were formulated to facilitate discharge home. OITP facilitated discussion of infant's care between hospital staff and families and provided medical updates to the families. Anticipatory discharge guidance was provided approximately 14 days from the discharge home date in order to ensure parents were able to transition from NICU care to community care without difficulty. Care conferences were up from 27 in 2020 to 41 in 2021.

Many of the OITP families in the NICU came from rural areas in Oklahoma. OITP staff worked with rural agencies for resources and information when the infant was discharged home. One success story on these endeavors includes: *OITP had a patient discharging home to a rural community who needed home health services, transportation assistance, pharmacy services for total parenteral nutrition (TPN), lab draws and weight checks. No home health agencies offered pediatric services in their community. OITP staff were concerned this barrier would not allow the infant to go home with his parents and would require him to be admitted to The Bethany Children's Center for rehab. A small group of social workers, discharge planners and OITP staff were able to make inquiries and find the services this family needed to allow them to take their child home. OITP staff continued to keep in contact with the parents for further needs and to assess the family for stressors and needed coping strategies.*

OITP staff continued to be members of the Oklahoma Family Support focus group to advise and to find appropriate resources for the needs of families in transition from the NICU to a medical home. OITP also continued to be members of the Transition Services Committee and the Fetal/Infant Mortality Review Committee, addressing the disparity of services for CYSHCN.

Many of the families in the NICU were Spanish-speaking only and needed an interpreter for updates, consents for medical procedures, and nursing updates. This need was met by the OITP Spanish-speaking interpreter who interpreted for physicians in the prenatal period, during the NICU stay, and in the OITP follow-up clinics. The Spanish-speaking interpreter also interpreted during phone calls to parents after discharge to check on their well-being. The OITP interpreter was a valuable asset for OITP's underserved population of Hispanic families.

The Sickle Cell Clinic had a social worker available to help identify families who were able to work on developing a plan to address individual needs. The social worker remained actively involved in preparing patients for transition (discussing health insurance, life goals, jobs) and providing support services, referrals, help with school letters, medical accommodations, and financial issues. Follow-up with patients was provided in-between visits for those who needed more support.

Parent Promise Family Services Navigator attended and completed Circle of Parents training on August 4, 2021. The Circle of Parents training provided information and guidance on how to facilitate parent self-support groups.

Challenges:
The most commonly reported barrier staff faced was that families did not know who to contact for services for their child and needed help finding people who would advocate for them. Families lacked awareness of the services available to their children when unsatisfied with their current provider service.

OK FS360 reported that Hispanic families were often unaware of the services and tools that support children and youth at transitional age. Hispanics, in comparison to other communities, were disproportionately affected by COVID-19. During FFY21, OK FS360 lost caregivers to COVID-19, which made providing reliable information to keep the family and child safe, a priority.

OITP reported that once families discharged from the NICU, it was difficult to maintain current phone numbers and addresses. It was a time-consuming effort to contact parents who had moved, changed phone carriers or phone numbers and had not provided any email information for the file.

The Sickle Cell Clinic found more research needed to be done to understand the baseline when developing a plan to address individualized needs.

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.

Data:
The combined 2019-2020 National Survey of Children's Health found that 43.6% of Oklahoma children with special health care needs, age 0 to 17 years, have a medical home. This is slightly higher than the national average of 42.2%.

Successes:
OFN staff supported families in FFY21 and connected 773 cases to other families, support groups and resources in their community. The 2021 OFN Joining Forces Conference hosted 97 families and 200 professionals virtually. Speakers' presentations were made available on the OFN YouTube Channel with a total of 30 views during the reporting period. Accommodations were provided with live Spanish translation and captioning during each presentation.

During FFY21, OFN provided Transition Care Notebook Training to 9 individuals. A total of 630 Care Notebook and 258 Transition Care Notebook sets of documents, as well as 153 sets of the Genetic Module of the Care Notebook, were downloaded from the OFN website. OFN staff provided Community Resources Training to 56 individuals during FFY21. OFN provided HCT training during the OK Transition Institute for 84 individuals and 27 families during the Family Matters Conference. OFN posted flyers for the Chronic Illness and Disability Transition Conference to seven Facebook groups/pages. OFN provided registration information to Saint Francis Children's Hospital, who included it in their newsletter to 800 families and providers. Two OFN staff were on the OK Transition Institute Planning Committee and were very involved with the planning and implementation.

OFN, in collaboration with the National Alliance on Mental Illness Oklahoma (NAMI), Developmental Disabilities Council of Oklahoma, and Pervasive Parenting Center, provided the Family Matters Conference, a conference for families of children and youth with special health care needs. The conference registration included 376 individuals, 39% were rural residents, 31% suburban and 30% urban. One hundred and forty-three (143) caregivers, 15 self-advocates and 50 professionals attended, while 256 received conference boxes with 20 resources and words of encouragement. Sessions were determined following a survey provided to families served by OFN and other partners in spring 2021. Keynotes were Dr. Jennifer Jones and Dr. Kami Gallus on "*Fostering Belonging to Support the Ordinary Needs of Families*". Other topics included health care transition (27 participants), Parenting an Anxious Child (89 participants), Understanding TEFRA Coverage (15 participants), Health of the Caregiver (48 participants), Understanding IEPs (26 participants), Youth Independence (15 participants) and Making sense of Challenging Behaviors (68 participants). A total of 18 sessions were provided. The final Keynote, Mike Veny spoke on "*How to Find Peace in Times of Uncertainty*". The feedback, from families and professionals alike, was very positive with 100% stating their knowledge had increased and 97% satisfied with the conference.

OFN, in collaboration with National Family Voices, developed Telemedicine Training in English and Spanish. OFN reported that posters were developed in English and in Spanish to direct families of children in NICUs to OFN support in order to improve access to care during a time that OFN staff cannot reach families in person at NICUs. The posters (with QR code to referral form and web site information) were placed at three of the largest NICUs in the state.

An example of OFN services provided and the impact for one family is: *"A Spanish-speaking mother whose child was born with a genetic condition could not access needed services due to agencies closing to in-person services. The family had limited English proficiency and no technology capacity. Most of the services or programs from Oklahoma Human Services required a birth certificate, which the family did not have and required on-line applications. OFN staff supported the parent virtually by helping her apply for her child's birth certificate and the services she desperately needed such as respite, the Family Support Assistance Payment, etc. OFN connected the family to a Spanish-speaking supporting parent with similar experiences via phone, and she has been connected to local support groups. The family is very grateful for the services provided."*

During FFY21, OK FS360 provided one-on-one support services for families served. Additionally, OK FS360 was able to reopen in-person in order to better serve the most vulnerable families with urgent support. CDC guidelines were followed, along with the OUHSC policy regarding social distancing, to reduce the risk of COVID-19 exposures.

OK FS360 continued to build capacity with the goal for families served to be more self-sufficient and better prepared to make wiser choices for their children and youth. Learning opportunities were provided through health care notebook training, adolescent and mental health training and Applied Behavioral Analysis trainings for Spanish-speaking families.

OITP began transitional instruction while the infant was still in the NICU. OITP provided information about a medical home, answered questions and addressed concerns parents had. OITP increased the percent of infants seen in the Oklahoma Transition Clinic with special health care needs in a medical home. In this clinic, OITP provided instruction and information regarding additional resources and programs the child may need for transitional care. In FFY21, 100 families were seen in clinic.

Sickle Cell Clinic continued to employ a nurse navigator to help coordinate discharge education and follow up appointments. Sickle Cell Disease educational packets were provided to each family and education was provided with families at each visit. Handouts/links were utilized to direct patients/families to appropriate educational resources.

The Parent Promise Family Services Navigator attended and completed Circle of Parents training on August 4, 2021. The Circle of Parents training provided information and guidance on how to facilitate parent self-support groups.

Challenges:
OFN referrals declined since staff were not in hospitals, at meetings or hosting trainings in person. Attempts were made to connect with partners but there is no replacement for relationships that are developed and nurtured in person.

OK FS360 access to information and services during COVID-19 moved to online rather than in-person or telephone contact and trainings were conducted through Zoom. Many of the families served did not have access to the technology needed or they did not feel comfortable using technology the way it was required in order to access the information. Subsequently, fewer families attended the meetings, in comparison to in-person meetings.

Many OITP families had a knowledge deficit regarding health needs for their child in the NICU. OITP stressed the importance of follow-through for their childs health care needs. Some families were unwilling to acknowledge need for services due in part to the stigma associated with a child with special health needs.

A challenge for the Sickle Cell Clinic was that many patients lacked a Primary Care Physician (PCP).

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.

Data:
In FFY21, OITP initiated 41 multidisciplinary care conferences for NICU patients with complex medical issues and their families.

Successes:
Sooner SUCCESS staff worked with the OUHSC Marketing Department to develop outreach materials for providers on an upcoming HCT Provider Training sessions, to include billing information. The three-session training received CME approval.

OK FS360 continued to have a strong relationship with OU Family Medicine clinic during FFY21. The relationship allowed the opportunity for the OK FS360Center staff to provide training to medical residents going through the Family Medicine rotation. Included in the training was information regarding the unique needs of families who speak Spanish, and those from other minority populations. Also included was the perspective of medical transition when a family has a child with a disability or special health care need.

Oklahoma Infant Transition Program scheduled multidisciplinary care conferences for NICU patients with complex medical issues and their families. Consulting physicians were invited to attend. The goal was to initiate a care conference for infants with a length of stay greater than 90 days in order to identify barriers to discharge and to formulate a plan of care to facilitate discharge to home or to a long term care facility. In FFY21, all care conferences scheduled while the infant was in the NICU were teleconferences for parents and for consulting physicians who were unable to attend in person. This allowed the parents to speak with physicians without arranging for transportation and/or child care. This appeared to be a success according to parent feedback.

The Sickle Cell Clinic continued to increase educational resources available to families and implemented an Annual Sickle Cell Disease educational event.

Challenges:
Sooner SUCCESS reported that increasing COVID numbers and the concerns associated with that, as well as waiting on approved publicity materials, delayed the HCT Provider Training, which was initially planned to begin in fall of 2021.

OK FS360 reported that training was limited to Zoom during FFY21. Zoom was a great avenue for training during a national Public Health Emergency but there were barriers associated with it. Staff reported that interaction was greatly reduced in a virtual format, rather than in-person, no matter how much students were encouraged to ask questions, interrupt or raise their hand.

OITP reported that some parents were intimidated about asking for a physician meeting. OITP worked with Child Life to break down those beliefs and barriers.

Sickle Cell Clinic had to limit in-person visits due to the COVID pandemic and rely on 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.

Data:
The combined 2019-2020 National Survey of Children's Health found that 56.5% of children in Oklahoma, ages 3 through 17, with a mental/behavioral condition received treatment or counseling.

Successes:
OFN continued to partner with NAMI Oklahoma, Parents Helping Parents and Evolution Foundation as a project of Oklahoma Mental Health and Substance Abuse Services in the CBHN, providing connections to supports and resources for families who have children with mental health concerns/diagnoses and training. OFN hosted 81 parents and 16 young adults at the Children's Behavioral Health Conference in May 2021 for a variety of trainings and a lunchtime gathering for resource information. This allowed families to realize they were not alone in caring for a child with mental health concerns. They also learned skills for their own child and to share with other families in their area. In December 2020, CBHN also hosted a virtual family retreat for 127 caregivers which included self-help strategies for themselves as parents and for their children.

Oklahoma Mental Health and Substance Abuse Services, in collaboration with OFN, Systems of Care sites, Evolution Foundation and school districts in eastern Oklahoma counties developed Multi-Disciplinary Teams (MDT) to guide referral and treatment planning and practices with the Community Mental Health Centers and address individual student mental health needs. During this project, called EMBRACE, OFN provided professional development for school personnel including a virtual Summertime Summit for 72 teachers where the focus was trauma training with 12 different sessions. Teachers received their annual certification for human trafficking and suicide prevention. EMBRACE was focused on 14 schools in eastern Oklahoma, including 3 of the top 10 school districts in the state for numbers of students. OFN provided training to 54 caregivers and 127 school personnel to encourage calming for children experiencing anxiousness or problem behaviors.

OFN assisted in providing support and resources for 256 family cases related to mental health during this reporting period. Trainings were provided such as **"***Advancing Your Advocacy*" for 32 caregivers and "*Engaging Your Legislator with Sen. Julia Kirt*" for 13 parents at the Family Matters Conference in September 2021. OFN co-hosted "*Basics in Advocacy Training"* with the Coalition of Advocates for Behavioral Health for 10 family members and 18 providers.

OFN provided registration for 15 families to attend the National Federation of Families Conference for Children's Mental Health in November 2020. Families learned leadership skills including how to run a family organization.

Sooner SUCCESS hosted Wrightslaw Special Education Advocacy trainings for parents and professionals on September 14 and 16, 2021; 264 attended the trainings. Caregiver mental health and self-care bags across the state were provided during the summer of 2021 and in many counties during the fall of 2021 to reduce caregiver stress, anxiety, and isolation. Sooner SUCCESS staff supported multiple parent support groups, via zoom and in-person, to reduce social isolation. Additionally, Sooner SUCCESS hosted a 2-day statewide training for caregivers covering a wide array of topics relevant to caregivers across the lifespan.

To directly support CYSHCN, Sooner SUCCESS staff, as part of a local Autism Task Force, assisted with 2 weeks

of sensory friendly summer camp for CYSHCN. Sooner SUCCESS staff provided fidget kits to some law enforcement and juvenile justice professionals to help reduce stress and anxiety experienced by children when they are removed from the home due to trauma or juvenile justice proceedings. Staff also facilitated holiday gifts and food boxes for those in need for multiple CYSHCN and their families.

To better support system-involved CYSHCN, Sooner SUCCESS staff provided multiple trainings on how to better support families impacted by disabilities in healthcare and child protective services settings. A staff member served as an ongoing member of a Multidisciplinary Team on a Child Abuse Response Team as a disability resource for the tea. The staff person was able to integrate education and mental health providers into the team to ensure a more inclusive and well-rounded team responses.

Sooner SUCCESS shared a family story where staff aided a family in their ability to cope with a stressful situation. Sooner SUCCESS staff also worked to improve systems change concerning the situation. *"A provider at OU Children's sent a referral to Sooner SUCCESS for a family. The family had a child with complex needs and had been receiving treatment out of state. Due to the licensing requirements in Oklahoma, telemedicine follow-ups must be completed by traveling out of state. The coordinator was able to assist with respite, medical equipment needs, and provide information on lodging assistance related to travel". The coordinator contacted a local legislator who was learning about the issues and hoping to improve interstate licensing to educate them on how this impacts families.*

The Family Partner and JumpStart Preschool Autism Evaluation Team provided assistance to a total of 120 families in accessing behavioral/mental health services for FFY21. This was similar to the prior year in which 127 families were directly served. The Family Partner/JumpStart Team participated in team evaluation/feedback sessions with 91 families seen in JumpStart Clinic for FFY21. The Family Partner continued to provide continuity of care through direct resource navigation to 29 families in other clinical programs at the Child Study Center, including the A Better Chance Prenatal Substance Exposure, JumpStart Follow-Up, and Developmental-Behavioral Medical Clinics. Many of these families were Spanish-speaking.

All families seen in JumpStart Clinic in FFY21 received a diagnosis/diagnoses (e.g. autism spectrum disorder, developmental delay, intellectual disability, receptive-expressive language disorder, anxiety, disruptive behavior disorder, ADHD) and a plan of action, referral recommendations, and resources. This process was maintained even when providing periodic virtual visits to meet the needs of families during the pandemic. Families were encouraged to call back after appointments with any questions, or if additional help was needed.

The Family Partner at JumpStart contacted several families after their visit to discuss follow-up concerns. This role was enhanced, given the Family Partner's combined position serving 50% of their time as Family Partner at JumpStart Clinic and 50% of their time as an Oklahoma County Coordinator for Sooner SUCCESS. The Family Partner/JumpStart Team assisted with scheduling a 6-month follow-up with a Developmental Behavioral Pediatrician (DBP) physician for those children diagnosed with autism to check-in and determine if additional assistance was needed in accessing behavioral/mental health, school, medical and other community resources.

The Family Partner continued a monthly "*Community Conversations*" Zoom support session for Spanish-speaking families whose children were previously seen in JumpStart or other clinics. The Family Partner reported how grateful the families were for these meetings in helping the families better understand their child's Individualized Education Plan, general resources, and all the respite programs that were available. Caregivers felt safe to open their hearts about their challenges and stressors. Caregivers asked questions and listened to the struggles of other parents and the methods that helped them.

The Family Partner shared this experience: *"There was one caregiver who had no idea she could access the Family Support Assistance Program. She currently has an 8-year-old daughter recently diagnosed with intellectual disability and 4-year-old twins. She was unaware that this resource was available to her and was so excited. Within days, she filled out the application and submitted it. On the most recent call, she had just gotten the debit card in the mail and took the opportunity to thank all of us on our community conversation meeting for telling her about this resource. Now she has helped a friend learn about it, and her friend is planning to attend the next Zoom meeting. She could not stop thanking me."*

OK FS360 continued to bring awareness about behavioral and mental health services to families served and to the Spanish-speaking support groups in the community. OK FS360 utilized knowledge about the attitudes concerning mental health care within the Spanish-speaking community to help support understanding and acceptance. OK FS360 Center, in partnership with OFN and a community medical provider, who was skilled and knowledgeable on Applied Behavioral Analysis (ABA) intervention, offered informational trainings to families. The trainings included information about mental health and better ways to support children who may have a behavioral health need, autism, ADHD or any related condition. Four trainings were offered during FFY21 and all were translated into Spanish in real-time.

OK FS360 Center continued to refer/connect children for assessment, and also referred children to mental health and behavioral supports. OK FS360 offered translation when the provider was not bilingual.

OITP staffed and scheduled approximately 47 clinics in FFY21 which provided neurodevelopmental assessments at 1 and 2 years of age. Referrals were made for each child that may have had neurodeficits or behavorial opportunities. Parents were given resources and educational information for developmental, mental health and other needs as indicated. Social workers continued to assess mothers for any mental and/or mood disorders and were able to connect families with other Title V partners for counseling and resources. OITP screened mothers of our NICU patients, as well as mothers who brought their child to the NICU follow-up clinics, for mood disorders and offered counseling along with written or online resources. OITP used the PHQ-9 questionnaire in the NICU and follow-up clinic. Scores were compared to see if mothers were improving or facing different difficulties once they were home.

OITP scheduled care conferences at the physician's request or if the patient was in the NICU for greater than 60 days. Parents were contacted to make sure they were receiving updates from the neonatologist and asked if they would like to meet with consulting physicians for an update. OITP scheduled care conferences for the purpose of discharge planning with consulting physicians, The Children's Center, if needed, occupational and physical therapy, wound care, etc., to make sure the parents had all the resources they needed for a successful transition from the NICU to home. OITP also called parents within 72 hours of discharge to see how they were coping and if they needed additional resources.

OITP staff were members of multiple support and education groups throughout the county and outside of OU Health. The information and resources provided in these activities was utilized by OITP staff to enable NICU parents to have a successful transition home.

The Sickle Cell Disease social worker continued to meet with all patients/families at least twice per year. To better serve families, the Sickle Cell Clinic added a second full time licensed psychologist. Sickle Cell Clinic had a psychologist and licensed counselor available to all patients with Sickle Cell Disease for counseling services. They met with patients at least one time annually and provided behavioral and mental health services as well as referrals for neuropsychological testing, counseling services, cognitive behavioral therapies and psychiatry.

J.D. McCarty Center provided services for children birth to 21 years of age through a Title V CSHCN partnership. J.D. McCarty Center provided free therapeutic services screenings to any family in Oklahoma that had a child that they believed may be in need of services for an intellectual or developmental disability. The total number of therapeutic screenings provided in FFY21 was 59. During therapeutic services screenings, J.D. McCarty Center assessed the needs of the child being screened, as well as their families, and identified any correlating services that may be available in the state of Oklahoma to assist the child and/or their family, including any necessary mental health services.

J.D. McCarty Center continued the C.A.R.E. program (Connecting With Families. Assessing Resources. Responding To Needs. Enhancing Lives.) that provided assessments and educated families about services. Staff visited with children and families out in the community rather than having the families come to the facility for the assessments. The C.A.R.E. program was a great marketing tool as it allowed staff to inform families of the different services the J.D. McCarty Center provides. It also allowed staff to help the family find services that were needed if the J.D. McCarty Center did not provide those services, including mental health services. The C.A.R.E. program served 89 families in FFY21.

Parent Promise Family Services Navigator attended and completed the Standards of Quality for Family Strengthening and Support training. This training provided information and guidance on using a multi-generational, strengths-based, family-centered approach working with families. Parent Promise Family Services Navigator staffed a resource booth at the Oklahoma Association for the Treatment of Opioid Dependence (OKATOD) Conference.

Challenges:
OFN reported that Infant and Early Childhood Mental Health Coalitions have disengaged during COVID-19 and have not resumed.

For most of the FFY21 period, the Family Partner position at JumpStart Clinic was a part-time (20 hours/week) position. Follow-up with all individual families seen in JumpStart Clinic was a challenge given the limited time constraints and other responsibilities. Resource navigation for families of children with autism substantially increased as ABA became covered by SoonerCare/Medicaid. 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 given the ongoing impact of COVID-19. Title V CSHCN approved expansion of the Family Partner/JumpStart Clinic position to full-time at the end of the FFY21 period. However, the person in the Family Partner position left the role in August 2021 for another position. The Family Partner position remained vacant until after the FFY21 period. During that time, the JumpStart Team provided family support and navigation services, although their capacity was limited compared to that of the dedicated position.

The Family Partner "*Community Conversations*" Zoom sessions for Spanish-speaking families was put on hold when the position became vacant in August 2021.

OK FS360 reported that the term "mental illness" was stigmatized as a weakness in the Spanish-speaking community. Mental illness was not viewed as a medical condition. This attitude continued to be a barrier. Additionally, there were a limited number of bilingual mental health providers skilled at providing care to children and consequently, there were long waiting lists for those.

Many of the NICU families experienced denial regarding their child's neurodevelopmental deficits and did not realize that developmental assessments were an important part of their child's well being. OITP staff educated parents about the intricacies of the premature brain and the capacity to continue development due to neuroplasticity. For

families, emphasizing the importance of early intervention to prevent some of the major neuromuscular deficits that develop in the prenatal and neonatal period due to brain injuries, was critical for buy-in.

The Sickle Cell Clinic cited lack of transportation as a reason that sometimes limited their patients from coming for their clinic visit.

COVID-19 continued to be the most prevalent challenge that J.D. McCarty Center encountered during FFY21. The respite program, which allowed caretakers to seek out support for mental health care, was put on hold during FFY21 due to the ebb and flow of community COVID-19 cases. As a result, the Center had difficulty retaining Direct Care staff since no new respite admissions were allowed during the project period in order to keep the current, vulnerable inpatient population safe. Additionally, the J.D. McCarty Center continued to face challenges in relation to a lack of marketing (a broad outreach) for the respite program.

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.

Objective 1: Maintain the Healthcare Transition Toolkit by continuing to update specific resources for families and providers by 2025.

Objective 2: Increase number of families who are aware of need for provision of transition services from 37% in 2019-2020 to 40% in 2025.

Sooner SUCCESS will utilize the recently hired dedicated Health Care Transition (HCT) Coordinator in meeting the requirements under the HCT performance measure, including development and maintenance of the family and provider toolkits with the most up-to-date resources.

Sooner SUCCESS will continue to gather links to resources specifically designed for families and will prepare and publish a separate toolkit specifically for families in the upcoming year. Sooner SUCCESS will record and provide the number of times each toolkit is accessed from the website.

Sooner SUCCESS, upon request by providers, community partners and/or families, will continue to get guidance from Dr. Patience White from The National Alliance to Advance Adolescent Health in DC.

Oklahoma Family Support 360° will continue to collaborate with Sooner SUCCESS in the quarterly HCT committee meetings with plans to bring the voice of the Black community to the committee meetings.

Oklahoma Infant Transition Program (OITP) will resume normal parent activities that will allow parents and family members to speak about their experiences, express needs and prepare for a transition home. OITP will update the speaker list once family gatherings can resume. OITP will add additional information from community resources and will contact agencies for written information and speakers for parent groups.

OITP will seek additional clinic time (adding an afternoon clinic) for parent convenience and the ability to have additional discharged NICU patients. This will allow OITP to double outpatient education regarding transitioning from the NICU to home.

Sickle Cell Clinic will continue the Sickle Cell Disease Transition Program and will continue to utilize a database to track patients in the Transition Program. In addition, Sickle Cell Clinic will enhance collaboration with Adult Hematology at Stephenson Cancer Center and participate in the Sooner SUCCESS educational webinar regarding HCT. Moreover, the Clinic will maintain/update toolkit with updated American Society of Hematology and CDC guidelines and increase use of disease modifying strategies.

Sickle Cell Clinic will continue to provide sickle cell education to increase the number of providers knowledgeable in Sickle Cell Disease. Sickle Cell Clinic staff will continue to work with primary care providers to increase awareness and facilitate transition of care.

Sickle Cell Clinic will increase screening for cognitive challenges with use of screening brain MRI and neuropsychological testing to be able to provide accommodations to increase successful transition, completion of education and job success.

Sickle Cell Clinic will encourage patient participation in community-based efforts and participation in family advisory boards – so that challenges/needs in the community can be tackled effectively.

Parent Promise Community HOPE Center Family Services Navigator will assist families navigating social service systems and acquire concrete supports that meet the specific needs of the CYSHCN population. This will be accomplished by supporting an increase in the inventory in the Community HOPE Center resource room with concrete supports specifically beneficial to those families identified in the CYSHCN population. These concrete supports will provide immediate need relief to help stabilize barriers among the CYSHCN population.

Oklahoma Family Support 360° Center (OK FS360°) will create training opportunities for families in minority communities to learn about technology including a process to allow access to loaned tablets to the families served by the Center. This will provide access to opportunities of virtual learning. OK FS360° will continue to share the one-page bilingual documents about adult medical transition to the families served.

Objective 3: Increase number of families of CYSHCN who report receiving transition services from 21.8% in 2017-2018 to 24.4% in 2025.

Oklahoma Family Network (OFN) will continue to participate on OK Transition Council and planning of institute. Additionally, OFN will continue to provide health transition training and LifeCourse skills training.

Oklahoma Family Support 360° Center (OK FS360°) will continue to disseminate the one-page bilingual document about health care transition to the families served by the Center. OK FS360° plans to print and distribute to alumni families, and other families as well. The one-page document will also be posted to the Center's website for the community to be able to locate and share. OK FS360° will continue to work one-on-one with families of transition age children and provide an array of trainings, such as care notebook training. Materials related to adult medical transition will also be provided.

Sickle Cell Clinic will continue Sickle Cell Disease Transition Program. The transition coordinator, social worker and psychologist will meet with patient/families twice a year to provide transition education and support.

Sickle Cell Clinic will continue using a 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.

Sickle Cell Clinic will continue the annual Sickle Cell Disease education/networking event for patients/families.

Parent Promise Family Services Navigator will administer community needs assessment to the current client list of Parent Promise to identify families within the program community that identify in the CYSHCN population. Utilizing the data, Family Services Navigator will conduct a focus group with the assessment participants to make further connection and determine through family voice what community resources and services are needed to assist families within the CYSHCN population.

Objective 4: Continue to expand the ongoing initiative between Sooner SUCCESS and selected clinics at OUHSC, as well as other urban and rural clinics across the state, to establish a formal health care transition policy by 2025.

Sooner SUCCESS will implement provider training on health care transition to raise awareness about the need for education in this area. Sooner SUCCESS will be collaborating with the Child Study Center and the Sickle Cell Clinic on the HCT Provider Webinar trainings.

Sooner SUCCESS will be moving forward at the Child Study Center to utilize iPads in clinic for parents and their child to complete the readiness assessment surveys related to HCT.

Sooner SUCCESS will make additional efforts to promote healthcare transition awareness at community events focused on families.

Objective 5: Complete a minimum of two provider trainings on Healthcare Transition by 2023.

Sooner SUCCESS will host Health Care Transition Provider Training sessions. There will be scholarship slots for 25 providers, targeted toward rural providers. CME credit will be available. The upcoming modules will be repeated two additional times.

Oklahoma Family Network is willing and able to disseminate flyers for Health Care Transition Provider Training.

OITP will seek an additional 4-5 hours weekly for follow-up clinic making it a full day. This will allow OITP to train additional providers more efficiently and increase the availability for NICU families.

Sickle Cell Clinic will increase outreach to clinics outside of the Children's Hospital to include Primary Care Physicians (PCP's), Emergency Room (ER) providers and hospitalists across the state.

Sickle Cell Clinic will create of an educational handbook/compilation of resources for Primary Care Physicians (PCP's).

Parent Promise Family Services Navigator will seek further provider trainings to support the CYSHCN population.

Health Equity Objective 1: Develop a plan to increase healthcare transition awareness among the CYSHCN population, to include addressing health disparities for CYSHCN, by 2025.

Sooner SUCCESS County Coordinators will work with OSDH Health Equity Specialists in each region to raise awareness about Healthcare Transition among the CYSHCN population.

Oklahoma Family Network will continue to be part of the Health Care Transition committee meetings and will assist in finding families and resources.

Oklahoma Family Support 360° Center (OK FS360°) will continue to support the families of transitional age children with resources.

The OK FS360° Center office will continue to provide in-person support for Latinx families to try to minimize health disparities. The Center will provide support and will continue helping families navigate and access transition services.

OITP plans to start developmental assessments at an earlier age (3-6 months) as this will help staff develop a relationship with the NICU families and keep in communication with the families before they change their contact information.

Sickle Cell Clinic will identify a Sickle Cell Disease family to serve on the Parent/Patient Advisory Board.

Sickle Cell Clinic will begin an institutional effort to address racial disparities in healthcare, advocacy, research, clinical practices, etc.

Parent Promise Family Services Navigator will attend and complete a Parent Advisory Committee training. Following training, Family Services Navigator will develop and sustain a Parent Advisory Committee by identifying individuals to help address health disparities for CYSHCN.

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.

OFN reported that Heartland Regional Genetics Network will complete development of an application (app) to hold the OFN Care Notebook documents. The app will be free for anyone wanting to use it. OFN staff will continue to be actively engaged in the development, testing and dissemination of the app.

OFN will continue to host training virtually and transition to hybrid training as COVID precautions allow, utilizing a Meeting Owl to improve the quality of the experience for all attendees, live, virtual, or accessed on the OFN YouTube channel.

OFN and OITP will partner to provide OFN Care Notebooks and training to families at, or transitioned from, OU Children's Hospital.

OK FS360° will continue care coordination and the continuation of different categories of trainings tailored to the Hispanic community, with the focus on the trainings being culturally sensitive to the minority communities.

OK FS360° Center will begin offering services to the African American/Black community with the new additional Family Support Specialist on the OK FS360° team.

OITP will develop discussion groups for parents in the NICU. Parents will be able to talk over things with one another and to receive resources and/or counseling for known health issues that they may be experiencing as parents of a medically fragile infant. They will receive family education regarding the importance of health care needs and transition to a medical home.

OITP plans to actively pair current NICU families with families that have been discharged from the NICU. The purpose of the pairing is to offer support and encouragement. It will also be about conveying that children with special needs are a family treasure and not to be hesitant about getting care. OITP will be hiring a family advocate to support NICU parents and offer a unique insight about CYSHCN.

Sickle Cell Clinic will continue to develop family-centered educational materials.

Sickle Cell Clinic will increase use of iPads in clinic to provide more educational resources and effective time utilization.

Parent Promise Community HOPE Center will develop and sustain parent support groups, such as Circle of Parents, supporting areas of focus expressed by participant involvement.

Parent Promise Family Services Navigator will also attend and complete a Parent Advisory Committee training. Following training, Family Services Navigator will develop and sustain a Parent Advisory Committee. Individuals engaged in this advisory committee will represent the Community HOPE Center, with a focus on the CYSHCN population.

Parent Promise Family Services Navigator will partner with other CYSHCN contract providers to engage in training and professional development that will support families of the CYSHCN population. Parent Promise Community HOPE Center will collaborate and/or co-facilitate with other CYSHCN contract providers to provide events, trainings, support groups for families of CYSHCN population.

Parent Promise Family Services Navigator will supply educational materials directly accessible to parents in the Community HOPE Center such as a one pager consisting of medical home information.

Objective 2: Continue to improve care integration and cross-provider communication for healthcare providers using evidence-based tools by 2025.

Sooner SUCCESS plans to repeat the CME approved Health Care Transition (HCT) Provider Training sessions.

Oklahoma Family Support 360° Center plans to continue the trainings offered to the OU Family Medicine clinic with the expectation that it will be in-person when it is safe for all involved.

Work will begin on a survey for pediatricians and materials revised to reflect the feedback.

Objective 3: Educate health care providers on the use and benefits of telemedicine and how to implement strategies to increase usage, including billing, by 2025. [New]

OITP plans to provide an in-service for the neonatology group regarding care conference structure and initiating a care conference.

Work will begin on a system for neonatologists to provide a warm handoff for complex patients to local pediatricians.

Materials will be created to assist parents with accessing and understanding telemedicine.

Sickle Cell Clinic will continue the use of 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.

Oklahoma Family Network (OFN) will improve access to care by hiring two regionally-based staff who are family members of children with special needs. This will improve access to emotional support, information, training and opportunities for leadership for families of children and youth with behavioral health needs and other special health care needs.

OFN will help to host the 2022 National Federation of Families Conference in Oklahoma City in November. OFN staff and partners are helping to plan the conference and plan to provide registration costs and family gathering dinners for the three days families attend.

OFN 2023 Joining Forces Conference will be held in the spring of 2023.

The Family Partner position at JumpStart Clinic, expanded over the last year to full-time, will implement follow-up support calls with all families after their initial evaluation visit. The Family Partner will utilize a simplified questionnaire to obtain feedback by phone from families approximately 4-6 weeks after the initial appointment. The Family Partner will obtain family input about their JumpStart evaluation and feedback session, discern what recommended resources/services they have already accessed as a result of the JumpStart evaluation and elicit any further areas of resource access/other concern with which the Family Partner or other JumpStart team members can assist the family in obtaining.

The bilingual Family Partner will explore specific strategies to improve strengthening communication and connection between Child Study Center, Sooner SUCCESS, the Latino Community Development Agency, and other agencies serving Spanish-speaking families in the metro and state. This will allow the Family Partner to provide more direct, comprehensive follow-up services for Spanish-speaking families of children with autism and related disabilities seen in JumpStart Clinic and the other Child Study Center programs. Specifically, the Family Partner will meet regularly with other Spanish-speaking Sooner SUCCESS and Child Study Center team members to receive training and to improve services and outreach for Spanish-speaking families being served.

The Family Partner at JumpStart will collaborate with other clinical programs at Child Study Center to strengthen longitudinal support of families initially served in JumpStart and those with children with autism and related disorders.

The Family Partner will engage in the planning of a new Mobile Autism Clinic being developed by the JumpStart Team and Oklahoma LEND program designed to increase outreach to Oklahoma families in underserved communities.

The Family Partner will meet regularly with the Oklahoma County and state Sooner SUCCESS teams to bolster services provided to families served at Child Study Center and strengthen connections to Sooner SUCCESS resources.

Oklahoma Family Support 360° Center (OK FS360°) will continue to bring awareness to the Latinx community that mental health is brain health and that mental illness is not a weakness. Staff will continue to communicate that it is an illness like a person would have in any other part of the body that it needs to be treated to help one feel better and function better in daily life.

OK FS360° will continue to provide the Applied Behavioral Analysis (ABA) training to families, and work to expand it in the coming years.

OK FS360° will also expand mental health awareness to other minority communities.

OITP staff will develop a plan to reach parents of NICU patients while their child is still in the NICU. OITP will develop a tool for parents to see the weekly developmental advances their child should be making and offer encouragement when their child is off target for milestones.

OITP plans to incorporate a developmental pediatrician into the developmental clinic.

OITP will provide written and verbal information regarding the importance of neurodevelopmental assessments along with adding testing for 3-6 month NICU graduates.

Sickle Cell Clinic will increase the number of patients receiving counseling/psychology services. The plan is to increase the number of patients living with chronic pain/severe disease receiving cognitive behavioral therapy.

Sickle Cell Clinic will use telemedicine to provide counseling/psychosocial services if a patient is unable to come to clinic.

Sickle Cell Clinic hematology psychologists will participate in the 47th Annual Advances in Pediatrics: Meeting the Needs of Oklahoma's Children.

J.D. McCarty Center will continue to provide respite care services and free therapeutic services screenings through the upcoming Title V grant plan year.

J.D. McCarty Center respite will be expanded beyond inpatient care that is available once per year for eligible children. The expanded respite assistance will include scholarships for children with developmental disabilities to attend Camp ClapHans, a residential summer camp for children with disabilities age 8 to 18. The camp is held five weeks per year with 12 children (6 males and 6 females) per week (4 days, 3 nights). A variety of activities will be available for interaction and integration services aimed at strengthening the child physically and mentally.

The C.A.R.E. program (Connecting With Families. Assessing Resources. Responding To Needs. Enhancing Lives.) with J.D. McCarty Center will be expanded into additional counties and eventually statewide, in order to educate families about services.

Parent Promise Community HOPE Center will build partnerships with behavioral and mental health providers for screening events with direct referral sources to guide families to for services.

Parent Promise Community HOPE Center will implement the two key frameworks of the Standards of Quality for Family Strengthening and Support—*The Principles of Family Support Practice* and the *Strengthening Families Approach* to encourage and increase family voice in the CYSHCN population.

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 2024.
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:

No counties were able to implement the project due to disruption from the COVID-19 pandemic and public health response.

Successes:

The goals of the fatherhood initiative continued to be working to empower fathers to increase their level of engagement with their child(ren) and increase the quality of co-parenting with the mother of their child(ren) or another primary caregiver. Although there was interest from multiple counties to begin the project, and in previous implementers to engage a new population, COVID-19 duties were first priority.

Several of the individuals who were initially trained in the curriculum have since moved onto other agencies or into the private sector. As such, there was a discussion about having several of the early trainees train new “workshop leaders” in the curriculum in communities where new projects would start. A training for Muskogee County was planned for October 2021. The project continued to be structured as a state-county partnership with funding from the state office to county-level applicants for project administration.

Despite not engaging in curriculum; there was success in spreading positive information and resources to Oklahoma fathers in the form of the bi-monthly fatherhood newsletter. Newsletters were distributed to the Central Oklahoma Healthy Start Fatherhood Program and to health educators statewide trained in the curriculum, to disseminate in their counties. This newsletter continued to be a tool to spread new research into the power of fathers in their children’s lives, how-to processes for fathering skills, and information for Oklahoma fathers on local resources.

Challenges:

There continued to be a significant impact on implementation of this project due to the COVID-19 pandemic for multiple reasons. First, the public health staff who facilitated curriculum and trainings needed to shift responsibilities from traditional roles to pandemic response (such as COVID-19 testing and vaccine distribution). Second, the practice of community engagement with fathers took place in community and church environments and meeting in-person would have been in opposition to the public health recommendation to reduce interaction with large groups. Third, although some public health projects were able to shift to a virtual format, the group dynamic and rapport building with the participants that is vital to the project’s success was not possible to replicate in a virtual format. The curriculum was designed to be facilitated in-person with pen and paper workbooks and assessment instruments and the developers did not adapt it for virtual implementation.

Cross-Cutting/Systems Building - Application Year

Objective: Implement a fatherhood initiative project in at least three pilot counties.

The fatherhood project will continue with the support of several of local community leaders and MCH Title V.

Additional trainings will occur to bring the curriculum into wider use for those communities that express interest.

The fatherhood newsletter, focused on resources and information for Oklahoma fathers, will continue to grow in distribution, with several additional organizations committing to dispense it to their membership. These include community health organizations, and a rural church.

Discussions to expand the project's operation and scope beyond the current counties will continue, pending additional funding.

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. A link routing public comment to MCH is listed under CSHCN on the Oklahoma Department of Human Services website, http://www.okdhs.org/services/health/Pages/default4.aspx, with a request for public comment. Hard copies and pdfs of the MCH Title V Block Grant are also provided upon request to MCH.

Due to the ongoing pandemic, many of the ways MCH and CSHCN typically collect public input (customer surveys, listening sessions, public meetings and trainings) were limited. Efforts to mitigate the COVID-19 virus were 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.

In March 2022, a survey was distributed via partners, social media, email and through the Joining Forces Conference attendees. The survey asked for input on the existing priorities, their current relevance, and additional needs for mothers, children and families in local communities. The survey had 234 respondents, 30% of which identified as family members. The majority of respondents felt that the priorities were applicable and did not warrant change at this time. Respondents commenting on what would improve the ability of families in their communities to meet their goals recommended solutions ranging from transportation assistance to improved program coordination and referral systems, and reduced stigma in help-seeking for mental health needs. Limited access to mental health and health care specialists was also cited as a barrier. A public input session was held during Joining Forces with approximately 22 family members, partner staff, and agency representatives to learn more about how the priorities of health equity, access to quality health care, and improved mental and behavioral health were perceived and could be more successfully operationalized by Title V. Results and ideas were compiled and will be shared with the Title V leadership team, which includes MCH, CSHCN and Oklahoma Family Network Staff. The information will also be shared with program staff to inform their revision process for the Title V State Action Plan table.

The MCH communication campaign (streaming TV, streaming radio, internet and Facebook ads) highlighting a variety of topics, such as maternal health, child health clinics, teen pregnancy prevention, infant safety, drowning prevention, and bullying prevention was launched to educate and engage the public. Information gleaned from the campaign and its successes and challenges will also be used to inform our MCH priorities and strategies moving forward.

III.G. Technical Assistance

At this time, Oklahoma is not requesting technical assistance for MCH or CSHCN.

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 - Title V Bio Sketches OK.pdf

Supporting Document #02 - CSHCN MOA FFY22 signed.pdf

Supporting Document #03 - Acronyms_2022_OK.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - OK Organization Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oklahoma

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,310,479	
A. Preventive and Primary Care for Children	$ 2,412,458	(32.9%)
B. Children with Special Health Care Needs	$ 2,193,145	(30%)
C. Title V Administrative Costs	$ 731,047	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,336,650	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,482,860	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 5,482,860	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,684,317		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,793,339	
9. OTHER FEDERAL FUNDS 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)	$ 7,737,047	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 20,530,386	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
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) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 619,805
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) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 125,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,072,222
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,660,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,215,434 (FY 21 Federal Award: $ 7,310,479)		$ 7,310,479	
A. Preventive and Primary Care for Children	$ 2,525,402	(35%)	$ 2,303,258	(31.5%)
B. Children with Special Health Care Needs	$ 2,164,631	(30%)	$ 2,359,205	(32.2%)
C. Title V Administrative Costs	$ 721,542	(10%)	$ 564,986	(7.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,411,575		$ 5,227,449	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,411,576		$ 6,193,837	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 1,082,489	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 5,411,576		$ 7,276,326	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,684,317				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,627,010		$ 14,586,805	
9. OTHER FEDERAL FUNDS 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)	$ 8,147,585		$ 7,506,294	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 20,774,595		$ 22,093,099	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 655,696	$ 661,136
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500	$ 160,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	$ 100,000	$ 100,136
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 5,000,000	$ 5,000,000
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) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,134,389	$ 1,485,002

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Actual administrative costs expended at OKDHS were less than 10% for management of the CSHCN program. As a result, additional funds were able to be expended by OKDHS on CSHCN services.	
2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: OSDH policy is to budget at the required grant match amount in the application. Actual match expenditures were greater than the match requirement.	
3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Funds are based on Contractor contributions, which can change from year to year and are not required anymore for some categories.	

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 529,481	$ 558,774
2. Infants < 1 year	$ 1,444,348	$ 1,524,256
3. Children 1 through 21 Years	$ 2,412,458	$ 2,303,258
4. CSHCN	$ 2,193,145	$ 2,359,205
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 6,579,432	$ 6,745,493

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 96,095	$ 144,847
2. Infants < 1 year	$ 1,196,395	$ 1,430,265
3. Children 1 through 21 Years	$ 2,362,749	$ 3,862,906
4. CSHCN	$ 1,827,620	$ 1,838,307
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 5,482,859	$ 7,276,325
Federal State MCH Block Grant Partnership Total	$ 12,062,291	$ 14,021,818

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 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 1,629,284	$ 1,922,543
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 401,269	$ 411,268
B. Preventive and Primary Care Services for Children	$ 10,000	$ 4,155
C. Services for CSHCN	$ 1,218,015	$ 1,507,120
2. Enabling Services	$ 2,092,733	$ 1,899,474
3. Public Health Services and Systems	$ 3,588,462	$ 3,488,462
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		$ 13,842
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 1,461,898
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 31,380
Laboratory Services		$ 415,423
Direct Services Line 4 Expended Total		$ 1,922,543
Federal Total	$ 7,310,479	$ 7,310,479

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 1,881,187	$ 2,496,530
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 930,804	$ 1,235,273
B. Preventive and Primary Care Services for Children	$ 93,668	$ 124,307
C. Services for CSHCN	$ 856,715	$ 1,136,950
2. Enabling Services	$ 2,961,940	$ 3,930,802
3. Public Health Services and Systems	$ 639,733	$ 848,993
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		$ 10,442
Physician/Office Services		$ 538,085
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 1,102,835
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 23,673
Laboratory Services		$ 821,495
Direct Services Line 4 Expended Total		$ 2,496,530
Non-Federal Total	$ 5,482,860	$ 7,276,325

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: 47,617 **Data Source Year: 2020**

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
Phenylketonuria	47,617 (100.0%)	5	4	3 (75.0%)
Congenital Hypothyroidism	47,617 (100.0%)	83	51	51 (100.0%)
Galactosemia	47,617 (100.0%)	5	0	0 (0%)
Sickle Cell Disease	47,617 (100.0%)	16	16	16 (100.0%)
Congenital Adrenal Hyperplasia	47,617 (100.0%)	5	4	4 (100.0%)
Biotinidase Deficiency	47,617 (100.0%)	8	7	7 (100.0%)
Cystic Fibrosis	47,617 (100.0%)	8	8	8 (100.0%)
Sickle Cell Trait	47,617 (100.0%)	210	210	0 (0.0%)
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	47,617 (100.0%)	7	0	0 (0%)
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	47,617 (100.0%)	6	2	2 (100.0%)
Short-Chain Acyl-CoA Dehydrogenase Deficiency/Glutaric Aciduria Type II	47,617 (100.0%)	13	10	10 (100.0%)

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	47,617 (100.0%)	7	2	2 (100.0%)
Tyrosinemia	47,617 (100.0%)	8	0	0 (0%)
Proprionic/Methylmalonic Acidemia	47,617 (100.0%)	7	0	0 (0%)
Glutaric Aciduria Type I	47,617 (100.0%)	5	4	4 (100.0%)
3-methylcrotonyl-CoA carboxylase (3MCC) deficiency (infant/mother); 3-hydroxy-3-methylglutaryl (HMG)	47,617 (100.0%)	2	0	0 (0%)
Carnitine Palmitoyltransferease I Deficiency	47,617 (100.0%)	4	0	0 (0%)
Carnitine Uptake Defect	47,617 (100.0%)	3	0	0 (0%)
Homocystinuria	47,617 (100.0%)	2	2	2 (100.0%)
Isovaleric Acidemia	47,617 (100.0%)	3	1	1 (100.0%)
Maple Syrup Urine Disease	47,617 (100.0%)	1	0	0 (0%)
Carnitine Acylcarnitine Translocase Deficiency (CACT)	47,617 (100.0%)	3	0	0 (0%)
Malonic Aciduria	47,617 (100.0%)	3	0	0 (0%)
Severe Combined Immunodeficiency	47,617 (100.0%)	8	1	1 (100.0%)

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:	**2021**
	Column Name:	**Aggregate Data Not Available Notes**
	Field Note: Data provided for individual conditions. Source: OSDH, Screening and Special Services	
2.	**Field Name:**	**Phenylketonuria - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: Rather than PKU, one case was diagnosed as benign hyperphenylalinemia which does not requirement treatment.	
3.	**Field Name:**	**Sickle Cell Trait - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: Sickle cell trait individuals are identified as carrier 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.	

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 2021

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	48,100	50.8	0.0	45.4	3.8	0.0
2. Infants < 1 Year of Age	48,100	50.8	0.0	45.4	3.8	0.0
3. Children 1 through 21 Years of Age	72,682	32.2	0.0	62.2	5.6	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,355	35.1	0.0	50.0	9.4	5.5
4. Others	475	24.9	0.0	66.5	8.6	0.0
Total	169,357					

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	47,623	No	74,555	80.0	59,644	48,100
2. Infants < 1 Year of Age	46,092	No	48,100	100.0	48,100	48,100
3. Children 1 through 21 Years of Age	1,120,765	Yes	1,120,765	30.0	336,230	72,682
3a. Children with Special Health Care Needs 0 through 21 years of age^	274,818	Yes	274,818	12.0	32,978	3,355
4. Others	2,811,343	Yes	2,811,343	5.0	140,567	475

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: Number reflects the count of women delivering a live birth in Oklahoma in 2020. Primary source of coverage obtained from payment source on birth certificate. It is not possible to report on the percent covered under Title XXI.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: Number reflects the count of resident live births delivered in 2020. All births occurring in the state are subject to newborn metabolic and hearing screening. Source: Oklahoma Vital Statistics, 2020.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: Percentage reflects the coverage of Oklahoma's children 1-21 through MCH Title V programs - Period of Purple Crying, The Oklahoma Toddler Survey, Youth Risk Behavior Survey, teen pregnancy prevention, Personal Responsibility Education Program, school health programs, child safety seat installations, poison control hotline calls.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: 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). 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:	**2021**
	Field Note: MCH Title V programs provide services to small percentage of individuals through maternity services and males seeking family planning services at county health departments.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**
	Field Note: Pregnant Women: Reflects those reported on Form 5a plus women estimated to have received non-direct care services related to postpartum screening, postpartum visits, and pregnancy tests.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2021**
	Field Note: Pregnant Women: Reflects those reported on Form 5a plus women estimated to have received non-direct care services related to postpartum screening, postpartum visits, and pregnancy tests.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**
	Field Note: With funding for newborn hearing and metabolic screening, Becoming Baby-Friendly Hospital project, infant safe sleep efforts, Oklahoma MCH covers 100% of all infants in the state.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: With funding for newborn hearing and metabolic screening, Becoming Baby-Friendly Hospital project, infant safe sleep efforts, Oklahoma MCH serves 100% of infants in the state.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Percentage reflects the coverage of Oklahoma's children 1-21 through MCH Title V programs - Period of Purple Crying, TOTS, YRBS, teen pregnancy prevention, PREP, school health programs, child safety seat installations, poison control hotline calls, and broader education and outreach activities.	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

	Field Note: 3,355 children received direct/enabling services from one of our contracted partner agencies, including Oklahoma Family Network, Sooner SUCCESS, Oklahoma Family Support 360° Center, Oklahoma Infant Transition Program, Sickle Cell Clinic, Family Partners and JD McCarty Center. Information obtained from our DHS Data Survey as well as partner data. 9,858 children were indirectly served (population based) through 370 separate events (i.e. training events, public education, conference, etc.) from one of our contract partner agencies (listed above). This would be population based services. 926 children received enabling services through TEFRA with OHCA. There were 17,827 children receiving blind/disabled services in Oklahoma, per OHCA September 2021 Fast Facts. In all, 31,966 children received direct, enabling, or population-based services.	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**
	Field Note: add note for flag	

Data Alerts:

1.	Pregnant Women Denominator is greater than or equal to 110% of the Pregnant Women Reference Data. Please double check and justify with a field note.
2.	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 2021

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	47,611	28,343	4,801	7,602	5,198	1,667	0	0	0
Title V Served	47,611	28,343	4,801	7,602	5,198	1,667	0	0	0
Eligible for Title XIX	27,138	16,155	2,737	4,333	2,963	950	0	0	0
2. Total Infants in State	96,746	57,755	9,733	15,370	10,648	3,240	0	0	0
Title V Served	72,560	43,316	7,300	11,528	7,986	2,430	0	0	0
Eligible for Title XIX	59,499	35,519	5,986	9,453	6,548	1,993	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2021**
	Column Name:	**Total**

Field Note:
Numbers reflect live births for the years 2019 and 2020. Census counts of infants < 1 year of age underestimate this population. Birth data used as an approximation of population size. 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	2023 Application Year	2021 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) 840-9396
5. Number of Calls Received on the State MCH "Hotline"		138,436

B. Other Appropriate Methods	2023 Application Year	2021 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"		128,278
3. State Title V Program Website Address	https://www.ok.gov/health/Family_Health/Maternal_and_Child_Health_Service/index.html	https://www.ok.gov/health/Family_Health/Maternal_and_Child_Health_Service/index.html
4. Number of Hits to the State Title V Program Website		2,462
5. State Title V Social Media Websites	https://www.facebook.com/OKMaternalAndChildHealth/	https://www.facebook.com/OKMaternalAndChildHealth/
6. Number of Hits to the State Title V Program Social Media Websites		378

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	Title V MCH Director
Address 1	123 Robert S Kerr
Address 2	STE 1702
City/State/Zip	Oklahoma City / OK / 73102
Telephone	(405) 301-1027
Extension	
Email	joycem@health.ok.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Carla McCarrell-Williams
Title	Title V CSHCN Director
Address 1	2400 N Lincoln
Address 2	
City/State/Zip	Oklahoma City / OK / 73105
Telephone	(580) 471-1990
Extension	
Email	Carla.McCarrell-Williams@okdhs.org

3. State Family or Youth Leader (Optional)	
Name	Joni Bruce
Title	Executive Director, Oklahoma Family Network
Address 1	PO Box 21072
Address 2	
City/State/Zip	Oklahoma City / OK / 73156-1072
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 2023

No.	Priority Need
1.	Reduce infant mortality
2.	Improve the health of reproductive age individuals
3.	Improve access to social workers and support systems throughout the state
4.	Improve quality health education for children and youth
5.	Improve the mental and behavioral health of the MCH population
6.	Improve access to family-centered programs via family support navigators
7.	Increase quality health care access for the MCH population
8.	Increase health equity for the MCH population

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 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
2020	75.8 %	0.2 %	35,478	46,801
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**
2019	68.8	3.9	312	45,356
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
2016_2020	23.7	3.1	59	249,372
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
2020	8.4 %	0.1 %	3,972	47,567
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
2020	11.2 %	0.1 %	5,316	47,588
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
2020	30.9 %	0.2 %	14,707	47,588
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
2020/Q3-2021/Q2	2.0 %			
2019/Q4-2020/Q3	2.0 %			
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
2019	6.6	0.4	326	49,289
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
2019	7.0	0.4	344	49,143
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
2019	4.4	0.3	215	49,143
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**
2019	2.6	0.2	129	49,143
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**
2019	246.2	22.4	121	49,143
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
2019	154.7	17.8	76	49,143
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
2019	6.3	0.4	286	45,316
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
2019_2020	12.3 %	1.2 %	110,765	902,101
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**
2020	22.6	2.2	107	474,015
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
2020	47.0	3.0	252	535,810
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
2018_2020	16.6	1.5	132	793,980
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
2018_2020	17.8	1.5	141	793,980
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
2019_2020	23.5 %	1.5 %	223,770	951,321
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
2019_2020	15.5 %	2.5 %	34,757	223,770
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
2019_2020	3.7 %	0.8 %	28,955	783,111
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
2019_2020	10.5 %	1.1 %	81,361	776,876
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
2019_2020	56.5 %	4.8 %	68,624	121,524
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
2019_2020	88.1 %	1.4 %	837,247	950,268
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
2019_2020	18.7 %	2.4 %	75,451	403,680
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
2017	69.9 %	4.0 %	35,000	50,000
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
2020_2021	49.0 %	1.9 %	442,305	902,663
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
2020	65.5 %	3.1 %	176,097	268,886
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**
2020	83.8 %	2.5 %	225,367	268,886
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
2020	80.0 %	2.7 %	215,132	268,886
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
2020	25.0	0.4	3,218	128,759
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
2018	15.8 %	1.4 %	7,353	46,567
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
2019_2020	2.3 %	0.5 %	22,023	947,636
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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				71.1	71.6
Annual Indicator			69.7	70.3	71.1
Numerator			471,074	463,707	465,393
Denominator			675,608	659,936	654,197
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS 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 with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	73.0	74.5	76.0	77.5

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	77.4	79.8	77.4	83.4	79.3
Annual Indicator	79.2	75.9	82.2	77.7	82.1
Numerator	41,230	38,194	38,328	34,343	40,689
Denominator	52,032	50,306	46,652	44,223	49,582
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	80.8	82.5	84.1	85.8

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	16	21.7	22.2	29.6	24.2
Annual Indicator	21.3	21.6	29.6	23.7	24.7
Numerator	10,883	10,756	13,540	10,126	11,666
Denominator	51,056	49,712	45,739	42,737	47,187
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	24.7	25.2	25.7	26.2

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	76.9	82	79.1	80.7	79.2
Annual Indicator	81.2	77.6	77.6	77.6	81.6
Numerator	40,173	36,090	36,090	36,090	37,866
Denominator	49,458	46,523	46,523	46,523	46,392
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2017	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	80.7	82.3	84.0	85.7

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**	**2021**
Annual Objective		39.9	40.7	41.5
Annual Indicator	39.2	39.2	39.2	38.3
Numerator	17,658	17,658	17,658	17,190
Denominator	45,065	45,065	45,065	44,880
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.4	43.2	44.1	44.9

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**	**2021**
Annual Objective		41.6	42.4	43.2
Annual Indicator	40.8	40.8	40.8	43.7
Numerator	18,485	18,485	18,485	19,921
Denominator	45,328	45,328	45,328	45,571
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	44.1	45.0	45.9	46.8

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**	**2021**
Annual Objective			28.1
Annual Indicator	31.4	27.5	29.9
Numerator	93,110	89,475	96,949
Denominator	296,779	325,093	324,556
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	28.6	29.2	29.8	30.4

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23.6	24.5	26.6	26.6	24.7
Annual Indicator	25.0	27.2	27.2	24.2	24.2
Numerator	44,898	49,239	49,239	43,594	43,594
Denominator	179,440	180,854	180,854	180,410	180,410
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2015	2017	2017	2019	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			26.6	26.6	24.7
Annual Indicator			20.9	20.9	17.8
Numerator			71,345	68,450	55,986
Denominator			341,223	328,275	315,365
Data Source			NSCHP	NSCHP	NSCHP
Data Source Year			2018	2018_2019	2019_2020

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**	**2021**
Annual Objective			26.6	26.6	24.7
Annual Indicator			45.0	42.7	37.4
Numerator			153,408	140,343	118,300
Denominator			341,223	328,882	315,972
Data Source			NSCHV	NSCHV	NSCHV
Data Source Year			2018	2018_2019	2019_2020

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				
2022	**2023**	**2024**	**2025**	
Annual Objective	25.2	25.7	26.2	26.7

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)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		76	74.9	75	81.9
Annual Indicator	75.2	73.5	73.5	80.3	74.3
Numerator	229,371	225,282	225,282	252,941	236,394
Denominator	304,952	306,365	306,365	314,972	318,014
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	83.5	85.2	86.9	88.7

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**	**2021**
Annual Objective			42.4
Annual Indicator	44.0	41.6	43.6
Numerator	95,790	91,264	97,601
Denominator	217,565	219,136	223,770
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	43.3	44.1	45.0	45.9

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		11.5	16.7	22.2	29.1
Annual Indicator	11.3	16.4	21.8	28.5	37.0
Numerator	10,795	14,252	18,388	26,312	31,935
Denominator	95,220	87,022	84,532	92,174	86,423
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	29.7	30.2	30.8	31.5

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**	**2021**
Annual Objective			14.4	17.5	17.9
Annual Indicator	12.5	14.2	17.2	17.2	15.2
Numerator	26,234	31,388	41,549	40,910	35,470
Denominator	210,453	220,834	241,098	237,455	233,632
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	18.2	18.6	19.0	19.4

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	17.4	20.8	24.1	22.3	23
Annual Indicator	26.3	28.8	29.5	25.2	25.2
Numerator	41	44	44	37	37
Denominator	155,953	152,623	149,158	146,561	146,561
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2015-2017	2016-2018	2017-2019	2018-2020	2018-2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	24.8	24.4	24.0	23.6

Field Level Notes for Form 10 SPMs:

1.	**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. These data reflect: OK residents only who were female, ages 10-59, Manner=Not accidental, Pregnancy checkbox=while pregnant or within 42 days or unknown pregnancy, with ICD codes = O00-O95, O98-O99, A34. Including 'unknown' pregnancy checkbox.	
2.	**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. These data reflect: OK residents only who were female, ages 10-59, Manner=Not accidental, Pregnancy checkbox=while pregnant or within 42 days or unknown pregnancy, with ICD codes = O00-O95, O98-O99, A34. Including 'unknown' pregnancy checkbox. Annual Objectives have been revised to reflect current status of the maternal mortality rate.	
3.	**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. These data reflect: OK residents only who were female, ages 10-59, Manner=Not accidental, Pregnancy checkbox=while pregnant or within 42 days or unknown pregnancy, with ICD codes = O00-O95, O98-O99, A34. Including 'unknown' pregnancy checkbox.	
4.	**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 2018-2020. These data reflect: OK residents only who were female, ages 10-59, Manner=Not accidental, Pregnancy checkbox=while pregnant or within 42 days or unknown pregnancy, with ICD codes = O00-O95, O98-O99, A34. Including 'unknown' pregnancy checkbox. Annual Objectives have been revised to reflect current status of the maternal mortality rate.	
5.	**Field Name:**	**2021**
	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 2018-2020. Data for reporting year 2021 are not yet available, previous year's data used as an estimate.	

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

Measure Status:	Active				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	7.3	7.5	7	6.7	6.5
Annual Indicator	7.7	7.1	7	6	7
Numerator	387	352	344	285	336
Denominator	50,214	49,787	49,143	47,617	47,978
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	6.9	6.7	6.6	6.5

Field Level Notes for Form 10 SPMs:

None

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					
	2017	2018	2019	2020	2021
Annual Objective	61.9	63.2	64.2	57.7	57.5
Annual Indicator	60.7	62.9	56.6	56.4	56.5
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	2016	2017	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	58.7	59.9	61.0	62.3

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					
	2017	2018	2019	2020	2021
Annual Objective	95	100	100	105	100
Annual Indicator	90	95	95	95	95
Numerator					
Denominator					
Data Source	PHOCIS	PHOCIS	PHOCIS	PHOCIS	PHOCIS
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	105.0	110.0	115.0	120.0

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	2021
Annual Objective			2,055
Annual Indicator	1,707	1,957	1,957
Numerator			
Denominator			
Data Source	Breastfeeding Hotline	Breastfeeding Hotline	Breastfeeding Hotline
Data Source Year	FY2019	FY2020	FY2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2,158.0	2,265.0	2,378.0	2,497.0

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					
	2017	2018	2019	2020	2021
Annual Objective	15.6	16	23.3	34.7	36.4
Annual Indicator	15.2	22.6	33.4	30.3	30.6
Numerator	7,598	11,247	15,926	14,439	14,702
Denominator	50,008	49,787	47,664	47,617	47,978
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	38.2	40.1	42.1	44.2

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 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.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 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, 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					
	2017	2018	2019	2020	2021
Annual Objective	70.6	71.2	75.3	80.6	82.2
Annual Indicator	69.5	73.8	81.7	80.8	75.7
Numerator	34,913	36,756	38,948	38,484	36,342
Denominator	50,214	49,787	47,664	47,617	47,978
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	77.2	78.8	80.3	81.9

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 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.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 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	2021
Annual Objective			110
Annual Indicator	125	101	112
Numerator			
Denominator			
Data Source	Child and Adolescent Health, MCH program data	Child and Adolescent Health, MCH program data	Child and Adolescent Health, MCH program data
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	120.0	130.0	140.0	150.0

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					
	2017	2018	2019	2020	2021
Annual Objective	4	5	6	7	5
Annual Indicator	3	1	2	1	1
Numerator					
Denominator					
Data Source	MCH Training Log	MCH Training Log	MCH Training Log	MCH Training Log	MCH Training Log
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	5.0	7.0	9.0	11.0

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					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	4,300	4,500	4,400	4,900	4,400
Annual Indicator	4,389	4,204	4,651	4,092	459
Numerator					
Denominator					
Data Source	MCH PREP Program	MCH PREP Program	MCH PREP Program	MCH PREP Program	MCH PREP Program
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	4,700.0	5,000.0	5,300.0	5,600.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 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: 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: Reported figure reflects the number of youth served during the period August 1, 2018 through July 1, 2019.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This was at the height of COVID. OCCHD did not implement any curriculum during this time frame and THD had a small caseload compared to previous years and was 100% virtual.	

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	2021
Annual Objective			42.4
Annual Indicator	39.7	41.6	43.6
Numerator			
Denominator			
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	43.3	44.1	45.0	45.9

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					
	2017	2018	2019	2020	2021
Annual Objective		170	170	175	80
Annual Indicator	164	164	164	77	31
Numerator					
Denominator					
Data Source	Sooner Success	Sooner Success	Sooner Success	Sooner Success	Sooner Success
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	90.0	95.0	100.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 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: 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: 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. Targets revised based on current reporting.	

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 **Unit Number:** 100,000 **Numerator:** The number of deaths related to or aggravated by pregnancy and occurring within 42 days of the end of the pregnancy **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 **Unit Number:** 1,000 **Numerator:** The number of deaths to infants from birth through 364 days of age **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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of families who are able to access services for their child with behavioral health needs **Denominator:** The number of families who have a child needing behavioral health services
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."

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of women served by Title V-funded breastfeeding support services</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>Number of women receiving in-person, telehealth, or telephonic breastfeeding support</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Contractor reports</td></tr>
<tr><td>Significance:</td><td>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.

Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. 2016 revision. Baby-Friendly USA, Inc.</td></tr>
</table>

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 **Unit Number:** 100 **Numerator:** The number of births occurring at Baby-Friendly hospitals **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. 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 **Unit Number:** 100 **Numerator:** The number of births occurring at birthing hospitals participating in the sleep sack program **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. 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 **Unit Number:** 1,000 **Numerator:** Number of schools **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 **Unit Number:** 100 **Numerator:** The number of trainings provided by MCH staff annually on bullying prevention **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 **Unit Number:** 10,000 **Numerator:** The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum **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. 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 **Unit Number:** 100 **Numerator:** Number of clients assisted with care coordination services from contractor reports **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 **Unit Number:** 300 **Numerator:** The number of providers who address transition to adult health care in their practice **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. Center for Health Care Transition Improvement, Maternal and Child Health Bureau and the National Alliance to Advance Adolescent Health.

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 2021

	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:

None