

**Maternal and Child
Health Services Title V
Block Grant**

Oklahoma

**FY 2016 Application/
FY 2014 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



Oklahoma State Department of Health
Creating a State of Health

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 Maternal and Child Health Services Title V Block Grant Annual Report for October 1, 2013, thru September 30, 2014, and Annual Plan for October 1, 2015, thru September 30, 2016.

For further information regarding this application, please contact Joyce Marshall, Director, Maternal and Child Health Service at 405-271-4480 or JoyceM@health.ok.gov.

Sincerely,

Terry Cline, Ph.D.
Commissioner
Secretary of Health and Human Services

Terry L. Cline, PhD
Commissioner of Health
Secretary of Health
and Human Services

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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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

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 35 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. Every state has a Title V Block Grant and is required to write annual reports and complete a statewide needs assessment every five years. For 2014, 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 Department of Human Services (DHS), in close partnership with the Oklahoma Family Network (OFN), assuring families have a voice in the services they receive.

Emergent Needs and Priority Selection:

Beginning in the Fall of 2013, MCH (Maternal and Child Health Service at OSDH) and CSHCN (Children with Special Health Care Needs Program at DHS) released a public input survey, with the help of OFN, to identify emergent needs for the state of Oklahoma's MCH population. CSHCN also sought input from Sooner SUCCESS on the needs of Medicaid-eligible CYCHSN (children and youth 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. Tribal listening sessions were conducted with seven of the largest tribal nations in the state and their health care providers. Coalition meetings and partner meetings were also used to gather information on needs and the capacity of the state to serve the MCH population.

MCH, CSHCN, and OFN synthesized and discussed the information received from the public input survey, tribal listening sessions, coalition and partnership meetings, and the data analysis to establish the following Title V priorities for 2016-2020. Two priorities are continued from the 2011-2015 Title V Needs Assessment, infant mortality and unplanned pregnancy; the others are new (See Table 1). The 2016-2020 priorities are those most likely to "move the needle" in improving the health of the Oklahoma MCH population.

Table 1. Oklahoma's Title V Priorities for the 2016-2020 Title V Block Grant	
Reduce infant mortality	<i>Continued priority</i>
Reduce the incidence of preterm and low birth weight births	<i>New priority</i>
Reduce the incidence of unintentional injury among children	<i>New priority</i>
Reduce the incidence of suicide among adolescents	<i>New priority</i>
Reduce health disparities	<i>New priority</i>
Improve the transition to adult health care for children and youth with special health care needs	<i>New priority</i>
Reduce teen pregnancy	<i>New priority</i>
Reduce unplanned pregnancy	<i>Continued priority</i>
Improve the mental and behavioral health of the MCH population	<i>New priority</i>
Reduce the prevalence of chronic health conditions among childbearing age women	<i>New priority</i>

Development of the 5-year State Action Plan:

The MCH Title V Block Grant is arranged by population domains. The six domains include Maternal/Women's Health, Infant and Perinatal Health, Child Health, Adolescent Health, Children and Youth with Special Health Care Needs (CYSHCN), and Cross-cutting or Life Course. Table 2 highlights the National Performance Measures which were selected for Oklahoma and the rationale for selecting each particular measure. MCH and CSHCN staff then created a 5-year State Action Plan (available in the narrative section of the block grant application) to impact these measures. Each objective and strategy outlined in the State Action Plan was created to assist the program areas in impacting their designated performance measure. Over the next year, Oklahoma Title V will work to identify State Performance Measures to further address identified priority needs and create Evidence-Based Strategy Measures to facilitate work on the National Performance Measures.

Table 2. National Performance Measures Selected for Oklahoma, by Population Domain		
Domain	National Performance Measures	Priorities Impacted and Rationale
Maternal	Percent of women with a past year preventive visit	MCH Priorities Impacted: Chronic Disease, Family Planning, Preterm and LBW, Health Disparities, Teen Pregnancy, Infant Mortality Rationale: Impacts 6 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and 4 statewide Oklahoma Health

		<p>improvement plan priority flagship and goal areas (<i>Children's Health: Improve Maternal and Infant Health Outcomes</i> along with additional flagship priority areas in relation to Smoking, Obesity and Behavioral Health).</p>
Perinatal	<p>Percent of infants who are A) ever breastfed and B) Percent of infants breastfed exclusively through 6 months</p>	<p>MCH Priorities Impacted: Infant Mortality, Chronic Disease, Preterm and LBW, Health Disparities</p> <p>Rationale: Impacts 4 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children's Health: Improve Maternal and Infant Health Outcomes</i> along with priority flagship area, Obesity).</p>
	<p>Percent of infants placed to sleep on their backs</p>	<p>MCH Priorities Impacted: Infant Mortality, Unintended Injury, Preterm and LBW, Health Disparities</p> <p>Rationale: Impacts 4 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children's Health: Improve Maternal and Infant Health Outcomes</i>).</p>
Child	<p>Rate of injury-related hospital admissions per population ages 0 through 19 years</p>	<p>MCH Priorities Impacted: Unintended Injury, Health Disparities, Infant Mortality</p> <p>Rationale: Impacts 3 of 10 Title V/MCH Priorities as listed above and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children's Health: Improve Child and Adolescent Health Outcomes</i>).</p>
Adolescent	<p>Percent of adolescents, ages 12 through 17 years, who are bullied</p>	<p>MCH Priorities Impacted: Suicide Prevention, Behavioral and Mental Health, Health Disparities</p> <p>Rationale: Impacts 3 of 10 Title V/MCH Priorities as listed above and 2 statewide Oklahoma Health Improvement Plan priority flagships and goal areas (<i>Behavioral Health: Reduce Suicide Deaths and Children's Health: Improve Child and Adolescent Health Outcomes</i>).</p>
		<p>MCH Priorities Impacted: Suicide Prevention, Unintended Injury, Chronic Disease, Teen Pregnancy, Behavioral and Mental Health, Health Disparities</p>

	Percent of adolescents with a preventive services visit in the last year	Rationale: Impacts 6 of 10 Title V/MCH Priorities as listed above and 3 statewide Oklahoma Health Improvement Plan priority flagships and goal areas (<i>Tobacco Use: Reduce Adolescent Smoking Prevalence; Obesity: Reduce Adolescent Obesity Prevalence; and Children's Health: Improve Child and Adolescent Health Outcomes</i>).
CSHCN	Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	MCH Priorities Impacted: Transition to Adulthood, Health Disparities, Behavioral and Mental Health Rationale: Impacts 3 of 10 Title V/ MCH Priorities as listed above and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children's Health: Improve Child and Adolescent Health Outcomes</i>).
Crosscutting	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes	MCH Priorities Impacted: Infant Mortality, Chronic Disease, Preterm and LBW, Mental and Behavioral Health, Health Disparities Rationale: Impacts 5 of 10 Title V/MCH Priorities as listed above and 2 statewide Oklahoma Health Improvement Plan priority flagship and goal areas (<i>Tobacco Use: Adult Smoking Prevalence; and Children's Health: Improve Maternal and Infant Health Outcomes and Improve Child and Adolescent Health Outcomes</i>).

Major Accomplishments and Plans for the Coming Year:

Below is a summary of some of the major accomplishments and planned activities for the coming year by population domain.

Maternal/Women:

Accomplishments:

- Partnered with the Oklahoma Health Care Authority (OHCA, the state's Medicaid agency) to develop customized Text4Baby messages with Oklahoma specific programs and resources. Oklahoma won the 2014 Text4Baby enrollment contest in the medium state category.
- Assisted, through the county health departments, over 50,000 women with pregnancy testing and family planning services, linking women to appropriate services or assisting with Medicaid (SoonerCare) enrollment as needed.
- Produced and aired public service announcements (PSAs) on the importance of being healthy before pregnancy and on developing a life plan.

Plans:

- Continue to work with the OHCA to provide family planning services to low-income females and males of reproductive age not eligible for Medicaid-covered services, and help those who are eligible to enroll in

Medicaid.

- Encourage family planning providers to treat every visit as a preconception health visit and provide targeted preconception health counseling to every client using the Women's Health Assessment tool.
- Participate in the Association of Maternal and Child Health Programs (AMCHP) Every Mother Initiative and the Alliance for Innovation on Maternal Health (AIM) team, to improve data collection and develop and implement public health policy and strategies to prevent maternal death and improve health outcomes for mothers after and between pregnancies.
- Use the work from the Collaborative for Innovation and Improvement Network (CoIIN) strategy team on preconception health to inform future activities, and partner with OHCA and March of Dimes in new CoIINs to provide preconception/interconception care and education in the community and increase access to long acting reversible contraception.

Perinatal:

Accomplishments:

- Provided funding for the Oklahoma Mothers' Milk Bank (OMMB) and the Oklahoma Breastfeeding Hotline (OBH). Promoted breastfeeding duration and the establishment of Baby-Friendly Hospitals through the Hospital Breastfeeding Education Project (HBEP) and Becoming Baby-Friendly Projects in Oklahoma.
- Supported the *Every Week Counts* learning collaborative focused on providing birthing hospitals with support to reduce elective deliveries prior to 39 weeks. Ninety percent of Oklahoma birthing hospitals participated, resulting in a 94% decrease from baseline data in 2011 for scheduled deliveries prior to 39 weeks gestation.
- Increased the number of infants sleeping on their backs from 64.9% in 2009 to 72.6% in 2012.
- Reduced the preterm birth rate to 12.8%, moving up to a "C" grade on the March of Dimes grade card.
- Ensured the availability of tools and information developed by the Association of Women's Health, Obstetric and Neonatal Nurses and March of Dimes that could be readily adapted and disseminated.
- Oklahoma's hospitals saw a 30% increase in score on the Maternity Practices in Infant Nutrition and Care (mPINC) Survey, from 55 in 2009 to 71 in 2013.

Plans:

- Support newborn screening activities, including the "Every Baby Counts" project to enhance the process of newborn screening specimen collection by hospitals and submission to OSDH.
- Promote breastfeeding initiation and duration through joint efforts of the Breastfeeding Friendly Worksite Initiative, OMMB, OBH, HBEP, and Becoming Baby-friendly in Oklahoma. MCH will continue to work with partners to promote the Baby Café Project, focused on improving access to professional and peer support in African American, Native American, and Hispanic communities.
- Coordinate with the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) Preterm Birth initiative, to work with hospitals to appropriately screen and triage women who present with signs and symptoms of preterm labor; ensure the use of progesterone therapy for appropriate candidates to prevent preterm births; finalize formal designation for neonatal levels of care for Oklahoma hospitals; and, review new guidelines released for formal designation of hospitals related to maternal levels of care.

Child:

Accomplishments:

- Partnered with Safe Kids Oklahoma and Safe Kids Tulsa Area to support the prevention of unintentional child injuries.
- Presented distracted driving and Graduated Driver's Licensing information to communities using the Adolescent Health Specialists in county health departments.
- Provided outreach and education to clients and communities about available health insurance coverage for

children, including Medicaid (SoonerCare) enrollment and referrals to online enrollment at www.healthcare.gov.

- Continued to be involved in the Oklahoma Health Improvement Plan (OHIP) Children's Health Work Group.

Plans:

- Fund the 2015-2016 school year Oklahoma Oral Health Needs Assessment among Third Grade Children.
- Continue the Infant Injury Prevention Work Group, as part of the statewide infant mortality initiative, *Preparing for a Lifetime, It's Everyone's Responsibility*. MCH will continue to provide leadership for the work group.
- Maintain a supportive relationship with Injury Prevention Service (IPS) and Safe Kids Oklahoma, including car seat funding for IPS and designating MCH staff to become Child Passenger Safety (CPS) Technicians.
- Train and identify partners to provide education in local communities on Graduated Driver's Licensing, distracted driving, seatbelt use, and alcohol use while driving as they relate to children and youth.

Adolescent:

Accomplishments:

- Maintained five state-funded adolescent pregnancy prevention projects in local county health departments and continued administrating and monitoring the Personal Responsibility Education Program (PREP) grant for Oklahoma City and Tulsa County Health Departments.
- Reduced teen pregnancy from 40.8 per 1,000 females in 1994 to 20.5 in 2013.
- Provided family planning clinical services to adolescents in county health department and contract clinics.
- Served on the planning committee for the 2014 Annual Suicide Prevention Conference in May 2014. One staff member received training to become a *Question, Persuade, and Refer* (QPR) instructor.
- Provided presentations, educational materials, and fact sheets for several conferences to audiences of school administrators, teachers, counselors, and community members. Shared data on adolescent tobacco use, overweight and obesity in adolescents, and student hopelessness and suicidality.
- Funded ten rural district school nurses through a contractual agreement with the Oklahoma State Department of Education (OSDE).

Plans:

- Collaborate with local county health departments to establish, support, and sustain local Public Health Youth Councils to identify issues within their communities affecting adolescents and work with public health professionals to implement solutions.
- Conduct trainings with others who work with youth in evidence-based methods such as QPR, Positive Youth Development (PYD), and Life Course Perspective.
- Fund the ten rural school health nurses to continue school-based wellness programs.
- Partner with the Anti-Bullying Collaboration to provide training and staff OSDE committee updating bullying prevention curriculum.
- Ensure MCH-funded school health education and promotion programs will continue to provide age and grade appropriate nutrition education, promote physical activity, and assist in monitoring body mass index (BMI) of students attending those schools.

CYSHCN:

Accomplishments:

- Continued funding the Oklahoma Infant Transition Program, a program which helps families with infants in the neonatal intensive care unit make the transition from the hospital to home.
- Provided formula, adaptive equipment, medical care, and diapers to CYSHCN with financial need that was not otherwise covered by Title XIX (or Medicaid funds).
- Participated in the Joining Forces Conference, held by OFN, to bring families and professionals together to

work to improve service systems for CYSHCN and to promote Life Course Perspective understanding and activities.

- Funded Sooner SUCCESS activities, which worked to build a comprehensive system of health and educational services in 13 counties, to meet the needs of CYSHCN and their families.
- Helped plan the 9th Annual Oklahoma Transition Institute, providing opportunities for professionals and families to learn about a variety of subjects related to transition, including developing attainable goals.
- Funded parent-to-parent support, sibling support, training, and opportunities for family leadership via OFN.

Plans:

- Continue to provide formula, adaptive equipment, medical care, and diapers to CYSHCN with financial need.
- Continue to collaborate with and support Sooner SUCCESS to develop plans to address health care transition for adolescents across the state.
- Work with the OFN to identify gaps in the provision of transition services to youth with special health care needs.

Crosscutting:

Accomplishments:

- Participated on the COLLN Smoking Cessation Strategy Team in Regions IV and VI, focused on promoting tobacco cessation among expectant mothers and their families.
- Produced and aired PSAs for radio and television that provided various rationales for quitting, the Oklahoma Tobacco Helpline (OTH) number, and information on the effect of secondhand smoke on newborns.
- Counseled family planning and pregnant clients seen at county health departments (CHDs) and contract clinics on the impact of smoking across the life course, and referred to smoking cessation resource, as needed.
- Maintained MCH data capacity in spite of two key staff vacancies, by relying on the skills and expertise of analytic staff responsible for other MCH projects.

Plans:

- Disseminate pharmacy bags to pharmacies agreeing to share information on *Preparing for a Lifetime*, Text4Baby, and the OTH. The bags feature the *Preparing for a Lifetime* logo, as well as a bottle of folic acid, and both sides of the bags display the OTH number.
- Refer clients to OTH, as needed.
- Provide training and technical assistance to CHDs and other providers on the Edinburgh Post Natal (Depression) Screen (EPNS).
- Perform economic analysis to assist in the reduction of health disparities.

Other Emergent Needs:

Emerging needs identified by MCH and CSHCN include mental and behavioral health, particularly for children, e-cigarette use, and substance use, including opioid use by pregnant women. MCH and CSHCN will monitor the prevalence of these issues and determine how to best meet needs programmatically, as appropriate.

Comments and Contact Information:

MCH, CSHCN, and OFN welcome comments and suggestions for needs and issues not identified during this Title V Needs Assessment and Block Grant Application process. The Needs Assessment is meant to be an on-going review of health needs and capacity issues across the state. It is recognized that not all needs can be addressed by Title V nor can Title V address identified needs and priorities alone. Collaboration, partnership, and working with non-traditional partners will be the only way 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 at 405-271-4480 or joycem@health.ok.gov or **Karen Hylton**, CSHCN Title V Director at 405-521-3602 or Karen.Hylton@okdhs.org.

II. Components of the Application/Annual Report

II.A. Overview of the State

Overview

Oklahoma, which is located in the South Central region of the United States, has a diverse geography with a quarter of the state covered by forests and includes four mountain ranges: the Arbuckle, the Ouachita, the Ozark Plateau, and the Wichita. 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 central portion of the state transitional prairies and woodlands give way to the Ozark and Ouachita Mountains, which stretch out in an eastward direction towards the Arkansas border. The diversity of the geography is matched by the diversity of the state's people and their life experiences. Health care access and availability, transportation options, and employment opportunities are not always consistent and vary by region of the state.

Demographics

In 2013, data from the US Census Bureau indicated Oklahoma had an estimated 3,850,568 residents, an increase of 34,788 (0.9%) from 2012, and ranked as the 28th most populous state. The state's population has increased each year since the year 2010 Census was conducted. Since that time, the population has grown in absolute terms by 91,305 representing a relative growth of 2.4%. With its 77 counties, the state spans some 69,898 square miles, ranking 20th in land area, with approximately 55 persons per square mile, and ranking 36th among all US states in population density.

Roughly positioned in the center of the 48 contiguous states, Oklahoma is bordered by six states: Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas. Oklahoma, characterized mainly as a rural state, has three large cities. Oklahoma City, the state's centrally located capitol city, is the largest of the three and is home to 590,896 residents (15.3%). Approximately 100 miles to the northeast is Tulsa, a city that accounts for 10.2% (393,709) of the state's population. Nearly 90 miles to the southwest along Interstate 44 is the city of Lawton, which has a population of 97,147, or 2.5% of the state's total population.

Approximately 60% of the Oklahoma population resides in the metropolitan statistical areas (MSAs) of Oklahoma City (1,319,677; 34.3%) and Tulsa (961,321; 25.0%). A much smaller percentage of the Oklahoma population lives in the MSA of Lawton (131,396; 3.4%). The remainder of Oklahomans resides in rural locales, smaller cities, and towns beyond the periphery of the three metropolitan centers. Recent years have seen population shifts to the more metropolitan areas.

Oklahoma is home to the largest number of federally recognized tribal governments, with 38 American Indian tribal governments and an additional tribe pending federal recognition. According to the American Indian Cultural Center and Museum, there are more languages spoken in Oklahoma today than in all of Europe. Together, the 38 federally recognized tribes have a collective impact of \$10.8 billion on Oklahoma's economy.

Age

As of 2013, approximately 25% (947,027) of the Oklahoma population was under 18 years of age. Persons aged 65 years and older comprise 14.3% of the state's population, and roughly 61% of the population was between 18 and 64 years old. The male-female ratio was almost 1:1, with slightly more females than males. Females of childbearing age (15-44 years) numbered 756,016, or about 20% of the Oklahoma population.

Race/Ethnicity

Variations exist by race and ethnicity in the primary location of residences. While the White population is spread

geographically across the state, the African American population generally resides in the metropolitan areas of Oklahoma City and Tulsa. The American Indian population has greater presence in the northeast quadrant of the state, a legacy of the US federal government tribe relocation programs of the 19th century.

Shifts in the racial and ethnic makeup of the state have occurred in the last 15 years, moving Oklahoma towards a more diverse population. As of 2013, Whites comprised 75.4% of the total Oklahoma population, down from 76.2% in 2000. American Indians experienced an increase in percent of population, from 7.9% in 2000 to 9.0% in 2013. African Americans were 7.7% of the population, with little change from 7.6% in 2000. Persons of two or more races comprised 5.8% of the state's population, up from 4.5% in 2000. Asian/Native Hawaiian and Other Pacific Islanders made up 2.2% of the population, up from 1.5% in 2000. The Hispanic ethnic group, which can be of any race, represented 9.6% of the state's population, a significant increase from 4.1% in 1999. Initially, the Hispanic population growth was isolated in many of the rural farming communities of the state, particularly in the south and southwest regions, as well as the panhandle of the state; however, more recent trends show that this population has begun to move into the larger metropolitan areas. In 2010, persons of Hispanic origin comprised 17.2% of the population of Oklahoma City and 14.1% of the population for the city of Tulsa, compared with 2000 census estimates of 10.1% and 7.2%, respectively.

Poverty

According to data from the US Bureau of Economic Analysis, Oklahoma's per capita personal income was \$43,138 in 2014, ranking 34th among all states, and was about 93% of the national average of \$46,129. Data from the U.S. Census Bureau indicate that in 2013, an estimated 16.8% of Oklahomans were living below the federal poverty level. Among females aged 15-44 years, 22.1% lived below the federal poverty level. For children aged 17 years and younger, 24.0% lived below the federal poverty level. Oklahoma continued to be a poor state, despite relatively low unemployment rates. Data from the US Census Bureau estimated that 17.7% of all Oklahomans did not have health care coverage in 2013. Also in 2013, among children under the age of 19 years and below 200% of poverty, 12.2% did not have health care coverage. For children below 200% federal poverty level with health care coverage, 25.8% were privately insured and 67.1% had government insurance.

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 major metropolitan centers, Oklahoma City and Tulsa, serve as the primary economic anchors for the state. The top employers within the state are the Department of Defense with 68,000-69,000 employees (both military and civilian), Walmart Associates, Inc. (31,000-35,000), and the State of Oklahoma (34,000). In the health care sector, INTEGRIS Health has 8,000-8,500 employees, followed by the University of Oklahoma Health Sciences Center (7,000-7,500), Saint Francis Hospital (5,500-6,000), and St. John Medical Center (5,500-6,000).

Oklahoma's real gross domestic product (GDP), the output of all goods and services produced by the economy in current dollars, totaled \$164.3 billion in 2013 (based on chained 2009 dollars), up 4.2% from \$157.37 billion in 2012. The private sector comprises 84% of Oklahoma's real GDP, with government comprising the remaining 16%. As a percentage of the GDP, industry share in the Oklahoma economy was led by natural resources and mining at 13.8%, finance, insurance, real estate, rental, and leasing (13.6%), trade (11.5%), and transportation and utilities (6.4%).

Gaming (lotteries and casinos) has become a significant contributor to the Oklahoma economy. Behind California, Oklahoma now has the second largest gaming revenue from American Indian gaming ventures. In state fiscal year (SFY) 2014, the state of Oklahoma collected \$122.6 million in tribal gaming exclusivity fees, down from \$128.1 million in 2013. As required by state statute, the exclusivity fees go to the Education Reform Revolving Fund (1017 Fund), the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), and the General

Revenue Fund (GRF). ODMHSAS receives \$250,000 annually to address remediation of gambling problems. Of the remaining fees, the 1017 Fund receives 88% and the GRF receives 12%. As of April 2015, there were 110 tribally-owned casinos operating in the state.

Data from the US Bureau of Labor Statistics for calendar year 2014 showed that annual average unemployment rates declined in all 50 states and the District of Columbia. This was the first year since 1984 in which all states and the District of Columbia had annual average declines. Oklahoma's 2014 unemployment rate was 4.5%, significantly lower than the national average of 6.2%. Annual average unemployment rates decreased from 2013 to 2014 in all 77 counties in Oklahoma. Six counties experienced a 20% or greater decrease: Alfalfa (24.2%), Major (23.5%), LeFlore (23.1%), Beaver (20.6%), Grant (20.6%), and Pontotoc (20.0%). Oklahoma's employment-population ratio, the number of working age persons who are employed divided by the total population of working age persons, was 58.1 in 2014, compared to the national average of 59.0.

Budgetary Concerns

The final SFY 2015 appropriation for the Oklahoma State Department of Health was \$60,632,476, down 3% from \$62,484,682 in FY 2014. The Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, and the Department of Human Services (DHS) had SFY 2015 budgets of \$953 million and \$674 million, respectively. The budget for the ODMHSAS was at \$338 million. Total Oklahoma Health and Human Services funding was set at \$2.2 billion, 31% of the state's budget. As of February 2015, oil prices had fallen 55% since June 2014, resulting in decreased revenues in the energy sector.

The Oklahoma Governor is required to submit an Executive Budget to the Legislature on the first Monday of each regular legislative session. On February 2, 2015, Governor Mary Fallin released her budget proposals in the State of Oklahoma Fiscal Year 2016 Executive Budget. This budget proposed increases in appropriations for the OHCA, DHS, and ODMHSAS of 2.1%, 2.4%, and 1.5%, respectively. The budget proposed neither an increase nor a decrease for the OSDH. On May 22, 2015 the Oklahoma Legislature passed the SFY 2016 budget and appropriated \$7.1 billion to fund state government. OSDH was flat funded for SFY 2016. The bill was sent to the governor for signature on May 22, 2015.

Population Health Ranking

The United Health Foundation (UHF) creates an annual report ranking each state within the US, as well as the US in comparison to other nations. The rankings are based on thirty core measures in the following areas: behaviors, policy, community and environment, clinical care, and outcomes. The UHF's report, America's Health Rankings 2014, has ranked the state of Oklahoma 46th among all US states, down two spots from 44th in 2013, but a significant drop from a ranking of 32nd in 1990. The UHF report cited three specific challenges that must be addressed if Oklahoma hopes to improve its national standing: the high prevalence of physical inactivity, low immunization coverage among children, and limited availability of primary care physicians. The report also identified areas of strength for the state; namely, the low prevalence of binge drinking, the low incidence of pertussis, and the low prevalence of low birthweight.

Oklahoma is perennially among the bottom 10 states in the UHF's health rankings. To address the state's slide and position in the national rankings over the years, the Board of Health and OSDH's Commissioner of Health, along with many external partners, launched the Oklahoma Health Improvement Plan (OHIP) in early 2010. The OHIP sets out flagship goals (e.g., tobacco use prevention, obesity reduction, and children's health) that must be given priority by OSDH program areas. Infrastructure goals that reviewed Oklahoma's public health finance, workforce development, access to care, and the effectiveness of health systems were established within the OHIP. In addition, there was a review of societal and policy integration that examined social determinants of health and health equity as well as a

recognition that the OSDH should pursue and advocate for policies and legislative reforms that maximize opportunities to improve the quality of life of Oklahoma's citizens. In 2014, OHIP 2020, the updated Oklahoma Health Improvement Plan, was released. The three original flagship issues of tobacco use, obesity, and child health were retained, but a new flagship issue was added - behavioral health. This flagship issue was added because of the known connection and interdependence between physical and mental health.

Public Health Workforce

Following a 2006 report by the Oklahoma's Health Care Industry Workforce and a subsequent follow up study in 2008, Oklahoma identified worker vacancies and projected shortages for nurses, lab technicians, physical therapists, surgical technologists, occupational therapists, pharmacists, radiology and respiratory professionals, emergency medical technicians, and chemical dependency counselors. National studies have shown that the public health workforce has: shortages of key public health personnel (e.g., epidemiologists and public health nurses); trends in insufficient number of experienced public health workers due to many approaching retirement age; inadequate incentives for recruitment and retention of qualified professionals; and insufficient preparation and orientation of students by professional education programs to the public health system.

The United Health Foundation report for 2014 has Oklahoma ranked 48th in the nation for the number of primary care physicians, 84.8 primary care physicians per 100,000 population, an increase from 78.5 in 2005 but significantly lower than the national average of 123.5. Migration of rural residents to the metropolitan centers has had a negative impact upon the availability of health care providers. Diminishing populations, rising medical liability costs, and low Medicaid reimbursement rates have influenced rural area physicians to relocate to larger cities or to restrict their practices. The net result has created a number of significant geographic gaps in obstetric and pediatric medical care across the state.

To address this low ranking, the legislature passed bills in 2013 to establish and fund new primary care residency training programs in rural and underserved areas of the state. As a result, three new residency programs with rural Oklahoma hospitals have been developed and approved. In McAlester, in southeastern Oklahoma, two programs have been established, with nine approved Family Medicine resident positions and nine Internal Medicine resident positions. One program has been established in Lawton, in southwest Oklahoma, and approved for sixteen Emergency Medicine resident positions. Another Emergency Medicine residency program was established in Norman, a university town 30 minutes south of Oklahoma City. The rural demographic of the Oklahoma population, its economic challenges, and the lack of primary care providers require that public health leaders identify new ways to assure that citizens in need of health services have access to those services.

In 2006 the state legislature authorized the Oklahoma Dental Loan Repayment Act. The Act resulted in the creation of the Oklahoma Dental Loan Repayment Program, which is designed to increase the number of dentists serving and caring for populations dependent upon the state for dental care and to make dental care accessible to underserved metropolitan and rural areas. This is accomplished by providing educational loan repayment assistance for up to a total of twenty-five Oklahoma licensed dentists for a 2 to 5 year period per dentist. All dentists who enter the program must agree to teach at the University of Oklahoma, College of Dentistry if applicable faculty positions are available, or provide dental care in a designated dental health professional shortage area. Additionally, dentists participating in shortage areas agree that a minimum of 30% of his/her patients treated during the service obligation or contract period are Medicaid recipients.

Oklahoma ranks 24th in the nation in public health funding at \$78.83 dollars per person, down from \$96.34 in 2007 and the high of \$112.86 observed in 2011. The national average of public health funding was \$90 per person. This does not include spending by county or city governments or state spending for health that is included under other spending efforts such as education.

Government

The government of Oklahoma, modeled on the US federal government, is a constitutional republic with legislative, executive, and judicial branches. Oklahoma has 77 counties, each having local jurisdiction over government functions, and five congressional districts. State officials are elected by plurality voting. The biennial Oklahoma legislature is bicameral, consisting of a Senate and House of Representatives. The Oklahoma Senate has 48 members serving four-year terms. Senators serve a staggered term; thus, only half of the senate districts have elections in any election year. The House has 101 members, each holding office for two-year terms. Term limits restrict elected officials to a total of 12 cumulative years of service between both legislative branches.

The Governor of the state is the principal head of government, serving as the chief officer of the executive branch of government. This office submits the budget and assures the enforcement of state law. Term of office is four years. The judicial branch consists of the Oklahoma Supreme Court, the Oklahoma Court of Criminal Appeals, and 77 District Courts, one for each Oklahoma county. Two independent courts, the Court of Impeachment and the Court on the Judiciary, are also included in the makeup of the judiciary branch. Judges sitting on the Supreme Court, the Court of Criminal Appeals, and the Court of Civil Appeals are appointed by the governor upon recommendation of the Judicial Nominating Commission. These judges stand for retention vote on a six year rotating schedule.

Thirty-eight American Indian tribal governments are based in the state of Oklahoma. Each of these tribal governments has limited powers within defined geographic areas. Indian reservations in the conventional sense do not exist in Oklahoma. Tribal governments, recognized by the US as quasi-sovereign, hold land granted by the federal government with limited jurisdiction and no control over state governing bodies. Executive, judicial, and legislative powers of the tribal governments are relevant to tribal members, but remain subject to federal authority held by the US Congress.

As of November 1, 2014, there were 2,022,456 registered voters in Oklahoma, among which 43.7% were Democrat, 43.6% were Republican, and 12.7% were Independent. The Oklahoma delegation to the US House of Representatives represents five congressional districts with all five being registered Republicans. These House representatives are Jim Bridenstine (R-OK1), Markwayne Mullin (R-OK2), Frank Lucas (R-OK3), Tom Cole (R-OK4), and Steve Russell (R-OK5). The two senators from Oklahoma are James Lankford (R) and James Inhofe (R). In 2014, Oklahoma voters re-elected the state's first female governor, Mary Fallin, to a second term in office.

When the Oklahoma Legislature convened for the 55th Legislature on Monday, February 2, 2015, the majority (40) of the seats in the Senate were held by the Republican Party, with the remaining eight seats held by the Democratic Party. Likewise, in the House, the Republican Party holds the majority, accounting for 72 of the 101 House seats.

Legislative Update

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 Director of the OSDH Office of State and Federal Policy. 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 bills that were closely followed by OSDH and MCH during the 2015 legislative session. SB indicates a Senate bill and HB is a House bill.

Administrative Rules

SB0126 allows the State Department of Health to enter into contracts with private vendors to obtain the services necessary to meet the requirements of the Oklahoma Advance Directive Act. It adds that any costs to the public to access the registry are to be negotiated in the contracts. Signed by the governor on 04/13/15.

Alcohol, Controlled Substances, and Mental Health

SB0178 prohibits consumption, possession, purchase of any intoxicating beverage and entry into places that sell intoxicating beverages by juveniles. Signed by the governor on 05/04/15.

Child Health

HB1847 increases the maximum age in which a child must be seated in a child restraint system from six to eight. It establishes that children under two years of age must be properly secured in a rear-facing child passenger restraint system or until they reach the highest weight and height allowed by the car seat's manufacturer; children at least two years of age but younger than four years of age must be secured in a forward-facing child passenger restraint system; and children at least four years of age but younger than eight years of age and less than 4 feet 9 inches in height must be properly secured in either a child passenger restraint system or child booster seat. Signed by the governor on 06/05/15.

HB1066 adds sexual exploitation to the information to be reported in the DHS central registry. Signed by the governor on 04/13/15.

HB1078 specifies which relatives may be notified for the removal of a child from the custody of his or her parents. It allows for the inclusion of planning for the child's transition into adulthood in his or her permanency plan upon reaching 14 years of age or older. It mandates that at least one person in the child's facility be authorized to apply "prudent parental standard" in decisions for the child. This bill establishes the Successful Adulthood Act, which requires a child's permanency plan be developed in consultation with the child and the conditions of that plan. Signed by the governor on 04/27/15.

HB1079 allows the foster parents of a child to submit a report to the court for presentation at a review hearing to assist the court in reviewing the placement or status of a child. Signed by the governor 04/13/15.

HB1273 modifies the scope of the definition of sexual exploitation. Signed by the governor 04/13/15.

HB2157 creates the Family Support Accountability Act, which directs any state department or agency implementing home-visiting programs to provide a framework for service delivery and accountability across all home-visiting programs to promote a continuum of care. The programs must provide face-to-face visits by specially trained parent educators to provide home-based family support services and must ensure these programs work in partnership to serve children and to collaborate with the Early Childhood Advisory Council. It also directs the State Department of Health to submit an annual report prepared by an independent party with expertise in family support research or evaluation on the outcomes of state-funded and administered home-visiting programs to the Governor and the Legislature. Signed by the governor on 04/28/15.

SB0511 requires the Oklahoma Commission on Children and Youth's Office of Planning and Coordination to include information concerning homeless children and youth in specific reports. It requires the Office of Planning and

Coordination for Services to Children and Youth Steering Committee to update the Legislature on existing programs to reduce child homelessness, to review relevant data, and propose policy-based solutions regarding child homelessness. Signed by the governor on 04/17/15.

SB0721 adds the definition of advertising or advertisement in relation to trafficking in children. The bill defines the terms to mean any communication that originates by newspaper, periodical, telephone book listing, outdoor sign, radio, television or any communication that is disseminated through the use of a computer or related electronic device. Signed by the governor on 04/17/15.

SB0763 requires the DHS, in conjunction with the Oklahoma State Regents for Higher Education, to provide parents/legal guardians of foster children with information on the Oklahoma Higher Learning Access Program (OHLAP) including, but not limited to, eligibility, application guidelines, academic requirements, and any other information required by the Oklahoma Higher Learning Access Act for participation in the Program. Signed by the governor 04/13/15.

SB0534 modifies the allocation of funds from the proceeds from the sale of heirloom birth certificates. The bill requires the funds to be allocated to the State Department of Health to provide child abuse prevention, training, and technical assistance. Signed by the governor on 05/06/15.

Pregnancy

HB1409 increases the time period to 72 hours for voluntary and informed consent prior to an abortion. It requires any printed materials concerning abortion to contain the statement, "Abortion shall terminate the life of a whole, separate, unique, living human being." It requires any facility performing abortions, which has a website, to publish an easily identifiable link on its homepage that links directly to the State Board of Medical Licensure and Supervision's website, which provides informed consent material under the Woman's Right-to-Know Act. Signed by the governor on 05/06/15.

HB1721 establishes the Oklahoma Unborn Child Protection from Dismemberment Abortion Act. The bill makes it unlawful to perform or attempt a dismemberment abortion unless the procedure is necessary to prevent serious health risk to the mother. It states only a physician or someone acting as a physician can be liable for performing a dismemberment abortion. The bill states violators will be fined \$10,000 and/or imprisoned for not more than two years. Signed by the governor 04/13/15.

HB1729 creates Ashlen's Law which modifies the definition of fetal death by specifying that the fetus has advanced to the 12th week of uterogestation. Signed by the governor 04/13/15.

Medicaid

SB0338 authorizes the Oklahoma Tax Commission to disclose specific information to the Oklahoma Health Care Authority for purposes of determining eligibility for current or potential recipients of assistance from the Oklahoma Medicaid Program. Signed by the governor 04/13/15.

Prevention

HB1965 makes texting while driving a primary offense, meaning an officer can pull over a motorist for texting. The law goes into effect November 1, 2015, and carries a \$100 fine. Oklahoma is the 46th state in the nation to ban texting while driving. Signed by the governor 05/05/15.

SB0183 adds operating a commercial motor vehicle while using a hand-held mobile telephone to the list of "serious

traffic offenses," for which the Department of Public Safety may disqualify a person from operating a Class A, B, or C commercial motor vehicle for 60 days after receiving a record of a second conviction within a three-year period. It makes it unlawful to use a hand-held mobile telephone while operating a commercial motor vehicle. Signed by the governor on 05/04/15.

SB0239 creates the Chase Morris Sudden Cardiac Arrest Prevention Act, which requires the State Department of Health and the State Department of Education to jointly develop and post on their websites materials covering the nature and warning signs of sudden cardiac arrest. It requires students and student's parent or guardian to sign and return to the school an acknowledgment of receipt and review of the information. It prohibits students who have collapsed or fainted without head injury from finishing the athletic activity. The bill requires athletic coaches to participate in a yearly sudden cardiac arrest training course. It states the State Board of Health and the State Board of Education will establish rules for the implementation of this act. Signed by the governor on 05/06/15.

SB0250 requires the Oklahoma Health Care Authority and the State Department of Health to collaborate on identifying benchmarks and developing goals regarding diabetes. Both agencies must submit a report to the President Pro Tempore of the Senate and the Speaker of the House by January 10 of odd numbered years. Signed by the governor on 04/13/15.

Title 10

HB2166 requires the Oklahoma Commission on Children and Youth to keep confidential information provided by those who receive its services and to request that cases involving children within its jurisdiction be transferred to the jurisdiction of the Oklahoma State Bureau of Investigation. Signed by the governor on 05/18/15.

Tobacco

HB1685 creates the 24/7 Tobacco-free Schools Act. The bill prohibits the use of a tobacco product on the grounds of any educational facility that offers early childhood education. This bill designates all educational facilities, as defined by the act, to be non-smoking. Signed by the governor on 05/06/15.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Oklahoma's Maternal and Child Health (MCH) Title V Five-Year Needs Assessment (Needs Assessment) process was directed by Title V legislation which requires states to conduct a statewide, comprehensive needs assessment every five years to determine the need for:

- Preventive and primary care services for all pregnant women, mothers, and infants up to age one
- Preventive and primary care services for children; and
- Services for children and youth with special health care needs (CYSHCN).

The state's approach to carrying out the Needs Assessment is ongoing, with routine data collection and management, review and assessment, and translation into and dissemination of information used in decision-making in program development, resource allocation, and policy formulation relevant to MCH populations. As per the guidance for the MCH Title V Block Grant to States Program, Oklahoma has organized its Needs Assessment by six population health domains – women/maternal health, perinatal/infant health, child health, CYSHCN, adolescent health, and cross-cutting/life course.

The overarching vision is to create a state of health whereby the conditions exist for pregnant women, mothers and infants, and children and youth, including those with special health care needs, to be successful in meeting health and life goals across their life course.

1. Goals, Framework and Methodology

Goals

The five-year needs assessment process was informed by MCH staff planning meetings, input from partners and stakeholders, guidance and past training received from the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), as well as previous efforts in completing the Title V Five-Year Needs Assessment. The shared goal of the OSDH, the Oklahoma Department of Human Services (DHS), the two state agencies administering Title V programs, and the Oklahoma Family Network (OFN) was to develop a document containing high quality data specific to the state's MCH populations which establishes a foundation for addressing and evaluating progress on health priorities. The Needs Assessment includes input from families and subject matter experts essential to the needs assessment process, and is readily available for use in health initiatives applicable to MCH populations. It should serve as an indispensable resource for the state in identifying priorities for the improvement of health status, the provision and utilization of services, and, ultimately, the health outcomes of pregnant women, mothers and infants, and children and youth, including those with special health care needs.

The MCH and the CSHCN Programs will use the Needs Assessment to guide Title V activities for the federal fiscal years 2016-2020. As required by the Title V Block Grant guidance, a five-year action plan addressing national and state priorities has been developed using the results of the Needs Assessment. Throughout the five-year period, Oklahoma will monitor and report on selected national and state performance measures. When necessary, changes to selected priorities and performance targets may be made to address emerging trends, as well as improvements in data collection and reporting. Resources allocated to produce improvement in the health status of MCH populations are continually monitored for change as a core function of the needs assessment process.

Framework

The OSDH MCH Title V Director, the DHS CSHCN Title V Director, and the Executive Director of the OFN provided leadership for the needs assessment process. The Administrative Program Manager (APM) for the MCH Assessment Division, the organizational unit within MCH having responsibility for the Needs Assessment, held

responsibility for coordinating needs assessment efforts. MCH Assessment staff (i.e., epidemiologists and biostatisticians) assisted with developing the process and was largely responsible for performing the work necessary for the Needs Assessment. The APM for MCH Assessment is the Oklahoma Title V Data Contact and in that role assured data quality for reporting. Routine meetings throughout the completion of the Needs Assessment aided communication, assignment of responsibilities, and accountability. Frequent follow-up discussions between meetings occurred by telephone and/or email.

The conceptual framework for Oklahoma's Needs Assessment is straightforward, complying with the MCHB Title V MCH Block Grant Needs Assessment Framework Logic Model provided in the grant guidance. The steps include:

Table II.B.1.1. Oklahoma Title V MCH Five-Year Needs Assessment Framework

1. Assess and summarize MCH population needs, program capacity, and partnerships/collaborations
2. Identify state Title V program priority needs and consider national MCH priority areas
3. Select national performance measures; develop interim strategies to address priority needs and selected national measures
4. Develop interim five-year action plan for MCH Block Grant Program; establish national performance measure objectives
5. Develop evidence based or informed strategy measures for national performance measures and establish performance objectives
6. Develop state performance measures and establish performance objectives
7. Refine five-year action plan for achieving progress on national and state measures
8. Develop/update performance objectives; report annual state performance indicator data
9. Analyze performance trends
10. Reassess

Source: Title V Maternal and Child Health Services Block Grant to States Program, Guidance and Forms for the Title V Application/Annual Report, OMB No. 0915-01172

Methodology

In July 2013, MCH initiated efforts to complete the Needs Assessment by convening an initial planning meeting to discuss projected activities, proposed analyses, staff assignments, and to establish a timeline. In the initial months of this process, MCH Assessment staff met on a bimonthly basis to assure work was progressing according to plan, to discuss developments on assignments, and to share ideas about how to proceed when facing obstacles or challenges. Along with the timeline, a data source list, narrative template, topic outline, and directory of partners were created. Each product was revised or refined if necessary as work on the Needs Assessment progressed.

In October 2013, MCH launched the Title V Needs Assessment Survey online via Survey Monkey. MCH promoted the survey by using press releases, website updates, Facebook postings, and email listservs. Participation in the survey was statewide, achieved by the efforts of many MCH partners. The Oklahoma Tobacco Settlement Trust (TSET) promoted the survey for six weeks by twice weekly Facebook postings. The Oklahoma Family Network (OFN), the OSDH Office of Minority Health, and the Central Oklahoma Healthy Start contributed substantively by administering paper questionnaires in their respective trainings and focus groups. These efforts helped significantly in capturing input from Oklahoma's African American population. Over a two week period in February 2014, county health departments were used to administer the Needs Assessment Survey to clients presenting for services. By administering the questionnaire in this manner, MCH was able to collect information from clients that might not otherwise be represented due to geographic remoteness or lack of awareness about the online survey. In the end, MCH collected 1,457 responses to the Needs Assessment Survey.

With past needs assessments, MCH had noticed a pattern in which the American Indian population was not fully represented. To address this weakness, MCH partnered with the OSDH Office of the Tribal Liaison to hold MCH Tribal Listening Sessions with Oklahoma Tribes. Designed to gain insight on MCH issues impacting tribal communities in the state, the listening sessions were held throughout the summer and fall of 2014. In total, seven

listening sessions were conducted with tribes including the Oklahoma City Indian Clinic, Choctaw Nation, Chickasaw Nation, the Oklahoma Area Indian Health Service (IHS), the IHS Clinton Service Unit in conjunction with the Cheyenne and Arapaho Nation, the Muscogee (Creek) Nation, and the Northeastern Tribal Health System, a multi-tribe health network based in Miami, Oklahoma. Participation by tribal health care providers and representatives in the listening sessions was strong and valuable information was collected and integrated into the Needs Assessment. MCH compiled summary reports of these sessions which were then provided to tribal leaders for their use. It is anticipated that the tribal listening sessions will serve as an initial step in building closer relationships with Oklahoma tribes to address mutual goals and objectives in improving MCH population health.

In April 2015, MCH conducted a Key Informant Survey via Survey Monkey. This survey was constructed to collect data from MCH partners about the capacity of their programs and/or organizations to provide essential public health services to the Title V legislatively-defined MCH populations – pregnant women, mothers and infants, children, and children with special health care needs. The survey allowed two weeks for response. Key informants included MCH partners who lead programs, departments, or agencies which provide health-related services to MCH target populations. Collected information was used to characterize the capacity of Oklahoma's MCH-oriented health services and programs to meet the needs of MCH populations.

In parallel to the information collected through the Title V Needs Assessment Survey, the MCH Tribal Listening Sessions, and the Key Informant Survey, MCH analysts reviewed state and national data to assess the health status, health care, and service utilization of Oklahoma's MCH populations. Analyses included data from PRAMS, TOTS, the Youth Risk Behavior Survey (YRBS), birth and death records, the National Immunization Survey, and the National Survey of Children's Health, among others. Data were summarized using a template developed to standardize reporting of health issues and to serve as individual stand-alone documents which can be used for dissemination to MCH partners, OSDH leadership, the state legislature, and the general public. Information was organized according to a narrative outline which included the six population health domains as the guiding theme. Initially, bimonthly meetings were convened to review progress and responsibilities, address common issues, and to revise the schedule of work as needed. As the Needs Assessment progressed, key projects were activated, and as the submission deadline came closer into view, more frequent meetings became necessary. Throughout 2015, MCH analysts had weekly scheduled meetings to discuss and prepare the Needs Assessment.

In 2014, Sooner SUCCESS, a collaborative project serving families with CYSHCN, conducted a community needs assessment (CNA) survey, which collected data on the detailed descriptions of health conditions, needed and received services, and barriers to services. The CNA survey was administered to two groups – families and providers. Nearly 7,400 families, those identified as having a CYSHCN and receiving assistance through the SoonerCare/Medicaid program, were included in the CNA sample. More than 1,600 SoonerCare providers were sent the provider survey.

In January 2015, MCH presented Needs Assessment findings, from the Title V Needs Assessment Survey, the MCH Tribal Listening Sessions, and the data analysis of relevant datasets, to the *Preparing for a Lifetime, It's Everyone's Responsibility*, the statewide infant mortality reduction initiative, the Oklahoma Health Improvement Plan (OHIP) Children's Health Workgroup, and the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC). These findings were also discussed in the monthly MCH/CSHCN program meetings staffed by public health professionals of these respective programs. Needs Assessment results were shared for the purpose of gaining contextual feedback from subject matter experts as a way of better understanding the collected data. These presentations also initiated the steps required to narrow the wealth of information into themes or broad categories that capture health issues essential to addressing the needs of MCH populations. Feedback from these presentations was used to prioritize the collected data.

MCH priorities were determined by using a priority matrix which allowed MCH and CSHCN staff to evaluate health issues by the following criteria: magnitude of problem, trend trajectory, severity of problem, state and national

importance, acceptability of addressing problem, amenability of problem to change, and availability of resources to address the problem. Each criterion was scored with a final score obtained by summing across all criteria. Items with the highest totals were reviewed in relation to established national MCH priority areas, existing state priorities, and whether or not MCH/CSHCN is considered the lead program for the issue under review.

2. Level and Extent of Stakeholder Involvement

Oklahoma’s Title V programs have long been dependent upon and place high value on the input of stakeholders. The collection of meaningful stakeholder feedback drew heavily on existing internal and external partnerships and collaborations. Established relationships enabled Oklahoma to use networks for the basis for mass distributions of information seeking participation and input of stakeholders throughout the Needs Assessment process. Personal and professional contacts between stakeholders and MCH/CSHCN staff allowed Oklahoma to expand coverage well beyond the stakeholders encountered on a day-to-day basis.

These individual and network contacts were essential in conducting the Title V Needs Assessment Survey, the MCH Tribal Listening Sessions, and the Key Informant Survey. Greater awareness and interest in these activities was achieved by utilizing the extensive arrangement of contacts across Oklahoma. Stakeholder participation in these needs assessment efforts strengthened the content and quality of the surveys, and resulted in greater survey response. See Table II.B.1.2. for a list of participants.

Table II.B.1.2. Participants in the Oklahoma Title V Five-Year Needs Assessment Process, 2016-2020

Association of Women's Health, OB & Neonatal Nurses	Indian Health Service (IHS)	Families
Blue Cross Blue Shield of Oklahoma	March of Dimes	Office of Minority Health (OSDH)
Child Death Review Board	Office of Perinatal Continuing Education	Oklahoma Dental Association
Child Guidance (OSDH)	OHIP Children's Health Flagship Workgroup	Injury Prevention Service (IPS)
Chronic Disease Service (OSDH)	Family Support and Prevention Service (OSDH)	Oklahoma Department of Mental Health and Substance Abuse Services
Coalition of Oklahoma Breastfeeding Advocates (COBA)	Oklahoma City-County Health Department	Oklahoma Development Disabilities Council
Community Services Council of Greater Tulsa	Oklahoma Areawide Services Information System (OASIS)	Oklahoma Health Care Authority
Consumer Representatives	Oklahoma City Area Inter-Tribal Health Board	Oklahoma Hospital Association
Dental Health Service (OSDH)	Oklahoma City-County and Tulsa Fetal and Infant Mortality Review Teams	Oklahoma Institute for Child Advocacy
Head Start State Collaboration Office	OU Department of Pediatrics (OKC)	Oklahoma Perinatal Quality Improvement Collaborative
Healthy Start Projects	SoonerStart (OSDH)	County Health Departments
Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV, OSDH)	OU Health Science Center Child Study Center	Oklahoma Primary Care Association
Oklahoma Commission on Children and Youth	OU Medical Center Women's Services	OU Health Sciences Center
Oklahoma State Medical Association (OSMA)	Schools for Healthy Lifestyles	Screening and Special Services (OSDH)
Oklahoma Turning Point	Sooner SUCCESS	Smart Start Oklahoma
OU Children's Medical Center	Center for the Advancement of Wellness (OSDH)	Children's Oral Health Coalition
Safe Kids in Tulsa and Oklahoma City	Oklahoma State Department of Education	Variety Health Center
Immunization Service (OSDH)	Tulsa Health Department	WIC (OSDH)
Oklahoma Family Expectations Program	Child Care Services (DHS)	Center for Health Statistics (OSDH)

3. Quantitative and Qualitative Methods

MCH Assessment conducted the identification and review of quantitative data for the Needs Assessment. Types of

data reviewed to determine need included trends of selected public health indicators and risk behavior and health outcomes data. A partial list of examined metrics included rates of infant, child, and maternal mortality; teen birth; low birth weight and preterm birth; early entry into prenatal care; confirmed child abuse or neglect; and tobacco, alcohol, and substance use. Analysts referenced available research literature and state and national reports that were pertinent to subject matter. Data were assessed along population characteristics, such as age, race/ethnicity, socioeconomic status, gender, and geographic setting as appropriate to interpretation.

The MCH Tribal Listening Sessions provided the bulk of qualitative information collected in the Needs Assessment. Seven sessions were conducted throughout 2014 to gain information from tribal representatives and health care providers. These sessions allowed Oklahoma to contextualize findings achieved by other methods (i.e., traditional analysis of surveillance data) and, therefore, facilitated a greater understanding of population health among Oklahoma's American Indians. Information was collected in written form (i.e., summary notes) and then broadly categorized for review and reporting. Additional qualitative information was collected via the Title V Needs Assessment Survey in which respondents had the ability to provide comments on issues important to them relevant to MCH populations. Respondents also could provide input on the ways the health of Oklahoma's women, infants, and children could be improved. These comments were classified into topics for review and discussion.

4. Data Sources

Multiple data sources were used in the development of Oklahoma's Needs Assessment (Table II.B.1.3). These sources include state and national data sets and reflect MCH surveillance data, state registry data for births and deaths, client services and encounters data, and population figures, as well as surveys and listening sessions designed specifically for the Needs Assessment.

Table II.B.1.3. Data Sources for the Oklahoma Title V Five-Year Needs Assessment

Source	Description	Type
Title V Needs Assessment Survey	MCH designed public input survey collecting information about priority issues for MCH populations.	Quantitative/Qualitative
MCH Tribal Listening Sessions	MCH/Office of Tribal Liaison developed sessions to gather information from tribal health providers and representatives about needs and experiences of tribal members	Qualitative
MCH Key Informant Survey	MCH designed stakeholder survey to collect information on the system capacity to address needs of MCH populations	Quantitative/Qualitative
Sooner SUCCESS Community Needs Assessment	Random sample survey of Oklahoma families of CYSHCN and health care providers which documents description of needs and services.	Quantitative
Public Health Oklahoma Client Information System (PHOCIS)	OSDH client information system capturing encounter and service information from health department clients, including family planning services.	Quantitative
Personal Responsibility Education Program (PREP)	PREP data document teen pregnancy prevention efforts to administer evidence-based curricula to adolescents.	Quantitative
Behavioral Risk Factor Surveillance System (BRFSS)	BRFSS is the system of health-related telephone surveys collecting state data about risk behaviors, chronic health conditions, and use of services.	Quantitative
OSDH Center for Health Statistics (CHS)	CHS provides birth, death, and stillbirth data in record level or web query form, via OK2SHARE.	Quantitative
Oklahoma Birth Defects Registry (OBDR)	OBDR is the state's database for the birth defects.	Quantitative
Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS)	PRAMS is the statewide, population-based surveillance of preconception, prenatal, and postpartum behaviors, attitudes, and practices of mothers with a recent live birth.	Quantitative
The Oklahoma Toddler Survey (TOTS)	TOTS is the Oklahoma follow-back survey to PRAMS and captures health-related information from mothers about their children at age two.	Quantitative
Women, Infants and Children Special Supplemental Nutrition Program (WIC)	WIC is the nutrition assistance program for low income pregnant, breastfeeding and postpartum women and children under age five who are at nutritional risk.	Quantitative
First Grade Health Survey (1GHS)	MCH developed survey of parents with a child attending 1 st grade in Oklahoma public schools. Information collected includes chronic illness, bullying, injury, insurance coverage, safety, physical activity, and household smoking rules.	Quantitative
Fifth Grade Health Survey (5GHS)	MCH developed survey of parents with a child attending 5 th grade in Oklahoma public schools. Information collected includes chronic illness, bullying, injury, insurance coverage, safety, physical activity, and household smoking rules.	Quantitative
Youth Risk Behavior Survey (YRBS)	CDC-sponsored survey of adolescent public school students designed to collect information on priority health-risk behaviors, among them: unintentional injury, substance use, sexual behaviors, dietary behaviors, physical activity.	Quantitative
National Survey of Child Health (NSCH)	CDC-sponsored survey collecting information on a broad range of health-related subjects in the child population.	Quantitative
National Immunization Survey (NIS)	CDC-sponsored survey collecting information on immunization coverage.	Quantitative

5. Priority Needs and the State Action Plan

Based on the identified priority areas from the qualitative and quantitative review, the priority matrix was developed and refined during MCH, CSHCN, and OFN monthly meetings. Three to five priorities for each population health

domain were identified as areas of need with the final 10 state priorities selected from among them. Each population health domain is represented by at least one priority. Title V priorities are aligned with OSDH and DHS agency priorities, as well as the Healthy Oklahoma 2020 Plan.

Oklahoma's Title V priorities were mapped to National Performance Measures (NPMs) which best represent the needs of the state's MCH population. Program staff was assigned to draft objectives and strategies based on program goals and existing capacity. Some NPMs map to more than one state priority, which is reflected in the Oklahoma Action Plan Table. Completed objectives and strategies for each NPM were reviewed by the Title V MCH and CSHCN Directors and key staff to ensure feasibility and likelihood to "move the needle" for the selected measure.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health

i. Overview

In 2013, the Oklahoma population of childbearing age females (15-44 years) numbered 756,016, representing 20% of the total population and 39% of the total female population (1,943,276). The majority of reproductive age females are white (76%), followed by American Indian (11%) and African American (10%). Eleven percent is of Hispanic origin. Approximately 17% percent of women of reproductive age are less than 20 years of age.

To improve the health of mothers and women of childbearing age, a number of primary concerns must be addressed. Oklahoma consistently reports unintended pregnancy rates near 50% and chronic conditions (hypertension, diabetes, obesity) among pregnant women and those of reproductive age are high. Unintended pregnancy is associated with adverse pregnancy outcomes like low birth weight and preterm birth, and children from unintended pregnancies experience higher rates of poor physical and mental health in childhood and higher rates of behavioral issues as adolescents. Chronic health conditions can lead to poor health outcomes when not identified, treated or monitored.

Preconception health has gained wide recognition as an important means to ameliorate health issues before they can impact a pregnancy. By focusing on health across the lifespan, risk reductions and improved health behaviors will impact a woman's health before, during and after pregnancy, resulting in healthier babies, healthier families and healthier aging populations.

ii. Strengths and Needs

Pregnancy intention: Unplanned pregnancy remains a significant problem in the state. In 2011, 46.5% of live births were the result of an unintended pregnancy: 9.7% of births were the result of an unwanted pregnancy and 36.8% were mistimed. Unintended pregnancy rates are considerably higher among women less than 20 years of age with nearly 8 in 10 live births (78.4%) the result of an unintended pregnancy. Rates also vary by race and ethnicity with minority populations tending to have higher proportions of unintended pregnancy: 44.8% white, 46.9% African Americans, 57.9% American Indians, and 42.4% for Hispanic mothers.

Chronic conditions: In Oklahoma, heart disease is the third most common cause of death for women 15-44. Among adult women (ages 18-44), BRFSS shows that 14% are hypertensive, 31.4% are obese, and 12% currently have asthma. Racial variation for health conditions and risk factors exist (Table II.B.2.a.1)

Table II.B.2.a.1. Health Conditions and Risk Factors among Oklahoma Women ages 18-44, 2011-2013

Condition or Risk Factor	Total	White, non-Hispanic	Black, non-Hispanic	American Indian	Hispanic
Currently smoke (age 18+)	27.10%	29.00%	20.90%	39.60%	13.50%
No leisure time activity in past month	25.00%	23.70%	25.40%	20.50%	36.10%
Overweight	27.10%	26.50%	26.70%	20.30%	38.30%
Obese	31.40%	29.40%	45.40%	43.70%	28.60%
High Blood Pressure	14.00%	12.80%	-	-	10.80%
Diabetes (not pregnancy related)	3.90%	3.60%	4.30%	5.30%	3.80%
Arthritis	11.90%	12.90%	11.80%	11.80%	5.60%
Asthma, currently	11.70%	11.30%	14.40%	17.30%	6.40%
- Cell size less than 5 or population group total less than 50					
Source: 2011-2013 BRFSS; table format from the Office on Women's Health. Women's Health in Oklahoma Fact Sheet: www.healthstatus2020.com/owh/PDF/FactSheetsv3/Oklahoma.pdf					

Preconception Care: In 2013, 15.9% of Oklahoma women aged 18-44 reported having fair or poor health according to BRFSS data. A sizable proportion of women had at least one physically (36.4%) or mentally (46.6%) unhealthy days in the previous month. A 2011 PRAMS study found that just 25% of new mothers had a health care visit in the 12 months prior to pregnancy in which 10 or more of the primary ACOG (American College of Obstetrics and Gynecology) recommended preconception topics were discussed with a provider. Variation by race and ethnicity across many preconception health variables was observed (Table II.B.2.a.2).

Table II.B.2.a.2. Preconception Health Variables for New Mothers, PRAMS 2009-2011 by Maternal Race and Ethnicity

Pre-pregnancy Health	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic American Indian	Non-Hispanic Other	Hispanic	p-value
Exercising 3 or more days a week	41.3	43.4	38	42.9	42.8	>0.05
Teeth cleaned	49.7	50.4	36.7	48	33.9	<0.05
Pre-pregnancy BMI						
Underweight	4.2	5.7	6.1	7.1	-	>0.05
Normal	50.1	41.3	41.7	49.4	41.9	
Overweight	24.4	27	23.6	25.8	24.7	
Obese	21.3	26.1	28.6	17.6	29	
Smoking 3 months before pregnancy	37.3	27.9	46	27.7	12.1	<0.05
Drinking 3 months before pregnancy	57.3	38.8	48.6	48.2	27.3	<0.05
Vitamin /Folic acid	40.7	27.9	27.3	30.6	35.7	<0.05
Birth control use	42.4	45.1	41.5	57.1	49.9	>0.05
Checked or treated for high BP	6.6	17.8	10.5	7.8	9.5	<0.05
Checked or treated for diabetes	4.4	12.8	15.5	3.3	10.9	<0.05
Checked or treated for depression	14.3	10.1	9.8	14.1	6.3	<0.05
Talked to provider about family medical history before pregnancy	21	29.3	22	23.5	18.2	>0.05

iii. State's priority needs

Oklahoma MCH priority needs for the Title V Block Grant cycle for 2016-2020 specific to the women/maternal health population domain include: Reduction of Infant Mortality, Reduction of Preterm and Low Birth Weight Infants, Reduction of Unplanned Pregnancy, Reduction in the prevalence of chronic health conditions among women of childbearing age, and Reduction of health disparities.

iv. Title V-specific programmatic approaches

Preparing for a Lifetime, It's Everyone's Responsibility: Preparing for a Lifetime, Its Everyone's Responsibility has a

workgroup focused on Preconception/Interconception Health, with focused efforts to raise awareness about the importance of health before and between pregnancies, including improving physical activity and nutrition and quitting tobacco.

Collaborative Improvement and Innovation Network (ColIN) to Reduce Infant Mortality: MCH participates in the ColIN Pre/Interconception Care Learning Network. Projected activities include promotion of long-acting reversible contraceptives (LARCs), the possibility of expanding interconception health benefits in the Medicaid/SoonerCare Program, and assisting women in understanding the importance of creating a life plan.

Family planning clinical services: Services are provided at 87 OSDH county health department service sites and eight contract clinic sites in 70 of Oklahoma's 77 counties. Sites target at-risk, hard to reach youth, and provide outreach and education services. Family planning providers are encouraged to treat every visit as a preconception health visit and provide targeted preconception/interconception health counseling to every client.

Perinatal/Infant Health

i. Overview

In Oklahoma for years 2010-2013, there were a total of 209,014 births; 72.2% of the births were to White mothers, 9.5% to African American mothers, 11.4% to American Indian mothers, 2.8% to Asian/Pacific Island mothers, and 4.1% to mothers listing race as Other. Hispanics comprised 13.6% of total births during this time.

The majority of births (60.2%) in 2010-2013 were to mothers whose maternal age was 20-29 years, followed by older mothers with an age of 30 years and older (28.5%). Younger mothers made up the remaining births, with those aged 15-19 making up 11.2% and those younger than 15 years, just 0.1% of all births. The majority of births among the older mothers are found among Asian/Pacific Islanders (47.0%), whites (29.9%) and Hispanics (28.4%). Births among the younger mothers are concentrated in the African American (16.4%) and American Indian (15.7%) populations.

In Oklahoma for years 2010 to 2013 births to teen mothers aged 15-19 decreased by 18.2% while births to mothers aged 30-39 increased by 13.0% and births to mothers 40 and older increased by 3.3%. The largest decrease in births was among the youngest mothers, those aged 15 and younger at 31.7%.

ii. Strengths and Needs

Prenatal Care (PNC): In Oklahoma for 2013, 68.5% of mothers initiated their PNC during the first trimester. Fifty-five percent (55.2%) of mothers that report having received PNC during their first trimester also report having attended 10 or more prenatal visits. A small percentage of mothers, 3.3%, report having received little or no PNC during their pregnancy. Among mothers that received less than adequate PNC, 68.1% were white, 11.7% were African American, and 11.8% were American Indian mothers.

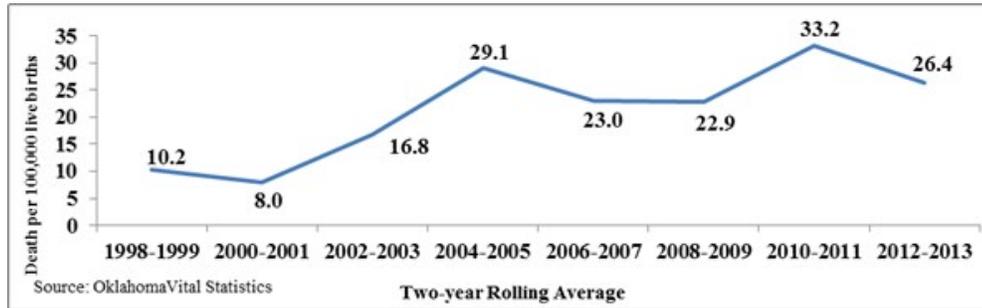
Pregnancy-Induced Hypertension (PIH): The experience of PIH in Oklahoma is very similar to the rest of the nation; 4.3% of births during years 2010-2013 were to mothers who experienced PIH. African American (4.7%) mothers were more likely to have had PIH compared to white (4.2%), American Indian (4.3%), or Hispanic (3.2%) mothers. Both older mothers, aged 40 or older (6.5%) and the youngest mothers, aged less than 15 years (5.3%), were among those most likely to have had PIH.

Postpartum Depression (PPD): Approximately 15% of new mothers will develop symptoms associated with postpartum depression in Oklahoma. The more severe cases of PPD will affect about 1 in 8 new mothers within the first year of giving birth.

Maternal Mortality: In Oklahoma the two year average of maternal mortality rates (Figure II.B.2.a.1) has shown an overall upward trajectory, like the US maternal mortality rate. Racial disparities in 2013 continue to be a challenge in Oklahoma in relation to maternal mortality, among women of reproductive age (15-44), the African American

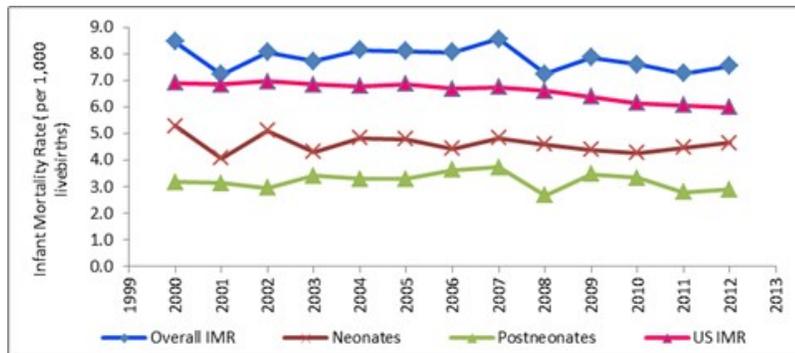
population experienced a maternal mortality rate of 38.5, while the American Indian rate was 32.5 compared to the white population at 27.3.

Figure II.B.2.a.1. Maternal Mortality Rate, Oklahoma 1998-2013



Infant Mortality: Oklahoma has experienced a statistically significant decline in fetal mortality between 2000 and 2012. In 2012, the fetal mortality rate was 5.0 per 1,000 live births and fetal deaths. A similar significant decline was observed for perinatal mortality rate with rates ranging from 11.8 in 2000 to 8.9 per 1,000 live births and fetal deaths in 2012. However, the infant mortality rate (IMR) has consistently remained above the national rate (Figure II.B.2.a.2). Black infants had the highest IMR, followed by American Indians. The disparity ratio in IMR between Black infants and White infants has not decreased since 2000.

Figure II.B.2.a.2. Infant Mortality Rate (IMR), Oklahoma and US 2000 – 2012



Contributors to Infant Mortality and Morbidity:

Preterm births: According to the CDC, Oklahoma’s preterm birth rate has shown some improvement since 2006, when the preterm birth rate stood at 13.9%. In 2013, the preterm birth rate dropped by 7.9% to 12.8%. In Oklahoma for years 2010-2013, the singleton preterm birth rate was 11.6%.

Smoking during Pregnancy: During 2010-2013, among women who delivered a preterm infant, 20.1% reported to have smoked three months before or during their pregnancy. Approximately 21% of white mothers who smoked delivered a preterm infant, compared to 18.3% of African American mothers, 21.9% of American Indian mothers, and 5.8% among Hispanic mothers.

Secondhand smoke exposure: Mothers less than 20 years, education less than high school, those with income less than \$25,000, unmarried mothers, and African American mothers all reported lower rates of completely smoke-free households.

Unintentional injury: This is the fifth leading cause of infant deaths, the percent of deaths accounted for this category have slightly declined since 2010. The top three causes for unintentional injuries among infants are suffocation, motor vehicle accidents, and drowning.

Safe Sleep: In 2011, results from the Oklahoma PRAMS indicate 70% of new mothers placed their infants on their backs to sleep. Nearly 67% of infants shared sleep surfaces with someone else. Safe sleep behaviors have steadily improved in Oklahoma since 2004, however significant racial and ethnic disparities persist. African American mothers had the lowest rate for laying infants on their back to sleep and not sharing a sleeping surface. SIDS is the third leading cause of infant deaths. It accounted for nearly 12% of the total infant deaths in 2012. Deaths due to both these conditions were higher among American Indian infants compared to White and African American infants.

Breastfeeding: In Oklahoma, over 75% of women initiate breastfeeding by the time of hospital discharge, but less than half are breastfeeding at eight weeks. Breastfeeding rates also reflect significant disparities by maternal age, race, and Hispanic origin. The initiation and duration rates of breastfeeding for American Indian and African American women are lower than rates for White and Hispanic women.

Birth Defects: Oklahoma has a rate of birth defects slightly higher at 3.9% or 38.7 per 1,000 births compared to 3% for the US. This rate translates to 1 in 28 babies born in Oklahoma with a major birth defect.

iii. State's priority needs

The state priorities for the 2016-2020 Title V program that were influenced by the data presented here include: Reduction of Infant Mortality, Reduction of Preterm and Low Birth Weight Infants, Reduction of Unplanned Pregnancy, Reduction of Unintentional Injuries, and Reduction in the Prevalence of Chronic Health Conditions among Women of Childbearing Age, and Reduction of Health Disparities.

iv. Title V-specific programmatic approaches

Preparing for a Lifetime. It's Everyone's Responsibility: *Preparing for a Lifetime, Its Everyone's Responsibility*, the statewide infant mortality reduction initiative, is working to address key perinatal and infant health challenges and disparities found in the state. Work groups are centered on the following priority needs: Preconception/Interconception, Prematurity, Tobacco Cessation, Infant Safe Sleep, Injury Prevention, Postpartum Depression, and Breastfeeding.

Perinatal Collaborative: The Oklahoma Perinatal Quality Improvement Collaborative is addressing early entry and quality prenatal care issues. Priority topics are promoting fetal fibronectin testing in all Oklahoma birthing hospitals and transfer to an appropriate level facility when warranted and use of progesterone therapy.

CollIN to Reduce Infant Mortality: Oklahoma participates in several CollIN learning networks working to reduce infant death.

Reproductive Health Services: The Medicaid State Plan Amendment (SPA), SoonerPlan, provides access to reproductive health services for women and men at or below 133% of federal poverty level. Family Planning clinics within the state are focusing on providing information on the most effective method of contraception first to help prevent unintended pregnancies, assist with reproductive life planning and ensure healthy spacing of pregnancies.

Oklahoma Every Mother Counts Collaborative: Oklahoma was recently awarded the Association of Maternal and Child Health Programs (AMCHP) "Every Mother Initiative" grant to reduce maternal mortality and severe maternal morbidity. The focus of activities for this grant includes early identification and treatment for postpartum hemorrhage and severe hypertension before, during, and after pregnancy.

Maternal Mortality Review Project (MMR): After several years of inactivity, in 2009, MCH re-established the state-level MMR. To date, the majority of MMR cases reflect chronic health conditions (obesity, hypertension, and cardiac issues) that may have been exacerbated due to the pregnancy.

Child Health

i. Overview

In 2013, approximately 17% (689,698) of the Oklahoma population was under 13 years of age. Fifty-one percent of Oklahoma children in this age range were male. By race, 71% of children were white, 14% were American Indian, 12% were African American and 16% were Hispanic.

The death of any child, regardless of the manner of death, is a tragedy. Child death rates have fallen significantly for more than two decades, decreasing from 64 per 100,000 to 26 per 100,000 for children ages 1 to 4 and from 31 to 13 per 100,000 for children ages 5 to 14. Unintentional injuries are the number one cause of death among children ages 1 to 14 years. While many causes of death, such as drowning, poisoning, and falls constitute the unintentional injury category, motor vehicle crashes comprise the majority of these deaths. Disparities exist by gender, as males have a significantly higher mortality rate than females.

ii. Strengths and Needs

Child mortality: Oklahoma as experienced notable declines in child mortality for children between the ages of 1 and 14 years, falling from 40.1 per 100,000 in 1984 to 25.3 in 2013. However, the state's rate remains considerably higher than the nation's (16.4). Male children (30.0) have higher rates than females (20.4). The five leading causes of death for children are shown in Table II.B.2.a.3.

Table II.B.2.a.3. The top 5 leading causes of child death for ages 1-14, Oklahoma.

Rank	1-4 years	5-9 years	10-14 years
1	Unintentional injury	Unintentional injury	Unintentional injury
2	Congenital anomalies	Malignant neoplasms	Malignant neoplasms
3	Homicide	Homicide	Suicide
4	Malignant neoplasms	Congenital anomalies	Congenital anomalies
5	Influenza & Pneumonia	Lower Respiratory Disease	Homicide

Unintentional injury: Nearly half of all deaths to children ages 1-14 are due to unintentional injury. More than one-third (37.6%) were due to motor vehicle traffic injuries, while another 23.5% was due to drowning, which was the leading cause of unintentional injury death for children ages one to four years.

iii. State's priority needs

Oklahoma MCH priority needs for the Title V Block Grant cycle for 2016-2020 specific to the child health population domain include: Reduction in the Incidence of Unintentional Injuries and Reduction of Health Disparities.

iv. Title V-specific programmatic approaches

Child Death Review Board (CDRB): Through case review, the CDRB collects statistical data and system failure information to develop recommendations to improve policies, procedures, and practices within and between the agencies that protect and serve the children of Oklahoma

Child Safety Seat Distribution: Oklahoma law requires that children less than 13 years of age are to be protected by a car seat or seat belt while traveling in a motor vehicle. The OSDH Injury Prevention Service provides free car/booster seats to eligible families, free child safety seat inspections to anyone by appointment, conducts child passenger safety technician classes, supports county health departments by providing technical assistance and car/booster seats for distribution, and offers basic car seat education classes for professionals who work with families.

Adolescent Health

i. Overview

In 2013, approximately 17% (650,265) of the Oklahoma population was between the ages of 13 and 24 years. Fifty-two percent of Oklahoma adolescents and youth in this age range were male. By race, 73% were white, followed by 13% American Indian and 11% African American. Hispanic youth made up 12%.

Teen pregnancy has been a long standing public health concern. Teens have higher rates of unplanned pregnancy and enter later into prenatal care than older mothers. Infants born to teen mothers are at elevated risk of poor birth outcomes, including higher rates of low birth weight, preterm birth, and death in infancy. Teen mothers are also less likely to get a high school diploma, less likely to be married when the child is born, and more likely to be unemployed during the first year of their child's life.

Unintentional injury is the number one cause of death for youth ages 15 to 24 years, among which the majority are due to motor vehicle crashes, followed by poisoning, drowning, and falls.

ii. Strengths and Needs

Adolescent mortality: In Oklahoma, the mortality rate for 15 to 24 year olds decreased significantly over the past 30 years from 103.4 in 1984 to 88.2 in 2013. Oklahoma's 2013 rate of 88.2 was significantly higher than the national average of 64.8. Racial disparities exist, as from 2009 to 2013; African Americans had the highest mortality rate at 122.9, followed by American Indians (102.3), whites (86.7), and Asian/Pacific Islanders (30.7). Disparities also exist by gender as males had a significantly higher mortality rate than females at 129.7 and 50.0, respectively. During this same timeframe, the top five leading causes of death for 15 to 24 year olds by age group were:

Rank	15-19 years	20-24 years
1	Unintentional injury	Unintentional injury
2	Suicide	Suicide
3	Homicide	Homicide
4	Malignant neoplasms	Malignant Neoplasms
5	Heart Disease	Heart Disease

The second and third leading causes of death for both 15 to 19 year olds and 20 to 24 year olds were due to intentional injuries of suicide and homicide. African Americans were more than 4 times as likely to die from homicide at 52.4 deaths per 100,000 population than American Indians (11.3), and whites (5.8). Disparities also exist by gender, as males were three times more likely than females to die from homicide at 10.3 and 3.1, respectively, and four times more likely than females to die from suicide at 27.6 and 6.8, respectively.

Contributing factors related to intentional self-harm include:

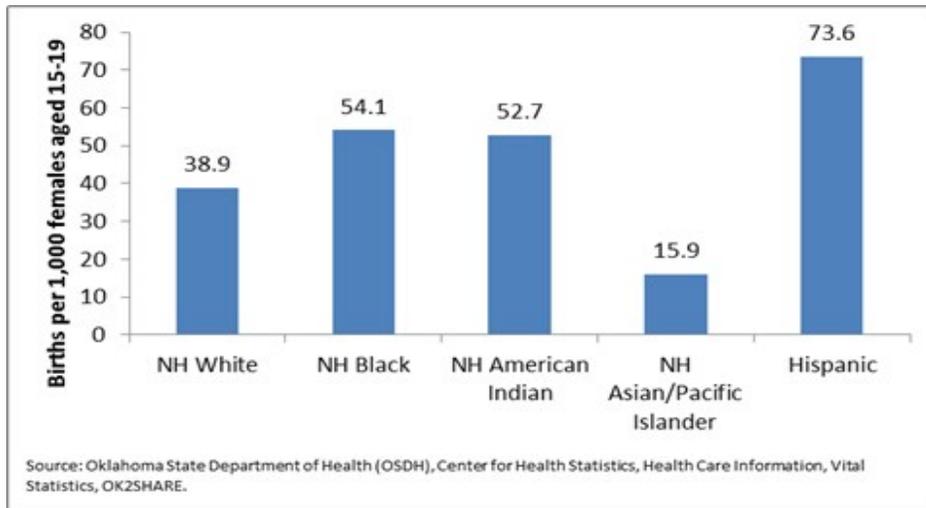
- 27.3% felt so sad or hopeless almost every day for two or more weeks that they stopped doing some usual activities during the past 12 months
- 15.7% seriously considered attempting suicide during the past 12 months
- 11.7% made a plan about how they would attempt suicide during the past 12 months
- 6.8% actually attempted suicide during the past 12 months

Teen pregnancy: Teen birth rates for 15-19 year olds are at historic lows in Oklahoma and have declined 40% over the past fifteen years from 60.1 births per 1,000 females aged 15-19 in 1999 to 42.9 in 2013.2 However,

Oklahoma's teen birth rate is declining at a slower pace than the national average, which decreased 46% during the same time span. Oklahoma's teen birth rate of 42.9 births per 1,000 females aged 15-19 was 38% higher than the national rate of 26.5.

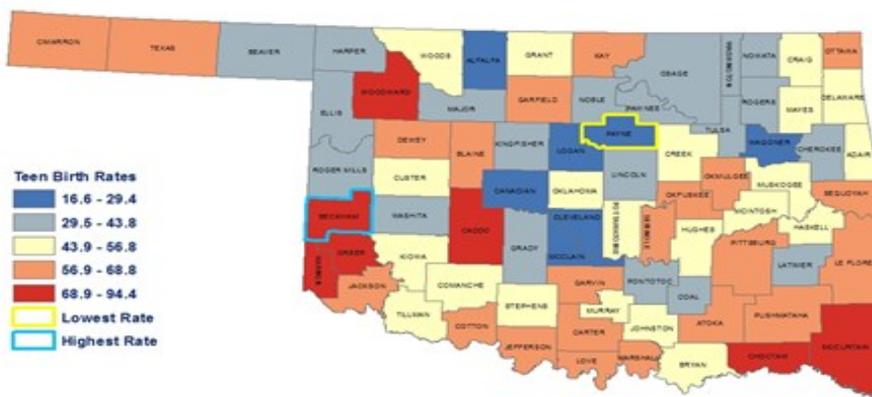
Racial and ethnic disparities exist for teen births in Oklahoma. From 2011-2013, Hispanics had the highest teen birth rate at 73.6 births per 1,000 females aged 15-19, followed by blacks at 54.1, American Indians at 52.7, whites at 38.9, and Asian Pacific Islanders at 15.9 (Figure II.B.2.a.3). While the rates may differ from national averages, the disparities observed in Oklahoma are similar throughout the nation.

Figure II.B.2.a.3. Birth Rates for Teens aged 15-19 by Race/Ethnicity: Oklahoma, 2011-2013



Disparities in teen birth rates also exist geographically in Oklahoma. Counties with the highest teen birth rates in Oklahoma tend to be in the northwest, southwest, and southeast regions of the state (Figure II.B.2.a.4).

Figure II.B.2.a.4. Teen Birth Rates (15-19 years) by County: Oklahoma, 2011-2013



National Rate (2013) 26.5 per 1,000 females
Oklahoma Rate (2013) 42.9 per 1,000 females

Teen Birth Rate^a Birth to females 15-19 years x 1,000
Total female population 15-19 years

Data Source: Oklahoma State Department of Health, Health Care Information, Birth Certificate Data

Created: 04.17.2015

Projection/Coordinate System: USGS Albers Equal Area Conic



Disclaimer: This map is a compilation of records, information and data from various city, county and state offices and other sources, affecting the area shown, and is the best representation of the data available at the time. The map and data are to be used for reference purposes only. The user acknowledges and accepts all inherent limitations of the map, including the fact that the data are dynamic and in a constant state of maintenance.



Behavioral and Child Health Assessment Division
Community and Family Health Services
Oklahoma State Department of Health

iii. State's priority needs

The state's MCH priority needs for the Title V Block Grant cycle for 2016-2020 specific to the adolescent health

population domain are: Reduction in the Incidence of Suicide, Improvement in Mental and Behavioral Health, Reduction of Teen Pregnancy, and Reduction of Health Disparities.

iv. Title V-specific programmatic approaches

Family Planning: OSDH is the Title X Family Planning Grantee providing confidential services and all methods of birth control to adolescents, regardless of age or parental consent, with an emphasis on the Long Acting Reversible Contraceptives (LARC). Family planning clinical services are provided at 87 OSDH county health department service sites and eight contract clinic sites in 70 of the 77 counties. All of these sites plus one additional site in Tulsa that targets at-risk, hard to reach youth provide outreach and education services. The remaining seven counties are rural and sparsely populated.

Pregnancy Prevention: MCH continued the administration and monitoring of the Personal Responsibility Education Program (PREP) grant, which supported implementation of adolescent pregnancy prevention projects through contractual agreements with the city-county health departments in Oklahoma City and Tulsa. Target populations remained youth 11-19 years of age in middle, high, and alternative schools in the Oklahoma City and Tulsa metropolitan statistical areas (MSAs). PREP projects continued to use evidence-based curriculum. The number of state-funded adolescent pregnancy prevention projects in local county health departments supported by MCH totaled five administrator areas in 24 counties. The existing projects used the same curriculum and evaluation tools as the PREP grant recipients. MCH continued to provide guidance, oversight, and technical assistance to the PREP and adolescent pregnancy prevention projects.

MCH finalized the "Women's Health Assessment" tool which addresses key issues to assess prior to becoming pregnant. This tool was developed to use with all women of child-bearing age, including adolescents. "My Life. My Plan" which encourages adolescents to take charge of their health, take better care of themselves, set goals, and understand how pregnancy will affect these goals continued to be used in some clinics and was available online.

Public Health Youth Councils (PHYC): MCH intends to increase the number of local youth councils from 3 in 2014 to 12 by 2020. PHYC will provide input regarding health issues, including reproductive health information to help prevent risk-taking behaviors that contribute to suicide, bullying, HIV, STDs, and teen pregnancy. Plans include training additional council facilitators, recruiting more youth, conducting asset inventory survey of council members, and providing education on adolescent health issues.

Suicide Prevention: MCH, the Injury Prevention Service (IPS), and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) work together to implement the state's suicide prevention plan including community-based suicide prevention training, suicide screening for youth, and improved referral and follow-up networks for youth at risk for suicide.

Children and Youth with Special Health Care Needs (CYSHCN)

i. Overview

Children and youth with special health care needs (CYSHCN) are "those who have or are at increased risk for a chronic physical, developmental, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." This broad definition makes a precise estimate of the number and percentage of Oklahoma CYSHCN difficult. The 2009/10 National Survey of Children with Special Health Care Needs estimated that in Oklahoma there were 161,799 CYSHCN, representing approximately 18% of all state children. The prevalence of CYSHCN increases with age: 10.9% 0-5 years, 20.7% 6-11 years, and 21.7% 12-17 years. Having special health care needs is more common among male children (20.4%) than female children (14.8%). CYSHCN rates vary by household income and race and ethnicity.

ii. Strengths and Needs

The Sooner SUCCESS 2014 Community Needs Assessment Survey showed that an overwhelming majority (92%) of the state's CYSHCN are affected on a regular basis by their condition(s), with 55% affected a great deal and 37% affected some.

Common Conditions: The most commonly occurring conditions are reflected in Table II.B.2.a.4. Learning, disruptive behavior, and speech language disorders affected 41.5%, 37.7%, and 35.0% of CYSHCN, respectively. Approximately 45% of CYSHCN reported to have 4 or more conditions.

Table II.B.2.a.4. Commonly Reported Sooner SUCCESS Diagnoses Among CYSHCN, 2014

Diagnosis	Sooner SUCCESS 2014 %
Learning Disorder	41.5
Disruptive Behavior Disorder	37.7
Speech Language Disorder	35
Autism/PAD	27
Allergies	23.8

Commonly Reported Service Needs: Families of CYSHCN were more likely to have medical service needs met than social or economic needs (e.g., play groups, diapers and clothing assistance) and caregiver needs (e.g., respite care and daycare). Table II.B.2.a.5 displays the most commonly reported service needs.

Table II.B.2.a.5. Most Commonly Reported Service Needs among CYSHCN Families, Sooner SUCCESS 2014

Service Need	Sooner SUCCESS 2014 %
Special Education Classes	50.4
Dental Care	48.4
Well-child Checkup	45.7
Certified Special Education Personnel	41.1
School-based Speech & Language Therapy	39.2
Non School-based Speech & Language Therapy	34.8

Services Received: Overall, most medical service needs were generally met. Three medical service needs – psychiatric evaluation, inpatient care, and residential nursing – met less than 70% of stated family need. Community based services not typically provided by certified professionals has much lower rates of meeting family need. Seventeen percent of family respondents reported a need for respite care, yet only 28 percent of them had that need fulfilled. Ten percent of family respondents identified home care as a need but only 43 percent of those families were able to obtain home care. Lastly, nearly 20 percent of family respondents expressed a need for assistance with transition to adulthood for their child. Only 19 percent of families had this need for assistance satisfied.

Families noted concerns about opportunities for their children during the transition to adulthood. These anxieties reflect issues dealing with future residence, finances, transportation, assistance with making health appointments, and independence and self-sufficiency. Parents identified as a need the provision of classes and coaching to prepare CYSHCN for adult life.

iii. State's priority needs

The state's MCH priority needs for the Title V Block Grant cycle for 2016-2020 specific to the CSHCN health population domain are: Improvement in the Transition to Adult Health Care for Children and Youth with Special Health Care Needs and Reduction of Health Disparities.

iv. Title V-specific programmatic approaches

Transition toolkit development: CYSHCN program will partner with pediatricians and family medicine physicians, along with the Oklahoma Chapter of the American Academy of Pediatrics, to develop a toolkit for use by primary care physicians.

Transition awareness: CYSHCN program to convene transition workgroup of Title V partners and families of CYSHCN to discuss transition services, gain valuable family input, and spread awareness that the need exists for more robust transition services in Oklahoma.

Cross-cutting/Life Course

i. Overview

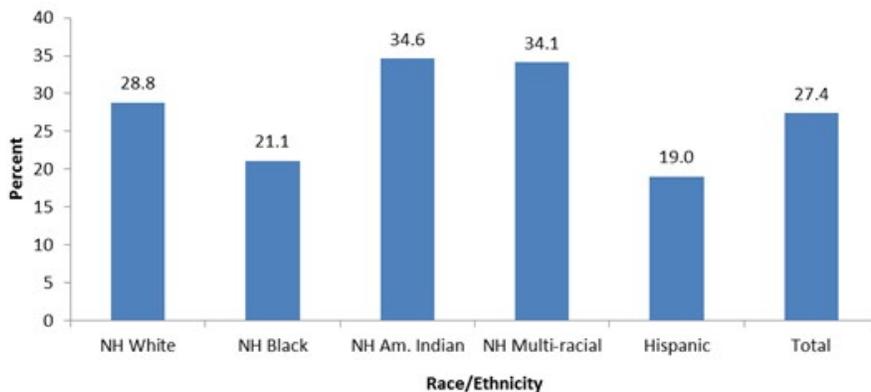
The life course perspective is a useful conceptual framework for understanding and addressing health. This approach helps incorporate the interplay of risk and protective factors and stages of critical development to further explain health outcomes as they occur across the lifespan. It has been particularly helpful in addressing health disparities by emphasizing differential opportunities and experiences across population demographics.

The assessment of cross-cutting issues is informed by the knowledge that select issues may differentially impact population groups across time and space, and have varying degrees of criticality or intensity of impact.

ii. Strengths and Needs

Mental and Behavioral Health: Thirty percent of women 18-44 years old had 1-13 mentally unhealthy days and 17.3% reported having more than 13 mentally unhealthy days in the last month. More than a quarter (27.4%) of adult women has had a depressive disorder; rates of depressive disorders vary by race/ethnicity (Figure II.B.2.a.5).

Figure II.B.2.a.5. Prevalence of Depressive Disorders among Oklahoma Females 18-44, by Race/Ethnicity, BRFSS 2011-2013



Source: OSDH, Center for Health Statistics, Health Care Information, Behavioral Risk Factor Surveillance System 2011 to 2013, OK2SHARE. Accessed at <http://www.healthok.gov/ok2share> on March 18, 2015.

Data from the 2013 YRBS show that more than one in six students (18.6%) were bullied on school property, 14.3% had been bullied electronically, and 4.6% had been threatened or injured by someone with a weapon on school property (Table II.B.2.a.6).

Table II.B.2.a.6. Prevalence (%) of bullying and partner violence, YRBS 2013

Violence Indicators	Female	Male	Total
Bullied ¹	22.6	14.7	18.6
Bullied Electronically ¹	21.5	7.4	14.3
Threatened or injured by someone with a weapon	3.7	5.5	4.6
Hit, slapped, or physically hurt by their partner	11.3	5.7	8.3
Forced to do sexual things by their partner	13.9	5.4	9.5
1 On school property during the past 12 months			

iii. State’s priority needs

Oklahoma MCH priority needs for the Title V Block Grant cycle for 2016-2020 specific to the cross-cutting/life course population health domain include: Reduction in the Prevalence of Chronic Health Conditions among Childbearing Age Women, Reduction in the Incidence of Preterm and Low Birth Weight Infants, and Reduction of Health Disparities.

iv. Title V-specific programmatic approaches

Preparing for a Lifetime. It’s Everyone’s Responsibility: The Postpartum Depression Work Group is developing screening tool trainings for county health departments.

PHYC: See Adolescent Health Section *iv*.

Safe School Committees: MCH will work with the Oklahoma State Department of Education (OSDE) to increase the number of Safe School Committees; reporting to OSDE as required by the School Safety and Bullying Prevention Act. Training will be provided to school staff and administrators. Other training about the impact of bullying will be provided to parents and community members.

Curriculum Development: MCH staff will participate in the OSDE Executive Committee to develop Pre-K to 12th grade health curricula that incorporate information about prevention, recognition and intervention to reduce the incidence of bullying.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

In Oklahoma, state health and human services are organized under the Cabinet Secretary of Health and the Cabinet Secretary of Human Services who are appointed by the governor. Terry Cline, PhD, Oklahoma Commissioner of Health, is the Cabinet Secretary of Health and Human Services. Health and Human Services agencies in Oklahoma including the Oklahoma State Department of Health (OSDH), Oklahoma Department of Human Services (DHS), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Department of Rehabilitation Services, Office of Juvenile Affairs, Oklahoma Health Care Authority (OHCA) and the Oklahoma Commission on Children and Youth (OCCY). The Department of Corrections and the Oklahoma State Department of Education are under different cabinet secretaries. The OCCY is charged with planning and coordinating children's services in the state in addition to providing oversight for juvenile services. The agency heads of all the major agencies serving children are appointed to serve on the OCCY.

Oklahoma administers the MCH Title V Block Grant through two state agencies, the OSDH and the 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, charge the Commissioner of Health to serve under the Board of Health, 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 MCH Title V Program is located in the OSDH within the Community and Family Health Services (CFHS). The CFHS is organizationally placed under the Commissioner of Health. Joyce Marshall, Director of MCH, is directly responsible to the Deputy Commissioner of the CFHS, Stephen Ronck, who is directly responsible to the Commissioner of Health, Dr. Terry Cline. Dr. Edd Rhoades is Medical Director for the CFHS and the Chief Medical Officer for the OSDH.

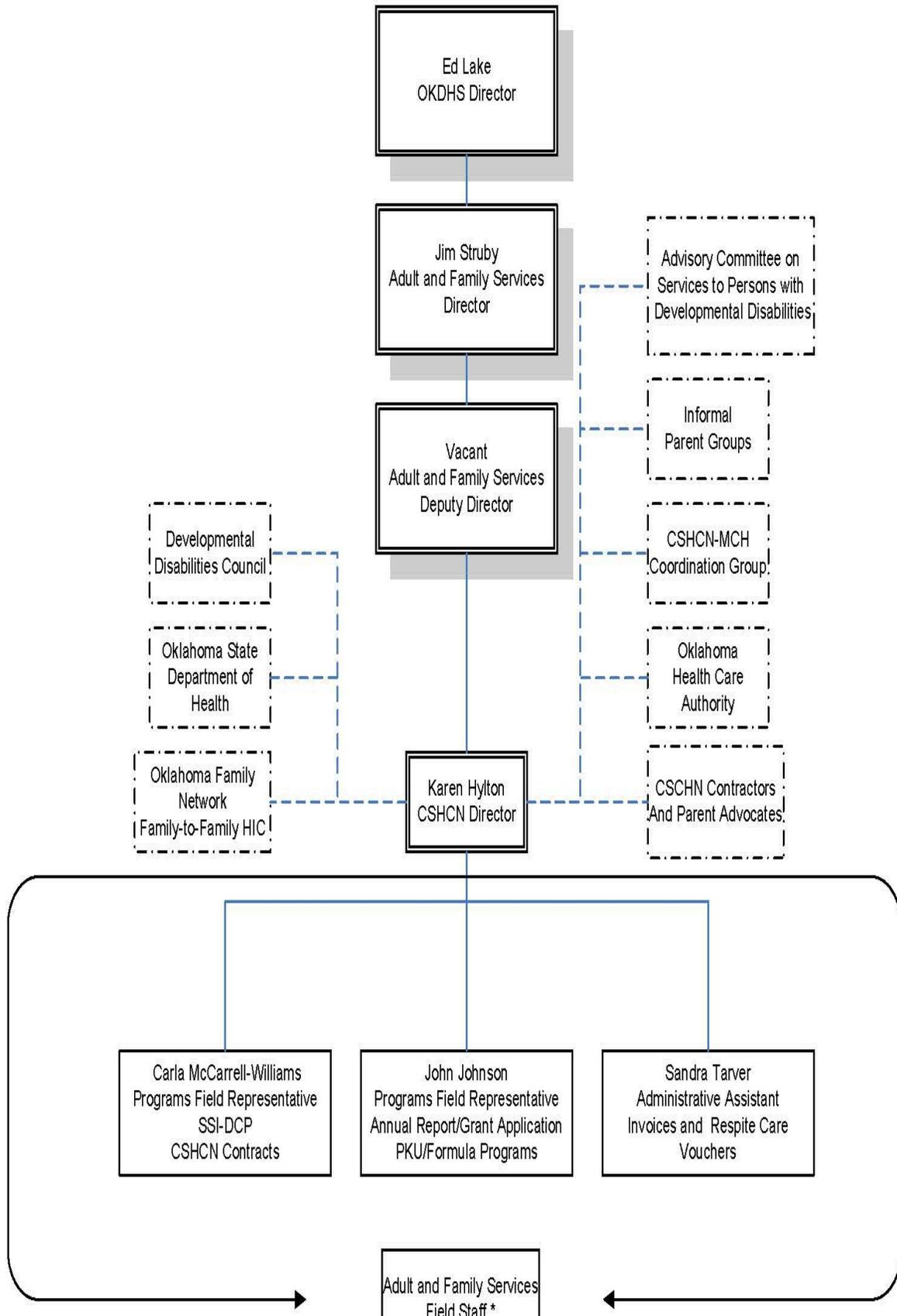
Programs administered in some part with Title V funds include: *Preparing for a Lifetime, It's Everyone's Responsibility*; the CollN Prematurity, Preconception/Interconception, Safe Sleep and Social Determinants of Health national projects; *Every Mother Counts*, the maternal mortality and morbidity reduction initiative; Pregnancy Risk Assessment Monitoring System (PRAMS) The Oklahoma Toddler Survey (TOTS), First and Fifth Grade Health Surveys and the Youth Risk Behavior Survey (YRBS) surveillance programs; Teen Pregnancy Projects throughout the state; the Third Grade Oral Health Needs Assessment; State Systems Development Initiative (SSDI); Fetal and Infant Mortality Review; School Health; Oklahoma Birth Defects Registry; *Becoming Baby Friendly Oklahoma*; *Every Week Counts*; and, other-related programs and initiatives.

The Title V CSHCN Program is located in the DHS within the Health Related and Medical Services (HRMS) unit. The HRMS is organizationally placed under Adult and Family Services. Karen Hylton is the Director of the CSHCN Program and Program Manager for HRMS. Karen Hylton reports to the Deputy Director for Programs and the Deputy Director for Programs reports to Jim Struby, the Director of Adult and Family Services. Jim Struby reports to Ed Lake, the Director of DHS.

Title V CSHCN provides funding for respite, equipment, diapers, and formula not covered by Title XIX, as well as funding to the Oklahoma Family Network which provides training and support to families of CSHCN, and to several groups at the University of Oklahoma Health Sciences Center that provide various services to CSHCN. These groups include the Autism Network, the Sickle Cell clinic, Sooner SUCCESS which provides a comprehensive system of health and educational services to CSHCN, the Oklahoma Infant Transition Program which assists families of newborns in the neonatal intensive care unit, and the Family Support 360 Center which helps families of CSHCN navigate the health system. Title V CSHCN also provides funding to Child Welfare Services of DHS for physician's services that are not Medicaid compensable.

Brief biographies for key MCH, OSDH, and CSHCN staff are attached and can also be obtained by contacting MCH at (405) 271-4480 or PaulaW@health.ok.gov. Organizational charts are below.

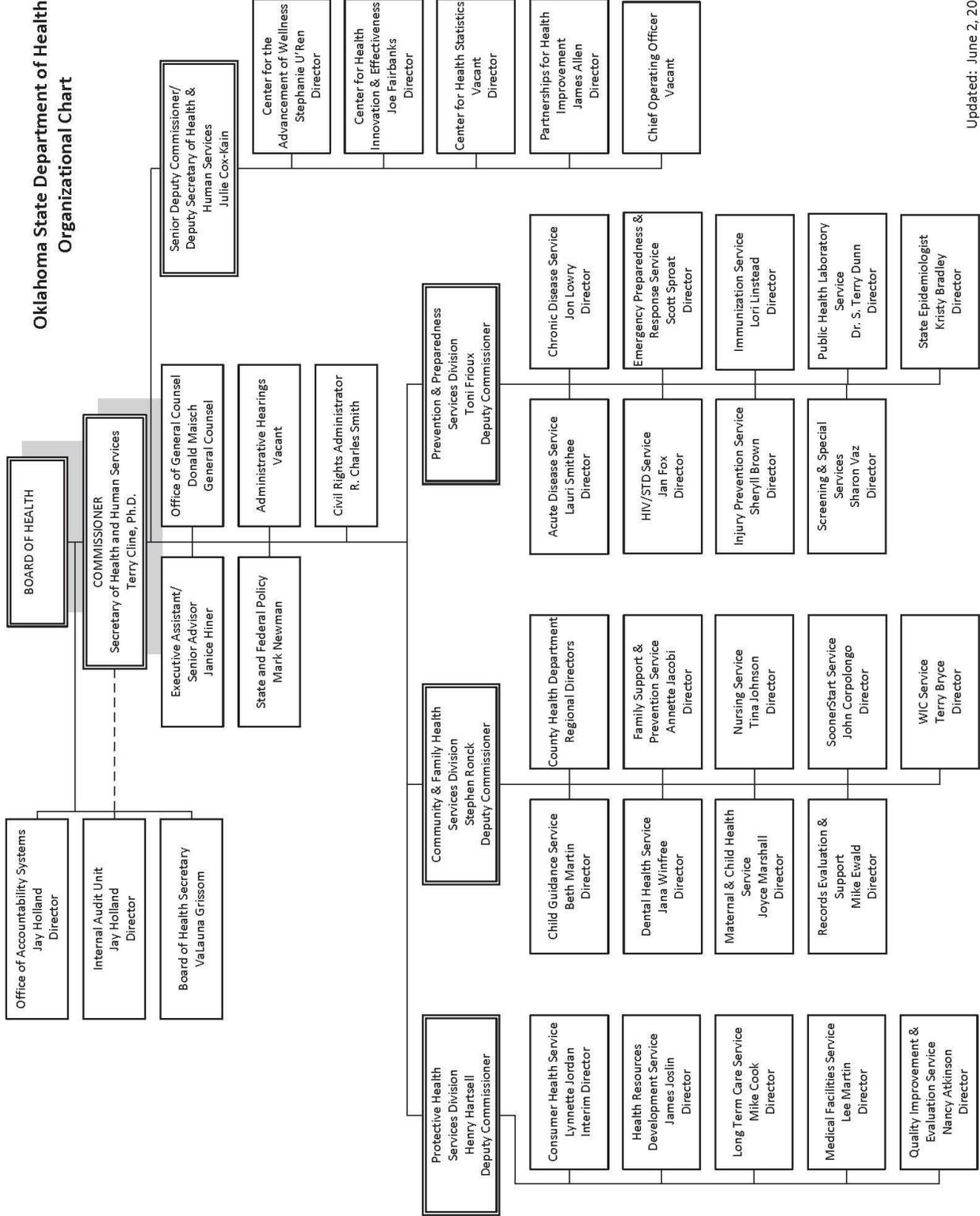
OKLAHOMA DEPARTMENT OF HUMAN SERVICES
CHILDREN WITH SPECIAL HEALTH CARE NEEDS
PROGRAM ORGANIZATIONAL CHART



1.10.2020

* 36 Adult and Family Services County Directors administer over 90 locations with over 1500 Social Service Specialists state-wide

Oklahoma State Department of Health Organizational Chart

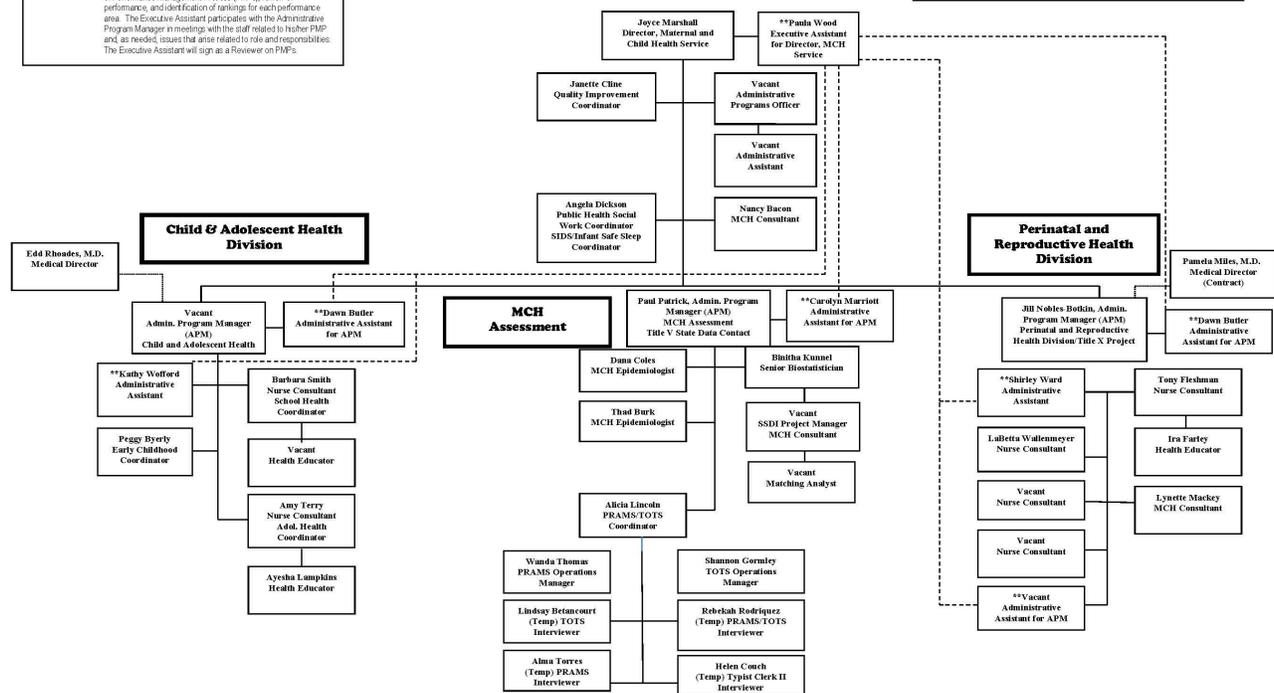


Updated: June 2, 2015

**The Executive Assistant serves as technical supervisor and mentor to the Administrative Assistants. The Executive Assistant works directly with the Administrative Program Manager of the Division on defining the staff's role and responsibilities, development of Performance Management Process (PMP), review of performance, and identification of ratings for each performance area. The Executive Assistant participates with the Administrative Program Manager in meetings with the staff related to his/her PMP and, as needed, issues that arise related to role and responsibilities. The Executive Assistant will sign as a Reviewer on PMPs.

Maternal and Child Health Administration 405-271-4480
 Child & Adolescent Health Division 405-271-4471
 MCH Assessment 405-271-6761
 Perinatal and Reproductive Health Division 405-271-4476

MATERNAL AND CHILD HEALTH SERVICE
 May 29, 2015 (37 FTE)



II.B.2.b.ii. Agency Capacity

MCH serves as the lead for the state's infant mortality reduction initiative, *Preparing for a Lifetime, It's Everyone's Responsibility*. MCH continues to be integrally involved with the work of the Oklahoma Perinatal Quality Improvement Collaborative, improving the care of women and infants throughout the state.

MCH has close working relationships with state level programs and with the Regional Directors of the county health departments. Multiple opportunities exist to engage in activities with OSDH leadership to communicate about Title V, including a monthly leadership meeting which is attended by Deputy Commissioners, Directors, and Managers. The MCH Title V Director interacts with all CFHS Directors in bimonthly meetings, affording an opportunity to discuss crosscutting activities. MCH routinely collaborates with other OSDH programs to address issues of mutual interest, including preconception care and health across the life course, 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, early childhood and social determinants of health.

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.

CSHCN oversees the provision of services to children receiving Title XVI Supplemental Security Income (SSI) by providing training and guidance to the over 70 social services specialists, who are responsible for writing and monitoring service plans for all children who receive SSI and other services through the DHS. Families of children, who receive SSI, but not Medicaid, are contacted to assure they are informed of services available through the CSHCN Program. CSHCN contracts with clinics to provide care to neonates in the Tulsa and Oklahoma City

metropolitan areas and with physicians for the provision of non-Medicaid compensable services to children in DHS custody.

Results from the MCH-administered 2014 Key Informant Survey indicate both strengths and limitations in the system capacity of Title V programs and other programs and agencies in meeting the needs of MCH populations (Table II.B.2.b.ii.1). Designed to capture input on the ability of programs and organizations to provide the essential public health services, the survey offers mixed findings. State strengths include the capacity to assess and monitor health status, mobilize partners, inform and educate the public and families, provide MCH-related leadership, and assure the competency of the public health workforce to address MCH needs. Yet, challenges exist, such as the capacity for diagnosing and investigating health problems and risk factors, promoting and enforcing legal requirements that protect the MCH population, and support for research to study MCH-related issues. Further review and interpretation of this information is needed, along with a more comprehensive assessment of state capacity to address essential services, particularly in those areas where challenges may exist.

Table II.B.2.b.ii.1. Findings of the 2014 MCH Key Informant Survey

Essential Public Health Service	Strengths ¹	Challenges ²
Assess and monitor the health status of MCH populations to identify and address problems	<ul style="list-style-type: none"> Assess and monitor health status Report results of population health analyses to MCH programs and stakeholders Use data to develop program or projects to address MCH-related problems Use needs assessment results to identify and solve problems 	<ul style="list-style-type: none"> Document and report identified health disparities in MCH populations
Diagnose and investigate health problems and risk factors affecting the MCH populations		<ul style="list-style-type: none"> Administer population surveys on health conditions and behaviors Identify and report on current and emerging issues with potential impact to MCH populations
Mobilize partnerships between community leaders, policymakers, health care providers, families, the general public and others to identify and solve issues	<ul style="list-style-type: none"> Engage with community or statewide partnerships to inform prevention efforts Partner with local and state MCH program areas Participate in community coalitions, local committees, or workgroups 	
Inform and educate the public and families about MCH health issues	<ul style="list-style-type: none"> Support and provide expertise and resources to inform and educate the MCH populations Provide culturally appropriate expertise to develop education materials and programs to address MCH issues Partner with community coalitions and stakeholders to improve and expand awareness of MCH issues 	<ul style="list-style-type: none"> Conduct program evaluation on health education efforts
Provide leadership for priority setting, planning, and policy development to support efforts to assure the health of the MCH populations	<ul style="list-style-type: none"> Use performance measures or health indicators to set priorities and develop action plans Formulate quality improvement plans and efforts to improve data system processes and the provision of services Promote and advocate for MCH issues to be given priority by policymakers and public health leadership 	<ul style="list-style-type: none"> Provide MCH-related consultation and/or technical training to community partners or stakeholder groups
Promote and enforce legal requirements that protect the health and safety of the MCH population, and ensure public accountability for their well-being		<ul style="list-style-type: none"> Assess and monitor the impact of legislative mandates, regulation, or policy to the provision of services and health status of MCH populations Provide education and training to staff and community partners regarding MCH relevant laws Collect and report data relevant to the implementation and enforcement of changes to law and program practices
Link the MCH population to health and community and family services, and assure access to comprehensive, quality systems of care	<ul style="list-style-type: none"> Provide community, family, or health services for MCH populations Partner with appropriate community agencies across service systems to enable access to MCH services 	<ul style="list-style-type: none"> Provide rehabilitation services for the blind and disabled children and youth receiving SSI benefits Evaluate and report on the ability of clients to access care when needed
Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address MCH needs	<ul style="list-style-type: none"> Employ staff with expertise in MCH-related issues Offer MCH-related educational and professional development opportunities for staff 	
Evaluate the effectiveness, accessibility, and quality of MCH services	<ul style="list-style-type: none"> Identify and address the unmet needs of the MCH populations Identify and address barriers to care 	<ul style="list-style-type: none"> Provide health system evaluations to state and local entities for the purpose of quality improvement
Support research to study MCH-related issues		<ul style="list-style-type: none"> Conduct scientific or special studies to improve the understanding of MCH-related issues Partner with MCH stakeholders to disseminate study findings Fund studies related to MCH-related issues

¹Greater than 80% of respondents indicated capacity for performing service

²Less than 80% of respondents indicated capacity for performing a given service

Title V funds are used to support state program collaboration and coordination, and community activities, in various settings. See Table II.B.2.b.ii.2 for a list of partners working on Title V-funded projects.

Child Care Services (DHS)	County Health Departments
Center for the Advancement of Wellness (OSDH)	Family Support and Prevention Service (OSDH)
Office of Perinatal Continuing Education	Injury Prevention Service (IPS)
Public Health Youth Councils	Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV) and other statewide home visiting programs (OSDH)
Healthy Start Projects	Office of Minority Health (OSDH)
March of Dimes	Oklahoma Breastfeeding Hotline
Coalition of Oklahoma Breastfeeding Advocates (COBA)	Oklahoma City-County and Tulsa Fetal and Infant Mortality Review Teams
Chronic Disease Service (OSDH)	Oklahoma City-County Health Department
Collaborative Improvement and Innovation Network (CoIIN)	Oklahoma Department of Mental Health and Substance Abuse Services
OU Department of Pediatrics (OKC)	Oklahoma Development Disabilities Council
Oklahoma State Department of Education	Oklahoma Family Network
OHIP Children's Health Flagship Work Group	Oklahoma Health Care Authority
Oklahoma Areawide Services Information System (OASIS)	Oklahoma Hospital Association
WIC (OSDH)	Oklahoma Hospital Breastfeeding Education Project
Dental Health Service (OSDH)	Oklahoma Mothers Milk Bank
OU Health Science Center Child Study Center	Oklahoma Perinatal Quality Improvement Collaborative
OU Medical Center Women's Services	Screening and Special Services (OSDH)
Schools for Healthy Lifestyles	Smart Start Oklahoma
Sooner SUCCESS	Tulsa Health Department

II.B.2.b.iii. MCH Workforce Development and Capacity

Currently, MCH Title V funds and staffs 37 full-time equivalent positions (FTEs). CSHCN consists of three staff funded by Title V, including the CSHCN Title V Director and two program staff. For a more detailed description of the Title V-funded workforce in the state and trainings, including those to improve cultural understanding for the public health workforce, please see Section 2 of the block grant narrative, Workforce Development and Capacity. Biographies for key staff are attached.

II.B.2.c. Partnerships, Collaboration, and Coordination

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. The MCH Title V Director, CSHCN Director, and the OFN Executive Director are members of the Oklahoma Health Improvement Plan (OHIP) Children's Health Work Group and have provided continuing input into the formulation of statewide efforts to address health needs in the child population. One examples is the priority focus areas, bullying and youth suicide prevention, as work has been accomplished in partnership with the OSDE and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). MCH has worked closely with the OSDE on curriculum that schools can implement. MCH has committed to assist in further building community level infrastructure for recognizing and intervening to prevent youth suicide across the state by assuring these staff provide the required number of trainings requested by the ODMHSAS.

Table II.B.2.c.1 highlights key partner programs and agencies that Oklahoma Title V and OFN collaborate with to improve health across the six domains: women/maternal, perinatal/infant, child, adolescent, CYSHCN, and life course/crosscutting.

Table II.B.2.c.1. Key Partner Programs and Agencies for Oklahoma Title V

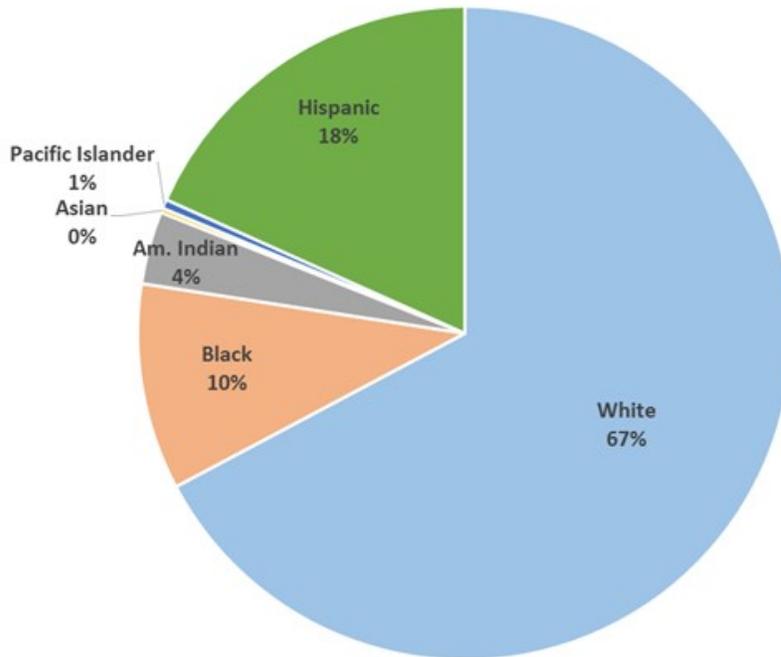
Association of Women's Health, OB & Neonatal Nurses	Indian Health Service (IHS)	Families
Blue Cross Blue Shield of Oklahoma	March of Dimes	Office of Minority Health (OSDH)
Child Death Review Board	Office of Perinatal Continuing Education	Oklahoma Dental Association
Child Guidance (OSDH)	OHIP Children's Health Flagship Workgroup	Injury Prevention Service (IPS)
Chronic Disease Service (OSDH)	Family Support and Prevention Service (OSDH)	Oklahoma Department of Mental Health and Substance Abuse Services
Coalition of Oklahoma Breastfeeding Advocates (COBA)	Oklahoma City-County Health Department	Oklahoma Development Disabilities Council
Community Services Council of Greater Tulsa	Oklahoma Areawide Services Information System (OASIS)	Oklahoma Health Care Authority
Consumer Representatives	Oklahoma City Area Inter-Tribal Health Board	Oklahoma Hospital Association
Dental Health Service (OSDH)	Oklahoma City-County and Tulsa Fetal and Infant Mortality Review Teams	Oklahoma Institute for Child Advocacy
Head Start State Collaboration Office	OU Department of Pediatrics (OKC)	Oklahoma Perinatal Quality Improvement Collaborative
Healthy Start Projects	SoonerStart (OSDH)	County Health Departments
Maternal, Infant and Early Childhood Home Visiting Programs (MIECHV, OSDH)	OU Health Science Center Child Study Center	Oklahoma Primary Care Association
Oklahoma Commission on Children and Youth	OU Medical Center Women's Services	OU Health Sciences Center
Oklahoma State Medical Association (OSMA)	Schools for Healthy Lifestyles	Screening and Special Services (OSDH)
Oklahoma Turning Point	Sooner SUCCESS	Smart Start Oklahoma
OU Children's Medical Center	Center for the Advancement of Wellness (OSDH)	Children's Oral Health Coalition
Safe Kids in Tulsa and Oklahoma City	Oklahoma State Department of Education	Variety Health Center
Immunization Service (OSDH)	Tulsa Health Department	WIC (OSDH)
Oklahoma Family Expectations Program	Child Care Services (DHS)	Center for Health Statistics (OSDH)

One key aspect of partnership and collaboration for Oklahoma Title V is family participation. The Oklahoma Family Network (OFN) assures family input is received in the planning, development, and evaluation of Oklahoma Title V policy, procedures, and services. OFN participated in the planning, information gathering activities, and prioritization process for the 2016-2020 Title V Needs Assessment.

Diversity of partnership members

Figure II.B.2.c.1 shows the diversity of members engaged and served by the Oklahoma Family Network for Federal Fiscal Years 2010-2015. Two-thirds were white and almost 1 in 5 were Hispanic. The majority of families served were from rural areas.

Figure II.B.2.c.1 Diversity of those served by OFN from FY 2010-2015



Quantitative Information on Engagement in Family/Consumer Partnership

Since the last 5-year Needs Assessment, 453 unduplicated families have been engaged in leadership activities and received stipends for their involvement through OFN. Families have been engaged in a variety of activities, providing input on access to care issues, transition, education, family leadership, etc. See Table II.B.2.c.2 for more information on the number of families served, compensated, and trained.

Table II.B.2.c.2. Title V Family/Consumer Partnerships in Oklahoma, from 2010-2015	
Number of families engaged (unduplicated)	453
Number of families being compensated for involvement (unduplicated)	453
Number of families trained in core MCH competencies	877
Range of issues being addressed	Access to care, respite, transition to adulthood, children and youth with special health care needs, infant mortality, breastfeeding, infant mental health, children in custody, issues related to military families, access to education, leadership training, information, etc.

Degree of Engagement

OFN families provided input to multiple agencies, via focus groups, Advisory Councils, trainings, and sharing of personal stories. Table II.B.2.c.3 lists the organizations and committees with current family involvement in the state.

Table II.B.2.c.3. Organizations and Committees with Current Family Involvement		
ABCD 3 Canadian County Planning Advisory	Oklahoma Health Improvement Plan Children's Health Work Group	Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Systems of Care State Advisory Team
ABCD 3 Garfield County Planning Advisory	Oklahoma Health Improvement Plan Health Efficiency & Effectiveness Work Group	ODMHSAS Children's State Advisory Work Group
ABCD 3 Oklahoma County Planning Advisory	Oklahoma Interagency Council for Autism	ODMHSAS Systems of Care County Coalitions in twenty counties
ABCD 3 State Planning Advisory and three counties' planning advisories	<i>Preparing for a Lifetime</i> Postpartum Depression Work Group	Oklahoma Department of Rehabilitation Services Deaf and Hard of Hearing Advisory
ABCD 3 Tulsa County Planning Advisory	Screening and Special Services Advisory	Oklahoma Health Care Authority Medical Advisory Committee
Canadian County Infant Mental Health Advisory	The Children's Hospital at Saint Francis Family Advisory Council	Oklahoma Health Care Authority Member Advisory Task Force
Communities of Care Mental Health and Child Welfare Action Team	Title V Block Grant Reviews	Oklahoma Health Care Authority Member Advisory Task Force Steering Committee
DHS Developmental Disabilities Services (DDS), the Governor's task force regarding individual on the Waiver Waiting List	OFN Board of Directors	<i>Preparing for a Lifetime</i> Breastfeeding Work Group
Hearts for Hearing Board of Directors	OFN Family to Family Health Information Center Advisory Committee	Oklahoma Transition Council
Integrus Baptist Patient and Family Advisory Council	Oklahoma Commission for Children and Youth	OSDH Newborn Screening Advisory
Integrus Bass Baptist Patient and Family Advisory Council	Oklahoma Communities of Practice State Team	Perinatal Quality Improvement Collaborative
Interagency Coordinating Council for SoonerStart	Oklahoma Department of Human Services (DHS) Developmental Disabilities Services Policy Advisory Committee	Title V Directors' Meetings
MCH Service Interview Teams, OSDH	Oklahoma County Fetal and Infant Mortality Review Community Action Team	Title V Region 6 Directors' Calls

Efforts to build and strengthen family consumer partnerships

MCH CSHCN has provided funding to OFN for quite some time. Increased funding has been provided the past two years. OFN has hired a Health Coordinator to connect families to opportunities for leadership within MCH and

Regional Family Support Partners partner with CSHCN and their funded agencies to assure family involvement is key and coordination of efforts is evident based on Title V Block Grant priorities. OFN provides a family/professional partnerships leadership institute annually for about 150 families and agency leaders. Outcomes of these conferences include a better understanding of and more significant use of the life course theory as services are developed and provided. The Member Advisory Task Force for the Medicaid agency was developed as an outcome of the conferences as well. Overall, Oklahoma has made a big effort in recognizing families as consultants and providing funding to the statewide family network to support identification, training and coaching of family leaders for input to agencies.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Reduce infant mortality	Continued	
2	Reduce the incidence of preterm and low birth weight births	New	
3	Reduce the incidence of unintentional injury among children	New	
4	Reduce the incidence of suicide among adolescents	New	
5	Reduce health disparities	New	
6	Improve the transition to adult health care for children and youth with special health care needs	New	
7	Reduce teen pregnancy	New	
8	Reduce unplanned pregnancy	Continued	
9	Improve the mental and behavioral health of the MCH population	New	
10	Reduce the prevalence of chronic health conditions among childbearing age women	New	

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

Title V Needs Assessment Survey: MCH administered the survey online via Survey Monkey beginning in October 2013. Review of preliminary results indicated that certain populations were underrepresented. As a result, MCH partnered with OFN and the OSDH Office of Minority Health to gain access to a broader range of respondents, particularly families and African Americans. The survey was also administered to clients presenting for services at randomly selected county health departments. In total, 1,457 responses were captured in the survey.

MCH Tribal Listening Sessions: In completing past Title V Needs Assessments, Oklahoma had noticed that the American Indian population was underrepresented in its reporting of strengths and needs of the MCH populations. To give a fuller accounting of this important Oklahoma population, MCH partnered with the OSDH Office of Tribal Liaison to conduct seven tribal listening sessions during the summer and fall of 2014. Those tribes hosting a listening session included: Oklahoma City Indian Clinic, Choctaw Nation, Chickasaw Nation, Oklahoma Area Indian Health Service, IHS Clinton Service Unit, Northeastern Tribal Health System, and Muskogee (Creek) Nation. The qualitative information provided by tribal health care providers and representatives was particularly important in understanding cultural and geographical health issues.

Data Analysis: MCH Assessment staff analyzed surveillance data (e.g., PRAMS, TOTS, YRBS), vital records, census data, client service records, and Oklahoma specific national data (e.g., NSCH, NIS). An outline was created to guide this work and a narrative template was used to draft stand-alone documents with standard content. Both tools were informed by past experience in developing the Title V Needs Assessment and by extensive knowledge of MCH-related topics and data sets. The result was a set of topic-specific population health domain narratives that can readily be used to inform program and policy development. MCH staff was instrumental in developing the narratives by providing the subject matter expertise and current strategy information.

MCH Key Informant Survey: MCH administered the key informant survey online via Survey Monkey in April 2014. The survey was announced to MCH partners and stakeholders seeking their response within a two week period. Survey content focused on the capacity of Title V and programs and organizations to provide the essential public health services to the MCH populations. Approximately 100 partners/stakeholders received the survey invitation; 40 responses were obtained.

MCH/CSHCN Staff Involvement: Monthly MCH/CSHCN staff meetings were held in which needs assessment planning and results were discussed and shared. Results were presented to the *Preparing for a Lifetime, It's Everyone's Responsibility* infant mortality initiative, the Oklahoma Health Improvement Plan (OHIP) Children's Health Workgroup, and the Oklahoma Perinatal Quality Improvement Collaborative. Obtaining feedback from members of these groups was essential in understanding analysis findings.

From these data collection methods, a broad set of potential priorities was formed and considered for selection as Title V priority needs, which were then reduced by using a priority matrix. Using the matrix, MCH/CSHCN staff scored items on a set of review criteria including magnitude of problem, trend, severity of consequences, state and national priority, acceptability of population, amenable to change, and whether resources were available to address need. Scoring was summed across criteria and then ranked in order of magnitude. MCH/CSHCN staff then reviewed and discussed the ranked list of potential priorities in relation to which OSDH program area was considered the lead authority for positively impacting the issue. Those issues clearly not considered under the authority of MCH were removed as potential Title V priorities. For those issues, MCH will look to collaborate/partner with the lead authority when shared goals and objectives are in play. Table II.C.1 shows the potential priorities considered by Oklahoma Title V for inclusion in the top ten for the state.

Table II.C.1. List of Potential Title V Priorities for Oklahoma

Women/Maternal health	Perinatal/Infant health	Child Health	Adolescent Health	CSHCN	Cross-cutting/Life Course
Preconception/Interconception care	Prenatal care	Bullying	Teen pregnancy	Mental/behavioral health	Access to care
Mental/behavioral health	Breastfeeding	Mental/behavioral health	Mental/behavioral health	Respite care	Transportation
Substance Abuse	Maternal mortality/morbidity	Overweight/obesity	Overweight/obesity	Access to community based services	Poverty
Family planning	Preterm birth/low birth weight	Physical abuse/neglect	Smoke exposure	Medical home	Mental/behavioral health
Chronic conditions (hypertension, diabetes, obesity, asthma)	Mental/behavioral health	Smoke exposure	Oral health	Transition to adult care	
Oral health	Oral health	Immunizations	Substance Use	Family participation in care and services	
Health disparities	Health disparities	Oral health	Health disparities	Physical abuse	
Unintended pregnancy	Interconception care	Unintentional injury	STDs/risky sexual behavior		
	Congenital anomalies	Health disparities	Suicide		
	Immunizations	Child mortality			
	Safe sleep	School readiness			
	Newborn screening				
	Child abuse/neglect				
	Unintentional injury				
	Fetal/perinatal mortality				
	Smoke exposure				

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

Table II.C.2. Oklahoma Title V Priority Needs 2016-2020

Priority Need	Need Type	Rationale
Reduce infant mortality	Continued	State and national priority. Oklahoma compares poorly to the US and other states, ranking near the bottom with a high IMR. Racial disparities in IMR are marked and persistent.
Reduce the incidence of preterm and low birth weight births	New	Despite recent improvements, Oklahoma continues to experience higher rates of preterm birth and there has been little change in the rate of low birth weight births. Second leading cause of death and highly correlated with infant mortality.
Reduce the incidence of unintentional injury among children	New	Leading cause of child mortality for the state is unintentional injury, especially motor vehicle crashes and drownings.
Reduce the incidence of suicide among adolescents	New	Surveillance data indicate elevated rates of depression and suicide ideation among youth.
Reduce health disparities	New	Disparities in health, particularly by race/ethnicity, are persistent across many birth outcomes and risk behaviors.
Improve the transition to adult health care for children and youth with special health care needs	New	Sooner SUCCESS community needs assessment survey shows that those CYSHCN needing transition to adult health care services are not being met.
Reduce teen pregnancy	New	Despite improvement, Oklahoma ranks in the top 5 for states with the highest teen birth rates. The state continues to invest in teen pregnancy prevention through PREP and other teen pregnancy prevention projects.
Reduce unplanned pregnancy	Continued	Unintended pregnancy continues to be high in Oklahoma with an estimated half of all live births the result of an unintended pregnancy. Rates vary by race/ethnicity with minority groups experiencing higher rates. With greater adoption of LARC methods, there are opportunities for improvement.
Improve the mental and behavioral health of the MCH population	New	Needs Assessment findings support the need for programs and services to address mental and behavioral health across population groups to include bullying, substance use/misuse (opiates), mood disorders, and postpartum depression. There is a notable lack of providers in rural locations and inpatient bed availability is lacking across the state.
Reduce the prevalence of chronic health conditions among childbearing age women	New	Chronic conditions (diabetes, hypertension, obesity) remain high for Oklahoma women. A leading cause of infant death in 2013 was newborn affected by maternal conditions during pregnancy. Data for Oklahoma Maternal Mortality Review support the finding that a high proportion of maternal deaths are affected by chronic conditions.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	55.9	57.1	58.2	59.3	60.4

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.6	74.0	75.4	76.8	78.3

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	15.6	16.8	17.9	19.1	20.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	71.3	72.7	74.1	75.5	76.9

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	239.7	234.8	229.9	225.0	220.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.6	23.1	22.6	22.1	21.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.7	77.2	78.7	80.2	81.7

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.3	42.1	42.9	43.7	44.5

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	12.8	12.1	11.4	10.7	10.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	29.2	28.1	27.1	26.1	25.0

The following national performance measures were selected based upon the findings from our current five-year needs assessment and alignment to priorities defined in our Healthy Oklahoma 2020 Oklahoma Health Improvement Plan (OHIP); Agency Strategic Plan; and Maternal and Child Health (MCH) Service Strategic Priority Areas. Specific rationale is listed in the third column for each national performance measure selected along with the Oklahoma MCH Title V Priorities impacted by each measure.

National Performance Measures Selected for Oklahoma, by Population Domain		
Domain	National Performance Measures	Priorities Impacted and Rationale
Maternal	Percent of women with a past year preventive visit	<p>MCH Priorities Impacted: Chronic Disease, Family Planning, Preterm and LBW, Health Disparities, Teen Pregnancy, Infant Mortality</p> <p>Rationale: Impacts 6 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and 4 statewide Oklahoma Health Improvement Plan priority flagship and goal areas (<i>Children’s Health: Improve Maternal and Infant Health Outcomes</i> along with additional flagship priority areas in relation to Smoking, Obesity and Behavioral Health).</p>
	Percent of infants who are A) ever breastfed and B) Percent of infants breastfed exclusively through 6 months	<p>MCH Priorities Impacted: Infant Mortality, Chronic Disease, Preterm and LBW, Health Disparities</p> <p>Rationale: Impacts 4 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children’s Health: Improve Maternal and Infant Health Outcomes</i> along with priority flagship area, Obesity).</p>
Perinatal		<p>MCH Priorities Impacted: Infant Mortality, Unintended Injury, Preterm and LBW, Health Disparities</p> <p>Rationale: Impacts 4 of 10 Title V/MCH</p>

	Percent of infants placed to sleep on their backs	Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children's Health: Improve Maternal and Infant Health Outcomes</i>).
Child	Rate of injury-related hospital admissions per population ages 0 through 19 years	MCH Priorities Impacted: Unintended Injury, Health Disparities, Infant Mortality Rationale: Impacts 3 of 10 Title V/MCH Priorities as listed above and statewide Oklahoma Health Improvement Plan priority flagship and goal area (<i>Children's Health: Improve Child and Adolescent Health Outcomes</i>).
Adolescent	Percent of adolescents, ages 12 through 17 years, who are bullied	MCH Priorities Impacted: Suicide Prevention, Behavioral and Mental Health, Health Disparities Rationale: Impacts 3 of 10 Title V/MCH Priorities as listed above and 2 statewide Oklahoma Health Improvement Plan priority flagships and goal areas (<i>Behavioral Health: Reduce Suicide Deaths and Children's Health: Improve Child and Adolescent Health Outcomes</i>).
	Percent of adolescents with a preventive services visit in the last year	MCH Priorities Impacted: Suicide Prevention, Unintended Injury, Chronic Disease, Teen Pregnancy, Behavioral and Mental Health, Health Disparities Rationale: Impacts 6 of 10 Title V/MCH Priorities as listed above and 3 statewide Oklahoma Health Improvement Plan priority flagships and goal areas (<i>Tobacco Use: Reduce Adolescent Smoking Prevalence; Obesity: Reduce Adolescent Obesity Prevalence; and Children's Health: Improve Child and Adolescent Health Outcomes</i>).
CSHCN	Percent of children with and without special health care needs who received services necessary to make transitions to adult	MCH Priorities Impacted: Transition to Adulthood, Health Disparities, Behavioral and Mental Health Rationale: Impacts 3 of 10 Title V/ MCH Priorities as listed above and statewide Oklahoma Health Improvement Plan priority

health care	flagship and goal area (<i>Children’s Health: Improve Child and Adolescent Health Outcomes</i>).
Crosscutting A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes	MCH Priorities Impacted: Infant Mortality, Chronic Disease, Preterm and LBW, Mental and Behavioral Health, Health Disparities Rationale: Impacts 5 of 10 Title V/MCH Priorities as listed above and 2 statewide Oklahoma Health Improvement Plan priority flagship and goal areas (<i>Tobacco Use: Adult Smoking Prevalence; and Children’s Health: Improve Maternal and Infant Health Outcomes and Improve Child and Adolescent Health Outcomes</i>).

The above referenced national performance measures were chosen as those that best represented the needs of the Oklahoma maternal and child health population through extensive surveys and listening sessions held throughout the state. These measures were also selected based upon data trends and health impact upon residents, along with current alignment to State of Oklahoma and Agency priorities.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

The National and State Performance Measures for the 2010-2014 Title V Block Grant were organized by population domain in order to document completed activities for the 2014 Annual Report. Table II.F.1. provides the assigned population domain for each of the 2010-2014 National and State Performance Measures. Completed activities addressing each of the measures are included, by domain, in the following section. The number and wording of the measure accompanies the narrative. Those measures with activities neither staffed nor funded by MCH or CSHCN are described under *Other Programmatic Activities*, not in their assigned domain. Future plans are listed by domain only for continuing or new performance measures under the new state priorities.

Table IL.F.1. Title V 2010-2014 National and State Performance Measures by Population Domain

Title V MCH National Performance Measures	Population Domain
NPM #1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.	Perinatal/Infant
NPM #2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)	CSHCN
NPM #3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)	CSHCN
NPM #4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)	CSHCN
NPM #5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)	CSHCN
NPM #6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.	CSHCN
NPM #7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.	Child Health
NPM #8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.	Adolescent Health
NPM #9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	Child Health
NPM #10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.	Child Health
NPM #11: The percent of mothers who breastfeed their infants at 6 months of age.	Perinatal/Infant
NPM #12: Percentage of newborns who have been screened for hearing before hospital discharge.	Perinatal/Infant
NPM #13: Percent of children without health insurance.	Child Health
NPM #14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.	Child Health
NPM #15: Percentage of women who smoke in the last three months of pregnancy.	Crosscutting
NPM #16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.	Adolescent Health
NPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	Perinatal/Infant
NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	Maternal/Women's Health
Title V MCH Oklahoma State Performance Measures	Population Domain
SPM #1: The percentage of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.	Maternal/Women's Health
SPM #2: The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.	CSHCN
SPM #3: The percentage of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution)	Adolescent Health
SPM #4: The percentage of children with special health care needs who receive child care services at licensed child care facilities and homes.	CSHCN
SPM #5: The percentage of women receiving quality [American College of Obstetrics and Gynecology (ACOG) standards] pre-conception care.	Maternal/Women's Health
SPM #6: The percentage of infants who are put to sleep on their backs.	Perinatal/Infant
SPM #7: The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.	Crosscutting
SPM #8: The percentage of Medicaid eligible children with special health care needs who report receiving dental services other than for routine dental care.	CSHCN
SPM #9: The percent of adolescents grades 9-12 smoking tobacco products	Adolescent Health
SPM #10: The percent of live singleton births delivered before 39 completed weeks of gestation.	Perinatal/Infant

State Action Plan Table

Women/Maternal Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce the incidence of preterm and low birth weight births	Reduce the rate of preterm births (births < 37 weeks gestation) from 13.0 in 2012 to 11.4 by 2020	<p>Lead state team on the national Prematurity ColIN Initiative</p> <p>Increase utilization of progesterone therapy among pregnant women with a previous preterm delivery</p> <p>Increase the number of hospitals utilizing fetal fibronectin testing to assist in determining the plan of care for women with preterm contractions</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (<37 weeks)</p> <p>Percent of early preterm births (<34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p>	Percent of women with a past year preventive medical visit		

			<p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <hr/> <p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Preterm-related mortality rate per 100,000 live births</p>			
<p>Reduce the prevalence of chronic health conditions among childbearing age women</p>	<p>1. 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</p> <hr/> <p>2. Reduce maternal mortality rate from 29.1 per 1,000 live births in 2012 to 26.2 by 2020</p> <hr/> <p>3. Increase the number of women returning for the postpartum visit by 2020</p> <hr/> <p>4. By July 2016, improve birth intention by</p>	<p>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.)</p> <hr/> <p>1b. As a part of postpartum / interconception care, partner with home visitation programs (Healthy Start, Children First) to promote the importance of postpartum</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <hr/> <p>Maternal mortality rate per 100,000 live births</p> <hr/> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <hr/> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <hr/> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <hr/> <p>Percent of preterm births</p>	<p>Percent of women with a past year preventive medical visit</p>		

	<p>increasing the usage of the most effective methods of contraception among women on Medicaid and at risk for unintended pregnancy by 5%</p>	<p>visits and early prenatal care for future pregnancies.</p> <p>2a. Continue participation in Association of Maternal and Child Health Programs Every Mother Initiative and continue to facilitate the Maternal Mortality Review Project</p> <p>2b. As part of Every Mother Initiative, disseminate tool kits to all birthing facilities with information on evidence-based practices, provide technical assistance for hospitals in developing policies for care of patients with postpartum hemorrhage and hypertension to decrease morbidity and mortality, and provide simulation exercises to ensure all staff are familiar with policy and procedures</p> <p>3. Partner with a</p>	<p>(<37 weeks)</p> <p>Percent of early preterm births (<34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p> <p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>Infant mortality rate per 1,000 live births</p> <p>Neonatal mortality rate per 1,000 live births</p> <p>Post neonatal mortality rate per 1,000 live births</p> <p>Preterm-related mortality rate per 100,000 live births</p>		
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physician clinic and Central Oklahoma Healthy Start to educate women on the importance of the postpartum visit and assist in ensuring they attend the visit

4a. Lead the state team for the national ColIN Initiative on Pre / Interconception Health and promote LARC usage in family planning clinics and private physician practices

4b. Educate reproductive age males and females on being healthy before and between pregnancies through community baby showers, health fairs, March of Dimes walks, Blue Cross, Blue Shield Caring Van, public service announcements. Educate health care providers on the importance of preconception

		health education and screening through Oklahoma Perinatal Quality Improvement Collaborative activities and Maternal Mortality Review				
Reduce unplanned pregnancy	Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births by 5% by 2020	<p>Promote the importance of reproductive life planning through utilization of the Women’s Health Checklist and My Life. My Plan for adolescents</p> <p>Promote long acting reversible contraception to prevent unintended pregnancies and closely spaced pregnancies in county health departments and Medicaid recipients</p> <p>See activities to reduce teen pregnancy in the Adolescent Health Plan</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <hr/> <p>Maternal mortality rate per 100,000 live births</p> <hr/> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <hr/> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <hr/> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <hr/> <p>Percent of preterm births (<37 weeks)</p> <hr/> <p>Percent of early preterm births (<34 weeks)</p> <hr/> <p>Percent of late preterm births (34-36 weeks)</p>	Percent of women with a past year preventive medical visit		

			<p>Percent of early term births (37, 38 weeks)</p> <hr/> <p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <hr/> <p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Preterm-related mortality rate per 100,000 live births</p>			
Reduce health disparities	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 2015	<p>Continue to assist all clients visiting a county health department for a preventive health visit with development of a reproductive life plan</p> <hr/> <p>Distribute preconception / interconception health materials at community events (Farmer's Markets, Community Baby Showers, etc.)</p> <hr/> <p>Create and provide targeted</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <hr/> <p>Maternal mortality rate per 100,000 live births</p> <hr/> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <hr/> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <hr/> <p>Percent of moderately low birth weight deliveries (1,500-2,499</p>	Percent of women with a past year preventive medical visit		

		preconception health information to populations in need the information as identified by PRAMS and other data sources	grams)			
		Utilize Text4 Baby messages to develop media effective at reaching African Americans regarding infant mortality and being healthy	Percent of preterm births (<37 weeks)			
			Percent of early preterm births (<34 weeks)			
			Percent of late preterm births (34-36 weeks)			
			Percent of early term births (37, 38 weeks)			
			Perinatal mortality rate per 1,000 live births plus fetal deaths			
			Infant mortality rate per 1,000 live births			
			Neonatal mortality rate per 1,000 live births			
			Post neonatal mortality rate per 1,000 live births			
			Preterm-related mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

County health department staff will continue to assist individuals and families to apply for Medicaid benefits through the online enrollment process. This process assists pregnant females with obtaining earlier access to prenatal care, as eligibility will be determined at the time of application and they will immediately possess a Medicaid ID number for use in setting up appointments with providers. Medicaid administrative match funds will be provided by the OHCA to support these positions.

County health departments will continue to provide maternity clinical services as a safety net provider. County health departments and contract providers no longer having maternity clinics will provide pregnancy testing and will be expected to keep updated resource lists available to assist in linking clients with maternity providers.

The web pages for *Preparing for a Lifetime, It's Everyone's Responsibility* will continue to be updated with information regarding the importance of preconception care and early entry into prenatal care as a method of impacting infant mortality in the state. Resource cards identifying practices to promote a healthy pregnancy, to include entry into prenatal care during the first 12 weeks, and a multitude of resources will continue to be promoted at community events, with health care providers, and in pharmacies as a resource for pregnant females.

MCH will continue Comprehensive Program Reviews with county health departments and routine site visits to contractors and assess access issues in communities related to prenatal care especially in communities without MCH funded maternity clinics. Guidance will be provided to health care providers on strategies to educate women on the importance of receiving early prenatal care. Clinic records will continue to be audited to assure women with positive pregnancy tests are counseled on the need to initiate prenatal care within 15 days and linked with needed resources.

MCH will work with OPQIC to identify ways to impact issues related to access to care.

PRAMS data and data from the linkage of PRAMS, vital records, and Medicaid records will be used to inform stakeholders and policymakers.

MCH will continue to work with the OHCA to provide family planning services to low-income females and males of reproductive age who would otherwise not be eligible for Medicaid covered services through the SPA.

MCH will continue working with the OHCA on the national Collaborative Improvement and Innovation Network (CoIIN) Interconception Care team. Projected activities include promotion of LARCs in collaboration with community partners at community events, continuing to explore the possibility of expanding interconception health benefits by Medicaid Program, and assisting women in understanding the importance of creating a life plan, including a reproductive health plan.

Participate in the Association of Maternal and Child Health Programs (AMCHP) Every Mother Initiative and the Alliance for Innovation on Maternal Health (AIM) team, to improve data collection and develop and implement public health policy and strategies to prevent maternal death and improve health outcomes for mothers after and between pregnancies.

Family planning services will be provided through county health departments and contract clinics incorporating the new recommendations for expanded preconception health services and education.

Family planning providers will continue to be encouraged to treat every visit as a preconception health visit and provide targeted preconception/interconception health counseling to every client. MCH will continue to promote use of the Women's Health Assessment tool to screen for health risks and provide education to help women evaluate their risks and behaviors prior to pregnancy, promote use of the My Life, My Plan, and finalize a men's health resource. LARCs will continue to be offered as an effective strategy to increase the percent of women who have intended pregnancies.

MCH will continue to collaborate with OHCA on the Text4 Baby pilot to increase the number of individuals enrolled who receive text messages including information on birth control and healthy spacing of pregnancies with Oklahoma specific information.

Numerous staff development opportunities will be provided throughout the year with topics to include unintended pregnancy and adolescent pregnancy prevention. MCH will continue to provide an annual continuing education opportunity for advanced practice providers to ensure practitioners are up-to-date on standards of care and evidence-based practices for preventing unintended pregnancies.

Oklahoma will use the work from the CoIIN strategy team to inform future activities in preconception/interconception health and continue to partner with OHCA and March of Dimes in the new CoIIN teams with a focus on providing preconception/interconception care and education in the community and increasing access to long acting reversible

contraception.

The Preconception/Interconception Care and Education Workgroup will continue promoting use of the Women's Health Assessment tool and My Life, My Plan tool in county health departments, Indian Health Clinics, FQHCs, and home visitation programs across the state. Electronic versions of the Women's Health Assessment tool and adolescent tool "My Life. My Plan" are posted on the website for public use. Work will continue to identify ways to involve males in reproductive health planning. Activities to this point have promoted the broad idea of preconception health care. Future efforts may identify projects targeting particular groups or populations based on organizational priorities or OSDH areas of expertise including males and females in areas with large African American/ Native American populations, sororities or college health centers, pharmacies and Farmer's Markets. Preconception health information will be provided in cloth bags at Farmer's Markets across the state as part of the *Preparing for a Lifetime* initiative to reduce infant mortality.

MCH will work with partners to increase the utilization of progesterone treatment for women with previous preterm births and to increase the number of hospitals utilizing fetal fibronectin testing to assist in determining the plan of care for women with preterm contractions.

MCH leadership will continue to promote awareness of the Life Course Perspective and strengthen partnerships focusing on this model of health care and education.

Also see future activities in the Adolescent Health Section under NPM #8 for teen pregnancy prevention.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	55.9	57.1	58.2	59.3	60.4

National Performance Measure #18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Data Interpretation: In 2013, 68.5% of all Oklahoma births occurred to females beginning prenatal care during the first trimester of pregnancy. Oklahoma experienced a 4.7% increase of women that gave birth having had prenatal care during their first trimester since 2010 (65.4%).

Success Factors: In FY 2014, approximately 62% 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. The STBS program was expanded to cover pregnant women with incomes between 133% of Federal Poverty Level (FPL) and 185% FPL when eligibility requirements were raised January 1, 2014.

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

A PRAMS Brief was created and disseminated discussing “Barriers to Prenatal Care in Oklahoma” in October 2014. The three most commonly reported barriers were: 1) could not get an appointment earlier; 2) did not know they were pregnant; and, 3) did not have their Medicaid card. Transportation was an issue for 16.3%.

The contract with a local obstetrician was extended continuing provision of prenatal care at the health departments in Sapulpa and Bristow due to a lack of obstetric (OB) providers in Creek County.

CHD staff assisted clients with a positive pregnancy test in signing up for Text4Baby prior to leaving the clinic and OHCA received approval to text all women enrolled for prenatal care offering to enroll them in Text4Baby. One of the first messages was about connecting with a prenatal care provider. Oklahoma won the competition among medium-sized states for enrolling the most women.

Entry into first trimester care has been an ongoing area of concern for the Perinatal Advisory Task Force (PATF). The PATF successfully transitioned to the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) this year. The collaborative addressed issues identified by providers and continued to serve as the link between providers and policy makers.

MCH staff led tribal listening sessions with the Oklahoma City Indian Clinic, North Eastern Tribal Health System, Choctaw Nation, Muscogee (Creek) Nation, Chickasaw Nation, Clinton Indian Health Service (IHS), and the IHS Directors. Some provide prenatal care onsite or through formal referrals and some have to refer to other IHS or tribal services. Transportation and lack of OB providers were identified as major issues in accessing prenatal care.

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

County health departments and contract providers served as safety net providers for maternity clinical services. Clinics served as the point of entry for 30,205 females for pregnancy testing and linkage with appropriate services depending on pregnancy test results. With the continuation of STBS as a Medicaid option for health care coverage, there was a decreased need for safety net providers. Five counties continued to retain the ability to provide maternity services but only three had an active caseload.

The Prematurity Work Group for *Preparing for a Lifetime* worked with hospital nurses to educate women with a preterm delivery, prior to discharge, about the importance of early prenatal care in subsequent pregnancies to gain access to timely interventions to prevent another preterm birth.

Challenges/Barriers: In January of 2014, eligibility requirements for SoonerCare (Medicaid) pregnancy benefits changed from 185% of FPL to 133% of FPL leaving many women without coverage for prenatal care. Although the STBS program was expanded to accommodate these changes, the STBS program offers a limited benefit package which only includes prenatal care services that benefit the infant.

Another major barrier to access was the continued lack of OB providers in the state and, consequently, transportation issues which prevented women from accessing available care. Only 31 of the state's 77 counties had hospitals providing delivery services.

State Performance Measure #1: *The percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in a live birth.*

Data Interpretation: Pregnancy Risk Assessment Monitoring System (PRAMS) data are used to monitor unintended pregnancy within Oklahoma. For collection year 2012, the latest for which final weighted data are available, 51.3% of Oklahoma live births were the result of an unintended pregnancy. In 2012, the answer options for

unintended pregnancy in PRAMS changed, allowing mothers to select "I wasn't sure what I wanted." As a result data are not comparable to previous years'.

Success Factors: OHCA continued provision of family planning services through SoonerPlan, the state plan amendment (SPA). SoonerPlan provided coverage for uninsured men and women 19 years of age or older who were United States citizens or qualified aliens, residents of Oklahoma, not eligible for regular Medicaid, and who met the income standard. Services provided included physical exams related to family planning; birth control information, methods, and supplies; laboratory tests including pap smears and screening for sexually transmitted diseases (STDs); pregnancy tests; tubal ligations for females age 21 and older; and, vasectomies for males age 21 and older. OSDH continued to support eligibility staff in all county health departments trained to assist clients with the enrollment process to help link clients with services (including contraception). SoonerPlan provided coverage to 87,838 enrollees during state fiscal year 2014.

Family planning services were provided through county health departments and contract clinics. Services included medical histories; physical exams; laboratory services; methods education and counseling; provision of contraceptive methods; STD/human immunodeficiency virus (HIV) screening and prevention education; pregnancy testing; immunizations; and preconception health education including smoking cessation, nutrition, and exercise. New guidelines for the provision of family planning services were released in April 2014 (Providing Quality Family Planning Services) requiring contraceptive counseling to present information on the most effective methods of contraception first and eliminating the requirement for an unclothed physical exam for many contraceptive options. The intent is to decrease barriers, perceived or real, for access to effective birth control. The Family Planning Annual Report for calendar year 2014 indicated an increase in clients relying on one of these methods for contraception from 10.79% in 2013 to 11.15% in 2014. Special projects focused on serving the African American population continued in Oklahoma and Tulsa counties. Family planning services were provided to a total of 50,158 females and males of reproductive age for calendar year 2014.

Effective 9/1/14, the OHCA started covering the placement of long acting reversible contraception (LARC) prior to hospital discharge after delivery. Information on this new benefit and the availability of LARCs through county health departments was provided during the first Oklahoma Perinatal Quality Improvement Collaborative Summit 9/26/14.

Two MCH staff and the Perinatal and Reproductive Health Medical Director attended the national Title X Clinical conference 9/4-9/6/14 which provided information on evidence-based care and reducing barriers for family planning clinical service delivery.

MCH continued to receive funding through the federal PREP grant to expand teen pregnancy prevention efforts. PREP funds continued to support projects in the Oklahoma City County Health Department (OCCHD) and Tulsa Health Department (THD). Both projects continued to build connections with schools and expanded their reach in providing the evidence-based curricula, "Making a Difference!", "Making Proud Choices!", and "Reducing the Risk."

Three counties supported public health youth councils. The councils reviewed health department materials and addressed health issues affecting adolescents in their communities including ways to reduce teen pregnancy.

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 including adolescent and unintended pregnancy prevention; preconception health and reproductive life planning; and, male involvement in reproductive health.

Staff employed in the MCH administered both the Title V and Title X programs, along with PREP funds. Many activities between these programs overlap to prevent unintended pregnancies. Central Oklahoma Healthy Start was a partner for the Preconception/Interconception Work Group for *Preparing for a Lifetime, It's Everyone's Responsibility*, which worked to promote the Women's Health Assessment Tool and the My Life, My Plan adolescent reproductive life plan tool.

Challenges/Barriers: The biggest challenge remained 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. The second biggest challenge was the cost of promoting the LARC methods. Although effective at preventing unintended pregnancies, the upfront cost of LARC methods was prohibitive for some health care providers.

Another barrier was the impact from the change in Medicaid eligibility for SoonerPlan. The income standard changed from 185% of Federal Poverty Level to 133% of Federal Poverty Level in 2014. This left many men and women uninsured, with the assumption that they would enroll in health care plans through the federal market place in a state that is not politically supportive of the Affordable Care Act changes.

State Performance Measure #5: *The percent of women receiving quality (American College of Obstetrics and Gynecology [ACOG] Standards) preconception care.*

Data Interpretation: At this time, no data are available to report for this measure.

Success Factors: The release of updated recommendations (4/2014) from the Office of Population Affairs and the Centers for Disease Control and Prevention “Providing Quality Family Planning Services” includes preconception health care as a core service for family planning service providers. MCH continued to encourage health care providers to treat every visit as a preconception health visit and provide targeted preconception/interconception health counseling to every client.

The Oklahoma State Department of Health (OSDH) continued providing family planning and reproductive health care, including preconception health care, in county health departments and contractor clinics through the Title X grant. The new guidelines were implemented in November 2014 in all county health department clinics. MCH continued promoting the use of the Women’s Health Assessment Tool to assist clients in identifying risk factors, provide related education on risks identified, and promote reproductive health planning. Staff was also encouraged to utilize the My Life, My Plan tool to assist adolescents in understanding the need to develop a life plan, including a reproductive life plan.

Central Oklahoma Healthy Start remained a partner for the Preconception/Interconception Work Group for *Preparing for a Lifetime, It’s Everyone’s Responsibility* which continued its work to promote preconception and interconception health for all Oklahomans.

MCH staff worked on a tool to educate men on their role in reproductive health decisions and with IT staff to develop an interactive version of the Women’s Health Assessment.

Public service announcements (PSAs) were produced promoting the importance of being healthy before a pregnancy and developing a life plan and aired between November and February.

Oklahoma continued participation in the Centers for Medicare and Medicaid Services (CMS) 3-year pilot project for Text4Baby. Goals of this project are to: Increase enrollment of pregnant SoonerCare members, customize message content to include state-specific programs and resources, and improve health quality measures including postpartum care and well-baby visit attendance. The advisory committee for this project includes OSDH and Oklahoma Health Care Authority (OHCA) staff and community partners. County Health Department staff were encouraged to assist clients with a positive pregnancy test in signing up for this service prior to leaving the clinic. Texts after the baby’s birth promote early decisions on contraception and healthy spacing of pregnancies. Oklahoma won the Text4Baby contest in the medium state category in October for enrolling the most women in the program.

Preconception/Interconception health continued as one of five priority focus areas identified by Regions IV and VI in their work toward reducing infant mortality. OSDH and OHCA staff participated in the national Preconception Strategy Team of the CoIIN expanding interconception health benefits to high risk adolescents covered by SoonerCare in the 10 Oklahoma counties with the highest infant mortality rates. These first CoIIN teams officially

completed activities and reported out in June 2014 however, OHCA continued to provide these services.

Staff development training on preconception health care topics offered to county health department, FQHC, and tribal clinical staff included: Preconception/Interconception Health Care Updates; Interpersonal Violence and Depression; Family Participation in Reproductive Health Care for Adolescents and Male Involvement; and, Unintended/Adolescent Pregnancy Prevention.

The annual Advanced Practice Forum this year "All Aboard: Addressing Flagship Issues in Oklahoma" provided information on Resistant Gynecological Infections, Men's Reproductive Health, Obesity Across the Reproductive Life Span, and What's New in Contraception in May 2014.

The Central Oklahoma Fetal and Infant Mortality Review (FIMR) staff and MCH Outreach staff at Oklahoma City County Health Department, partially funded by Title V funds, provided education to women with a previous pregnancy loss, including those currently pregnant or in the postpartum period. Education was provided to individuals on preconception/interconception care, life planning, and the Women's Health Assessment. Information was also provided to middle school and high school students through the Life Course Game.

Challenges/Barriers: Moving the needle on this measure faced the same challenges as those cited in SPM#1, the paradigm of valuing preventive health and the costs of LARCs.

State Action Plan Table

Perinatal/Infant Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce infant mortality	<p>1. Increase the percent of mothers who breastfeed their infants at hospital discharge from 75.0% in 2013 to 78.0% by 2020</p> <p>2. Increase the percent of mothers who breastfeed their infants at 6 months of age from 34.8% in 2013 to 38.3% by 2020</p>	<p>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 healthcare providers</p> <p>1b. Provide support for the Oklahoma Breastfeeding Hotline</p> <p>1c. Provide support for the Oklahoma Hospital Breastfeeding Education Project</p> <p>1d. Provide support for the Becoming Baby-Friendly in Oklahoma (BBFOK)</p>	<p>Post neonatal mortality rate per 1,000 live births</p> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	<p>A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months</p>		

		<p>Project</p> <hr/> <p>1e. 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</p> <hr/> <p>2a. Partner with the Coalition of Oklahoma Breastfeeding Advocates (COBA) to increase Oklahoma Breastfeeding Friendly Worksites / Businesses</p> <hr/> <p>2b. See also strategies for Objective 1</p>				
Reduce health disparities	Improve breastfeeding duration rates	Support COBA's efforts to establish Baby	Post neonatal mortality rate per 1,000 live births	A) Percent of infants who are ever breastfed		

	among racial and ethnic minorities	<p>Cafés and Chocolate Milk Cafés targeting African American and American Indian breastfeeding mothers and families</p> <p>Support COBA's efforts to further expand Baby Cafés, targeting Hispanic mothers / families</p> <p>Partner with WIC to increase the number of ethnically diverse peer counselors</p> <p>Partner with WIC to encourage involvement of peers as co-facilitators in Baby Cafés</p>	Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	and B) Percent of infants breastfed exclusively through 6 months		
Reduce infant mortality	<p>1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 11 in 2015 to 20 in 2020</p> <p>2. Increase the number of trainings given to providers and professional organizations on infant safe sleep by 50% by 2017</p>	<p>1. Provide safe sleep training and technical assistance to birthing hospitals</p> <p>2. Provide training and technical assistance to home visiting programs, child care centers, and other community and health</p>	<p>Infant mortality rate per 1,000 live births</p> <p>Post neonatal mortality rate per 1,000 live births</p> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	Percent of infants placed to sleep on their backs		

3. Increase the number of community outreach activities by Safe Sleep Work Group members from 10 in 2015 to 20 in 2020

4. Increase the number of hits by 20% to the Preparing for a Lifetime website and MCH Facebook page by 2020

organizations that address the needs of newborns and infants

3a. Create a presentation and / or training for community members on the safe sleep guidelines

3b. Provide presentations to community organizations and coalitions to increase awareness of infant mortality and safe sleep practices

3c. Provide community outreach and education to non-traditional partners, including faith-based organizations and non-profit organizations that help women and infants

3d. Create an event during safe sleep awareness month to educate the public on infant mortality rates and safe sleep guidelines

		<p>4a. Establish a baseline for the Preparing for a Lifetime website and MCH Facebook postings</p> <p>4b. Implement social marketing strategies and promote the PFL website and MCH Facebook page</p> <p>4c. Assign a person from the Infant Safe Sleep Work Group to assist with social media projects</p>				
Reduce health disparities	Increase the percent of American Indian and African American births in hospitals participating in the Safe Sleep Sack Program, from 52.6% in 2013-2014 to 60.5% in 2020	<p>Provide safe sleep training and technical assistance to birthing hospitals with high numbers of African American and American Indian births</p> <p>Target specific populations through outreach efforts, including, community baby showers, health fairs, family conference partners (Oklahoma Family Network, DHS), and local schools to</p>	<p>Infant mortality rate per 1,000 live births</p> <p>Post neonatal mortality rate per 1,000 live births</p> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	Percent of infants placed to sleep on their backs		

		<p>increase education on safe sleep practices and guidelines</p> <p>Provide opportunities to train community leaders and educate non-traditional partners, including faith based organizations and non-profit organizations that help women and infants</p>				
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Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

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

The OSDH employee breastfeeding room and worksite policy information will continue to be shared in agency intranet and bulletin boards, on the Breastfeeding website, and in breastfeeding conferences, serving as models for state and community agencies and worksites.

MCH will work with WIC's Breastfeeding Task Force to plan the 2016 annual WIC Breastfeeding Conference. The Task Force will coordinate WBFW activities, review breastfeeding promotion and duration materials for county health departments and area clinics, plan for upcoming trainings, and identify expansion sites for the Breastfeeding Peer Counseling Program.

Breastfeeding duration will be promoted through joint efforts of the OSDH Breastfeeding Friendly Worksite Initiative and COBA Workplace Breastfeeding Awareness Project, the Turning Point Annual Conference, COBA and Oklahoma BirthNetwork websites, the HBEP and website, the annual WIC Breastfeeding Symposium, and statewide news releases and trainings. The websites will serve as statewide breastfeeding resources.

MCH and partners will support legislative efforts to prohibit harassment of breastfeeding mothers.

MCH will continue to partner with OU to maintain support for the OBH. The support line will be promoted during trainings for healthcare professionals, through services to pregnant and breastfeeding females, and via media sources and websites. With others, MCH will continue to fund development of the OMMB as it establishes additional milk depots statewide.

Through a MCH contract, the Oklahoma HBEP leader, working with birthing hospitals, will offer in-person evidence-based education through staff trainings, individual train-the-trainer sessions, ongoing technical support, and resources. MCH will collaborate with WIC, COBA, the Oklahoma Health Care Authority, the Oklahoma Hospital

Association, OPQI, and the HBEP to address the nine objectives in the US Breastfeeding Committee's *Vision for the Future* and promote the Baby-Friendly designation for Oklahoma hospitals.

MCH will continue to work with COBA, WIC and Chronic Disease Services, and the Center for the Advancement of Wellness to promote the Baby Café Project, initially part of the Association of State and Territorial Health Officials Breastfeeding Learning Community and focused on improving access to professional and peer support in African American, Native American, and Hispanic communities. Efforts will be coordinated to offer Baby Cafés in Tulsa and Lawton, providing support in Oklahoma's three largest metropolitan areas.

As part of OPQIC Preterm Birth initiative, work will continue with hospitals to appropriately screen and triage women who present with signs and symptoms of preterm labor; ensure the use of progesterone therapy for appropriate candidates to prevent preterm births; finalize formal designation for neonatal level of care for Oklahoma hospitals; and, review new guidelines released for formal designation of hospitals related to maternal levels of care.

The *Preparing for a Lifetime* Safe Sleep Work Group has been working with the National Institute of Child Health and Human Development and their Safe to Sleep Public Education Campaign to hold two state-specific webinars in Oklahoma. One will be for hospital nursing staff, and one for home visitors and child care providers. The webinars will be made available online for future viewing and trainings.

The Safe Sleep Work group is also working to increase the number of hospitals participating in the sleep sack distribution program, from 11 to 14. The new MCH Social Work/Safe Sleep and SIDS Coordinator, who is the co-lead for the work group, will also work to develop additional resources for families and communities.

Prematurity will remain a priority area of focus for the national CoIN team; a strategy team comprised of state staff, data support, and content experts including representatives from OHA, the OSDH, and the March of Dimes. AIM statements for this team's new focus include:

1. Increase the percentage of pregnant women on Medicaid with a singleton pregnancy and a previous preterm birth who receive progesterone from ~ 10% to 25%.
2. Increase the percentage of Oklahoma birthing hospitals utilizing standardized preterm labor assessment, including fetal fibronectin testing, from 30% to 60%.

The OHA HEN will continue work to sustain the progress made in eliminating early, elective deliveries.

MCH, OHCA, and OPQI will continue to support the activities of the Oklahoma Perinatal Quality Improvement Collaborative in addressing perinatal quality of care issues in Oklahoma.

Preconception/Interconception Care and Education and Tobacco Cessation, two additional work groups with the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative, will continue activities to impact the number of preterm births by working to decrease smoking rates during pregnancy and to promote reproductive life planning to address preconception health risks prior to pregnancy through dissemination of preconception information at Farmer's Markets and pharmacies. To lower the number of preterm births due to tobacco use, the Tobacco Cessation Work Group, the OHCA, and the Preconception/Interconception Care and Education Work Group will continue to distribute information and education on the 1-800-QUIT NOW hotline and options for provider reimbursement for counseling clients to stop smoking using the 5 A's (Ask, Advise, Assess, Assist, and Arrange). MCH staff will continue to participate in the Smoking Cessation Work Group. See the Crosscutting Section, National Performance Measure 15 for more information on cessation efforts.

The Preconception/Interconception Care and Education Work Group will continue to be co-led by MCH and will promote healthy lifestyles with all males and females of reproductive age. Collaboration will continue with OHCA to work with physicians on promoting the importance of preventive health care visits for adolescents and the development of a life plan, including reproductive health plans, as adolescent pregnancy continues to be a risk factor for preterm deliveries.

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

Perinatal/Infant Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.6	74.0	75.4	76.8	78.3

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	15.6	16.8	17.9	19.1	20.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	71.3	72.7	74.1	75.5	76.9

National Performance Measure #1: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening program.*

Data Interpretation: All newborns born in Oklahoma in 2014 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; and biotinidase deficiency. Ninety-nine 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 2014, all 661 newborns with sickle cell trait and hemoglobin C trait received educational material regarding trait status and were referred for genetic counseling. Many of the families 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 57 families received counseling with a board-certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (33 of the 68 received counseling). All cases of confirmed diagnosis for newborn screening disorders were referred for genetic

counseling.

Success Factors: Title V funding continued to support the newborn screening activities statewide. The NSP, housed within the Screening and Special Services Division of the Oklahoma State Department of Health (OSDH), continued activities to educate providers and hospitals about the need for newborn screening and procedural issues regarding screening and testing. In addition, educational sessions were provided to county health department nurses, Children First (the State's Nurse Family Partnership program) nurses, and medical personnel. Long-term follow-up activities continued to include family education, and other public and stakeholder education, such as schools and transition committees. The Oklahoma Genetics Advisory Council (OGAC) did not meet physically during the calendar year of 2014; however the OGAC sponsored a Grand Rounds on Severe Combined Immunodeficiency Syndrome (SCID) for pediatricians and other primary care providers. Additionally, work group meetings were held to plan for the implementation of SCID and Pulse Oximetry (PO) Screening for Critical Congenital Heart Disease.

House Bill 1347, requiring all birthing facilities to perform PO screening on every newborn prior to discharge, was signed into law. The NSP developed rules to implement PO screening in all birthing facilities in Oklahoma and the Oklahoma Board of Health (BOH) approved the implementation of Pulse Oximetry screening through rules and regulations in January 2014. Additionally, rules for the addition of SCID were also approved by the BOH in January 2014.

Staff from Screening and Special Services actively collaborated with MCH on several projects, including the *Preparing for a Lifetime, It's Everyone's Responsibility* infant mortality reduction initiative, the Office of Perinatal Quality Improvement (OPQI), the Oklahoma Health Improvement Plan (OHIP) Child Health Work Group, and the Oklahoma Fetal and Infant Mortality Review (FIMR) projects.

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

Challenges/Barriers: Funding continued to be a barrier to services, especially related to adding disorders recommended by the Secretaries Advisory Committee on Heritable Disorders in Newborns and Children approved by the HHS Secretary. Challenges related to the addition of pulse oximetry screening to the newborn screening panel included assessing or accurately ensuring that all infants received a PO screen, especially if the pulse oximetry results were not documented on the newborn screening blood spot card. Capacity, an additional challenge related to the number of medical specialists in the state, remained inadequate to serve the population of the state and many specialty services were located only in the two large metropolitan cities, requiring families to travel long distances for appropriate care.

National Performance Measure #11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Data Interpretation: The Oklahoma Toddler Survey (TOTS) provided data to monitor National Performance Measure #11. According to 2013 TOTS data, 34.8% of women reported breastfeeding their infants to six months of age, not significantly different from 2010. MCH monitored breastfeeding initiation, duration, and exclusivity using Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children Supplemental Nutrition Program (WIC), TOTS, and the National Immunization Survey (NIS) data. This information was shared with state policymakers, health care providers, families, and community groups.

Success Factors: One hundred and twenty people attended the *Becoming Baby-Friendly in OK (BBFOK) Summit* with leadership teams from 24 hospitals. Claremore Indian Hospital was recognized as the first Oklahoma hospital to receive the Baby-Friendly designation. Fourteen hospitals were working toward Baby-Friendly designation and more indicated interest. Half of the state's birthing hospitals (28) stopped providing formula discharge bags, and

according to NIS data, the six month exclusive breastfeeding rate surpassed the national average. A manuscript, *Hospital Efforts to Improve Breastfeeding Outcomes*, outlining Oklahoma's efforts to promote Baby-Friendly Hospitals was included in a special Child Health Edition of the Oklahoma State Medical Association Journal.

As part of the WIC Breastfeeding Task Force, MCH helped plan the 14th Annual WIC Breastfeeding Conference for 462 staff and healthcare providers featuring ways to promote exclusive breastfeeding and case studies of breastfeeding challenges. One hundred and forty Oklahoma Breastfeeding Friendly Worksites received Gold Star recognition at the conference and on the website.

The Task Force promoted the World Breastfeeding Week (WBFW) theme and reviewed state and community news releases. Clinics hosted receptions, shared materials to support mothers and increase breastfeeding rates, distributed breastfeeding legislation cards, encouraged mothers and families to sign up for Text4Baby messages, and continued to share *the hospital experience* booklets. The theme and materials were displayed by MCH in the OSDH central office lobby area.

Funding and support continued for the Oklahoma Breastfeeding Hotline (OBH), providing information and referrals for 2,743 mothers, their families, and health care providers. MCH also supported the 13th accredited Oklahoma Mothers' Milk Bank (OMMB), which celebrated its first anniversary and served 7 of the 8 self-designated level III Neonatal Intensive Care Units (NICUs). MCH funds were also used to support the Oklahoma Hospital Breastfeeding Education Project (HBEP). Oklahoma's hospitals saw a 30% increase in score on the Maternity Practices in Infant Nutrition and Care (mPINC) Survey, from 55 in 2009 to 71 in 2013.

MCH promoted breastfeeding duration and Baby-Friendly Hospitals through a variety of venues; the Oklahoma Health Improvement Plan Children's Health Work Group and Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) meetings, the Oklahoma Turning Point Conference and Partners Conference for Oklahoma Families displays, and National Nutrition Month activities and displays.

Preparing for a Lifetime, It's Everyone's Responsibility Breastfeeding Work Group met monthly with members representing the Oklahoma Family Network, MIECHV, Oklahoma City County Health Department Fetal Infant Mortality Review Team, Oklahoma Family Expectations Program, Oklahoma Birth Network, Chickasaw Nation, Oklahoma Turning Point, OMMB, SoonerStart, OUHSC, and MCH and WIC Services.

MCH partnered with the Early Childhood Comprehensive Systems (ECCS) and the Central Oklahoma and Tulsa Healthy Start and MIECHV programs, sharing information and resources for consistent educational materials on breastfeeding.

Challenges/Barriers: More hospitals wanted to participate in the BBFOK project and were challenged to acquire physician and leadership buy-in. Competing priorities contributed to the loss of active work group and Baby-Friendly curriculum development team members. Oklahoma continued to struggle to increase its breastfeeding duration rate. Community support for mothers after hospital discharge was an ongoing challenge, which a US Breastfeeding Committee grant awarded to the Coalition of Oklahoma Breastfeeding Advocates (COBA) was designed to address.

National Performance Measure #12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Data Interpretation: Of the 52,149 Oklahoma births in calendar year (CY) 2013 (the most recent hearing screening data available per the Center for Disease Control reporting process), 51,613 infants (99%) had hearing screened prior to hospital discharge, while only 536 (1%) were not screened at any time. Of the infants screened, 2,884 (5.53%) were referred for diagnostic assessment for failing the hospital screen and 70 had confirmed hearing loss. At least 57 infants with a diagnosis of hearing loss born in 2013 were enrolled in Oklahoma's Part C early intervention program, SoonerStart, or other related programs.

Success Factors: The Oklahoma Newborn Hearing Screening Program (NHSP) continued to improve efforts regarding Loss to Follow-up/Loss to Documentation (LTF/LTD). This includes quality improvement methodology to achieve measurable improvement in the number of children who receive appropriate and timely follow-up. Efforts were placed on ensuring all children in Oklahoma receive an initial hearing screening and actively tracking children who did not pass a physiologic newborn hearing screening prior to discharge from an Oklahoma birthing hospital.

The NHSP continued weekly requests to Oklahoma birthing hospitals for missing and/or conflicting hearing screening information. Quarterly reports were provided to all facilities with information about missing data requests (Not Reported Rates), missed screenings (Not Performed Rates) and infants who did not pass at the location (Refer Rates). A trend analysis was completed each quarter to prioritize hospitals for training and quality improvement. These enhanced hospital efforts focused on ensuring that all Oklahoma infants receive an initial hearing screening by one month of age, and if needed, diagnostic audiological evaluations by three months of age, and appropriate early intervention services by six months of age. Activities at the hospital level determined the number of children needing additional hearing screening follow-up, and influenced NHSP case management efforts and the timeliness of receiving follow-up screening and/or audiological diagnostic testing.

Challenges/Barriers: Approximately fifty Oklahoma counties maintained the equipment available to screen children from birth to thirteen years. This included automated auditory brainstem response (AABR), Otoacoustic emissions (OAE), tympanometry, and audiometry. Devices required annual calibration, ongoing supplies, and replacement due to aging. The Oklahoma NHSP has received federal funds through a Health Resources and Services Administration (HRSA) grant since April 1, 2001. A portion of the funds were utilized annually to purchase new hearing equipment for county health departments throughout Oklahoma. However, only a small number of devices were replaced each year with grant funding and were prioritized due to county size and age of devices.

Equipment continued to be dispersed to county health departments through Child Guidance Service, SoonerStart Part C Early Intervention, and MCH. This required a substantial amount of training and technical assistance provided by the NHSP. Sixteen counties have Child Guidance professionals within county health departments and only eleven counties have Speech-Language pathologists available to provide hearing screening. SoonerStart was able to provide hearing screenings for those families who opted for a full evaluation test battery. Therefore, due to limitations through Child Guidance and SoonerStart, MCH assisted in providing “stop gap” services where screenings were not available in communities as most providers, including Primary Care Physicians, do not have the appropriate equipment to screen newborns and children. MCH assistance included use of staff as well as funding for nurse screeners.

The availability of equipment at county health departments has drastically improved the ability for infants to be screened and diagnosed faster than the national average. Every year, several children continued to be screened at the hospital, rescreened at the county health department, referred for diagnostic testing at a pediatric audiology clinic, diagnosed with hearing loss and fit with hearing aids by one week of life. This accomplishment has been recognized during several national conferences. However continued national grant funding and partnerships with MCH continued to be vital to ensure ongoing local screenings at county health departments to assist the families of Oklahoma.

National Performance Measure #17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Data Interpretation: Final Oklahoma birth data for 2013 show that 81.9% of infants born weighing less than 1,500 grams were delivered at high-risk facilities. If final data show a similar result, it will mark an increase for very low birth weight (VLBW) births delivered at high-risk facilities, as the 2007 rate was 78.7%. Since 2000, the rate has increased by 8.2%, up from 75.7%.

MCH provided data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and vital records through

PRAMSGrams, presentations, and trainings to educate the public, health care providers, and policymakers on health issues including *Barriers to Prenatal Care in Oklahoma* and *Multivitamin Use before Pregnancy among American Indian Mothers*. MCH used this information to make recommendations and facilitate discussion on concerns and changes needed to enhance the perinatal health care system infrastructure, improve access to care, and reduce prematurity rates.

Success Factors: Two work groups of the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative addressed preconception/interconception health and prematurity in Oklahoma. The Preconception/Interconception Work Group focused on educating women about the planning for pregnancy and the importance of early and appropriate prenatal care. The Prematurity Work Group promoted the new edition of the March of Dimes Preterm Labor Assessment Toolkit, created an online version of the assessment, and distributed it to all birthing hospitals with a 93% response rate. The results were analyzed by OPQI staff and a plan for standardizing preterm labor assessment was completed encouraging hospitals to develop preterm labor protocols to identify preterm labor accurately and consistently and to initiate policies for transporting women in preterm labor to the most appropriate facility if indicated. The work group also connected with a vendor for fetal fibronectin (fFN) testing to strategize on ways to ensure all hospitals have access to and appropriately utilize fFN testing to help identify women at high risk of preterm labor and to develop an appropriate plan to ensure they deliver at the most appropriate facility.

OPQI and the Oklahoma Hospital Association (OHA), with funding from MCH and the March of Dimes, continued work on quality improvement activities with birthing hospitals, including the elimination of elective, non-medically indicated inductions and scheduled cesarean sections prior to 39 weeks of gestation. The “Every Week Counts” learning collaborative focused on providing birthing hospitals with support to reduce elective deliveries prior to 39 weeks. Approximately 90% of Oklahoma birthing hospitals participated affecting 95% of Oklahoma births resulting in a 94% decrease from baseline data in 2011 for elective scheduled deliveries prior to 39 weeks. Hospitals that participated in the EWC collaborative submitted monthly data to the OPQI. Monthly and quarterly reports were generated and sent back to participating hospitals, including Chief Executive Officers. The reports provided individual hospital results and blind comparisons to other hospitals that participated in the collaborative. EWC continued its partnership with the OHA Hospital Engagement Network (HEN), who also had a goal to improve Oklahoma birth outcomes by eliminating early, elective deliveries. OHA HEN hospitals also participated in EWC. Activities for the collaborative ended 12/31/14 as hospitals transitioned to reporting these numbers to the Centers for Medicare and Medicaid Services for The Joint Commission’s PC-01 measure “Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 weeks and < 39 weeks of gestation.”

Financial support of the FIMR projects at the Tulsa Health Department (THD) and the Oklahoma City County Health Department (OCCHD) remained a priority. Accomplishments included conducting full case review of fetal, neonatal and infant deaths and community action activities, along with health disparity/inequity summits.

MCH, the OPQI, and the OHA continued exploring the issue of designated levels of neonatal care in an effort to assure infants are delivered at the most appropriate facility. OSDH and OHA staff participated in the Regions IV and VI Collaborative Improvement and Innovation Network (CoIIN) team on Perinatal Regionalization. Team members worked collaboratively with the CDC and submitted hospital information to the CDC for review. MCH staff partnered with staff from the two FIMR projects and the Office of Perinatal Quality Improvement to abstract hospital records for all very low birth weight infants delivered in level I or level II hospitals in Oklahoma between July 1, 2011 and June 30, 2013. Data analysis began but was not yet completed.

The Healthy Start projects in Oklahoma and Tulsa counties and the MIECHV received technical assistance and support from MCH. These projects and programs provided in-home support to pregnant females and their families. The Oklahoma Health Care Authority (OHCA, the State’s Medicaid agency) Fetal and Infant Mortality Case Management project provided phone support to decrease infant morbidity and mortality, including education on the signs and symptoms of pregnancy complications and where to seek prompt medical attention.

The Perinatal Advisory Task Force (PATF) successfully transitioned to the OPQIC. The collaborative addressed issues identified by providers and continued to serve as the link between providers and policy makers. Members were educated on perinatal regionalization activities, fFN testing, and progesterone therapy to prevent preterm births in women with a previous preterm birth. MCH participated in and provided funding for the OPQIC. The first annual OPQIC Summit was held in September 2014.

Successes included reducing the preterm birth rate to 12.8%, moving up to a “C” grade on the March of Dimes grade card; maintaining a close collaborative relationship with MCH contractors and community partners; and, ensuring the availability of tools and information developed by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and March of Dimes that could be readily adapted and disseminated.

Challenges/Barriers: Challenges included identifying causes of spontaneous preterm birth, especially in the African American population; competing priorities for hospitals; access to care in the absence of prenatal care providers and delivering hospitals in some counties; transportation to both prenatal care appointments and appropriate facilities for those women identified as high risk; obstetric providers wanting to keep women and deliver them to receive the higher reimbursement rates based on third party reimbursement; and, lack of formal designation for hospitals related to neonatal levels of care.

National Performance Measure #6: *The percent of infants who are put to sleep on their backs.*

Data Interpretation: The percent of infants who were put to sleep on their backs was 72.6% in 2012. This is an increase from 64.9% in 2009. However, 59.3% of African American and 56.8% of Hispanic mothers reported placing their infants to sleep on their backs, compared to 76.4% of white mothers and 70.0% of American Indian mothers.

Success Factors: The Title V supported, statewide initiative, *Preparing for a Lifetime, It's Everyone's Responsibility*, continued to be active, with the goal of reducing infant mortality and racial disparities. The *Preparing for a Lifetime* Safe Sleep Work Group continued to work toward the goals and objectives in the Infant Safe Sleep Work Plan. Representatives from the Central Oklahoma Healthy Start project and the MIECHV grant participated in work group activities. The Safe Sleep for Your Baby website pages were updated, and the OK Train modules on Infant Sleep Safety continued to be offered online for nurses and health professionals, early childhood professionals, and home visitors.

In collaboration with the OPQI and FIMR programs, additional hospitals with a high rate of African American and American Indian births were trained in infant safe sleep, implemented written safe sleep hospital policies, and began participating in the *Preparing for a Lifetime* Safe Sleep Work group's sleep sack distribution program. Between October 1, 2013 and September 30, 2014 approximately 8,500 sleep sacks were provided to families upon discharge from 8 participating Oklahoma birthing hospitals serving high risk populations.

MCH released a RFP (Request for Proposals) in May 2014 to purchase additional infant sleep sacks. A contract was signed with Halo Innovations, Inc. in June 2014 to purchase 15,000 infant sleep sacks for the hospital program.

The Oklahoma FIMR programs, supported by Title V funds, provided safe sleep education in their communities, including providing updated training for home visitors. The Safe Sleep Work Group and MCH issued a press release for SIDS Awareness Month in October of 2013, which listed the most current safe sleep recommendations from the American Academy of Pediatrics (AAP).

In collaboration with the OSDH Office of Minority Health (OMH), *Preparing for a Lifetime* urged communities to host a community baby shower at local libraries, community centers, or other venues. A short program with games and speakers was provided. Expectant parents, parents, grandparents, and foster parents were invited to attend and hear local experts present information on infant mortality, including steps everyone can take to reduce infant mortality. Some of the topics included risks for having low birth weight babies, the importance of prenatal and well-baby care, infant safe sleep, and taking care of oneself during and after pregnancy. Community partners provided free door

prizes and light snacks for those attending. The program is modeled after an evidence-based initiative promoted by the National Office of Minority Health and Department of Health and Human Services.

The Oklahoma City-County FIMR organized a training for law enforcement employees on utilizing the Sudden Unexplained Infant Death Investigation (SUIDI) reporting form. There were 57 participants from nine counties.

The Oklahoma Department of Human Services (OKDHS) Child Care Services requested in-person training sessions for specific child care programs. To accommodate their needs and those of other agencies and programs who may request training in the future, the Safe Sleep Work Group created a statewide list of infant safe sleep trainers available for in-person trainings.

Challenges/Barriers: The vacancy of the MCH Social Work/Safe Sleep and SIDS Coordinator created challenges for work on this measure. Keeping home visitors, hospital staff, local county health departments, child care programs, and parents up-to-date on the most current infant safe sleep recommendations was difficult, as staff time dedicated to working on infant safe sleep was limited.

Another challenge was the large racial/ethnic disparity for both safe sleep and infant mortality in the state. African Americans had lower safe sleep (back to sleep and no bed-sharing) rates and higher infant mortality rates when compared to other races/ethnicities in the state.

State Performance Measure #10: *The percent of live singleton births delivered before 39 completed weeks of gestation.*

Data Interpretation: In 2013, 38.3% of singleton infants were delivered before 39 completed weeks of gestation. This is a decrease from the 42.6% of singleton infants born before 39 completed weeks in 2010.

Success Factors: MCH staff participated in the Prematurity Work Group, part of the *Preparing for a Lifetime, It's Everyone's Responsibility*, which provided leadership for the statewide, voluntary collaborative of Oklahoma birthing hospitals called "Every Week Counts" (EWC) (See National Performance Measure #17).

Prematurity remained a priority area of focus for the Regions IV and VI CoIIN team; a strategy team comprised of state staff, data support, and content experts. Activities of this team also focused on eliminating early elective deliveries and included representatives from OHA, the OSDH, March of Dimes, and the Oklahoma Family Network.

Oklahoma continued working toward the Association of State and Territorial Health Officers challenge to reduce preterm births by 8% by 2014, however the 12.8% rate reported for 2014 (based on 2013 data) represents a 7.9% decline.

Support of the FIMR projects at the THD and the Oklahoma City County Health Department (OCCHD) remained an MCH priority including conducting full case review of fetal, neonatal and infant deaths and community action activities. FIMR data indicates that maternal infection may play a role in preterm births.

The OPQIC addressed issues identified by providers and continued to serve as the link between providers and policy makers. Members were educated on perinatal regionalization activities, and discussions were held on fetal fibronectin testing and progesterone therapy to prevent preterm births in women with a previous preterm birth. MCH continued to participate in the OPQIC and provided funding to support the OPQI and OPQIC in efforts to reduce preterm birth.

Challenges/Barriers: Challenges included competing priorities for hospitals and providers; implementing practice changes for physicians who felt they were being told how to practice; identifying causes of spontaneous preterm birth, especially in the African American population; fiscal impact of implementing fFN testing in all hospitals; and lack of education or combating misinformation regarding progesterone indications/use for women with a previous preterm delivery.

State Action Plan Table

Child Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce the incidence of unintentional injury among children	<p>1. Increase the number of delivering hospitals participating in the Period of PURPLE Crying Abusive Head Trauma curriculum from 39 to 45 by 2020</p> <p>2. Increase by 15% the number of caps received from community volunteers through the CLICK for Babies campaign from 2,487 in 2014 to 2,860 by 2016</p> <p>3. Provide, via Adolescent Health Specialists, a total of 3 trainings in communities on adolescent distracted driving and graduated drivers licensing each year</p> <p>4. Reduce nonfatal motor vehicle injuries in</p>	<p>1a. Contact delivering hospitals to increase participation in the curriculum</p> <p>1b. Provide training and support needed to participating hospitals</p> <p>2. Utilize existing resources and available partners to distribute materials and provide community education</p> <p>3. Train and provide materials to Adolescent Health Specialists for distribution and training in their local communities</p> <p>4a. Continue to provide funding for car seats to be distributed</p> <p>4b. Have one MCH staff member</p>	<p>Child Mortality rate, ages 1 through 9 per 100,000</p> <p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	<p>Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19</p>		

	children ages 0-19 from 394 in 2013 to 366 by 2020	complete the Child Passenger Safety certification and assist Injury Prevention Services with a minimum of two child safety seat events by 2016				
Reduce health disparities	Reduce by 2% by 2020 the number of suicide attempts requiring hospitalization among white females less than 25 years of age from 382 attempts in 2013	Increase the number of annual trainings in evidence-based methods of suicide prevention to youth and those that work with youth	Child Mortality rate, ages 1 through 9 per 100,000 <hr/> Adolescent mortality rate ages 10 through 19 per 100,000 <hr/> Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 <hr/> Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

Child Health

Child Health - Plan for the Application Year

Children’s health will remain one of the priority areas for the OSDH with a focus of preventing injury deaths for children and youth in motor vehicle crashes. IPS, in consultation with MCH, will continue to focus on policy changes, public education, and services related to motor vehicle safety.

The Infant Injury Prevention Work Group will continue as part of the statewide infant mortality initiative, *Preparing for a Lifetime, It's Everyone's Responsibility* with MCH providing leadership for the work group.

MCH will maintain a supportive relationship with IPS and Safe Kids Oklahoma. The IPS and Safe Kids Oklahoma will provide Child Passenger Safety (CPS) Technician classes and conduct child safety seat checks. IPS and Safe Kids Oklahoma will continue to provide child safety seats to county health departments for distribution to families in need. MCH and IPS will provide technical assistance to Safe Kids Oklahoma, as requested, to support expansion of community-based activities.

MCH will provide funding for car seats for IPS to distribute and will assign a staff person to complete CPS Technician training to assist with child safety seat checks as needed.

MCH and IPS will train and identify partners to provide education in local communities on Graduated Driver Licensing, distracted driving, seatbelt use, and alcohol use while driving as they relate to children and youth. Educational materials and technical assistance will also be provided to birthing centers, midwives, child care programs, and hospitals regarding child passenger safety.

MCH will continue to collaborate with local county health departments to establish, support, and sustain local Public Health Youth Councils. These councils will keep providing input on health services and materials. Youth serving on the councils will continue to identify issues in their communities that affect adolescents, including distracted driving, and work with public health professionals to implement solutions.

MCH will provide funding for Oklahoma's Poison Control Center.

Child Health - Annual Report

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	239.7	234.8	229.9	225	220.1

National Performance Measure #9: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Data Interpretation: Data from eight statewide dental health needs assessment surveys over a ten-year period show the percentage of third grade children with protective sealants on at least one permanent molar tooth averaged approximately 35%. The most recent 2013 assessment reflected 35.4% of the 3rd graders surveyed had sealants on at least one permanent molar tooth.

Success Factors: The Oklahoma Dental Loan Repayment Program (ODLRP) continued to operate with 16 full-time equivalent (FTE) dentists practicing in designated shortage areas treating 30% Medicaid patients, and two faculty members at the University of Oklahoma (OU) College of Dentistry. The Dental Health Service at the Oklahoma State Department of Health (OSDH) administers this program.

Dental health educators provided 42,901 dental health education and tobacco use prevention instruction encounters to children, preschool through high school in 26 counties, with an emphasis on reaching those in kindergarten through sixth grades. Topics included appropriate dental hygiene and care of teeth, playground safety, the use of mouth guards, dental disease prevention practices, sealants, fluoridation, regular dental care, and proper nutrition with healthy snacks.

Three county health department clinic sites provided dental services to children. Procedures and services included dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction, and prescriptions for infections.

Fluoride varnish application training for primary care physicians was provided through the Head Start Children's Oral Health Coalition Dental Home Initiative grant. There were 2,113 paid claims to physicians for reimbursement of fluoride varnish applications during well child exams.

Title V funds were provided for the 2015-2016 school year's *Oklahoma Oral Health Needs Assessment among 3rd*

Grade Children.

Challenges/Barriers: Dental educational and clinical staffing decreased resulting in fewer client encounters and community water fluoridation has declined. Funds are needed for advocacy and public awareness campaigns to effectively inform stakeholders.

National Performance Measure #10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Data Interpretation: Unintentional injuries were the top cause of death among children 14 years and younger in 2013, comprising nearly half (45.2%) of all deaths for this age group. Among unintentional injury deaths, more than one-third (37.6%) were due to motor vehicle traffic injuries. Motor vehicle accident deaths decreased significantly over the past 15 years, from 7.2 deaths per 100,000 population aged 14 and under in 1999 to 4.9 in 2013.

Success Factors: MCH continued to collaborate with local county health departments to establish, support, and sustain local Public Health Youth Councils (PHYC). The PHYC in Seminole County (in the central part of the state) identified distracted driving as a local issue to champion.

MCH continued to collaborate with the Oklahoma Child Death Review Board (CDRB) in the *Preparing for a Lifetime, It's Everyone's Responsibility* Infant Injury Prevention Work Group. Three MCH staff members also participated on the CDRB on a monthly basis. The 2014 Oklahoma Child Death Review Board Recommendations related to motor vehicle deaths included:

- Enforce child passenger safety laws, including appropriate seat restraint use. The CDRB reviewed and closed 43 cases that involved motor-vehicles and found seat restraint use to be at less than 30%.
- Document sobriety testing results in the Oklahoma Uniform Traffic Collision Report submitted to Department of Public Safety.
- Enact legislation banning the use of hand-held devices while operating a motor vehicle.
- Enhance child passenger safety laws, including appropriate seat restraint use.

MCH continued to partner with Safe Kids Oklahoma and Safe Kids Tulsa Area, organizations dedicated to the prevention of unintentional injuries. Representatives from Safe Kids Oklahoma and the state's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program participated in the Infant Injury Prevention Workgroup for *Preparing for a Lifetime*.

MCH and the OSDH Injury Prevention Service (IPS) worked to disseminate information about Graduated Drivers Licensing, distracted driving, seatbelt use, and alcohol use while driving. This information was targeted to middle and high school youth and their parents.

IPS continued to employ a full-time educator to provide education to parents, teens, children, educators, and others on motor vehicle safety, graduated driver licensing and child passenger safety, offering free presentations and technical assistance. The Adolescent Health Specialists in the county health departments, funded in part by MCH, were trained by IPS to present information in their communities on distracted driving and the Graduated Driver's Licensing. MCH remained available for technical assistance to IPS as needed.

MCH purchased infant car seats for IPS to distribute and install.

Challenges/Barriers: The Adolescent Health Coordinator position in MCH, which provides statewide leadership in the area of adolescent health, was vacant until February 2014.

National Performance Measure #13: *Percent of children without health insurance.*

Data Interpretation: The percentage of children without health insurance coverage decreased slightly over the last few years from 11.4% in 2011 to 10.6% in 2013.

Success Factors: OSDH county offices and MCH contract providers continued to provide outreach and education to their clients and to the communities about available health insurance coverage for children, including referrals to online enrollment at healthcare.gov. Many county health departments continued to have dedicated staff facilitate the SoonerCare (Oklahoma's Medicaid program) enrollment process for qualified individuals and their children. The county health department sites provided safety net services for children, including immunizations, metabolic and newborn screening, lead screening, and enabling services as needed. These sites also provided community resource directories and referrals to other health services as needed.

MCH continued to be involved in the Oklahoma Health Improvement Plan (OHIP) Children's Health Work Group. The Children's Health Work Group had the opportunity to comment on the Draft Healthy Oklahoma 2020: Oklahoma Health Improvement Plan (OHIP). The updated plan includes four flagship issues: 1) Tobacco Use 2) Obesity 3) Behavioral Health and 4) Child Health, with a focus on the infrastructure of access to health services. The work group membership has representation from OSDH, the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the Oklahoma Department of Human Services (DHS), the Oklahoma Family Network (OFN), the Oklahoma Commission on Children and Youth (OCCY), hospitals, physicians, dentists, nurses, social workers, and community service organizations.

The OSDH continued to work in collaboration with OHCA to enroll individuals and families, and to educate and engage SoonerCare members regarding personal responsibility for utilizing their health services in order to reach, maintain, and enjoy optimal health.

Challenges/Barriers: The county health department sites no longer provide many direct health services to children; therefore, some sites have a limited ability to assist families with enrolling their children in SoonerCare. Families who did not qualify for SoonerCare were given a pamphlet describing other insurance options, including the federal health insurance exchange.

State Action Plan Table

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce the incidence of suicide among adolescents	<p>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 to 3 by 2020</p> <p>2. Increase the number of local Public Health Youth Councils across the state from 3 in 2014 to 12 by 2020 that will provide input regarding adolescent health issues, including suicide prevention and bullying, to MCH, CSHCN, as well as other programs within and outside of OSDH</p> <p>3. Among county health departments that have</p>	<p>1. Provide training and TA to county health departments and other youth-serving organizations in evidence-based methods following appropriate best practices</p> <p>2. Train additional council facilitators, recruit for more youth, conduct asset inventory survey of council members, provide education to council members on adolescent health issues, and prepare some members to be peer facilitators</p> <p>3. Work with county health department directors and local web coordinators to place the Suicide</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

webpages, increase to 85% the sites that have the Suicide Prevention Lifeline Number displayed by 2020

4. Increase the number of the Safe Schools Committees reported to the Oklahoma State Department of Education mandated by School Safety and Bullying Prevention Act by 5%

5. Participate in the development and updating of curriculum for use by public schools Pre-K through 12th grade on bullying prevention, recognition, and intervention to help reduce the incidence of bullying which contributes to the incidence of suicide by students

Prevention Lifeline Number and logo on the most appropriate place on their website

4a. Work with the Oklahoma State Department of Education to determine a data source for the collecting information on the number of schools and school districts in Oklahoma that have Safe Schools Committees that meet the requirements mandated by the School Safety and Bullying Prevention Act

4b. Work with the agency members of the Anti-Bullying Collaboration to provide training to school staff and administrators on the requirements of the School Safety and Bullying Prevention Act

4c. Work with the Oklahoma

Department of Mental Health and Substance Abuse, the Department of Human 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

5. Continue to staff the Oklahoma State Department of Education Executive Committee to rewrite and update health curricula for use in public schools to present for the approval of the Oklahoma State

		Board of Education in December 2015 and legislative approval by February 2016				
Improve the mental and behavioral health of the MCH population	Reduce the percentage of children 0-17 years experiencing two or more adverse family experiences from 32.9% in 2013 to 30.6% by 2020	<p>Partner with home visitation programs, child guidance, early childhood initiatives, or other programs achieving best practices to provide education, counseling, and referrals to families</p> <hr/> <p>Leverage existing and developing networks such as Systems of Care to identify and locate referral and resource information</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <hr/> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p> <hr/> <p>Percent of children in excellent or very good health</p> <hr/> <p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <hr/> <p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal</p>	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

			<p>influenza</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>			
Reduce teen pregnancy	<p>1. Increase by 5% annually the number of adolescents initiated in state or federally funded evidence-based teen pregnancy prevention programs</p> <hr/> <p>2. Increase the number of adolescent family planning clients aged 15 to 19 that choose Long Acting Reversible</p>	<p>1a. Increase by 5% the number of adolescents initiated in state funded evidence-based teen pregnancy prevention programs from a baseline of 486 students / school year (August 1, 2014-May 31, 2015)</p> <hr/> <p>1b. Maintain the current number of adolescents participating in the Personal Responsibility</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <hr/> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p>	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

Contraception (LARC) methods from 31% in 2013 to 35% by 2020

3. Increase the number of available trainers statewide who have gone through a training of trainers (TOT) in Oklahoma's selected evidence-based teen pregnancy prevention curricula from 5 to 12 by 2020

4. Increase the number of local Public Health Youth Councils across the state from 3 in 2014 to 12 by 2020 that will provide input regarding adolescent health issues, including teen pregnancy prevention, to MCH, the CSHCN, as well as other programs within and outside of OSDH

Education Program (PREP) at a minimum of 3,750 students / year (April 1, 2014-March 31, 2015)

1c. Establish or leverage existing networks of administrators, principals, teachers, school nurses, health educators, adolescent health specialists, community leaders, and parents that are advocates for evidence-based education

1d. Increase capacity for curriculum instruction by providing or coordinating evidence-based trainings

2a. Continue to educate on the most effective methods of contraception first

Percent of children in excellent or very good health

Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Percent of adolescents, ages 13 through 17, who have received at least one dose of the

5. 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 24 to 30 by 2020

2b. Increase adolescent education in the community about available methods

3. Identify individuals that could best reach the target population of trainers

4. Train additional council facilitators, recruit for more youth, conduct asset inventory survey of council members, provide education to council members on adolescent health issues, and prepare some members to be peer facilitators

5a. Identify areas of highest need based on most current data available

5b. Partner with county health department regional directors in the areas of highest need to begin targeted prevention efforts

meningococcal conjugate vaccine

<p>Reduce health disparities</p>	<p>Identify disparities that exist among suicide attempts and completion percentages by race / ethnicity, gender, geography, and age by August 2015</p>	<p>Analyze most current surveillance systems (OKVDRS, Injury Inpatient Discharge Data) to detect disparities, identify program targets, and inform interventions</p> <p>Implement interventions to address the populations of highest risk by December 2016</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	<p>Percent of adolescents, ages 12 through 17, who are bullied or who bully others</p>		
<p>Reduce health disparities</p>	<p>Identify gaps in points of referrals, access, and utilization of mental and behavioral health services among the adolescent population to establish baseline data by January 2016</p>	<p>Analyze data from proven systems to identify program targets, inform interventions, and develop referrals</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <hr/> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p> <hr/> <p>Percent of children in excellent or very good health</p>	<p>Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.</p>		

			<p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <hr/> <p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>			
Reduce the incidence of unintentional injury among	See Child Health for Objectives to impact this	See Child Health for Strategies to impact this	Child Mortality rate, ages 1 through 9 per 100,000	Rate of hospitalization for non-fatal injury per		

children	measure	measure	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	100,000 children ages 0 through 9 and adolescents 10 through 19	
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Adolescent Health

Adolescent Health - Plan for the Application Year

MCH will work closely with the Oklahoma State Department of Education (OSDE), Oklahoma Department of Human Services (OKDHS), and tribal contacts to explore the possibilities of using their school-based staff to support and provide adolescent pregnancy prevention projects.

MCH, adolescent pregnancy prevention project, and PREP staff will continue to encourage parent and child communication surrounding sexuality through support of Parents Let's Talk month in October.

MCH will continue to promote awareness of teen birth rates and provide resources to communities.

As infants born to teen mothers have higher risks for infant mortality and adverse birth outcomes, MCH will continue to offer education, provide resources, and collaborate with external partners to reduce infant mortality through the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative.

MCH will continue to support comprehensive reproductive and sex education in schools so teens can have access to medically accurate information in order to make informed decisions.

MCH will continue to pursue a Train-the-Trainers for at least two state office staff in the curricula utilized in order to expand the adolescent pregnancy prevention programs. MCH staff will also provide Positive Youth Development training to county health departments and youth serving organizations.

MCH will continue to collaborate with local county health departments to establish, support, and sustain local Public Health Youth Councils. These councils will provide input to MCH, the Children with Special Health Care Needs Program (CSHCN), as well as other programs within and outside of OSDH. Youth serving on the councils will continue to identify issues in their communities that affect adolescents, including teen pregnancy and youth suicide, and work with public health professionals to implement solutions.

MCH will continue to provide technical assistance to county health departments that have identified reducing teen births as a quality improvement measure or who have established or are interested in establishing a teen pregnancy prevention project.

The My Life. My Plan booklet will continue to be available electronically on the *Preparing for a Lifetime, It's Everyone's Responsibility* website. This booklet encourages adolescents to take charge of their health, take better care of themselves, set goals, and understand how pregnancy will affect these goals.

Child health will continue as one of the flagship issues for the Oklahoma Health Improvement Plan (OHIP), with an objective of reducing the rate of birth (per 1,000) for teenagers aged 15 through 17 years from 20.5 in 2013 to 19.2 by 2020. Behavioral health will be addressed as one of the OHIP flagship issues, and will further support statewide suicide prevention efforts as well as provide a platform for emerging efforts.

MCH will conduct evidence-based trainings such as QPR, Positive Youth Development (PYD), and Life Course Perspective with others working with youth.

The State Suicide Prevention Council will implement the 2015-2020 State Strategy for Suicide Prevention and MCH will continue to have a presence on the legislatively-mandated council. The Council will provide strategic direction and technical assistance in the field of suicide prevention and intervention, including responsible media reporting, community involvement, and promoting trainings.

All MCH school nurses will continue with the school based tobacco prevention and cessation programs throughout the continuance of their contracts. Each is required to work to promote tobacco prevention and cessation programs, and public policies to address reducing access to tobacco products and exposure to second and third hand smoke. They will continue to be encouraged to work with local health departments and other tobacco prevention programs to provide education on tobacco prevention and provide resources on tobacco cessation to student and community members, as well as PYD and risk behavior reduction strategies for children and youth.

The MCH School Health Coordinator will continue to provide technical assistance to the school nurses supported by Title V monies, review work plans, and provide direction to the local administrators of the schools supported by the MCH funding. The MCH School Health Coordinator will review required reports and work with the OSDE to keep them informed that contract requirements are met, provide them with copies of annual work plans and scheduled reports, provide technical assistance to OSDE on questions related to the contract and contract requirements. The MCH School Health Coordinator will provide the school nurses with information on local programs that can be utilized to enhance their tobacco prevention and other related youth programs.

MCH-funded school health education and promotion programs will continue to be expected to provide age and grade appropriate nutrition education, work with the physical education program to promote physical activity throughout a lifetime, and assist in monitoring body mass index (BMI) of students attending those schools.

MCH staff will continue to provide technical assistance to the school based programs through the Center for the Advancement of Wellness (the Center). MCH will collaborate with the Center and Schools for Healthy Lifestyles to implement the FitnessGram Program in their schools and review data collection as it becomes available. MCH staff will continue to work with the Oklahoma Action for Healthy Kids to promote physical activity and nutrition in schools.

Adolescent Health - Annual Report

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	239.7	234.8	229.9	225	220.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.6	23.1	22.6	22.1	21.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.7	77.2	78.7	80.2	81.7

National Performance Measure #8: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Data Interpretation: Although rates are improving, the National Center for Health Statistics reported that the 2013 birth rate for Oklahoma teens aged 15-19 years was significantly higher than the national average. Compared to other states in the nation, including the District of Columbia, Oklahoma ranked 3rd highest for teen birth rates for 15-19 year olds, 4th highest for teen birth rates for 15-17 year olds, and 2nd highest for teen birth rates for 18-19 year olds. Oklahoma’s teen birth rate for 15-17 year olds has decreased significantly over the past 20 years, from 40.8 births per 1,000 females aged 15-17 in 1994 to 20.5 in 2013.

Success Factors: MCH continued the administration and monitoring of the Personal Responsibility Education Program (PREP) grant from the Administration of Children, Youth, and Families and Family and Youth Services Bureau (FYSB). The \$582,792 in federal funds supported implementation of adolescent pregnancy prevention projects through contractual agreements with the city-county health departments in Oklahoma City and Tulsa. Target populations remained youth 11-19 years of age in middle, high, and alternative schools in the Oklahoma City and Tulsa metropolitan statistical areas (MSAs). PREP projects continued to use evidenced-based curriculum from the Health and Human Services (HHS) approved list. Throughout the month of October 2013, both PREP sites held activities associated with Let’s Talk Month, a national public education campaign encouraging parent and child communication about sexuality.

MCH maintained the number of state-funded adolescent pregnancy prevention projects in local county health departments in five areas. The existing projects used the same curriculum and evaluation tools as the PREP grant recipients. MCH continued to provide guidance, oversight, and technical assistance to the PREP and adolescent pregnancy prevention projects. Two new adolescent health specialists were hired during this period to implement the adolescent pregnancy prevention projects in local county health departments.

PREP, the adolescent pregnancy prevention projects, and MCH staff completed activities throughout the month of May 2014 highlighting National Teen Pregnancy Prevention Month and the National Day to Prevent Teen Pregnancy. On May 1, 2014, the Administrative Program Manager for Child and Adolescent Health (CAH) was featured in a television interview with a local news outlet highlighting teen pregnancy issues in Oklahoma. MCH displayed teen pregnancy prevention information and resources in the lobby of the Oklahoma State Department of Health through the end of June. Adolescent pregnancy prevention projects and PREP staff shared presentations, displays, supplied resources, and distributed the National Day to Prevent Teen Pregnancy quiz to young people in their areas. MCH staff also promoted National Teen Pregnancy Prevention Month using social media.

CAH staff met quarterly with tribal PREP, Abstinence, and Personal Responsibility Education Innovative Strategies (PREIS) staff to collaborate on adolescent pregnancy prevention efforts across the state.

County health departments and contract facilities continued to provide family planning clinical services to adolescents. These services included a comprehensive physical examination, preventive education on HIV and STD transmission, education on contraceptive methods (including abstinence), provision of a method when appropriate, and encouragement of parental involvement. Between October 1, 2013 and September 30, 2014, 7,522 clients ages 15-17 were seen in family planning clinics in county health departments and the two city-county health departments.

On June 20, 2014, MCH held videoconference training for health department staff in all county health departments focusing on teen pregnancy prevention.

MCH staff coordinated training for PREP and adolescent pregnancy prevention staff on Life Course Perspective, Building Relationships with Stakeholders and Students, and reporting/data protocols in July 2014.

In August 2014, MCH staff gave input regarding the development of an Oklahoma County Teen Pregnancy Prevention Plan as part of the Wellness Now Coalition Adolescent Health Work Group.

Challenges/Barriers: The Adolescent Health Coordinator position, which provided statewide leadership in the area of adolescent health, was vacant until February 2014. Challenges continued with lack of parental involvement regarding reproductive and sexual education, as documented by poorly attended parent nights and other events related to teen pregnancy prevention.

Without a comprehensive sexual education mandate, the adolescent pregnancy prevention curricula used by OSDH remained optional for schools. This continued to be a barrier for project implementation in some high need areas.

Rural areas with high teen birth rates remained difficult to reach due to their location and limited staffing resources. Lack of additional funding for teen pregnancy prevention staff made program growth challenging. Moreover, the lack of available Train-the-Trainers programs for MCH staff in the curricula utilized also made program expansion challenging.

National Performance Measure #16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Data Interpretation: The suicide death rate among youth 15-19 years old has seen little change over the last 30 years with observed rates of 11.9 in 1984 and 13.3 in 2013 (per 100,000 youths). In 2013, disparities were observed by gender as males had a suicide rate more than twice that of females at 45.3 and 18.6, respectively. Data from the 2013 Youth Risk Behavior Survey (YRBS) indicated that females were significantly more like than males to have attempted suicide in the past 12 months at 9.0% and 4.2%, respectively. However, although females reported more suicide attempts overall, they tended to use less lethal means of suicide than males, creating a greater probability of surviving their attempt.

Success Factors: The Oklahoma Suicide Prevention Council continued the state's suicide prevention plan including community-based suicide prevention training, suicide screening for youth, and improved referral networks for youth at risk for suicide. MCH and Injury Prevention Service (IPS) staff attended the council meetings. MCH staff served on the planning committee for the 2014 Annual Suicide Prevention Conference for May 2014.

The National Suicide Prevention Hotline, 1-800-273-TALK (8255), was distributed on posters and billboards throughout the state with MCH and IPS staff providing Hotline materials to local health departments. The Hotline number was displayed on the MCH website and suicide prevention messages were highlighted on the MCH Facebook page.

Question, Persuade, and Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), and awareness presentations were provided statewide with participants receiving the message that suicide is a preventable public

health problem. Oklahoma's Youth Suicide Prevention Toolkit was available on the MCH website for download by communities to assist with developing prevention strategies.

Nationally recognized prevention experts, advocates, and survivors came to the state for the Zero Suicide Summit on September 29, 2014. MCH staff participated in the afternoon planning workgroup regarding community and suicide survivors' engagement and outreach.

MCH, IPS, and the Council attended monthly Community of Practice (CoP) youth suicide prevention webinars to gain knowledge about evidence-based practices, learn about activities in other states, and strengthen Oklahoma's existing suicide prevention programs and response.

An additional MCH staff member received training to be a QPR instructor in July, bringing the total number of MCH staff that can provide training in this area to two.

YRBS 2013 fact sheets were compiled by MCH staff and posted on the MCH website that included measures on student hopelessness and suicide attempts.

The Oklahoma State Department of Health participated in the National Violent Death Reporting System, collecting detailed surveillance data that was used to help develop a state strategic plan for suicide prevention and community-based suicide prevention efforts.

Challenges/Barriers: Suicide continued to be a sensitive subject to address, due to myths surrounding the issue and a lack of community or organization buy-in regarding prevention. Ensuring that media were following responsible reporting guidelines after a suicide was also a challenge. Some media outlets used outdated suicide reporting methods, sensationalizing the issue or person, creating an additional barrier to reducing suicide deaths among adolescents. Such reporting tactics have been shown to contribute to a contagion effect particularly among youth (who may then contemplate, attempt, or complete suicide as a result of what has been shown or said surrounding another suicide).

Another barrier in reducing suicide attempts and deaths has been a slow-uptake for some agencies that work with youth on the need to have an encompassing view of wellness that addresses different areas of health, including mental health.

State Performance Measure #9: *The percent of adolescents grades 9-12 smoking tobacco products*

Data Interpretation: The statewide YRBS was conducted during the second semester of the 2012-13 school year and was completed in May 2013. MCH YRBS staff once again collaborated with the Cherokee Nation YRBS staff and the OSDH Youth Tobacco Survey staff to coordinate the survey administration. The 2013 data were released to the state in the fall of 2013. The percentage of high school students who ever tried cigarette smoking, even one or two puffs, decreased significantly from 64.1% in 2003 to 45.7% in 2013. The percentage of students who smoked cigarettes on one or more of the past 30 days decreased significantly from was 26.59% in 2003 to 18.5% in 2013.

Success Factors: From August through October 2014, MCH staff delivered presentations and provided educational materials at several conferences to audiences of school administrators, teachers, counselors, and community members, reporting YRBS data from the 2013 survey. Included in this information were data on tobacco use by adolescents. During this time, MCH staff developed eye-catching posters and fact sheets that were shared with education administrators, teachers, and counselors as well as placed on the agency website.

MCH continued to fund ten rural school district school nurses through a contractual agreement with the OSDE. Tobacco prevention and cessation programs remained a focus requirement for these school nurses. MCH staff provided technical support and follow up on work plans and reports from each of the school nurses. These plans and reports defined who received tobacco prevention education, the curriculum used, and all community activities completed promoting tobacco prevention and cessation. The MCH-funded school nurses have continued to

collaborate with local health departments, tribal entities, and staff from the Tobacco Settlement Endowment Trust (TSET) to reinforce district policies and provide education in tobacco prevention and tobacco cessation programs. All school districts that received MCH funding were required to have 24/7 Tobacco Free Campus policies in place, which included no tobacco use during after-school hour activities such as sporting events. All schools participating in the MCH school program received recognition as Certified Healthy Schools during the 2013-2014 school year, in part due to their 24/7 tobacco free policies.

Challenges/Barriers: There was little push back from districts receiving funds from MCH to support the health promotion and health education requirements of the program. The districts continued to allow classroom time for the tobacco prevention programs and enforced the 24/7 tobacco free campus policies with staff, students, parents, and general community members. These programs also utilized the Students Working Against Tobacco (SWAT) Teams to make public presentations to encourage communities to develop more stringent local policies and rules to reduce underage access to tobacco products and create tobacco free public areas. The development of these policies will assist local communities in becoming Certified Healthy Communities. The increasing popularity of electronic cigarettes, the proliferation of stores dedicated to vapor devices in Oklahoma, and the unknown health effects of these devices presented an on-going challenge to staff working on tobacco cessation and prevention.

State Performance Measure # 3: *The percentage of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution)*

Data Interpretation: Data from the 2013 YRBS found that, among public high school students in Oklahoma, 11.8% were obese, which was not statistically different from the 2003 rate of 11.0%. No statistically significant differences in prevalence were found by gender, race/ethnicity, or grade. YRBS data showed that 15.3% were overweight, also not statistically different from the 2003 rate of 14.0%.

Success Factors: MCH staff presented 2013 YRBS information related to overweight and obesity in adolescents from July through September 2014 at conferences whose specific audiences were teachers, school administrators, and school counselors from across the state. MCH staff provided technical assistance to staff from the Center for the Advancement of Wellness (the Center) to contact and encourage schools to sign up for the FitnessGram Program, a nationally recognized program promoting physical fitness in students, through a grant from TSET. One hundred ninety-two elementary and middle schools signed up for the program. The program was administered through the Center.

Applications began in August 2014 for the Certified Healthy Schools program administered through the Center. The Center collaborated with other programs, such as the national Action for Healthy Kids, Department of Tourism, and Alliance for a Healthier Generation, and the MCH-supported Schools for Healthy Lifestyles, to promote physical activity, healthy eating, and tobacco prevention. Districts who received funding for school nurses through MCH were encouraged to sign up for the Certified Healthy School Award. Six out of ten of these districts received awards in one of three levels of the Certified Healthy Schools program through the Center. Those schools receiving awards through the Certified Healthy Schools Program have adopted district and school policies to promote nutritious school food offerings, physical activity, and tobacco prevention/cessation programs throughout the school year.

Challenges/Barriers: Not all districts receiving MCH funding for the school health program were open to changing their policies on foods offered at breakfast and lunch and foods offered during sporting events or at other after-school time activities. Several of the schools receiving MCH funding have such limited budgets that offering additional foods or expanding current physical education classes or after-school programs were cost-prohibitive. Most of the schools receiving MCH funding for school health promotion and education programs used funds from food sold during sporting events or at other after-school time activities to supplement their budgets and remained fearful that revenue would fall significantly if they changed the type of food and beverages offered.

MCH staff began planning for the implementation of the 2015 YRBS in July 2014. A list of high schools was obtained

from the Oklahoma State Department of Education and sent to Westat for the sample draw. During September and October of 2014 MCH staff met with representatives from the Cherokee Nation and the coordinator of the Youth Tobacco Survey at OSDH to collaborate on both surveys and responsibilities. The YRBS maintained specific questions related to weight, physical activity, and nutrition patterns of those adolescents participating in the survey.

State Action Plan Table

Children with Special Health Care Needs

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
<p>Improve the transition to adult health care for children and youth with special health care needs</p>	<p>1. Develop a toolkit for primary care physicians by 2020</p> <hr/> <p>2. Increase number of families who are aware of need for provision of transition services by 10% by 2020</p> <hr/> <p>3. Increase number of families of CSHCN who report receiving transition services by 10% by 2020</p> <hr/> <p>4. Add a health care transition goal to the Oklahoma Department of Education's transition toolkit by 2020</p>	<p>1a. Access a network of pediatricians and family medicine physicians to gather information on how they provide transition services for patients</p> <hr/> <p>1b. Collaborate with the Oklahoma American Academy of Pediatrics (AAP) chapter to get their assistance in engaging pediatricians</p> <hr/> <p>2. Convene a work group of Title V partners and families of CSHCN to discuss how each can provide input into transition planning</p> <hr/> <p>3. Determine and compile a list of resources available within</p>	<p>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <hr/> <p>Percent of children in excellent or very good health</p>	<p>Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care</p>		

		the state to address transition to adult health care				
		4. Work with family organizations to advocate for the addition of transition to the OSDE tool kit				
Reduce health disparities	Develop a plan to address health disparities for CYSHCN by 2020	Identify resources within the state that have data regarding health disparities for CYSHCN, including the Oklahoma Health Care Authority Identify individuals, families and agencies to help develop plan to address health disparities for CYSHCN	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care		

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

The Oklahoma Transition Council will plan the 10th Annual Oklahoma Transition Institute, pending the availability of state funds.

CSHCN staff will continue to collaborate with Sooner SUCCESS to develop plans to address health care transition for adolescents across the state.

CSHCN will work with the Oklahoma Family Network (OFN) to identify gaps in the provision of transition services to youth with special health care needs. Activities of OFN related to effective transition from adolescence to adulthood will include: Transition Care Notebook trainings; workshops and training sessions for families and communities about transition; professional development for health care professionals on transition resources; and, resource development and social media messaging on effective adolescent transition.

Children with Special Health Care Needs - Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.3	42.1	42.9	43.7	44.5

National Performance Measure #2: *The percent of children with special health care needs age 0 to 18 whose families partner in decision making at all levels and are satisfied with the services they receive.*

Data Interpretation: Data from the 2009-2010 National Survey of Children with Special Health Care Needs showed that 69.9% of families, with a child member aged 0 to 18 with special health care needs, were partners in decision making at all levels and were satisfied with the services they receive. Data are not comparable to earlier versions of the survey due to revisions in the questions used for this measure.

Forty-nine percent (49%) of the 151 people who attended the 8th Annual Joining Forces conference reported this was their first time at the conference. Sixty-six (66%) of participants were from the urban centers in the central and eastern parts of the state. Ninety-five (95%) of those who were at the conference reported they would use the information presented at the conference in their personal life and advocacy work.

Successes/Accomplishments: The 8th Annual Joining Forces conference was held on February 19, 2014 in Oklahoma City. This conference was developed to bring families and professionals together to address how to work together to improve the service systems for CYSHCN. The Oklahoma Family Network (OFN), who developed and organized the annual conference, is a parent mentorship group as well as the state Family-to-Family Health Information Center. Title V CSHCN and MCH staff also served on the organizing committee for the conference. Topics addressed how attendees could learn to work together for the improvement or refinement of programs and services. The 2014 conference focused on developing a lifespan perspective. For a family, this meant considering where they wanted their child to be 10, 20, and 40 years in the future, taking into consideration the skills their child would need. Families were asked to organize themselves, friends, programs, and services so their child could reach those goals. Providers and agencies were asked to think about how to not only provide services and benefits to meet present needs, but also how they could help families achieve future goals.

Planning for the 9th Annual Joining Forces Conference began. The conference was designed to continue with the theme of developing a lifespan perspective. CSHCN and MCH staff also served on the organizing committee.

Challenges/Barriers: OFN reported difficulties funding the conference, particularly in helping families from the farthest parts of the state pay for lodging. Families from western Oklahoma may need more targeted outreach to encourage attendance at future conferences.

National Performance Measure #3: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.*

Data Interpretation: Data from the 2009-2010 National Survey of Children with Special Health Care Needs found that 46.1% of children less than 19 years of age received coordinated, ongoing, comprehensive care within a medical home. This was down from 49.7% reported for the CSHCN survey of 2005-2006.

According to data for state fiscal year (SFY) 2014 from the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, 12,928 children categorized as blind or disabled received services through SoonerCare Choice,

a patient-centered Medical Home program that provides basic health services. This represented 78.5% of children enrolled in the SoonerCare (Medicaid) program who were categorized as blind and disabled, and compared to 80% of children enrolled in SoonerCare (Medicaid) who were not categorized as blind or disabled and enrolled in SoonerCare Choice.

Success Factors: The SoonerCare Choice program continued to allow children to receive primary health care through a primary care case manager (PCCM) who coordinated all the child's health care needs. Even when the child needed specialized services that may have required traveling a distance from the home, the PCCM was informed every step of the way and ensured the child received assistance with such services as transportation and lodging when necessary.

CSHCN continued to provide funding for the Oklahoma Infant Transition Program (OITP), to work with families who had an infant in the neonatal intensive care unit (NICU) at the University of Oklahoma Health Sciences Center (OUHSC) Children's Hospital in Oklahoma City. When the infant was ready to go home, OITP helped the families understand prescribed treatment programs for their infant and find ways to pay for the child's care, both in the NICU and at home. OITP coordinated with the primary care physician, therapists and the family so everyone involved understood what the infant needed.

OITP staff worked with the Sooner NIDCAP (Newborn Individualized Developmental Care and Assessment Program) Training Center. NIDCAP continued to focus on teaching medical professionals and students how to provide family-centered, developmentally supportive care, tailored to the individual patient. During the learning process, medical caregivers studied the how and why of moving away from protocol-based care into relationship-based care that supported the infant and family. Participants were introduced to material that shows evidence-based individualized developmental care that is cost effective and has been shown to facilitate earlier discharge for infants with improved medical and developmental outcomes compared to standard NICU care.

CSHCN staff partnered with the parent advocate on staff at OITP on their activities as well as medical home activities involving other divisions and agencies, such as the Oklahoma Family Network, OHCA and Developmental Disabilities Services and Child Welfare Services within the Oklahoma Department of Human Services (DHS), providing funding to Child Welfare Services for physicians' services that were not SoonerCare compensable.

Challenges/Barriers: The on-going challenge for this measure was (and remains) convincing medical professionals of the value of the medical home model and helping them make the necessary changes to adopt the model in their practices.

National Performance Measure #4: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.*

Data Interpretation: Data from the 2009-2010 National Survey of Children with Special Health Care Needs found that 59.3% of children less than 19 years of age had sufficient insurance coverage to ensure payment for needed health care services. This was a decrease from the 61.6% reported in 2005-2006.

The number of children in foster care receiving services through SoonerCare went up (10,747 in SFY 2013 versus 11,483 in SFY 2014), as did the number of children classified as blind or disabled receiving services covered by SoonerCare (19,100 in SFY 2013 versus 22,248 in SFY 2014). Additionally, the number of children approved for the Tax Equity and Fiscal Responsibility Act (TEFRA) program increased (492 in SFY 2013 versus 591 in SFY 2014). TEFRA was designed to provide Medicaid eligibility to children who live at home and are ineligible for SSI (Supplemental Security Income) because of the income or resources of their families, but have needs that require an institutional level of care.

Successes/Accomplishments: Medical assistance for CYSHCN continued to be managed by two agencies, DHS and the OHCA. DHS remained responsible for determining eligibility for people determined by the Social Security

Administration to be blind or disabled, as well as overseeing the foster care system in Oklahoma. Almost all children in foster care were enrolled in SoonerCare.

The SSI-Disabled Children's Program (SSI-DCP) provided certain formula (not covered by SoonerCare), diapers, and adaptive equipment to children receiving SSI. The SSI-DCP is funded entirely by Title V funds and provides equipment, diapers and formula not covered under Title XIX, in accordance with Section 501(a)(1)(C). If a child received a least \$1 of SSI, the family could go to a DHS office and apply for this help. A social services specialist discussed the needs of the child and explained to the parents which ones CSHCN could help with. The local offices ordered diapers from the DHS warehouse to be delivered to the office or family once a month. Formula was provided to children with metabolic disorders who required non-specialized formula. Equipment that aided the child in accessibility or mobility could also be ordered. Parents went to a local DHS office with a statement from a professional, such as a special education teacher or physical therapist, that described the equipment being requested, how it would help the child with accessibility or mobility and the vendor from whom it would be ordered. A CSHCN program staff member authorized all orders. The social service specialist in the local office made arrangements with the family to pick up the equipment at the office.

OITP, funded in part by Title V CSHCN, helped families make sure they were ready to take care of their children at home when their infants were released from the NICU. OITP helped arrange doctors and specialists and secure needed equipment. OITP also had a social worker on staff who helped families find resources to cover all the medical bills incurred in the NICU as well as needed future services. The social worker assisted families with applying for Medicaid if they needed it.

Challenges/Barriers: Unfortunately, the increase in the number of children in foster care over the past year added an additional burden to the OHCA during a time when the Federal Medical Assistance Percentage (FMAP) rate decreased for Oklahoma, contributing to a major budget shortfall for SoonerCare. All health care providers were financially impacted when, in the summer of 2014, OHCA announced a 7.75% cut to the provider reimbursement rate. The rate cut has the potential to limit services for CYSHCN as, even before the cut, there were medical providers who were resistant to having too many patients on Medicaid due to the low provider reimbursement rate.

National Performance Measure 5: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.*

Data Interpretation: Data from the 2009-2010 National Survey of Children with Special Health Care Needs showed that 65.7% of families with children less than 19 years of age having special health care needs believed that health services were organized in such a way that they could be easily used. Comparisons to previous CSHCN survey data (2005-2006) cannot be made due to modifications in the survey tool.

In the 2014 Community Needs Assessment completed by Sooner SUCCESS (State Unified Comprehensive Exemplary Services for Special Needs), only a little more than one-fourth of the families who needed respite services indicated they were able to get them. In addition, 20% of respondents indicated they needed services to assist their children with transition to adulthood, but only 19% stated this need was being met. The assessment was completed by the families of SoonerCare (Medicaid) eligible children who were categorized as blind or disabled.

Successes/Accomplishments: Sooner SUCCESS, funded in part by Title V CSHCN funds, continued their work to provide a comprehensive system of health and educational services to meet the needs of CYSHCN and their families across the state. There were county coordinators overseeing 13 counties: Blaine, Kingfisher, Major, Logan, Canadian, Cleveland, Garfield, Pottawatomie, Oklahoma, Creek, Delaware, Rogers and Tulsa. Mayes County was recently added to the northeast region in January 2015. The coordinators maintained a knowledge base of the resources and services in their assigned county which allowed them to help families find programs that could fill their needs. They also worked with the members of their communities to develop resources that could help with unmet needs. Title V CSHCN staff worked with Sooner SUCCESS on a variety of activities throughout the year.

Sooner SUCCESS was involved in developing a CHIO (County Health Improvement Organization) in Delaware County (eastern Oklahoma). The CHIO was created with the Public Health Institute of Oklahoma (PHIO). The PHIO is a non-profit organization, established in 2004 whose mission is to promote health improvement through collaborative partnerships with governmental agencies, academia, and the community. The PHIO gave Delaware County a grant to host a Diabetes Expo in March, 2014. The expo brought in speakers to discuss therapies, the importance of physical activity and the impact of diabetes on the eyes and the heart. Attendees could visit the booths of organizations and businesses offering products and services to help people with their diabetes maintenance.

During 2014 Sooner SUCCESS hosted a series of events called "On The Road" Family Perspective Conferences. These one-day symposiums were held in communities around the state, such as Ardmore (southern Oklahoma), Tulsa (northeastern Oklahoma), and Sallisaw (eastern Oklahoma). Parents who attended heard from and interacted with representatives from a variety of private and public agencies that served the needs of CYSHCN. These spokespersons explained what their organizations did and how families could apply for services. CSHCN staff attended the conferences and explained how to access the SSI-DCP. Sooner SUCCESS had a county coordinator at each "On the Road" conference to discuss what they did for families.

Sooner SUCCESS maintained an online database of resources from around the state for people with disabilities which is located at <http://soonersuccess.bowmansystems.com/>. Individuals could go online and find resources by type and county. The resource site provided contact information as well as the days and times the resource could be accessed. Visitors to the site could create a free account that would allow the visitor to pull up previous searches and save specific resources for easier access. Account holders could also correct resource information and even add new agencies and providers.

The coordinator for Blaine County, in western Oklahoma, worked with Hearts of Hope, a behavioral health care provider, to bring a Spanish-speaking counselor to Weatherford.

Challenges/Barriers: Sooner SUCCESS continued to work on finding ways to obtain increased funding so they could have local resource coordinators providing services to families in all 77 counties in the state. Because of the current state budget shortfall, the concern is being able to maintain current funding levels without any cuts.

National Performance Measure #6: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Data Interpretation: Data from the 2009-2010 National Survey of Children with Special Health Care Needs showed that 40.5% of children less than 19 years of age received services necessary to make the appropriate transitions to adult health care, work, and independence. This was a decrease from 43.7% from 2005-2006 data.

At this time there is no recent data available for this measure. However, 1,089 families completed the 2014 Community Needs Assessment conducted by Sooner SUCCESS and 20% of respondents reported they needed services to assist their children with transition to adulthood. Of those who indicated a need, only 19.2% stated this need was being met. The assessment was completed by the families of SoonerCare-eligible children who were categorized as blind or disabled.

Successes/Accomplishments: The Oklahoma Transition Council (OTC), an interdisciplinary, interagency group formed to work toward improving transition practices across multiple agencies, held its 9th annual Oklahoma Transition Institute (OTI) on October 28-29, 2014. The OTC continued to draw members from a variety of agencies and community organizations, local school districts, and parents. A Title V CSHCN staff member served on the OTC and the planning committee for the OTI. The Council, organized into 34 area teams developed from different parts of the state, worked to improve education transition. The OTI provided an opportunity for professionals and family members to learn about a variety of subjects related to transition and the transition teams had opportunities to discuss ideas and directions for the succeeding year. The event brought together speakers on a wide range of

topics on transition for several breakout sessions for each day.

One of the breakout sessions discussed how Applied Behavioral Analysis (ABA) helps adolescents and adults who have Autism Spectrum Disorder (ASD). The presenter discussed how ABA could help children and youth have socially positive interactions with family members or roommates. Therapists could explain every aspect of visiting a doctor and then teach the individual how to complete every part of the visit without a problem.

Another session discussed developing post-secondary goals for students with significant developmental disabilities, and focused on developing attainable goals before high school based on the students' plans and goals. Skills should be taught and supports developed while making sure the student is involved in all IEP (Individualized Education Program) meetings and understands the steps that must be taken to reach all desired objectives.

CSHCN continued to partner with the Oklahoma Family Network, Oklahoma's Family-to-Family Health Information Center, to identify gaps in the provision of transition services to youth with special health care needs.

Challenges/Barriers: If more accountability to the area teams were provided by OTC to meet team goals, with a greater emphasis on the health aspects of transitioning to post-secondary life, teams might make better progress.

State Performance Measure #2: *The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.*

Data Interpretation: A total of 407 respite vouchers were issued in 2014, more than double the number issued in the previous year.

Successes/Accomplishments: All applications for respite vouchers went through Developmental Disabilities Services (DDS). Caregivers could call the nearest DDS office to request respite or complete and submit an online request form. DDS required that the caregiver live with the child full time and the child could not be receiving any other services through DDS, nor could the child or youth be living in a drug treatment center or group home. If a child was receiving other services through DDS or was otherwise ineligible through their program, the application was sent to CSHCN staff. The vouchers for both programs were used to directly pay someone to take care of the child so the primary caregiver could take a break or run errands. Title V CSHCN funds were used to pay for the respite vouchers. In accordance with Section 505(a)(5)(F)(iii), the CSHCN program worked with DDS to ensure CSHCN received respite services.

CSHCN staff provided training for DHS workers who worked with CSHCN. Part of the training described the respite voucher program so the workers could explain this program to applicants for any DHS services. The CSHCN staff member also talked about the availability of respite vouchers at the Sooner SUCCESS "On The Road" Family Perspective Conferences. These one-day events occurred in towns throughout the state and brought together representatives from a variety of agencies and organizations that serve the special needs' community. Each agency described their program to the audience and answered questions. The events started after parents took their children to school and ended in time for parents to pick them up.

Sooner SUCCESS partnered with DHS Aging Services to administer the Lifespan Respite Grant Voucher program. This program was funded by the Administration for Community Living which is under the Administration on Aging at the US Department of Health and Human Services. The grants were awarded to states to implement systems of community-based respite for family caregivers of individuals with special needs of all ages, and in Oklahoma some vouchers were issued to grandparents who were primary caregivers for their grandchildren. The grandparents could not have received respite assistance from any other program and they could use the vouchers to pay anyone over the age of 18 to provide the respite care.

Challenges/Barriers: Families in need of respite were not always aware of the availability of the respite program, or knowledgeable about how to apply for it. In some communities, there were no trained adults who could care for children with special needs.

State Performance Measure #4: *The percentage of children with special health care needs who receive child care services at licensed child care facilities and homes.*

Data Interpretation: According to Oklahoma Child Care Resource and Referral Association (OCCRRA) reports, during 2014, except for the first quarter, the state's total licensed child care capacity was anywhere between 72,000 and 78,000 (in the first quarter it was 84,000). It is theorized that the increased criteria to qualify as a child care provider in the state attributed to the decrease from the previous year (between 91,000 and 95,000). The reports showed the number of children who have behavioral (impairment that affects the child's behavior and may require non-traditional behavior strategies), developmental (child has not reached the expected developmental milestone), medical (impairment that requires medical intervention in order to carry out regular expected activities) and physical (physical impairment that prevents a child from engaging in regular activities performed by typically developing children) needs. Child care facilities reported more slots available for children with behavioral needs than any of the other categories, but child care homes reported more slots available for children with medical needs. A total of 1,564 slots were filled with children who had either a behavioral, developmental, medical or physical need and received a child care subsidy through DHS.

According to OCCRRA's report on the number of requests received from parents looking for child care for CYSHCN, a total of 307 requests were received throughout the year, which represented a 20% increase from the previous year. However, this is lower than the number received in 2012 (373). The highest number of requests (114) was for children with behavioral needs. There were 81 requests for children with developmental needs, 70 for children with medical needs and 42 for children with physical needs. These data represented the number of people who indicated the child had a special need, so the numbers do not reflect families who requested a referral to a child care provider but did not disclose that their child had a special need.

Successes/Accomplishments: The Inclusive Child Care Committee completed their goal to update the guides for parents of children with special needs and for providers of children with special needs. These new guides, expected to be released soon, were developed to help families and providers feel more confident with their ability to enhance the growth and development of CYSHCN by including them in typical child care settings. The family guide was created in English and Spanish.

Changes were implemented which further streamlined the process for families to receive the enhanced special needs child care rate. The number of families approved for the special needs subsidy rate for child care almost doubled from 28 in 2013 to 50 at the end of 2014. It is believed that the changes made in the process for requesting the enhanced rate contributed to the increase.

Challenges/Barriers: No progress was made regarding provision of training for child care providers. There are some online trainings with good information regarding children with specific health conditions, but otherwise there isn't any in-person or online training regarding children with special needs.

State Performance Measure #8: *The percent of Medicaid eligible children with special health care needs who report receiving dental services other than for routine dental care.*

Data Interpretation: Federal fiscal year (FFY) 2014 data from the OHCA reported 1,321 non-routine dental services for Medicaid-eligible children who were classified as disabled or who were in the custody of the state. Non-routine services included crowns, endodontic and periodontal services. In FFY 2013, 1,432 services were provided, representing an 8% drop. OHCA reported that there was a general drop in all dental services from FFY 2013 to FFY 2014.

Successes/Accomplishments: The Governor's Task Force on Children and Oral Health was formed in August, 2009. The Children's Oral Health Coalition (COHC) was formed to implement the recommendations of the task force. The COHC continued to have representatives from organizations such as Delta Dental Foundation,

Department of Human Services, Community Action Agencies of Oklahoma, Oklahoma Dental Foundation (ODF) and OHCA. A Title V CSHCN staff member served on COHC, attending all the leadership meetings. Completed goals included the 2006 development of a loan repayment program for dental students who agreed to open practices in underserved parts of the state. In 2014, legislation was passed that increased the amount that could be paid on dental school loans each year on behalf of participating dentists from \$25,000 to \$50,000.

The COHC launched its website in February 2014, www.oohc.org. The site was created to consolidate information on oral hygiene from a variety of internet sources and Oklahoma. The site was designed to include a calendar that shows low-cost or free events providing dental services. Pages were made specifically for parents, children, adolescents, and CYSHCN. Information was also included for teachers and dental professionals.

The COHC continued to review the original task force recommendations, to determine progress to date and to develop new plans to fulfill the remaining unmet recommendations. In addition, the coalition decided to research additional funding opportunities to increase sustainability. To make as great an impact as possible in the oral health of Oklahomans, the coalition changed its name to the Oklahoma Oral Health Coalition and changed its focus to include adults as well as children.

Challenges/Barriers: Many health care providers, including dental providers, continued to express concerns about wanting to or having to limit the number of Medicaid patients in their practices due to low reimbursement rates.

State Action Plan Table

Cross-Cutting/Life Course

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce the prevalence of chronic health conditions among childbearing age women	Reduce the percent of women who smoke during the last 3 months of pregnancy from 18.0% in 2011 to 16.7% by December 2019	<p>Encourage pregnant women to quit smoking through referral to the QUIT line</p> <p>Air public service announcements at least annually on smoking and pregnancy and the impact of second hand smoke on infants</p> <p>Analyze PRAMS data and BRFSS data on e-cigarette use to determine prevalence and create data briefs, etc.</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (<37 weeks)</p> <p>Percent of early preterm births (<34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p>	<p>A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes</p>		

			<p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <hr/> <p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Preterm-related mortality rate per 100,000 live births</p> <hr/> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p> <hr/> <p>Percent of children in excellent or very good health</p>			
Reduce the incidence of preterm and low birth weight births	Reduce the percent of women who smoke during the last 3 months of pregnancy from 18.0% in 2011 to 16.7% by December 2019	Explore data related to e-cigarette use among women of reproductive age and pregnant women to determine the impact these devices have on tobacco use and health	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <hr/> <p>Maternal mortality rate per 100,000 live births</p> <hr/> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <hr/> <p>Percent of very</p>	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

			low birth weight deliveries (<1,500 grams)			
			Percent of moderately low birth weight deliveries (1,500-2,499 grams)			
			Percent of preterm births (<37 weeks)			
			Percent of early preterm births (<34 weeks)			
			Percent of late preterm births (34-36 weeks)			
			Percent of early term births (37, 38 weeks)			
			Perinatal mortality rate per 1,000 live births plus fetal deaths			
			Infant mortality rate per 1,000 live births			
			Neonatal mortality rate per 1,000 live births			
			Post neonatal mortality rate per 1,000 live births			
			Preterm-related mortality rate per 100,000 live births			
			Sleep-related Sudden Unexpected Infant Death			

			(SUID) rate per 100,000 live births			
			Percent of children in excellent or very good health			
Reduce health disparities	<p>1. Reduce the number of African American and American Indian women who smoke during pregnancy</p> <p>2. Reduce the percent of children who ride in vehicles where smoking is allowed</p>	<p>1a. Distribute pharmacy bags to tribal pharmacies who agree to fax referrals for customers who wish to quit smoking to the QUIT Line. Bags have the QUIT line number and a reminder to take folic acid</p> <p>1b. Research other avenues to effectively disseminate smoking information to minority populations</p> <p>2a. Examine TOTS, 1GHS and 5GHS data to examine disparities and prevalence of vehicle rules on smoking and create data briefs to distribute to partners</p> <p>2b. Create messages for social media on the prevalence</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Percent of low birth weight deliveries (<2,500 grams)</p> <p>Percent of very low birth weight deliveries (<1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (<37 weeks)</p> <p>Percent of early preterm births (<34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p>	<p>A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes</p>		

		of children riding in vehicles where smoking was allowed	<hr/> Perinatal mortality rate per 1,000 live births plus fetal deaths <hr/> Infant mortality rate per 1,000 live births <hr/> Neonatal mortality rate per 1,000 live births <hr/> Post neonatal mortality rate per 1,000 live births <hr/> Preterm-related mortality rate per 100,000 live births <hr/> Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births <hr/> Percent of children in excellent or very good health			
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Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

The Preconception/Interconception Work Group for *Preparing for a Lifetime, It's Everyone's Responsibility*, will disseminate pharmacy bags to pharmacies agreeing to share information on *Preparing for a Lifetime*, Text4Baby, and the Oklahoma Tobacco Helpline (OTH). The bags feature the *Preparing for a Lifetime* logo, as well as a bottle of folic acid, and both sides of the bags have the OTH number.

The Tobacco Cessation Work Group for *Preparing for a Lifetime* will continue to focus on implementation of the media campaign set and follow up on quality improvement (QI) efforts related to the SoonerCare call center's tobacco screening and referral protocol.

The OHIP Child Health Work Group will continue to explore the policy and budget impacts of extending Medicaid tobacco cessation benefits to mothers who bring infants to child health appointments.

Family planning clients seen at the CHDs and contract clinics will continue to receive counseling and referrals to the OTH. Maternity providers will continue to assess pregnant women for smoking through use of the Psychosocial Risk

Assessment and provide counseling and referral to the OTH as needed.

MCH will continue to promote use of faxed referrals to the OTH to increase follow-up contact after the initial encounter. The faxed referral will ensure patient follow-up by a trained smoking cessation counselor as opposed to patient initiation.

The OTH is set up for electronic referrals, so additional emphasis will be placed on screening and referral modules within EMR. As the use of traditional fax referrals declines, tobacco cessation infrastructure will make a transition into the electronic realm.

Provide training and technical assistance to health departments and health care providers on the Edinburgh Post Natal (Depression) screen EPNS). Create a resource list for referrals to mental health services for health care providers and county health departments across the state.

Partner and collaborate with community partners to increase awareness of postpartum mood disorders.

Economic analysis, with the assistance of the Robert Wood Johnson Foundation, will be completed to better assure the reduction of health disparities among populations at risk. In addition, other work to reduce health disparities will be on-going within each population domain.

Cross-Cutting/Life Course - Annual Report

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	12.8	12.1	11.4	10.7	10.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	29.2	28.1	27.1	26.1	25.0

National Performance Measure #15: *Percentage of women who smoke in the last three months of pregnancy.*

Data Interpretation: Data for monitoring NPM #15 were drawn from the 2012 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). These data show that 12.0% of pregnant females reported smoking during the third trimester of pregnancy.

Success Factors: The Center for the Advancement of Wellness (the Center) houses two flagship issues of the Oklahoma Health Improvement Plan: tobacco use prevention and cessation and obesity (physical activity and nutrition). As part of the *Preparing for a Lifetime, It's Everyone's Responsibility* infant mortality reduction initiative, cessation staff assisted the Oklahoma Health Care Authority (OHCA) with the call center-based electronic referral system connecting new Medicaid clients with the Oklahoma Tobacco Helpline (OTH). Upon registration with SoonerCare, expectant mothers were instructed to contact OHCA for enrollment confirmation, and were then screened for tobacco use, offered a brief intervention, and offered a referral to the OTH. Client information was

entered into a database that was submitted via a secure FTP process to Oklahoma's Helpline Vendor who then reached out to the SoonerCare member for OTH enrollment. Outcomes reports were sent back to OHCA.

In addition, linkages were established with the SoonerStart program (for children with developmental delays) to engage parents in tobacco cessation, as many of these children are at heightened risk of complications due to secondhand smoke exposure.

During federal fiscal year (FFY) 2014, 336 tobacco users who were also pregnant accessed the Helpline for assistance in quitting smoking. This represents about a 19% decrease in the number of pregnant women using the Helpline as compared to FFY 2013. One hundred and forty-three (143) women who were planning pregnancy and 74 breastfeeding mothers also utilized the Helpline. The resurgence of e-cigarettes and vaping devices may have contributed to the decreased utilization of the OTH. Additional projects and program expansion were discussed to address the decline.

Medicaid providers continued to receive compensation for completing the Psychosocial Risk Assessment and for counseling clients on the 5 A's for tobacco cessation. The 5 A's screening form (based upon the 2008 Clinical Practice Guidelines for Treating Tobacco Dependence) and the OTH outcomes reports were utilized to increase the number of referrals to the OTH, as well as the number of quit coaching sessions completed.

MCH continued to participate in the Collaborative Improvement and Innovation Network (COIIN) Smoking Cessation Strategy Team in Region IV and VI, focused on promoting tobacco cessation among expectant mothers and their families. A public service announcement was produced for radio and television and provided various rationales for quitting, along with information on the effect of secondhand smoke on newborns. The radio and television advertisements aired during the period between Mother's and Father's Day. These ads featured an American Indian father holding his newborn baby while discussing reasons for quitting. A second radio advertisement featured a mother and grandmother discussing the impact of secondhand smoke on the mother's unborn child. Content development was supported by MCH funding, and the Center's CDC grant funded the purchase of airtime.

Family planning clients and pregnant females seen at county health departments (CHDs) and contract clinics were counseled on the impact of smoking during the preconception, interconception, and prenatal periods. Females who smoked or reported family members who smoked were referred to the OTH, 1-800-QUIT-NOW, for support with smoking cessation. MCH monitored county health departments' and contract clinics' smoking intervention documentation to ensure appropriate referrals for clients who reported tobacco use.

The Center continued to work with the Children First Program (Oklahoma's Nurse-Family Partnership and part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program) on motivational interviewing with clients enrolled in the program in order to decrease the number of pregnant women and new mothers who smoke.

MCH and the Center collaborated with the three Cessation Systems Initiatives funded by the Oklahoma Tobacco Settlement Endowment Trust (TSET), including the Oklahoma Hospital Association, the Oklahoma Health Care Authority, and the Oklahoma Department of Mental Health and Substance Abuse Services, in an effort to incorporate tobacco screening and referral into electronic medical records (EMR).

Challenges/Barriers: Challenges included social and family norms and support (or lack thereof) for tobacco use and cessation. If tobacco use was normalized in a family, social circle, etc., it made it much more difficult for women to quit. This difficulty could then be compounded even more if the smoker received little or no support/encouragement to quit from those closest to her.

Outside of the obvious physical addiction, tobacco users often said they associated smoking, chewing, etc. with many different aspects of life (having a cigarette on breaks, on the way to work, after work, out with friends). For some women, quitting equated to losing a huge part of daily structure.

Another challenge was the rapid increase of vaping and e-cigarette devices and stores in the state. Prevalence of

use among pregnant women remained unknown, as did the potential impact of e-cigarette use on pregnancy and infant health.

State Performance Measure #7: *The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.*

Data Interpretation: Principally, expanding MCH data capacity was carried out through the efforts of the State Systems Development Initiative (SSDI) Manager/Analyst, a position funded by the SSDI grant, with complementary work provided by the MCH Medicaid Analyst, a position jointly funded by MCH and the Oklahoma Health Care Authority, the state's Medicaid agency. These positions had responsibility for supporting the MCH Title V Block Grant and the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality and to expand the use of the SSDI minimum/core data sets (SSDI Manager/Analyst), and to link and analyze birth and Medicaid records (MCH Medicaid Analyst). MCH faced challenges in maintaining capacity levels due to vacancies in these two key positions, both of which were vacant for the majority of the grant reporting period. No expansion of data capacity was possible. Title V grant funds were used to partially fund the SSDI Manager/Analyst position.

Success Factors: The unit within MCH with the responsibility for data reporting and analysis relevant to the Title V Block Grant (including the Title V Five-Year Needs Assessment), MCH Assessment, had ultimate responsibility for expanding MCH data capacity. MCH Assessment, where the SSDI Manager/Analyst and the MCH Medicaid Analyst reside, was successful in maintaining existing levels of data capacity by relying on the skills and expertise of analytic staff responsible for other key MCH projects. Other analysts were detailed to cover duties normally assigned to the SSDI Manager/Analyst and the MCH Medicaid Analyst.

Challenges/Barriers: The primary challenges faced were the vacancies in the SSDI Manager/Analyst and MCH Medicaid Analyst positions. These positions had key roles in expanding MCH data capacity and were designed to contribute meaningfully to the completion of the Title V Block Grant and the Title V Five-Year Needs Assessment. With the vacancies, assignments were given to other MCH analysts to complete. While a basic level of work completion was possible, no expansion of data capacity could be achieved.

Other Programmatic Activities

National Performance Measure #7: *Percent of 19 to 35 month olds who have received the full schedule of age appropriate immunizations against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Haemophilus influenzae type b, hepatitis B, varicella, and Pnuemococcal diseases.*

Data Interpretation: According to the National Immunization Survey (NIS) results for 2013, an estimated 72.3% of Oklahoma children 19-35 months of age completed the 4:3:1:4 series plus the full *Haemophilus Influenzae* type b.

Success Factors: During 2013, the Oklahoma State Department of Health (OSDH) maintained its policy of providing immunizations to any child who presented at a county health department needing immunizations. All children served were screened for eligibility for VFC vaccines. With the billing module already in place, OSDH now has the ability to bill clients with private insurance to assure that private pay patient are not turned away from County Health Departments (CHDs). Additionally, county health departments were able to recoup year-round cost reimbursement for services provided to children eligible for Medicaid.

Immunizations continued to be tracked by both private and public health care providers using the state immunization registry, the Oklahoma State Immunization Information System (OSIIS). The Oklahoma Health Care Authority (OHCA, the state's Medicaid agency) provided additional support to OSIIS by maintaining a contractual requirement that all Medicaid practices participating in the Vaccines for Children (VFC) Program report administered doses in OSIIS.

Immunization Service field staff (IFCs) continued to utilize the recall report generated from OSIIS to identify children past due for vaccines to be recalled to providers' offices to receive the missing vaccinations.

Immunization Service's epidemiologist, whose primary responsibility is the analysis of OSIS data, continued to use OSIS data to assess the immunization level for the 4:3:1:3:3:1:4 primary childhood series for all 77 counties in Oklahoma, to develop strategies and targeted interventions for the 5 counties with the lowest immunization rates.

The OSDH and the Immunization Service partnered with the OHCA on a Quality Improvement (QI) project to improve childhood immunization coverage in Oklahoma. Bryan County was selected for a pilot. At the end of the project, estimated immunization coverage for children 19 – 35 months in Bryan County increased from 73.9% in 2013 to 77.4% in 2014.

Immunization Service staff continued to assess immunization rates in individual clinics using the CDC's Assessment, Feedback, Incentives and eXchange (AFIX) tool to educate providers on areas of focus to ensure increased immunization coverage rates and improved standards of care.

Child care facilities were also audited to ascertain compliance with Oklahoma State immunization law. OSDH Immunization IFC continued to conduct immunization audits and worked with centers to raise vaccination levels through follow-up visits to centers with coverage below 90%. Staff at child care facilities often changes and continuing education is vital to maintaining immunization levels in child care facilities. A QI project was conducted in 2014 with a goal to ensure that at a minimum, 90% of children enrolled were compliant with the state immunization law. About 5,000 copies of the Child Care Guide to Immunization in Oklahoma were distributed in 2014 to educate child care facility staff on the state immunization law requirements and how to enforce the law.

MCH continued to review the immunization status of children during site visits to county health departments and contractors and provide technical assistance as indicated.

Challenges/Barriers: The Immunization Service encountered significant staff turn-over in 2014 in terms of both central office staff and field staff which impacted certain QI projects. Manpower was also a significant barrier to accomplish some vital projects. The roll-out of a new OSIS with full meaningful use capability remained a major challenge.

Budget reduction from the federal level also affected the ability to maintain certain key contracts for local immunization outreach.

National Performance Measure #14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Data Interpretation: Data from the Women, Infants, and Children (WIC) Supplemental Nutrition Program showed that for children 2 to 5 years of age receiving WIC services through the Oklahoma State Department of Health (OSDH), 29.1% had a body mass index (BMI) at or above the 85th percentile in calendar year 2014. This was not significantly different than the 2007 figure of 27.6%.

Success Factors: Nutrition Education strategies for WIC participants continued to focus on increases in breastfeeding initiation and duration rates, increases in fruit and vegetable consumption, decreases in fat intake through lower fat milk in WIC food package, and increases in physical activity. Training to increase WIC staff knowledge of current nutrition information, support for breastfeeding, and education methods to use when working with WIC participants were recognized as essential activities. All strategies were integral in addressing BMI for children 2 to 5 years of age.

Evidence-based reports and reviews have determined that a history of breastfeeding is associated with a reduction in risk of obesity later in life. WIC's efforts to promote and support breastfeeding have resulted in a significant increase in breastfeeding initiation rates among WIC participants from 67.1% in 2004 to 82.1% in 2014. Important to note, Oklahoma WIC's 2014 breastfeeding initiation rate of 82.1% surpassed the Healthy People 2020 Initiation Rate of 81.9%. Of even greater significance, clinics with Breastfeeding Peer Counselors had an even higher

breastfeeding initiation rate of 85.1%. The WIC Breastfeeding Peer Counseling Program continued to expand and was utilized in 30 clinics within 19 counties.

At certification, all prenatal participants received breastfeeding educational materials developed through the Southwest Region USDA WEBS project. All prenatal participants were scheduled for breastfeeding education classes and through facilitated discussions learned why breastfeeding is important, the basics of “how to breastfeed,” and were given additional breastfeeding support at clinics. In 2014, emphasis included the breastfeeding mother’s experience in the hospital, empowering her with information to exclusively breastfeed, provide “skin-to-skin” after delivery, and avoid the use of artificial infant milk, if not medically indicated. In 2014, a total of 23 WIC staff members carried the designation of International Board Certified Lactation Consultant (IBCLC).

The 2014 *Cooking with WIC* series continued with *Cooking with WIC: Kids Rock Nutrition in the Kitchen*. *Cooking with WIC* is an ongoing series of facilitated group nutrition education sessions. The purpose of the project is to promote healthier eating habits and present nutrition education concepts using methods that are not feasible in a clinic setting. The *Kids Rock Nutrition in the Kitchen* DVD with corresponding lesson plan was developed to encourage the involvement of children in meal preparation based on developmental readiness with focus on increasing interest in fruits and vegetables.

Through Value Enhanced Nutrition Assessment, WIC participants identified a specific health goal for improvement of diet and physical activity at certification and mid-point wellness checks. Participants had access to a registered dietitian for individual nutrition assessment and dietary counseling to address high BMI. Group nutrition education classes provided a setting for participants to learn about healthy eating and integrating physical activity in a facilitated discussion format. Physical activity classes involved the child and parent in fun and simple play that resulted in increased activity.

Online nutrition education via the website www.wichealth.org provided participants with another option to complete their nutrition education requirement. Based on stages of readiness, the participant chose from lesson plans ranging from “*Create Good Eating Habits in Your Child*” to “*Fun and Healthy Drinks for Kids*”. In federal fiscal year (FFY) 2014, the monthly average number of WIC participants using this state of the art on-line nutrition education classes was 4,025.

Additional efforts directed at improved staff training and competencies included the continued expansion of professional development, education, and staff training through various multi-media, online instruction, and state conferences. The WIC Training Link (www.ok.gov/wic) provided up-to-date online training and information to WIC staff. The Lifecycle Module of the Certified WIC Nutrition Technician Training Course was completely updated to provide clinic staff with the latest nutrition information to use when educating participants on ways to increase nutrient dense foods while reducing fat and sugar intake. Training was directed at educating participants on important changes in the WIC food package. Children, ages 2-5 years, and women must select 1%, ½%, or skim milk. Children 1-2 years of age may receive 2% milk or less if their nutrition assessment determined the child was at risk due to obesity, overweight, or a family history of obesity, hyperlipidemia, or cardiovascular disease. Infants, 9-11 months, could receive \$4.00 worth of fresh fruits and vegetables, in place of a portion of jarred baby food fruits and vegetables.

Over 450 WIC and health care professionals attended the 2014 WIC Nutrition Conference and Breastfeeding Symposium. An important focus of the conference was on recognizing common infant behaviors that may trigger early weaning of breastfeeding or overfeeding behaviors. Conference speakers provided information on paced feeding, various infant states, and how crying does not always indicate hunger.

Challenges/Barriers: Continued challenges for mothers receiving WIC were increasing the breastfeeding duration rates at six and twelve months of age. The latest data (2012) indicated a duration rate of 25.9% at six months and 10.4% at twelve months for mothers receiving WIC. The provision of low and no fat milk products (such as 1% and

skim milk) for children 2 to 5 years old and women has not been well received by some WIC families.

II.F.2 MCH Workforce Development and Capacity

Description of MCH Workforce funded by Title V:

Organizationally, MCH consists of MCH Administration, the Child and Adolescent Health Division, the Perinatal and Reproductive Health Division, and MCH Assessment. MCH also has Service level staff, the Public Health Social Work Coordinator, MCH Consultant for Quality Improvement and the MCH Nutrition Consultant, who work across all MCH programs. MCH Administration is comprised of the Title V MCH Director and administrative support staff. The Child and Adolescent Health Division includes primarily nurses and health educators. Programs and services include clinical services, school health, adolescent health, early childhood, child care, bullying, suicide prevention, teen pregnancy prevention, and injury prevention. The Perinatal and Reproductive Health Division staff includes nurses, nurse practitioners, and health educators. Programs and services include preconception and interconception care, clinical maternity and family planning services, and preventive health education services for females and males of reproductive age. MCH Assessment staff includes epidemiologists, biostatisticians, and program analysts. These staff members evaluate MCH programs and services and provide leadership for needs assessments and provision of data on the MCH population for state level and community-based planning and development of policy, programs, and services internal and external to the Oklahoma State Department of Health (OSDH) and MCH. MCH Assessment staff is also responsible for carrying out statewide population-based surveillance to include the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Oklahoma Fifth Grade Health Survey (5GHS), and the Oklahoma First Grade Health Survey (1GHS).

Over the last year Title V MCH has experienced some turnover, including the resignation of the Child and Adolescent Health Administrative Program Manager, however the position will be refilled soon and there are no expected changes to the total number of FTEs (37) funded by Title V for MCH. MCH Assessment, the MCH division with responsibility for preparing the Title V Five-Year Needs Assessment, has had two vacancies that have significantly impacted work timeliness and performance. The MCH Medicaid Analyst, an OSDH/Oklahoma Health Care Authority (OHCA) jointly funded position responsible for linking and analyzing birth records and Medicaid administrative data, has been vacant since October 2013. This position has data and analysis responsibilities to inform MCH and OHCA program staff and Oklahoma Title V programming, and to provide data to be included for CoIIN reporting. With the prolonged vacancy, this work cannot be completed as planned. The State Systems Development Initiative (SSDI) Analyst position became vacant in March 2014. In Oklahoma, the SSDI Analyst has responsibility for coordinating the Title V Five-Year Needs Assessment which included establishing a completion schedule, preparing working documents, convening planning and strategy meetings, and editing documents written by staff assigned to complete sections of the needs assessment. With the vacancy, these responsibilities fell to the Administrative Program Manager of MCH Assessment with work distributed among division staff, putting strain on the ability to complete assignments according to schedule and to the extent initially conceived. Recruitment for these positions is ongoing, but to date qualified candidates have not been identified and hired.

In January 2015, the Social Work Coordinator position was hired. This position had been vacant for almost two years. Having the position filled will enhance the state's ability to attract and mentor social workers in several county health departments in areas with high infant mortality rates and need for social work services.

CSHCN, located at the Oklahoma Department of Human Services (DHS), consists of three staff funded by Title V, including the CSHCN Title V Director and two program staff, who are responsible for overseeing the provision of services to children receiving Supplemental Security Income (SSI) within the state by providing training and guidance to the over 70 social services specialists located in DHS county offices across the state. These social services specialists are responsible for writing and monitoring service plans for all children who receive SSI and other services through DHS. All equipment and services available through CSHCN must be pre-approved by CSHCN

staff. Families of children who receive SSI, but do not receive Medicaid, are also contacted to assure they are informed of services available through CSHCN.

CSHCN initiates and monitors several professional service contracts including clinics that provide care to neonates; physicians for provision of psychiatric services to children in DHS custody; the state's Family-to-Family Health Information and Education Center; the state's referral and resource network for CSHCN; a respite care facility; and, a program that provides integrated community-based services for CSHCN. CSHCN meets with these contractors quarterly to ensure goals are being met. Each contract includes one or more parents of a child with special needs who is a paid employee. CSHCN also has a representative on numerous parent advocate groups for CSHCN throughout the state and attends their meetings at least every other month. At this time there are no expected changes to the total number of FTEs or contracts supported by Title V funds for CSHCN.

In addition, the Oklahoma Family Network (OFN), the state's Family-to-Family Health Information and Education Center, added several staff, including a health coordinator who has identified opportunities for enhanced family involvement with MCH and matched trained family leaders for those opportunities.

MCH Workforce throughout the State:

Shortages in the number of behavioral and mental health care providers are a MCH workforce concern, one repeatedly mentioned in the tribal listening sessions, written in comments on the online public input survey, described in focus groups conducted by OFN, and discussed during parent contact with DHS. Additionally, in rural areas, specialist shortages and the reduced capacity of rural hospitals impact available health care for women and children across the state. Please see Section II.B.2.b for more information on the MCH Workforce and Capacity issues affecting the health of all Oklahomans.

Training and Workforce Development:

All new MCH staff members are required to complete the MCH New Employee Orientation Checklist 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, the Oklahoma Health Improvement Plan review, including the Children's Health Plan, and a site visit to both the Oklahoma Family Network and a county health department.

MCH developed a Life Course Training which is available to groups, coalitions, staff, etc. upon request. Visiting students and interns, such as nursing students doing clinical rotations in MCH, are given the Life Course Training and new MCH staff members are invited to attend. The MCH Life Course Training was also conducted for the Teen Pregnancy Prevention Project facilitators this year. Social determinants of health and factors influencing health across the life course are addressed.

Annual trainings are provided by MCH to staff in county health departments, OSDH central office and contract staff.

These trainings include required trainings like child abuse identification and reporting and sexual coercion, including human trafficking. During State Fiscal Year (SFY) 2015 trainings on mental health and interpersonal violence; improving birth outcomes for mothers and infants; community outreach; quality improvement; Life Course Theory; infant mental health; Title X guidelines; preconception and interconception health care; adolescent health and teen pregnancy prevention; fatherhood and male involvement; and, family participation were also held. Approximately 2,000 participants attended trainings in SFY 2015 (through April 2015).

Upcoming trainings requested by staff for SFY 2016 include unintended pregnancy prevention activities; healthy relationships; immunizations; grandparents raising grandchildren; sexually transmitted infections (STIs); effects of STIs on pregnancy outcomes; breastfeeding; adolescent suicide; fatherhood and male involvement; and, contraceptives training.

Eligibility workers in county DHS offices attend New Worker Academy when hired or when reassigned to a new caseload that assists children receiving Supplemental Security Income (SSI). At the academy they receive training

on Title V regulations, how to complete a service plan, and how to request services that are funded through the Title V Block Grant. Additional training is available for staff through online tutorials developed by CSHCN staff.

CSHCN staff presents at the “On the Road” conferences, which are one-day events sponsored by Sooner SUCCESS (State Unified Comprehensive Exemplary Services for Special Needs). These conferences are held at different locations across the state. Representatives from a variety of agencies and local organizations that serve CSHCN provide information to parents and others in the community regarding available programs and services.

II.F.3. Family Consumer Partnership

In Oklahoma, the Oklahoma Family Network (OFN) assures family involvement in Title V work at the individual, community, and policy levels. The OFN utilizes a statewide network of families to engage families as partners. MCH has a multi-year agreement with the OFN to ensure family involvement at the state and local levels through family participation and engagement in Title V activities. Family members are hired as paid staff or consultants for CSHCN via contractors, including OFN. The Executive Director of OFN works 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 activities. Financial support (financial assistance, technical assistance, travel, and child care) is offered for parent activities, parent groups, and sibling support groups.

The involvement of family members in both the CSHCN and MCH elements of the MCH Title V Block Grant application process is essential. OFN participated in the planning, information gathering activities, and prioritization process for the 2016-2020 Title V Needs Assessment. The Executive Director of OFN also attends the annual review for the block grant, providing valuable insight into programmatic activities, family needs, challenges, and participation opportunities.

Family members participate on advisory committee or task forces state-wide and are offering training, mentoring, and reimbursement, when appropriate. Some of the committees and advisory councils include: hospitals serving children across the state; Oklahoma Department of Human Services (DHS) Developmental Disabilities Services; Oklahoma Commission for Children and Youth; Interagency Coordinating Council for SoonerStart; Oklahoma State Department of Health (OSDH) *Preparing for a Lifetime* Breastfeeding Work Group and Postpartum Depression Work Group; Screening and Special Services and Newborn Screening Advisory Groups; Children with Special Needs and Child Health Advisories; Perinatal Quality Improvement Collaborative; Oklahoma Health Improvement Plan; 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; ABCD 3 State Planning Advisory and three counties’ planning advisories; Oklahoma County Fetal and Infant Mortality Review Community Action Team; Oklahoma Health Care Authority Member Advisory Task Force; Medical Advisory Committee; Infant Mental Health; DHS Developmental Disabilities Services (DDS); the Governor’s task force regarding individuals on the waitlist for DDS services; Communities of Care Mental Health and Child Welfare activities to reduce the number of children in custody and number of blown foster care placements.

Service area training for CSHCN staff and providers is provided by family members. Trainings on Life Course Perspective, family-centered care, the importance of family/professional partnerships, and family involvement at every level of decision-making have been presented to state MCH 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 Governor’s Conference on Developmental Disabilities, The Oklahoma Transition Institute, Oklahoma Parents Center Annual Conference and regional institutes, Oklahoma Association of School Based Social Workers State Conference and regional workshop, Autism Symposiums, University of Central Oklahoma (UCO) School of

Nursing, UCO's Master's Program for Licensed Practical Counselors, education classes for students majoring in Special Education and Early Childhood Education, Special Education Bootcamps for teachers, Rose State Child Care Program class, and the Oklahoma Health Care Authority Strategic Planning Meetings.

Family members of diverse cultures are involved in all of the listed activities. OFN has hired and contracted with family leaders from multiple cultures. OFN trainings are available in Spanish, and 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 families with experiences such as single moms, military families, rural and urban families, disability-specific, etc.

II.F.4. Health Reform

Implementation of the Affordable Care Act (ACA) has provided extended insurance coverage to adult children through age 25, regardless of whether the adult child was enrolled in college. Pre-existing conditions clauses in insurance plans have been removed as well. Full implementation for the ACA is yet to be realized, as courts are still trying to determine the legalities of different aspects and interpretation of the law. Changes to the healthcare landscape in Oklahoma will be followed closely by the Oklahoma State Department of Health (OSDH). Staff is currently reviewing how to meet the needs of reproductive age males and females and ensure continued coverage for services based on the changes associated with implementation of the ACA and the changes in Medicaid eligibility from 185% to 133% of Federal Poverty Level.

A major aspect of the ACA is the Medicaid expansion and the creation of an insurance exchange. Oklahoma, under the direction of its Governor, rejected federal funds for the Medicaid expansion. However, in relation to Medicaid and the Federally-Facilitated Marketplace (FFM), the OSDH, CSHCN, and OFN have assisted clients who are eligible in enrolling in Medicaid, and directed others to the FFM, where applicable. Under the FFM, it is projected the number of uninsured residents in Oklahoma will be reduced from 645,000 in 2012 to 573,000 in 2017.

OSDH is currently working on an Insure Oklahoma (Section 1115 waiver) amendment with the federal Health and Human Services and the Oklahoma Health Care Authority in an effort to expand private insurance coverage to uninsured American Indians who seek care at tribal facilities in the state and who do not seek coverage on the FFM. American Indians represented approximately 27% of the uninsured population in Oklahoma and were the only ethnicity in Oklahoma to see an increase in preventable hospitalizations in the last year for which data was available. Built into this amendment are measurable health outcome reporting requirements (National Quality Forum (NQF) measures), which are expected to help control certain chronic health problems prevalent among American Indians, thereby reducing preventable hospitalizations and emergency room utilization in the state.

The State Innovation Model Grant, which officially began on February 1st, now has all contracts in place and planning is well underway. Contractors are gathering input from community partners to identify needs in their communities regarding value-based provision of health care. The stakeholder engagement sessions will be held on multiple occasions in the four quadrants of the state and in Oklahoma City and Tulsa. A slightly modified combination of the Oklahoma Health Improvement Plan: Healthy Oklahoma 2020 and the State of the State's Health Report will serve as the basis for the population health needs assessment. An environmental scan of the state's electronic health records and health information exchange capabilities has begun and will provide information about Oklahoma's health system's ability to electronically process and deliver health information to patients, providers, and state agencies. It is expected that this scan will reveal areas of need in regard to electronic health record (EHR) capability, thereby allowing us to focus strategies on EHR adoption, a key component in the creation of evidence and value-based payment models.

Community Needs Assessments

Through Turning Point community coalition partners and consultants, services are being provided to various communities throughout the state to collaborate with health departments, hospitals and other organizations to complete community health assessments that address accreditation and regulation requirements for the communities. Many of the county health departments, hospitals, and partnering organizations have discovered that while it may be more challenging in the beginning, it works better for both the organizations and clients involved, if assets and resources are shared to create only one assessment exploring the health needs for the community.

Cultural and Linguistic Competence and Health Equity

Serious efforts have been made to assure cultural and linguistic competence and to promote health equity. State MCH staff has undergone specific Tribal and African American cultural competency training. Additionally, general trainings in cultural consciousness and MCH population stress factors and the public health response were undertaken in the last year to assure development of staff competencies and sensitivities in these areas.

Health disparities in both infant and maternal mortality continued to be addressed to reduce disparities and assure fair and equal treatment for the MCH population. Inroads were made. In particular, the hospitals with the highest birth rates for African American and American Indian populations were prioritized for intervention. Birthing hospitals initiated and implemented safe sleep policies according to the American Academy of Pediatrics (AAP) guidelines and entered into an agreement with OSDH to follow the policy and provide safe sleep education upon discharge to the new mother. In exchange, a sleep sack was provided to the hospital for the mother upon successful completion of education at discharge, along with dissemination of safe sleep practice materials. For the period 2013-2014, in Oklahoma, there were 22,925 African American and American Indian births; 12,063 (52.6%) of them were delivered at hospitals participating in the sleep sack project. Hospitals are actively being recruited to participate in the on-going project to further increase these numbers.

Community baby showers, conceptualized by a committee of minority health professionals as a means of providing health information in a non-intrusive way, have been provided statewide to minority women who wanted to become pregnant, were pregnant, or were direct primary caretakers of young children under two years of age. Local medical providers, as well as health information mavens, presented and distributed relevant information at the showers to increase awareness of infant mortality; increase knowledge of prenatal and infant health, development, and safety; and, to challenge popular myths about pregnancy and raising children to reduce infant mortality. Pre- and post-survey evaluation found there was a statistically significant increase of infant mortality and well-baby knowledge among all of the participants. The program is being further developed to assure that current successes are built upon. All participants, irrespective of race or ethnicity, should have a statistically significant increase in knowledge, which will hopefully lead to improved health behaviors.

Finally, sessions were held jointly with the Office of Tribal Liaison and tribal provider representatives of the state's largest seven tribal nations to gather maternal, infant, and child health successes, challenges, and needs from the tribal perspective. This information was used in determining the needs and priorities of the Oklahoma MCH population for the next five years. MCH will continue these efforts, along with related efforts, to reduce health disparities to assure all Oklahoma mothers, infants, and children have the opportunity to enjoy healthy lives.

II.F.5. Emerging Issues

Social Determinants of Health

According to the Centers for Disease Control and Prevention (CDC), social determinants of health (SDH) are conditions in the environment in which people are born, live, learn, work, play, worship, and age. SDH have been shown to affect a wide range of health and quality of life outcomes. Social determinants include socioeconomic status, living conditions, neighborhood safety, transportation, access to care, insurance status, citizenship status,

availability of nutrition, employment, income, and reliance on government programs. Examples of available resources that can mitigate certain SDH and improve health and well-being include: safe and affordable housing, access to quality education, public safety, the availability of healthy foods, local emergency and health services, and environments free of life-threatening toxins.

Oklahoma ranks among the poorest in the nation for tobacco use, infant mortality, and maternal mortality. The state is largely rural, therefore, access to healthcare and transportation create challenges for the state. The quality of healthcare provided statewide is difficult to measure and is not consistent. Additionally, Oklahoma experiences persistent racial disparities in morbidity and mortality rates among the state's American Indian and African American MCH populations. Work has begun to examine the role of SDH, but more is needed to understand both the scope of the impact and the actions needed to address SDH.

The 2020 Oklahoma Health Improvement Plan (OHIP) identifies poor SDH as barriers in improving the health outcomes of Oklahomans, particularly as they relate to obesity reduction and health education of the population. Strategies in the OHIP 2020 plan target contributing SDH to address obesity through a partnership-framework based on the Health in All Policies model from the Public Health Institute.

Oklahoma also has a CoIIN (Collaborative Outreach Initiative and Innovation Network) Work Group with goals and objectives to address SDH. One of the first pilot projects addressing SDH is distributing portable cribs (or pack-n-plays), sleep sacks, and safe sleep educational materials to three groups: families of infants in neonatal intensive care unit (NICU, who are at an increased risk for infant mortality), families participating in home visitation programs, and families participating in community baby showers. The community baby showers, sponsored by the Oklahoma State Department of Health's Office of Minority Health, are typically held in communities with pregnancy and infant health disparities and/or access to care issues.

E-cigarettes

Approximately 30% of Oklahomans currently use traditional tobacco products (including adults, high school and middle school students). However, e-cigarette use is climbing in the state, due to the lack of public awareness of the potential dangers of e-cigarette use and marketing for tobacco cessation. Many Oklahomans report using e-cigarettes or "vaping" products as a replacement for combustible tobacco. Approximately 32% of adults and 10.5% of high school and middle school students report using e-cigarette or vapor products. At this time, there is no regulatory body to inspect or certify "vaping" supplies or shops. The health impact of e-cigarette or vaping products is currently undetermined, as consumers can purchase a product with or without nicotine.

Ideally, Oklahomans who are pregnant or of child-bearing age should stop all inhalant use including e-cigarettes and vaping products. As the health effects are largely unknown at this time, messaging for non-use and for reduction in use is difficult. Survey questions were added to the 2015 Pregnancy Risk Assessment Monitoring System (PRAMS) to assess the uptake of e-cigarette use in the state among pregnant and postpartum women. Data will be made available to assist in the understanding of this issue and its impact on the health of mothers and infants in the state.

Mental and Behavioral Health

Underdiagnoses of mental and behavioral health issues for children, and the lack of resources to address those issues are of primary concern in Oklahoma. With the increase in numbers of children diagnosed with Autism Spectrum Disorder and Attention Deficit Disorder, more children experience difficulties in school, home life and in the community, thus having a need for specialized services. Conduct disorder and oppositional defiance disorder, in conjunction with other behavioral health diagnoses, require more specialized treatment which is not often available in rural communities and scarce in metropolitan areas. These issues can be difficult to address in family therapy, as it is unknown if these disorders are organic (naturally occurring) or non-organic (a result of the environment).

Since the introduction (and subsequent changes) to the DSM-5 (Diagnostic and Statistical Manual of Psychiatric

Disorders, Fifth Edition), it has been difficult to reach a consensus on these disorders, and whether they fall into the category of mental or behavioral health. Various practitioners look at the problem differently, especially now that the DSM-5 has identified Autism as a “spectrum disorder.” Methods of intervention have changed, as well as billing and identification codes. All these changes have created confusion for some practitioners and training has been limited.

In 2014, MCH participated in tribal listening sessions, where clinicians and staff at tribal health facilities were asked about their perception of MCH health among the patients and tribes they serve. Questions centered on the difficulty in access to care, and the types of care needed for MCH populations. One of the major areas identified during these listening sessions was the overall lack of resources for adolescents in need of mental health treatment. Oklahoma has too few resources for inpatient mental health treatment, but this is especially true for children and young adults. Many inpatient treatment programs that do take children can only accommodate a small number (approximately 5-8 beds per unit). This could be due to funding, or lack of knowledge of mental health professionals on how to work with children and families. The state has an urgent need to address the issues of resources for behavioral and mental health in the coming years.

Infants Exposed to Harmful Substances

Drug or alcohol use in pregnancy is an alarming issue, as it directly impacts the health of the developing fetus as well as the pregnant woman, and can have life-long effects seen far beyond the perinatal and post-natal phase. Infants born drug-exposed have typically been addressed by other entities such as the Department of Human Services, but due to the increased risks for preterm birth and birth defects among the population it is a growing public health concern.

Based on listening session and the public input survey information, the use of opioids has increased in prevalence among the state’s pregnant population. A question has been added to the 2016 PRAMS to measure the use of opioids during pregnancy. According to reports from DHS (Department of Human Services) and DMHSAS (Department of Mental Health and Substance Abuse Services) the numbers of women giving birth at state hospitals testing positive for substance use has increased in the state. OPQIC will look into neonatal abstinence syndrome as a topic of interest for the upcoming OPQIC Summit. MCH will work to monitor prevalence and determine programmatic activities based on need.

For all of these emerging issues, MCH will continue to monitor prevalence and available resources. MCH will also continue to collaborate with other community and government agencies to work on projects to address these needs.

II.F.6. Public Input

Input into the Maternal and Child Health Services (MCH) Title V Block Grant (needs assessment, priorities, programs, and activities) is 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, *Public Input Sought For Maternal and Child Health Services Title V Block Grant*, is found at the bottom of the MCH web page, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/, 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 directly 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 in English and Spanish on the MCH webpage. The CSHCN, Oklahoma Department of Human Services (OKDHS), has a link to the OSDH MCH web page on the CSHCN web page, <http://www.okdhs.org/programsandservices/health/cshcn/> on the OKDHS website. Hard copies and pdfs of the MCH Title V Block Grant are also provided on request to MCH at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov.

Public input via e-mail and telephone calls is received intermittently throughout the year. To date, calls have been received requesting more program information about MCH projects in general and seeking details on CSHCN Title V funded activities. Questions were answered and contact information was given for follow-up. MCH and CSHCN use these calls and emails to determine better ways to seek feedback from the public, and for the evaluation, planning, and development of policies, procedures, and services that are reported and described in the MCH Title V Block Grant annual report and application.

Another avenue for public input is the MCH Facebook page. The call for public input on the Title V block grant and needs assessment survey was posted approximately 10 times on the MCH Facebook page throughout the Needs Assessment process, as well as posted on the Oklahoma Family Network (OFN) website and Facebook page. Links to the block grant and requests for public comments are now distributed at least annually via social media, including the OSDH Facebook page and Twitter account. Comments, if received, are given to the appropriate program area for response.

A SurveyMonkey survey opens whenever someone visits the Title V Needs Assessment webpage for MCH. The survey requests feedback to improve the 2010-2015 Needs Assessment document and process, asks for areas not covered by the assessment, and how the document will be used by the reader. Comments have been used to improve the readability of the online document (easier access to survey link) and to improve the 2016-2020 document (bulleted lists, shorter paragraphs, easier to read).

Customer satisfaction surveys are conducted by county health departments and contractors to explore ways to better serve clients. These surveys are also posted on the MCH web page for direct submission to MCH.

The CSHCN program receives input at monthly meetings with the Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs) State Interagency Coordinating Council which consists of professionals and family members from numerous agencies that provide services to children with special needs. Additionally, CSHCN receives input from parents at meetings, face-to-face interactions, and conferences held throughout the state each year, and from DHS eligibility staff who visit with parents in their homes or at the local DHS offices.

OFN receives input at each of the Regional Institutes across the state. An open session is held at the end of each meeting where participants talk about challenges and needs in the surrounding community. Five-to-seven counties are typically represented at each Institute. The needs expressed by parents and providers at the meetings over the past year reflected many of the priority needs outlined in 2016-2020 Needs Assessment. Identified needs were shared with OFN funding agencies, the OFN Advisory Committee, and with attendees for distribution to their local community coalitions.

Public input was sought in a variety of ways for the Title V 2016-2020 Needs Assessment. In September 2013, a press release announced the State's intent to open up an anonymous, online survey about the health needs for the maternal and child health (MCH) population in Oklahoma. The press release, published in several newspapers and newsletters, explained Title V, its funding source, and mission. It directed the potential respondents where and how to access the survey. Approximately 1,450 individuals representing stakeholders from various professions, agencies, programs, and consumers participated in the survey. OFN shared the survey via email lists and their newsletter. The survey was shared via social media outlets, like Facebook, and partners distributed hard copies to families and health department clients to facilitate participation among the population as a whole, and not just the MCH workforce.

A series of seven tribal listening sessions were organized to obtain input on MCH priorities and health needs among tribal communities across the state. The listening sessions were planned with the assistance of the Office of Tribal Liaison at OSDH and tribal partners, such as the Oklahoma City Area Inter-Tribal Health Board. The listening sessions were held from May-October 2014.

Public input from both the online survey and the listening sessions was utilized and referenced often during the selection process for Title V priorities. For more details highlighting the public input process for the MCH Title V

Needs Assessment, please refer to Section II.B 1.

II.F.7. Technical Assistance

At this time, no technical assistance is being requested by Oklahoma.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$ 7,290,174	\$ 7,102,438	\$ 7,190,901	\$ 6,692,198
Unobligated Balance	\$ 0	\$ 0	\$ 0	\$ 0
State Funds	\$ 5,524,073	\$ 7,085,011	\$ 5,453,690	\$ 6,940,843
Local Funds	\$ 0	\$ 1,028,044	\$ 0	\$ 741,557
Other Funds	\$ 0	\$ 0	\$ 0	\$ 0
Program Funds	\$ 110,098	\$ 74,916	\$ 119,252	\$ 92,625
SubTotal	\$ 12,924,345	\$ 15,290,409	\$ 12,763,843	\$ 14,467,223
Other Federal Funds	\$ 5,276,389	\$ 4,995,181	\$ 5,121,950	\$ 4,801,808
Total	\$ 18,200,734	\$ 20,285,590	\$ 17,885,793	\$ 19,269,031

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$ 6,747,316	\$ 6,903,092	\$ 6,903,092	\$
Unobligated Balance	\$ 0	\$ 0	\$ 0	\$
State Funds	\$ 5,060,487	\$ 5,252,960	\$ 5,184,379	\$
Local Funds	\$ 0	\$ 641,942	\$ 0	\$
Other Funds	\$ 0	\$ 0	\$ 0	\$
Program Funds	\$ 52,016	\$ 75,564	\$ 64,006	\$
SubTotal	\$ 11,859,819	\$ 12,873,558	\$ 12,151,477	\$
Other Federal Funds	\$ 4,980,591		\$ 4,801,808	\$
Total	\$ 16,840,410	\$ 12,873,558	\$ 16,953,285	\$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	\$ 6,903,092	\$
Unobligated Balance	\$ 0	\$
State Funds	\$ 5,252,960	\$
Local Funds	\$ 641,942	\$
Other Funds	\$ 0	\$
Program Funds	\$ 52,724	\$
SubTotal	\$ 12,850,718	\$
Other Federal Funds	\$ 4,917,594	\$
Total	\$ 17,768,312	\$

III.A. Expenditures

See Forms 2, 3a, and 3b.

The Oklahoma State Department of Health (OSDH) MCH value for parts A, B, and C is determined through the OSDH time and effort reporting system in which all state and local staff code their daily time to program activities. Non-personnel expenses are made as direct charges to the appropriate program budgets. State funds include state and county appropriations for local health departments. Other contributions include in-kind monies. Program income includes fee revenues from Medicaid. The OSDH is audited each year by the state auditor's office following the federal guidelines applicable to the MCH Title V Block Grant. All appropriate fiscal records are maintained to insure audit compliance.

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 coverage of direct health care services through Medicaid for MCH populations over recent years has assisted the Title V Program to accomplish critical realignments to benefit Oklahoma in having needed data and evaluation available for policy and services decisions, quality improvement activities, training for health care providers, public education, and improved coordination among health and human services agencies.

Form 2 denotes a decrease of approximately 1.8 million dollars expended in state match dollars when comparing 2013 to 2014 numbers. The decline in the state's economy has affected state and local expenditures with no increases in funding received; even for cost of living or maintenance of effort. Additionally, program income has continued to decline with children covered by Medicaid and Federally-Facilitated Marketplace (FFM) being linked with medical homes and pregnant women being linked with providers accepting Medicaid and/or FFM coverage. Many state funded positions in county health departments were not refilled and contracts have been decreased. MCH contract providers also experienced difficulty in maintaining state and local funds that they have previously shown on budgets as expenditures for MCH services. Nevertheless, it should be noted that the three to four dollars match was still met and exceeded even in light of this decline.

Form 3a documents expenditures by the MCH types of individuals served. There was a shift in dollars for types of individuals served from children 1-22 years to infants based upon a focused infant mortality reduction campaign. Pregnant women and CSHCN expenditure levels remained close to previous year levels.

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 services decreased by \$395,477 and public health systems and services (including population-based and infrastructure services) decreased by \$2,499,099. Reasons underpinning these shifts were multi-factorial: inability to refill county health department positions providing direct health care and public health services; changes in MCH contract provider services; and an increased focus on enabling services such as outreach to disparate minority populations.

With all this change, it needs to be noted that the Oklahoma Title V Program is very thoughtful in its process of looking at the priority needs of the MCH population and realigning funds and resources to meet those needs. As opportunities present with changes in Medicaid policy, state policy, 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 for mothers, infants, children, and their families.

III.B. Budget

Maintenance of effort from 1989:

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

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

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

	State Health Department	Department of Human Services	Total
Title V	\$4,634,578	\$1,345,522	\$5,980,100
Match	\$3,475,932	\$1,061,546	\$4,537,478
Overmatch	\$146,839	0	\$146,839
Income	\$250,000	0	\$250,000

Local/Other	<u>\$236,644</u>	<u>0</u>	<u>\$236,644</u>
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/resource provision 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 diapers, 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 2016, 46% of the federal Title V Block Grant funds are designated for programs for preventative and primary care services for children and 30% for services for children with special health care needs.

State provides a reasonable portion of funds to deliver services:

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

The OKDHS administers the CSHCN Program through Adult and Family Services (AFS). AFS also administers the SSI-DCP for SSI recipients to age 18. Other components of the CSHCN Program include a project that supports neonates and their families; support of the Sooner SUCCESS toll-free information and referral system for CYSHCN; a project that provides sickle cell services; respite care services for medically fragile children; medical, psychological and psychiatric services to the CSHCN population in the custody of the OKDHS; a project that is establishing an integrated community-based system of services for children with special health care needs in several communities in the state; funding for a statewide mentorship program for families of children with special needs; and, funding of two parent advocates 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 Women, Infants, and Children Supplemental Nutrition Program (WIC) data with birth certificates and 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 Early Childhood Comprehensive Systems Initiative (ECCS), a grant funded by the MCHB, provides funds to assist Oklahoma in efforts to build and integrate early childhood services systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education; and family support. Implementation is being accomplished as a collaborative effort of state and community-based public and private partners.

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 Oklahoma State Department of Education (OSDE) provides federal funds received from the CDC to the OSDH through a contractual agreement. MCH uses these funds 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.

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 such as preconception and interconception care and education, support of mothers and health care providers with breastfeeding information, education, and a statewide 24 hour 7 day a week breastfeeding hotline, Fetal and Infant Mortality Review (FIMR) projects, and Maternal Mortality Review (MMR); adolescent pregnancy prevention efforts; childhood injury prevention; school health to include funding of school nurses in priority areas of the state; Oklahoma's Poison Control Center; public education; and data matching and analysis. Medicaid administrative match funds are received to support FIMR, and data matching and analysis. The OSDH/MCH received another \$1.7 million dollars 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; prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS); and increasing knowledge of human sexuality. The Oklahoma State Department of Health was designated as the state agency to apply for and receive funding from the Administration on Children, Youth, and Families (ACYF), Family and Youth Services Bureau (FYSB) to implement a Personal Responsibility Education Program (PREP). Grant approval has been received and funds are being used to implement projects in the two large metropolitan areas of Oklahoma City and Tulsa through contractual agreements with the two city-county health departments. These projects will focus on educating adolescents on both abstinence and contraception to prevent pregnancy and STDs, including HIV/AIDS, and adulthood preparation (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, healthy life skills).

Budget Documentation:

Overall budget preparation and monitoring are provided through administrative support within the OSDH Administrative Services. Agency budgeting, grants, and contract acquisition staff meet routinely with program areas. The MCH Director is responsible for budget oversight and, along with each individual 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. This staff reports directly to the Board of Health. Additionally, MCH performs onsite program reviews with county health departments and contractors to assure programmatic compliance for both Title V and Title X.

The comptroller for the Adult and Family Services prepares and oversees the budget for the CSHCN Program. The CSHCN Director is responsible for compliance with federal and state requirements. CSHCN program staff monitor 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, 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 makes available more state and local funded resources (e.g., staff, supplies, travel) as available for provision of MCH services as an agency priority. This results in increased funding reported as expended on Forms 2, 3a, and 3b. It is understood each year that these additional state and local funded resources are fluid and may be redirected at anytime by the Commissioner of Health based on state and/or agency priorities, or in the event of a state health event or emergency/disaster needing to be addressed.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [OHCA Interagency Agreement_DHS and OSDH.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Block Grant Bios_OK.pdf](#)

Supporting Document #02 - [MCH Block Grant MOA 2015.pdf](#)

Supporting Document #03 - [Org Charts_OK_2015.pdf](#)

Supporting Document #04 - [OK Acronyms 2015.pdf](#)

Supporting Document #05 - [authorityletter_OK.pdf](#)

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oklahoma

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	\$ 6,903,092	\$ 6,903,092
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	\$ 3,177,985 (46%)	\$ 3,177,985 (46%)
B. Children with Special Health Care Needs	\$ 2,070,928 (30%)	\$ 2,070,928 (30%)
C. Title V Administrative Costs	\$ 690,309 (10%)	\$ 690,309 (10%)
2. UNOBLIGATED BALANCE	\$ 0	\$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	\$ 5,252,960	\$ 5,252,960
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	\$ 641,942	\$ 641,942
(Item 18d of SF-424)		
5. OTHER FUNDS	\$ 0	\$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	\$ 52,724	\$ 75,564
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	\$ 5,947,626	\$ 5,970,466
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	\$ 4,684,317	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	\$ 12,850,718	\$ 12,873,558
(Same as item 18g of SF-424)		
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	\$ 4,917,594	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	\$ 17,768,312	\$ 12,873,558
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

FY14 Annual Report Budgeted

1. FEDERAL ALLOCATION	\$ 6,747,316
A. Preventive and Primary Care for Children	\$ 3,263,496
B. Children with Special Health Care Needs	\$ 2,024,195
C. Title V Administrative Costs	\$ 674,731
2. UNOBLIGATED BALANCE	\$ 0
3. STATE MCH FUNDS	\$ 5,060,487
4. LOCAL MCH FUNDS	\$ 0
5. OTHER FUNDS	\$ 0
6. PROGRAM INCOME	\$ 52,016
7. TOTAL STATE MATCH	\$ 5,112,503

**FY16 Application
Budgeted**

9. OTHER FEDERAL FUNDS

Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	\$ 636,606
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS);	\$ 145,093
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	\$ 140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	\$ 97,495
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	\$ 3,838,400
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior;	\$ 60,000

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	4. LOCAL MCH FUNDS
	Fiscal Year:	2014
	Column Name:	Annual Report Expended
	Field Note:	The decline in the state's economy has affected state and local expenditures with no increases in funding received; even for cost of living or maintenance of effort. Many state funded positions in county health departments were not refilled and contracts have been decreased. MCH contract providers also experienced difficulty in maintaining state and local funds that they have previously shown on budgets as expenditures for MCH services.
2.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2014
	Column Name:	Annual Report Expended
	Field Note:	Program income has continued to decline with more children and pregnant women being covered by Medicaid and the Federally-Facilitated Marketplace (FFM) linking clients with Medicaid medical homes and Medicaid and FFM providers.
3.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	PREP funds expended: \$636,606
4.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	PRAMS funds expended: \$145,093

5.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	ECCS funds expended: \$127,845
6.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	SSDI funds expended: \$97,495
7.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	Title X funds expended: \$3,838,400
8.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	Youth Risk Behavior Survey (YRBS) funds expended: \$60,000

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Oklahoma

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	\$ 249,185	\$ 249,185
2. Infants < 1 year	\$ 714,685	\$ 714,685
3. Children 1-22 years	\$ 3,177,985	\$ 3,177,985
4. CSHCN	\$ 2,070,928	\$ 2,070,928
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 6,212,783	\$ 6,212,783
IB. Non Federal MCH Block Grant		
1. Pregnant Women	\$ 171,738	\$ 251,884
2. Infants < 1 year	\$ 2,015,718	\$ 1,978,957
3. Children 1-22 years	\$ 2,266,636	\$ 2,246,091
4. CSHCN	\$ 1,493,534	\$ 1,493,534
5. All Others	\$ 0	\$ 0
Non Federal Total of Individuals Served	\$ 5,947,626	\$ 5,970,466
Federal State MCH Block Grant Partnership Total	\$ 12,160,409	\$ 12,183,249

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

1.	Field Name:	IA. Federal MCH Block Grant, 1. Pregnant Women
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	Since lines 3 & 4 are auto filled, line one is a pro-rated figure. MRD
2.	Field Name:	IA. Federal MCH Block Grant, 2. Infant < 1 Year
	Fiscal Year:	2016
	Column Name:	Application Budgeted
	Field Note:	Since lines 3 & 4 are auto filled, line two is a pro-rated figure. MRD
3.	Field Name:	IA. Federal MCH Block Grant, 1. Pregnant Women
	Fiscal Year:	2014
	Column Name:	Annual Report Expended
	Field Note:	Since lines 3 & 4 are auto filled, line one is a pro-rated figure. MRD
4.	Field Name:	IA. Federal MCH Block Grant, 2. Infant < 1 Year
	Fiscal Year:	2014
	Column Name:	Annual Report Expended
	Field Note:	Since lines 3 & 4 are auto filled, line two is a pro-rated figure. MRD

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Oklahoma

	FY16 Application Budgeted	FY14 Annual Report Expended
II. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	\$ 2,442,537	\$ 933,236
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 446,495	\$ 291,156
B. Preventive and Primary Care Services for Children	\$ 313,828	\$ 152,407
C. Services for CSHCN	\$ 1,682,214	\$ 489,673
2. Enabling Services	\$ 691,328	\$ 1,759,230
3. Public Health Services and Systems	\$ 3,769,227	\$ 4,210,626
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		
Physician/Office Services		\$ 120,661
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		\$ 812,575
Laboratory Services		
Direct Services Total		\$ 933,236
Federal Total	\$ 6,903,092	\$ 6,903,092

IIB. Non-Federal MCH Block Grant

1. Direct Services	\$ 1,413,026	\$ 704,020
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 236,236	\$ 201,330
B. Preventive and Primary Care Services for Children	\$ 185,021	\$ 112,096
C. Services for CSHCN	\$ 991,769	\$ 390,594
2. Enabling Services	\$ 1,049,522	\$ 1,189,421
3. Public Health Services and Systems	\$ 3,485,078	\$ 4,077,025
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		
Physician/Office Services		\$ 91,025
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		\$ 612,995
Laboratory Services		
Direct Services Total		\$ 704,020
Non-Federal Total	\$ 5,947,626	\$ 5,970,466

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

53,351

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Classic phenylketonuria	53,351 (100.0%)	5	1	1 (100.0%)
Primary congenital hypothyroidism	53,351 (100.0%)	57	39	39 (100.0%)
Cystic fibrosis	53,351 (100.0%)	14	14	14 (100.0%)
S,S disease (Sickle cell anemia)	53,351 (100.0%)	15	15	14 (93.3%)
Congenital adrenal hyperplasia	53,351 (100.0%)	25	3	3 (100.0%)
Classic galactosemia	53,351 (100.0%)	15	1	1 (100.0%)
Biotinidase deficiency	53,351 (100.0%)	10	8	8 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	53,351 (100.0%)	10	3	2 (66.7%)
Medium-chain acyl-CoA dehydrogenase deficiency	53,351 (100.0%)	4	4	4 (100.0%)
Citrullinemia, type I	53,351 (100.0%)	8	2	2 (100.0%)
Tyrosinemia, type I	53,351 (100.0%)	3	0	0 (0%)
Propionic acidemia	53,351 (100.0%)	4	0	0 (0%)
Glutaric acidemia type I	53,351 (100.0%)	5	1	1 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
3-Methylcrotonyl-CoA carboxylase deficiency	53,351 (100.0%)	8	1	1 (100.0%)
Homocystinuria	53,351 (100.0%)	2	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	53,351 (100.0%)	6	0	0 (0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Carnitine palmitoyltransferase type II deficiency	53,351 (100.0%)	6	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	53,351 (100.0%)	4	2	2 (100.0%)

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	51,613 (96.7%)	2,884	70	70 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Oklahoma Newborn Screening (NBS) Program provides contracted services for long-term follow-up for infants identified with a metabolic, endocrine, dietary management and transition for hemoglobinopathies. The NBS Program 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 includes 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:

None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Oklahoma

Reporting Year 2014

		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	80,178	63.1	0.0	36.9	0.0	0.0
2. Infants < 1 Year of Age	58,330	60.2	0.0	19.3	8.8	11.7
3. Children 1 to 22 Years of Age	566,232	55.8	0.0	26.3	16.9	1.0
4. Children with Special Health Care Needs	27,621	65.1	17.1	14.2	3.6	0.0
5. Others	532,384	25.3	0.0	42.7	26.1	5.9
Total	1,264,745					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2014
	Field Note:	The number of pregnant women served by Title V in 2013 is estimated by counting the number of unduplicated live singleton births (n=51,728) multiplied by the factor 1.55 to estimate the number of miscarriages and abortions (51,728 x 1.55 = 80,178). The inflation factor for miscarriages and abortions is based on the 2004 pregnancy estimates from the National Survey of Family Growth (NSFG) administered by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2014
	Field Note:	Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2014.
3.	Field Name:	Children 1 to 22 Years of Age
	Fiscal Year:	2014
	Field Note:	Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2014.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2014
	Field Note:	Source: CSHCN Program, Oklahoma Department of Human Services.
5.	Field Name:	Others
	Fiscal Year:	2014
	Field Note:	Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2014.

Form 5b
Total Recipient Count of Individuals Served by Title V
State: Oklahoma
Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	80,178
2. Infants < 1 Year of Age	58,330
3. Children 1 to 22 Years of Age	566,232
4. Children with Special Health Care Needs	27,621
5. Others	612,562
Total	1,344,923

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oklahoma

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	53,351	36,624	4,303	5,152	1,257	180	3,321	2,514
Title V Served	53,351	36,624	4,303	5,152	1,257	180	3,321	2,514
Eligible for Title XIX	32,841	22,544	2,649	3,171	774	111	2,044	1,548
2. Total Infants in State	106,091	72,762	8,705	10,421	2,507	359	6,370	4,967
Title V Served	71,925	49,329	5,902	7,065	1,700	243	4,319	3,367
Eligible for Title XIX	55,149	37,824	4,525	5,417	1,303	187	3,311	2,582

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	45,223	8,128	0	53,351
Title V Served	45,223	8,128	0	53,351
Eligible for Title XIX	27,838	5,003	0	32,841
2. Total Infants in State	90,164	15,927	0	106,091
Title V Served	61,127	10,798	0	71,925
Eligible for Title XIX	46,870	8,279	0	55,149

Form Notes For Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oklahoma

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 362-1606	(877) 362-1606
2. State MCH Toll-Free "Hotline" Name	OKC Heartline 2-1-1	OKC Heartline 2-1-1
3. Name of Contact Person for State MCH "Hotline"	Karen Poteet	Karen Poteet
4. Contact Person's Telephone Number	(405) 521-6206	(405) 521-6206
5. Number of Calls Received on the State MCH "Hotline"		124,387
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	Tulsa 2-1-1 Helpline	Tulsa 2-1-1 Helpline
2. Number of Calls on Other Toll-Free "Hotlines"		138,657
3. State Title V Program Website Address	http://www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/	http://www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/
4. Number of Hits to the State Title V Program Website		5,681
5. State Title V Social Media Websites	https://www.facebook.com/pages/Oklahoma-Maternal-and-Child-Health/451472241604992?fref=ts	https://www.facebook.com/pages/Oklahoma-Maternal-and-Child-Health/451472241604992?fref=ts
6. Number of Hits to the State Title V Program Social Media Websites		116

Form Notes For Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Oklahoma

Application Year 2016

**1. Title V Maternal and Child Health (MCH)
Director**

Name	Joyce Marshall
Title	Director, Maternal and Child Health Service
Address 1	1000 NE Tenth St
Address 2	
City / State / Zip Code	Oklahoma City / OK / 73117
Telephone	(405) 271-4480 x56839
Email	joycem@health.ok.gov

**2. Title V Children with Special Health Care
Needs (CSHCN) Director**

Name	Karen Hylton
Title	Director, CSHCN Program
Address 1	P.O. Box 25352
Address 2	
City / State / Zip Code	Oklahoma City / OK / 73125
Telephone	(405) 521-3602
Email	karen.hylton@okdhs.org

3. State Family or Youth Leader (Optional)

Name	Joni Bruce
Title	Executive Director, Oklahoma Family Network
Address 1	P.O. Box 21072
Address 2	
City / State / Zip Code	Oklahoma City / OK / 73156
Telephone	(405) 271-5072
Email	jonib@ofn.mobi

Form Notes For Form 8:

None

**Form 9
List of MCH Priority Needs**

State: Oklahoma

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Reduce infant mortality	Continued	
2.	Reduce the incidence of preterm and low birth weight births	New	
3.	Reduce the incidence of unintentional injury among children	New	
4.	Reduce the incidence of suicide among adolescents	New	
5.	Reduce health disparities	New	
6.	Improve the transition to adult health care for children and youth with special health care needs	New	
7.	Reduce teen pregnancy	New	
8.	Reduce unplanned pregnancy	Continued	
9.	Improve the mental and behavioral health of the MCH population	New	
10.	Reduce the prevalence of chronic health conditions among childbearing age women	New	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

**Form 10a
National Outcome Measures (NOMs)**

State: Oklahoma

Form Notes for Form 10a NPMs and NOMs:

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
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%, 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: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	180.2	6.1 %	862	47,841
2011	227.8	6.9 %	1,084	47,578
2010	186.2	6.2 %	900	48,324
2009	178.4	6.0 %	889	49,826
2008	129.5	5.1 %	642	49,560

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
2009_2013	32.3	3.5 %	86	266,183
2008_2012	29.5	3.3 %	79	267,595
2007_2011	30.4	3.4 %	82	269,909
2006_2010	28.0	3.2 %	76	271,653
2005_2009	28.9	3.3 %	78	270,216

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-4.1 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
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%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts: None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4 %	0.1 %	732	53,341
2012	1.4 %	0.1 %	756	52,697
2011	1.4 %	0.1 %	750	52,242
2010	1.4 %	0.1 %	749	53,206
2009	1.5 %	0.1 %	799	54,453

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts: None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.7 %	0.1 %	3,565	53,341
2012	6.5 %	0.1 %	3,444	52,697
2011	7.1 %	0.1 %	3,681	52,242
2010	7.0 %	0.1 %	3,709	53,206
2009	6.9 %	0.1 %	3,759	54,453

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts: None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts: None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.9 %	0.1 %	1,544	53,284
2012	2.7 %	0.1 %	1,434	52,555
2011	2.9 %	0.1 %	1,522	52,121
2010	3.0 %	0.1 %	1,566	53,017
2009	2.9 %	0.1 %	1,562	54,294

Legends:
🚩 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts: None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.7 %	0.1 %	4,081	53,284
2012	8.1 %	0.1 %	4,276	52,555
2011	7.9 %	0.1 %	4,117	52,121
2010	8.2 %	0.1 %	4,353	53,017
2009	8.0 %	0.1 %	4,345	54,294

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 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
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%, 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
2013/Q2-2014/Q1	6.0 %			

Legends:
🚩 Indicator results were based on a shorter time period than required for reporting

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
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
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
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
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
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 Sleep-related 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
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 The percent of infants born with fetal alcohol exposure 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
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 a confidence interval width >20% and should be interpreted with caution

NOM-10 Notes:

None

Data Alerts: None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	6.3	0.4 %	302	47,842
2011	5.6	0.3 %	264	47,579
2010	4.7	0.3 %	228	48,324
2009	3.3	0.3 %	166	49,827
2008	2.4	0.2 %	118	49,561

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)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts: None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

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 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.5 %	1.4 %	169,970	871,038

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% 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
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
2013	44.1	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
2011_2013	20.3	1.6 %	157	772,259
2010_2012	22.3	19.0 %	174	780,352
2009_2011	24.3	20.8 %	192	790,954
2008_2010	28.6	24.9 %	228	796,647
2007_2009	30.0	26.2 %	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
2011_2013	14.0	11.4 %	108	772,259
2010_2012	12.8	10.3 %	100	780,352
2009_2011	10.8	8.6 %	85	790,954
2008_2010	10.4	8.3 %	83	796,647
2007_2009	9.9	7.9 %	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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	24.5 %	1.4 %	228,303	932,265
2007	23.2 %	1.3 %	209,572	903,460
2003	20.6 %	1.1 %	180,536	874,700

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	16.6 %	1.6 %	24,595	148,583

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts: None

NOM-17.3 Percent of children 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
2011_2012	2.0 %	0.5 %	15,345	773,184
2007	1.2 %	0.3 %	9,228	750,197

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts: None

NOM-17.4 Percent of children 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
2011_2012	9.2 %	1.1 %	71,534	773,989
2007	7.8 %	1.0 %	58,532	748,656

Legends:
🚫 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts: None

NOM-18 Percent of children 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
2011_2012	62.7 % ⚡	5.2 % ⚡	54,278 ⚡	86,551 ⚡
2007	53.8 % ⚡	5.9 % ⚡	42,149 ⚡	78,283 ⚡
2003	50.0 % ⚡	5.5 % ⚡	28,115 ⚡	56,225 ⚡

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts: None

NOM-19 Percent of children 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
2011_2012	84.4 %	1.2 %	786,661	932,265
2007	85.8 %	1.1 %	774,945	903,460
2003	86.3 %	1.0 %	754,706	874,700

Legends:
🚩 Indicator has an unweighted denominator <30 and is not reportable
⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts: None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	33.9 %	2.4 %	135,449	399,780
2007	29.6 %	2.1 %	113,564	384,346
2003	28.2 %	1.8 %	109,824	389,319

Legends:
 Indicator has an unweighted denominator <30 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	32.0 %	0.2 %	11,760	36,807

Legends:
 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	27.2 %	1.5 %	42,060	154,860
2011	33.0 %	2.1 %	54,808	165,875
2009	30.2 %	1.5 %	50,920	168,736
2007	29.7 %	1.3 %	48,840	164,638
2005	30.9 %	1.6 %	51,137	165,310

Legends:
 Indicator has an unweighted denominator <100 and is not reportable
 Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts: None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts: None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	62.7 %	3.2 %	47,453	75,705
2012	61.0 %	3.9 %	47,372	77,629
2011	66.0 %	3.6 %	52,355	79,358
2010	49.2 %	3.3 %	39,522	80,259
2009	51.9 %	3.4 %	41,144	79,326

Legends:

- 📄 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts: None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 95% confidence interval half-width/estimate > 0.6
 ⚡ 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) - Female

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	54.8 %	4.4 %	68,542	125,027
2012	55.1 %	4.9 %	69,007	125,317
2011	49.8 %	5.1 %	61,992	124,522
2010	47.4 %	4.5 %	57,131	120,468
2009	40.1 %	4.4 %	48,223	120,228

Legends:
 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
 Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	45.2 %	3.8 %	59,763	132,160
2012	24.4 %	3.9 %	32,170	131,847
2011	8.9 %	2.5 %	11,735	131,649

Legends:
 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
 Estimates with 95% confidence interval half-widths > 10 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)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6
-  Estimates with 95% confidence interval half-widths > 10 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)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: Oklahoma

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	55.9	57.1	58.2	59.3	60.4

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	72.6	74.0	75.4	76.8	78.3

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	15.6	16.8	17.9	19.1	20.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	71.3	72.7	74.1	75.5	76.9

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	239.7	234.8	229.9	225.0	220.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.6	23.1	22.6	22.1	21.6

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.7	77.2	78.7	80.2	81.7

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	41.3	42.1	42.9	43.7	44.5

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	12.8	12.1	11.4	10.7	10.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	29.2	28.1	27.1	26.1	25.0

Form 10b
State Performance/Outcome Measure Detail Sheet
State: Oklahoma

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c
Evidence-Based or Informed Strategy Measure Detail Sheet
State: Oklahoma

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

**Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)**

State: Oklahoma

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	98.9	
Numerator	93	85	95	93	
Denominator	93	85	95	94	
Data Source	Screening and Special Services, OSDH				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	Source: Screening and Special Services, Oklahoma State Department of Health.
2.	Field Name:	2013
	Field Note:	Source: Screening and Special Services, Oklahoma State Department of Health.
3.	Field Name:	2012
	Field Note:	Source: Screening and Special Services, Oklahoma State Department of Health.
		Previous reporting for this measure has been revised to more accurately reflect the screening and follow-up practices of the state newborn screening program.
4.	Field Name:	2011

Field Note:

Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health. For reporting year 2011, data for 2010 are used as an estimate. Year 2011 are not available at this time.

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	61.5	70.5	71.3	72.0	72.7
Annual Indicator	69.9	69.9	69.9	69.9	
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
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Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	Field Name:	2013
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Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	Field Name:	2012
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Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	Field Name:	2011
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Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	51.2	46.5	47.0	47.4	47.9
Annual Indicator	46.1	46.1	46.1	46.1	
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
2.	Field Name:	2013
	Field Note:	For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
3.	Field Name:	2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	Field Name:	2011
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Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised downward due to recent estimates provided by CSHCN survey. Forecasted targets anticipate a 1% relative increase in the annual indicator.

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	66.8	59.6	60.2	60.8	61.4
Annual Indicator	59.3	59.3	59.3	59.3	
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
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Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	Field Name:	2013
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Field Note:

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	Field Name:	2012
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Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.

Field Name:

2011

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised downward due to recent estimates provided by CSHCN survey. Forecasted targets anticipate a 1% relative increase in the annual indicator.

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	94.0	66.3	67.0	67.6	68.3
Annual Indicator	65.7	65.7	65.7	65.7	
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	<p>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.</p> <p>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>
2.	Field Name:	2013
	Field Note:	<p>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.</p> <p>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>
3.	Field Name:	2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	Field Name:	2011
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Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised downward due to recent estimates provided by CSHCN survey. Forecasted targets anticipate a 1% relative increase in the annual indicator.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	48.0	40.9	41.3	41.7	42.1
Annual Indicator	40.5	40.5	40.5	40.5	
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	<p>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.</p> <p>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>
2.	Field Name:	2013
	Field Note:	<p>For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.</p> <p>All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.</p>
3.	Field Name:	2012

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	Field Name:	2011
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Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised to reflect targets that are more reasonable given recent surveillance data derived from CSHCN Survey.

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	72.1	73.0	79.9	68.6	70.0
Annual Indicator	72.8	67.3	72.3	72.3	
Numerator	38,468	35,585	38,250	38,250	
Denominator	52,841	52,875	52,926	52,926	
Data Source	National Immunization Survey & U.S. Census Bureau				
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

- Field Name:** 2014

Field Note:
Source: National Immunization Survey, 2013. Year 2014 data are not yet available. Reflects antigen series 4:3:1:4 plus full Hib series.
- Field Name:** 2013

Field Note:
Source: National Immunization Survey, 2013. Reflects antigen series 4:3:1:4 plus full Hib series.
- Field Name:** 2012

Field Note:
Source of data: Numerator is estimate from National Immunization Survey, Q1/2012-Q4/2012, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:4:FS vaccination series. Denominator is 2012 population estimate of 2 year olds obtained from the U.S. Bureau of the Census. 95% CI: 67.3% ± 7.7%.
- Field Name:** 2011

Field Note:
Source of data: Numerator is estimate from National Immunization Survey, Q1/2011-Q4/2011, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:* vaccination series.

Denominator is 2011 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

95% CI: 72.8% ± 6.7%.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	29.6	29.4	21.8	20.5	20.3
Annual Indicator	22.9	22.8	20.5	20.5	
Numerator	1,684	1,667	1,518	1,518	
Denominator	73,508	73,233	74,085	74,085	
Data Source	OSDH vital statistics & U.S. Census Bureau.				
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

- Field Name:** 2014

Field Note:
Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11MAY2015:11:51:50. Final data for 2014 are not yet available; therefore, 2013 is used as an estimate.
- Field Name:** 2013

Field Note:
Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11MAY2015:11:51:50.
- Field Name:** 2012

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, Vital Statistics 2012, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11 September 2013.
- Field Name:** 2011

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, Vital Statistics 2011, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11 September 2013.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	33.4	33.7	34.0	36.1	36.8
Annual Indicator	33.1	33.1	35.4	35.4	
Numerator					
Denominator					
Data Source	Oklahoma Oral Health Needs Assessment				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH. Assessment is conducted every 3 years with a next cycle to be available in 2016.
2.	Field Name:	2013
	Field Note:	Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH.
3.	Field Name:	2012
	Field Note:	Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH. Needs Assessment is completed on a schedule of every third year. As a result, data for 2010 are used as an estimate for 2012 reporting. New data for this measure are projected to be released in the fall of 2013.
4.	Field Name:	2011
	Field Note:	Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH. Needs Assessment is completed on a schedule of every third year. As a result, data for 2010 are used as an estimate for 2011 reporting.

Annual Performance Objectives have been revised in line with recent experience. Targets project a 10% growth by 2020 in the percentage of 3rd graders with a protective sealant on at least one molar.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	5.3	5.8	5.7	5.6	5.5
Annual Indicator	6.0	6.0	4.9	4.9	
Numerator	47	47	39	39	
Denominator	784,948	784,948	794,571	794,571	
Data Source	Vital records & U.S. Census Bureau				
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

- Field Name:** 2014

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 27 May 2015. Final data for year 2014 are not yet available; therefore, year 2013 is used as an estimate.
- Field Name:** 2013

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 27 May 2015.
- Field Name:** 2012

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, Vital Statistics 2011, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11 September 2013.

Data for year 2011 have been used as a provisional estimate for 2012 reporting due to questions about reliability of motor vehicle crash data for this year. Further review of data is ongoing and measure will be updated after assessment is completed.
- Field Name:** 2011

Field Note:

Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, Vital Statistics 2010, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11 September 2013.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	35.2	35.5	35.9	36.2	36.6
Annual Indicator	34.1	35.2	34.8	34.8	
Numerator	17,901	17,968	17,502	17,502	
Denominator	52,572	51,100	50,280	50,280	
Data Source	Oklahoma TOTS survey	Oklahoma TOTS survey	Oklahoma TOTS survey	Oklahoma TOTS survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
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Field Note:

Source: The Oklahoma Toddler Survey (TOTS), 2013. Final TOTS data for collection year 2014 are not available. Year 2013 data are used as an estimate.

2.	Field Name:	2013
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Field Note:

Source: The Oklahoma Toddler Survey (TOTS), 2013.

3.	Field Name:	2012
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Field Note:

Source: The Oklahoma Toddler Survey (TOTS), 2012.

Denominator reflects the enumeration of Oklahoma live births from the preliminary 2012 birth dataset. This count is subject to change pending finalization of the registration process and closeout of the annual dataset.

4.	Field Name:	2011
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Field Note:

Source: The Oklahoma Toddler Survey (TOTS), 2011.

Annual performance objectives have been revised, based on recent reporting experience, to project a 10% increase by year 2020.

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	99.1	99.0	99.0	99.0	
Numerator	50,616	51,010	51,613	51,613	
Denominator	51,075	51,502	52,149	52,149	
Data Source	Screening and Special Services, OSDH				
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	Source: Data were obtained from Screening and Special Services, Oklahoma State Department of Health. Data are not yet available for 2014; therefore, 2013 data are used as a provisional estimate. Not all infants were screened for hearing loss due to parental refusal and at home deliveries.
2.	Field Name:	2013
	Field Note:	Source: Data were obtained from Screening and Special Services, Oklahoma State Department of Health. Not all infants were screened for hearing loss due to parental refusal and at home deliveries.
3.	Field Name:	2012
	Field Note:	Source: Data were obtained from Screening and Special Services, Oklahoma State Department of Health. Data are not yet available for 2012; therefore, 2011 data are used as a provisional estimate. Data previously reported for 2011 have been revised to reflect final data for that year. Not all infants were screened for hearing loss due to parental refusal and at home deliveries.
4.	Field Name:	2011

Field Note:

Source: Data were obtained from Screening and Special Services, OSDH. Data are not yet available for 2011, hence 2010 data are used as a provisional estimate.

Due to the nature of hearing loss diagnosis, CDC requires that states report one year from the end of the birth year. Therefore, Oklahoma 2011 data will not be available until 2013. That allows time for families to follow-up, audiologists to complete several appointments if needed to obtain diagnosis, and placement in early intervention services as suggested by the CDC/Healthy People goals.

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	12.3	11.7	10.4	9.7	9.6
Annual Indicator	11.4	10.7	10.6	10.6	
Numerator	110,603	104,155	104,214	104,214	
Denominator	972,775	972,807	980,187	980,187	
Data Source	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

- Field Name:** 2014

Field Note:
Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2013. Data for year 2014 are not yet available. Estimate for 2013 used as a provisional estimate until more recent data are released.
- Field Name:** 2013

Field Note:
Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2013.
- Field Name:** 2012

Field Note:
Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2012
- Field Name:** 2011

Field Note:
Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2011

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	20.6	20.6	29.2	24.6	24.3
Annual Indicator	29.1	29.5	24.8	29.1	
Numerator	15,003	14,416	10,760	12,446	
Denominator	51,591	48,852	43,387	42,826	
Data Source	Oklahoma WIC	Oklahoma WIC	Oklahoma WIC	Oklahoma WIC	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
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Field Note:

Source: WIC Service, Oklahoma State Department of Health, 2014.

2.	Field Name:	2013
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Field Note:

Source: WIC Service, Oklahoma State Department of Health, 2013.

3.	Field Name:	2012
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Field Note:

Source: WIC Service, Oklahoma State Department of Health, 2012.

Reporting for 2010 and 2011 has been updated to reflect the most recent data available for those years. This results in a higher prevalence of children with a BMI equal to or greater than 85th percentile of the age-gender specific distribution than originally reported.

Targets for years 2013 to 2017 have been revised due to 2012 reporting. Previous targets were unreasonable given magnitude of estimate.

4.	Field Name:	2011
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Field Note:

Source: 2010 Oklahoma WIC data. Year 2011 not yet available; therefore, 2010 data have used to provide an estimate.

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	18.3	18.1	17.9	17.7	17.5
Annual Indicator	18.0	18.0	12.0	12.0	
Numerator	8,934	8,934	6,010	6,010	
Denominator	49,550	49,550	50,208	50,208	
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
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Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for years 2013 and 2014 are not yet available; therefore, 2012 data are used to provide an estimate for reporting.

2.	Field Name:	2013
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Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2013 are not yet available; therefore, 2012 data are used to provide an estimate for reporting.

3.	Field Name:	2012
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Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2012 are not yet available; therefore, 2011 data are used to provide an estimate for reporting.

Data previously reported for year 2011 have been updated to reflect final release of PRAMS 2011 data.

4.	Field Name:	2011
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Field Note:

Source: 2010 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS).

Data for year 2011 have not been released to date, hence PRAMS survey data for 2010 have been used to provide an estimate for this measure.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.4	12.7	8.1	8.0
Annual Indicator	12.7	16.0	13.3	13.3	
Numerator	33	41	34	34	
Denominator	260,328	255,540	256,391	256,391	
Data Source	Vital Records & U.S. Census Bureau				
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

- Field Name:** 2014

Field Note:
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 27MAY2015:15:56:34. Final data for year 2014 are not yet available. Year 2013 is used as an estimate.
- Field Name:** 2013

Field Note:
Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 27MAY2015:15:56:34.
- Field Name:** 2012

Field Note:
Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2012, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11SEP2013:14:45:23.

Targets for years 2013-2017 have been revised.
- Field Name:** 2011

Field Note:
Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2011, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11SEP2013:14:45:23.

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	82.5	83.0	83.5	85.3	86.2
Annual Indicator	76.1	81.2	81.9	81.9	
Numerator	522	537	534	534	
Denominator	686	661	652	652	
Data Source	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
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Field Note:

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division, 2013. Final data for year 2014 are not yet available. Year 2013 is used as a provisional estimate.

2.	Field Name:	2013
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Field Note:

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division, 2013.

3.	Field Name:	2012
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Field Note:

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division, 2012.

4.	Field Name:	2011
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Field Note:

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division, 2011.

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	77.5	78.0	69.7	71.1	72.5
Annual Indicator	66.3	68.3	68.5	68.5	
Numerator	31,307	32,559	32,228	32,228	
Denominator	47,234	47,695	47,082	47,082	
Data Source	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	Field Name:	2014
	Field Note:	Suggested Citation: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at http://www.health.ok.gov/ok2share on 27MAY2015:16:02:59. Final data for year 2014 are not yet available; therefore, 2013 is used as an estimate. Data for Prenatal Care after 2009 & before 2009 should not be compared due to the changes of how the information is derived
2.	Field Name:	2013
	Field Note:	Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2013, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at http://www.health.ok.gov/ok2share on 27MAY2015:16:02:59. Data for Prenatal Care after 2009 & before 2009 should not be compared due to the changes of how the information is derived
3.	Field Name:	2012

Field Note:

Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2012, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11SEP2013:14:45:23.

Targets for years 2013-2017 have been revised based on reporting of data for 2012.

It should be noted that Oklahoma implemented the 2003 Revision of the Live Birth Certificate in 2009. This revision captures the date of first prenatal care visit differently than did the 1989 Revision of the Live Birth Certificate. While the previous birth certificate captured the month of the pregnancy in which care was initiated, the current birth certificate captures the date (mm/dd/yyyy) of initiation. It is believed that this has fundamentally altered the measurement of this health indicator and, as a result, makes data from the two separate certificates non-comparable. With the change in measurement, it appears that Oklahoma has experienced a sharp drop off in the rate of first trimester entry into prenatal care for women having a live birth. While a decline is possible, the magnitude shown here is unrealistic given previous experience. This artifactual decline cannot be properly addressed with the way data are reported on Form 11.

4.	Field Name:	2011
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Field Note:

Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2011, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE). Accessed at <http://www.health.ok.gov/ok2share> on 11SEP2013:14:45:23.

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Oklahoma

SPM 1 - The percentage of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.

	2011	2012	2013	2014	2015
Annual Objective	47.2	45.1	44.6	44.2	43.7
Annual Indicator	46.5	46.5	51.3	51.3	
Numerator	23,075	23,075	25,730	25,730	
Denominator	49,616	49,616	50,130	50,130	
Data Source	Oklahoma PRAMS	Oklahoma PRAMS	Oklahoma PRAMS	Oklahoma PRAMS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2014
	Field Note:	Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2013 and 2014 are not available at this time; therefore, 2012 data are used as provisional estimate. NOTE: With the 2012 PRAMS collection cycle, the pregnancy intention question was modified. The response options were changed to allow for a response of 'I don't know'. Strictly speaking, data prior to 2012 are not comparable to those for 2012 and beyond. Any interpretation based on the differences between the two collection periods should be viewed cautiously and used only generally and not as a definitive finding about any change in the intention of pregnancy among Oklahoma women.
2.	Field Name:	2013
	Field Note:	Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2013 are not available at this time; therefore, 2012 data are used as provisional estimate. NOTE: With the 2012 PRAMS collection cycle, the pregnancy intention question was modified. The response options were changed to allow for a response of 'I don't know'. Strictly speaking, data prior to 2012 are not comparable to those for 2012 and beyond. Any interpretation based on the differences between the two collection periods should be viewed cautiously and used only generally and not as a definitive finding about any change in the intention of pregnancy among Oklahoma women.
3.	Field Name:	2012

Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2012 are not available at this time; therefore, 2011 data are used as provisional estimate.

Data previously reported for year 2011 have been updated to reflect final release of PRAMS 2011 data.

4.

Field Name:

2011

Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2010. Data for year 2011 are not available at this time, hence 2010 data are used as provisional estimate.

Annual Performance Objectives for SPM#1 have been revised downward given recent PRAMS survey estimates. Forecasted targets through year 2016 anticipate an annual 1% relative decrease.

Data Alerts: None

SPM 2 - The number of families with a child with special health care needs receiving respite care provided through the CSHCN program.

	2011	2012	2013	2014	2015
Annual Objective	80.0	85.0	90.0	95.0	100.0
Annual Indicator	75.0	75.0	68.0	71.0	
Numerator					
Denominator					
Data Source	CSHCN Program, OK Dept of Human Services				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

- Field Name:** 2014

Field Note:
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services (OKDHS).
- Field Name:** 2013

Field Note:
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services (OKDHS).
- Field Name:** 2012

Field Note:
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services (OKDHS). Data are not available regarding number of vouchers processed because of transition to a different agency responsible for keeping data. Reporting authority was not aware that separate numbers must be kept based on age demographics.

Data for 2011 repeated as an estimate for year 2012.
- Field Name:** 2011

Field Note:
Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Data Alerts: None

SPM 3 - The percentage of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution)

	2011	2012	2013	2014	2015
Annual Objective	28.7	32.5	32.0	26.9	26.7
Annual Indicator	33.0	33.0	27.2	27.2	
Numerator	54,808	54,808	42,060	42,060	
Denominator	165,875	165,875	154,860	154,860	
Data Source	YRBS & OK State Department of Education	YRBS & OK State Department of Education	YRBS	YRBS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

- Field Name:** 2014

Field Note:
Source: Youth Risk Behavior Survey, 2013. YRBS conducted in the spring school semester of odd-numbered years. For year 2014 reporting, 2013 data are used as an estimate.
- Field Name:** 2013

Field Note:
Source: Numerator derived from 2013 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted total who gave height and weight measurements.
- Field Name:** 2012

Field Note:
Source: Numerator derived from 2011 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted total who gave height and weight measurements.

The YRBS is conducted bi-ennially in odd-numbered years. The next release of statewide data will be for 2013.
- Field Name:** 2011

Field Note:
Source: Numerator derived from 2011 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted total who gave height and weight measurements.

Annual performance objectives have been revised to reflect recent reporting experience. Forecasted targets anticipate a 10% reduction by year 2020.

Data Alerts: None

SPM 4 - The percentage of children with special health care needs who receive child care services at licensed child care facilities and homes.

	2011	2012	2013	2014	2015
Annual Objective	4.0	5.0	6.0	7.0	8.0
Annual Indicator	3.4	3.9	4.5	4.3	
Numerator	1,389	1,321	1,500	1,564	
Denominator	40,517	34,004	32,995	36,371	
Data Source	CSHCN Program, OKDHS	CSHCN Program, OKDHS	CSHCN Program, OKDHS	CSHCN Program, OKDHS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2014
	Field Note:	Source: CSHCN Program, OKDHS. Numerator – Number of CSHCN receiving child care subsidy through OKDHS (as reported by Family Support Services Division) Denominator – Number of children in licensed child care facilities receiving child care subsidy (as reported by the Oklahoma Child Care Resource and Referral Association)
2.	Field Name:	2013
	Field Note:	Source: CSHCN Program, OKDHS. Numerator – Number of CSHCN receiving child care subsidy through OKDHS (as reported by Family Support Services Division) Denominator – Number of children in licensed child care facilities receiving child care subsidy (as reported by the Oklahoma Child Care Resource and Referral Association)
3.	Field Name:	2012
	Field Note:	Source: CSHCN Program, OKDHS. Numerator – Number of CSHCN receiving child care subsidy through OKDHS (as reported by Family Support Services Division) Denominator – Number of children in licensed child care facilities receiving child care subsidy (as reported by the Oklahoma Child Care Resource and Referral Association)
4.	Field Name:	2011

Field Note:

Source: CSHCN Program, OKDHS.

Numerator – Number of CSHCN receiving child care subsidy through OKDHS (as reported by Family Support Services Division)

Denominator – Number of children in licensed child care facilities receiving child care subsidy (as reported by the Oklahoma Child Care Resource and Referral Association)

It is intended that this measure show all Oklahoma children rather than be restricted to those children receiving a child care subsidy through OKDHS. However, at this time, data are not available to report in this manner. As a result, Oklahoma is reporting on only those children receiving a child care subsidy. Efforts continue to be made to develop a source of data for this measure as it was intended to be reported.

Data Alerts: None

SPM 5 - The percentage of women receiving quality [American College of Obstetrics and Gynecology (ACOG) standards] preconception care.

	2011	2012	2013	2014	2015
Annual Objective			0.0	0.0	0.0
Annual Indicator	0.0	0.0	0.0	0.0	
Numerator	0	0	0	0	
Denominator	52,252	52,740	52,740	52,740	
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

- Field Name:** 2015

Field Note:
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data reflect the percentage of women with a recent live birth who have received quality preconception care as defined by the American Congress of Obstetricians and Gynecologists (ACOG). The ACOG criteria incorporates 17 items reflecting standards of practice deemed adequate for the provision of preconception care. No targets have been set at this time.
- Field Name:** 2014

Field Note:
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data reflect the percentage of women with a recent live birth who have received quality preconception care as defined by the American Congress of Obstetricians and Gynecologists (ACOG). The ACOG criteria incorporates 17 items reflecting standards of practice deemed adequate for the provision of preconception care. No data are available to report for this measure. No targets have been set at this time.
- Field Name:** 2013

Field Note:
Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data reflect the percentage of women with a recent live birth who have received quality preconception care as defined by the American Congress of Obstetricians and Gynecologists (ACOG). The ACOG criteria incorporates 17 items reflecting standards of practice deemed adequate for the provision of preconception care. No data are available to report for this measure. No targets have been set at this time.
- Field Name:** 2012

Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data reflect the percentage of women with a recent live birth who have received quality preconception care as defined by the American Congress of Obstetricians and Gynecologists (ACOG). The ACOG criteria incorporates 17 items reflecting standards of practice deemed adequate for the provision of preconception care.

No targets have been set at this time.

5.	Field Name:	2011
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Field Note:

No data are yet available to report for this measure. Data are collected by using a supplementary insert in the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Oklahoma began collecting baseline preconception data with the June 2010 PRAMS batch.

Expected availability of the preconception care (PCC) data from the 2010 collection cycle, originally anticipated for spring 2012, has been pushed back so that MCH analysts can aggregate these data with those from the 2011 cycle. This was done with a mind towards improving reliability and robustness of PCC data estimates. Preliminary analyses of 2010 data show that few Oklahoma females receive the full range of PCC as prescribed by ACOG standards. Small cell sizes limit the extent to which data can be interpreted and generalized. Combined 2010 and 2011 PRAMS PCC data should be available for reporting in early 2013. A full year of PCC data will be available with the final release of 2012 PRAMS data in year 2014.

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2011 SPM# 5. Please review your data to ensure this is correct.
2.	A value of zero has been entered for the numerator for year 2012 SPM# 5. Please review your data to ensure this is correct.
3.	A value of zero has been entered for the numerator for year 2013 SPM# 5. Please review your data to ensure this is correct
4.	A value of zero has been entered for the numerator for year 2014 SPM# 5. Please review your data to ensure this is correct.

SPM 6 - The percentage of infants who are put to sleep on their backs.

	2011	2012	2013	2014	2015
Annual Objective	65.5	67.0	70.5	71.3	72.0
Annual Indicator	69.9	69.9	72.6	72.6	
Numerator	34,186	34,186	35,336	35,336	
Denominator	48,930	48,930	48,650	48,650	
Data Source	Pregnancy Risk Assessment Monitoring System				
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2014
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Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data for year 2013 and 2014 are not yet available; therefore, 2012 data are used as provisional estimate.

2.	Field Name:	2013
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Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data for year 2013 are not yet available; therefore, 2012 data are used as provisional estimate.

3.	Field Name:	2012
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Field Note:

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data for year 2012 are not yet available; therefore, 2011 data are used as provisional estimate. Targets for years 2013-2017 have been revised upward based on reporting for 2011. Data previously reported for year 2011 have been revised to reflect final release of PRAMS 2011 data.

4.	Field Name:	2011
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Field Note:

Source: 2010 Oklahoma PRAMS. PRAMS data for year 2011 are not yet available, hence 2010 used as provisional estimate.

Annual Performance Objectives have been revised upward to reflect recent surveillance experience. Forecasted targets to 2016 anticipate a 1% relative growth per year.

Data Alerts: None

SPM 7 - The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.

	2011	2012	2013	2014	2015
Annual Objective	19.0	19.0	20.0	20.0	21.0
Annual Indicator	18.0	19.0	20.0	20.0	
Numerator					
Denominator					
Data Source	MCH Assessment, OSDH	MCH Assessment, OSDH	MCH Assessment, OSDH	MCH Assessment, OSDH	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2014
	Field Note:	Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A-B.
2.	Field Name:	2013
	Field Note:	Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A-B.
3.	Field Name:	2012
	Field Note:	Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A-B.
4.	Field Name:	2011
	Field Note:	Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A-B.

Data Alerts: None

SPM 8 - The percentage of Medicaid eligible children with special health care needs who report receiving dental services other than for routine dental care.

	2011	2012	2013	2014	2015
Annual Objective	6.8	5.9	6.2	6.3	6.3
Annual Indicator	5.8	6.2	5.2	4.6	
Numerator	1,556	1,533	1,432	1,321	
Denominator	26,624	24,732	27,621	28,748	
Data Source	OHCA & CSHCN Program				
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2014
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Field Note:

Source: Oklahoma Health Care Authority and the CSHCN Program, Oklahoma Department of Human Services.

2.	Field Name:	2013
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Field Note:

Source: Oklahoma Health Care Authority and the CSHCN Program, Oklahoma Department of Human Services.

3.	Field Name:	2012
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Field Note:

Source: Oklahoma Health Care Authority and the CSHCN Program, Oklahoma Department of Human Services.

4.	Field Name:	2011
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Field Note:

Source: Oklahoma Health Care Authority and the CSHCN Program.

Annual Performance Objectives for this measure have been revised downward based on recent reporting experience. Forecasted targets out to 2016 anticipate a 1% relative increase year on year.

Data Alerts: None

SPM 9 - The percent of adolescents grades 9-12 smoking tobacco products

	2011	2012	2013	2014	2015
Annual Objective	22.1	22.4	22.2	18.3	18.1
Annual Indicator	22.7	22.7	18.5	18.5	
Numerator	38,913	38,913	31,072	31,072	
Denominator	171,422	171,422	167,993	167,993	
Data Source	YRBS	YRBS	YRBS	YRBS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	Field Name:	2014
	Field Note:	Source: Numerator derived from 2013 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS. YRBS conducted in spring school semester of odd-numbered years. For year 2014, data for 2013 are used as an estimate. Data reflect cigarette smoking only.
2.	Field Name:	2013
	Field Note:	Source: Numerator derived from 2013 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS. Data reflect cigarette smoking only.
3.	Field Name:	2012
	Field Note:	Source: Numerator derived from 2011 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS. Data reflect cigarette smoking only. The YRBS is conducted bi-ennially in odd-numbered years. The next release of statewide Oklahoma YRBS data will reflect 2013.
4.	Field Name:	2011

Field Note:

Source: Numerator derived from 2011 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS.

Data reflect cigarette smoking only.

Annual Performance Objectives have been revised upward to be more in line with recent YRBS survey estimates. Forecasted targets to 2016 anticipate a relative decrease of 1% per year.

Data Alerts: None

SPM 10 - The percent of live singleton births delivered before 39 completed weeks of gestation.

	2011	2012	2013	2014	2015
Annual Objective		42.2	37.0	36.0	34.9
Annual Indicator	40.3	38.6	38.3	38.3	
Numerator	20,380	19,695	19,596	19,596	
Denominator	50,609	51,011	51,139	51,139	
Data Source	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

- Field Name:** 2014

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, 2013. Final data for 2014 are not yet available. Year 2013 is used as a provisional estimate.
- Field Name:** 2013

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, 2013.
- Field Name:** 2012

Field Note:
SOURCE: Health Care Information, Oklahoma State Department of Health, 2012. Targets for years 2013-2017 have been revised.
- Field Name:** 2011

Field Note:
Source: Oklahoma State Department of Health, Center for Health Statistics, Health Care Information, 2011.

Data Alerts: None

Form 11
Other State Data
State: Oklahoma

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Oklahoma

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)